Table of Contents

INTRODUCTION 1

DOCUMENTATION ELEMENTS—AGENCY LEVEL 1

DOCUMENTATION ELEMENTS—PROGRAM VARIATIONS 2

CLIENT RECORD FORMAT—ISIS AND PAPER FILES 2

SERVICE DOCUMENTATION—CONTENT 3

REQUIRED SUPPLEMENTAL INFORMATION 3

CASE SUPERVISION 4

WORKING NOTES AND PAPER FILES 4

INTRODUCTION

It is a professional responsibility to provide complete and accurate documentation of client service. The records which result provide the basis upon which we bill for and receive compensation for our work. They also provide legal protection to the agency in the event services are questioned. Most importantly, however, they serve the essential clinical function of providing the information which we use to assess the effectiveness of our work for the benefit both of the individual client and family and for overall program operations. To be meaningful, our records must be uniform in content and sufficient to meet these clinical and business standards. To be useful, they must be in a form that any service provider within or without the agency, with or without familiarity with the individual case may review them and understand exactly what occurred and what service was provided, and when and how it was provided. The following guidelines are mandated to achieve those ends:

DOCUMENTATION ELEMENTS—AGENCY LEVEL

Documentation elements are the primary components of information that are required to be a part of every client record. The exact requirements relating to the depth and detail of information to be included with each element for a particular client may vary from discipline to discipline, but some information regarding each element must be in each file. For our practice, Family Resources adopts the required elements identified by the Council on Accreditation (COA). Those elements are:

- ✓ Biographical or other identifying information.
- ✓ The reason for requesting or being referred for services.
- ✓ The assessment.

Ref: COA G9.5, G9.6.04, FRI Client Confidentiality, FRI Quality Monitoring

- ✓ The service plan, including mutually negotiated goals and objectives.
- ✓ Copies of all signed, written consent forms.
- ✓ A description of the services provided either by directly or by referral.
- ✓ Routine documentation of ongoing services.
- ✓ Recommendations for ongoing and/or future service needs and assignment of aftercare or follow up responsibility, if needed and appropriate; and
- ✓ A closing summary entered within thirty days of termination or discharge.

No file, then, can be considered complete if any of these identified elements is missing. In those instances where essential information is unavailable or cannot be obtained, this must be noted and the record must contain evidence of our due diligence in an effort to obtain the data. In other words, there is no such thing as a blank response or an "NA" with regard to any of these items.

DOCUMENTATION ELEMENTS—PROGRAM VARIATIONS

Each discipline within the Family Resources array of programs will have its own version of the format and content of the documentation required to meet these elements. Much of this variation is determined by the nature of the service provided. Are they time limited and crisis oriented, or are they long term and in depth? In addition to this natural variation, however, there exists another overriding influence in the form of the documentation requirements related to regulated, grant funded, or contracted services. Simply put, our funders, regulators, licensors, and third party payers have their own specific requirements that apply to some or all of these elements. For that reason, each program is required to develop individual requirements addressing the essential elements in the following particulars:

- ✓ Identifying the depth of information required to be included for each element.
- ✓ Identifying any additional requirement imposed by the nature of the service or regulatory or funding source applicable to the service.
- ✓ Providing instruction to staff relating to the level of documentation required in relationship to missing or incomplete information.
- ✓ Detailing any additional documentation required within the program not otherwise identified. (Control or restraint reports in a residential setting, client grievances, or collateral contacts provide non exclusive examples of this type of record keeping requirement.)

CLIENT RECORD FORMAT—ISIS AND PAPER FILES

Family Resources uses a combined system of electronic data entry (ISIS or Integrated Service Information System) and traditional paper files to archive its official client records. In general, internally generated information, such as client demographics, client service, and billing and business information is entered by computer into ISIS. External documents, and documents required to be available for authentication (signed consents, service plans, service authorizations, etc) are retained in paper files. Where the service is available, paper documents that are not required originals (copies of court orders, etc) may be "scanned" into ISIS as a space saving technique. The format and process relating to the creation of ISIS records is detailed in the ISIS manual and through ISIS training. By contrast, this section of the

practice manual deals with the required content and substance of records, regardless of the medium by which they are created.

