QUALITY OF DOCUMENTATION **INPATIENT**	**GUIDELINES FOR SCORING INDIVIDUAL RECORDS** **1 = Poor, 2 = Below Standard, 3 = Meets Standard, 4 = Above Standard, 5 = Excellent** **Y = Meets Standard, P = Partial, N = Does Not Meet Standard**	**GUIDELINES FOR DETERMINING PROGRAM COMPLIANCE WITH STANDARDS** ***Programs are expected to strive to achieve all quality of documentation standards in 100% of the instances. Programs that are compliant in less than 75% of the charts reviewed will be required to develop a plan for improvement in conjunction with the auditing agency.***
1. Has the consumer (or their legal guardian) consented to treatment? *42 C.F.R. 482.13(b)* *Md. Annot. Code Health-General 10-706(c)*	**N =** Consent for services is not documented by signature of the consumer, a child's parents or, when applicable, other legal guardian. **Y =** Consent for services is documented by signature of the consumer, a child's parents or, when applicable, other legal guardian. There is legal/agency documentation of change in guardian status when a legal guardian signs the consent. **NA =** Consumer was committed to inpatient hospitalization.	75% of all medical records reviewed have documented consent for services.
2. If the consumer is a child for whom courts have adjudicated their legal status or an adult with a legal guardian, are there copies of court orders or custody agreements? *42 C.F.R. 482.61(a)(1)*	**Y =** Court orders and custody agreements regarding healthcare decision-making are present in the chart **OR** if an agency such as DSS has custody, there is a letter from the agency naming a specific person to make healthcare decisions. **N =** There are court orders or custody agreements establishing healthcare decision-making responsibility, but the required documentation is not present in the chart. **NA =** Health-care decision-making has never been reviewed through court orders or custody agreements in juvenile, or family court **OR** consumer was committed to an inpatient hospitalization.	75% of all applicable medical records reviewed have the required documentation necessary to confirm custody and health-care decision-making authority by the guardian consenting to treatment.
3. Does the medical record meet all requirements for the documentation of the orders and implementation, monitoring, medical treatment provided (*if necessary)***, and follow-up of a restraint or seclusion?**	**1 =** There is little or no documentation of seclusion/ restraint episodes. **3=** Documentation required by CFR for orders, restraint/seclusion, monitoring, and follow-up is present in the medical record. In emergency situations, orders are not required until such an order could be reasonably obtained. **4** = All of # 3 plus The patient and staff were de-briefed to understand their experience of the restraint and/or seclusion. **5 =** All of #4 plus the information discussed from the de-briefing led to modifications in the consumer's safety plan and/or subsequent treatment plans and clinical services.	75% of all medical records reviewed have documented the orders for, implementation and monitoring of, medical treatment provided (if necessary), and the follow-up of a restraint or seclusion.

4. When clinically indicated and in accordance with protocols established by the facility and the local CSA *(where applicable)***, did the initial evaluation in the Emergency Room document the consideration and involvement of community-based crisis programs prior to developing an initial inpatient plan of care?** *CSA Guidelines, Transmittals*	**N =** There is little of no documentation of the consideration of alternative crisis responses other than hospitalization or the involvement of community crisis providers. Where applicable, the emergency room did not follow established protocols with the CSA for referral to community crisis response programs. **Y =** There is documentation of the consideration of alternative crisis responses other than hospitalization or the involvement of community crisis providers. Where applicable, the emergency room did follow established protocols with the CSA for referral to community crisis response programs. **NA** = Not applicable due to no community-based crisis programs in this CSA jurisdiction.	75% of all medical records reviewed documented the consideration and involvement of community-based crisis programs prior to developing an initial inpatient plan of care when clinically indicated and in accordance with protocols established by the facility and the local CSA (where applicable).
