PRTF services are appropriate when a child does not require emergency or acute psychiatric care but does require supervision and treatment on a twenty-four (24) hour basis. A board-certified child/adolescent psychiatrist (or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry) with admitting privileges must approve each admission.

When applicants are approved for PRTF admission by the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid, they are authorized a limited number of hospital days for that admission. It is the PRTF's job to help the child accomplish his/her treatment goals within that time frame. If treatment goals cannot be reached within the time allotted, the PRTF must justify to the UM/QIO why additional treatment time is needed. Refer to Provider Policy Manual Section 18.11 for Continued Stay policy.

The role of the ~~peer review organization~~ UM/QIO is to determine the medical necessity of PRTF services for child/adolescent Medicaid beneficiaries with psychiatric diagnoses, the appropriateness of a particular PRTF setting for each child, and the number of days reasonably required to treat each child's condition.

The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible. (42 CFR 441.152 (a)(3)) The general expectation is that this level of symptom reduction/resolution can be reached within one hundred eighty (180) days of admission.

The need for PRTF admission must be supported by documentation that:

- The child has a diagnosable psychiatric disorder. (42 CFR 456.180(b)(1)) Admission for a primary diagnosis of substance abuse is not authorized.
- The child can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.
- The child's psychiatric symptoms (disturbance of thought and/or mood, disruptive behavior, disturbances in social/family relationships) are severe enough to warrant residential treatment under the direction of a psychiatrist (42 CFR 441.152 (a)(2)).
- The referring psychiatrist or psychologist advises that residential treatment is needed (42 CFR 441.152 (a)(2)).
- At least one of the following:
  - The child has failed to respond to less restrictive treatment in the last three (3) months, **OR**
  - Adequate less restrictive options are not available in the child's community (42 CFR 441.152 (a)(1)), **OR**
  - The child is currently in an acute care facility whose professional staff advise that residential treatment is needed

- The admission has been certified by the UM/QIO as medically and psychologically necessary. (42 CFR 441.152)

If a facility provides for the use of seclusion/restraint, it must inform the incoming resident and his/her parent/guardian at the time of admission of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program The facility must provide the parent/guardian with a copy of its policy regarding seclusion/restraint and obtain a signed acknowledgment from the parent/guardian documenting that the policy was explained and a copy given to them. This acknowledgment must be filed in the resident's record. (42 CFR 483.356(c)) The facility must inform the parent/guardian of his/her right to be notified within ~~24~~ twenty-four (24) hours after any special procedure is applied with his/her child. (42 CFR 483.366(a)) The PRTF must also provide contact information, including the phone number and mailing address, ~~for the appropriate State Protection and Advocacy organization~~ for Disability Rights Mississippi (formerly known as the State Protection and Advocacy office) and document in the record that this was done. (42 CFR 483.356(d))

When a child is denied admission, the PRTF must notify the referral source of the reason(s) for the denial within seventy-two (72) hours. The PRTF must keep a log of denial notifications for review by DOM.

Records Content

The clinical record is an essential tool in treatment. It is the central repository of all pertinent information about each resident. It provides an accurate chronological accounting of the treatment process: assessment, planning, intervention, evaluation, revision, and discharge. Clinical records must be complete, accurate, accessible, legible, and organized. Records must contain the following four (4) broad categories of information:

- **Administrative**: This portion of the record contains all information related to resident identification. It must include, at a minimum, a copy of the resident's birth certificate and/or social security card, a recent photograph of the resident, a copy of any legal documents verifying custody or guardianship of the resident when the responsible party is anyone other than the resident's legal parent(s). The name, address and phone number of the party bearing legal responsibility for the resident should be clearly identified, along with his/her relationship to the child, e.g. "mother", or "paternal aunt, legal guardian". If the resident is in the custody of the Department of Human Services (DHS), the county of custody should be specified and the caseworker identified as an agent of DHS, e.g. "Walthall County DHS, Susan Smith, caseworker."

- **Assessments**: This portion of the record contains information gathered through history taking, observation, testing and examination of the resident. It must include, at a minimum, those documents specified in Provider Policy Manual Section 18.05 Assessment.

- **Treatment Planning**: This portion of the record contains the individualized interdisciplinary treatment plan, as well as all reviews and revisions. This section must meet the criteria specified in Provider Policy Manual Section 18.06 Treatment Planning. It should be noted that the treatment planning process is intended to take place in an interdisciplinary forum where many points of view may be expressed and consensus reached, rather than through a process of serial communication among professionals. Treatment planning documents should reflect the collaborative nature of the process.

