ORDER AND CONTENT OF CLINICAL FILES – CRT-I-1

POLICY:

All people who are receiving and/or who have received services from the Community Resource Team shall have a complete file of required documentation. Thunder Bay Regional Health Science – Forensic partnership are excluded from this as documentation in that setting is completed as specified by the Manager of TBRHSC – Forensic Unit.

PURPOSE:

The purpose of the clinical file is to document services in a recognizable form in order to ensure the continuity and quality of service, to establish accountability for and evidence of the services rendered, and to enable the evaluation of service quality.

PROCEDURE:

Each section appears in the person's file in the following order:

- Person Summary
- Referral/Intake information
- Clinical Notes
- Assessments/Consultation Reports
- Correspondence/Consents
- Discharge/closure report

1. Person Summary
   - This section shall be completed by the assigned employee following acceptance and provision for service. The process will be started at Intake.
   - Subsequent changes or additions to the person summary shall be updated by the assigned clinician.

2. Referral and Intake:
   - Each individual shall have a completed referral on file requesting service from the Community Resource Team.

3. Clinical Notes:
   - There shall be a minimum of monthly recordings completed regarding services provided to people who are actively receiving services. If monthly contact cannot be made then a note to explain why is to be documented.

- These notes should reflect actions taken by the assigned clinician, goals, objectives, progress and future goals of the referred person.

- When the service is no longer required by the person and/or the file is closed for other reasons, the assigned clinician will note the reason for closure in the file.

4. Assessments/ Reports/ Consultations:
   - People requiring assessment shall have a completed assessment on file.
   - All consultation reports with other service providers shall be contained in the file. These include case summaries, progress notes and closed summaries.

5. Correspondence and Consents:
   - All people receiving services from the Community Resource Team shall have a signed consent form for service.
   - Any disclosures, transmittal or examination of a clinical record shall have a completed release of information form on file signed either by the referred person, substitute decision maker or their guardian.
   - Correspondence includes letters, quotes, ADP forms, faxes and emails.

6. Discharge/Closure Report:
   - All people receiving services from the Community Resource Team shall have a discharge/closure report on file when services are no longer required.
   - The reason for discharge/closure shall be articulated in the report i.e. services no longer required, death of the person, service declined, etc.

RECOMMENDED BY: Community Resource Team **APPENDICES:** 0

OPERATIONAL ACCOUNTABILITY: Community Resource Team, Administration

ORIGINAL POLICY DATE: July 2007

AUTHORIZED BY: Executive Director **SIGNATURE:**