Ethics and Documentation

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From the first moment of contact, you become responsible and accountable to the individual you serve, your profession, your colleagues, your employer, your community, the funding source, and a legal system that protects the rights of each individual.

Unethical actions always affect more than one person, especially when the violation becomes public. Professionals involved in unethical behaviors damage the credibility of all helping professionals. Therefore, we must strive to be the best we can be. Our client's and our professions deserve nothing less.

A code of ethics should be at the core of your professional and personal life. A code offers a set of values, principles and standards to guide "decision-making" and "conduct." A code will not provide a set of rules that prescribe how you should act in every situation; cannot specify which standards are most important or which ones outweigh others; and cannot guarantee ethical behavior. Ethical behavior will result, only, from your personal commitment to engage in ethical practice.

Purposes of a Code: identify core values; establish standards to guide our work; provide standards to which the general public can hold us accountable; and articulate standards to assess whether someone has engaged in unethical conduct.

This workshop will focus on integrity, records, billing, competence, confidentiality, electronic media, misrepresentation, and sexual relationships. The session is designed not only to promote an understanding of and compliance with a code of ethics but also to reduce risk exposure related to unethical actions, malpractice lawsuits, and paybacks to funding sources.

The Essential Principles: (1) ***Service:*** Your primary goal is to help people in need and to address social problems. Elevate service to others above self-interest. (2) ***Dignity and worth of the person:*** Treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Promote the clients' socially responsible self-determination. (3) ***Human relationships:*** Engage clients as partners in the helping process. Seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well being of individuals, families, social groups, organizations, and communities. (4) ***Competence:*** Practice only within your areas of competence. Continually strive to increase your professional knowledge and skills by

reading and attendance at conferences and training opportunities; and (5) ***Integrity:*** Behave in a trustworthy manner. Be aware of (and live by) your profession's mission, values, principles, and standards.

Some of the Essential Standards:

Your primary responsibility is to promote the well being of clients and, in general, a client's interests are primary. However, your responsibility to the larger society or specific legal obligations may (on limited occasions) supersede the loyalty owed clients, and clients should be advised of this fact. For example: the law requires you to report a client who has abused a child or, has threatened to harm self or others.

Respect and promote the ***right of clients to self-determination*** and assist them in their efforts to identify their goals. You may limit a clients' right to self-determination when, in your professional judgment, a clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others. Document activity and rationale.

Integrity: Maintain and promote the highest values of your profession. Protect and improve its honor through study, discussions, and self-evaluation. Contribute time and professional expertise to activities that promote respect for the integrity of your profession by teaching, supervising, legislative testimony, presentations in the community, participation in your professional organization, and offering a workshop at staff meetings or conferences. Take responsibility and credit only for work you have actually performed and acknowledge the contributions made by others.

Competence (being legally qualified to function in a specific manner): Provide services and represent yourself only within the boundaries of your education, training, license, certification, consultation received, supervised experience, or other relevant professional experience. Maintain a current and comprehensive personnel file.

Do not discuss ***confidential information*** in any setting unless privacy can be ensured, for example: in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants. Respect the right to privacy by not soliciting information unless it is essential to providing services. For example, don't ask a food stamp applicant about sexual behavior.

Protect the ***confidentiality*** of all information obtained in the course of professional service, except for compelling professional reasons, i.e., disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, disclose the least amount of information necessary to achieve the desired purpose.

Discuss with clients and other interested parties the nature of ***confidentiality*** and limitations of a clients' right to confidentiality. Discussion should occur at the beginning of the therapeutic relationship and reminders may be needed throughout the course of your relationship. Document your activity.

To the extent permitted by law, protect ***confidentiality*** during legal proceedings by working with an attorney who is familiar with laws in your state.

Protect ***confidentiality*** in the event of your termination of practice, incapacitation, or death especially if you are in private practice. (Also applies to deceased clients)

When you provide ***services to families, couples, or groups***, seek agreement among the parties involved concerning each individual's right to confidentiality and each individual's obligation to preserve the ***confidentiality*** of information shared by others. Inform participants you cannot guarantee all participants will honor such agreements. Document your activity.

