CHAPTER
EFFECTIVE CASE DOCUMENTATION
(2 CE HOURS)

Learning objectives

- To recognize that case documentation serves as a “gatekeeper” to approve/deny service to a client.
- To define the essential components of good case documentation.
- To facilitate understanding of how progress notes are connected to other documents found in the client chart.
- To recognize a significant event in the life of a client and understand the importance of including documentation about these events in a client’s progress notes.
- To provide recommendations to ensure that case records reflect unbiased data collection and information management (i.e. separating fact from fiction – “… as evidenced by …”).
- To introduce a variety of progress note formats that meet the diverse documentation needs of clinicians.
- To provide an overview of legal implications related to the accuracy and use of case documentation (i.e., the legacy of documentation).
- To understand the quality management perspective of reviewing case documentation.

Introduction

Clients seek the services of mental health practitioners for a variety of mental health issues. Case documentation in mental health is the mechanism that is utilized by clinicians to track the progress or decline of client functioning and to assess how close the client is to achieving treatment goal(s). Without documentation regarding the issues addressed during therapeutic sessions, intervention methods utilized and the client’s response to the intervention, the clinician would find it difficult to determine if the intervention was effective or whether the most pressing issues presented by the client were being addressed. Good case documentation demonstrates practitioner competency, allows readers of the information to understand how client needs have been addressed and protects the clinician from legal liability.

Purpose of case documentation

The content of case records can have a powerful and profound effect on the lives of clients and their families. For example, the professional opinion that is expressed in a case record can deny benefits to a client, determine whether a child is removed from the home, or support whether a parolee is released from prison. Long after professionals leave their employment, what has been written about a client will endure for others to read, interpret, implement, speculate about its meaning or evaluate its accuracy or related recommendations.

To help maintain focus, clinicians should keep in mind the importance of what they write, for whom, and for what purpose. For example, a psychological evaluation may be utilized to determine which parent should gain custody of his/her child or whether an individual is a safety risk to society and should be sent to prison. In either scenario, a clinician’s recommendations will have an impact on the client and those who are touched by the client’s life (i.e., family, friends, coworkers, neighbors, victims of the client’s crime, etc.)

While a number of professions utilize case notes, progress notes, chronological notes, etc., to document the concerns presented by a client/patient and a clinician’s intervention, for the purposes of this course, we will generically refer to “progress note” documentation. The intent of such documentation is to summarize the content of an encounter with a client and to state any interventions by clinicians or other staff that were utilized, as well as the outcomes of those interventions. To that end, progress notes should address the following:

- Concerns presented by the client or identified by the clinician.
- Client’s current status in treatment.
- Clinician/staff interventions.
- Changes in the client’s condition or diagnosis.
- Client’s progress toward discharge.

Connection between case documentation and client chart contents

Progress note information may be collectively utilized to develop an initial treatment plan, revise an existing treatment plan or determine that the client is no longer in need of services and is recommended for discharge. Thorough progress notes will clearly identify how the clinician arrived at treatment plan goals and objectives or other recommendations for client interventions.

Well-written progress notes should reflect client needs or behaviors that are addressed in the treatment plan. But, what happens if progress notes identify a client’s behavior that is not addressed in the treatment plan? If the need/behavior is something that is not a safety concern or is something that can wait to be addressed at a later time in the course of therapy while addressing more pressing issues (i.e., client is thinking about changing careers), some notation should be indicated in the progress notes. An example of this would be to document, “While processing concerns related to client’s current abuse of cocaine during substance abuse recovery treatment, client disclosed that he was thinking about changing careers when he completes his inpatient treatment. Clinician will address the reasons that lead to client’s substance abuse before addressing future employment plans.”

Safety concerns should be considered a priority to be addressed and incorporated into an amended treatment plan. Examples include emergency medical conditions, substance use, risk of suicide, self-injurious or attacking behavior. (COA 8th Edition Standards – RTX 3.05, 2006.) Prior to taking action, such as notifying other people at risk or filing a child abuse report, a client should be notified that subsequent actions/notifications are required by law, as the mental health Practitioner is a mandated reporter who is required to make these notifications to protect the client and/or others from harm.

Basic elements of case documentation

Good case documentation should tell the story of why a client was referred for services, the nature of services that were delivered, by whom services were delivered, the outcome of each intervention and the client’s response to strategies that were administered. Progress notes do not replace other types of documentation, such as assessments, treatment plans or incident reporting. However, progress notes act as a unifying framework to objectively document client mental health or behavioral concerns that may be identified in any of these other documents.

