



*Mastering the Art of Ethical,
Client-Centered Note Writing*

Strategies for Effective Counseling Documentation

with Christine Finnegan, LPC-MHSP, NCC, MT-BC

Objectives

01

Ethics

02

Clinical Notes

03

Treatment
Planning

04

Discharging

05

Time Management





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- Founder and Clinical Director Replenish Counseling
- Inpatient Psych, IOP, Domestic Violence, ICU, Skilled Care, Residential Substance Abuse, and Special Needs Schools
- Supervising Graduate Counseling Students since 2017



1

Ethics according
to ACA

2

Ethics according
to TN Board

3

Ethics according
to HIPAA



Clinical Documentation: American Counseling Association



A.1.b.

Records and Documentation

"Counselors Create, safeguard, and maintain documentation necessary for rendering professional services...."



A.1.c.

Counseling Plans

"Counselors and their clients work jointly in devising counseling plans that offer reasonable success and are consistent with the abilities, temperament, developmental level, and circumstances of clients...."



B.6.a

Creating and Maintaining Records

"Counselors create and maintain records and documentation necessary for rendering professional services."



Clinical Documentation: Tennessee Board for Licensed Professional Counselors



0450 - 01 - .13

Professional Ethics

“All licensees and certificate holders shall comply with the current code of ethics adopted by the American Counseling Association, except to the extent that it conflicts with the laws of the state of Tennessee or the rules of the Board....”



0450 - 01 - .13 - (1)

Professional Ethics

“The certified professional counselor and licensed professional counselor and anyone under his supervision shall conduct their professional practice in conformity with the legal, ethical, and professional standards promulgated by the Board under its current statutes and rule and regulations.”



Clinical Documentation: HIPAA



164.316: (b)(1)

Standard Documentation

“(i) Maintain the policies and procedures implemented to comply with this subpart in written (which may be electronic) form; and (ii) If an action, activity or assessment is required by this subpart to be documented, maintain a written (which may be electronic) record of the action, activity, or assessment.”



164.508: (6)

Documentation

“A covered entity must document and retain any signed authorization under this section as required by § 164.530(j).”



Intake Notes....

What's important?

Time, Location, Length, People Present

History

Presenting Concerns and Need

Safety Concerns Reported

Client Consent and Expectation of Care



Why?



Things to keep in mind...

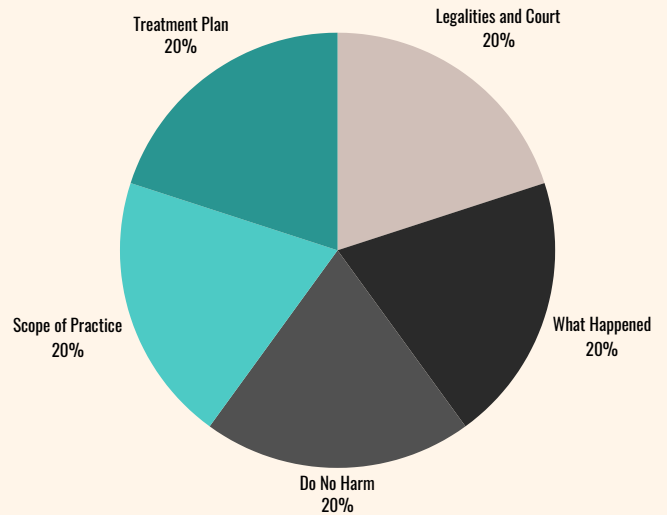
Legalities and Court: Does your documentation cover the safety concerns, thorough history, and consent to care?

What Happened: Does your documentation provide evidence and support of who was present, where it took place, the time etc?

Do No Harm: Are you documented to cover these legalities and ethics, while also protecting confidentiality of client?

Scope of Practice: Are you able to support you accurately assessed symptoms, needs? Did you document direction of tx plan and interventions that are within your scope of practice?

Treatment Plans: Does this information provided in intake support your diagnosis and treatment plan?



Progress Notes....

What's important?

Time, Location, Length, People Present

Risk Factors Documented

Interventions and Progress Towards Goals

Symptoms Reported



Why?



Things to keep in mind...

Legalities and Court: Does your documentation cover thorough screening of safety concerns and client presentation?

What Happened: Does your documentation provide evidence and support of who was present, where it took place, the time etc?

Do No harm: Are you documented to cover these legalities and ethics, while also protecting confidentiality of client?

NEW! **Scope of Practice:** Are you able to show evidence that you intervened and stayed inside scope of practice. Are you able to show evidence that you referred and recommended appropriate provider when not within scope?

NEW! **Treatment Plans:** Does this information provided in intake support progress or regression made in treatment plan?

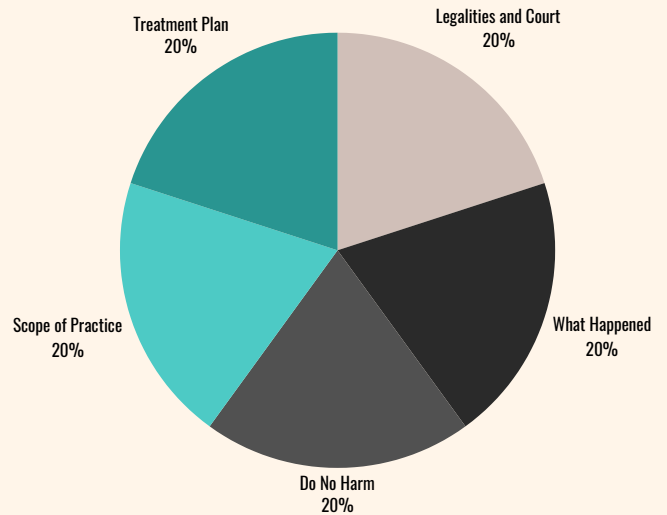


Chart or Contact Notes...

What's important?

Cancellations

Collaboration of Care

(i.e. parents, physician, dietician etc.)

Client Phone Calls



Why?



Things to keep in mind...

NEW!

Legalities and Court: Are you providing proof that an interaction took place? i.e.: following through on client request, filing of CPS report.

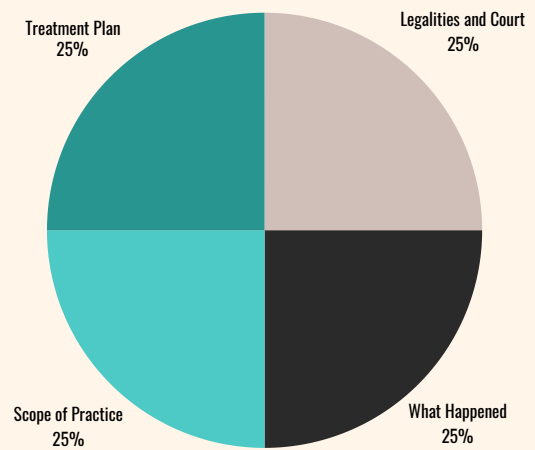
NEW!

What Happened: Does your documentation provide evidence and support of who you collaborated with, including day and time?

NEW!

Scope of Practice: Are you documenting recommendations made to collaborative team including their agreement or disagreement for recommendations?

Treatment Plans: Does this information support progress or regression made in treatment plan?



Treatment Planning...
What's important?

Diagnosis Supports Treatment Plan

Session Interventions Support Treatment Plan

Evidenced Based, Attainable, & Collaborative



Why?



Things to keep in mind...



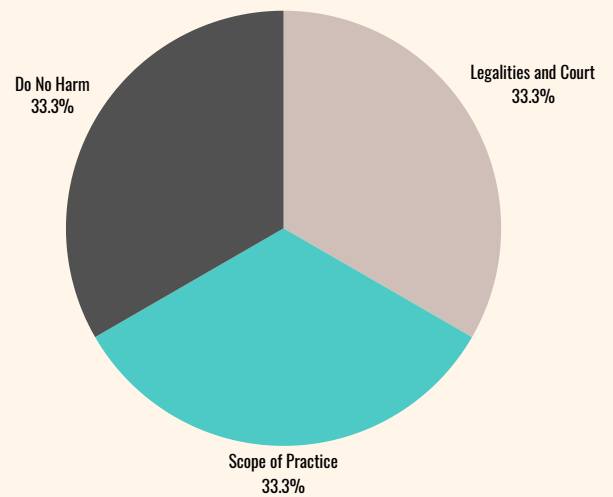
Legalities and Court: Are you able to prove your treatment direction was both ethical and evidenced based?



Scope of Practice: Are you able to prove your clinical treatment was within your scope of practice AND competency level?



Do No Harm: Have you involved your client in the treatment planning process? Are they aware of their diagnosis and treatment plan?



Discharge Notes...
What's important?

Supports Future Treatment of Client

Shows Evidence of Client Care

(i.e. client abandonment and client rights met)



Things to keep in mind...

NEW!

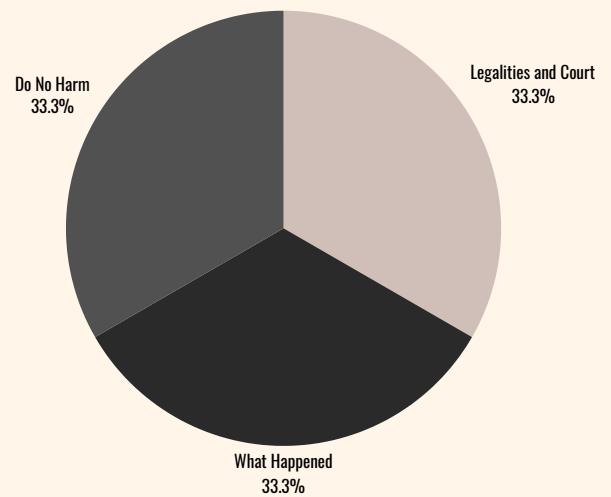
Legalities and Court: Can you prove that your care with a client ended? Can you prove they were given referrals and not abandoned?

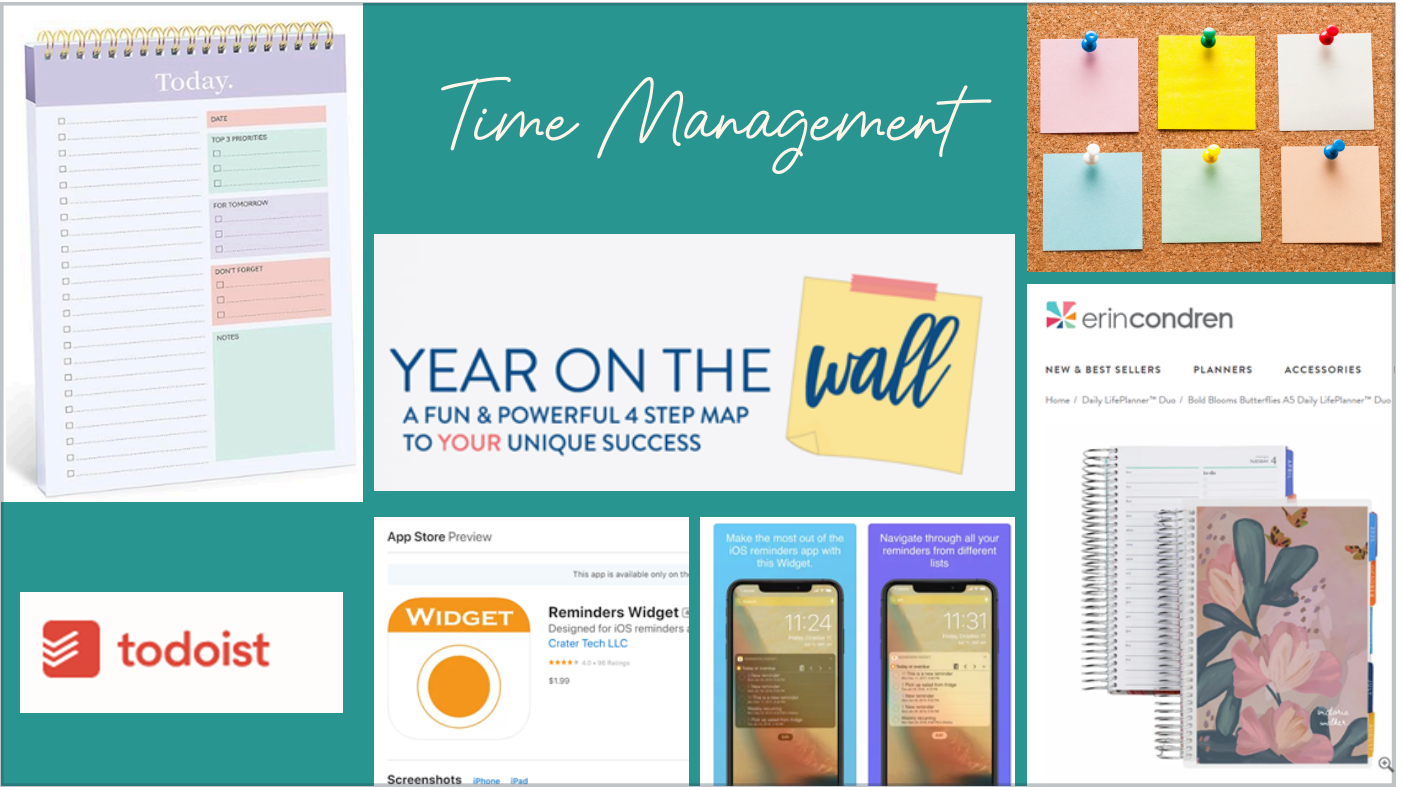
NEW!

Do No Harm: Does your summary and documentation empower your client to have continued and supported care in the future?

NEW!

What Happened: Does your summary show the date client care was concluded? Does it show that you adequately notified your client of discontinuation of care?





References

American Counseling Association

[Code of Ethics](#)

Tennessee Board for Professional Counselors

[General Rules and Governing Professional Counselors](#)

U.S. Department of Health and Human Services

[HIPAA Administrative Simplification: Regulation Text](#)





Thank you!

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