5. Is there a comprehensive assessment completed, and with consent and when possible, with the involvement of the family/guardians and community providers? *42 CFR 482.61(a)* *42 CFR 441.155 (b)*	**1 =** Assessment missing or contains only one or two components of the CFR standards for assessments. **3 =**Complete assessment includes the coordination of family/guardian participation throughout the assessment process and completes the following screenings/assessments: • Medical Evaluation o Diagnosis o Summary of present medical findings o Medical History o Mental & physical functioning capacity o Prognosis o Symptoms, complaints, & complications indicating need for admission o Recommendations by admitting physician • Psychiatric Evaluation o Mental Status o Chief Complaint o Adequately notes the onset of illness and circumstances leading to admission o Estimates intellectual, memory, and orientation o Describes attitudes, emotions, and behavior o Includes inventory of assets • Social History o Developmental History required for Children **4 =** Everything in #3 plus the comprehensive assessment process which is individualized, holistic, and accurate. It includes the consumer's current and potential support system, motivation, and goals. The assessment documents a synthesis of the information into an overall picture. **5 =** Everything in #4 plus the documentation of process for informing the consumer and their family/legal guardian regarding the results of the assessment, the nature of their illness, the treatment options and effectiveness, and their role in illness management and wellness.	75% of all medical records reviewed include a completed comprehensive assessment, and when possible and with the required consent, documenting the involvement of the family/guardians and/or community providers.

6. Does the medical record document active participation in establishing the goals, objectives, and interventions of the treatment plan by the consumer and/or their parent/guardian? *COMAR 10.21.03.03*	**1 =** The legal guardian and consumer did not sign and date the ITP or the unit has documented the involvement of the consumer and, when appropriate, the parent/legal guardian in the development of the Plan of Care. **3 =** The legal guardian and consumer signed and dated the ITP or the unit has documented the involvement of the consumer and, when appropriate, the parent/legal guardian in the development of the Plan of Care. Documentation of the consumer's involvement may recorded and kept on the unit in an accessible manner – but not be part of the medical record. **4 =** Everything in #3 plus the consumer, guardian (if any), and, with a signed release, the family's input into the ITP is documented by the consumer/service provider. **5 =** Everything in #4 plus techniques for assisting consumers and family members in articulating goals and identifying incremental steps for recovery.	75% of all medical records reviewed have a score of 3 or above and meet the standard for documenting active participation in establishing the goals, objectives, and interventions of the treatment plan.
7. Are the treatment plan goals/objectives related to the assessment? (strengths, symptoms, skill deficits, resources)	**1 =** Goals/objectives have no relationship to the current assessment. **3 =**The goals/objectives have direct correlation to the most recent assessment. Items identified at more intensive levels should be accounted for on the Plan of Care either through a goal/objective or documentation of resident/parent/legal guardian refusal. Medical needs identified in the assessment are addressed in the plan of care. The treatment plan includes any specialized recommended for the health and safety of the consumer. **5 =** A comprehensive assessment is incorporated into the treatment planning process and integrated with consumer and family involvement to result in a treatment/recovery plan.	75% of all medical records reviewed have a score of 3 or above and meet the standard for the relationship between the goals/objectives of the Plan of Care and the most recent assessment.
8. Does the treatment plan contain goals, objectives or outcomes that are individualized, specific and measurable with an achievable timeframe? *42 CFR 180 (b)* *42 CFR 482.61 (c)* *42 CFR 441.154* *42 CFR 441.155* *42 CFR 441.156 (b)* *COMAR 10.21.03.03*	**1 =** All of the goals/objectives are general statements with vague language and no measures of accomplishment and/or all consumers reviewed in this service have the same goals/objectives. **3 =** The objectives are written in observable terms that can be measured with a timeframe for demonstration. The objectives listed are individualized and not the same for all other consumers reviewed in this service. Goals reflect changes in the consumer's symptoms, behaviors, emotions, and thoughts. **5 =** All goals/objectives are written in observable terms that can be measured with a timeframe for demonstration. The objectives are individualized to this consumer based on their assessment and directly related to the resident's discharge plan.	75% of all medical records reviewed have a score of 3 or above and meet the standard for the treatment plan containing goals, objectives or outcomes that are individualized, specific and measurable with an achievement timeframe

9. Are the interventions on the treatment plan congruent with goals/objectives?	**1 =** Interventions are unrelated to the objective (i.e. skill building objective with intervention related to medication compliance) **3 =** Interventions represent an integrated program of therapies designed to meet treatment objectives. Activity services are incorporated into the plan of care, treatment, and services. The interventions are correlated to the stated objective. For example, symptoms of illness are typically addressed through medication, individual, family, and group therapy. Resource deficits are addressed through adaptation of current resources, steps to obtain new resource, etc. **5 =** Interventions named in the treatment plan reflect evidenced-based or promising practice for consumers with specified diagnosis, symptom profile, and/or psycho-social stressors.	75% of all medical records reviewed have a score of 3 or above and meet the standard for the interventions on the treatment plan being congruent with goals/objectives.
