SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Department
Policy and Procedure

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|---|---|---|---|
| **Section** | Clinical | **Effective:** | 4/1/2009 |
| **Sub-section** | Documentation | **Version:** | 2.4 |
| **Policy** | Mental Health Progress Notes | **Last Revised:** | 7/10/2019 |
| **Policy #** | 8.102 | | |

**Director's Approval** _____ Alice Gleghorn, PhD **Date** 8/6/19

**Deputy Director's Approval** _____ Pam Fisher, Psy.D **Date** 8-6-19

**Audit Date:** 7/10/2022

**Supersedes:** PP #41 – Timeliness of Progress Notes (rev. 12/14/16)

## 1. PURPOSE/SCOPE

1.1. To describe clinical medical record documentation standards that are reflective of best practices and health care ethics for the accurate and timely completion of progress notes.

1.2. This policy applies to all Santa Barbara County Department of Behavioral Wellness (hereafter "the Department") employees and contracted community-based organizations (CBOs) that provide and document mental health services, with the exception of psychiatrists (MD/DO).

## 2. POLICY

2.1. The Department shall ensure that all progress note documentation[1] is written and maintained in a manner that is clear, complete, current, and organized in accordance with state and federal regulatory requirements. In addition, the Department shall comply with the provisions stipulated in the Mental Health Plan (MHP) contract with the California Department of Health Care Services (DHCS).

## 3. BACKGROUND

3.1. Behavioral health professionals are tasked with providing care and treatment to some of the most vulnerable individuals of society. Adequately meeting the intense needs of these individuals is impossible without documenting each service provided in a complete, accurate and timely manner. Documentation that is completed during or immediately following service delivery is more likely to capture and preserve the clinical integrity of those services. Conversely, treatment records that are incomplete, incorrect or written

[1] For information on documentation standards for client assessments and treatment plans, please see policy 8.100 "Mental Health Client Assessment" and 8.101 "Client Treatment Plans".

long after the service date are considered unreliable. Documentation that does not meet minimum standards may influence whether or not the individual receives proper care, and could result in unintended complications or negative consequences.

3.2. The Board of Behavioral Sciences (BBS) is a consumer protection agency that has established standards for competent and ethical behavior by professionals under its jurisdiction. Per BBS record keeping standards, "the failure to keep behavioral health records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered," could result in suspension or revocation of a license if a licensee is found to be guilty of professional misconduct.

## 4. DEFINITIONS

The following terms are limited to the purposes of this policy:

4.1. **Draft or pending** – progress note that can be in any state of development, or has been submitted for note review.

4.2. **Finalized** – officially signing and submitting a progress note. Finalizing a note signifies that the documentation for that service is complete and the result is the legal document on record. A note that is finalized cannot be edited directly; any changes will require separate documentation via an addendum.

## 5. TIMELINESS

5.1. Per the California Code of Regulations (CCR), Title 9, all progress notes must be completed in a timely manner. Best practices dictate that progress notes are completed immediately following the service, but no later than the end of the day on which the service is provided.

5.2. A progress note will be considered "on time" if completed within the following timeframes (NOTE: Staff will strive to meet these timeliness standards whenever possible):

1. **Crisis Intervention progress notes** should be completed immediately following a crisis interaction but no later than the end of the staff's shift. If mitigating circumstances interfere with the completion of documentation within this timeframe, staff may consult an immediate supervisor and request an extension not to exceed 24 hours. In the event that a supervisor is not available, staff will consult and seek approval from a Regional Manager or on-call administrator.
2. **Individual progress notes** are ideally **finalized** within 10 calendar days from the date and time of service.
3. **Group progress notes** and associated individual progress notes are ideally **finalized** within 7 calendar days from the date and time of service. Staff will ensure an individual progress note is written for each client participant in the group.
4. For staff on note review and/or notes requiring co-signature, progress notes must be **submitted for review** within 5 calendar days from the date and time of service. These

notes will be reviewed, sent back to staff and **finalized** within 10 calendar days from the date and time of submission.

5.3. Staff are expected to self-monitor completion of progress notes on a regular basis. Any outstanding progress notes will be completed by staff prior to departing on vacations, planned leaves or planned separations from employment.

## 6. "DIRT" STRUCTURED PROGRESS NOTE FORMAT

6.1. To ensure progress notes are written in a standard format and capture all required elements, staff will utilize the DIRT format (**D**escription, **I**ntervention, **R**esponse, **T**reatment [Plan]) documentation structure. With the exception of services that are not claimed to the State (i.e. indirect service codes), all progress notes will use this format, including, but not limited to: Assessment, Crisis Intervention, Therapy, Rehabilitation, Targeted Case Management, Medication Support, Collateral, Plan Development, ICC (Intensive Care Coordination), and IHBC (Intensive Home-Based Services).

