

University of Toronto
Psychotherapy Documentation and Communication Guidelines
2009

Rationale: Timely, comprehensive documentation/charting is a key skill for any psychiatrist in the face of the establishment of more rigorous standards with regards to accountability from licensing bodies (for example, the CPSO here in Ontario). Moreover, maintaining the highest documentation standards is an integral part of providing good clinical care.

Below is a brief algorithm to guide trainees in psychotherapy documentation. For more comprehensive guidelines, please refer to the CPSO guidelines (Section 3), which can also be found at <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1686>

Section 1: The Documentation Lifecycle

Beginning

- Register patient at your site
- Establish chart for patient that includes a comprehensive initial psychiatric consultation note (see CPSO Guidelines regarding the minimum content)
- Storage of chart /medical records must be secure and must ONLY be at the site where the patient is being seen - do NOT bring chart or any medical records pertaining to the patient home with you
- In the case of off-site psychotherapy supervision and/or where the patient cannot be registered under the psychotherapy supervisor, the resident must register the patient under their primary supervisor (or another staff) with permission at the site where they are seen. The primary supervisor should be kept up to date as to patient progress and the patient should be made aware of the arrangement. (Please see off-site supervision guidelines: http://www.utpsychiatry.ca/Education/PostGraduate/DirectorsLetters/2007/Supervision_of_Residents-by_Off-Site-Guidelines.pdf)

Middle

- Progress notes
 - Include:
 - Assessment/opening note
 - Progress Notes
 - Termination note
 - Photocopies of homework (if any)
 - See Section 2 for further guidance regarding progress notes
- Process Notes
 - from supervision need to be securely stored (NEVER at home or in your brief cases) and are not part of the chart; supervision notes should not be recorded on the patient's chart; leave identifying data of the patient off of the process/supervision not (no full names; for example initial of first name would be acceptable); they should be shredded at the end of each rotation.

Transitions

- Transferring patients between sites
 - when a resident and his or her patient changes sites:

- chart should be closed from the site that the resident is leaving and the patient should be registered, along with a new chart being opened at the site where the patient will be subsequently seen
- consent must be signed for transfer/communication of information to the new site (post- form online)
- what is transferred?, with consent....
 - **HIGHLY RECOMMENDED** - 6 month summaries of progress, themes discussed, changes in mental status/functioning/goals, and formulation, along with a plan that documents who the supervisor was and who the supervisor will be (when known) along with the new site that the care will be delivered in; and this summary would be the only thing transferred to the new chart
 - Alternatively, all notes can be copied and transferred to the next site's new chart

Ending (Termination)

- A summary note of the nature and course of the therapy including (but not limited to the following)
 - Progress made during therapy
 - Discharge plans, if any (e.g. referral for long-term therapy after course of CBT, marital therapy, return to GP for follow-up etc)
 - Patient's response to termination
 - Mental status at time of termination
 - Comment on patient's clinical status at time of termination (e.g. if being treated for MDD, if depression is in partial or full remission etc., including any relevant rating scores if relevant)
 - Send the summary discharge note to the GP or referring physician to inform them of the termination of therapy and any discharge plans

Section 2: Progress Notes for Individual Psychotherapy

All notes MUST

- Include the date, start and stop time, patient's name and medical record number
- Be legible, permanent, completed the same day, signed (legibly and identifiably)
- Be stored in a secure place ONLY at the site where the patient is being seen
- Document cancellations or no-shows, document telephone calls, document if the patient was seen with anyone, document information from other sources (if any)

Recommend use of SOAP format (however if you don't use the SOAP format, please ensure that the following information is included in progress notes):

- Subjective - Content that the patient reports during the session (using quotation marks and paraphrases where appropriate), (*should not be speculative or interpretive)
- Objective - pertinent mental status (may be brief but must contain information relevant to the process of the session and the patient's condition), must comment on presence or absence (and nature) of suicidal ideation

- **Assessment** - diagnosis (if any), themes, course / trajectory, response to treatment, safety concerns
- **Plan** - therapy (type, total number of sessions if time-limited, frequency of appts, next appt), medications (*type and dosages of all medications, specify any changes), referrals, review in supervision (include supervisor's name)

Forgotten or late entries, errors or omissions

- Enter forgotten or late information at the earliest opportunity in the next available space in the chart - include the date and time the session was held AND the date the information was recorded
- Additional comments go in a separate entry - do not add to / remove from or alter a prior entry
- Corrections should still leave the erroneous information visible / retrievable

All charts are potentially shared charts

- Do not add to or alter someone else's note
- Do not leave blank lines between entries

Patient's rights

- Patients have the right to view their chart if they so request; however, patients must make such requests through health records
- If such a request arises it should be discussed in supervision

E-mailing / electronic communication

• **Please see recent CMPA 2009 guidelines on using email communication with patients:**
http://www4.cmpa-acpm.ca/cmpapd04/docs/resource_files/infosheets/2005/pdf/com_is0586-e.pdf

- AVOID this type of communication if possible as it is difficult to guarantee secure confidentiality

Legal risks: There are three potential areas for liability in email communication: confidentiality, privacy and security; timeliness of responses; and clarity of communication.

- If this mode of communication is used, all identifying data must be removed
- Consider using written email consent form (sample provided by CMPA in above link)
- All documents need to be encrypted with password protection

Note that this guideline cannot cover all possible scenarios arising during the conduct of psychotherapy and any situations the resident is uncertain about can and should be discussed in supervision.

Group and multi-person documentation guidelines

Family/Couple Therapy: If the family of an identified patient is interviewed for the purpose of obtaining collateral history and information, this can be entered into the chart of the identified patient; if family therapy is the primary treatment, notes can also be entered into the chart of the identified patient; however, if couple therapy is the primary treatment, each partner should be registered as a patient, and the same note for each session should be entered (copied) into both charts (*please confer with you supervisor to comply with documentation standards at your site).

Group Treatment: Documentation of group therapy involves a lower level of confidentiality and anonymity that can be achieved in individual psychotherapy and patients should be informed of this.

The ideal standard would be to have a separate entry for each member of each group session, and in some hospital settings (i.e. where there are electronic records), this is a requirement. However, the burden of documentation in this model is such that an alternative method of documentation is sometimes used. This includes the following:

i) A notebook is kept for the group as a whole, into which is entered an attendance log noting attendance at each meeting; the nature of issues addressed in that particular group; progress or obstructions to progress; any unusual developments or difficulties emerging in that session. This book becomes a permanent record of the group treatment and should be maintained as the treatment record.

ii) At the beginning of treatment patients should be listed in this book by their name and last initial, and a hospital identifying number. Last names should not be used in this treatment record.

iii) A progress note that is relevant to each individual patient should be charted at regular intervals in each individual's chart. It should refer to the group record. These progress notes supplement the combined group therapy record, that serves as the permanent group therapy record. It is proposed that the following intervals be utilized, for groups:

16 weeks duration or less, a progress note should be charted every four weeks

16 - 40 weeks, a progress note should be charted every eight weeks

Ongoing and open-ended groups, a progress note should be charted every three months

NOTE that residents should consult with their group psychotherapy supervisor to receive guidance on which format of documentation should be used in the hospital setting where the group is held

Section 3: CPSO Guidelines for Psychotherapy Records

Source: College of Physicians and Surgeons of Ontario
<http://www.cpso.on.ca/policies/policies/default.aspx?ID=1686>
(Retrieved June 8, 2009)

Patient Encounters where Focus is Psychotherapy

Psychotherapy is a form of treatment for mental illness, behavioural maladaptations or other problems that are thought to be of a psychological nature or to have an emotional component. The same legal requirements apply to records maintained for psychotherapy as to other sorts of records. Maintaining records that “tell the patient’s story” is particularly crucial in the psychotherapeutic context because there may be less objective physical data upon which to base treatment plans.

The following are the minimum components of a complete psychotherapeutic record:

- History;
- Mental status;
- Diagnosis and assessment;
- Medical Health and allergies
- Current (and past) medications
- Treatment plan (medications, treatment methodology, etc.);
- Progress notes/follow-up visits (which, in the psychotherapeutic context, should include the physician’s input and also information regarding the patient’s response);
- Outcome assessment (at the end of the treatment period);
- Termination note (which describes the patient’s reaction to the conclusion of the doctor-patient relationship).

SOAP Documentation for Psychotherapy

The SOAP record-keeping format may be easily adapted to gather and document information obtained during psychotherapeutic sessions. The College recommends that physicians use the SOAP format but recognizes that other systems are acceptable as long as they capture all of the information stipulated above.

Subjective

- Initial visit: problem statement, duration, relevant background history, evolution of the problem, and present status;
- Follow-up visits (progress notes): development since last visit, response to therapy.

Objective

- Exploration of the biopsychosocial axis (such as the effects of physical symptomatology on the patient’s personal life, family life, work and relationships);
- Mental status (may not be noted in a particular progress note if there is no change).

Assessment

- Diagnosis (may not be noted in a particular progress note if there is no change);
- Summation of issues/physician's input (for example, even though the physician has been silent throughout the session he or she may record an analysis of the patient's ongoing issue).

Plan

- Therapeutic goals/plans;
- Types of psychotherapeutic approaches/models; for example, psycho-dynamic (insight oriented), behavioural modification, cognitive therapy (whether supportive or instructional);
- Medications;
- Referral details.

Respectfully submitted,

Nadiya Sunderji, Adrienne Tan, Paula Ravitz
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