MILLE LACS BAND OF OJIBWE
HEALTH AND HUMAN SERVICES POLICY & PROCEDURE

Department: Substance Use Disorder-Four Winds Lodge **Policy Number:** HHS-SUD-FW 4790

Policy Title: Charting/Progress Notes

Attachments:

Revision History: **Revised by/Date:** Lindsay Misquadace-Berg 7/2021

Approved by:
Lindsay Misquadace-Berg, Four Winds Treatment Director **Date:** 10/15/21

Approved by:
Nicole Anderson, Commissioner of HHS **Date:** 12-2-21

POLICY STATEMENT: Progress notes serve as a basis for planning clients care, documenting communication between the health care provider and any other health professional contributing to the client's care. They assist in protecting the legal interest of the client and the health care providers responsible for the clients care, and documenting the care and services provided to the client.

PURPOSE: The purpose of this policy is to provide a written chronological account of the client's status, interventions performed, and the client's response to those interventions.

RESPONSIBILITIES: The Program Manager or designee is responsible for implementing this procedure and to ensure that all staff are aware of and receive training.

PROCEDURE:

A. All Progress Notes:

1. Will be documented in the narrative charting format.
2. All entries will have the month, day, year and time noted (a.m. and p.m. must be specified).
3. All entries will be permanently entered electronically, typed or handwritten.
4. If entries in the client's medical record are handwritten, the entry must be written in black ink.
5. Red ink can be used to document client safety concerns only, i.e. MAR, client allergies.
6. Entries must be legible using correct spelling and grammar.
7. Entries will be dated and authenticated with the signature and title/credentials of the person making the entry, i.e. Jane Smith, LADC, or John Smith, LPN. Entries placed into the electronic medical chart will be electronically authenticated.
8. Entries will be chronological, descriptive, objective, factual, and relevant to the client's care.
9. No individual is authorized to change or delete information entered by another individual.
10. Corrections to an entry may be corrected only by the person who made the documentation entry.
11. No blank lines will be left on progress note sheets. If a line is missed draw a single line through the space.
12. For handwritten entries, when the end of the page is reached and the progress note has not been completed, enter "continue" at the bottom of the completed page along with your signature. Enter date, time and "continued" on the new page where the note will be completed.
13. Documentation will be entered into the medical record immediately after its occurrence.

14. Late entries shall contain the date and time of documentation as well as the actual date and time of occurrence. Late entries must be clearly labeled "late entry."

B. Internal Charting References:
When referencing another person in the client's chart use the medical record number of the client. When referencing a staff in the client's chart reference the discipline of the staff. **Do not use the name of the other client or staff member, i.e. contacted client's LADC, i.e. called charge nurse. Exception to this is when a staffing is done with a client and the names of the staff present may need to be referenced.**

C. External Charting References:
When referencing external contacts in the client's chart, reference the name and discipline of the contact.

D. Nursing and Counselor Aide Progress Notes:
1. ***Chart on each admission, on every shift, for 72 hours/3 days unless there is a need to chart more frequently than one time per shift.***
2. After the initial 72 hour's document in the progress notes as indicated.

E. Alcohol and Drug Counselor (including Interns) and Mental Health Therapist:
1. Progress notes must be entered in a client's medical record weekly, or after each treatment service, whichever is less frequent, by the staff person providing the service. The progress note must reference the treatment plan and include:
a. The type and amount of each treatment service the client has received and the client's response;
b. Monitoring of client physical and mental health problems and the participation of others in the treatment plan;
c. Documentation of the participation of others;
d. Documentation the client has been notified of each treatment plan change and the client agrees or does not agree with the change.
e. A qualified staff person must review and sign all assessments, progress notes and treatment plans prepared by a student intern.
f. Progress notes will be printed upon discharge for each client and the paper progress notes will be put in the client's chart when the client is discharged.

Internal and/or External References	Minnesota Rule SLF-4665.4100 Residents health record Minnesota Rule SLF-4665.3300 Purpose of health service
Compliance - Posting Date	12/2/2021 (HH)
Replaces – Policy Number	
Next Review - Due Date	