245I.08 DOCUMENTATION STANDARDS.

Subdivision 1. **Generally.** A license holder must ensure that all documentation required by this chapter complies with this section.

Subd. 2. **Documentation standards.** A license holder must ensure that all documentation required by this chapter:

(1) is legible;

(2) identifies the applicable client and staff person on each page; and

(3) is signed and dated by the staff persons who provided services to the client or completed the documentation, including the staff persons' credentials.

Subd. 3. **Documenting approval.** A license holder must ensure that all diagnostic assessments, functional assessments, level of care assessments, and treatment plans completed by a clinical trainee or mental health practitioner contain documentation of approval by a treatment supervisor within five business days of initial completion by the staff person under treatment supervision.

Subd. 4. **Progress notes.** A license holder must use a progress note to document each occurrence of a mental health service that a staff person provides to a client. A progress note must include the following:

(1) the type of service;

(2) the date of service;

(3) the start and stop time of the service unless the license holder is licensed as a residential program;

(4) the location of the service;

(5) the scope of the service, including: (i) the targeted goal and objective; (ii) the intervention that the staff person provided to the client and the methods that the staff person used; (iii) the client's response to the intervention; (iv) the staff person's plan to take future actions, including changes in treatment that the staff person will implement if the intervention was ineffective; and (v) the service modality;

(6) the signature, printed name, and credentials of the staff person who provided the service to the client;

(7) the mental health provider travel documentation required by section 256B.0625, if applicable; and

(8) significant observations by the staff person, if applicable, including: (i) the client's current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with or referrals to other professionals, family, or significant others; and (iv) changes in the client's mental or physical symptoms.

Subd. 5. **Medication administration record.** If a license holder administers or observes a client self-administer medications, the license holder must maintain a medication administration record for each client that contains the following, as applicable:

(1) the client's date of birth;

(2) the client's allergies;

(3) all medication orders for the client, including client-specific orders for over-the-counter medications and approved condition-specific protocols;

(4) the name of each ordered medication, date of each medication's expiration, each medication's dosage frequency, method of administration, and time;

(5) the licensed prescriber's name and telephone number;

(6) the date of initiation;

(7) the signature, printed name, and credentials of the staff person who administered the medication or observed the client self-administer the medication; and

(8) the reason that the license holder did not administer the client's prescribed medication or observe the client self-administer the client's prescribed medication.

History: *2021 c 30 art 15 s 9*

NOTE: This section, as added by Laws 2021, chapter 30, article 15, section 9, is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2021, chapter 30, article 15, section 19.