CHILDREN, YOUTH AND FAMILIES DEPARTMENT

FAMILY SERVICES • COMMUNITY AND BEHAVIORAL HEALTH SERVICES BUREAU • LCA

CLIENT RECORD REVIEW · DAY TREATMENT SERVICES [ref Cert Stds 3/29/02] UPDATED 7/13/2004

Agency:____________________________ **Date:**__________ **Client Name:**___________________________ **DOA:**__________

DOB:____________ **Guardian:** [ ] CYFD SW____ **Reviewer (init):**____________

DX:____

Medications:____

(note with "Ξ" if no informed consent present)

Admission, Consent, Rights, Initial Screening, Initial Treatment Plan	C	P	D	N A	N R
22.F (1) Date of admission documented, consistent *DOA:*					
22. C. Client Rights explained; written explanation given to the parent/legal guardian upon admission.					
(3) (a) Record contains all applicable **consents** for ☐ treatment, incl. ☐ emergency medical treatment ☐ informed consent for Rx medication taken during program hrs and/or prescribed by program Dr.					
(c) Consent forms complete prior to being signed by a client or guardian.					
(4) At admission, **orientation** of the client and parents/legal guardians is documented in the client's record.					
Orientation incl. ☐ basic expectations of the clients, ☐ rules for client conduct/bx.					
(5) Written **grievance/complaint procedure** reviewed w/ client & parent/legal guardian at admission; documented.					
23.D (1) **Initial Screening** @ admission to determine need for tx, need for further assessment**:** *Date:*					
☐ physical, ☐ psychological, ☐ social functioning					
Identifies risk of dangerous behavior, incl. need for special supervision or intervention.					
23.E Initial treatment plan is developed and documented within 72 hours of admission to each service					
ITP: E (3) (a) incl. full participation of team, incl. ☐ client; ☐ parent/guardian; ☐ involved to the max. possible					
ITP: reasons for nonparticipation are documented in the client=s record					
ITP: (b) Is conducted or explained in a language the client and/or family members can understand					
ITP: (c) Is designed to improve the client's motivation and progress, and strengthen family relationships					
ITP: (d) Is designed to improve the client's self-determination and personal responsibility;					
ITP: (e) Utilizes the client's strengths;					
ITP: (f) Is conducted under the direction of person who has experience & qualifications to conduct tx planning.					
ITP: (g) specific behavioral changes targeted in measurable terms					
potential high-risk behaviors identified; *omissions:*					
Identifies (as appl) ☐ medications ☐ bx mgt ☐ specific safety measures					
ITP identifies Tx goals & objectives corresponding to specific bx changes targeted; omissions:					
ITP goals and objectives are ☐ time-limited; incl. ☐ intermediate, ☐ long-range					
ITP identifies ☐ frequency & duration of intervention(s); ☐ staff responsible for each intervention;					
ITP: (h) Specifies & incorporates the client's permanency plan, if in CYFD custody;					
ITP: (i) Provides for supv of clients w/known or alleged hx of sexually inappropriate behavior, sexual aggression or sexual perpetration, so as to ensure their safety and that of others;					
ITP: (j) Includes a preliminary discharge plan: ☐setting ☐ specific criteria ☐ projected discharge date					

Key: C: Compliant or mostly compliant in this record. **P: Partially** compliant and partially non-compliant in this record.
D: Significant Deficiency noted. **N/A:** Standard **not applicable** to this record. **N/R:** Standard **not reviewed/evaluated** in this record.
Use "Ξ" to indicate item missing/deficient; " T" if present. ☐ **Check here if add'l info is noted on back of sheet. ➔**