- **Therapeutic Interventions:** All interventions attempted/provided during the course of the resident's treatment must be appropriately, accurately and legibly documented.

Psychotherapy

Essential elements that must be documented for each therapy session are as follows:

- The date and time of the session (time in and time out)
- The type of therapy (individual, family or group)
- The person(s) participating in the session
- The length of the session

- Clinical observations about the resident (demeanor, mood, affect, mental alertness, thought processes, risks, etc.)
- The content of the session
- Therapeutic interventions attempted and the resident's response to the intervention(s)
- The resident's response to any significant others who may be present in the session
- The outcome of the session
- A statement summarizing the resident's degree of progress toward the treatment goals
- Periodic (at least monthly) reference to the resident's progress in relation to the discharge criteria and the estimated discharge date
- The signature (and printed name, if needed for clarity) of the therapist

Monthly summaries are not acceptable in lieu of psychotherapy session notes.

Milieu Therapy

Milieu Notes
Milieu notes must present a clear picture of the resident's participation and interactions in the therapeutic community. Milieu notes for each day should describe the resident's actions, staff interventions, and the resident's response to those interventions. Milieu notes are usually completed by direct care staff. If a checklist is used, it must be accompanied by at least a brief narrative. Milieu notes should be behaviorally focused. Behavior and events should be described rather than labeled. For example:

- Behavior labeled: Resident was oppositional
- Behavior described: Resident refused to make up bed when asked

Milieu notes should reflect a pattern of clear, respectful communication between staff and resident, with emphasis on the resident's involvement and collaboration in his/her own treatment.

Community Meeting Notes
Community meeting notes must be clearly identifiable. Each resident's participation must be documented (or his/her absence justified) in a minimum of one (1) community meeting per day. Notes must reflect that the community meetings are therapeutic in nature, i.e. that they address treatment issues such as problem identification, goal-setting, problem-solving, conflict resolution, behavioral observations/evaluation, problems in community living, etc. The nature of each resident's participation should be described. If a checklist is used, it must be accompanied by at least a brief narrative (i.e. more than he/she did not practice).

Medication

Medication is an important cornerstone of psychiatric treatment. Documents pertaining to this aspect of treatment (patient/family education and consent, medication orders, administration, monitoring) must be accurate and readily located. When medication is a prescribed intervention for a problem identified in the resident's treatment plan, it should be noted as such in the treatment plan. When medication changes

are made, they should be made during treatment planning meetings whenever possible. When circumstances preclude this, the changes should be reviewed for all team members' update at the next available staffing opportunity.

Consent for Medication
When medications are prescribed or changed, a member of the professional staff will review with each resident's parent/guardian the following information:

- The name/class of medication
- The method of administration (oral, injection, etc.)
- The symptoms targeted
- Possible side effects of the medication
- Possible long-term effects of the medication
- Treatment alternatives
- Likely outcomes of using/not using the medication

When a face-to-face encounter cannot be held with a parent/guardian prior to starting a medication regimen, the "informed consent" conference may be held by telephone, with the parent's/guardian's responses noted and dated. This form must be signed by the parent/guardian within thirty (30) days after the telephone consent. Two (2) PRTF staff must witness the form after talking with the parent/guardian.

Administration of Medication

Documentation must substantiate that medications have been accurately administered in accordance with the physician's or PMHNP's orders. Any variances must be justified in the record by medical staff.

Monitoring of Side Effects

An instrument for monitoring medication side effects will be identified and routinely administered to each resident who is prescribed psychoactive medication upon admission, at least every ~~60~~ sixty (60) days during his/her stay, and again at discharge.

Medication Adjustment vs. Pharmacological Restraint

The term **medication adjustment** is used to describe the use of a resident's routine medication *in a non-routine way* to help the resident through a period of heightened stress or agitation. This might involve ordering the administration of an extra dose (usually in a lower amount) of the same (or a similar, from the same class) medication that is already part of the resident's treatment program, or ordering that the regular medication be administered sooner than the routine time, without making a permanent change in the resident's treatment plan. Medication adjustment is not considered to be a special procedure. Unlike medications administered for the purpose of pharmacological restraint, medication adjustments are not sedating, are only administered orally, and must be taken voluntarily by the resident (and in some cases may be requested by the resident). Standing PRN orders for medication adjustments are acceptable.

