SUBJECT:	DOCUMENTATION	REFERENCE: RC.01.01.01, RC.01.02.01, RC.01.03.01, RC.02.01.01, RC.02.01.05, RC.02.04.01
SECTION:	RECORD OF CARE	PAGE: 1 OF: 4
DEPARTMENT:	PINE STREET CLINIC	EFFECTIVE: 03-02-14
APPROVAL:	ADMINISTRATION	REVISED:

PURPOSE:

To provide guidelines for documenting the care, treatment, or services provided to individuals served

PROCEDURE:

- Only authorized staff and, members of the treatment team when indicated, make entries in the record of care, treatment, or services.

- Clinicians collaborate with individuals and engage them in the processes of documenting the assessment, plan of care, and progress notes.

- Clinicians work collaboratively with the treatment team when indicated to develop plans for care, treatment, or services.

  - Complete the Comprehensive Assessment within seven (7) days of admission.

  - Complete the Individualized Action Plan within seven (7) days of action planning.

  - Complete the Discharge Summary/Transition Plan within seven (7) days of discharge/transfer from the program.

- Clinicians work collaboratively with individuals to complete progress notes within the period of care, treatment, or services. There may be circumstances in which Clinicians must complete progress notes after the delivery of care, treatment, or services (e.g., group therapy). Clinicians in such cases must complete progress notes by the end of their work shift or within 24 hours with evidence to support the needed extended time.

- Clinicians complete and resubmit returned clinical documentation including any necessary corrections for approval within 48 hours.

- Clinicians include only information germane to the purpose of the care, treatment, or services provided.

- Clinicians are sensitive to the language they use in the record and its potential impact on individuals (e.g., derogatory terms, pathologizing language).
- Clinicians must balance the level of detail of the care, treatment, or service record with legal and ethical requirements and risks.
- The record of care, treatment, or services includes information of three general types:
  - Information in the individual's record
  - For each substantive contact with the individual
  - Other specific information depending upon the circumstances
- Information in the individual's record includes as follows:
  - Identifying data
  - Contact information
  - Fees and billing information
  - Where appropriate, guardianship or conservatorship status
  - Documentation of informed consent or assent for treatment
  - Documentation of waivers of confidentiality and authorization or consent for release of information
  - Documentation of any mandated disclosure of confidential information (e.g., report of child abuse, release secondary to a court order)
  - Presenting complaint, diagnosis, or basis for request for care, treatment, or services
  - Plan for care, treatment, or services, updated as appropriate

- Client history (e.g., social, family, work, psychological, treatment, substance use)
- Transfer/discharge information

- Information for each substantive contact with the individual includes as follows:
  - Date of service
  - Duration of session
  - Type of service (e.g., consultation, assessment, treatment, training)
  - Nature of the intervention or contact (e.g., treatment modality, phone contact, referral source)
  - Target behavior or goal
  - Individual's responses or reactions to the intervention
- Other specific information depending upon the circumstances may include as follows:
  - Current risk factors in relation to dangerousness to self or others
  - Other treatment modalities employed, such as medication or biofeedback treatment
  - Emergency interventions (e.g., hospitalization)
  - Plans for future interventions
  - Information describing the qualitative aspects of the professional-client interaction
  - Prognosis
  - Assessment of summary data (e.g., psychological testing, structured interviews, behavioral ratings, client assignments or behavior logs)

  - Consultations with or referrals to other professionals
  - Case-related telephone, mail, and e-mail contacts
  - Relevant cultural and sociopolitical factors

- Other considerations regarding the level of detail of the record include as follows:
  - The individual's wishes
  - Alteration or removal of information
  - Legal and regulatory standards
  - Third-part contracts

- The Program uses Massachusetts standardized documentation for electronic health records including at least the following forms:
  - Personal Information
  - Comprehensive Assessment
  - Individualized Action Plan
  - Multidisciplinary Treatment Review
  - Discharge Summary/Transfer Plan
  - Progress Note
  - Additional forms and addenda as necessary