The narrative should contain only the most relevant information related to services being rendered. If the following statement, “Clinician played checkers with client. Staff won.” appeared in a client chart, consider the relevance of this stand-alone statement. But what if the service being provided was anger management therapy? This statement is more meaningful when it goes on further to describe how the client handled the loss. The following additional information, “Client became red in the face, hands were shaking and threw the checker board across the room,” would make the previous statement relevant enough to be included in the case record. Without the additional information, the original statement gives no insight to client functioning or service provision and would be better if omitted from the documentation.

Consider this example: The case record reads, “Offered the client ice cream. Client chose chocolate.” What is the relevance of this stand-alone statement? What if the treatment goal being addressed was improving a client’s decision-making skills? Enhancing the documentation to include the following information would provide a more descriptive picture of the clinician’s intervention and the client’s progress with this goal: “Clinician offered client a choice between vanilla, chocolate and strawberry ice cream. After considering the choices for approximately 60 seconds, client chose chocolate. This is an improvement over last attempt of 90 seconds delay in making a selection.”

Information that is documented in a client chart can come from a variety of sources such as:

- Interviews with the client, family, caregivers, or other interested individuals.
- Input from treatment team members.
- Assessment tools.
- Diagnostic tests.
- Monitoring of the treatment plan.

Collecting as much information from the client directly will not only aid in gathering detailed information about a client and his/her circumstances, but it will provide insight into how the client perceives his/her history and current situation. Contacts with family members, caregivers and partnering service providers
should also be included in the progress notes. This will assist in giving the entire picture of involved parties who provided support or were identified as part of the client’s concerns.

Elements to be included in a standard progress note may include:
- Identification of the client.
- Dates and times of contact with the client or individuals involved with the client.
- Type of contact (i.e. telephone call, home visit, office visit, etc.).
- Factual summary of the encounter with the client, including outcomes of interventions.
- Documentation of client’s progress/decline relative to treatment plan goals.
- Client adherence to treatment plan as measured by increase in attendance at planned treatment sessions or decrease in unplanned treatments or procedures (Social Work Best Practice, 2007).
- Interventions.
- Description of services provided directly or by referral.
- Each entry should be initialed/signed by the author.

In addition, entries should be clearly legible, kept up-to-date from intake through termination and written within 24 hours of contact with the person served.

Additional documentation elements in an out-of-home setting
Therapeutic services that are provided to clients residing in an out-of-home setting (i.e. foster care, emergency shelter, group home, residential treatment, transitional housing, etc.) incorporate additional elements that should be documented in progress notes. Good documentation in this type of setting will assist in preparing reports to the court or other authorities to establish the client’s adjustment to and continued appropriate placement in or discharge from a residential setting. Features of documentation in an out-of-home placement include:
- Justification that the client is placed in the most appropriate setting.
- Explaining why continued placement is appropriate.
- Description of behavioral interventions employed and the client’s response to the intervention.
- Description of client’s connection with family, other residents and the community.
- Providing a logical connection between documentation and any recommendation to terminate a parent’s rights.
- Why returning the client to the family is recommended.
- Transition from out-of-home placement back to the home or another setting.
- Whether an advanced mental health directive is in place.

Additional documentation elements in a clinical or medical setting
A clinical or medical setting also has its own unique features that impact what is documented in a progress note. Medical settings, in particular, may have numerous professionals that have access to a client’s chart. While this may aid in providing comprehensive care for a client, it also has the potential of making massive amounts of information available to more than one person and allows for conflicting professional judgment or diagnoses to be documented. Following are some elements that might be included in documentation found in a clinical or medical setting:
- Identifying precipitating crisis events.
- Documenting which support services and resources were utilized and by which professional(s) to stabilize the client.
- Identifying client’s coping skills.
- Documenting of conducting a risk assessment and the findings of that assessment.
- Documenting development of a safety plan, if needed.
- Justification for more intensive care or discharge.
- If documentation by various treatment team members are integrated into the same chart, the chart reflects continuity of care among various professionals.

