

A Practical Approach to Documentation

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Objectives:

At the conclusion of this lesson you will:

- Recognize the importance of documentation
- Understand the purposes of accurate record keeping
- Be familiar with some practical approaches to documentation
- Learn about computer-based documentation risks

In today's world of litigation, managed care, and time-management crunches, counselors, social workers, marriage and family therapists, and psychologists need a practical and meaningful approach to documentation. There is important information to learn about why we should document, what we should document, how we should document, who owns the records, how long the records must be maintained, confidentiality, and computer charting. Documentation is, perhaps, one of the greatest struggles for many mental health professionals; the struggle to find the time to do it being the greatest.

WHY SHOULD WE DOCUMENT?

Protection of the Client:

The primary purpose of documentation is to protect the client and to plan for their treatment and care. That is, to ensure continuity of care for the client, that they received treatment that was appropriate for their identified disease or disorder, that the actions of the therapist and client together were therapeutic for the client, and that the therapist operated within their scope of practice.

The client's file should contain enough meaningful data to ensure, if therapy ends for any reason or if anything suddenly befalls the therapist, the client will essentially be able to continue where they left off. In other words, they would not have to start over with another therapist without the new therapist's knowledge of the client's work thus far.

Assessment drives diagnosis, diagnosis drives treatment, and treatment drives evaluation and further assessment. The process is fluid and should be evident in the client's chart. Mental health professionals have a legal duty to accurately diagnose and treat their clients or make an appropriate referral for the safety and benefit of clients.

The evaluation of therapy is led by the professional and includes the client. Efficacy is discussed periodically and both the therapist and the client determine if the goals they set together, in the beginning of therapy, are being accomplished or if they remain the focus of therapy.

The therapist informs the client on the initial visit of their scope of practice in their Professional Disclosure Statement. This protects the client from therapists who knowingly or unwittingly operate outside the legal and ethical guidelines that govern their practice.

Protection of the Therapist: *“If it wasn’t documented, it wasn’t done.”*

Many times a therapist’s documentation has made the difference between successful and unsuccessful litigation in a legal tort against the therapist, an action by the governing board, or an action from the courts. Keeping accurate records that reflect all that happens and all that is said or not said in session can be crucial protection for the therapist. It also reflects the professionalism of the work done with the client. The scariest words to a therapist are State Board Investigation, Lawsuit, and Subpoena.

Documentation should always be written with the assumption that someone else *will* be reading the client file, perhaps the client, a member of State Board, a Judge, a District Attorney, a Defense Lawyer, etc.

Therapist Accountability:

The records reflect the clinical work performed and show the structure and focus of therapy. The documentation holds the therapist accountable to other professionals and, as previously stated, assists other therapists in providing care that is appropriate to the client.

The documentation addresses risk management and clearly identifies appropriate actions were taken. Under any form of scrutiny, the record shows the therapist acted appropriately and with accountability to their colleagues and their profession.

The Record Provides the Structure and Focus of the Therapy:

The documentation reflects the assessment data and the plan for the client’s care. This helps the therapist in planning for and conducting sessions that are structured and meaningful to the client. The agreed upon goals become the focus of the work to be done and the therapist and the client collaborate based on information the client has shared.

The record also shows a periodic review of the goals and any subsequent changes agreed upon by the therapist and the client. Additionally, goals that have been achieved are recorded with the date both the therapist and the client agreed they were accomplished.

Accurate Documentation Meets Individual Agency and Other Payer Source Requirements:

Professional records are the expectation of mental health agency management, peer review committees, and risk management teams. Additionally, insurance companies and other payer sources have established standards and requirements for documentation by the therapist. The reporting not only determines the appropriateness of the care given, it reflects on the professionalism of the therapist.

Meets Quality Assurance Requirements and Outcome Measures:

The Ohio Department of Mental Health (ODMH) and other state funding organizations require the agencies therapists work with to provide some form of quality assurance for services offered. The use of standardized outcome measures gives an accurate reflection of the efficacy of the therapy being provided. Documentation that is a true reflection of the work being done meets these requirements for quality and measurability

WHAT SHOULD WE DOCUMENT?