SERVICE DOCUMENTATION—CONTENT

The most basic of the required client record elements is the "routine documentation of ongoing services". Within our ISIS format, this documentation generally takes the form of case notes and progress reports or summaries. A case note is a description of a client contact resulting in the provision of service or otherwise relevant to the provision of service. Case notes are to be recorded within 24 hours of the contact. A progress report is a summary of relevant actions and events and their implications with regard to the service plan over a defined period of time. Progress reports are required to be included in all open files no less than quarterly, and in some instances, according to program requirements, more frequently.

In this context, it must be recognized that there will be variation between programs related to what constitutes a contact relevant to the provision of service and with regard to the form and content required to satisfy external requirements for billing and accreditation. Notwithstanding these variations, however, there are some fundamental benchmarks for acceptable documentation which have universal application. Thus, Family Resources expects all client service records to meet the following criteria:

- ✓ Each entry must be specific and factual. (Describe what happened. Avoid using jargon or adjectives, such as "client processed", client was "assaultive", etc. Such terminology is subjective and does not allow subsequent analysis of the event).
- ✓ Each entry should be related to the nature of the service and the needs of the client. (How does what happened relate to the service plan, assessment or progress?)
- ✓ Each entry must provide factual information concerning the service provided. (What did the service provider actually do and why? Once again jargon and adjectives are uninformative and to be avoided.)
- ✓ Each entry must be authenticated by the person providing the service and provide the time and location of service provision.

REQUIRED SUPPLEMENTAL INFORMATION

A complete client record must contain any supplemental or collateral information relevant or necessary to the intake, assessment, service plan or service objectives. Without that information, those processes are, at best, guess work. At a minimum, such supplemental information would include the following:

- ✓ Medical, psychological or psychiatric records and evaluations for any client having a history in any of those areas relevant to the present need or service.
- ✓ All court orders mandating or relating to the service anticipated to be provided.
- ✓ Other legal or court documents relevant to the issues being addressed.
- ✓ Sufficient legal documentation regarding who has authority to provide consent when the client is a minor or an adult under legal disability.

Ref: COA G9.5, G9.6.04, FRI Client Confidentiality, FRI Quality Monitoring

- ✓ Complete information concerning services provided by other organizations or service providers.
- ✓ Any other information necessary and relevant to the service provided or required under program specific guidelines.

CASE SUPERVISION

Family Resources' quality monitoring protocols require ongoing case work or clinical supervision. The assigned supervisor must document this activity through case supervision notes or approving progress reports no less than quarterly, or by approving closing summaries for short term cases.(See FRI practice manual, Quality Monitoring)

WORKING NOTES AND PAPER FILES

As noted, essential client related documents not susceptible to electronic recording in ISIS are maintained in traditional client files. These files are official agency documents which must be kept in a secure fashion. (See FRI procedure re: Client Records in Client Confidentiality). Inevitably, a number of less official documents will be generated during the course of client service. These documents may consist of working notes of the service provider, extra copies of documents from the official file kept for easy reference, drafts of work in progress, and the like. While these documents serve are at least temporarily functional, it must be recognized that they present a security problem relating to client confidentiality. The following requirements are to be followed to alleviate those issues:

- ✓ Supplemental documentation (Court orders, letters, etc) are to be converted to electronic documents by scanning where that technology is available. Where scanning is not yet available, they are to be kept in secure client files.
- ✓ Working notes, papers and "hard copy" documents being used by a service provider are to be kept by that provider in a sufficiently secure manner. (See procedure for Client Confidentiality).
- ✓ Any such paper document or duplicate is to be shredded or disposed of in a secure manner immediately on the termination of its use.
- ✓ Such documents should not be created or printed except when necessary.
- ✓ Any note or document which the provider believes should be a part of the permanent client record should be scanned or secured in the same manner as supplemental documentation.