The term **pharmacological restraint** refers to the use of a medication which is not a standard part of the resident's treatment regimen to control or alter the resident's mood or behavior or to restrict his/her freedom of movement. Pharmacological restraint is considered to be a special procedure and special documentation is required (see section below). Standing PRN orders for pharmacological restraint are prohibited.

Adjunct Therapies

When other therapies are employed (art therapy, recreational therapy, occupational therapy, dance/movement therapy, music therapy, speech/language therapy), their use is documented in the clinical record in much the same manner as psychotherapy: date, length, type of session, together with a summary of the session's content, process, outcome and the therapist's name/signature.

Special Procedures

Seclusion/Restraint
Documentation of each incident of seclusion or restraint (personal, mechanical and pharmacological restraint) will include, but not be limited to, the following information:

- The date/time the procedure started and ended (42 CFR 483.358(h)(2))
- The name of the physician or PMHNP who authorized it, the name(s) of staff who initiated the procedure, were involved in applying or monitoring it, and/or were responsible for terminating it (42 CFR 483.358(h)(5))
- Whether or not the resident returned from therapeutic leave within the preceding ~~twenty-four~~ twenty-four (24) hours
- The reason the procedure was used ~~(42 CFR $83.358(h)(4))~~ (42 CFR 83.358(h)(4))
- Which less restrictive options were attempted, and how they failed
- Criteria for ending the procedure (except for pharmacological restraint, when the end time is identified by the physician or PMHNP)
- The results of a face-to-face assessment conducted by a physician, PMHNP or RN within one (1) hour after initiation of the procedure to include (1) the resident's physical and psychological status, (2) the resident's behavior, (3) the appropriateness of the intervention measures and (4) any complications resulting from the intervention (42 CFR 483.358(f))
- The resident's condition at the time of each fifteen (15) minute reassessment and at the end of the procedure
- The signature of the person documenting the incident
- A record of both debriefing sessions (staff/resident and staff only) which are required to take place within twenty-four (24) hours of the use of seclusion/restraint, to include the names of staff who were present for or excused from the debriefing and any changes to the resident's treatment plan that resulted from the debriefings. (42 CFR 483.370(c))

- Notification of the resident's parents/guardians within twenty-four (24) hours of the initiation of each incident, including the date and time of notification and the name of the staff person providing the notification. (42 CFR 483.366(b))

This documentation must be part of the resident's permanent record.

A separate log documenting all episodes of seclusion/restraint in the PRTF must be maintained. (42 CFR 483.358(i)) A multi-disciplinary team, including at least nursing personnel, physician or PMHNP, therapist, and quality management personnel, must review incidents of seclusion/restraint monthly. These meetings must be documented.

Information regarding the number of times seclusion or restraint have been employed by a facility must be included each month as part of the facility's census report to the UM/QIO.

Therapeutic Pass

A therapeutic pass consists of a resident's absence from the facility for less than eight (8) hours. If a resident leaves the facility on a therapeutic pass accompanied by PRTF staff, no documentation is required by DOM. If a resident leaves the facility on a therapeutic pass with anyone other than staff (e.g. relatives or representatives of DHS), therapeutic goals for the pass must be identified and documented. At the conclusion of the pass, documentation should indicate whether or not the therapeutic goals were met.

Therapeutic Leave

The attending physician or PMHNP must approve all therapeutic leave days. An absence from the facility of eight (8) or more hours between 12:01 a.m. and 11:59 p.m. on the same calendar day constitutes one (1) day of leave. Therapeutic leave is not allowed during the fourteen (14) day assessment period.

Documentation at the time a resident leaves the facility must include:

- The date/time of check-out
- The required time of return
- The name(s) of the person(s) with whom the leave will be spent
- The resident's physical/emotional condition at the time of departure (including vital signs)
- The types/amounts of medication being provided and instructions (in lay terms) for taking them
- Therapeutic goals for the leave. Goals must relate to the goals established in the treatment plan ("have time with the family" or "spend Christmas at home" is not considered a therapeutic goal)
- The name and signature of the person with whom the resident is leaving
- The signature of the staff person checking the resident out

Documentation at the time of the resident's return must include:

