Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MR#\_\_\_\_\_\_\_\_\_\_\_ Admit Date\_\_\_/\_\_\_/\_\_\_\_\_\_\_\_ MH Prof: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Compliance Requirement: | Due: | Yes/No boxes | Action Item/Drop down if answer is no |
| MH Safety PlanDoes the client need a crisis assessment? (Include crisis intervention and stabilization services) | **As needed**  |  |  |
| Co-Occurring: was DA completed?Update completed at new level of care? | **Within 10 days of admission for IOP, within 5 days of admission for residential (Standard DA, if not one in file from past year; update DA when starting new level of care if there have been significant changes)** |  |  |
| Initial Treatment Plan (residential and outpatient) | **After completion of DA, within following treatment week; update every 30 days for IOP, no update needed for residential** |  |  |
| Level of care assessment  | **As needed**  |  |  |
| Discharge summary completed? | **Within 5 days**  |  |  |
| **Progress Note**  |
| Type of service  | Within 48 hours  |  |  |
| Date of service  | Within 48 hours  |  |  |
| Start and stop time | Within 48 hours  |  |  |
| Location of service  | Within 48 hours  |  |  |
| Scope of service (target goal/objective, intervention method, client’s response, plan for future actions, treatment plan updates, and service modality) | Within 48 hours  |  |  |
| Plan section includes updates on client progress with treatment, identifies goal and initiatives taken to further goals will be documented. Most have identifiable progress on a scale of 1-10.  | Within 48 hours  |  |  |
| Significant observations including risk factors, emergency interventions, consultations, or client’s mental or physical symptoms | Within 48 hours  |  |  |
| Signature and credentials for MH professional providing service | Within 48 hours  |  |  |
| **Group Progress Notes** |
| Date, time, and Location of service are accurate for each client | Within 48 hours  |  |  |
| MH Group doesn’t exceed 16 clients/MH lecture 17-48 clients (residential MH staff) | Within 48 hours  |  |  |
| Situation section states, “ This clinician facilitated a MH recovery group/lecture for these clients on this date” | Within 48 hours  |  |  |
| Intervention section indicates tools/materials used, describes any activities facilitated, and identifies interventions utilized by facilitator (motivational interviewing, psychoeducation, supportive reflection, etc.)  | Within 48 hours  |  |  |
| Service Format: indicated for every client (face-to-face) | Within 48 hours  |  |  |
| Reason missed/other box is filled out for each client, commenting on their participation in group (ex. Client was present and engaged, client was present and required redirection to stay engaged in group, Client became agitated and left the group following an interaction with a peer, etc.)  | Within 48 hours  |  |  |
| Signature includes facilitator name and credentials | Within 48 hours  |  |  |
|  **Record Keeping Requirements** |
| A late entry must clearly be labeled “late entry”. A correction to an entry must be made in a way in which the original entry can still be read. | As needed  |  |  |
| Ensure nothing is left blank. Please make N/A and an explanation.  | As needed |  |  |
|  **Diagnostic Assessment**   |
| Responsivity factors- This includes a client's learning style, abilities, cognitive functioning, cultural background, and personal circumstances.  | Within 10 days for IOP or 5 days for residential |  |  |
| Did you identify at least one mental health diagnosis and recommend mental health service to develop a TP? If not, state the client doesn’t meet the criteria. | Within 10 days for IOP or 5 days for residential |  |  |
| Did you include the client’s age, current living situation, status of client’s basic needs, education level and employment status, medications, immediate risks to health and safety, client’s perceptions of their condition, client’s description of symptoms, history of mental health treatment, and what cultural influences exist? | Within 10 days for IOP or 5 days for residential |  |  |
| Did identify the strengths and resources of client including quality of the client’s social network? | Within 10 days for IOP or 5 days for residential |  |  |
| Did you identify important developmental incidents in the client’s life? | Within 10 days for IOP or 5 days for residential |  |  |
| Did you identify maltreatment, trauma, potential brain injuries, and abuse that client has suffered? | Within 10 days for IOP or 5 days for residential |  |  |
| Did you discuss the client’s history of or exposure to alcohol and drug usage and treatment? | Within 10 days for IOP or 5 days for residential |  |  |
| What is the client’s health and family history including physical, chemical, and mental health history? | Within 10 days for IOP or 5 days for residential |  |  |
| Did you use the CAGE-AID questionnaire or the most recent DSM-5 to screen for SUD? Did you include the following substance use-related information:amount and types of substances, frequency and duration, route of administration, periods of abstinence, and circumstances of relapse; impact to functioning when under the influence of substances, including legal interventions? | Within 10 days for IOP or 5 days for residential |  |  |
| Did you complete a mental status examination? | Within 10 days for IOP or 5 days for residential |  |  |
| Did you include the client’s baseline measurements: symptoms, behavior skills, abilities, resources, vulnerabilities, and safety needs? | Within 10 days for IOP or 5 days for residential |  |  |
| Did your explanation include client’s interview assessment, psychology testing, and collateral info, client’s needs, risk factors, strengths, and responsivity factors? | Within 10 days for IOP or 5 days for residential |  |  |
| Did you consult with client and client’s family about what services they prefer? Please coordinate with their primary LADC. | As requested by client  |  |  |
| **Treatment Plan Review** |
| Is the treatment based on the diagnostic assessment and baseline measurements? | Within treatment week following completion of DA |  |  |
| Did you use a person-centered, culturally appropriate planning process? | Within treatment week following completion of DA |  |  |
| Did identify the client’s treatment goals with measurable treatment objectives within scheduled timeframes? | Within treatment week following completion of DA |  |  |
| Did you develop a treatment strategy to engage the client? Is the client court order or has a history of not engaging in treatment? | Yes/No |  |  |
| Did you ensure the client involvement in the treatment plan? | Yes/No |  |  |
| Review the client’s individual treatment plan to update treatment progress, new treatment objectives and goals, or if the client hasn’t made progress | Every 30 days for IOPNA for residential |  |  |
| How are you measuring success of treatment methods? | After 1:1  |  |  |
| Did the client sign the initial TX plan | **Upon completion**  |  |  |
| If the client disagrees with treatment plan, did you document the reasons why?  | **As needed**  |  |  |
| Approval of the TX plan must be obtained by a person authorized to consent on the client’s behalf  | **Within 5 days of treatment plan development** |  |  |
| **Discharge Standards** |
| With Staff Approval (WSA)(1) a brief review of the client's problems and strengths during the period that the license holder provided services to the client; (2) the client's response to the client's treatment plan; (3) the goals and objectives that the license holder recommends that the client addresses during the first three months following the client's discharge from the program; (4) the recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting; (5) the client's crisis plan; and (6) the client's forwarding address and telephone number.) | **Within 5 days** |  |  |
| Against Staff Advice (ASA)**(**1) the reasons for the client's discharge; (2) a description of attempts by staff persons to enable the client to continue treatment or to consent to treatment; and (3) recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting. | **Within 5 days** |  |  |
| At Staff Request (ASR)(1) the reasons for the client's discharge; (2) the alternatives to discharge that the license holder considered or attempted to implement; (3) the names of each individual who is involved in the decision to discharge the client and a description of each individual's involvement; and (4) recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting. | **Within 5 days**  |  |  |
| Was there a court order? | **Y/N** |  |  |
| Did you provide a referral for the client or ensure that their aftercare program (IOP) provides MH services? | **Upon discharge**  |  |  |

**Abbreviations:**

D/C- Discharge

TX- Treatment Plan

ITP- Initial Treatment Plan

ISP – Initial Service Plan

IAPP- individual Abuse Protection Plan

ASA- Against Staff Advice

SA- Staff Advice

TPR – Treatment Plan Review

WPN- Weekly Progress Note

Audited Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Auditor Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Audit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Auditor Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff/Clinician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor reviewed date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Uploaded into client Procentive file: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date uploaded into personnel file: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_