TIP SHEET #4 G.I.R.P DOCUMENTATION

General Documentation Guidelines for **Encounter Note** writing.

The **content** in encounter note documentation should provide all the necessary supporting evidence to justify the need for your level of services based on medical necessity criteria and support all the requirements for your services. The **purpose** of encounter note documentation is to accurately describe the actual delivery of services so it provides sufficient information to determine;

- Who provided the service
- Where the service was provided
- When the service was provided
- Why the service was provided
- How the service was provided

The **GIRP** format is used by DMHAS and supplies all the information necessary to satisfy funders, accreditation bodies, reviewers and auditors. It is not a format to only be used when documenting a TCM service, it contains all the essential elements of good documentation that anyone reviewing a note is looking for.

GOAL- Describes the individualized goals and objectives of services and issuers related to the reason why the client is participating in **your** particular level of care and this particular time.

- It is reflected on the Individualized Recovery Plan (IRP)
- The client's hopes, dreams, preferences and desired outcomes specific to your setting and level of care are included.
- It is a statement of why the client is in your program.
- It is expected that the information will answer the question of **why** the client needs these services.

INTERVENTIONS- Describes the services, interventions and modalities planned and provided in enough detail to clarify to all who read it;

- What was provided
- Why it was provided
- When it was provided
- Where it was provided
- With what intensity and for what duration
- Who provided it and how it was provided

It is expected that the information will answer the question about what was **specifically** done for the client.

RESPONSE-

- The client's response to the intervention and related progress or lack of progress.
- Response of the service provider and related service decisions to continue with the same planned interventions or to modify, add, delete or completely alter and change the interventions.

PLAN- Summaries the plan for continued services and describes if any modifications need to be made and whether any referrals or new services are recommended. It is expected that the information will answer the questions;

- What has happened
- What is next