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| **Inpatient Psychiatric Hospital/Unit Consumer Record Review** | |
| Hospital/Unit: Choose an item. | Date of Review: Click or tap to enter a date. |
| Reviewer Organization: Choose an item. | Reviewer Name: |
| Paying CMHSP:Choose an item. | Consumer: |
| Admission Date(s): | Discharge Date(s): |

| **Section/**  **#** | **Standard** | **Compliance Score**  0 = Non-Compliant  1 = Partial  2 = Full  NA = Not Applicable | **Notes/Comments**  Reviewer **MUST** include a comment for any standard scored 0 or 1. |
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| **A** | **Development of Assessment/Diagnostic Data**  **Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.** | | |
| A1 | The identification data must include the inpatient’s legal status.  *Legal status is defined by state statutes and dictates the circumstances under which the patient was admitted and/or is being treated (i.e. voluntary, involuntary, committed by court*) | 0  1  2  NA |  |
| A2 | A provisional or admitting diagnosis must be made on every inpatient at the time of admission and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.  *Is the diagnosis written in DSM nomenclature? If the diagnosis is absent, is there written justification for the omission? (for example, the patient was psychotic on admission and not accompanied by family) Is treatment provided for physical illnesses requiring immediate attention? Is there an evaluation and treatment plan for identified physical illnesses that may impact the patient’s psychiatric outcome?* | 0  1  2  NA |  |
| A3 | The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both  *The records should include who, what, where, when, and why the patient was admitted to the facility.* | 0  1  2  NA |  |
| A4 | The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.  *Does the assessment include the following components? 1) Factual and historical information, 2) Social evaluation (baseline social functioning including strengths and weaknesses), and 3) Conclusions and Recommendations (in anticipation of social work’s role in treatment and discharge planning).* | 0  1  2  NA |  |
| A5 | H&P completed within 24 hours  *Consumer has the right to refuse.* | 0  1  2  NA |  |
| Development of Assessment/Diagnostic Data Section Summary  Findings:  Strengths:  Recommendations: | | | |
| **B** | **Psychiatric Evaluation** | | |
| B1 | The psychiatric evaluation must include the following components:  *1) Chief complaints, reaction to hospitalization, 2) History of any psychiatric problems and treatment, including previous precipitating factors, diagnosis, and course of treatment, and 3) Past family, educational, vocational, occupational, and social history.* | 0  1  2  NA |  |
| B2 | Be completed within 24 hours of admission | 0  1  2  NA |  |
| B3 | Include a medical history  *Does the evaluation include any medical conditions that may impact the patient’s recovery/remission?* | 0  1  2  NA |  |
| B4 | Contain a record of mental status  *Does the mental status record describe the appearance, behavior, emotional response, verbalization, thought content, and cognition of the patient?* | 0  1  2  NA |  |
| B5 | Note the onset of illness and the circumstances leading to admission  *Are the identified problems related to the patient’s need for admission?* | 0  1  2  NA |  |
| B6 | Describe attitudes and behavior  *Does the problem statement describe the behavior(s) which require modification in order for the patient to function in a less restrictive environment?* | 0  1  2  NA |  |
| B7 | Estimate intellectual functioning, memory functioning, and orientation | 0  1  2  NA |  |
| Psychiatric Evaluation Section Summary  Findings:  Strengths:  Recommendations: | | | |
| **C** | **Treatment Planning** | | |
| C1 | Each consumer must have a comprehensive treatment plan that must be based on an inventory of the consumer's strengths and weaknesses  *Is the treatment plan a result of collaboration between the patient and the treatment team? Is the treatment plan individualized? Is there a primary diagnosis upon which the treatment interventions are based? Are the treatment plan goals written in a manner that allows for changes in the patient’s behavior to be measured? If the consumer is a minor, the plan is family-focused* | 0  1  2  NA |  |
| C2 | Must include the specific treatment modalities utilized; the responsibilities of each member of the treatment team. It clearly identifies what the condition/status the consumer should be to discharge to a less restrictive setting. Goals and objectives meet SMART criteria  *Does the treatment team encourage the patient’s active participation and responsibility for engaging in the treatment regimen? Do completion of goal/objectives identify the desired behavioral outcomes that will reflect readiness to discharge to a less restrictive setting (i.e. - when no longer verbalizing intent to commit self-harm; not acting on persecutory hallucinations; willing to contract for safety; demonstrating orientation to all spheres, etc.)* | 0  1  2  NA |  |
| C3 | Plan includes all required signatures and evidence that consumer was offered a copy of plan  *Consumer has the right to refuse and if so, is documented.* | 0  1  2  NA |  |
| Treatment Planning Section Summary  Findings:  Strengths:  Recommendations: | | | |
| **D** | **Service Delivery Consistent with Plan** | | |
| D1 | Progress notes must be recorded by the psychiatrist responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities.  *Does the content of the treatment notes and progress notes relate to: 1) the treatment plan 2) what the staff is doing to carry out the treatment plan, and 3) the patient’s response? Evidence of daily psychiatry progress notes. Progress notes should document progress or lack of progress and any adjustments/changes to the treatment plan* | 0  1  2  NA |  |
| D2 | Doctor's orders are followed | 0  1  2  NA |  |
| D3 | There is evidence of discharge planning documented within the record | 0  1  2  NA |  |
| Service Delivery Consistent with Plan Section Summary  Findings:  Strengths:  Recommendations: | | | |
| **E** | **Medications** | | |
| E1 | Was medication reconciliation completed at admission and discharge | 0  1  2  NA |  |
| E2 | Evidence of informed consent for all psychotropic medications  *Consents are signed by the consumer/guardian or evidence of refusal. Consent should state explanation of medications and side effects* | 0  1  2  NA |  |
| E3 | There is evidence medication is administered as prescribed | 0  1  2  NA |  |
| Medications Section Summary  Findings:  Strengths:  Recommendations: | | | |
| **F** | **Discharge/Transfers** | | |
| F1 | Include a summary of the patient’s hospitalization, the patient’s condition on discharge, and recommendations for follow-up or aftercare  *Does the discharge planning process include the participation of the multidisciplinary staff and the patient? Are the details of the discharge plan communicated to the post-hospital treatment entity? Evidence of coordination with CMH on discharge/transition planning. Follow-up appointment is scheduled within 7 days of discharge*. | 0  1  2  NA |  |
| Discharge / Transfers Section Summary  Findings:  Strengths:  Recommendations: | | | |