# Counselor Spotlight: Documentation

Healthcare Providers Service Organization (HPSO), in collaboration with CNA, has published the 2nd Edition of our *Counselor Claim Report*. It includes statistical data and legal case studies from CNA claim files, as well as risk management recommendations designed to help counselors and other behavioral health professionals reduce their malpractice exposures and improve patient safety.

You may access the complete report, and additional Risk Control Spotlights, at: www.hpso.com/counselorclaimreport

This Counselor Spotlight focuses on our analysis and risk recommendations regarding one of the most significant topics in the report, issues related to documentation.

According to professional standards, maintaining consistent documentation throughout the counseling relationship is essential to mental health practice. Section A.1.b. of the American Counseling Association (ACA), *ACA Code of Ethics* (2014) advises that counselors must "include sufficient and timely documentation to facilitate the delivery and continuity of services" and "ensure that documentation accurately reflects client progress and services provided." Inadequate documentation can severely hinder the counselor's legal defense in the event of a lawsuit, and it can even lead to state licensing boards imposing disciplinary action against the counselor's license. In fact, the 2nd Edition of the HPSO/CNA *Counselor Claim Report* observed that 4.7 percent of the license protection claims in the analysis involved allegations related to improper or inadequate documentation, and these claims incurred an average expense of $4,712. An example of such a claim includes the following case:

## **CASE STUDY:** Inadequate Documentation Constitutes Unprofessional Practice

This case involves a licensed mental health practitioner who had been treating a female client for depression, anxiety, post-traumatic stress disorder, and dissociative identity disorder for about 14 years. The client terminated therapy with the counselor, and shortly thereafter filed a complaint with the state board of mental health ("the board") asserting that the counselor had been verbally abusive toward her during therapy.

Upon receipt of the client's complaint, the board subpoenaed the counselor's mental health records for the client from the last 12 months of treatment. The counselor provided the available records to the board, though the records failed to include any progress notes or a discharge summary. During an investigative interview on the matter, the counselor confirmed that she does not write progress notes for therapy sessions and that she does not generally complete formal discharge summaries for any of her clients.

**Risk Management Comments**

Experts who reviewed the investigative materials related to the complaint opined that in the absence of a clinical record, any conclusions regarding the care the counselor did or did not provide, and whether it was consistent with the standard of care, would be limited to conjecture. Further, experts opined that the absence of well-documented differential diagnosis, treatment planning, and ongoing treatment and assessment is inconsistent with the *ACA Code of Ethics*, and the ethical guidelines of other mental health professional organizations.

In the disciplinary documents related to this case, the board cited state statutes, which defined "unprofessional conduct" as including "the failure to keep and maintain adequate records of treatment or service." Therefore, the board ultimately concluded that the counselor's inadequate documentation was grounds for discipline.

**Resolution**

The counselor was placed on probation for one year and was required to complete continuing education on documentation and record keeping. The costs of defending the counselor in this case exceeded $13,500.

## Risk Management Recommendations: Documentation and Record Retention

The following risk control recommendations are designed to help counselors create, safeguard, and maintain documentation necessary for the rendering of professional services.

### Documentation

Proper documentation is a key element in avoiding adverse legal action and licensing board complaints. In fact, in a lawsuit or licensing board investigation, your documentation distinguishes your word from the client's, and may be the sole item of evidence. The following measures can serve to lessen these exposures:

