QUALITY OF DOCUMENTATION **RTC**	GUIDELINES FOR SCORING INDIVIDUAL RECORDS 1 = Poor 3 = Meets Standard 5 = Excellent Y = Meets Standard 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?	**N=** Consent for services is not documented by signature of the child's parents or, when applicable, other legal guardian, **Y=** Consent for services is documented by signature of the 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. In addition, the parent/legal guardian provides informed consent for all prescribed medications. There is clear documentation of the discussion with the resident and parent/guardian of risks and benefits of the medication.	75% of all medical records reviewed have documented consent for services
2. Have the courts adjudicated the resident's legal status, are there copies of court orders or custody agreements?	**Y=** Court orders and custody agreements regarding healthcare decision-making are present in the chart. **N=** There are court orders or custody agreements establishing healthcare decision-making responsibility, but they are not present in the chart. **N/A=** Health-care decision-making has never been reviewed through court orders or custody agreements in juvenile, or family court.	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. Has the resident and their parents/legal guardians received a complete and thorough notification regarding the Restraint and Seclusion Policies? *42CFR Ch.IV 483.356 (c) (d)*	**N=** The medical record does not contain documentation that the seclusion and restraint policies were provided and adequately explained to the resident and the parent/legal guardian. **Y=** The medical record does contain documentation that the seclusion and restraint policies were provided and adequately explained to the resident and the parent/legal guardian.
4. Have the parents/legal guardians been notified each time there has been a seclusion or restraint intervention? *42CFR Ch.IV 483.366*	**N=** The medical record does not document the notification of parent(s)/legal guardian(s) of each instance of a seclusion or restraint intervention. The date and time of the notification and the staff person providing notification must also be included. **Y=** The medical record documents the notification of parent(s)/legal guardian(s) of each instance of a seclusion or restraint intervention. The date and time of the notification and the staff person providing notification must also be included.

5. Does the Medical Record document a safe environment plan that was developed in collaboration with the resident and parents/legal guardians?	**1=** There is no safe environmental plan developed in the medical record. **3=** The safe environment plan includes the following: • What the facility will provide to help the resident feel safe, comforted, and in control of his/her behavior • Triggers increasing stress, fear, anger, and loss of control • Preferred methods for calming or soothing the resident • Medications the resident may choose voluntarily should the agitation increase despite the use of other interventions identified in the safe environment plan • Type of restraints or seclusion preferred and to be used as a last resort • Medical information that can effect the safety of a medical intervention. 5= The safe environment plan is periodically reviewed and updated as needed when more information is learned regarding triggers and preferred methods for preventing and de-escalating emergency situations.
6. Does the medical record meet all requirements for the documentation of the orders and implementation, monitoring, medical tx provided (*if necessary)***,and follow-up of a restraint or seclusion?** *42CFR Ch.IV 483.358, 360, 362, 364, 366, 370*	**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. **5=** All of #3 plus the information discussed from the de-briefing led to modifications in the resident's safety plan and/or subsequent treatment plans and clinical services.

7. Are all of the required elements of the Certificate of Need (CON) present and does the facility's assessment confirm that the resident requires this Level of Care (LOC). *42CFR Ch.IV 441.152, 153*	**N=** Either all required elements of the CON are not present and/or the provider assessments and evaluations do not confirm that the resident requires this LOC. **Y=** All required elements of the CON are present and the provider assessments and evaluations confirm that the resident requires this LOC.	75% of all medical records reviewed have a score of 3 or above and have documentation that meets the standard for establishing the diagnosis and medical necessity for services

8. Is there a comprehensive assessment completed with the involvement of the resident and the family/guardians? *CFR 441.155 (b) 1* *JCAHO PC.2.1.0 – 2.110* *3.20, 3.30*	**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 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 • Nutritional Screening *(full assessment if necessary)* • Legal Status Screening *(full assessment if necessary)* • Substance Abuse Screening *(full assessment if necessary)* • Educational Screening *(full assessment if necessary)* **4=** Everything in #3 plus 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 have a score of 3 or above and meet the standard for documenting assessments.

9. Is a plan of care developed within 14 days and every 30 days thereafter? *CFR 441.155 (c)*	**Y=** Plans of Care are developed in a timely fashion. The plan of care determines that inpatient services continue to be needed and changes are recommended in response to the resident's overall adjustment. **N=** A plan of care was not developed within 14 days and updated within every 30 days thereafter. Where an update is timely, the new plan does not adequately respond to changes in the resident's/family's functioning.	
10. Does the medical record document active participation in establishing the goals, objectives, and interventions of the Plan of Care by the consumer and their parent/guardian? *CFR 441.155 (b) (2)* *JCAHO PC 4.50, 4.60*	**1=** The legal guardian and consumer did not sign the Plan of Care. Parents/Guardians were not notified of Treatment Planning Meetings. No reasonable efforts were made to involve parents/legal guardians/resident in the planning process **2=** The legal guardian and consumer did not sign thePlan of Care. Not all of the relevant efforts contained in # 3 were employed. **3=** The legal guardian and consumer signed and dated the ITP or the program has made reasonable efforts to involve the parent/legal guardian in the development of the Plan of Care. Reasonable efforts include attempting to contact the parent/guardian with advance notice (7-10 days) of the treatment team planning meeting by phone and letter. Offering to resolve barriers to participation (i.e. transportation, scheduling, telephone conferencing). **4=** The legal guardian and consumer signed and dated the ITP. The consumer and family/guradian'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. A person-centered planning process results in an integrated holistic treatment/recovery plan.	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 Plan of Care.

