Handout

Principles of Good Record Keeping:
Quality Care, Risk Management and Documentation in the Record

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Usefulness requires specificity

A person can run a red light everyday and the action has no consequence until the driver hits or kills someone. Inadequate records or incompetent personnel who are responsible for entries in the record may be of no consequence until a malpractice lawsuit is filed or until a funding source demands a payback.

From the first moment of contact, we become responsible and accountable to our profession, the community, the individual we serve, the payer, our co-workers, and a legal system which protects the rights of each individual. The record serves, not only as a treatment tool, but also as the source document for fiscal, legal and clinical accountability.

Before you write anything, make seven assumptions:

1. Someone else will have to read and understand what I write, because I'll be sick or on vacation and there will be an emergency.
2. This entry will be selected by the State Site Visit Team to verify a reimbursable service.
3. This record is going to be subpoenaed and the court must understand what went on. I may or may not be with the agency when it happens.
4. Legislation which opens a record to the client will be passed.
5. I can't be as accurate if I wait days or weeks to write a note, so I'll do it today.
6. This note will be the best possible reflection of my professional abilities.
7. No contact is considered a service until my entry is in the record.

Treatment plan/Service plan/Plan of care

A plan is **the** basic source document. It must be legible and easily understood; contain information which agrees with and/or supplements the History-Assessment forms; be the starting point for subsequent staff notes, and case reviews; combine with the note to document progress or lack of progress; and confirm the need for reimbursable service.

Components of a plan

(a) **Problem Statement** - Must answer these questions: Why is the client here? What specific problem(s) requires service? What is the specific problem for which my organization will be billing?

Unclear examples: "Anxiety"; or "depression"
Clear examples: "Anxiety related to possible loss of job", "depression caused by father's recent death".

(b) **Goals/Objectives** - Must be written so clearly that anyone can understand its meaning. Will answer these questions: What is the aim of treatment? What specifics will result from intervention? What is the expected date of goal achievement?

Unclear	Clear
Develop self-awareness	Work on his problems without blaming others.
Improve hygiene	Brush teeth and shower each day.
Become responsible	Take medications as prescribed.
Dress appropriately	Put coat on before going out into the cold.
Become less withdrawn	Eat meals and watch TV with family once per day.
Increase self-esteem	Will not be critical of self or personal decisions concerning discipline of children.

(c) **Assets** - A listing of items which will assist you in achieving treatment goals. Includes personality and emotional characteristics, community resources, family support, etc.

Unclear examples: Family, or money, or car
Clear examples: "Supportive/understanding spouse who is involved with therapy." or "Client is able to work each day and has steady income." or" Is able to drive and has transportation."

(d) **Barriers** - A listing of items which will hinder achievement of treatment goals. Includes personality and emotional characteristics, lack of community or family resources, etc.

Unclear examples: Family or money
Clear examples: "Spouse sees client as selfish, and says there is no value to counseling." or "Client lost job, has no income and no prospect of employment."

(e) **Modality** - Specify intervention(s) to be rendered. Answer these questions: Is it a billable service by a covered professional? Does other information within this plan clearly confirm a need for this kind of intervention?

Unclear example: Non-threatening, support

Clear example: Abused Partners Group each week and individual therapy as requested; or Weekly Group to provide information about the nature of chemical dependency as an illness.

(f) **Clinical Impression/Diagnosis** - Must be an accurate reflection of the client's mental health as indicated within other sections of the plan and from Data Base. Spell out the full diagnostic term(s) and list the code(s)

(g) **Members of Planning Team** - List the names and professions of each person who participated in the development of the plan. (Signatures are optional).

(h) **Name of Assigned Therapist/Case Manager/Service Provider**

(I) **Signature** of person who wrote the plan.

(j) **Date** plan was developed (month/day/year).

(k) **Date of Next Review** (month/day/year).

(l) **Signature of MD and/or Psychiatrist** who approves plan and who assumes responsibility for overall client care plan. Signature may be optional, depending on licensure and payer regulations in your state.

STAFF NOTE

The essential elements for each entry are:

1. Specific words which document an intervention related to the plan of care.
2. Specific reference to client reaction, attitude, and symptoms, and
3. Signature, professional title and date (mo/da/yr).

Some staff notes may be repeats of previous entries. You do not have to think of something new and original for each note, but a simple statement of fact, an observation or an opinion is insufficient. The content must:

1. Permit an auditor to determine that a billable service was given;
2. Provide adequate information which allows another professional to intervene when the assigned provider is not available, and;
3. Confirm there are no grounds for a malpractice suit.

VERBS ARE STILL IMPORTANT

An entry must specify the kind(s) of service(s) rendered and client response(s). Verbs answer two questions, "What did you do"? and "What did the client do"?

advised	confront	facilitate	provide	review
advocated	directed	focus	reassure	stabilize

assess	discuss	identify	recommend	suggest
assist	encourage	instruct	refer	support
clarify	evaluate	interpret	reflect	urge

NOUNS ARE STILL IMPORTANT

What issue(s) received your professional intervention? Remember, one word is not sufficient. Elaborate rather than create doubt.

aggression	defenses	guilt	projection	self-image
alcoholism	dependence	hostility	rationalization	sobriety
anxiety	depression	isolation	rejection	stress
behavior	drugs	loneliness	relationships	withdrawal

MODIFIERS ARE STILL IMPORTANT

A modifier can enhance an entry **but only when you define the word** you use. Each person is capable of a multitude of mannerisms for any given characteristic. Therefore, the record must document what it is that confirms being depressed, agitated, confused, hostile, etc. You can clarify a word by adding "as evidenced by..."

abusive	dependent	homicidal	manipulative	suicidal
argumentative	disheveled	hysterical	marginal	superficial
chronic	disorganized	immature	mild	threatening
compulsive	disruptive	inappropriate	moderate	unkempt
dangerous	excessive	inflexible	passive	unmanageable
demanding	frequently	irresponsible	severe	unresponsive

Word, choice is complex and difficult. A word may convey, deliberately or not, a view which tends to be more negative than reality.

