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 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; 2022 c 98 art 4 s 24*