- The date/time of check-in

- The resident's physical/emotional condition at the time of return (including vital signs and notation of any physical injury or complaint)
- Whether or not any contraband was found
- The types/amounts of medication being returned, if any, and explanation of any missed doses
- An explanation of any early or late return from leave
- A brief report on the outcome of the leave by the parent or guardian (were therapeutic goals achieved? Was the resident's behavior appropriate?)
- The name and signature of the person returning the resident's to the facility
- The signature of the staff person checking resident in
- An assessment of the outcome of the leave conducted by the resident's therapist within ~~seventy two~~ seventy-two (72) hours of the resident's return from leave

Records Maintenance

Clinical records must be maintained for a period of five (5) years from the date of discharge. The facility must insure that the clinical record is not lost, destroyed or put to unauthorized use. The facility must insure the confidentiality of all information contained in the resident's record except when its release is authorized by the resident's parent/legal guardian or required by ~~state~~ State or federal law.

Reporting Requirements

The PRTF is required to keep DOM informed of changes in key staff as well as serious occurrences involving residents of the PRTF. Information regarding the time frames and methods of reporting for each situation is provided in the following table.

Staff changes which must be reported to DOM are changes in PRTF Administrator, Medical Director or Clinical Director. Notification should be sent as soon as possible, but no later than ~~seventy-two~~ seventy-two (72) hours following the effective date of the change.

The death of ANY resident or a serious incident involving ANY resident, regardless of whether or not those involved were Medicaid beneficiaries, must be reported to DOM. If Medicaid beneficiaries were involved, their names should also be provided as a part of the report.

Serious incidents are defined as:

- Serious injury of a resident, defined as any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else. All serious injuries that require medical intervention are to be reported.
- Suicide attempt by a resident
- Elopement of a resident
- Allegations of sexual contact between residents
- Allegations of maltreatment (abuse/neglect) of a resident
- Any injury of a resident sustained in the course of a seclusion or restraint

Any death of a resident should be reported to DOM by telephone as soon as possible (but no later than close of business the same day), with a follow-up written report faxed by the close of business the following day. Reports made for any other reasons should not be phoned in, but should be submitted by fax in the time frame indicated.

Each report should include:

- The name of the resident, if she/he is a Medicaid beneficiary
- A description of the occurrence, and
- The name, street address, and telephone number of the facility

Some reports are required to be submitted to other agencies or entities in addition to DOM. These are indicated in the table below as DHS (Department of Human Services), MSDH (Mississippi State

Department of Health, Bureau of Health Facilities Licensure and Certification), ~~P&A (the state Protection & Advocacy office)~~ DRM (Disability Rights Mississippi), formerly known as the State Protection and Advocacy office, CMS (the regional office of the Center for Medicare/Medicaid Services), MFCU (Medicaid Fraud Control Unit, Attorney General) and the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid.

Refer to the table on the following page.

EVENT	PARENT	DOM	DHS	MSDH	~~P&A~~ DRM	CMS	UM/QIO	MFCU
Death	ASAP, but within 24 hrs	Phone ASAP, but by COB same day; follow-up ~~Fax~~ fax by COB next day		Within 24 hrs	Within 24 hrs	Within 24 hrs	Within 24 hrs	~~Within 24 hrs~~
Serious Injury	ASAP, but within 24 hrs	Fax only, by COB next day		Phone , within 24 hrs; follow-up in writing within 72 hrs	Within 24 hrs		Within 24 hrs	~~Within 24 hrs~~
Suicide Attempt	ASAP, but within 24 hrs	Fax only, by COB next day		Phone , within 24 hrs; follow-up in writing within 72 hrs	Within 24 hrs		Within 24 hrs	~~Within 24 hrs~~
Elopement	ASAP, but within 24 hrs	Fax only, by COB same day		Phone , within 24 hrs; follow-up in writing within 72 hrs			By COB same day	~~Within 24 hrs~~
Allegations of sexual contact between residents	ASAP, but within 24 hrs	Fax only, by COB next day		Phone , within 24 hrs; follow-up in writing within 72 hrs			By COB next day	~~Within 24 hrs~~
Allegations of maltreatment (abuse/neglect) of resident	ASAP, but within 24 hrs	Fax only, by COB next day	By COB next day	Phone , within 24 hrs; follow-up in writing within 72 hrs				Within 24 hrs
Any injury in the course of seclusion or restraint	ASAP, but within 24 hrs	Fax only, by COB next day		Phone , within 24 hrs; follow-up in writing within 72 hrs				~~Within 24 hrs~~
Staff changes of Administrator, Medical or Clinical Director		Fax only, ~~w/in~~ within 72 hrs of change		Phone , within 24 hrs; follow-up in writing within 72 hrs				

