

Chapter 5122-27 Minimum Requirements for Integrated Clinical Records

5122-27-01 Purpose.

(A) The purpose of this chapter is to state the minimum requirements for documentation in individual client records (ICR).

R.C. [119.032](#) review dates: 11/29/2010 and 11/29/2015

Promulgated Under: [119.03](#)

Statutory Authority: 5119.61(A), 5119.611(C)

Rule Amplifies: 5119.61(A), 5119.611(C)

Prior Effective Dates: 9/4/03

5122-27-02 Applicability.

(A) The provisions of the rules contained in this chapter are applicable to each agency providing mental health services that are funded by or funding is being sought by a community mental health board; is subject to department licensure according to section 5119.22 of the Revised Code; or that voluntarily requests certification. Any service contact(s) provided by an agency that is paid for in whole or in part by any community mental health board shall be subject to the provisions of this chapter.

(B) The provisions of the rules contained in this chapter are applicable to the following mental health services:

- (1) 5122-29-03 Behavioral health counseling and therapy service;
- (2) 5122-29-04 Mental health assessment service;
- (3) 5122-29-05 Pharmacologic management service
- (4) 5122-29-06 Partial hospitalization service;
- (5) 5122-29-10 Crisis intervention mental health service;
- (6) 5122-29-11 Employment/vocational service;
- (7) 5122-29-13 Adult educational service;
- (8) 5122-29-14 Social and recreational service;
- (9) 5122-29-17 Community psychiatric supportive treatment (CPST) service;
- (10) 5122-29-23 Adjunctive therapy service;
- (11) 5122-29-24 Occupational therapy service;
- (12) 5122-29-25 School psychology service;
- (13) 5122-29-28 Intensive home based treatment (IHBT) service; and

(14) 5122-29-29 Assertive community treatment (ACT) service.

(C) Additional requirements for ICRs may be specified in Chapter 5122-29 of the Administrative Code.

(D) Modified requirements for record keeping apply to the following services:

(1) Behavioral health hotline service shall maintain a log of all telephone calls including but not limited to the following information:

(a) Reason for call;

(b) Presenting problem;

(c) Disposition and/or referral(s) made;

(d) Date, time and person receiving call; and

(e) Name of caller, if given.

(2) Forensic evaluation service shall maintain records according to rule [5122-29-07](#) of the Administrative Code, including the requirement to:

(a) Provide a written summary of the forensic evaluation to the court or adult parole authority; and

(b) Store reports of forensic evaluations and any related records separately from records of persons served in other services.

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Rule Amplifies: 5119.22, 5119.61(A), 5119.611(C)

Prior Effective Dates: 9/4/03, 3/25/04, 1/09/06

[5122-27-03 Listing of components.](#)

(A) Each mental health agency shall maintain a complete and adequate individual client record for each client. For purposes of this chapter, an individual client record shall mean the account compiled by health and mental health care professionals of a variety of client health and mental health information, including, but not limited to, assessment of findings, treatment details, and progress notes.

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Prior Effective Dates: 9/4/03

5122-27-04 Consent for treatment.

(A) Each agency shall have policies and procedures for obtaining the written informed consent for treatment from the client or a legal guardian, as applicable; and in the instances of children and youth, from a parent or legal guardian/custodian, as applicable. Such policies shall address, as applicable, the treatment of persons in instances when obtaining prior consent for treatment is not feasible, e.g., crisis situations.

(B) In accordance with section 5122.04 of the Revised Code, mental health services, except for the use of medication, may be provided to minors fourteen years of age or older for not more than six sessions or thirty days whichever occurs first without a consent for treatment form signed by the minor's parent or guardian.

(C) Documentation of consent for treatment, refusal to consent, or withdrawal of consent, shall be kept in the individual client record.

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Rule Amplifies: 5119.06(A)(8), 5119.61(A), 5119.611(C)

Prior Effective Dates: 9/4/03

5122-27-05 Individualized service plan.

(A) The development of the individualized service plan is a collaborative process between the client and service provider(s) based on a diagnostic assessment, a continuing assessment of needs, and the successful identification of interventions/services. The individualized service plan shall document, at minimum, the following:

- (1) A description of the specific mental health needs of the client;
- (2) Anticipated treatment outcomes based upon the mental health needs identified in paragraph (A)(1) of this rule. Such outcomes shall be mutually agreed upon by the provider and the client. If these outcomes are not mutually agreed upon, the reason(s) needs to be fully documented in the ICR;
- (3) Name(s) and/or description of all services being provided. Such service(s) shall be linked to a specific mental health need and treatment outcome;
- (4) Evidence that the plan has been developed with the active participation of the client. As appropriate, involvement of family members, parents, legal guardians/custodians or significant others shall also be documented; or
- (5) As relevant, the inability or refusal of the client to participate in service planning and the reason(s) given; and
- (6) The signature(s) of the agency staff member(s) responsible for developing the individualized service plan, the date on which it was developed, and documented evidence of clinical supervision of staff developing the plan, as applicable.

(B) The individualized service plan must be completed within five sessions or one month of admission, whichever is longer.

(C) The individualized service plan shall be periodically reviewed at the client's request, when clinically indicated, and/or when a recommended service is terminated, denied, or no longer available to the client.

- (1) Documentation of the results of such periodic review shall occur at least annually, and shall include:

- (a) Evidence that the plan has been reviewed with the active participation of the client, and, as appropriate, with involvement of family members, parents, legal guardians/custodians or significant others;
- (b) As relevant, the inability or refusal of the client to participate and the reason(s) given; and
- (c) The signature(s) of the agency staff member(s) responsible for completing the review, the date on which it was completed; and documented evidence of clinical supervision of staff completing the review, as applicable.