Significant events that should be addressed in case documentation
At least one presenting concern is identified during the intake process. But in the course of living everyday life, other additional stressors may also occur that could have an impact on how treatment is conducted. Be alert for signs of any of the following stressors that affect a client’s life, document the potential impact on the client and adjust the treatment plan accordingly:
- Death, illness or injury of an individual who is significant to the client.
- Marriage.
- Divorce or separation of the client from their spouse or partner.
- Change in family or household configuration.
- Domestic violence.
- Child abuse or neglect.
- Substance use/abuse.
- Witness to or participation in violent or illegal acts.
- Financial difficulties.
- Employment related concerns.
- Relationship stressors.

When documentation indicates that a client be discharged/terminated
At some point, discharge of a client from treatment will be appropriate for a variety of reasons. If any of the following circumstances should occur, the clinician should consider discharging the client from treatment:
- When the client achieves his/her treatment goals.
- When the client no longer wants the organization’s/therapist’s services.
- When the client no longer meets eligibility criteria.
- When the client refuses to meet program standards or requirements.
- When the client has needs that exceed organizational/therapist resources/expertise.
- When the client is court-involved and the court approves closure for mandated clients (COA 7th Edition Standards – G9.7.02, 1999).
- When the client moves out of the service area.
- When the client is referred to another service provider.

Thorough documentation throughout the duration of the client’s treatment will lead to a logical conclusion that the client’s discharge should occur. Best practice would indicate that the clinician should make recommendations for continuity of the client’s care, if necessary, prior to the client’s discharge.

Case documentation formats for implementation
A variety of formats are currently being utilized by clinicians to aid them in recording client treatment. The format utilized by each clinician will be dependent upon work place requirements or personal preference of the clinician. Each of the following examples has common themes and may be organized into a logical flow that meets the clinician’s needs. Some of the more common examples are as follows:

SOAP style notes
What does SOAP stand for?
S = subjective
The subjective information pertains to what the client reveals during the session. Subjective information may include a client’s chief complaint or history of present illness. (Aghili, 1997) A clinician would also document client/family reports of relevant information. Direct quotes from the client should be put in quotation marks (“…”). Only exact words from the client should be in quotes. Things discussed during the session are actually paraphrased statements from the client. What the therapist said to the client may include sentences starting with the words: “discussed,” “talked about” and “stated.” The clinician should use few quotes to avoid the possibility of misquoting.

O = objective
The objective information deals with facts of the matter such as baseline data, vital signs, physical exam or a diagnosis. (Aghili, 1997) What the client looked like, if different from usual or related to the treatment objective, could be included in this section. Orientation X 3 (is the client aware of person, place and time?) is an example of objective information. Behaviors, actions, mood or affect may also be considered objective recordings. In describing mood, use such words as “appeared dysphoric,” “euphymic,” “eledated,” “eluellent,” “elevated,” “neutral,” “apathetic.” Affect describes the physical or behavioral indicators of mood such as smiling, frowning, teary, fidgeting, etc. Do not use words such as happy, sad, scared or mad without qualifying how the clinician arrived at this determination.
**A = assessment**
The assessment section is where the clinician interprets the objective information, as well as the subjective data. The clinician will relay the client’s mood and affect, how well he/she is oriented, suicidal/homicidal, etc. In this section, the clinician should use sentences starting with the words: “appears” or “seems.” This is a clinical impression of the client’s progress toward his/her goals and objectives. Does the client appear to be making progress in this area? If the client needs to address a new treatment goal, it is stated in this section.

**P = plan**
The plan includes what the clinician plans to do next with this client. This may be what the clinician plans to do during the next session or the clinician may continue to follow up from the previous session. The clinician may indicate that he/she intends to continue the assessment, if it has not been completed, or may outline the intervention plan. Frequency and duration of therapy should be documented in this section. Long-term goals and at least one short-term objective should be noted as part of the plan. Any new goals should also be stated in this section. (Indiana University, 2006.)

Here, the clinician may include what assignments the clinician gave to the client to complete. Does the clinician plan to continue with the treatment objective the way it is written or is the clinician going to vary or change his/her method? Avoid simply stating, “Continue treatment plan,” as it gives no detail regarding how the clinician intends to move forward with the client’s treatment plan. Multiple goals may be grouped together for discussion in this section.

When using the SOAP note format, be sure to incorporate the following elements into the progress note for further clarity.

**Client’s response**
This is a client’s response to the intervention provided by the clinician. For example, the client may respond by “angrily stating that he/she had never cheated on his/her spouse,” or the client may respond by “shrugging his/her shoulders and refusing to respond verbally.”

**Intervention**
This is a critical element of progress notes because it tells the reader what the clinician did during the session. Interventions can vary, from “providing conflict resolution skill building,” to “assisting the client to externalize the problem.” The intervention should be appropriate to the needs of the client. For example, a client who presents loss issues during a session would need a counselor to provide active listening and mirroring of responses, normalizing of mood, etc. Following is a non-exhaustive list of interventions that may be documented in progress notes.

**Intervention ideas:**
- Crisis/supportive counseling.
- Conflict resolution skill building.
- Behavior management instruction.
- Provided child development information.
- Effective parenting skills development.
- Child and family behavior management development techniques.
- Modeling.
- Role playing.
- Providing educational literature.
- Discussion.
- Cognitive behavioral techniques.
- Communication techniques.
- Housing, food, clothing and budgeting needs may be assessed and referrals made.
- Referrals, phone calls, follow-up, case documentation, contacts with other involved/interested parties, court appearances, case staffings and interaction with community institutions.
- Joining with the client.
- Reframing.
- Strength focusing.
- Restructuring/building parental authority.
- Boundary clarification.
- Helping clients express feelings/affect.
- Relaxation techniques.
- Systemic interventions.
- Psycho-educational handouts.
- Play therapy.
- Development of a natural support system.
- Problem-solving skills.
- Expanding family focus from problem-focused to solution-focused.
- Re-labeling problem behavior.
- Assisting client to externalize the problem.
- Coping skills clarification/education.

**TALP style notes**
A similar style of notes to the SOAP format, TALP replaces the term “subjective” with “topic” and replaces “objective” with “level of participation.” A brief description of TALP terms follows:

**Topic:** Topic addressed in the session or during client contact. In this section, indicate the treatment plan goal that the topic is related to.

**Assessment:** Assessment of the client, progress related to the goal since the last session, observations, data, findings.

**Level of participation:** Quality of involvement of client in the session, client’s reaction and response to interventions.

**Plan:** Plan of action for future sessions, any assignments given to the client, follow-up to be performed by the clinician, staff or client, treatment focus until next session, etc.

**BIRP style notes**
Yet another version of progress note documentation utilizes terms similar to the SOAP style notes, as follows:

**Behavior:** Documentation of the client’s behavior that can be described with some of the following terms: withdrawn, adjusting well, hyperactive, impulsive, friendly, interacting w/peers, angry, assertive, aggressive, isolating, sad, tearful, scared, clingy, needy, attention seeking, well mannered, polite, calm, anxious, edgy, irritable, excited, happy.

**Intervention:** Describes the clinician’s intervention with the client, as noted with the following terms: praised, redirected, encouraged, educated, reviewed, supported, outcomes, explained, processed.

**Response:** Describes the client’s response to the clinician’s intervention by utilizing the following terms as examples of documentation: cooperated, accepted redirection, followed directions, completed task, acted out, responded positively, negatively, demonstrated understanding.

**Plan:** As with the two previous note styles, BIRP notes incorporate some of the following terms in describing the plan for future services to the client: assess, monitor, support, educate, encourage.

**APIE style notes**
One more example of how progress notes may be configured involves the APIE format. Here, the order of documenting the information is rearranged from the familiar SOAP style.

**Assessing the client** – Assessment of how the client appears at initial contact. Items may include manner of dress, affect, feelings expressed, etc. Examples: Disheveled appearance, neatly dressed, angry over not getting day pass, affect sad, as evidenced by teary eyes.

**Problem** – May be one of the problems listed on the client’s treatment plan, or a new concern that is being presented.

**Intervention** – Method of effecting change with the client. Examples: Process group, relaxation training, 1:1, social skills group, role-playing.

**Evaluation and response**
**Response** – Includes the response of the client upon receiving intervention. Examples: Client sat quietly and responded only upon direct prompting; client became angry at peers upon confrontation; client participated in all group activities.

**Evaluation** – Recommendations for further work, justification for further treatment. Examples: continue relaxation training to facilitate ability to reduce the number of emotional outbursts; continue group therapy to work through abuse issues.

**Example:**
A – Client appeared anxious, as evidenced by shifting in chair.

P – Problem: Depressive symptomology.

I – Art therapy group, 1:1 intervention.

