December-16

Optum - Behavioral Network Services

PSYCHOSOCIAL REHAB RECORD AUDIT TOOL

Facility Name:

Reviewer Name:

Date of Facility Review:

	Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
General Documentation Standards				
1	Each consumer has a separate record.			
2	Each record includes the consumer's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
3	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate. where appropriate.			
4	The record is clearly legible to someone other than the writer.			
5	There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the consumer and/or legal guardian.			
6	There is documentation that the service provider provides education to consumer/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.			

7	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the consumer and/or family or legal guardian.			
Initial Assessment				
8	The reasons for initiation of services are documented.			
9	An SPMI psychiatric diagnosis is included in the record.			
10	A behavioral health history is in the record.			
11	A medical history and/or physical exam, along with documentation of any infectious diseases, is in the record.			
12	Was a current medical condition identified? **This is a non-scored question. (If #11 is no, then 12 is NA)**			
13	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. **This is a non-scored question.**			
14	If a medical condition was identified, there is documentation that the patient/guardian refused consent for the release of information to the treating medical clinician. **This is a non-scored question.**			
15	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			

16	The assessment documents the spiritual variables that may impact services			
17	The assessment documents the cultural variables that may impact services			
18	An educational assessment appropriate to the age of the consumer and level of service is documented.			
19	The assessment includes documentation that the consumer is ready to participate in services.			
20	The assessment includes evidence the consumer identified the skills and resources they wanted to develop.			
21	There is documentation of an assessment of the consumer's level of functioning in the domains of Activities of Daily Living.			
22	For consumers 12 years and older, a screening is in evidence of use or exposure to alcohol, nicotine, and/or illicit drugs.			
23	The record documents the presence or absence of relevant legal issues of the consumer and/or family.			
24	There is documentation that the consumer was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.			
25	There is documentation of a screening for risk issues in the record.			

26	When risk issues are identified, there is evidence that an initial safety plan has been developed.			
Service Planning				
27	There is evidence that the results of the assessment are considered in the development of the service plan.			
28	The service plan is consistent with diagnosis and has objective and measurable short and long term goals, and included skills and resources identified in the assessment.			
29	The service plan includes a safety plan when active risk issues are identified.			
30	There is evidence the service plan was reviewed with and agreed upon by the consumer.			
31	There is evidence that the service plan is reviewed and updated at regular intervals.			
Progress Notes				
32	All progress notes include the date of service.			
33	All progress notes include the time of service provided.			
34	Progress notes include assessment of how activities relate to the service plan goals.			

35	All progress notes include who rendered services.			
36	All progress notes include ongoing monitoring of risk issues, including, but not limited to self-harm or harm to others.			
37	Progress notes include an ongoing assessment of the consumer's capacity to complete ADL's.			
38	As appropriate, progress notes document assessment of any additional services needed by the consumer.			
Coodination of Care				
39	Does the consumer have a medical physician (PCP)? **This is a non-scored question.**			
40	The record documents that the consumer was asked whether they have a PCP. **Y or N Only**			
41	If the consumer has a PCP there is documentation that communication/collaboration occurred.			
42	If the consumer has a PCP, there is documentation that the consumer/guardian refused consent for the release of information to the PCP.			
43	Is the consumer being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
44	The record documents that the consumer was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			

45	If the consumer is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
46	If the consumer is being seen by another behavioral health clinician, there is documentation that the consumer/guardian refused consent for the release of information to the behavioral health clinician.			
Discharge and Transfer				
47	Was the consumer transferred/discharged to another clinician or program? **This is a non-scored question.**			
48	If the consumer was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
49	If the consumer was transferred/discharged to another clinician or program, there is documentation that the consumer/guardian refused consent for release of information to the receiving clinician/program.			
50	Prompt referrals to the appropriate level of care are documented when consumer cannot be safely treated at their current level of care secondary to homicidal or suicidal risk or an inability to conduct activities of daily living.			
51	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
52	The discharge/aftercare/safety plan describes specific follow up activities.			
53	Clinical records are completed within 30 days following discharge.			