Obtain written ***informed consent*** before taping, or permitting observation by a third party.

If you provide services ***via electronic media*** (such as computer, telephone, radio, and television) inform clients of the limitations and risks associated with such services.

Establish and maintain ***billing practices*** that accurately reflect the nature and extent of services provided and that identify who provided the service. Don't bill for services you did not provide. Bill only for actual service time, i.e., don't provide a 44 minute service and bill for one hour (unless you have an authorized procedure explaining when billed time is "rounded up" or "rounded down.") List start and stop time on each entry. Some funding sources require certain professionals to render services "under supervision of" another professional. It is your responsibility to know what the payer requires before you submit a bill and accept reimbursement.

Before using ***techniques or approaches that are new to you***, engage in appropriate study, training, consultation, and supervision from people who are competent in such interventions or techniques. Some methodologies are not universally accepted as a reimbursable therapeutic intervention. Bill a third party payer when interventions have been approved as payable and when the service provider is qualified according to the payer's regulations.

Make reasonable efforts to ensure ***continuity of services*** in the event services are interrupted by factors such as unavailability, relocation, illness, disability, or death.

Do not participate in, condone, or associate with ***dishonesty, fraud, or deception***. Marketing material must be factual. Do not inflate statistics in order to make a program appear more effective than it is.

Do not, under any circumstances, engage in ***sexual activities or sexual contact*** with current clients, with clients' relatives, with other individuals with whom clients maintain a personal relationship, or with former clients (whether such contact is consensual or forced).

Do not provide services to individuals with whom you have had a prior ***sexual relationship***.

Professionals who function as supervisors or educators must not engage in ***sexual activities or sexual contact*** with supervisees, students, trainees, or other colleagues over whom they exercise professional authority. Professionals who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities to avoid a conflict of interest.

Do not sexually harass supervisees, students, trainees, or colleagues. ***Harassment*** includes

sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature. (Note: Sexual harassment is against the law because it violates Title VII of the Civil Rights Act of 1964.)

Physical contact can be construed ***sexual harassment***. Do not sexually harass clients. Harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Implied in this standard is the directive not to harass former clients, colleagues, or students. In fact, you should never harass anyone.

Do not terminate services to pursue a social, financial, or ***sexual relationship*** with a client.

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Special Note: This training is based on forty-three years experience, countless numbers of books, articles, discussions, workshops, the National Association of Social Worker's Code of Ethics, and the American Counseling Association Code of Ethics. It is impossible to credit each source of information. The program and handout is not a substitute for legal advice. When in doubt, consult with an attorney. The presenter is not liable for a participant's behavior or damages that may result from the use of training materials. The presenter also acknowledges the following professionals for their encouragement, insights, opinions, and suggestions: Lisa Beran, JD. (KY); Bob Bushorn, LISW (OH); Leila Carlson, ACSW, LISW (IA); Dianne Golden, LCSW (CA); Sam Hickman, ACSW, LCSW (WV); Mary Lee Perry, JD (KY); Eileen Recktenwald, MSW (KY); David Riffe, ACSW, LCSW (KY); Tricia Williams, JD (OK); Bonnie Thuma Hawley, MA, CRC (VA); Kim Reynolds, LCSW (KY); and Sue Gauger, ACSW, LISW (IA).

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Six Steps for the Resolution of Ethical Problems:

(1) Look to the code first. The standards take precedence over your personal values.
(2) If the code does not address your specific issue, or if sections of the code provide conflicting guidance, then
* identify the individuals, groups and organizations to be affected by your action,
* list and evaluate possible actions with benefits and risks,
* ask yourself, "What will be the worst case scenario if the action occurs? What are all of the things that can possibly go wrong?"
(3) If you have doubts, don't make a decision until you consult with colleagues, experts or an attorney.
(4) Document your decision making process.
(5) Make your final decision.
(6) Evaluate and document the results.
NOTE: If the situation is an emergency that requires immediate response and if consultation is not possible, follow the steps listed above, but without the consultation. After the decision has been made and acted upon, evaluate the results and document reasons that eliminated the possibility of consultation.