11. Are the Plan of Care goals/objectives related to the assessment? {symptoms, skill deficits, resources} *CFR 441.155 (b) (1)* *JCAHO PC.4.40*	**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. **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 thePlan of Care and the most recent assessment.
12. Does the Plan of Care contain goals, objectives or outcomes that are individualized, specific and measurable with an achieveable timeframe? *CFR 441.155 (3)*	**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, 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 Plan of Care containing goals, objectives or outcomes that are individualized, specific and measurable with an achievement timeframe
13. Are the interventions on the Plan of Care congruent with goals/objectives? *CFR 441.155 (4)* *JCAHO PC 4.80*	**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 Plan of Care 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 Plan of Care being congruent with goals/objectives.

14. Does the medical record document the development of a comprehensive discharge plan beginning at the initial assessment and continuing during treatment planning? *JCAHO 15.10, .20* *CFR 441.155 (5)*	**1=** There is little or no discharge planning documented in the medical record. **3=** Discharge planning begins at admission. Comprehensive plan includes identifying natural and community supports for the resident and family, as well as, ongoing supports and services for the resident and their family. The resident and family are actively involved in the development of discharge plan. **4=** All of #3 and specific contributions to the discharge plan by the resident and family member are identified in the documentation. **5=** All of #3 and #4 and techniques assisting the resident and family to identify discharge supports are documented.	75% of all medical records reviewed have a score of 3 or above and meet the standard for thePlan of Care reflecting a transition/discharge date and plan consistent with the services provided.
15. Do the discharge planning process and services include ongoing communication and planning with key community resources (i.e. CSA's, LMB's, DSS, DJS, Education, involved providers, etc.) *CFR 441.155 (5)*	**1=** There is little or no documented communication between the CSA, LMB, education, and/or providers, and other community and natural supports regarding discharge plan and community supports that will be needed and available at the time of discharge. **3=** There is sufficient, ongoing, and timely communication between the RTC and community resources and supports. Communication with other agencies includes a properly executed Release of Information.The family and resident are involved in choosing and contacting aftercare agencies when indicated and appropriate. **5=** CSA child and adolescent coordinator and placement agency representatives, are encouraged to participate in treatment and discharge planning. They participate in Team meetings and a scheduled basis. There is ongoing communication between community agencies to facilitate transition to community.	
16. Does the ITP include all required signatures? *CFR 441.156*	**Y=** All required signatures with dates are present. **N=** A signature or date is missing.	75% of all applicable medical records reviewed had the required signatures on the Plan of Care.

17. Does the RTC exhibit a strong commitment to a family/provider partnership?	**1=** None, one, or two of the items listed in #3 are provided to families. **3=** There is documentation in the medical record that family members are encouraged to attend team meetings and participate in family therapy. The RTC provides transportation assistance and has an open visitation schedule. The family has access to their child by phone and mail and is invited on units (vs. separate family visiting area). Therapeutic leaves of absence are encouraged. Family members have easy access to filing a complaint or grievance. **5=** The program adopts other extra-ordinary methods to facilitate family involvement including offering child care, developing and offering support groups, unique opportunities to participate in program, and closely monitoring consumer satisfaction,	
18. Are the Progress/Contact notes complete?	**1=** No (or very few) progress/contact notes contain all of the following items: date, start time, end time,, location, 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 medical records reviewed have a score of 3 or above and meet the standard for progress/contact notes being complete.
19. Do Progress/Contact Notes reflect interventions in the Plan of Care are being implemented to achieve their related goals *CFR 441.154* *JCAHO PC 5.10*	**1=** No (or very few) progress/contact notes contain interventions but rather give information unrelated to the consumer Plan of Care. **3=** Seventy-five percent (75%) of the progress/contact notes identify staff interventions that are consistent with the Plan of Care. For residents receiving medications, medications are reviewed by the physician every 30 days. Progress notes document active treatment designed to achieve resident's discharge at the earliest possible time. **5=** All progress/contact notes contain 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 Plan of Care are being implemented.

20. Do the Progress/Contact Notes reflect the consumer's progress towards the goals of the Plan of Care?	**1=** No (or very few) progress/contact notes contain the consumer responses to interventions included in the Plan of Care, 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 Plan of Care. **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 Plan of Care.
21. Are the assessment, Plan of Care and Progress/Contact Notes consistent with the current ProviderConnect? *Provider Manual*	**1=** The assessment and none of the goals/objectives relate to the current ProviderConnect. Progress/contact notes document interventions unrelated to those indicated on ProviderConnect or give a different picture than the assessment. **3=** The assessment and more than half the goals/objectives have correlation to the current ProviderConnect and more than half the progress/contact notes reflect staff interventions consistent with those indicated on the ProviderConnect. **5=** The assessment and all goals/objectives on the ITP 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. .