

**CHILDREN, YOUTH AND FAMILIES DEPARTMENT
FAMILY SERVICES • COMMUNITY AND BEHAVIORAL HEALTH SERVICES BUREAU • LCA**

CLIENT RECORD REVIEW : Residential Treatment Services Group Home Services [ref Cert Stds 3/29/02] Updated: 7/13/2004

Agency/Unit: _____ Client Name: _____ Date: _____

DOB: _____ Guardian: CYFD SW _____ Reviewer (init): _____

DX: _____

Medications:

(note with "X" 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 <i>DOA:</i>					
22. C Client Rights explained; written explanation given to parent/legal guardian upon admission.					
22. C (3) (a) Record contains all applicable consents for <input type="checkbox"/> treatment, incl. <input type="checkbox"/> emergency medical treatment <input type="checkbox"/> informed consent for Rx medication.					
(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. <input type="checkbox"/> basic expectations of the clients, <input type="checkbox"/> 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: <i>Date:</i> <input type="checkbox"/> physical, <input type="checkbox"/> psychological, <input type="checkbox"/> social functioning Identifies risk of dangerous behavior, incl. need for special supervision or intervention.					
23.E Initial treatment plan developed & documented within 72 hrs of adm. <i>Date:</i>					
ITP: 23.E (3) (a) incl. full participation of team, incl. <input type="checkbox"/> client; <input type="checkbox"/> parent/guardian; <input type="checkbox"/> 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; <i>omissions:</i>					
Identifies (as appl) <input type="checkbox"/> medications <input type="checkbox"/> bx mgt <input type="checkbox"/> specific safety measures					
ITP identifies Tx goals & objectives corresponding to specific bx changes targeted; <i>omissions:</i>					
ITP goals and objectives are <input type="checkbox"/> time-limited; incl. <input type="checkbox"/> intermediate, <input type="checkbox"/> long-range					
ITP identifies <input type="checkbox"/> frequency & duration of intervention(s); <input type="checkbox"/> 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: <input type="checkbox"/> setting <input type="checkbox"/> specific criteria <input type="checkbox"/> proj DC 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 "X" to indicate item missing/deficient; "T" if present.					

Assessment	C	P	D	N A	N R
23. B, D <input type="checkbox"/> Assessment is multidisciplinary; <input type="checkbox"/> Clinical decisions made by qualified clinical personnel.					
Assessment incl: <input type="checkbox"/> physical, <input type="checkbox"/> emotional, <input type="checkbox"/> cognitive, <input type="checkbox"/> educational, <input type="checkbox"/> social development; <input type="checkbox"/> nutrition					
23.D (3) Comprehensive Assessment prior to comprehensive treatment plan; <i>Date:</i>					
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) prev. records/collateral info. <i>Placements/omissions:</i>					
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) <input type="checkbox"/> Medical history, <input type="checkbox"/> 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; <input type="checkbox"/> status <input type="checkbox"/> needs					
(ii) Intellectual functioning; <input type="checkbox"/> status <input type="checkbox"/> needs					
(iii) Educational/vocational functioning; <input type="checkbox"/> status <input type="checkbox"/> needs					
(iv) Social functioning; <input type="checkbox"/> status <input type="checkbox"/> needs					
(v) Developmental functioning; <input type="checkbox"/> status <input type="checkbox"/> needs					
(vi) Substance abuse; <input type="checkbox"/> status <input type="checkbox"/> needs					
(vii) Culture; <input type="checkbox"/> status <input type="checkbox"/> needs					
(viii) Leisure and recreation. <input type="checkbox"/> status <input type="checkbox"/> 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 <i>Date:</i>					
23.D (6) Assessment reviewed and updated as indicated; updated annually as addendum					
23.D. Reassessment is conducted when significant changes occur in condition or dx					
<i>Assessment notes, incl. issues to track in Tx Plan:</i>					

Treatment Planning and Discharge Planning; Tx Plan Reviews [if Bx Mgt used, see also p.5]	C	P	D	N A	N R
23.E (2) Comprehensive Tx plan <input type="checkbox"/> based on comp. assessm't; <input type="checkbox"/> dev. within 14 days of adm. <i>Date:</i>					
(a) includes full participation of team, incl. <input type="checkbox"/> client; <input type="checkbox"/> parents/legal guardian; <input type="checkbox"/> 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; <i>omissions:</i>					
Identifies (as appl) <input type="checkbox"/> medications <input type="checkbox"/> bx mgt <input type="checkbox"/> specific safety measures					
identifies Tx goals & objectives corresponding to specific bx changes targeted; <i>omissions:</i>					
treatment goals and objectives are <input type="checkbox"/> time-limited; incl. <input type="checkbox"/> intermediate, <input type="checkbox"/> long-range					
identifies <input type="checkbox"/> frequency & duration of intervention(s); <input type="checkbox"/> 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;					
23.E (4) Plan contains a statement of the least restrictive conditions necessary to achieve the purposes of treatment;					
incl. <input type="checkbox"/> eval. of client's cultural needs; <input type="checkbox"/> provision for access to cultural practices, incl. traditional treatment.					
(j) Incl. DC Plan w/: <input type="checkbox"/> bx/clinical criteria; <input type="checkbox"/> barriers to DC; <input type="checkbox"/> level of care; <input type="checkbox"/> living situation; <input type="checkbox"/> 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;					
(vi) DC plan establishes a projected discharge date, which is updated as clinically indicated.					
23.F Treatment Plan Reviews every 30 days; <i>Dates:</i>					
Tx plan is <input type="checkbox"/> reviewed by tx team, incl. <input type="checkbox"/> client; <input type="checkbox"/> 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) Rrevisions of goals, objectives, and interventions, if applicable;					
(g) Change(s) or updates in diagnosis, mental status or level of functioning;					
(h) <input type="checkbox"/> need for consultation <input type="checkbox"/> 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) <input type="checkbox"/> All required elements are documented <input type="checkbox"/> in a timely manner <input type="checkbox"/> by qualified clinical personnel;					
(b) client's record contains evidence of participation of tx team members					

Medications; Discharge; Documentation	C	P	D	N A	N R
25 Medications and 22.G Physician Documentation					
A. Agency follows established P&P governing storage, handling, use, admin., disposal of all meds.					
C. Medications are self-admin. by client with supv.					
D. [& 22.G (2)] Documentation: <input type="checkbox"/> time taken, <input type="checkbox"/> side efx observed, <input type="checkbox"/> client response, <input type="checkbox"/> meds refused/ held.					
E. The agency has controls in place for locked storage of medication					
F. Medications are properly labeled					
H. When adverse or unusual conditions are observed, appropriate consultation/medical response sought					
I. Medication monitoring is used to maintain and improve the outcomes of medication therapy					
J. When medications that require periodic testing of drug levels are used, test results are accurately recorded.					
K. [& 22.G] Physician documents <input type="checkbox"/> indication for, <input type="checkbox"/> response to, <input type="checkbox"/> side effects of med(s).					
22.G (1) Response to Rx/medical Tx is documented when follow-up visit occurs					
23. I. Non-emergency discharge occurs in accordance with the client's discharge plan.					
(1) The agency evaluates appropriateness of release to parent/guardian;					
(2) agency provides that discharge occurs in a manner that provides for a safe and orderly transition;					
(3) agency provides for adequate pre-discharge notice, including specific reason for discharge.					
23. G Aftercare involves <input type="checkbox"/> client, <input type="checkbox"/> case mgr, <input type="checkbox"/> parent/guardian, or GAL (if appl.) in arranging identified needs.					
22.F (2) <input type="checkbox"/> Entries identify writer; <input type="checkbox"/> Late entries correctly documented					
22.F (2) Client record entries are <input type="checkbox"/> accurate; <input type="checkbox"/> objective; <input type="checkbox"/> factual; <input type="checkbox"/> legible; <input type="checkbox"/> timely; <input type="checkbox"/> clinically-based					
22. H. A written discharge summary is placed in record within 15 days of termination of services; includes:					
(1) Clinical and safety status;					
(2) Medications being taken at discharge;					
(3) Documentation of notification to Primary Care Physician;					
(4) Specification of referrals/appointments made with specific names;					
(5) Target behaviors addressed;					
(6) Services provided;					
(7) Progress attained, or lack thereof;					
(8) Description of interventions to which the client did and did not respond, including medications;					
(9) Recommendations for continued treatment and services.					
23. H. Emergency Discharge (1) The agency follows P&P for mgt of child who is danger to self or others or presents likelihood of serious harm to self or others.					
(a) Agency makes all appropriate efforts to manage child's bx prior to proposing emergency discharge;					
(b) Agency takes all appropriate action to protect health & safety of others who are endangered.					
(2) In the event of a proposed emergency discharge , the agency provides, at a minimum, procedural due process including written notice to the family/legal guardian, GAL and Department, if applicable.					
(a) Agency documents prov/ participation of parent/guardian & GAL in emerg DC process, when possible.					
(b) A conference is held incl. all interested persons to discuss the proposed emerg DC when possible.					
(3) If parent/guardian is unavailable, agency does not DC the child until safe DC is effected.					

Residential Treatment and Group Home Services; Client Rights; Behavior Management	C	P	D	N A	N R
30. F. Services (1) provided through team approach					
(2) Daily program provided in accordance with needs identified in Assessment, Treatment Plan					
(a) Therapy provided per Tx Plan					
Individual <i>Dates:</i>					
Family <i>Dates:</i>					
Group <i>Dates:</i>					
(b - g) <input type="checkbox"/> Access to med. care [24 hrs. per F (3) (a)] <input type="checkbox"/> Supv. of self-admin. medication <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Education <input type="checkbox"/> ADLs <input type="checkbox"/> Recreation, leisure, planned activities					
(3) Care & supervision provided at all times; adequate staff ratio* [<i>see staff schedule</i>]					
(c) Supervision and transportation provided for off-grounds activities					
(d) Provide response to significant life events that may affect client's treatment outside facility					
(4) Services and activities appropriate to age, behavioral, and emotional development level of client					
(5) Contacts and efforts to encourage family contact and reunification are documented					
Contraindication is documented when determined; issue reconsidered when indicated					
(6) Svcs & supv considers risks of: victimizing others, inappropriate consensual activity; victimization by others					
G. If RTS and GHS populations are mixed, <input type="checkbox"/> clinically-based safety criteria are followed & documented; <input type="checkbox"/> RTS minimum staffing ratios apply.					
<i>*Min. Staff-client ratios: RTS Day & Eve 1:6. GHS Day & Eve 1:8; RTS & GHS Night 1:12; must add as needed.</i>					
22.C (1) Client Rights per Children's Code (32-A-6-6). <i>Note & explain any violation.</i>					
<input type="checkbox"/> Right to visitors at reasonable hours; <input type="checkbox"/> access to writing materials, postage, <input type="checkbox"/> uncensored mail, <input type="checkbox"/> phone contact; <input type="checkbox"/> religious practice/abstinence therefrom; <input type="checkbox"/> humane psychological & physical environment <input type="checkbox"/> reasonable privacy; <input type="checkbox"/> exercise, rec/equip't; <input type="checkbox"/> freedom from aversive stim/substantial deprivation					
25 Behavior Management (R/S = Restraint and/or Seclusion; TH = Therapeutic Hold; BMx = Bx. Mgt., which includes R/S & TH)					
E. If BMx is used, treatment planning includes regular review of the necessity for, type and frequency of BMx used					
G. Tx plans document the use of BMx and include: <input type="checkbox"/> consideration of the client's medical condition(s); <input type="checkbox"/> role of client's hx of trauma in his/her bx patterns; <input type="checkbox"/> tx team's solicitation/consideration of suggestions from client re prevention of future physical interventions.					
F. When BMx is used, the agency protects client's safety, dignity, privacy to max. extent possible at all times.					
H. BMx used only by trained staff; clients do not participate w/ other clients					
I. Mechanical and chemical restraints prohibited exc. under NMSA 23-9-1					
J. R/S used only in emergency to ensure safety after less restrictive means determined to be ineffective.					
<i>See also specific requirements for R/S in JCAHO and non-JCAHO facilities.</i>					