**Section 2060.425 Progress Notes** **and Documentation of Service Delivery**

a) Progress notes shall reflect patient progress and shall be consistent with the clinical assessment, level of care and expectation of progress. Progress notes can include a summary of services delivered prior to each continued stay review. Progress notes shall be summarized a minimum of every 14 calendar days for patients in Level II care, daily for patients in Level III care, and upon each continued stay review for patients in Level I and Residential Extended Care. Progress notes shall be entered in the patient record and include the following:

1) chronological documentation of the patient's progress in treatment;

2) documentation of any change in the patient's behavior; and

3) descriptions of the patient's response to treatments, the outcome of treatment, and the response of significant others to events in the course of treatment.

b) Documentation of service delivery in the patient record shall specify the name and credentials of the individual who provided the service and be signed or initialed and dated in ink by the individual making the entry or in accordance with the provisions for electronic signature specified in 2060.325(c)-(e) of this Part.

c) Any entry that includes a subjective interpretation of the patient's progress shall include a description of the actual behavior observed.

d) Each service delivered shall be documented in the patient record and include the specific type of service delivered, location of service delivery, date, time and duration of each service rendered to the patient (with the exception of HIV counseling and testing). Clinical notes, clinical checklists and clinical rating scales may also be included with this documentation.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)