

5122-27-04

**Progress notes.**

(A) The provider shall document the progress or lack of progress toward the achievement of specified treatment goals identified on the ITP and the continuing need for services.

(B) Documentation of progress may be done through brief narrative or checklists. Such documentation shall provide sufficient detail to address all required components.

(C) Progress notes shall be documented either on a per provision of the service basis, or on a daily or weekly basis.

(D) Urinalysis testing is exempt from this rule.

(E) Service level progress notes shall include, at a minimum, the following:

(1) Client identification (name or identification number);

(2) The date, time of day, and duration of the service contact;

(3) The location of the service contact;

(4) A description of the service rendered;

(5) The assessment of the client's progress or lack of progress, and a brief description of progress made, if any;

(6) Significant changes or events in the life of the client, if applicable;

(7) Recommendation for modifications to the ITP, if applicable; and,

(8) The signature and credentials of the provider of the service and the date of the signature.

(F) Daily or weekly progress notes shall include, at a minimum, the following:

(1) Client identification (name or identification number);

(2) For daily progress notes, the calendar day the progress note is applicable to;

(3) For weekly progress notes, the weekly period, i.e. the continuous seven day period to which the progress note is applicable;

(4) The assessment of the client's progress or lack of progress, and a brief description of progress made, if any;

(5) Significant changes or events in the life of the client, if applicable;

(6) Recommendation for modifications to the ITP, if applicable; and,

(7) Date, original signature and credential of the staff member writing the daily or weekly progress note. The staff member must be qualified to provide all of the services documented in the daily or weekly service log.

(G) Client records utilizing daily or weekly progress notes must contain a service log that includes, at a minimum, the following:

(1) The date, time of day and duration of each service contact;

(2) The location of each service contact;

(3) A description of the service rendered; and,

(4) The signature and credential of each clinician who provided services during the day or week.

(H) Documentation in the progress note, or elsewhere in the individual client record, may include a notation addressing the client's risk of harm to self or others, including a review of the client's ideation, intent, plan, access, and previous attempts, if relevant.

Replaces: 5122-27-04

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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