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

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

(d) 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.)

16. A patient had several complaints that stemmed from her alleged misdiagnosis by one of the provider's doctors. The patient was diagnosed with bi-polar II, which allegedly caused severe problems in her life. The patient alleged that the diagnosis was arbitrary. **The patient had the burden to show that the diagnosis was not based upon a legitimate treatment, management or security interest to prove that it was not arbitrary.** The provider's documentation supported the conclusion that the diagnosis was based on a legitimate treatment interest. The doctor believed that the patient had bipolar and made the diagnoses to get the patient the assistance that she needed to feel better. The patient was suffering badly until she started taking the medication prescribed for bipolar disorder and then recovered. **There was no violation of the patient's right to non-arbitrary decisions.** (Level III decision in 12-SGE-0006 decided on 11/14/2012)

17. A parent filed a complaint based on her belief that her daughter was being over-medicated by a County doctor. The County did not appeal the Level III decision's findings of rights violations for the lack of informed consent and for inadequate documentation. Nor did the County provide any reply to the grievant appeal to Level IV. Thus, "mootness" was the only issue decided at Level IV. The Level III decision analyzed the grieving party's allegation that the County doctor should have provided better documentation of his reasons for initiating a medication and adjusting the patient's dosage. On two occasions, the County doctor failed to provide any reason or justification for increasing the dosage, including to a dosage that appeared to be double the approved dosage. Doctors' decisions regarding medication were given significant deference in the grievance process. However, **doctors were still required to articulate the specific reasons for such decisions. This requirement took on even greater importance when a doctor may be deviating from accepted guidelines.** The required documentation not only protects the patient; it also protects the doctor and the County in the event concerns are later raised and the doctor's judgment is scrutinized. The County doctor's lack of proper documentation on at least two dates violated the patient's right to have clear documentation for the reason for the use of medication and for changes to the medication regimen. (Level IV decision in Case No. 12 SGE-0011 decided on 05/09/2013)

18. A dual diagnosis patient with a history of anxiety, major depression, prior suicide attempts and substance abuse was admitted into the hospital's

inpatient psychiatry unit. She was put on one of the least restrictive precautionary treatment levels despite the fact that she had attempted to commit suicide in the past 48 hours prior to admission. The patient was given a butter knife with a meal and stabbed herself in the abdomen. **The client had unique safety needs because she had attempted to end her life with a knife before and had within the last couple of days attempted to commit suicide.** The provider had knowledge of these circumstances and still put the patient on a level on which knives are given to clients with food and on which the client had a semi-private bathroom. The level I-B decision argued that the decision to put the patient on one of the least restrictive precautionary treatment levels with additional monitoring and open seclusion (a monitored but private room because of the patient's pseudo-seizures) was individualized and took into consideration the client's rights and needs. **However, no documentation of the consideration process was provided in evidence.** The patient's exceptional safety needs and her unique situation would seem to require a greater level of precaution than the level she was admitted to afforded, even with the added services. Namely, **the individual need of not giving the client sharps was not met. As a whole, the provider failed to correctly weigh safety versus the least restrictive treatment conditions**. Thus, the client's right to an individualized, safe environment was not met and her right was violated by the provider in this regard. (Level III decision in 13-SGE-0004 decided on 11/5/2013)

19. A patient with a history of anxiety, major depression, prior suicide attempts and substance abuse was admitted into the hospital's inpatient psychiatry unit. She was put on one of the least restrictive precautionary treatment levels despite the fact that she had attempted to commit suicide in the past 48 hours prior to admission. The patient was given a butter knife with a meal and stabbed herself in the abdomen. **There was no information in the treatment record pertaining to the decision to place the patient in the least restrictive precautionary treatment level.** During the investigation, provider staff recounted that many aspects of the patient's diagnosis and circumstances were considered. **The client's needs were documented in the treatment record but none of the reasoning behind a significant treatment decision was documented. A lack of documentation for a treatment decision, especially an important treatment decision, is a violation of the patient's right to the maintenance of an adequate treatment record.** Here, the determination of the patient's safety level led to her being allowed to have a knife with her meal, which in turn led to her otherwise preventable suicide attempt. Documentation should have shown that the treatment team's decision was carefully considered. A violation of the patient's right to a record that included the supporting reasons for any conclusions made about her was found. (Level III decision in 13-SGE-0004 decided on 11/5/2013)

20. A patient experienced unwanted sexual side effects from a medication. The patient alleged that there were sexual side effects of eight weeks duration. The side effects went away after weaning from the medication. The record did not contain a signed medication consent form and the provider admitted that no written consent form was obtained. Applicable statute and administrative code provide that no medication may be given to any patient without the prior consent of the patient unless there is a court order or an emergency situation. **It was the position of the Client Rights Office that all inpatient and outpatient providers were required to obtain written informed consent prior to distributing psychotropic medications.** On the other hand, the record did contain evidence that the doctor did discuss the proposed medications with the patient and the patient agreed to take them. Thus a technical violation of the client's right to participate in his treatment through written informed consent for psychotropic medication was found. (Level IV decision in 14-SGE-0001 decided on 12/22/2014)

21. A patient claimed that her right to a humane environment was violated when a strip search was conducted without warning upon her admission to an inpatient psychiatric hospital. Strip searches are allowed before a patient leaves or enters the security enclosure of maximum security units, before a patient is placed in seclusion, or where there is documented reason to believe that the patient has, on her person, objects that threaten the safety or security of patients or staff. In the case at hand, **no documentation was done by the provider staff that indicated that staff suspected that the grievant had any threatening objects on her person**. Even though a strip search is reasonable measure to ensure the safety of staff and patients, **the fact that there was no individualized documentation of the need for a strip search is a violation of the code. A violation of the grievant's right to a humane environment was found because of the lack of documentation.** (Level III decision in Case No. 15-SGE-0008 on 6/16/2016)

22. A county provider was aware that a patient was unhappy with his services at the time that he was discharged. Although no violation of the patient's right to grieve was found, the State Grievance Examiner noted that **documentation should address when the DHS 94 grievance procedure was discussed and the outcome of the discussion when the record shows that a patient is upset with a provider's services**. (Level III decision in Case No. 15-SGE-0006 on 7/11/2016)

23. A patient grieved that he was wrongly denied Targeted Case Management (TCM), was wrongly discharged from Comprehensive Community Services and was misled about his ability to return to TCM. The discharge was held to be voluntary. Per DHS 36.17, w**hen a patient is voluntarily discharged from CCS programs, the patient must be given written notice that includes (i) a copy of the discharge summary, (ii) written procedures on how to reapply for CCS and (iii) information on how the patient can**

submit a written request to have the discharge reviewed by DHS. The summary must include (a) the reasons for the discharge, (b) the patient's status, condition and progress, (c) documentation on the circumstances that would lead to a renewed need for services (to be created with input from the patient) and (d) for a planned discharge, signatures of the patient and staff. There was a dispute as to whether the patient received any of this information. However, the information that the provider claimed to have provided was incomplete and was not addressed to the grievant. It was a violation of the patient's right to adequate treatment when the provider failed to create and send to the grievant the required documentation. (Level IV decision in Case No. 15-SGE-0007 on 12/9/2016)

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