Behavioral Health Hospital Survey

Date of Facility Review:

Facility Name:		**Facility Address:**	
Reviewer Name(s):			

Scoring Procedure

	Points possible per chart	Yes Pts. Given	No's Pts. Given	N/A's	Section Score %
I. Policies and Procedures	**9**				
II. Format	**9**				
III. Documentation	**12**				
IV. Initial Assessment	**27**				
V. Treatment Planning	**18**				
VI. Progress Notes	**6**				
VII. Medication Management	**5**				
VIII. Coordination of Care	**6**				
IX. Discharge and/or Transfer	**11**				
	Total (103) Points Possible	**Yes Pts. Given**	**No's**	**N/A's**	

Medical Record Scores

Scoring is based on up to 10 medical records.

1) Add points given in each section.
2) Add points given for all sections.
3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible.
4) Divide the total points given by "adjusted" total points possible.
5) Multiply by 100 to determine compliance rate as a percentage.

_____ ÷ _____ = _____ **x 100** = _____%
Points Given / Total/ Adjusted Pts. Poss. / Decimal Score / Compliance Rate

Compliance Rate

Note: Deficiency in any of the critical elements requires a CAP for the entire BH Hospital Survey, regardless of the Total Survey Score.

___**Exempted Pass:** ≥ 90% without deficiencies in critical elements

___**Conditional Pass:** 80-89% or ≥ 90% with deficiencies in critical elements

___**Not Pass:** 79 % and Below
****

____ CAP Required

____ Other follow-up

Next Review Due: _____

Additional Comments/Notes:

I. Policies and Procedures Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	**Score**	**Findings/Comments**
A. Staff competence is assessed initially and again, with documentation, once every three years.	**1**		
B. The hospital follows a written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage.	**1**		
C. The hospital follows a written policy for as needed (PRN) orders: orders acted on based on the occurrence of a specific indication or symptom.	**1**		
D. The hospital follows a written policy for standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances.	**1**		
E. The hospital follows a written policy for titrating orders: orders in which the dose is either progressively increased or decreased in response to the patient's status.	**1**		
F. The hospital follows a written policy for taper orders: orders in which the dose is decreased by a particular amount with each dosing interval.	**1**		
G. The hospital follows a written policy for orders for medications at discharge or transfer.	**1**		
H. The hospital follows a written policy that defines actions to take when medication orders are incomplete, illegible, or unclear.	**1**		
I. The hospital follows a written policy that defines actions to take and report for a sentinel event.	**1**		
Total Points: 9	**Yes**		
Comments:	**No**		

II. Format Criteria

RN/MD/DO Review only

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Each Member has a separate record.	**1**											
B. Each record includes the Members address, employer or school, home and work telephone numbers.	**1**											
C. Emergency "contact" is identified.	**1**											
D. Guardianship information, as appropriate.	**1**											
E. Medical records are maintained and organized.	**1**											
F. Member's attending physician and/or rendering physician (PCP) is identified.	**1**											
G. Primary language and interpreter service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted.	**1**											
H. Person or entity providing medical interpretation is identified, as necessary.	**1**											
I. Signed Copy of the Notice of Privacy.	**1**											
Total Points: 9	**Yes**											
Comments:	**No**											
	NA											