Be precise and current. Why not write the plan and note with a client? It can be good therapy, and give you a starting point next time. It can enhance the service relationship and promote empowerment.

ANTICIPATING THE LEGAL SYSTEM

Malpractice suits are changing the traditional definition of confidentiality, and suits which question treatment or diagnosis are becoming more common. Documentation (or lack of it) can spell the difference in a favorable or unfavorable decision.

A prosecuting attorney is duty-bound to be the best possible advocate for a client. Your feelings, opinions and documents are of use only insofar as they contribute to a financial settlement of the client's claim.

Every legal method will be used to obtain documents that may support a malpractice

claim. Information will be reviewed with a fine-toothed comb and the record could provide the evidence that establishes guilt. Four of the most frequent causes for a malpractice suit relate to sexual allegations, suicide attempts, failure to diagnose, and negligent treatment. Without adequate documentation, credibility and professionalism can easily be questioned.

Abandonment is the negligent interruption or termination of services. Risk exposure increases when (1) "high risk" clients "drop out" of treatment, (2) a client comes to treatment erratically, (3) a client is "fired" or refused service, (4) records do not verify "reaching out" efforts to a client who breaks/misses appointments, (5) clients are not notified in writing, their case is being "closed", (6) a professional therapist and client have not discussed/agreed on closure, (7) records indicate a failure to review/consult/refer, (8) goals and methods listed in the plan do not relate to the assessment and history, or (9) staff notes do not verify that a plan is being followed.

Laws differ from state to state and they change from day to day. Laws are not absolutely clear on every possible area of exposure. In fact, many issues have yet to be ruled on.

Information in this handout, the video tape and workshop is not a substitute for legal advice. Contact a lawyer of your choice when you have questions about legal issues. (Our topic is Risk Management, not Risk Elimination.)

WHO USES A RECORD AND WHY

Primary Provider: Adhere to established plan of care and assure continuity.
Another Staff Person: Assure appropriate intervention when the primary provider is out.
Primary Provider's Supervisor: Review of quality of service, adherence to plan of care, evaluate provider's professional growth.
Utilization Review and Quality Assurance: Evaluate appropriateness of service; review use of professional time; and examine program effectiveness.
State Auditor and any other External Monitor: Determine compliance with licensure and payer regulations.
Court of Law and/or Prosecuting Attorney: "Educate" the jury by pointing out missing dates; changed dates; wrong dates; missing notes/plans; vague entries; inconsistent or conflicting information, etc.

PAPERLESS / ELECTRONIC RECORDS

This handout and workshop can not resolve the myriad of confidentiality concerns generated by an electronic record. The program deals with documentation, not "data protection".

Confidentiality issues are legitimate concerns because new age technology has compromised the privacy of each individual you serve. As organizations increase dependence on non-paper records, the risk for improper access and disclosure increases. There is also the danger that a "virus" can intentionally or inadvertently alter

and/or negate the integrity of electronic data **.**

Information is no longer kept on pieces of paper in a "guarded" room. It is stored and distributed through e-mail, voice mail, fax machines, dictation, computers, and computerized printouts. Electronically stored information is accessible by countless numbers of people. The most comprehensive security system can fail when unethical or disgruntled employees and "external hackers" obtain information for misuse.

The patchwork of state and federal laws does not provide 100% protection to anyone. Unfortunately, you can be sure that someone who has no right to information will obtain it and misuse it. Never the less, **computerized information is here to stay. Regardless of whether you use paper or an electronic medium, the following points remain valid:**

- Service providers need timely, accurate, and comprehensive information. Lack of information can impede quality of care because the decision making process is placed at risk.

- An organization must comply with its own written policy related to recordkeeping and confidentiality. In the event of litigation, "failure to comply" can be used against the service provider.

- One way to avoid misuse of information is to have trained employees who are committed to protecting the privacy of each consumer.

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Mr. Mitchell is available to provide programs for your organization. In addition to being a popular seminar leader, he frequently provides conference keynotes. He has spoken to more than 170,000 people in 44 States and Canada. **For information contact: Bob Mitchell, ACSW, at PO Box 7281, Louisville KY 40257**, 1-(502)-387-7836 or by email B_MITCHELL@prodigy.net

A comprehensive web site has handouts, workshop information, a resume, and more.
http://pages.prodigy.net/b_mitchell

Other topics include: "Where There is Laughter, There is Hope" (Humor in coping and wellness) and "How to Stay Cool When The Heat is On" (Stress Management)

Continuing Education Information

Please send the following item(s). Prices listed below include postage and handling
Audio Cassette: "Some Days This Place is A Zoo" (Humorous music - $12)
Compact Disk: "Some Days This Place is A Zoo" (Humorous music - $17)
Audio Cassette: "Where There Is Laughter There Is Hope" (Humor and Wellness - $12)
VHS Tape: Laughter & Hope: The Role of Humor in Coping ($32)
Book: "Documentation in Counseling Records: Second Edition" ($27)
Audio Cassette: "For the Record" (Documentation Skills - $12)
VHS Tape: The Record: A Tool for Optimizing Quality Care and Malpractice Prevention ($37)

Make check payable to Bob Mitchell and mail to PO Box 7281, Louisville KY 40257
Be sure to include a legible Name; Address; City, State and Zip code