CCS Policy/Procedures
Client Records
DHS 36.07 (5) (a)/36.18

Policy Statement: The CCS program will maintain a service record for each client that will be protected and confidential and will meet the requirements under HIPAA, s. 51.30, Stats., 42 CFR Part 2, and DHS 92. Electronic records will also conform to HIPAA requirements of 45 CFR 164, Subpart C. This policy will ensure that there is effective and consistent information storage and retrieval and that records are maintained in a safe and secure manner.

Discussion and Procedures:

1. The CCS Administrator will be responsible for the maintenance and security of service records.

2. Client records will be maintained in a secure online electronic records system.

3. The record will include information that is sufficiently detailed so that anyone not familiar with the client would be able to identify the types of services received. Documentation will be specific and objective and will adequately explain the reasons for the conclusions and decisions made regarding the client.

4. Service records will include:
    a. The comprehensive assessment, including diagnosis and the assessment summary;
    b. Service plans and updates, including attendance rosters from service planning meetings;
    c. Authorization of services;
    d. Any request by the client for a change in services or service provider and the response of the CCS
    e. Service delivery information, including:
        i. Service facilitation notes and progress notes
        ii. Records of referrals to outside resources
        iii. Significant events related to plan and help with overall understanding of client's level and quality of functioning
        iv. Evidence of progress, response to services, changes in client's condition and changes in services provided
        v. Observation of changes in activity level or in physical, cognitive, or emotional status and details of any related referrals
        vi. Consultation or case conference notes
        vii. Service provider notes in accordance with standard professional documentation practices
        viii. Reports of treatment, or other activities from outside resources that may be influential in CCS service planning

f. A list of current prescription medication and regularly taken over the counter medications. Documentation of each prescribed medication shall include all of the following:
    i. Name of the medication and dosage
    ii. Route of administration
    iii. Frequency
    iv. Duration, including the date the medication is to be stopped
    v. Intended purpose
    vi. Name of the prescriber. The signature of the prescriber is also required if the CCS prescribes medication as a service
    vii. Activities related to medication monitoring including monitoring for desired responses and possible adverse drug reactions, as well as an assessment of the client's ability to self-administer medication
    viii. If medication is administered by CCS staff (physician, nurse, or practitioner only) documentation on the individual medication administration record shall include:
        1. Time of administration
        2. Name of staff administering medication
        3. Observation of adverse drug reactions
        4. Date and time prescribing physician was notified of adverse drug reaction observations
        5. Medications missed or refused and reason

g. Informed Consents for medications prescribed by the CCS

h. Discharge summary and other information

i. Legal documents related to commitment, guardianship and advanced directives, as well as signed Releases of Information will be immediately available upon request