

<b>Chapter:</b>	Service Delivery		
<b>Title:</b>	Case Record Organization & Maintenance		
<b>Policy:</b> <input checked="" type="checkbox"/> <b>Procedure:</b> <input type="checkbox"/>	<b>Review Cycle:</b> Triennial  <b>Author:</b> Service/Treatment Leadership	<b>Adopted Date:</b> 10.2023  <b>Review Date:</b> 10.2023	<b>Related Policies:</b> <a href="#">Document Retention &amp; Destruction</a> <a href="#">Confidentiality and Privacy</a>

**Purpose:**

Hopeful Horizons (HH) has adopted this policy to establish standard expectations and guidelines for case records of individuals engaged in service/treatment.

**Scope:**

This policy applies to

- All HH Staff                       Selected HH Staff, as specified: Service/Treatment Staff
- HH Board Members               HH Volunteers: Service/Treatment Volunteers
- Other: Service/Treatment Contractors

**Policy:**

A case record shall be maintained for each individual served by HH. Records are retained in hard copy and electronically using an Electronic Client Record (ECR). Case records contain Protected Health Information (PHI) and Electronic Protected Health Information (EPHI) and consist of confidential and sensitive personally identifying and health information. Consistent with federal and state law and HHs' policies and procedures, confidentiality and disclosure requirements apply to all client records.

- A. Minimum Case Record Content: Each service/treatment program shall establish clear procedures for case record organization and maintenance that includes the following:
- Sufficient information to identify the person served
  - Sufficient information to support the need for services and to identify services provided directly or by referral
  - Assessments
  - Treatment plan/goals
  - Treatment monitoring/progress notes
  - Signed consent for treatment
  - Information release forms (as appropriate)
  - Routine documentation for on-going treatment/services (e.g., progress notes, periodic reviews, etc.)
  - Recommendations for ongoing and/or future service needs and referrals
  - Case/discharge summary and aftercare plan (if applicable) and completed within thirty days of case closing
  - When indicated for treatment/service needs, the case record contains medical and legal information
  - Other information may be contained in the case record as appropriate and necessary for the care and treatment of the individual

- B. **Case Record Entries:** Case record entries are to be made by authorized personnel and are specific, factual, and pertinent to the nature of the service/treatment and the needs/preferences of the persons served. All entries in the case record must be:
- Entered within twenty-four (24) business hours of the service/treatment provided
  - Written in blue or black ink (or typed)
  - Complete
  - Signed and dated by the person who provided the service and/or made the entry
  - Signed and dated by the clinical supervisor when appropriate
  - Credentialed (when appropriate)
  - Legible (when hand-written)
  - As required by HH policy and/or department procedure, staff must maintain documentation in the electronic client record (ECR). Children's Advocacy Center (CAC) staff shall maintain all client records in the ECR or in designated electronic spreadsheets. Where paper records are created/retained, general practice should be that they are scanned to the ECR unless otherwise prohibited by policy or procedure.
- C. **Record Access:** Access to the case records is limited to:
- Authorized HH personnel on a "need to know" basis
  - Others outside of the organization whose access is permitted with the appropriate signed release of information and consent of the client or as required by law
  - The individual served and, as appropriate, the parent, or legal guardian of the individual served.
- D. **Case Review:** Clients may review and, when desired, add a statement to their files in accordance with HH policies and procedures, and:
- The review shall be conducted in the presence of HH personnel on the organization's premises
  - Reviews shall be carried out in a manner that protects the confidentiality of family members and others whose information may be contained in the record
  - Any HHs' personnel response(s) to client's additions shall be added with the client's knowledge
  - The client is given the opportunity to review and comment on HHs' personnel response(s)

Pursuant to South Carolina Law, HH may limit release of case record information to a client/their legal guardian if:

1. If the specified information in the record was provided by a third party under assurance that the information remains confidential; or
2. If the treating professional determines, in writing, that the excluded information is detrimental to the client's treatment regimen. The determination must be placed in the patient's records and must be considered part of the restricted information.

**Communication and Training:**

The Board shall receive a copy of the policy at the time of periodic review and will have an opportunity to ask clarifying questions during the approval process. Employees and volunteers shall receive notice of the Board's policy review and approval including notice of any substantive changes. The notice will provide a link to the policy located on the HH website.

Staff involved in service delivery shall have initial departmental orientation on this policy, its related procedure(s) and forms.

**Definitions:**

1. **Confidential Information:** Includes any written or spoken information shared in confidence between a service participant and a HH service provider in the course of that relationship, which includes any information that might identify the location or identity of someone who has sought services. Confidential communication includes all information received by the service participant and any advice, report, or working paper given or made by the service provider. Any and all knowledge, advice, records, logs, client and organizational records, or working papers (including electronically maintained records relating to a service participant) are confidential and are not to be shared with a third party. Communications are confidential even if the service participant shares the information with third parties, who are working to further the interest of the service participant, in the presence of the counselor/advocate. Confidential documents received from other agencies (for which a service participant had to execute a written release) are confidential and part of the scope of confidential communications.
2. **Electronic Client Record:** An ECR is a digital version of a client's paper record. ECRs are real-time, client-centered records that make information available instantly and securely to authorized users. HHS' uses Collaborate as its ECR.
3. **Need to Know:** A criterion used in service/treatment confidentiality that requires the custodian of confidential or private information to establish, prior to disclosure to another HH employee, that the intended recipient must have access to protected client information to perform his or her official duties as an employee of HH.
4. **Personally Identifying Information:** Information about an individual that may directly or indirectly identify that individual. In the case of a victim of domestic violence, dating violence, sexual assault, or stalking, it also means information that would disclose the location of that individual. Personally identifying information includes information such as an individual's name, address, other contact information, and social security number, but it also can include information such as an individual's race, birth date, or number of children if, in the particular circumstances, that information would identify the individual. Personally identifying information also may include information that is encoded, encrypted, hashed, or otherwise protected.
5. **Protected Health Information:** Individually identifiable health information is information, including demographic data, that relates to:
  - a. the individual's past, present or future physical or mental health or condition,
  - b. the provision of health care to the individual, or
  - c. the past, present, or future payment for the provision of health care to the individual, and
  - d. that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

**Other Related Materials:**

Release of Confidential Information Procedure

Responding to Subpoena, Search Warrant and Privileged Communications Procedure

**References/Legal Authority:**

[Case Records Standards, Council on Accreditation, 2023.](#)

[South Carolina Code of Laws, Title 44 – Health, Section 44-22-110. Access to medical records; appeal of denial of access, 2022.](#)

**Change Log:**

Date of Change	Description of Change	Responsible Party
10.2023	This is a New Policy	N. Miller Prog. Eval. Consultant in consultation with Treatment and Service Program Leadership