Assessment	C	P	D	N A	N R
23. B, D. ☐ **Assessment** is multidisciplinary; ☐ Clinical decisions made by qualified clinical personnel.					
Assessment incl: ☐ physical, ☐ emotional, ☐ cognitive, ☐educational, ☐ social development; ☐ nutrition					
23.D (3) **Comprehensive Assessment** prior to comprehensive treatment plan; *Date:*					
Involves active participation of the family or guardian,					
23.D (4) If assessment completed prior to admission, updated at the time of admission					
23.D (3) (a) includes client′s personal, family, medical and social history, including:					
(i) previous records/collateral info. *Placements:*					
23.D (6) comprehensive assessment is amended as collateral becomes available					
23.D (3) (a) (ii) Relevant family and non-familial custodial history & guardianship;					
(iii) Client and family abuse of substances;					
(iv) ☐ Medical history, ☐ medications;					
(v) History as victim of physical/sexual abuse, neglect, trauma;					
(vi) History as a perpetrator of physical or sexual abuse					
(vii) client's/ family's perception of his or her current need for services and priorities					
(viii) client's/ family's strengths and resources;					
(ix) current mental status.					
23.D (3) (b) **Psychosocial evaluation** of client′s status and needs relevant to					
(i) Psychological functioning; ☐ status ☐ needs					
(ii) Intellectual functioning; ☐ status ☐ needs					
(iii) Educational/vocational functioning; ☐ status ☐ needs					
(iv) Social functioning; ☐ status ☐ needs					
(v) Developmental functioning; ☐ status ☐ needs					
(vi) Substance abuse; ☐ status ☐ needs					
(vii) Culture; ☐ status ☐ needs					
(viii) Leisure and recreation. ☐ status ☐ needs					
(c) Evaluation of high risk behaviors or potential for such;					
(d) A summary / clinical formulation including underlying dynamics					
(5) Assessment processes include the following:					
(a) educational evaluation /IEP, or evidence of satisfactory school performance (30 days);					
(b) a psychiatric evaluation when indicated					
(c) a psychological evaluation when indicated					
23.D (2) **EPSDT** within 30 days unless within 12 months prior *Date:*					
(6) Assessment reviewed and updated as indicated; updated annually as addendum					
D. Reassessment is conducted when significant changes occur in condition or diagnosis					
Assessment notes, incl. issues to track in Tx Plan:					

Treatment Planning and Discharge Planning; Treatment Plan Reviews	C	P	D	N A	N R
23.E (2) **Comprehensive Tx plan** ☐ based on comp. assessm't; ☐ dev. within 14 days of adm. *Date:*					
(a) includes full participation of team, incl. ☐ client; ☐ parents/legal guardian; ☐ involved to max. possible					
reasons for nonparticipation are documented in the client=s record					
(b) Is conducted or explained in a language the client and/or family members can understand					
(c) Is designed to improve client's motivation and progress, and strengthen family relationships					
(d) Is designed to improve the client's self-determination and personal responsibility;					
(e) Utilizes the client's strengths;					
(f) Is conducted under the direction of person who has the experience and qualifications to conduct tx planning.					
(g) specific bx changes targeted in measurable terms					
potential high-risk behaviors identified; *omissions:*					
Identifies (as appl) ☐ medications ☐ bx mgt ☐ specific safety measures					
Identifies Tx goals & objectives corresponding to specific bx changes targeted; omissions:					
Treatment goals and objectives are ☐ time-limited; incl. ☐ intermediate, ☐ long-range					
Identifies ☐ frequency & duration of intervention(s); ☐ staff responsible for each intervention;					
(h) Specifies & incorporates the client's permanency plan, if in CYFD custody;					
(i) Provides for adequate supervision of clients w/known or alleged hx of sexually inappropriate behavior, sexual aggression or sexual perpetration, so as to ensure their safety and that of others;					
(j) Incl. **DC Plan** w/: ☐ Bx/clinical criteria; ☐Barriers to DC; ☐Level of care; ☐Living situation; ☐Proj date					
(i) DC plan requires that the client has achieved the objectives of the treatment plan;					
(ii) DC plan requires that the discharge is safe and clinically appropriate for the client;					
(iii) DC plan evaluates high risk behaviors or the potential for such;					
(iv) DC plan explores options for alternative or additional services that may better meet the client's needs;					
(v) DC plan establishes specific criteria for discharge to a less restrictive setting; and					
(vi) DC plan establishes a projected discharge date, which is updated as clinically indicated.					
23.F Treatment Plan Reviews every 30 days; *Dates of reviews:*					
Tx plan is ☐ reviewed by tx team, incl. ☐ client; ☐ parents/legal guardian					
(1) Reviews/revisions include (a) Progress, or lack thereof, toward each treatment goal and objective					
(b) Progress toward and/or identification of barriers to discharge					
(c) The client's response to all interventions, including specific behavioral interventions;					
(d) The client's response to medications;					
(e) Consideration of significant events, incidents, and/or safety issues occurring in the period under review;					
(f) Revisions of goals, objectives, and interventions, if applicable;					
(g) Change(s) or updates in diagnosis, mental status or level of functioning;					
(h) ☐ need for consultation ☐ results of any referrals					
(i) The effectiveness of behavior-management techniques used in the period under review.					
23.F (2) If elements of review are documented in place other than Tx plan review, (a) ☐All required elements are documented ☐ in a timely manner ☐ by qualified clinical personnel;					
(b) Client's record contains evidence of participation of tx team members					