III. Documentation Criteria

RN/MD/DO Review only

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Allergies are prominently noted.	**1**											
B. Chronic problems and/or significant conditions are listed.	**1**											
C. Current *continuous* medications are listed.	**1**											
D. Evidence of a Consent for Treatment or Informed Consent in the record that is signed by the Member and/or legal guardian. For minors, the Consent for Treatment must be- signed by the Member's parent/caregiver/court officer (CFS worker or probation officer))	**1**											
E. The patient is given information to create psychiatric advance directives.	**1**											
F. The patient is provided with referrals to peer support services.	**1**											
G. All entries in the record include the responsible service provider's name, professional degree and/or relevant identification number, if applicable, and are signed and dated (including electronic signature for EMR systems) where appropriate.	**1**											
H. The service provider provides education to Member/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.	**1**											
I. Evidence that the risks of noncompliance with treatment recommendations are discussed with the Member and/or family or legal guardian. For minors, discussions may also be made with the Member's parent/caregiver/ court officer (CFS worker or probation officer if appropriate)	**1**											
J. There is information that documents the course and result(s) of patient's care, treatment, and services.	**1**											
K. The record is clearly legible.	**1**											
L. Errors are corrected according to legal medical documentation standards.	**1**											
Total Points: 12	**Yes**											
Comments:	**No**											
	N/A											

IV. Initial Assessment Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point or two (2) points (if a critical element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. A complete clinical case formulation is documented in the record (e.g. primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).	**1**											
B. Psychiatric evaluation is complete within 24 hours of admission.	**1**											
C. A medical history and/or physical exam (appropriate to level of care) is in the record.	**1**											
D. Was a current medical condition identified?	**1**											
1. If a medical condition was identified, is there documentation that communication/collaboration with the treating medical clinician occurred?	**1**											
2. If a medical condition was identified, is there documentation that the patient/legal guardian refused consent for the release of information to the treating medical clinician? For minors, release of information may also be refused by the parent/caregiver/court (CFS worker or Probation Officer).	**1**											
3. The medical treatment history includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses.	**1**											
E. A complete mental status exam is in the record, documenting the patient's affect, speech, mood, thought content, judgement, insight, attention or concentration, memory, and impulse control. Also documented is the frequency in which the mental status exam is completed.	**1**											

Criteria met: Give one (1) point or two (2) points (if a critical element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
F. There is documentation of patients' overall level of risk for suicidal/homicidal tendencies and the plan to mitigate the risk for suicide/homicide.	**1**											
G. The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	**1**											
H. The record includes documentation of previous behavioral health hospitalization(s) are assessed and/or documented.	**1**											
I. **The record includes documentation of previous suicidal or homicidal/violent behaviors and risk, including dates, method, and lethality.**	**2**											
J. **The behavioral health history includes an assessment of any abuse or psychological trauma the member has experienced or if the member has been the perpetrator of abuse.**	**2**											
K. **If abuse was reported, there is documentation that a report was completed to the appropriate authorities.**	**2**											
L. **The assessment documents the patient's substance use history.**	**2**											
M. The assessment documents the spiritual and cultural variables that may impact treatment.	**1**											
N. **The assessment of the patient's strengths**	**2**											
O. **The record documents screening for metabolic disorders**	**2**											
P. The record documents the presence or absence of relevant legal issues of the patient and/or family.	**1**											
Q. There is documentation that the patient was asked about community resources (support groups, social services, school-based services, other social supports) that they are currently utilizing.	**1**											

Criteria met: Give one (1) point or two (2) points (if a critical element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
R. The hospital obtains information on the medications the patient is currently taking when he or she is admitted to the hospital. This information is documented in list format that is useful to those who manage medications.	**1**											
Total Points: 27	**Yes**											
	No											
	N/A											

Comments:

V. Treatment Planning Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point or two (2) points (if a Critical Element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. There is documentation (a signed form) that the patient or legal guardian (based on each state's age of consent) has agreed to the treatment plan. For minors, the parent/caregiver/court officer (CFS worker or Probation Officer) may agree to the treatment plan.	**1**											
B. The hospital involves the patient in making decisions about his or her care, treatment, and services.	**1**											
C. When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.	**1**											
D. Services provided are under an individualized treatment or diagnostic plan.	**1**											
E. Services provided are reasonably expected to improve the patient's condition or are for the purpose of diagnosis.	**1**											
F. The treatment plan is consistent with diagnosis and has objective and measurable short- and long-term goals.	**1**											
G. There is adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.	**1**											
H. Based on the goals established in the patient's plan of care, staff evaluate the patient's needs. The frequency of evaluation is also documented.	**1**											
I. The treatment plan includes a safety plan when active risk issues are identified.	**1**											
J. The treatment plan and goals for care are revised based on the patient's needs.	**1**											