Documentation in the Record

The record serves, not only as a treatment tool, but also as THE source document for ethical, clinical, legal, and fiscal accountability.

Who uses a record and why?

Primary Provider: Adhere to established plan of care and assure continuity.
Another Staff Person: Assure appropriate intervention when the primary provider is not available.
Primary Provider's Supervisor: Review quality of service, adherence to plan, and evaluate provider's professional growth.
Utilization Review and Quality Assurance: Evaluate appropriateness of service, review use of professional time, and examine program effectiveness.
State Auditors and other External Monitors: Determine compliance with licensure regulations or payer regulations to verify reimbursable activity.
Prosecuting Attorney: "Educate" the jury by pointing out missing, changed, or wrong dates; missing notes and plans; vague entries; inconsistent or conflicting information, etc.
Ethics Committee of Inquiry: Evaluate allegations of non-compliance with the code of ethics.

Personal note: I audited records for 25 years. Some of the most frequent problems: missing, incomplete, or altered dates; incomplete forms; brief vague content; notes that do not relate the plan or review; no signatures; signatures without credentials; notes signed by unqualified staff; missing and altered entries; and vague plans that do not verify a need for service.

Several years ago, the Medicare web site contained an article that said, in part, "The inspector general audit found services to be inappropriate, rendered by unqualified staff, undocumented, or poorly documented (canned language appeared to be computer generated)... were medically unnecessary because the recipient lacked the cognitive or communication skills necessary to participate in and benefit from therapy."

The code says, do not use ***derogatory language*** in written or verbal communications to or about clients...use ***accurate and respectful language*** in all communications to and about clients... provide services only in the context of a professional relationship based (when appropriate) on ***informed consent***... use ***clear and understandable language*** to inform clients of the purpose of the services...provide clients with an opportunity to ask questions... ensure that ***documentation is accurate*** and ***reflects the services provided***... include ***sufficient and timely documentation*** to facilitate the delivery of services and ***to ensure continuity*** of services provided to clients in the future... documentation should protect privacy to the extent that is possible and appropriate and, ***include only information directly relevant to the delivery of services***... store records in a ***secure location*** (not available to unauthorized persons)... dispose of records in a manner that protects confidentiality and is consistent with state statutes... and provide reasonable access to their records.

If you are concerned access might cause misunderstanding or harm it is your responsibility to provide assistance in interpreting the records. You may limit access to all or portions of the records only in "exceptional circumstances." For example, when there is "compelling evidence" that access would cause "serious" harm to the client. Client requests and the

rationale for withholding some or all of the record should be documented in the chart. When providing access to records, take steps to protect the confidentiality of other individuals identified in records as well as information obtained from other social service or health care organizations (For example, if you are employed by the local mental health agency, you may not release copies of a psychological test from obtained from a local private practitioner.)

Usefulness Requires Specificity: A person can run a red light everyday and the action has no consequence until the driver hits or kills someone. Inadequate records or incompetent personnel who are responsible for entries in the record may be of no consequence until allegations of unethical behavior are made, a malpractice lawsuit is filed, the funding source demands a payback, or someone must provide emergency services in the absence of the assigned professional.

Before you write anything, make seven assumptions:

1. Another professional must be able to read and understand what I write, because I'll be sick or on vacation during an emergency.
2. This entry will be selected by the Funding Source Auditor to verify a reimbursable service by a qualified professional.
3. This record is going to be subpoenaed and the court must understand what went on. I may or may not be with the agency when it happens.
4. The client will request and read my documentation (or it will "show up" in the newspapers during a malpractice suit).
5. I can't be as accurate if I wait days or weeks to write a note, so I'll do it today.
6. This note will be the best possible reflection of my professional abilities. (To verify compliance with the code of ethics, if necessary)
7. No contact is considered a service until my entry is in the record.

Treatment Plan / Service Plan / Plan of Care

The code says professionals and clients work jointly in devising individual plans that offer reasonable promise of success and are consistent with abilities of clients. Professionals and clients regularly review plans to ensure continued viability and effectiveness, respecting clients' freedom of choice.

