Clinical Records Compliance

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In order to be in compliance with CAHC's Standard V, clinical records for all clients should contain, at minimum:

- Intake and Job Order
- Health Care Provider's Orders (CBSN)
- Certification of Need for Services (Medicaid)
- Date of Service initiated (SOC)
- Advance Directive
- Service Agreement
- Client Bill of Rights
- Consumer Guide to Home Care
- Initial Assessment
- Medication Profile & Medication Administration Record (CBSN)
- Plan of Care (CPCS), Nursing Plan of Care (CBSN)
- Discharge Planning
- Orientation to the Case for each aide/Field Nurse
- Clinical supervision of Field Staff
- Case monitoring notes/30-day Telephone Calls
- Weekly Activity Sheets (CPCS), Nursing Progress Notes (CBSN)
- Reassessments as necessary
- Discharge Summary, if applicable

The following must always remain in active clinical files:

- Date service initiated
- Intake and Job Order
- Initial Assessment
- Discharge Planning
- Service Agreement
- Advance Directive
- Client Bill of Rights

The following must be accessible to the surveyor for at least the most recent 12 months:

- CBSN: Health Care Provider's Orders
- Certification of Need for Services, if applicable
- Plan of Care/Nursing Plan of Care
- CBSN: Medication Profile/Medication Administration Record
- Orientation to the Case
- Weekly Activity Sheets (CPCS), Nursing Progress Notes (CBSN)
- Case Monitoring/30-day Telephone Calls
- Clinical Supervision
- Reassessments
- Discharge Summary

Helpful Tip:

Use a tab system or file folder to organize client files so clinical documents are easier to find!
Clinical documents should be arranged in the same order in all client folders.