1. ***Provide accurate, complete and current documentation,*** to enhance continuity of client treatment by another authorized counselor or healthcare provider. Documentation should support the treatment plan and satisfy board regulatory and third-party billing requirements.
2. ***If a documentation error occurs, the clinical record must be amended contemporaneously, accurately noting the amendment or correction as such.*** Do not alter entries once legal or regulatory action is initiated.
3. ***Know and comply with documentation requirements in accordance with state-specific practice acts, laws, and regulations*** (for example, Department of Health and/or Department of Mental Health, Child and Family Services, Department of Transportation, workers compensation, etc.), as well as prevailing standards of care and the policies of licensing bodies and employers or group practices. When more than one requirement applies, adhere to the most stringent policy.
4. ***At the time of any assessment or evaluation of a client, include the date and time of the assessment, the specific findings and the length of time such findings are valid.*** For example, when assessing potential adoptive or foster parents, include both the approval and expiration date, to ensure timely reassessment, if necessary.
5. ***As a complete and accurate clinical record presents the strongest defense against any legal or licensing board action, document the following information, at a minimum:***
   - The clinical decision-making process, as well as the client's diagnosis, service plan, response to treatment, results of diagnostic testing and/or consultation findings, and assessments of the client's risk of being a danger to self or others. Document client education regarding the client's treatment agreement, and education regarding policies and procedures.
   - Session notes, including review and revision of problems and/or treatment plan, the client's response and any change in diagnosis.
   - Telephone encounters (including after-hours calls), documenting the name of the person contacted, advice provided, and actions taken.
   - Dated and signed receipts of test results, referrals, and consultations, including a description of subsequent actions taken.
   - Referrals for medical assessment and/or for the prescribing and monitoring of psycho-active medications.
   - Educational materials, resources, or references provided to the client.
   - The client's informed consent for proposed treatment and testing.
   - Signs of non-adherence to the agreed-upon treatment plan, including missed appointments, refusal to provide information, and rejection of treatment recommendations. Document all efforts to follow up with the client and efforts to educate the client about the risks of non-cooperation or non-participation with the agreed-upon treatment.
   - Discussions of privacy, confidentiality of personal information and possible exceptions to those protections.

Documentation should be **complete, objective** and **contemporaneous** to support the treatment plan and satisfy board regulatory and third-party billing requirements.

- Signed and dated consent forms for release of information, if necessary, to client-authorized parties, child welfare organizations in the case of suspected child abuse, law enforcement personnel if the client is deemed to be a risk to self or others, and a court of law in response to an official court order or subpoena.
- Counseling of noncompliant clients and/or responsible parties regarding the risks resulting from their failure to adhere to medication and treatment regimens.

## Record Retention

According to Section B.6.h of the *ACA Code of Ethics* (2014), a primary professional responsibility of the counselor includes providing reasonable access to records, and to store client records to ensure reasonable access following client termination. Client treatment records are also essential to defending a malpractice lawsuit, ethics complaint or licensure board complaint. Therefore, when implementing a records retention policy, counselors should consider the following risk control recommendations:

1. ***Retain counseling records for at least the minimum time established by state and federal laws, licensure laws and policies, and third-party contracts, whichever guideline is most stringent.*** Contact the licensure board in the state(s) where you practice for record retention guidelines.
2. ***If there is no set minimum record retention period in the state(s) where you practice:***
   - Consider retaining records for a minimum of seven years for adult clients.
   - For clients receiving Medicaid or other forms of federal assistance, retain their records for at least 10 years, since federal "false claims" actions can be brought against a healthcare provider for up to 10 years.
   - For child/adolescent clients, retain records until the time they reach the age of majority plus three years (or the applicable length of time that pertains to the statute of limitations where you practice).
3. ***Apply discretion and deliberation before destroying records that may be required by a court of law or licensing board,*** such as notes that pertain to child abuse, elder abuse, suicide, sexual harassment or assault, or other forms of violence.
4. ***Counselors have a responsibility to plan for their incapacitation or retirement*** by identifying a colleague or records custodian who can manage the transfer of their clients and the dissemination of records. See Section C.2.h. of the ACA Code of Ethics for more information.

Proper documentation is a key element in avoiding adverse legal action and licensing board complaints. A **complete** and **accurate clinical record** presents **the strongest defense** against any legal or licensing board action.