ASAP=as soon as possible
COB=close of business

PRTF Compliance Review Instrument (CRI)
Clinical Services Section A: Resident Record Review

Resident _____ ID# _____ OSCR Case #_____

Age _____ Sex _____ DHS Custody? Yes No Psychiatrist _____ Reviewer_____

Admission date: _____ Discharge target date: _____ Discharge actual date: _____

RATING SCALE : 4 - Exceeds Standards 3 - Meets Standards 2 - Sub-standard 1 - Unacceptable
Y – Yes N – No

Element	Rating	Comments
1. **Resident Record**	Y N	
a. Record is well organized and legible. A key identifies the location of all required documents.		
b. Copies of documents verifying custody, if other than parents.	Y N N/A	
2. **Admission**		
a. Resident's FS-IQ is appropriate for the program, documented within the last 12 months.	Y N	
b. Symptom severity warrants residential treatment	Y N	
c. Less restrictive treatment is not appropriate:	Y N	
_____Resident failed to respond to less restrictive treatment		
_____Adequate treatment options exist in resident's community		
_____Resident is being stepped-down from acute care		
d. Parents were informed re: special procedures		
e. Parents were given information regarding ~~state P&A Agency~~ Disability Rights Mississippi	Y N N/A Y N	
3. **Assessment**		
a. Psychiatric evaluation	Y N	
b. Medical history and physical exam	Y N	
c. Psychological evaluation by licensed psychologist within 12 months pre-admission or 14 days post-admission	Y N	
d. Psychosocial assessment	Y N	
1) Includes developmental profile	4 3 2 1	
2) Includes behavioral assessment	4 3 2 1	
3) Assesses potential family resources	4 3 2 1	
e. Educational assessment	Y N	
f. Nursing assessment	Y N	
g. Nutritional assessment, if indicated	Y N N/A	

OSCR Case #: _____

4. **Treatment Planning**		
a. Team composition:		
1) Psychiatrist or PMHNP/psychologist & physician	Y N	
2) LCSW **or** RN	Y N	
b. Time lines met:		
1) Initial plan within 72 hours	Y N	
2) Comprehensive plan within 14 days	Y N	
3) Reviews: once at end of first month of stay	Y N N/A	
4) Reviews: once monthly after first month of stay	Y N N/A	
c. Required elements		
1) Multi-axial diagnosis	Y N	
2) Resident's short-/long-term therapeutic needs	Y N	
3) Resident's strengths and liabilities	Y N	
4) Problems to be addressed in treatment	Y N	
5) Goals, measurable objectives, target dates for completion	4 3 2 1	
6) Treatment modalities, clinicians responsible	Y N	
7) Family therapy goals/objectives	Y N	
8) Discharge plan, estimated discharge date	Y N	
d. Reviews:		
1) Note treatment successes, explain failures	4 3 2 1	
2) Identify changes in treatment, if needed	Y N N/A	
3) Re-assess need for residential ~~vs.~~ versus less-restrictive treatment	Y N	
4) Assess progress in relation to projected discharge date	Y N	
e. Evidence that resident and parent/guardian actively participate	Y N	
f. Evidence that physician directs treatment	Y N	
g. Evidence of interdisciplinary collaboration in planning	Y N	
5. **Treatment Documentation**		
a. All modalities:		
1) Date/length of session	Y N	
2) Summary of content/process	4 3 2 1	
3) Sessions clearly have therapeutic focus	4 3 2 1	
4) Outcome of session	4 3 2 1	
5) Therapist's signature	Y N	
b. Individual therapy:		
1) Provided minimum 1 hr/week	Y N	
2) Resident's mental status	Y N	
3) Progress towards treatment goals	4 3 2 1	
4) Progress in relation to discharge date addressed at least monthly	4 3 2 1	
c. Family therapy:		
1) Provided 2 x month (2+ hrs from PRTF, 1 in-person + 1 phone session)	Y N	
2) Resident's response to family members	4 3 2 1	
d. Group therapy:		
1) Provided 3 hrs in minimum 3 sessions/week	Y N	

