

CF OPERATING PROCEDURE
NO. 155-39

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, March 17, 2021

Mental Health/Substance Abuse

GUIDELINES FOR PROGRESS NOTE DOCUMENTATION IN THE
HEALTH RECORD AT STATE MENTAL HEALTH TREATMENT FACILITIES

1. Purpose. This operating procedure describes departmental procedures and guidelines for documentation of progress notes in health records at state mental health treatment facilities.
2. Scope. This operating procedure applies to healthcare providers treating individuals residing in state mental health treatment facilities, whether operated by the Department of Children and Families or by contract with private entities, excluding the Florida Civil Commitment Center.
3. References.
 - a. Chapter [395](#), Florida Statutes (F.S.), Hospital Licensing and Regulation.
 - b. Chapters [458](#), [459](#), [464](#) and [490](#), F.S., Regulation of Professions and Occupations.
 - c. Children and Families Operating Procedure 155-16, Recovery Planning and Implementation in Mental Health Treatment Facilities.
 - d. [64B8-9.003](#), F.A.C., Standards for Adequacy of Medical Records.
 - e. [65E-5.160](#), F.A.C., Right to Treatment.
 - f. Title 42, Public Health, Code of Federal Regulation (CFR) Section 482.61, Condition of participation: Special medical record requirements for psychiatric hospitals.
4. Definitions. For purposes of this operating procedure, the following definitions shall apply:
 - a. Clinician. A Physician licensed pursuant to Chapter 458 or Chapter 459, F.S.; Advanced Practice Registered Nurse (APRN) or Registered Nurse licensed pursuant to Chapter 464, F.S.; Physician Assistant licensed pursuant to Chapter 458, F.S.; or, Psychologist licensed pursuant to Chapter 490, F.S.
 - b. Clinical Progress Notes. Notes that are written by individual clinicians that contain information regarding interventions, their relative benefit to the resident, resident's progress toward achieving recovery objectives and goals and the resident's perspective towards the progress and services provided.
 - c. Electronic Health Record (EHR). Data in patient records which is stored in a computer-based server.
 - d. Health Record. A general term referring to records and data related to an individual which are maintained on a paper based medium or by electronic means.

This operating procedure supersedes CFOP 155-39 dated October 1, 2020.

OPR: SMF

DISTRIBUTION: X: OSGC; ASGO; Region/Circuit Mental Health Treatment Facilities.

e. Progress Notes/Event Notes. Entries made in an individual's health record that describe observations made regarding a resident, incidents or events occurring in the process of caring for a resident, assessments and actions taken on behalf of a resident, treatment provided to a resident and the resident's perspective towards his or her progress and services provided. It may also reflect the status of any issue/need and entries that describe progress or lack of progress for a goal or objective established in the recovery plan.

f. Recovery Plan Note. An entry that reflects the status of any issue/need and a review of interventions reflecting progress or lack of progress in meeting a goal or objectives established in the recovery plan. The note will also reflect the discussions of the recovery team during the regularly scheduled recovery plan meeting and the resident's participation in the meeting and their perspective regarding their progress, satisfaction with their recovery plan and services provided.

g. Resident. A person who resides in a state mental health treatment facility (civil or forensic setting). The term is synonymous with "client", "consumer", "individual", "patient" or "person served".

5. General.

a. The Resident's care and treatment shall be comprehensively documented in facility health records.

b. All entries made in the health record must be legible and complete and must be authenticated and dated promptly by the person (identified by name and title) who is responsible for ordering, providing, or evaluating the service. The name and title shall be printed next to signatures that are illegible. All entries must be made in black or blue ink or typed as indicated by the facility administrator. Pencil or erasable ink shall not be used in health records.

c. All documentation mistakes made within paper-based health records will be corrected by drawing a thin pen line through the entry. The staff member making the correction will sign his or her name (first initial and last name), title, date and document the correct information. In an EHR, all documentation mistakes will be corrected by an addendum reporting the error and providing the correct information.

d. Entries in a paper-based health record will never be erased, and "white-out" shall not be used on paper based medium.

e. The health record shall not be used to settle a dispute, assign blame or write derogatory remarks concerning a resident, a resident's family or members of staff.

f. Blank lines or spaces are never to be left between entries.

g. Any person who fraudulently alters, defaces, or falsifies any health record or causes any of these offenses to be committed, commits a misdemeanor of the second degree.

h. All entries written as a group note, such as the Recovery Plan Note, shall always be signed first by the person that physically writes the progress note and then by the other members of the Recovery Team that participated.

i. All relevant information from a resident's family, friends, or guardian concerning the resident's progress will be documented in the health record.

j. Each facility shall use a system for its health records, which shall include the following elements: basic resident data collection; a listing of the resident's issues; the recovery plan with

diagnostic and therapeutic orders as appropriate for each issue identified; and progress notes. Each progress note must be linked to one (or more) of the resident's issues.

6. Progress/Event Notes.

a. The frequency of progress notes is determined by the condition of the resident but must be recorded at least weekly for the first month and at least once a month thereafter. (Facilities required to adhere to the Centers for Medicare and Medicaid Services standards contained in 42 CFR 482.61 are required to record weekly progress notes for the first two months and monthly thereafter).

b. All discipline's progress notes must include a precise assessment of the resident's progress toward the measurable behavioral objectives identified in the original or revised recovery plan, as well as recommendations for revisions in the recovery plan as indicated. Progress notes must also include resident perspective regarding progress and desire to continue or change services provided.

c. When documenting an event or observation, entries must be made as soon as possible after the event or observation is made. Entries must be dated at the date and time they are made. Late entries should be made whenever unusual circumstances prevent timely entry. Each entry must reflect the actual date and time the entry is being made and the time and date that the information being entered actually occurred.

d. Progress/Event Notes must be concise and specific descriptions of an observation. Progress/Event Notes shall be a compilation of factual and objective information about the resident.

e. When documenting a progress/event note, the following shall be entered:

(1) The date (month, day, and year) and time of day in the appropriate column of the event note.

(2) The discipline of the person making the entry in the appropriate column of the progress/event note.

(3) The issue number or need letter to which the progress/event note relates.

(4) The signature and professional title of the person making the entry at the close of the entry.

7. Clinical Progress Notes.

a. Clinical Progress Notes shall include the resident's current clinical status, any changes in the resident's mental and physical health over the previous month, responses to treatments, presence or absence of medication side effects, the resident's progress toward achieving the goals, and objectives established in the recovery plan and the resident's perspective towards the progress and services provided.

b. Following the first month or two of weekly notes (see paragraph 6a above for requirement), clinical staff will complete progress notes at least monthly and whenever there is a change in the resident's status.

8. Recovery Plan Notes.

a. At a minimum, recovery plan notes are completed at each regularly scheduled team meeting, and during team meetings to address acute issues related to a resident's change in condition, health, or behavior.

b. Recovery plan notes shall be pertinent, concise, and reflect the discussions of the meeting including the resident's perspective.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

JACQUELINE A. YOUNG
Director, Policy and Programs

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

In paragraph 2, changed the word "including" near the end of the sentence to "excluding" [so the sentence now ends with the phrase "excluding the Florida Civil Commitment Center"].