

Documentation Standards for Client Records

The documentation standards are described below under key topics related to client care. All standards shall be addressed in the client record; however, there is no requirement that the record have a specific document or section addressing these topics.

A. Assessments

1. The following areas shall be included as appropriate as part of a comprehensive client record.
 - Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.
 - Presenting problems and relevant conditions affecting the client's physical health and mental health status shall be documented, for example: living situation, daily activities, and social support.
 - Documentation shall describe client strengths in achieving client plan goals.
 - Special status situations that present a risk to client or others shall be prominently documented and updated as appropriate.
 - Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
 - Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.
 - A mental health history shall be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
 - For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.
 - Documentation shall include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs.
 - A relevant mental status examination shall be documented.
 - A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.
2. Timeliness/Frequency Standard for Assessment
 - The MHP shall establish standards for timeliness and frequency for the above-mentioned elements.

B. Client Plans

1. Client Plans shall:
 - have specific observable and/or specific quantifiable goals

- identify the proposed type(s) of intervention
- have a proposed duration of intervention(s)
- be signed (or electronic equivalent) by:
 - the person providing the service(s), or
 - a person representing a team or program providing services, or
 - a person representing the MHP providing services
 - when the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category,
 - a physician
 - a licensed/"waivered" psychologist
 - a licensed/registered/waivered social worker
 - a licensed/registered/waivered marriage and family therapist or
 - a registered nurse
- In addition,
 - client plans shall be consistent with the diagnoses, and the focus of intervention shall be consistent with the client plan goals, and there shall be documentation of the client's participation in and agreement with the plan. Examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.
 - client signature on the plan shall be used as the means by which the MHP documents the participation of the client
 - when the client is a long term client as defined by the MHP, and
 - the client is receiving more than one type of service from the MHP
 - when the client's signature is required on the client plan and the client refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability
 - the MHP shall give a copy of the client plan to the client on request

2. Timeliness/Frequency of Client Plan:

- Shall be updated at least annually.
- The MHP shall establish standards for timeliness and frequency for the individual elements of the client plan described in item 1

C. Progress Notes

1. Items that shall be contained in the client record related to the client's progress in treatment include:

- The client record shall provide timely documentation of relevant aspects of client care
- Mental health staff/practitioners shall use client records to document client encounters, including relevant clinical decisions and interventions

- All entries in the client record shall include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable
- All entries shall include the date services were provided
- The record shall be legible
- The client record shall document referrals to community resources and other agencies, when appropriate
- The client record shall document follow-up care, or as appropriate, a discharge summary

2. Timeliness/Frequency of Progress Notes:

Progress notes shall be documented at the frequency by type of service indicated below:

a. Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b. Daily

- Crisis Residential
- Crisis Stabilization (1x/23hr)
- Day Treatment Intensive

c. Weekly

- Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service
- Day Rehabilitation
- Adult Residential

d. Other

- Psychiatrist health facility services: notes on each shift
- Targeted Case Management: every service contact, daily, or weekly summary
- As determined by the MHP for other services