Important information is contained in client files: Identifying data, reason for client visit, a clear statement of the problem, family and social background, medical history, educational history, employment history, psychological development, social circumstances, hobbies, recreational activities, sexual history, spiritual information, any history of verbal, emotional, physical, or sexual abuse, and drug and alcohol history.

What Does an Accurate File Need to Include:

- A Professional Services Agreement that is HIPPA compliant and includes information on the therapist and their credentials, their fees, the limits of confidentiality, cancellation policies, and a work agreement between the therapist and the client.
- Session Notes
- A Session Activity Log that reflects the dates and lengths of all sessions, cancellations, no shows, phone calls, consultations, fees paid, and balance due.
- A Treatment Plan that includes a five axis diagnosis (universal language)
- A Mental Status Examination
- A Bio-psychosocial History
- Test Results and Interpretations
- Self-assessment Instruments (See Appendix A)
- Any release consents that apply
- Consent to Treat a Minor (if applicable)
- Suicide Lethality Checklist (if applicable) (See Appendix B)
- Duty to Protect Form (if applicable) (See Appendix C)

HOW DO WE DOCUMENT?

The clinician may assume someone else will read their documentation and need to understand what is recorded there. The document may be reviewed by Risk Management, Quality Assurance, or Peer Review Personnel for an analysis of professionalism and reimbursable service. No contact is reimbursable until the service is entered into record. The notes have to be an honest reflection of the therapist's professional abilities and the client's need for service.

Methods:

There are a variety of methods available to therapists for recording sessions. It is a matter of which one meets the requirements and is the most comfortable for the individual professional. Regardless of which technique is used there are certain pieces of information the record must reflect:

What is the current necessity for services?

What action is needed from the therapist and the client?

What is the response to those actions taken?

What achievable outcome is the goal?

Are the actions taken goal-oriented?

The following are just a few of the simple formats for recording the necessary information:

THE SOAP METHOD:

S (subjective data – what they perceive and how they express it)

O (objective data – measurable. The observer makes interpretations and draws conclusions)

A (assessment of presenting problem)

P (plan of care)

DO: **S** - Client states: “*My husband is a brute and a cruel man.*”

DON'T Client’s husband is a brute and a cruel man.

DO: **O** - Client is wringing her hands, is unable to sit still during session, and does not make regular eye contact.

DON'T Client is very upset today.

DO **A** - Client states she wants to learn how to set boundaries at home and be more assertive with her husband and others.

DON'T Client seems stuck and unable to cope.

DO **P** - Therapist will teach two new boundaries each week and will role play situations in which client will practice assertiveness and boundaries.

DON'T Client will get better at setting boundaries and assertiveness.

THE DAR METHOD:

D - (DATA: subjective and objective)

A - (ACTION: by therapist and client)

R - (RESPONSE: evaluation by therapist and client)

THE PIE METHOD:

P - (PROBLEM: focus of session)

I - (INTERVENTIONS: by therapist and client)

E - (EVALUATION: by therapist and client)

THE DYNAMIC METHOD: (See Appendix D and E)

Many therapists prefer a formatted documentation form which can include:

- Date and Time of service
- Length of session
- Problem to be the focus of the session
- Goals for the session
- Mini mental status checklist
- Client statements
- Therapist's observations
- Client's progress toward goals
- Therapist's interventions
- Client's response
- Recommendations
- Homework assigned
- Therapist signature

This can be agency specified or can be created by the therapist to include these and other data they deem important.

THE NARRATIVE METHOD:

This is descriptive information and chronological charting that records data in a sequence as time moves forward. The charting begins with the date and time of the entry and each entry should be signed with credentials. If an entry is missed and is to be made later, it should begin with the current date and time and then noted as Late Entry For: and the date and time of the service, consultation, phone contact, etc. If an entry needs to be corrected, draw a single line through the entry, initial it, and make the corrected entry. If an entry needs to be changed after the initial writing, **do not** discard the old notes and replace them. Simply date the entry for the current date and time and then note your entry as Correction to Entry Made: and the date and time of the entry you are correcting. If you wish to make a simple addition to an earlier entry, use the current date and time, then title it Addendum Entry for the date and time of the initial entry.