e. Milieu therapy:		
1) Community meetings held daily	Y N	
2) Therapeutic milieu provided 24 hours/day, 7 days/week	4 3 2 1	
3) Resident's participation in community meetings	4 3 2 1	
4) Milieu notes behaviorally-focused	4 3 2 1	
f. Medication:		
1) All orders in chart	Y N N/A	
2) Administration timely and accurate (MAR)	Y N N/A	
3) Reasons given for PRN meds	Y N N/A	
4) There were no orders for PRN pharmacological restraint	Y N	
5) Informed consent for meds properly executed	Y N N/A	
6) Resident assessed for side effects on admission, every 60 days, and at discharge	Y N N/A	
g. Therapeutic Pass:		
1) Goals were identified	Y N N/A	
2) Outcome of goals was documented	Y N N/A	
h. Therapeutic Leave:		
1) Authorized by physician's or PMHNP's order	Y N	
2) Not taken during 14-day assessment period	Y N	
3) Date/time patient checked out/in	Y N	
4) Required time of return	Y N	
5) Name of person with whom leave will be spent	Y N	
6) Resident's condition at check-out/in, vital signs, mental status	Y N	
7) Name/signature of person with whom child is leaving/returning	Y N	
8) Name/signature of staff checking child out/in	Y N	
9) Medications provided/returned noted, include number of doses	Y N N/A	
10) Medication instructions given, in lay terms	4 3 2 1	
11) Therapeutic goals for leave	4 3 2 1	
12) Outcome of leave assessed by therapist within 72 hours of return	Y N N/A	
6. **Special Procedures**		
a. Least restrictive effective intervention was used	4 3 2 1	
b. Seclusion/restraint initiated only by physician, PMHNP or RN	Y N N/A	
c. Personal restraint administered by trained personnel	Y N N/A	
d. Physician or PMHNP identified end times for pharmacological restraint	Y N N/A	
e. Documentation includes:		
1) Date/time procedure started/ended	Y N	
2) Names of staff involved in applying or monitoring	Y N	
3) Whether or not therapeutic leave ended ~~w/in~~ within last ~~12~~ 24 hours	Y N	
4) Reason procedure was used	4 3 2 1	
5) Which less restrictive measures were used, how they failed	4 3 2 1	
6) Order obtained from MD or PMHNP within 1 hour	Y N	

7) Orders for up to 9 year old children are 1 hour; 9-21 years old are 2 hours	Y N	
8) Order renewed when original order expires	Y N	
9) Clear criteria for ending procedure	Y N N/A	
10) Resident's health/comfort assessed every 15 minutes	Y N N/A	
11) Vital signs taken every hour	Y N	
12) In-person assessment conducted by physician, PMHNP, or RN within 1 hour, regardless of length of procedure	Y N	
13) Assessment includes		
a) Resident/s physical/psychological status	Y N	
b) Resident's behavior	Y N	
c) Appropriateness of Intervention	Y N	
d) Resulting complications	Y N	
14) Procedure ended at the earliest possible time	Y N N/A	
15) Resident's response to procedure	4 3 2 1	
f. Treatment plan modified within 1 working day of incident	Y N	
g. Parents notified within 24 hours (or had waived right in writing)	Y N	
h. Incident processed with resident by staff within 24 hours	Y N	
i. Staff debriefing conducted within 24 hours	Y N N/A	
7. **Discharge/Aftercare**		
a. Provisional plan developed 1 week prior to discharge	Y N	
b. Provisional plan includes:		
1) Anticipated date of discharge	Y N	
2) Recommendations for parents/caregivers	Y N	
3) Educational summary and recommendations	Y N	
4) Recommendations for mental health care providers	Y N	
c. Final aftercare plan includes:		
1) Dates of admission and discharge	Y N	
2) Person/agency to whom resident will be released	Y N	
3) Address where resident will reside	Y N	
4) Multi-axial diagnosis	Y N	
5) Medication information, in lay terms	Y N N/A	
6) Recommendations for parents/caregivers	4 3 2 1	
7) Educational summary and recommendations for teachers	4 3 2 1	
8) Recommendations for providers of follow-up mental health care	4 3 2 1	
9) Names, addresses, phone numbers of follow-up mental health care providers	Y N	
10) Date/times of initial aftercare appointments	Y N	
d. Parent received:		
1) Minimum of one week's supply of medications	Y N N/A	
2) Prescriptions for 30-day supply of meds	Y N N/A	
3) Copy of aftercare plan	Y N N/A	
e. Documentation that educational summary and recommendations were mailed to the resident's	Y N	

school within 24 hours post-discharge. f. Documentation that aftercare plan and discharge summary were mailed to follow-up mental health care providers within 2 weeks post-discharge.	Y N	

General Comments: