DOCUMENTATION REQUIREMENTS

THE LAW

"The treatment facility shall maintain a patient **treatment record** for each patient which shall **include**:

(a) A specific statement of the **diagnosis** and an explicit description of the **behaviors** and **other signs or symptoms** exhibited by the patient;

(b) A specific statement of the **diagnosis** and an explicit description of the **behaviors** and **other signs or symptoms** exhibited by the patient;

(c) **Documentation of the emergency** when emergency treatment is provided to the patient; and

(d) Clear documentation of the **reasons and justifications** for the **initial use** of medications and for **any changes** in the prescribed medication regimen.

(e) Documentation that is **specific and objective** and that adequately explains the reasons for any conclusions or decisions made regarding the patient."

DHS 94.09(6), Wis. Admin. Code [Emphasis added.]

DECISIONS

1. A patient **claimed a breach of confidentiality** by her therapist in a phone conversation with her mother. It was found that the mother initiated the call because of her concerns for her daughter and that the therapist was careful not to divulge any information about the daughter's treatment. The mother asked the therapist not to tell the daughter about the phone call. The therapist could not promise that she would not divulge that the mother called, but eventually decided not to inform the daughter. Her **reasons for making** that **decision were documented**. No breach of the daughter's confidentiality was found. (Level III decision in Case No. 00-SGE-02 on 6/17/00, upheld at Level IV.)

2. A mother complained that her **son's condition was worsening** since his **medications were discontinued**. Her son's doctor was on maternity leave and the service provider would not temporarily assign him to another doctor. She called the service provider several times, explaining her son's condition and asking to have another doctor assigned. These **requests were never**

documented in the son's records. The service provider **violated** the son's right to **proper documentation** in his records. (Level III decision in Case No. 00-SGE-08 on 7/28/00, upheld at Level IV.)

3. An inpatient, admitted to county hospital via an "**Emergency Detention**" due to suicidal ideation, felt staff did not provide her enough time and attention in dealing with her concerns - especially, why she was **not eating meals**. She was depressed during much of her six days there. She refused several meals. She wanted her meals served to her in her own room so she would not have to sit near a certain male peer. There was considerable charting as to the staff's plan to encourage the patient to eat meals and have proper nutrition and food intake. But two days passed with the patient not coming out for meals, and staff seemed to not be doing anything more to explore why she was not eating, and/or in what circumstances she would be able or willing to eat meals. Patients have a right to refuse meals. But, in this instance there were medical reasons why proper food intake was important, and the charting also stressed that eating meals was to be encouraged. That being the case, one might reasonably expect staff to do more than simply observe that a patient was not coming out to eat. They let her eat one meal in her room, then gave her a "take it or leave it" ultimatum. What really was the goal? Was it to encourage nutritional intake? Or to try to force compliance with the unit expectation that patients come out of their rooms to eat in the congregate setting? There was **no documentation** as to **why** they took that stance. No other approaches to encourage her to eat were made. Under these circumstances, the **lack of any documented team discussion** or decision **was a violation** of the patient's **right to specific and objective documentation** of the reasons and rationale for the decision that was made. (Level III decision in Case No. 99-SGE-08 on 3/23/01.)

4. A doctor filed a **late entry** in a patient's chart **clearing up some confusion** over when a specific medication was given to a patient. While this entry was **not timely,** it **did not mean** the original records were **falsified**. (Level IV decision in Case No. 01-SGE-01 on 5/25/01, upholding the Level III.)

5. The **notification of rights** is a **very important** task as it is intended to convey to clients that, indeed, they have many rights while receiving services, and that there are mechanisms designed to protect their rights – such as the DHS 94 grievance resolution procedure. Yet, as clients begin receiving services, they may be at various functioning levels in terms of their ability to process this information and understand their rights. The law emphasizes the need for flexibility and follow-up by providers as may be warranted in any given situation. For example, if a client is admitted to an inpatient setting in an acutely psychotic state, that may be a time when the rights are the least meaningful or understandable. Thus, someone will need to follow up with the rights notification at a later time when the client is more likely to understand them. There are creative and effective ways in which information can be

shared, explained, and discussed to make it meaningful. Usually some combination of oral notification (unless a client states that is not wanted) and written notification followed by an opportunity to ask questions, discuss what the rights mean, ensure the client knows who the Client Rights Specialist is, etc., is effective. The **key part of this entire process is documentation**. Having a patient **sign an acknowledgement** of receipt of rights information is always a good idea but, without more, this **alone is not always meaningful**. If there is a question later, additional and **contemporaneous documentation** about what the **rights notification** process entailed is a good protective measure for both a client and agency. It is always positive to include such documentation in the client's record. **Documentation** of the annual **re-notification** of rights is also necessary. Who does the follow-up in up to the provider, but logically the Client Rights Specialists should have some role. (Level III decision in Case No. 00-SGE-01 on 6/29/01.)

6. A patient **wanted to continue the individual therapy** she had received for 9 years, but the service provider shifted to **only** doing **group therapy** with her. She had been made aware months in advance of the upcoming change in services. But her **interim plan for transitioning** to group therapy was **not documented** or consented to by the patient. Thus, her right to treatment and her right to informed consent were violated. It was recommended that the service provider create a space on its treatment plans for the patient's signature and that they **fully document all services** received by the patient. (Level III decision in Case No. 01-SGE-09 on 3/27/02.)

7. A therapist **mis-dated some entries** about when he saw a client. He also documented one entry twice. These discrepancies were **ordinary human error** and they did **not amount to a violation** of the client's rights. (Level IV decision in Case No. 01-SGE-07 on 3/29/02.)

8. Patients have the **right** to have their **care and treatment coordinated** with **other treatment staff** who are involved in their care and treatment. A **doctor ordering a change** in a patient's **medication must ensure** that **other members** of the patient's treatment team are **informed** about the new medication and the expected benefits and potential adverse side effects which may affect the patient's overall treatment. This should be **documented**. (Level IV decision in Case No. 02-SGE-04 on 9/19/03.)

9. A Level III decision **described** a doctor's **progress notes as being** "**inadequate**", but found no rights violation. This issue was not addressed on appeal because, **no matter how the notes were characterized**, the **outcome** (no rights violation) was **not affected**. (Level IV decision in Case No. 02-SGE-04 on 9/19/03.)

10. In general, the **treatment decisions of professionals** are afforded "**due deference**" by peers and by the courts. However, if a treatment decision

"departs from professional judgment", the patient's right to treatment may have been violated. A "departure from professional judgment" may be evinced in any of three ways: a) where the **evidence** suggests that the professional exercised **no judgment** at all; b) where the individual was not qualified to make the judgment; or c) where a decision was made on an impermissible basis (e.g., as "punishment"). **Documentation** by the decision-maker is **key to ensuring** professionals are **not departing** from professional judgment. (Level IV decision in Case No. 02-SGE-04 on 9/19/03.)

11. In a situation where a **suicidal patient** has been put on a **new medication**, then **cancels her next appointment** with the doctor, the **clinic has a duty** to at least have someone **review** the situation to see if follow-up contact with the patient is necessary. There was no evidence that this was done here. While it could be assumed that, as a voluntary patient, she was exercising her right to discontinue treatment, there should have been some determination made as to whether or not to contact her. The clinic thus **violated the patient's right** to prompt and adequate treatment by **not making** and **properly documenting** that determination. (Level IV decision in Case No. 02-SGE-04 on 9/19/03.)

12. Where a **service provider** asserted that the **facts** in the Level III decision were **incorrect**, the **file records** were **re-reviewed** in the **Level IV** process. The **facts** of the Level III decision regarding **documentation** were found to be **incorrect**. However, the **documentation had been made in margin notes** rather than in some clearer form. This **poor documentation** resulted in the finding of a **rights violation** at Level III. There was sufficient evidence, on closer inspection, to indicate that the violation did not occur. (Level IV decision in Case No. 02-SGE-04 on 9/19/03, overturning the Level III.)

13. Sec. 51.30(4)(e), Stats., requires that, when **records are released**, "a **notation shall be made** in the records by the custodian thereof that includes the following: the name of the person to whom the information is released; the identification of the information released; the purpose of the release; and the date of the release". **Handwritten notes in the margin** of records request documents, due to their brief nature, are **unlikely to satisfy** all the **documentation requirements** of this statute. Subsequent to April 14, 2003, entities releasing records must also comply with the even more stringent federal Health Information Portability and Accountability Act (**HIPAA**). (Level IV decision in Case No. 02-SGE-04 on 9/19/03, overturning the Level III.)

14. An independent agency working on a contract with the county **did not have any documentation** regarding services they provided because they moved offices and, apparently, those **files were lost** during the move. The missing files should have been retained for a minimum of seven years. Offices and agencies move locations or may close one of their offices over time, but their records must be retained. The **loss of these records is inexcusable**. The

rights of the client **were violated** because the agency did not retain documentation as to the care and treatment of the client. (Level III Decision in Case No. 03-SGE-04 on 6/15/04.)

15. The **contract** between an **independent service agency** and a **county** should have been **more precise**. The treatment plan and the expectations of care protocols should have been as specific as possible to reflect the client's individual needs and the tasks required in the contracted agreement with the agency. **Documentation** of the expectations, and their implementation, is **essential**. (Level III Decision in Case No. 03-SGE-04 on 6/15/04.)

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