E – (Response) Client became actively involved in the therapy session after being initially resistant. Identified three irrational beliefs. (Evaluation) Continue art therapy group to help client gain insight into belief systems influencing behavior and depression.
**Progress note sample format**

The following progress note example utilizes an amalgam of the formats listed above, and is synthesized into the TALP progress notes. The client, Seth, is a group home resident. His documentation reflects staff information about Seth and provides insight into his (client) functioning. Some of the information provided by the youth care workers in this example does not address clinical issues that a mental health practitioner would determine to be relevant to address in a therapeutic session. However, the practitioner will review their notes and assess which behaviors or concerns should be discussed in session with the client. The progress notes allow the clinician to utilize all available information to provide better therapeutic care to the client.

The client’s treatment plan is as follows and is addressed in the subsequent sample progress note format.

**Goal No. 1:** Reduce the frequency of anger outbursts from three per week to two per week.
- **Obj. 1:** Client to participate in individual therapy once a week.
- **Obj. 2:** Therapist to monitor effects of medication and make referral to psychiatrist when deemed appropriate.
- **Obj. 3:** Staff to implement de-escalation techniques when necessary to minimize the potential of harm to client or others.

**Goal No. 2:** Reduce the frequency of suicidal ideations, gestures or attempts from one per month to zero.
- **Obj. 1:** Client to report feelings of harming self or others to staff before client takes action.
- **Obj. 2:** Staff will develop a safety plan/contract with client when client reports desire to harm self or others.
- **Obj. 3:** Staff will immediately report client’s desire to harm self or others to client’s clinician.
- **Obj. 4:** Clinician will provide crisis counseling to client as needed to reduce the likelihood of hospitalizing the client.

**Goal No. 3:** Client to improve independent living skills.
- **Obj. 1:** Client to learn to do his own laundry, purchase groceries and clothes.
- **Obj. 2:** Staff to provide client with opportunities to do his laundry and shop for clothes.
- **Obj. 3:** Staff to demonstrate laundry techniques and discuss comparison shopping, use of coupons, etc. with the client.

Client: Seth G. SSN: XXX-XX-XXXX
Medicaid #: XXXXXXXX
Diagnosis: 296.23 CGAS Score: XXX
Service Dates: 06/20/07
Primary Counselor: Arthur Mason

**Daily treatment interventions (including observations made by youth care workers)**

- **Sat.** Took client grocery shopping. Client engaged in verbal threats to another resident (V.F.) for sitting in the front seat of the van. Youth care worker calmed the situation by offering to have the client sit in the front seat on the return trip. Client made good choices in selecting produce. Client had trouble making change at the time of check-out.

- **Sun.** Youth care worker assisted client in doing his laundry. Staff had to prompt client three times. Several prompts were required to get client to fold his laundry and put it away in his room. Client had an argument with his girlfriend on the phone because he thought she was cheating on him.

- **Mon.** Client received a “U” in school for calling another student (A.R.) a name. Upon return home from school, client was slamming doors and throwing around his school books. Staff redirected client to take a 20-minute time out. Client did not complete any homework.

- **Tues.** After school, client engaged in a fist fight with V.F. for allegedly taking one of client’s CDs. Client was restrained. Therapist was called to intervene.

- **Wed.** Had trouble getting client out of bed for school. Client stated, “What’s the point? I’m going to flunk out anyway.” After much coaxing, client finally got dressed and arrived at school 20 minutes late. Client had 1:1 therapy this afternoon.

- **Thurs.** Client refused to go to school, stating, “I won’t need it when I’m dead.” Staff negotiated a safety contract and contacted client’s therapist. Staff to visually check on client every 15 minutes.

- **Fri.** Client went to school today. Staff received prescription for increase in Paxil dosage. Client non-compliant with setting the dinner table. As a result, client lost TV time.

**Treatment interventions addressed by clinician with client (Record as behavior presented, staff interventions, client response)**

Please indicate related treatment plan goals. (Include the following information in your documentation.)

**Topic:** The topic includes what is addressed in the session/contact. This can include direct quotes from the client, but direct quotes should be put in quotation marks, and only exact words from the client are put in quotation marks. Include what was discussed and/or paraphrased statements from the client, as well as what therapist said to the client. This includes sentences starting with the words, “discussed,” “talked about,” and “stated.” Use few quotes to avoid the possibility of misquoting. Include what the client looked like, if different from usual or related to the treatment objective. Also include orientation X 3 (is the person aware of person, place and time?) And include behaviors, actions and mood, affect. In describing mood, use the words such as “appeared” dysphoric, euthymic, elated, ebullient, elevated, neutral, and/or apathetic. The word “affect” describes the physical or behavioral indicators of mood, such as smiling, frowning, tearful, fidgeting, etc. Do not use words such as happy, sad, scared, mad.