10. Does the medical record document a completed written discharge plan prior to admission? *CFR 456.180 (a) (b)(6)*	**N =** There is little or no discharge planning documented in the medical record. There is no notation regarding preliminary discharge planning during the admission. Natural supports, community resources and outpatient providers are not identified and included in the discharge planning process. **Y =** Discharge planning begins at admission. A written discharge plan has been completed.	75% of all medical records reviewed have a score of 3 or above and meet the standard for early initiation of the discharge plan.
11. Do the staff providing discharge planning services assist the consumer in participating in discharge planning?	**N =** There is no documentation of the consumer participating in decisions regarding aftercare plans prior to the date of discharge. **Y =** The consumer participated in identifying their needs for services and supports following discharge from the hospital. The consumer was involved in developing an aftercare plan which included choosing providers, community agencies, and the use of natural supports. The consumer identified strategies they could employ to manage their illness and symptoms.	75% of all medical records reviewed document that staff has assisted the consumer with participating in the discharge planning process.
12. With the appropriate consents to release information, does the discharge planning process also involve communication and collaboration with community providers, family members and CSA's *(when applicable or necessary)*?	**1 =** There is little or no documented communication between the inpatient unit and the family, persons living with the consumer, or community providers. **3 =** There is sufficient, ongoing, and timely communication between the inpatient unit, family (with permission), and community providers (with permission). Communication with family, community providers and other agencies includes a properly executed Release of Information. The consumer and family (with permission) are involved in choosing and contacting aftercare agencies when indicated and appropriate. Problems with arranging timely mental health services or other vital community supports are referred to the consumer's CSA during the discharge planning process. **5 =** The aftercare plan includes other natural supports and non-mental health community agencies to increase support provided to the consumer following discharge. **NA** = Not applicable (consumer does not have family member involvement)	75% of all medical records reviewed document the collaborative discharge planning with family and community providers (when applicable or necessary).
13. Were all of the required elements of an aftercare plan documented? *COMAR 10.21.05.03*	**N =** None, or very few of the required elements were documented in the aftercare plan. **P =** Some of the required elements of an aftercare plan, but not all of the aftercare plan is documented in the aftercare plan **Y =** All of the required elements of an aftercare plan were documented.	75% of all medical records reviewed had an aftercare plan with all of the required elements.

14. When appropriate and with consents for the release of information, was a copy of the aftercare plan provided to the consumer, their family, and community providers? *COMAR 10.21.05.03*	**N =** A Copy of the aftercare plan was not provided to the consumer. There was no discussion with the consumer regarding sending a copy of the aftercare plan to the community provider(s)/family members, and no attempt was made to obtain permission for this communication. **P =** A copy of the aftercare plan was provided to the consumer. There was no discussion with the consumer regarding sending a copy of the aftercare plan to the community provider(s), family, or others with a personal interest in the consumer (if any) who are identified in the aftercare plan to provide housing. No attempt was made to obtain permission for one or all of these communications. **Y =** A copy of the aftercare plan was provided to the consumer. The consumer's signature on the aftercare plan indicates his/her approval to distribute the plan to community providers and family/significant others with whom the person is living. Copies of the aftercare plan were distributed according to the distribution list and to the community provider and family members/significant others **OR** the consumer refused to release the aftercare plan to the community provider/ family members/other interested persons (if any).	75% of the medical records reviewed had a copy of the aftercare plan given to the consumer and the inpatient unit discussed with the patient the option to provide this information to community providers/family members if the consumer signed a release of information. The aftercare plan was provided to providers and family members when the release was signed.