This type of documentation can be difficult for a reader to find the pertinent information about a specific problem; however, this is widely used because it can be written with the flow of conversation during the session. The therapist simply writes in sentences and paragraphs the communication of the session and includes direct quotes where applicable.

S.M.A.R.T. GOALS

Goals the client and clinician establish together must be S.M.A.R.T.

S small

M measurable

A action oriented

R realistic

T time factored

Example: A client states she is depressed and unhappy about her weight gain. She states she wants to be healthier and more physically fit. She sets the goal for herself to work out five days a week for thirty minutes a day. She currently does not exercise at all and has not been physically active in over a year. The therapist works on her goal to make it SMART: "Client will increase physical activity to three out of seven days for ten minutes this week." The client states, "Well anyone could do that." The therapist helps the client see the benefit in starting with consistent small steps and building a plan that will be successful.

Any of the above methods could allow for documentation to occur in full or in part during the session. There are, of course, some sessions in which it would not be appropriate to document. There is, however, an opportunity in most cases to take some notes and achieve the charting by the end of meeting. Sharing the direct quotes during the next session from the last one puts the client at ease with the process. The therapist should always discuss this with their clients to determine their feelings about it.

There are certain requirements regardless of which method is used to document. The notes must be legible and clearly stated, not vague or incomplete. They must be written in ink or typed. They must be timely so they must be written on the same day as the session or the notation must reflect that they are a late entry. By example: 3/3/06 LATE ENTRY FOR: 3/1/06... Never use White Out. If a mistake is made, draw a single line through the error, initial it, and make the correct statement after it. Grammar and spelling should be accurate. Abbreviations, if used at all, should reflect universally used terms that are readily accepted and understood in the clinical world.

The therapist should be objective and state as fact only that which they have observed. The notes should reflect the assessment of the client, the goals of therapy, the interventions by the therapist, the action taken by the client, and the outcome. Notes should be able to be used to provide continuity of care. The length of the note is less important than the content but it should be of sufficient length to provide meaningful data. A therapist should be able to read the note, even years later, and be able to determine what was the focus and content of the session. The record should never include anything that would be harmful to the client, thus language is chosen carefully to convey the important data without revealing anything the client would not want known. Again, it must be assumed someone else may someday read the documentation.

The therapist should choose what their professional signature will be and stick to it. This prevents confusion and provides consistency. All entries must be signed and dated.

Counselors, social workers, and marriage and family therapists licensed by the board shall use the following abbreviations to designate their titles as defined in paragraphs (Q) (1) to (Q) (6) of rule 4757-3-01 of the Administrative Code:

- (1) "L.P.C.C." or "P.C.C." means a "Professional Clinical Counselor";
- (2) "L.I.S.W." or "I.S.W." means an "Independent Social Worker";
- (3) "L.P.C." or "P.C." means a "Professional Counselor";
- (4) "L.S.W." or "S.W." means a "Social Worker";
- (5) "S.W.A." means a "Registered Social Work Assistant";
- (6) "R.C.T." means a "Registered Counselor Trainee."
- (7) "C.R." means "Registered Clinical Resident";
- (8) "I.M.F.T." means an "Independent Marriage and Family Therapist";
- (9) "M.F.T." means a "Marriage and Family Therapist".

WHO OWNS THE RECORDS?

As designated by HIPPA, the client owns their medical and mental health files with the clinician designated as responsible for the maintenance of the records in a confidential manner. The client must be informed of their rights in writing and it is the job of the clinician to ensure the client understands their rights.

The client may request a copy of their records and should do so in writing. The therapist should work with the client to understand the client's desire for the records and should then set a time to go through the records with the client. This allows for greater understanding of the written words and clarifies the client's concerns about their file.

It is recommended that the therapist demystify the records by periodically reading to the client from previous sessions. This allows the client to be more comfortable with the note taking and gives them peace of mind about what is being recorded about them. Knowing this will be done helps the clinician document in a way they would not be uncomfortable having read by others.

The clinician has the responsibility for the safety of the records. If agency policies are noted to be lax in any way, the duty falls to the therapist to ensure the privacy and privilege of their clients' files. Agency policies and procedures should be assessed for thoroughness and any identified problems should be reported to agency administrators. If this does not produce necessary changes, the therapist has the duty to notify their governing board.

