Guam Behavioral Health and Wellness Center		
TITLE: Clinical Documentation	POLICY NO.: CL 39	PAGE: 1
APPLICABILITY: CL 39 Outpatient-Clinical Services	REFERENCES: CARF Manual 2014; CMS 482.61	
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	REVISED:	

PURPOSE:

A. To provide a guideline in proper clinical documentation.

B. To clearly define time lines for completing screening notes, assessment/intake notes as well as interpretive summary, treatment plan and progress notes in the electronic behavioral health record of the person served..

POLICY:

A. It is the policy of GBHWC to document in writing every contact with the consumer, whether face to face or non face to face (e.g. telephone) in the consumer's electronic behavioral health record (EBHR).

B. All encounters shall be recorded in the appropriate fields in EBHR in their designated units of service or discipline.

C. All entries in the medical record shall be made as soon as possible after an encounter with the consumer or within 24hours.
   a. If there is a delay, the time of the event or encounter and the delay should be recorded.

D. All entries in the medical record shall be legible, complete, dated, timed, signed and authenticated in written or electronic form, by the person (identified by name and discipline) responsible for providing or evaluating the service provided.

   a. Additionally, the time and date of each entry (orders, reports, notes, etc.) must be accurately documented.

E. GBHWC uses accepted systematic process that captures the detailed description of the encounter, including the consumer's health and/or physical and psychological status and action or plan taken with the person served.

   a. The goal is to be concise, specific and accurate so anyone following up on consumer care would be able to clearly understand what is going on with the consumer and what the intended next steps are for each to respond.

   b. Accepted methods of writing case notes or clinical documentation in the medical field e.g. SOIRP, SOAP, DAR or DARP notes shall be use in documenting an encounter with the consumer.

c. Documentation should be pertinent, concise and reflect the consumer's status, presenting problem, needs or issues.

d. Any intervention or plan of care and consumer response shall be documented.

DEFINITIONS:

1. Interpretive summary: A written narrative of the assessment data gathered during intake process.

2. Progress Notes: A summary of a consumer encounter written in an accepted medical format e.g. SOIRP, SOAP, DAR, or DARP

3. Treatment Plan: see policy and procedure on treatment planning (Policy No.CL-23)

PROCEDURE:

Interpretive Summary:

A. An interpretive summary shall be written by the intake worker after the assessment process, and shall be completed after the shift or within 24 hours.

   a. It shall be entered in the progress notes field, entering the appropriate service type, and progress note type (e.g. interpretive summary).

   b. It shall include any identified co-occurring disabilities, co-morbidities, and/or disorders.

   c. It shall be used in the development of the treatment plan.

B. It should be in a narrative format, a paragraph written to capture the detailed description of the assessment and interpret from a broader perspective all history and assessment information collected.

C. The interpretive summary could address:
   a. The central theme apparent in the presentation of the consumer
   b. Histories and assessments, with special emphasis on potential interrelationships betweens set of findings.
   c. The perception of the consumer of his or her needs, strengths, limitations, and problems.
   d. Recommended treatments, including any special assessments or test, as well as routine procedures (e.g. laboratory tests).
   e. A general discussion of the anticipated level of care, length and intensity of treatment and expected focus (goals) with recommendations.

Progress Notes Clinical Documentation:

A. All encounters with the consumer shall be documented in the progress notes field in the electronic behavioral health record.

B. The provider shall fill in the specific service type field in the EBHR (AWARDS), followed by choosing the progress note type for that particular encounter.

C. Narrative documentation in the progress note will include, but not be limited to, the following;

   a. Date and time of entry
   b. Description of the contact/action, including face to face and location of visit e.g. phone, clinic, etc.
   c. Subjective report, or presenting issue
   d. Objective observations
   e. Assessment
   f. Plan
   g. Intervention
   h. Evaluation of consumer response
   i. Signature and title of the individual making an entry into the record

D. A summary of a consumer encounter written in an accepted medical format e.g. SOIRP, SOAP, DAR, or DARP. Should include the following if appropriate;
   a. Progress towards achievement of identified objectives, Goals.
   b. Significant events or changes in the life of the person served.
   c. Delivery and outcome of specific interventions, modalities, and/or services that support the person centered plan/treatment plan.
   d. Changes in frequency of services, and level of care

E. If services are provided to the consumer, specify what kind of services, intervention or counseling is provided.

REFERENCES:
CARF International 2014 Behavioral Health Standards Manual
CMS 482.61

SUPERSEDES:
A. Title; Policy No.; Effective date/signature date; Approving individual's name