**Assessment includes:**
- Client assessment.
- Progress on the goal since the last session.
- Observations, data, findings. Use sentences starting with the words, “appears” or “seems.” This is your clinical impression of the client’s progress toward his or her goal and objective.
- Does the client seem to understand the goals and the situation?
- Does the client appear to be making progress in this area?

**Level of participation includes:**
- Client’s involvement in the session.
- Client’s reaction.
- Client’s response to interventions.

**Individual therapy/counseling: Date: 6/19/07**

**Start time: 3:50p Stop time: 4:15p**

Discussed fist fight client had with another resident. Client had no evidence the other resident took his CD. Client knew other resident liked the same music, so assumed the other resident took the CD. Client has had difficulties with this resident before and feels that the other boy hates the client. Discussed needing to have proof before confronting others. Role played techniques for asking the other boy if he had taken the CD.

Asked client about what happened in the phone conversation with his girlfriend. Client stated that he saw the girlfriend looking at another student and felt that she was disrespecting him. Attempted to reframe the situation. Client became...
belligerent and started yelling that the therapist didn’t know what he was talking about.

Discussed reason for calling another student a name at school. Client didn’t like the way the other boy walked. Discussed perceptions of others and how others might perceive the client.

Individual therapy/counseling: Date: 6/20/07 Start time: 4:15p Stop time: 5:00p
Client seemed sullen, with eyes cast downward and reported feeling hopeless about making any progress at school. Did not complete homework earlier this week. Had an altercation with another student because of the way the other student “walked.” Asked the client if he had any plans to hurt himself. Client shrugged his shoulders and said, “Not really.” Requested that client inform staff or therapist if he thinks about hurting himself or someone else and reframed his perceptions. Client did not respond verbally, just stared into space.

Individual therapy/counseling: Date: 6/21/07 Start time: 9:15a Stop time: 10:00a
Client appeared depressed as evidenced by getting tears in his eyes several times during the session. Client reluctant to engage in discussion, but reported that he feels like he can’t do anything right and that he gets blamed for everything in the group home. Reviewed the elements of his safety plan. Discussed the importance of taking his Paxil daily. Client admits to “cheeking” his medication in the past. Therapist to talk to psychiatrist about increasing the importance of taking his Paxil daily. Client revealed that he has been having suicidal thoughts. Client shared that he has been having thoughts of walking away from his home. Client is currently not taking his Paxil. Therapist recommends that the client speak to their psychiatrist about increasing the importance of taking his Paxil daily.

Significant events that occurred this week (include contact with family, school and/or other involved agencies): Indicate related treatment plan goals, if applicable. Negative contact with his girlfriend on the phone. Client mentioned that he believes the girlfriend is seeing someone else. Client shared that he has been having thoughts of walking away from his home. Client is currently not taking his Paxil. Therapist recommends that the client speak to their psychiatrist about increasing the importance of taking his Paxil daily.

Plan of action: Include plan of action for future sessions, any assignments given, follow-up to be performed by counselor, staff or client, treatment focus until next session, etc. What are you going to do next session? What assignments did you make for the client to complete? Do you plan to continue with the treatment objective the way it is written, or are you going to vary or change your method? Do not simply copy the treatment plan description of the method. Avoid simply stating, “continue treatment plan.”

- Continue to engage client in discussion about how he perceives himself and others.
- Develop better communication skills by role-playing how to communicate with others, particularly when asking for assistance.
- Continue to monitor effects of medication.
- Reframe situations when client feels useless or hopeless.
- Redirect issues back to client.

Legal considerations in case documentation
“In addition to supporting the delivery of services, case records are an important risk management tool. Well-maintained records can help shield the organization or therapist from allegations of misconduct and negligence, while poorly-maintained records and improper documentation are known as a liability.” [COA 8th Edition Standards – RPM 7] While documenting in a case record, keep in mind that any part of the client file can be subpoenaed at any time or may be viewed by judges, attorneys and clients. Therefore, documentation should occur as soon as possible after contact with the client. Entries should be factual, objective, specific, clear. Use correct grammar and spelling that indicates that you at least were aware of the objective during the session. Do not leave an objective unaddressed.