Criteria met: Give one (1) point or two (2) points (if a Critical Element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
K. The plan of care includes the responsibilities of each member of the treatment team.	**1**											
L. There is clear documentation of medication dispensing, as appropriate and necessary. (NOTE: For DETOX Services, evidence of consistent documentation of vital signs throughout treatment in the record)	**1**											
M. There is evidence of documentation of vital signs throughout treatment or inpatient stay.	**1**											
N. **Tobacco use treatment was provided or offered**	**2**											
O. **There is clear documentation of physical restraint and/or seclusion and hours (if used)**	**2**											
P. The hospital begins the discharge planning process early in the patient's episode of care, treatment, and services.	**1**											
Total Points: 18	**Yes**											
Comments:	**No**											
	N/A											

VI. Progress Notes Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. The progress notes reflect reassessments when necessary.	**1**											
B. The progress notes document on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.	**1**											
C. The progress notes indicate treatment given to the patient and indicate their reaction to it.	**1**											
D. The progress notes written by Physicians, document medical necessity and confirm that level of care is appropriate for Member.	**1**											
E. The progress notes document the dates of follow up appointments with their specialists, medical and/or behavioral health provider(s), as appropriate.	**1**											
F. The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.	**1**											
Total Points: 6	**Yes**											
	No											
	N/A											

Comments:

VII. Medication Management Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. If the patient is on medication, there is evidence of medication monitoring in the treatment record. (physicians and nurses)	**1**											
B. When lab work is ordered, there is evidence the lab results were received and reviewed by the clinician.	**1**											
C. When the patient is on medications, the prescribing clinician documents that the patient was provided with education about the risks, benefits, side effects, and alternatives of each medication.	**1**											
D. When a primary care physician is identified, there is evidence the prescriber coordinated care within 14 calendar days after initiation of a new medication upon discharge.	**1**											
E. The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.	**1**											
Total Points: 5	**Yes**											
Comments:	**No**											
	N/A											

VIII. Coordination of Care Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. The record documents that the patient was asked whether they are being seen by a medical physician (PCP)?	**1**											
1. If yes, was the medical physician (PCP) documented?	**1**											
2. If the patient is being seen by a medical physician (PCP), there is documentation that communication/collaboration occurred.	**1**											
B. The record documents that the patient was asked whether they are being seen by multiple behavioral health clinician(s)? (e.g. psychiatrist and social worker, psychologist and substance/OTP/MAT counselors)	**1**											
1. If yes, were the behavioral health clinician(s) documented?	**1**											
2. If the patient is being seen by other behavioral health clinician(s), there is documentation that communication/collaboration occurred.	**1**											
Total Points: 6	**Yes**											
	No											
	N/A											

Comments:

IX. Discharge and/or Transfer Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point or two (2) points (if a Critical Element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Was the patient transferred/discharged to another program or hospital?	**1**											
B. Provide the patient with written information on the medications the patient should be taking when he or she is discharged from the hospital.	**1**											
C. If the patient was transferred/discharged to another program or hospital, there is documentation that communication/collaboration occurred with the receiving clinician/program.	**1**											
D. **If the patient discharged home, there is documentation that communication/collaboration occurred with aftercare providers.**	**2**											
E. **Patients discharged on multiple antipsychotic medications have appropriate justification documented.**	**2**											
F. Prior to discharge, the hospital arranges or assists in arranging the services required by the patient after discharge in order to meet his or her ongoing needs for care and services.	**1**											
G. **Tobacco use treatment provided or offered at discharge**	**2**											
H. Clinical records are completed within 30 days following discharge.	**1**											
Total Points: 11	**Yes**											
Comments:	**No**											

Criteria met: Give one (1) point or two (2) points (if a Critical Element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
	N/A											