15. With consent to release information, are family members, other interested individuals (if any), and community providers notified at the time of discharge? *COMAR 10.21.05.03*	**No =** No attempt was made to obtain consent or to notify family members, other interested individuals, and community providers. **Y =** With consent to release information, family members, other interested individuals and community providers were notified at the time the patient was discharged from the hospital. **NA =** Either the consumer denied permission to notify family members and community providers or the family member or community provider could not be located.	
16. Does the ITP include all required signatures? *COMAR 10.21.03.03*	**N=** A signature or date is missing. **Y=** All required signatures with dates are present.	75% of all applicable medical records reviewed had the required signatures on the treatment plan.
17. Are the progress/contact notes complete? *42 CFR 482.61 (d)* *42 CFR 482.62 (d)* *412.27(c)(4)*	**1 =** No (or very few) progress/contact notes contain all of the following items: date, start time, and a legible signature with job title or MH professional license (when required by law to provide the service.) **3 =** More than 75% of the progress/contact notes contain all of the listed items. **5 =** All progress notes contain all of the listed items.	75% of all applicable medical records reviewed had at least 75% of the reviewed progress notes with all of the required elements.
18. Do the progress/contact notes reflect goals and interventions on the ITP are being addressed and implemented?	**1 =** No (or very few) progress/contact notes contain interventions but rather give information unrelated to the consumer ITP. **3 =** Seventy-five percent (75%) of the progress/contact notes identify the goals and staff interventions that are consistent with the ITP. All of the interventions on the ITP are addressed in contact/progress notes **OR** there are changes to the plan documented in a contact/progress note that addresses why specific goals and interventions were not addressed. **5 =** All progress/contact notes contain the goals and staff interventions. Changes in interventions or objectives are included in progress/contact notes, as needed.	75% of all medical records reviewed have a score of 3 or above and meet the standard for progress/contact notes reflecting that interventions on the treatment plan are being implemented.

19. Do the progress/contact notes reflect the consumer's progress towards the goals of the treatment plan?	**1 =** No (or very few) progress/contact notes contain the consumer's responses to interventions included in the treatment plan, but rather give information unrelated to the interventions listed on the Plan of Care **3 =** Seventy-five per cent (75%) of the progress/contact notes mention consumer responses to the interventions mentioned on the treatment plan. **4 =** All progress/contact notes contain staff interventions and consumer responses to the staff's intervention. Changes in interventions or objectives are included in progress/contact notes, as needed. **5 =** Reviewing progress towards goals and treatment effectiveness with the client includes celebrating success, flagging consumers who are not making progress, and convening a recovery team to reorganize treatment.	75% of all medical records reviewed have a score of 3 or above and meet the standard for the progress/contact notes reflecting the consumer's progress towards the goals of the treatment plan.
20. Are the assessment, Plan of Care, progress/contact notes, and the discharge plan consistent with the current ProviderConnect? *Provider Manual*	**1 =** The assessment, the goals/objectives, and the discharge plan do not relate to the information supplied through ProviderConnect. Progress/contact notes document interventions unrelated to those indicated on the ProviderConnect or give a different picture than the ProviderConnect assessment. **3 =** The assessment, more than half the goals/objectives, and the discharge plan correlate to the information provided through ProviderConnect. More than half the progress/contact notes reflect staff interventions consistent with those indicated on the ProviderConnect. All of the goals and interventions are being addressed through services documented in the medical record **or** changes to the plan are documented and why specific goals and interventions will not be addressed. **5 =** The assessment, all goals/objectives on the ITP, and discharge plan are directly related to the current ProviderConnect and progress/contact notes contain information and interventions relevant to the ITP /ProviderConnect.	75% of all medical records reviewed have a score of 3 or above and meet the standard for the assessment, Plan of Care and progress notes being consistent with the current ProviderConnect.