DOCUMENTATION STANDARDS FOR CLIENT RECORDS

The documentation standards are described below under key topics related to client care. All standards must 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 will be included as appropriate as a part of a comprehensive client record.
   - Relevant physical health conditions reported by the client will be prominently identified and updated as appropriate.
   - Presenting problems and relevant conditions affecting the client's physical health and mental health status will be documented, for example: living situation, daily activities, and social support.
   - Documentation will describe client's strengths in achieving client plan goals.
   - Special status situations that present a risk to clients or others will be prominently documented and updated as appropriate.
   - Documentations will include medications that have been described by mental health plan physicians, dosage of each medication, dates of initial prescriptions and refills, and documentations of informed consent for medications.
   - Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities will be clearly documented.
   - A mental health history will 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 consultations reports.
   - For children and adolescents, pre-natal and perinatal events and complete developmental history will be documented.
   - Documentations will 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 will be documented.
   - A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, will be documented, consistent with the presenting problems, history mental status evaluation and/or other assessment data.

2. Timeliness/Frequency Standard for Assessment
   - An assessment will be completed at intake and updated as needed to document changes in the client's condition.
   - Client conditions will be assessed at least annually and, in most cases, at more frequent intervals.

B. Client Plans

1. Client plans will:
   - 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 the services are provided under the direction of an approved category of staff, and if the below staff are not the approved category,
     * a physician
     * a licensed/ “waivered” psychologist
     * a licensed/ “associate” social worker
     * a licensed/ registered/marriage and family therapist or
     * a registered nurse
   - In addition,
     * client plans will be consistent with the diagnosis, and the focus of intervention will be consistent with the client plan goals, and there will be documentation of the client’s participation in and agreement with the plan. Examples of the 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 will be used as the means by which the CONTRACTOR(S) documents the participation of the client
     * when the client’s signature is required on the client plan and the client refuses or is unavailable for signature, the client plan will include a written explanation of the refusal or unavailability.
   - The CONTRACTOR(S) will give a copy of the client plan to the client on request.

2. Timeliness/Frequency of Client Plan:
   - Will be updated at least annually
   - The CONTRACTOR(S) will establish standards for timeliness and frequency for the individual elements of the client plan described in item 1.

C. Progress Notes

1. Items that must be contained in the client record related to the client's progress in treatment include:
   - The client record will provide timely documentation of relevant aspects of client care
   - Mental health staff/practitioners will use client records to document client encounters, including relevant clinical decisions and interventions
   - All entries in the client record will 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 will include the date services were provided
   - The record will be legible
   - The client record will 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:
   - Every Service Contact
   - Mental Health Services
   - Medication Support Services
   - Crisis Intervention