### COUNSELOR SPOTLIGHT

For more risk control resources and top findings from the 2nd Edition of the *Counselor Liability Claim Report*, please review additional Counselor Spotlights on the following topics:

- Informed Consent
- Identifying Your Client
- Reporting to Third Parties
- Boundaries
- Supervision
- Release of Records
- Telebehavioral Health
- Preparing for a Deposition
- What to Do if you Receive a Subpoena

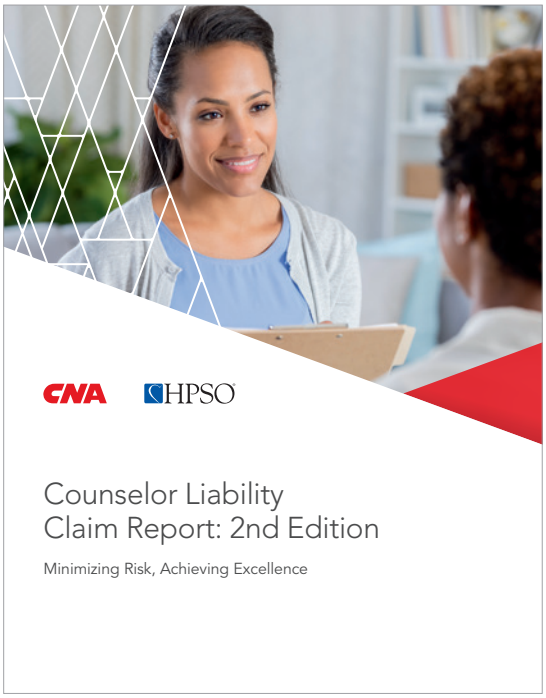
Visit www.hpso.com/counselorclaimreport

## Self-assessment Checklist: Documentation and Clinical Records

This checklist is designed to assist counselors in evaluating risk control exposures associated with their current practice. For additional risk control tools or to download the *Counselor Liability Claim Report 2nd Edition*, visit Healthcare Providers Service Organization **www.hpso.com** or CNA Healthcare **www.cna.com**.

| Self-assessment Topic | Yes/No | Comments/Action Plans |
|---|---|---|
| **Documentation** | | |
| **I document observations at the beginning of each session,** including restating the purpose of the counseling, the client's mood and attitude, and their actions and body language. | | |
| **Using the information obtained from past sessions, I outline the components of each counseling session**, including main points of discussion and possible comments or questions to help organize the session and help the client progress. I document the client's respective responses.<br>**I document the agreed-upon plan of action for treatment** and the client's accomplishments, improvements, personal preferences, problems, and expectations of the counseling sessions.<br>**I record the client's response to what I do and say,** including quoted statements, tone of voice, and any changes to the initial mood, attitude, actions, gestures, and body language. | | |
| **I record my plan of action in view of the client's response to therapy**. If the client exhibits change for the worse - or no progress - I indicate in my notes any appropriate adjustments to the plan of action and follow-up actions. | | |
| **I document any resources provided to the client**, any efforts to follow up on referrals, and consultations with the referring professional. | | |
| **If any actions are taken or must be taken after the client exits the session, I make detailed, contemporaneous notes in the client's record** while the thoughts are fresh in my memory, and I follow up with the results of the action. | | |
| **If I place notes or amendments to anything in the client's record at a later time**, I signify that they are late entries by initialing it, including the date and time, and indicating that the addition is a late entry/amendment. | | |
| **Clinical Records** | | |
| **I retain client clinical records in accordance with relevant state and federal law** and consult state-specific recommendations issued by professional associations. | | |
| **I perform periodic audits of clinical records** to identify departures from documentation standards and determine opportunities for improvement. | | |
| **I safeguard client records** from loss and/or unauthorized access. | | |
| **When copies of client clinical records are released for legal reasons, I sequester the records** to avoid allegations of tampering or making inappropriate late entries. | | |
| **I prepare a plan for the transfer of clients and the dissemination of records** to an identified colleague or records custodian in the event of my incapacitation or retirement. | | |

This checklist is designed to assist counselors with evaluating risk control exposures associated with their current practice. It is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.




This information was excerpted from HPSO and CNA's full report, *Counselor Liability Claim Report: 2nd Edition*. www.hpso.com/counselorclaimreport

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In addition to this publication, CNA and Healthcare Providers Service Organization (HPSO) have produced numerous studies and articles that provide useful risk control information on topics relevant to counselors, as well as information relating to counselor professional liability insurance, at www.hpso.com. These publications are also available by contacting CNA at 1.888.600.4776 or at www.cna.com.

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