CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Information Sharing: Guidelines and Examples for Clinical Documentation

Approved by Behavioral Health Services Division effective 2.25.2021
Please note Guidelines are subject to review, revision, and change.

Guidelines to remember when completing documentation:

1. Transparency is key! At the beginning of treatment, explain to the client that they have access to their notes through MyChart. Explain that as their provider, you may document things that the client does not agree with and you welcome a discussion with them if they have questions or concerns. Additionally, your communication with the client should reflect what you write in your note.
2. Ask for and use client feedback:
    - "I see us as a team working together to improve your health, so your feedback matters! big difference! If you see something you think might be a mistake in your note, please let me know so we can work together to fix it."
3. Be familiar with how to amend notes when a client disagrees or requests a change:
    - "I understand you want your history of cocaine use removed from the medical record, but this information has important implications for your blood pressure and chest pain."
4. Use supportive language / Highlight the client's strengths and achievements in addition to their problems.
    - "The patient chose not to pursue treatment," rather than "The patient refused treatment."
    - "The patient has lost 5 pounds and is motivated to continue this positive trend toward our goal of 20 pounds," rather than "The patient still needs to lose another 15 lbs."
5. Include clients in the note writing process:
    - Turn the computer screen toward the patient to show what you are typing.
    - Check for understanding and accuracy during the visit.
6. Describe behaviors rather than labeling the client: For example, consider these examples:
    - "Client could not recall" instead of "poor historian"
    - "Client is not doing ____" instead of "Non-compliant"
    - "Client prefers not to" or "Client declines" instead of "Client refuses"
7. Minimize jargon and abbreviations. Avoid terms that can be easily misinterpreted. Use terms that may be perceived as less judgmental or confusing:
    - "Shirt untucked" (rather than "disheveled")

- "Short of breath" (rather than SOB)
- "Follow up" (rather than f/u)

8. Be more specific within notes. Instead of writing "client was depressed" consider listing the specific symptoms, such as "poor appetite," "loss of interest" or "sleep disturbances."

9. Do not include complaints about other staff members, whether from the patient, staff, or a doctor.

    - For example: If the staff cannot be reached, call another member of that discipline and document your conversation. Do not identify the staff who was not available, there may be a valid reason Avoid: Doctor/nurse/etc did not reply the writer's message/call.

    - Instead of writing "patient wants a new doctor because their doctor is mean", instead write "patient is requesting a change of provider because he/she believes another provider can help his/her obtain his/her treatment goals.

Examples of documentation in challenging situations:

Scenario 1: Client is experiencing delusions.
Mr. A is a man with schizophrenia who believes that the FBI has placed "invisible" microphones and cameras in his apartment. He takes 1 mg of risperidone daily "to keep my family off my back," but you are trying to get him to take a higher dose. You have tried to discuss his diagnosis with him, but he dismisses it, and believes that "schizophrenia was made up by the FBI to incarcerate subversives."

Sample note:
Mr. A says he is taking risperidone 1 mg daily, but he continues to be convinced that the FBI is monitoring him. We disagree on this, as we do about whether he has a psychiatric problem in the first place. I believe that a higher dose of risperidone would help him with the anxiety he feels about being monitored, but he firmly refused to increase the dose to 2 mg daily. I nevertheless urged him to consider a brief trial of the higher dose, to see if he noticed any benefit. We will continue to assess his overall level of anxiety and how it affects his daily functioning. I am concerned that his anxiety limits his ability to feel safe on a day-to-day basis. But on a happier note, he continues to be very interested in current events and reads newspapers and books extensively.

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Scenario 2: Client has a diagnosis of Borderline Personality Disorder.
Ms. B is a young woman who frequently self-mutilates to manage stress. She is taking fluoxetine and aripiprazole for anxiety and depression. They help to increase her stress tolerance to a certain extent, but she finds that ongoing use of alcohol and marijuana "help me more" with anxiety. Her relationship with her boyfriend continues to be marked by frequent verbal fights and occasional pushing. You are trying to explore other medication options and also to encourage her to try dialectical behavior therapy.

Sample note:
Ms. B's condition remains about the same as it was during our last visit. She feels the medication helps somewhat, but I have shared my concerns with her that her continued use of marijuana and alcohol likely interferes with the ability of the medication to help. She recognizes her frustration and unhappiness, however, and was open to discussing a referral for dialectical behavior therapy. I think this could be very helpful for her. I also raised the question of AA. We agreed to see how she felt after a week of going without alcohol, and if she can do this we will consider a low dose of lithium to help her with her moods. While she has her ups and downs at her job as a receptionist, she does feel her boss is supportive, and that's encouraging.

Scenario 3: Client has a history of sexual trauma
Ms. C is a woman in her thirties whom you have seen for a year for depression and who now reveals that she was molested by an uncle several times when she was 9. She has never revealed this to anyone before and was overwhelmed with feelings when she mentioned it. She asks you not to reveal this in the medical record.on and who now reveals that she was molested by an uncle several times when she was 9. She has never revealed this to anyone before and was overwhelmed with feelings when she mentioned it. She asks you not to reveal this in the medical record.

Sample note:
Ms. C is functioning well on citalopram 40 mg qd, sleeping and eating well, and doing well at work. Today she mentioned some incidents in her past that we have not discussed before and that were very significant for her. We will continue the citalopram and explore the incidents when we meet next.