

## **INPATIENT DOCUMENTATION REQUIREMENTS**

The Physician Initial Assessment must contain the following:

1. Patient identification
2. A brief summary or history of the present illness
3. Past Psychiatric history
4. History of substance use
5. Medical history and physical examination
6. A mental status examination which details the behavior that leads to the patient being dangerous to self, others and/or gravely disabled
7. DSM-5 diagnosis
8. Recommendations for further evaluation and treatment
9. Initial discharge plan
10. The physician will oversee the development of the multi-disciplinary treatment plan, and sign off on the treatment plan, within 72 hours of admission.
11. The treatment plan is updated as needed, but at least every seven days.

The Physician Progress Notes must:

1. Be entered in the medical record daily for acute patients, and at least once every seven days for non-acute patients.
2. Address current Mental Status Examination daily
3. Address current medications daily
4. Address medication side effects daily
5. Address pain management needs daily
6. Address review of laboratory or diagnostic imaging studies daily
7. Document the working diagnosis daily
8. Document treatment response daily
9. Document placement plans weekly, or whenever there is a change in the placement plan
10. Document the discharge plans, including the Aftercare Plan on the day of discharge

**The Nursing Notes must:**

1. Be entered in the medical record each shift
2. Must address each identified problem on the multidisciplinary treatment plan
3. The RN admission note must include a full nursing assessment, including the assessment of pain management needs.

**The Social Services Notes must:**

1. Document a full psychosocial evaluation within 72 hours of admission.

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2. Document the placement and progress toward placement at least every 72 hours
3. Document all changes in the placement plan, as well as the rationale for changes

**The Multidisciplinary Treatment Plan** must be present and complete in the medical record by the 72<sup>nd</sup> hour following admission. There must be evidence that all disciplines participated in the development of the plan. There must be evidence that the treatment is physician directed and approved. The treatment plan must identify patient strengths. Patient and treatment team identified short and long-range goals must be documented. The treatment plan must identify all problems that will be a focus of treatment (both psychiatric and non-psychiatric medical problems) during the admission. For each identified problem measurable objectives toward the resolution of that problem must be identified, as well as discipline-specific interventions geared to the problem resolution. The assessment of progress toward the measurable objectives must occur regularly, but at least every seven days. The treatment plan must address pain management issues for every patient.