A plan must be legible and easily understood; contain information that agrees with and/or supplements the History and Assessment forms; be the starting point for subsequent staff notes, and case reviews; combine with the note to document progress or lack of progress; and confirm the need for reimbursable services rendered by qualified staff.

Components of a Plan

(a) **Problem Statement** - Must answer these questions: Why is the client here? What specific problem(s) requires service? What is the specific problem for which my organization will be billing?
Unclear examples: "Anxiety"; or "depression"
Clear examples: "Anxiety related to possible loss of job", "depression caused by father's recent death".

(b) **Goals/Objectives** - Must be written so clearly that anyone can understand its meaning.

Will answer these questions: What is the aim of treatment? What specifics will result from intervention? What is the expected date of goal achievement?

Unclear	Clear
Develop self-awareness	Accept responsibility by not blaming others.
Improve hygiene	Brush teeth and shower each day.
Become responsible	Take medications as prescribed.
Become less withdrawn	Eat meals and watch TV with family once per day.
Increase self-esteem	Will not be critical of self or personal decisions concerning discipline of children.

(c) **Assets** - A listing of items that will assist you in achieving treatment goals. Includes personality and emotional characteristics, community resources, family support, etc.
Unclear examples: Family, or money, or car
Clear examples: "Supportive/understanding spouse who is involved with therapy." or "Client is able to work each day and has steady income." or" Is able to drive and has transportation."

(d) **Barriers** - A listing of items that will hinder achievement of treatment goals.
Unclear examples: Family or money
Clear examples: "Spouse sees client as selfish and says there is no value to counseling." or "Client lost job, has no income and no prospect of employment."

(e) **Modality** - Specify intervention(s) to be rendered. Answer these questions: Is it a billable service by a competent/qualified professional? Does other information within this plan clearly confirm a need for this kind of intervention?
Unclear example: Non-threatening, support
Clear example: "Abused Partners Group each week and individual therapy as requested;" or "Weekly Group to provide information about the nature of chemical dependency as an illness."

(f) **Clinical Impression/Diagnosis** - Must be an accurate reflection of the client's mental health as indicated within other sections of the plan and from Data Base. Spell out the full diagnostic term(s) and list the code(s)

(g) **Members of Planning Team** - List the names and credentials of each person who participated in the development of the plan. Signatures may be optional, depending on licensure and payer regulations in your state.

(h) **Name of Assigned Therapist/Case Manager/Service Provider**

(I) **Signature** of person who wrote the plan.

(j) **Date** plan was developed (month/day/year).

(k) **Date of Next Review** (month/day/year).

(l) **Signature of MD and/or Psychiatrist** who approves plan and who assumes responsibility for overall client care plan. Signature may be optional, depending on licensure and payer regulations in your state.

Staff Notes

The essential elements for each entry are:

1. Specific words that document an intervention related to the plan of care.
2. Specific reference to client reaction, attitude, and symptoms, and
3. Signature with credentials and date (month/day/year).

Some staff notes may be repeats of previous entries. You do not have to think of something new and original for each note, but a simple statement of fact, an observation or an opinion is insufficient. The content must:

1. Permit an auditor to determine that a billable service was given;
2. Provide adequate information which allows another professional to intervene when the assigned provider is not available, and;
3. Confirm there are no grounds for a malpractice suit or allegations of unethical behavior.

Notes must focus on professional interventions, not activities such as playing cards, making cookies, celebrating a birthday, or taking a trip.

Notes must confirm rendering of payable service as defined by the funding source. Read the payer's service definitions. If you are not providing the defined service, stop billing - it's unethical and illegal.

Never embellish or lie in a note for the purpose of making it appear that a billable service was rendered. The note must be an accurate reflection of the service provided and of you as a qualified professional. Your actions must always be ethical and legal. Any deviation is unacceptable.