Imagine if the following scenario were to occur:
Several pages of your case documentation have been enlarged 50 times their original size to be displayed on poster board in the court room. It is apparent that the documentation shows numerous entry errors, misspellings and incorrect grammar. The Defense Attorney asks you, “So, Mrs. Doright, is this an example of your style of documentation?” You confirm that it is. He next asks you, “Would you say that this example shows a number of inaccuracies?” (Implying that your judgment is in question, based on the errors in documentation.) To reduce the likelihood that your professionalism isn’t suspect, ensure that the mechanics of your documentation are well prepared and reflect your attention to detail. Legal cases are won and lost every day based on what is/is not contained in the chart.

Since either the author of the progress note, and/or other staff members that subsequently provide services to the client may have to defend the content of the case record to an attorney or judge, clarity between observed facts and professional opinion is important to be distinguished. To avoid making subjective comments that cannot be substantiated, when describing any summarizing statement (e.g., the client appeared depressed), follow that statement with the phrase “as evidenced by…” (e.g., intermittent crying when discussing her relationship with her teenage son, etc.).

Progress note errors
Under no circumstances should Wite-Out or any other type of correction fluid/tape be used in correcting errors in a client record. Altering a record destroys your credibility in a lawsuit, could compromise professional liability insurance coverage, could lead to sanctions from a licensing body and will impact a clinician’s professional reputation. In addition, altering a record may be considered a criminal act. (Psychiatric News, 2007.) Errors will inevitably occur when preparing progress notes. While correcting these errors, the original data must still remain accessible for auditing purposes. (Aghili, 1997.) When correcting an error is necessary, such as changing “inside” to “outside,” strike through the original information, write the word “error” near the entry and initial the correction. Then enter in the correct information and initial that subsequent entry.

Example: “The client reported that she left the baby outside the home while she engaged in an argument with her boyfriend.” – It
“The client reported that she left the baby inside the living room while she engaged in an argument with her boyfriend.”

When a clinician changes his/her professional opinion or diagnosis, other parameters apply. Sometimes this occurs when additional information becomes available or following subsequent consideration. When this occurs, the original diagnosis of “depression” may be replaced with “bipolar disorder.” Each entry stands alone as its own diagnosis at the original point in time that it was written. The secondary diagnosis may refer to the original diagnosis of depression and indicate what led to the subsequent change in client diagnosis.

Signing progress notes
The availability of electronic documentation gives a new meaning to “signing” a progress note. Signing or initialing a paper chart addresses that statement (e.g., the client appeared depressed), follow that statement with the phrase “as evidenced by…” (e.g., intermittent crying when discussing her relationship with her teenage son, etc.).

The ideal progress note data entry system would allow for an electronic signature at the
Conclusion
Mental health practitioners’ works are documented for the most part in progress notes. The quality of their notes can identify the author as being thorough with sound, professional judgment or as a clinician that often makes errors, therefore casting doubt on their credibility. Detailed, accurate progress notes are beneficial to the clinician in that they accurately reflect the client’s concerns, how these concerns were addressed in therapy and the client’s response to the therapeutic intervention.

Implementing effective case documentation will allow for continuity of treatment should the clinician leave his/her position, the client is discharged from treatment and/or later needs additional treatment. Good progress notes always tell the story of the client’s concerns, his/her interventions and his/her progress from initiation of service until discharge.

1. Aclinician’s progress notes should address the following
   a. concerns presented by the client or identified by the clinician.
   b. client’s current status in treatment.
   c. clinician/staff interventions.
   d. all of the above.

2. Information that is documented in a client chart can come from a variety of sources such as
   a. interviews with the client, family caregivers, or other interested individuals.
   b. notes from gossip or group sessions.
   c. notes from a disgruntled employer.
   d. information from a ex-spouse.

3. Progress notes should be updated within
   a. 24 hours of contact with the person served.
   b. 3 days of contact with the person served.
   c. 5 days of contact with the person served.
   d. 7 days of contact with the person served.

4. What does S.O.A.P. stand for?
   a. Subjective, objective, assessment, plan.
   b. Substance, objective, assessment, plan.
   c. Subjective, objective, assessment, progress.
   d. Subjective, objective, assessment, potential.

5. The style of progress notes that document’s the client’s behavior and the clinician’s intervention using terms such as withdrawn, adjusting well, praised, encouraged is
   a. T.A.L.P.
   b. S.O.A.P.
   c. A.P.I.E.
   d. B.I.R.P.