4757-5-01 Code of ethical practice and professional conduct.

(B) Responsibility to clients/consumers of services

(4) Confidentiality

Counselors, social workers, and marriage and family therapists shall have a primary obligation to protect the client's right to confidentiality as established by law and the professional standards of practice. Confidential information shall only be revealed to others when the clients or other persons legally authorized to give consent on behalf of the clients, have given their informed consent, except in those circumstance in which failure to do so would violate other laws or result in clear and present danger to the client or others. Unless specifically contraindicated by such situations, clients shall be informed and written consent shall be obtained before the confidential information is revealed.

Ohio Counselor, Social Worker & Marriage and Family Therapist Board Laws and Rules, January, 2006

HOW LONG MUST THE RECORDS BE MAINTAINED?

The State of Ohio says the records must be maintained for seven years. Some professional organizations say five and some say ten. The therapist must adhere to the guidelines of any professional organization of which they are a member or by which they are certified as long as it is at least in accordance with state law.

It is recommended that at least a case summary is maintained indefinitely. Many agencies are now using databases on computer or microfiche to store old records. For minors, the requirement is age of majority plus

seven years because a minor client has the right to recourse once they have reached majority age which is twenty one years.

If a therapist closes a private practice, they have a duty to notify clients in writing about the status of their files. The records can be forwarded to a clinician of the client's choosing with written consent from the client, the therapist may continue to safeguard the files for the client, or, if enough time has passed, the records may be destroyed.

CONFIDENTIALITY:

Confidentiality is one of the highest duties of a therapist to their clients along with *Above all do no harm*, be beneficial, be loyal, be just, and preserve client autonomy. These are highly valued, universal, ethical standards for mental health professionals. Protection of confidentiality is not only an ethical standard, it is a legal duty.

Clients must be advised of their rights to confidentiality and its legal limits from the beginning of therapy. In fact, these details must be discussed with the client and the therapist must be certain of the client's understanding of their rights before therapy ever begins.

If more than one person is the client then it must be explained that the therapist cannot guarantee any one's confidentiality. This is true because when others are present, no one can be assured the others will not divulge what is disclosed in therapy. This is discussed at the beginning of sessions and the clinician states that what is said in therapy remains in therapy and should not be discussed with anyone outside of those present for therapy.

In the case of a court order for client files, the client should be notified immediately of any request for their private information. Remind the client of the limits to confidentiality discussed in the beginning of therapy and explain to them the need to comply with the court order. A court order is not the same as a subpoena. When a subpoena is received for client records, again notify the client immediately then contact state board, consult with several peers, and seek legal counsel in responding. A call to the party who sent the subpoena may help, explaining that you always comply with the law but client files are privileged information for which you have a legal duty to protect. The therapist may not even divulge whether or not the person in question is a client if we decide to make such a phone call. The soundest thing to do is gather data from the fore-mentioned resources and make a decision based on that.

If you do subsequently receive a court order, the therapist is expected to fight for privilege to the point of being in contempt of court and then they must release the records or they could be fined or placed in jail.

If a report is to be prepared for court, Ohio law states:

4757-6-01 (A) The role of the counselor, social worker, or marriage and family therapist is that of a professional expert who strives to maintain an objective, impartial stance. A counselor, social worker or marriage and family therapist does not act as a judge who makes the ultimate decision applying the law to all relevant evidence. Neither does a counselor, social worker or marriage and family therapist act as an advocating attorney who strives to present his or her client's best possible case. A counselor, social worker or marriage and family therapist in a balanced, impartial manner informs and advises the court and the prospective parties of the relevant mental health factors pertaining to the issue.

Ohio Counselor, Social Worker & Marriage and Family Therapist Board Laws and Rules, January, 2006

COMPUTER CHARTING:

It has become fairly common to document confidential information on clients using computer processing and storage. Therefore, security measures and safeguards need to be in place to protect the client's record from unauthorized access.

While the legal and ethical principles may not change, the risks to confidentiality and security of patient records appear to differ between paper-based and computer-based records. Breaches of system security, the potential for faulty performance that may result in inaccessibility or loss of records, the increased technical ability to collect, store, and retrieve large quantities of data, and the ability to access records from multiple and (sometimes) remote locations are among the risk factors unique to computer-based record systems. Managing these risks will require a combination of reliable technological measures, appropriate institutional policies and governmental regulations, and adequate penalties to serve as a dependable deterrent against the infringement of these precepts.

(PubMed – indexed for MEDLINE)

It is up to each clinical professional who chooses to or is required to use computerized documentation, to ensure that systems are in place that protect confidentiality. It is not enough to say that agency policy required its use and it was assumed safety measures were adequate. Remember that the primary responsibility for confidentiality rests with the individual therapist.

CONCLUSIONS:

Documentation is required of all clinicians; a task that must be done. Knowing the requirements and learning a meaningful approach to the work of creating and maintaining client records doesn't have to be as daunting as it sounds. If one's attitude toward mathematics is, "I can't do it!" then it can't be done. The same is true of documentation. If it is approached from an "I Can!" attitude, then it becomes less of a burden to the clinician. Like many things, it is a question of habit and finding what works for the individual. It also requires meaningful tools. The instruments provided in Appendices A through E may be of some help.

Also important, is the understanding and acceptance of the concepts of why we document. The protection of the client, the continuity of their care, and the ability to focus the sessions based on information previously gathered are the primary reasons keeping records is so essential. The protection and accountability of the therapist, and other reasons given herein are also helpful in motivating the clinician to get charting done.

Each professional must address time management issues and find ways to achieve required levels of recording client data in a timely manner. The most efficient and thorough approach will undoubtedly look different between therapists but must meet professional requirements and guidelines and standard of care expectations.

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Appendix A
SELF-ASSESSMENT AND EXPECTATIONS

Name _____

Date _____

CHIEF COMPLAINT (CHECK ALL THAT APPLY TO YOU):

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual abuse issues |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Spousal abuse issues |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Fear of dying |
| <input type="checkbox"/> Poor concentration | |
| <input type="checkbox"/> Hopelessness | |
| <input type="checkbox"/> Worthlessness | |
| <input type="checkbox"/> Guilt | |
| <input type="checkbox"/> Sleep disturbance (more/less) | <input type="checkbox"/> Fear of going crazy |
| <input type="checkbox"/> Appetite disturbance
(more/less) | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Thoughts of hurting yourself | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Thoughts of hurting someone | <input type="checkbox"/> Obsessions/compulsive
Behaviors (more/less) |
| <input type="checkbox"/> Isolation/social withdrawal | <input type="checkbox"/> Thoughts racing |
| <input type="checkbox"/> Sadness/loss | <input type="checkbox"/> Can't hold onto an idea |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Easily agitated |
| <input type="checkbox"/> Anxiety/panic | <input type="checkbox"/> Excessive behaviors
(spending, gambling) |
| <input type="checkbox"/> Heart pounding/racing | <input type="checkbox"/> Delusions/hallucinations |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Not thinking
clearly/confusion |
| <input type="checkbox"/> Trembling/shaking | <input type="checkbox"/> Other problems/symptoms:

_____ |
| <input type="checkbox"/> Sweating | |
| <input type="checkbox"/> Chills/hot flashes | |
| <input type="checkbox"/> Tingling/numbness | |
| <input type="checkbox"/> Feeling that you are not real | |
| <input type="checkbox"/> Feeling that things around
you are not real | |
| <input type="checkbox"/> Lose track of time | |
| <input type="checkbox"/> Unpleasant thoughts won't
go away | |
| <input type="checkbox"/> Anger/frustration | |
| <input type="checkbox"/> Easily agitated/annoyed | |
| <input type="checkbox"/> Defies rules | |
| <input type="checkbox"/> Blames others | |
| <input type="checkbox"/> Argues | |
| <input type="checkbox"/> Excessive use of drugs and/
or alcohol | |
| <input type="checkbox"/> Excessive use of prescription
medications | |
| <input type="checkbox"/> Blackouts | |
| <input type="checkbox"/> Physical abuse issues | |

SELF DESCRIPTION (complete the following)

I am _____

I feel _____

I think _____

I wish _____

EXPECTATIONS FOR THERAPY:

What would you like to see accomplished in therapy?

What characteristics should the ideal therapist possess?

How long do you think your therapy should last?

In a few words, what do you think counseling is all about (in terms of goals, methods, nature of relationship between therapist and client, etc)?

Appendix B
SUICIDE LETHALITY CHECKLIST

Client: _____ Date: _____

	LOW	MODERATE	HIGH
Suicidal Plan	Unplanned	General reference	Specific method
When	Unclear	Within few hours	Immediate
Where	Unspecified	May be at place	At location
Availability of means	Unavailable	Available – not present	Is at hand

Alcohol/Drugs Used	No		Yes
Final arrangements	Vague	Made some plans	Given away possessions, note, will
Previous attempts	None	One	Multiple
Significant others	None	Few or only one	None

Fixed on death	No	Somewhat	Markedly
Disoriented	In touch with reality	Difficulty focusing, thoughts disconnected	Delusional, hallucinations, loss of contact with reality
Affect	Appropriate	Appropriate & inappropriate	Flat, despair, detached, hysterical
Withdrawal	Will accept help	Hesitant to involve others	Alone, refuses help

Disorganization	None/little	Confused	Marked chaos
Health	No medical problems	Moderate problems	Chronic disability, illness, weight loss, anorexia, sleep disturbed
History of losses (please describe)			
History of drug use	No/infrequent	Occasional	Chronic

Emotional problems (please describe below *)	Infrequent	Recent	Chronic
Spiritual beliefs	Yes/active faith	Some/little	None
Self esteem	Normally strong	Depends on others	Self-hatred
TOTALS:	_____	_____	_____

COMMENTS: * _____

THERAPIST SIGNATURE/CREDENTIALS

Appendix C

Model Draft

Name of Client/Patient

Date of Birth

Chart Number

DUTY TO PROTECT

On _____, a threat to seriously physically harm another
(Date)
person or identifiable structure was communicated to me by:

(Name of Person)

(Relationship to Patient/Client)

The nature of the threat was to _____
(Explicit Threat)

to the following person(s) or structure _____
(Specific person(s) or structure)

Based on my knowledge of the patient/client, it is my judgment that the patient/client:

_____ Does not have the intent or ability to carry out the threat because:

NOTE: If the client/patient does not have the ability or intent to carry out the threat, no further action is legally mandated; however, clinical steps should be considered.

OR

_____ Does have the intent and ability to carry out the threat.

In accordance with Ohio Revised Code Section 2305.51, I have initiated the following option(s) and, after consideration, have chosen not to pursue other options at this time based on the following reasons in order to fulfill my duty to protect potential victims from threatened violence.

ALL FOUR SECTIONS BELOW MUST BE COMPLETED

1. Voluntary hospitalization

_____ Chosen _____ Not Chosen

Reason: _____

2. Involuntary hospitalization (Emergency or Judicial)

_____ Chosen _____ Not Chosen

Reason: _____

3. Establish and undertake a documented treatment plan reasonable calculated to eliminate the threat and concurrently initiate a risk assessment and management consultation with a consultant as described in the law.

_____ Chosen _____ Not Chosen

Reason: _____

4. Warning to law enforcement and, if feasible, intended victim(s)

_____ Chosen _____ Not Chosen

Reason: _____

Information shared if this option is chosen (name of client/patient, nature of threat, and names of potential victim(s)/structure):

STEPS TAKEN to implement the option(s) I have chosen are: (include any persons to who a warning is given, as well as the date, time and specifics; or specific changes in the treatment plan, the initiation of the required consultation and name of consultant; or specific steps taken to hospitalize the client/patient.)

<hr/> Date	Mental Health Professional	<hr/> Signature
		<hr/> Printed Name

Appendix D
SESSION NOTES

Session # _____ Name _____ Date _____

SUBJECTIVE: (client feelings, concerns, plans, thoughts, intensity of problems, family dynamics, orientation, changes, new issues and other)

OBJECTIVE: (appearance, affect, behavior, demonstrated strengths and weaknesses, test results, material from outside sources) _____

ASSESSMENT: Improved Worse No change/Stable

PLAN: (interventions used, treatment progress, direction, homework, change in goals)

Prognosis: Poor Fair Good Excellent

Time: _____ **Next Appointment** _____

Therapist's Signature _____

Appendix E

CLIENT _____ **DATE** _____

SESSION # _____

Pre-Session Planning: _____

Presenting Concerns/Symptoms; Changes from last session; new issues, other

Counselor Interventions: active listening, empathy, tx planning, goal clarification, history gathering, accountability, therapeutic confrontation, skill building, feedback, validation, encouragement, praise, humor, self disclosure, cognitive restructuring, crisis prevention, direction, suggestions, monitoring, modeling, other.

