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REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

Policy Title: Progress Notes Clinical Documentation
Policy No: CL-AP-10
Initiated by: Clinical Services

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GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER		
TITLE: Progress Notes Clinical Documentation	**POLICY NO:** CL-AP-10	Page **1** of **3**
RESPONSIBILITY: All Clinical Programs		
APPROVED BY: 1/13/20 THERESA C. ARRIOLA, DIRECTOR	**DATE OF ORIGINAL APPROVAL:** 3/1/2016	
	LAST REVIEWED/REVISED: 8/12/2019	

PURPOSE:

A. To provide a guideline in the proper use of progress note type selection in the electronic behavioral health record (EBHR) and define timelines for completing clinical notes.

POLICY:

A. It is the policy of Guam Behavioral Health and Wellness Center (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 EBHR.

B. GBHWC uses an accepted systematic process of writing case notes or clinical documentation in the progress notes field including **S**ubjective reports, **O**bjective findings using Mental Status Examination (MSE) assessment, **A**ssessment(s) conducted and administered, and **P**rogress/plans in session; **SOAP** notes shall be used in documenting an encounter with the consumer.

C. Documentation should be pertinent, concise, specific, and accurate with data to justify medically necessary treatment/interventions for reimbursement. Any staff following up on the consumer's care would be able to clearly understand their current status and the intended interventions for continuity of care across disciplines. Documentation shall reflect the consumer's status, presenting problems, needs, or issues, as well as any significant events or changes in symptoms and diagnosis, as appropriate.

D. All encounters shall be recorded in the appropriate fields of EBHR in their designated units of service by discipline and/or program. To capture the detailed description of each consumer encounter or service activity, different progress note type selections in EBHR shall be utilized (reference definitions of progress note types).

E. All consumer encounters shall be documented in EBHR and completed within specific timeframes. Should there be delay in documentation, the time of the event/encounter and the reason for delay shall be recorded. Time frames are as follows:
    1. Outpatient and Residential Programs: Within 72 hours of the consumer encounter or contact.
    2. Inpatient Units: Within the shift up to 24 hours.

DEFINITIONS:

A. Progress Notes: The progress notes data module in AWARDS is utilized to document and capture every encounter and service provided to the consumer.
   1. **Intake interpretive summary**: Shall be used for writing a narrative of the clinical intake assessment from a bio-psycho-social perspective to include prior diagnosis and behavioral health history. Summary will identify strengths and barriers to successful clinical care and treatment to include clinical recommendations for the level of care, and referrals for types and frequency of services. It shall include identified co-occurring disabilities, co-morbidities and/or disorders, clinical judgments regarding both positive and negative factors likely to affect the course of treatment, treatment recommendations (level of care, focus, intensity and length of treatment), outcomes, and discharges. It shall be used to drive the development of the initial treatment plan.
   2. **Admission Note:** Shall be used for writing an overview of a new consumer transferred or referred from one level of care to another. Content will follow an interpretive summary.
   3. **Periodic Summary Note**: Shall be used by the Lead Provider to document quarterly reviews of current issues and symptoms, current services, changes or current diagnosis, progress in treatment and recommendations to continue, revise or enhance clinical services and/or treatment goals/plans. Periodic summary shall be utilized for every quarterly treatment plan reviews.
   4. **Service Plan Linked**: Shall be used to document progress SOAP notes based on the current treatment plans, goals, or objectives being worked on.
   5. **General Chart Note:** Shall be utilized for non-face-to-face encounters with the consumer or administrative documentation pertaining to the consumer.
   6. **Collateral Note:** Shall be utilized to document any contact with an external agency involving a consumer or pertaining to a consumer's case. It shall also be utilized to document a service activity to a significant support person, family member, or caregiver of a consumer for the purpose of meeting the needs of the consumer in achieving the goals. A collateral note may include but not be limited to consultation and training of the significant support person and or family counseling.
   7. **Discipline specific Note:** (Psychiatry, Psychology, Counselor, Nurse and Social Worker Notes) shall be utilized by the clinical staff within their discipline when documenting the progress of the consumer.

PROCEDURE:

A. Progress Notes Clinical Documentation
   1. All encounters with the consumer shall be documented in the progress notes field in the electronic behavioral health record.
   2. The provider shall fill in the specific service activity/type field in EBHR (AWARDS), followed by choosing the corresponding progress note type for that particular encounter.
   3. Narrative documentation in the progress note will include, but not be limited to, the following:
      a. Date and time of entry, program location
      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
j. Return to clinic for future appointment

B. A summary of a consumer encounter written in an accepted medical professional or other health care provider format (e.g. DARP, SOAP) should include the following, if appropriate:
   1. **SOAP Notes:**
      a. **S**ubjective: Consumer's self-reported data on presenting problems and symptoms to include psychosocial stressors and life cycle issues impacting daily functioning in home, work and community. Significant events or changes in the life of the consumer, as appropriate.
      b. **O**bjective: Objective assessment using AWARDS Mental Status Examination (MSE).
      c. **A**ssessment: Provider's assessment of consumer's presenting problems and symptoms, coping mechanism, internal/external resources to access care, diagnosis and recommendations for type and level of care;
      d. **P**rogress/**P**lan: Provider's clinical rationale of consumer's progress toward achievement of identified treatment objectives and goals to include types of services/intervention provided. Note should include consumer's responses to services/interventions during the meeting/session with recommendations to continue type/frequency services and/or referrals for additional services as needed. Provider to document "Return to Clinic" (RTC) for future appointments and/or services.
   2. **DA(R)P Notes**
      a. **D**ata: This section includes subjective and objective or observable and identifiable behaviors and traits, as well as the therapist observations and all content and process notes from the sessions. Similar to SOAP note's objective and subjective findings.
      b. **A**ssessment & **R**esponse: includes the clinical impressions, hypotheses, and rationale for the provider's professional judgement. Progress is also noted in this section.
      c. **P**lan: refers to the original treatment and any response/revisions needed based on the provider's recent interaction with the consumer. Provider to document "Return to Clinic" (RTC) for future appointments and/or services.

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