Clinical Documentation

From Intake to Discharge

Sponsored by the Florida Alcohol and Drug Abuse Association, a subsidiary of the Florida Behavioral Health Association, and the State of Florida, Department of Children and Families

Florida Alcohol and Drug Abuse Association

The Florida Behavioral Health Association

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

MYFLFAMILIES.COM

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Purpose of Today's Session:

- To provide the foundation for understanding the importance of quality documentation.
- To ensure that participants are provided with the resources necessary to meet the demands for accurate and thorough documentation.
- To provide an overview of minimum basic standards, while incorporating contractual requirements into the documentation process.

Objectives

- Understand the need for accurate, thorough documentation
- Identify the problems with documentation
- Decrease the uncertainty as to what to document
- Identify the relationship between notes and treatment/service plans
- Identify the critical elements for good documentation

Quote for the Day

"If it isn't written down, it didn't happen"

What Do You Hear?

Free Clipart; clipart-library.com

Common Problems with Documentation

- Not enough time to document
- No formal training on how to document
- Afraid of lawsuits
- Let's discuss some others…

Case Summary and Practice Notes

Exercise Directions

- Trainer will read the Initial Assessment and the Individualized Plan to get an understanding of the family.
- Next review the progress notes dated 3/10/05 and 4/15/05. Identify what changes you would make to the progress notes and add them to the chat box.

Individual's Name: James G.	Medical Record #: 12345
Counselor Name: John Doe	Date: 3/10/15

PROGRESS NOTE

Start Time:

12:00pm

End Time 2:00 pm

Met with CL and Mom to discuss recent problem at the house. Conversation went well and we moved on to school issues. CL is still failing school and M is worried. CL agreed to try harder on a test coming up and that made M happy. Younger brother came into the room, so we spoke with him about doing chores and helping around the house. Will meet again later this week to see how family is making progress.

John Doe, MS, Registered intern

Individual's Name: James G.	Medical Record #: 12345
Counselor Name: John Doe	Date: 4/15/15

Start time: 3:00pm

Session began with Mom, sister, brother and CL talking about fun they had over the weekend. They were laughing and telling this writer about a movie they saw and what happened at church on Sunday. Siblings left and M and CL discussed plan goals and current status. Both M and CL feel that they are doing better. The family has begun using the chore charts and they are getting rewarded for their hard work. M fills in the chart everyday with the stars when a job is complete. Today CL has made his bed, picked up his room, helped with dishes and helped his younger brother with his chores. So, as of today CL has 4 stars and counting. He likes getting stars because they look good on the poster and he gets a candy bar (Twix) when he does well. CL will continue chart as long as he keeps getting Twix bars and M follows through with what she is supposed to do. Family has been participating in therapy weekly and feels that it is really helping. CL says it is nice to have somebody to talk to and wants to have therapy forever. He wishes that his brother would get therapy too because he is so annoying. He plans on talking to his therapist about bringing his brother into the sessions in the future. CL has not been late on his curfew for the past two weeks and says he doesn't need to stay out late anymore because he can have fun at home. Sessions have been consistent, and therapist will continue treatment for six more months based on the need of the family.

John Doe

Why Do We Need To Document?

- We need accurate, specific evidence necessary for ethical, professional, legal and financial reasons
- 3rd Party payers are becoming more stringent in their procedures of accountability
- Assessment, treatment planning, progress notes, and discharge planning are integrated items each affecting and dependent upon each other, and although independent, they represent a continuous process of treatment

Critical Elements of Documentation:

THE CARDINAL RULES

- Never use white-out, highlighting or sticky notes
- When you make a mistake slash through the error with one line and initial at the end
- Sign, date and credential all notes
- Do not backdate documents
- Use specific color pen (either black or blue)

Strengths-Based Documentation

- Make the document individual-centered
- Strike a balance between focusing on strengths and reflecting back to treatment plan goals
- Document success (even baby steps)
- Start with a strength-based assessment and the treatment process will follow

Let's Practice

- Individual is still fighting in school
- Mom and Juan cannot get along
- Antwone continues to skip school and stay home
- Mary still won't talk in the therapy session
- Dennis only got C's on his report card
- Family will not follow the rules we discuss in session
- All John wants to do is hang around the video store
- Shahira will not play with her sisters nicely
- Dan will not pick up his clothes after basketball practice
- Patrice will not complete her chores properly (she will wash but not dry the dishes)

Time for a Break!

The Assessment:

- Should thoroughly identify the individual’s preferences for treatment, outcomes and expectations
- Should be responsive to the individual’s age, gender, sexual orientation, social preferences, culture, physical condition and spiritual beliefs- stigma free
- Should focus on the individual strengths while recognizing the risk factors that brought them into treatment- should be non-judgmental
- Should include information from individual, family and collaterals

- What is culture?
- Do people from different cultures identify culture differently?
- Do people from different cultures share their personal business differently?
- Do people from different cultures tackle problems differently?

Planning:

- Should include family, treatment team and others involved in the life
- Treatment goals and objectives should be based on assessment
- Plan should incorporate strengths, needs, abilities and preferences of family
- Should include services to be provided and timeframes
- Should be written in the individual's language
- Reviewed regularly to ensure progress or the need to re-write goals
- Individual receives a copy and signed copy in the chart

Planning Continued:

Use:

SMART

Specific
Measurable
Attainable
Realistic
Time framed

- Goals should be appropriate to person's age and abilities
- Goals should be expressed in the individual's words
- Should also identify needs beyond the program
- Plans should be reviewed regularly, based on agency requirements

Progress Notes

- Notes should reflect that services were based on the goals identified on the treatment plan
- Should reflect treatment and progress towards goals and include on-going assessment of the individual
- Provide evidence that session occurred
- Progress notes are the primary source of information used during an audit
- Used for accountability of staff and individual

What Does a Good Progress Note Look Like?

- The content or topics discussed in the session
- How the session addressed treatment plan goals
- Progress made and setbacks that occurred
- Current status of treatment plan goals
- How risk factors are being addressed, current challenges and strengths
- Need for continued services
- Notes should be written with attention to grammar and spelling

Progress Note Content

- Timeframe of session (date, starting and ending times, duration, location)
- The type of session (individual, group…)
- At least one statement in each note should discuss session content (for more than one topic, one sentence per topic)

Formula for Success…

- One or two sentences as an opening (who was present, what type of session, where did it occur)
- One-three sentences ***per goal*** on the treatment plan/service plan (state goal, update on progress, intervention used)

- One sentence about next steps (need for referrals, continued service to address risk factors)
- One closing sentence about next session, homework, follow-up if necessary

Individual's Name: James G.	Medical Record #: 12345
Counselor Name: John Doe	Date: 4/15/15

Start time: 3:00pm End time: 4:00pm

Family session began with Mom, sister, brother and James talking in the family home. They shared about the fun they had over the weekend and were laughing and telling this writer about a movie they saw and what happened at church on Sunday. Siblings left and Mom and James discussed plan goals and current status. Both Mom and James feel that they are doing better and the family has begun using the chore charts and they are getting rewarded for their hard work. Mom fills in the chart everyday with the stars when a job is complete and today James has made his bed, picked up his room, helped with dishes and helped his younger brother with his chores. Family has been participating in therapy weekly and feels that it is really helping. James says it is nice to have somebody to talk to and wants to continue therapy. Sessions have been consistent, and therapist assigned family to complete chore chart again this week. The next family session is scheduled for next Thursday at 3:00pm.

John Doe L.M.H.C.

Discharge Planning

- Individual should identify when they are ready for discharge
- A transition plan should be completed with the individual to ensure they have support for sustainable success
- A discharge plan is the formal "closing" paperwork in the individual file
- Should include accomplishments as well as challenges during the course of service
- Identification of ongoing individual support should be documented

Document Effectively and Efficiently

- Chart Promptly
- Fill out forms completely and accurately
- Start each note with date, time (month, day, year, am/pm)
- Organize your thoughts before writing a note
- Report objective facts and observed behaviors-don’t judge
- Write legibly
- Use complete sentences
- If you are interrupted while charting read back a few sentences before you start again
- Use correct spelling & approved abbreviations

Let's Wrap it up

- Individual has a right to participate in treatment planning *(an expectation in a Recovery-Oriented System of Care)*
- Documentation is a collaborative process
- Person centered, individualized and adaptive
- Strengths-based with a recovery-focus
- On-going fluid process where assessment, treatment planning, progress notes and discharge planning are integrated and result in positive treatment outcomes.

Parting Thoughts:

In the helping field we strive to assist children and their families, by documenting your success you are telling others just how much you have helped!