Eff 9-4-03

Rule promulgated under: RC [119.03](#)

Rule authorized by: RC 5119.01(H), 5119.61(A), 5119.611(C)

Rule amplifies: RC 5119.01(H), 5119.61(A), 5119.611(C)

R.C. [119.032](#) review dates: 03/12/2003 and 09/04/2008

5122-27-06 Progress notes.

(A) The agency shall document progress or lack of progress toward the achievement of specified treatment outcomes identified on the individualized service plan (ISP). Documentation of progress may be done through use of checklists and/or brief narrative.

(B) Each individual staff providing services shall document progress or lack of progress each day that a service is provided.

The exception shall be the provision of group services, when a minimum of one staff person shall complete the progress note documentation.

(1) When multiple contacts of the same type of service are provided in one day, the staff may complete one progress note per day, rather than per service contact.

(2) When the same staff person provides more than one type of service in the same day to an individual client, e.g. behavioral health counseling and therapy service and community psychiatric supportive treatment service, the staff shall complete a separate progress note for each different type of service provided.

(C) Documentation shall include, at a minimum:

(1) The date of the service contact;

(2) The time of day and duration of each service contact;

(3) The location of each service contact;

(4) A description of the service(s) rendered;

(5) Whether or not the intervention provided is specifically authorized by the service plan that was developed based on a mental health assessment. The exception shall be the following circumstances, in which case the documentation must include the presenting problem in addition to the other requirements of this rule:

(a) Pharmacologic management service provided as the least restrictive alternative prior to completion of a mental health assessment, as described in paragraph (B) of rule [5122-29-04](#) of the Administrative Code, and

- (b) Crisis intervention mental health service when not listed on the treatment plan;
 - (6) The assessment of the client's progress or lack of progress, and a brief description of progress made, if any;
 - (7) Significant changes or events in the life of the client, if applicable;
 - (8) Recommendation for modifications to the ISP, if applicable; and
 - (9) The signature and credentials, or initials, of the provider of the service and the date of the signature. The credentials are the provider's qualifications to provide the service according to the matrix in Chapter 5122-29 of the Administrative Code. A provider signing a progress note utilizing initials must maintain a signature sheet, including credentials, in the individual client record (ICR).
- (D) Documentation in the progress note, or elsewhere in the individual client record, may include a notation that there is no change in the client's risk of harm to self or others, or, if there is a change, the results of a review of the client's ideation, intent, plan, access, and previous attempts.

Replaces: 5122-27-06

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Statutory Authority: 5119.61(A), 5119.611(C)

Rule Amplifies: 5119.61(a), 5119.611(c)

Prior Effective Dates: 9/4/03

5122-27-07 Discharge summary.

- (A) Each agency shall have policies and/or procedures addressing the completion of discharge summaries.
- (B) The discharge summary shall include, but not be limited to, the following information:
 - (1) Date of admission of the client;
 - (2) Date of the last service provided to the client;
 - (3) Results of the service(s) provided;
 - (4) Recommendations made to the client, as appropriate to the individualized service plan, including referrals made to other community resources;
 - (5) Medications prescribed by the agency upon the client's termination from service;
 - (6) Upon involuntary termination from service, documentation that the client was informed of his/her right to file an appeal; and
 - (7) Dated signature and credentials of the staff member completing the summary.

Eff 9-4-03

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Rule amplifies: RC 5119.01(H), 5119.61(A), 5119.611(C)

R.C. [119.032](#) review dates: 03/12/2003 and 09/04/2008

5122-27-08 Release of information.

(A) Each request for information regarding a current or previous client shall be accompanied by an authorization for release of information, except as specified in section 5122.31 of the Revised Code.

(B) The authorization for release of information shall include, but not be limited to, the following:

- (1) The full name of the client;
- (2) Date of birth of the client;
- (3) The specific information to be disclosed;
- (4) The name of the person or entity disclosing the information;
- (5) The name of the person or entity receiving the information;
- (6) The date, event, or condition upon which the authorization shall expire, not to exceed six months from the date of its completion, unless documentation reflects that the client agrees to a longer authorization period;
- (7) A statement notifying the client of his/her right to shorten or lengthen the authorization period, as well as his/her right to revoke the authorization at any time; and
- (8) The dated signature of the client or, as appropriate, a legally authorized agent and the agent's relationship to the client.

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5122-27-09 Security of clinical records systems.

(A) Each agency shall have policies and procedures addressing the security of its clinical records system.

(B) Policies and/or procedures for agencies maintaining a computer-based clinical records system shall include consideration of the following components:

- (1) Authentication – providing assurance regarding the identity of a user and corroboration that the source of data is as claimed;
- (2) Authorization – the granting of rights to allow each user to access only the functions, information, and privileges required by his/her duties;
- (3) Integrity – ensuring that information is changed only in a specific and authorized manner. Data, program, system and network integrity are all relevant to consideration of computer and system security;
- (4) Audit trails – creating immediately and concurrently with user actions a chronological record of activities occurring in the system;
- (5) Disaster recovery – the process for restoring any loss of data in the event of fire, vandalism, disaster, or system failure;
- (6) Data storage and transmission – physically locating, maintaining and exchanging data; and
- (7) Electronic signatures – a code consisting of a combination of letters, numbers, characters, or symbols that is adopted or executed by an individual as that individual's electronic signature; a computer-generated signature code created for an individual; or an electronic image of an individual's handwritten signature created by using a pen computer. Client record systems utilizing electronic signatures shall comply with section 3701.75 of the Revised Code.

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