Client Response: hostile, resistant, avoidant, defensive, passive, compliant, cooperative, initiating, engaging.

Client Focus/Themes; Client Progress Toward Goals; Objective Measurements; Outcomes; Testing

Recommendations; Treatment Plan; Adjustment to Goals; Homework Assignments

Mental Status Exam (N = none noted; L= low M = medium; AVG = average H = high)

Depression: N L M H Suicide: N Ideation Intent Plan Means Homicide N Ideation Intent Plan Means

Anxiety: N L M H Anger: N L M H Euphoria: N L M H Paranoia: N L M H

Affect: Inappropriate Constricted Flat Blocked Labile Full range Rapport: easy AVG hard

Cognition: Coherent Confused Distractible Self-deprecating Goal-directed Tangential Negative

Activity: Slowed AVG Agitated Eye Contact: Avoidant AVG intense GAF:

Prognosis: Poor Fair Good Excellent Comments:

Signature/Credentials

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Cincinnati, Ohio 45243
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513-271-5383 fax

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A Practical Approach to Documentation

Please Print Clearly or Type:

Name: _____

License #: (Psychologists only) _____

Address: _____

City/State: _____ Zip: _____

Phone: Work: _____ Home: _____

Email Address: _____

To register by credit card (Master Card or Visa) please call 800-388-2267 or Fax to 513-271-5383, or send your name, card number and expiration date to the above address. You can also register via e-mail at jheisel@heiselandassoc.com.

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Card Number _____

Billing Address: _____

Signature: _____

A PRACTICAL APPROACH TO DOCUMENTATION

POST TEST QUESTIONNAIRE

1. Which of the following is the correct sequence?
 - a. diagnosis drives assessment, assessment drives treatment and treatment drives evaluation and further assessment.
 - b. evaluation drives diagnosis, assessment drives treatment and treatment drives evaluation and further assessment.
 - c. assessment drives diagnosis, diagnosis drives treatment and treatment drives evaluation and further assessment.
 - d. assessment drives treatment, diagnosis drives evaluation and further assessment.

2. A five axis diagnosis is important for which of the following reasons:
 - a. it correctly labels the client and their disorder.
 - b. it provides universal language for understanding the client.
 - c. it ensures payment by third parties.
 - d. none of the above.

3. The primary purpose of documentation is:
 - a. to accumulate data.
 - b. to meet state standards.
 - c. to avoid losing your license.
 - d. to protect the client.

4. The therapist informs the client of their rights and the therapist's scope of practice:
 - a. at the very beginning of therapy.
 - b. no later than by end of second session.
 - c. when the client inquires of these things.
 - d. as soon as the client has gained trust of the therapist.

5. At least one piece of information the record must reflect is:
 - a. the most recent changes in client job status.
 - b. client hopes and dreams.
 - c. the current necessity for services.
 - d. who lives with the client.

6. The greatest problem with narrative charting is:
 - a. it can be difficult for a reader to find the pertinent information about a specific problem.
 - b. it is not considered professional.
 - c. it is not S.M.A.R.T.
 - d. none of the above.

7. The primary responsibility for maintaining client records in a confidential manner belongs to:

- a. the agency.
- b. the client.
- c. the clinical director
- d. the clinician

TRUE OR FALSE

8. T___ F___ The client owns their records.
9. T___ F___ Regarding standard abbreviations, C.R. stands for "Client Release."
10. T___ F___ According to state law, client records must be maintained 7 years.
11. T___ F___ The therapist can guarantee confidentiality even if more than one person is the client.
12. T___ F___ Computer charting is safe as long as the management says it is.
13. T___ F___ It is not acceptable to document during any session.
14. T___ F___ In order to be successful in documentation you must have good time management skills.

I, _____ (name of participant) affirm that I am the person who completed this home study and am responsible for this post test.

Signature: _____