1. Each progress note must contain at a minimum the following information:
2. **Description** of presenting problem and/or reason for the current service activity – Using behaviorally-specific language, explain exactly and objectively how the client presents themself, or the reason for the current service activity as it relates to the impairments listed in the current Treatment Plan. Do not provide an interpretation of the presentation or use general psychological terms or jargon (e.g. instead of "client and family report increased panic at bedtime", write "client and family reports that client paces back and forth in her room at night for up to 2 hours and fears going to sleep..."). **Each progress note must "stand on its own" in demonstrating Medical Necessity.**
3. **Interventions** provided – Explicitly state and elaborate on what interventions staff applied to reduce the client's impairments or prevent deterioration in functioning. Ensure that the interventions applied are in the current Treatment Plan.
4. **Response** from the client or outcome (What did the client do or how did the client react or respond to the current service/intervention provided?) – If the intervention involves others present during the current session (i.e. parents, spouse), describe their response/reaction as well.
5. **Treatment** follow-up with next steps in the recovery process. Provide any follow up information (i.e. referrals provided, specific focus of treatment for next session) and information not related to interventions provided in session.

## 7. CONTENT INTEGRITY

Below are integral components that are required to produce a high-quality progress note. The list is non-exhaustive; for a complete account of progress note documentation, including the various types of progress notes, please refer to the Clinical Documentation Manual.

7.1. **Brevity** – Write progress notes that are brief, concise and to the point. Avoid lengthy narratives or superfluous information. Focus on essential, clinically imperative information.

7.2. **Client Quotes** – Whenever possible, capture exact client quotes as they report mental health symptoms and impairments.

7.3. **Confidentiality** – When referring to family members, spouses, or other clients, do not use their real name or any other personal identifying information. Instead, refer to the individual by stating their relationship to the client (e.g. "The client's father reports that …").

7.4. **Cultural and Linguistic Adaptations** – Document all cultural and linguistic adaptations or accommodations in each and every progress note.

7.5. **Abbreviations** – Standard abbreviations are acceptable in a progress note. Please refer to this list of abbreviations. If a word or phrase is abbreviated and is not on the list, identify and/or define when it is first used in the progress note.

## 8. MONITORING DOCUMENTATION COMPLETION

8.1. The Team Supervisor or a designee is responsible for monitoring and ensuring that all staff progress notes are finalized within the optimal timeframe.

8.2. Management Information Systems (MIS) will generate reports that list all progress notes in **draft** and **pending** form by Team Supervisor or clinic.

8.3. Prior to staff departing on vacation, planned leave, or planned separation from employment, the Team Supervisor or a designee is responsible for ensuring that all progress notes in **draft** and **pending** form are finalized.

8.4. Monitoring of staff success in timely completion of documentation will be reflected in Employee Performance Reviews (EPRs).

## ASSISTANCE

Celeste Andersen, JD, Chief of Compliance

Ana Vicuña, LCSW, Division Chief of Clinical Operations

## REFERENCE

Department of Consumer Affairs, Board of Behavioral Sciences. "Disciplinary Guidelines". Revised July 1st, 2013.

California Code of Regulations – Rehabilitative and Developmental Services
*Title 9, Chapter 11, Section 1810.440(c)*

California Code of Regulations – Social Security
*Title 22, Division 3, Chapter 3, Article 4, Section 51341.1*

Department of Health Care Services – Mental Health Plan
*Exhibit A, Attachment 1, Section 11.A*

## REVISION RECORD

| DATE | VERSION | REVISION DESCRIPTION |
|---|---|---|
| 10/20/16 | 2.1 | • Clarified that majority of progress notes require the DIRT documentation format<br>• Corrected description of DIRT: Description of the presenting problem, updating treatment plan, etc.<br>• In Section 6.2, explained which services can be provided prior to finalizing a treatment plan (i.e. "Assessment") |
| 11/29/16 | 2.2 | • Language from section 3.4 moved to 8.4 and modified to concentrate on compliance with documentation requirements.<br>• In section 7.2, clarified that exact quotes are to capture what the client reports specific to mental health symptoms and impairments. |
| 12/14/16 | 2.3 | • Clarified that the policy does not apply to psychiatrists (MD/DO)<br>• Added definition for "draft or pending"<br>• Removed reference to Medical Board of California as requirements apply to psychiatrists only. |
| 7/10/19 | 2.4 | • Amended timeliness for entering and finalizing individual progress notes, group progress notes, and for staff on note review. |

### *Culturally and Linguistically Competent Policies*

*The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).*