Verbs Are Still Important

An entry must specify the kind(s) of service(s) rendered and client response(s). Verbs answer two questions, "What did you do"? and "What did the client do"?

advised	discuss	facilitate	reassure	stabilize
assess	encourage	identify	recommend	suggest
clarify	evaluate	interpret	refer	support

Nouns Are Still Important

What issue(s) received your professional intervention? Remember, one word is not sufficient. Elaborate rather than create doubt.

aggression	dependence	guilt	projection	self-image
alcoholism	depression	hostility	rationalization	sobriety
anxiety	drugs	isolation	relationships	withdrawal

Modifiers Are Still Important

A modifier can enhance an entry **but only when you define the word** you use. Each person is capable of a multitude of mannerisms for any given characteristic. Therefore, you must define words such as depressed, agitated, confused, hostile, etc. Word choice is important and difficult. A word may convey, deliberately or not, a view that tends to be more negative than reality. You can clarify a word by adding, "as evidenced by..."

abusive	dependent	homicidal	manipulative	suicidal
dangerous	disorganized	immature	marginal	threatening
demanding	disruptive	inappropriate	passive	unresponsive

Be precise and current. Consider writing the plan and note with a client. It can be good therapy, provide a starting point the next time you see him/her, enhance the service relationship and promote empowerment.

ANTICIPATING THE LEGAL SYSTEM

Lawsuits and legislation are changing the traditional definition of confidentiality. Suits which question treatment or diagnosis, are becoming more common. An opposing attorney is duty-bound to be the best possible advocate for his/her client. Your documentation and activities are of use only insofar as they contribute to a financial settlement of his client's claim against you. Every legal method will be used to obtain documentation from the record and your personnel file. Without adequate documentation, credibility and professionalism can easily be questioned.

The code says do not abandon clients who need services. Withdraw services precipitously, only under unusual circumstances, giving careful consideration to all factors in the situation, and taking care to minimize possible adverse effects. Assist in making arrangements for continuation of services and document your activity in the record.

Abandonment is the negligent interruption or termination of services. Risk exposure increases when (1) "high risk" clients "drop out", (2) a client comes to treatment erratically, (3) records do not verify "reaching out" efforts to a client who breaks/misses appointments, (4) a client is "fired" or refused service, (5) a professional and client have not discussed/agreed on closure, (6) clients are not notified in writing, their case is being "closed", (7) records indicate a failure to review/consult/refer, (8) notes do not verify the plan is being followed.

References and Suggested Readings

(1) Gelman, Sheldon R. Risk management through client access to case records (1992) Social Work Vol 37, Number 1, pp 73-79.
(2) Joint Commission on Accreditation of Healthcare Organizations. 1999. Joint Commission Comprehensive Accreditation Manual for Behavioral Health Care 1999-2000. Oakbrook Terrace, IL
(3) Loewenberg, F.M., Dolgoff, R., & Harrington, D (2002) Ethical Decisions for social work practice (6th ed.) Itasca Illinois F.E. Peacock Publishers, Inc.
(4) Reamer, Frederic G. (1999) Social work values and ethics (2nd ed). New York Columbia University Press

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A web site contains workshop information, handouts, a resume, song sheets, and more. http://home.bellsouth.net/p/PWP-bobmitchell

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(Effective date: November 5, 2006)

Please send the following item(s). **Prices include postage & handling.**
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"Documentation in Counseling Records:
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Be sure to include a legible Name; Address; City, State and Zip code

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Workshop Exercises:

1. The last time I read my code of ethics was (list date) _____ .
My promise: I will re-read the code on or before _____ (4-6 weeks from today).

2. What are the purposes of a code of ethics? List two:

3. List two "Standards" or "Responsibilities" in a code of ethics:

4. Staff note (names and dates deleted):
(4a) You must see this woman because there is an emergency and the assigned service provider is not available. What was done yesterday? What will you do today?
Rewrite this note in ten (10) sentences or less.
(4b) List any concern you have about the service, the note or the provider.
(4c) Underline any word or phrase that is not clear to you.
(4d) Circle any word or phrase that describes a billable service.

(Dated) I had session with client today at office. Client's affect was flat and was s/w non-verbal at times. Client and I talked about the letter she had left for me at the office. It seems that client has written letter out of depression with possible suicidal ideation present. Client and I talked about some ways she could deal with negative feelings she has about herself. I asked client if she had a suicidal plan - client did not. Client stated she doesn't want to harm herself but she feels empty, worthless. Client and I talked about her relationship with others and her daily activities. Client seems satisfied with present activities but concluded she would like to become more involved in arts and crafts, as she is extremely talented. I suggested to client she research what's available in the way of arts and crafts and possibly enroll herself. Client stated she felt much better after having wrote the letter to me and also in talking with me today. Client seemed to be much more relaxed and seemed to smile easily. I praised client for her honesty and her trust in me. I urged client to contact me at any time, day or night -- client and I too discussed what she feels is compulsive spending. I suggested to client she contact the crisis line to inquire whether or not there is a support group for compulsive spenders. However, in my opinion, I suspect client has been spending because of her depression. Client and I will set up an appointment as soon as possible. (Signed by provider)

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Special Note: Today's topic is risk management, not risk elimination. The following quotations are from the presenter's book, Documentation in Counseling Records: Second Edition (published in the Ethical-Legal Series by the American Counseling Association). "The patchwork of state & federal laws does not provide 100% protection to anyone. {p 24} .. Laws differ from state to state and they change from day to day... Laws are not absolutely clear on every possible area of exposure ... many issues have yet to be ruled on. {p 49} ... Without current and accurate documentation, risk exposure is increased... and no book or workshop will provide you with a bulletproof failsafe system of record keeping. When in doubt, consult with an attorney. {p 60} ... this monograph [and workshop] is not a substitute for legal advice. In no event is the American Counseling Association or the author liable for damages that may result from the use of any publication in the Ethical-Legal Series." {p 92}

HIPAA: Health Insurance Portability and Accountability Act (1996) Some basic facts:
Note: Complete regulations can be found at WWW.CMS.GOV/HIPAA

A large part of the regulations do not relate to patient management, but essential elements include national standards for: (a) security, (b) privacy, and (c) electronic transactions & transaction data code sets, specifically, ICD9-CM codes must be used.

The "Privacy Rule" relates to all protected health information in any medium, written, oral or electronic. This rule is most closely associated with this documentation workshop because it is designed to give the consumer/patient more control over the record's content, as it relates to them. Patients/consumers have:
(a) The right to be informed about the privacy practices. (Note: they must be given a "Notice of Privacy Practices");
(b) The right to object to or limit use and disclosure of personally identifiable health information;
(c) The right to review a "designated record set." {Note: There are many interpretations about what constitutes a "designated record set," so you must discuss specific concerns with a HIPAA expert.} ;
(d) The right to request amendment of information;
(e) The right to request alternate means of communication;
(f) The right to know to whom information has been disclosed

The "Security Standard" (Wireless, Wires, and Paper) // You must establish a policy and procedure related to
(a) "Access" to patient information;
(b) Ability to capture & report all consents and authorizations (and absences of consents & authorizations) granted by a client/patient;
(c) Ability to track & manage HIPAA complaints and/or requests;
(d) Security of the electronic client record and information that is transmitted by e-mail, e-mail readers such as RIM's Blackberry, cell phones, pagers, faxes, {Note: Some faxes and printers have a hard drive that will maintain client information unless they are cleaned}, etc
(e) Ability to handle problems related to "electronic downtime," termination of service (electronic or otherwise), hackers, encryption, (Note: encryption is required when information is transmitted over the public web)... etc;
(f) Nature & amount of transmitted content (and who receives it) {Note: content means clinical, administrative & fiscal information}; and
(g) Use of mobile technology & remote access

The Electronic Record (a) once entered and "saved", information cannot be altered but may be appended/changed when certified by the appropriate authority; (b) entries must include the specific date when information is entered; (c) must include sufficient information to make treatment decisions, must include such decisions, and must be signed/certified by the staff person making the decisions {Note: may also contain certified information from the affected patient/consumer}; and (d) must be current, complete, & easily accessed by authorized service providers