A-1650

(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.61(c)(2) The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included.

Interpretive Guidelines §482.61(c)(2)

Active treatment is an essential requirement for inpatient psychiatric care. Active treatment is a clinical process involving ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare, under the direction of a psychiatrist. The patient is in the hospital because it has been determined that the patient requires intensive, 24 hour, specialized psychiatric intervention that cannot be provided outside the psychiatric hospital. The medical record must indicate that

the hospital adheres to the patient's right to be counseled about medication, its intended effects, and the potential side effects. If the patient requires, because of danger to self or others, a more restrictive environment, the hospital must indicate that the staff attempted to care for the patient in the least restrictive setting before progressing to a more restrictive setting.
Through observation, look for evidence that each patient is receiving all the aspects of treatment to which the hospital has committed itself based upon his/her assessment, evaluation and plan of care. It is the hospital's responsibility to provide those treatment modalities with sufficient frequency and intensity to assure that the patient achieves his/her optimal level of functioning.

Through observation and interviews, look for evidence that each patient's rights are being addressed and protected. There should be policies and procedures in place to address the following areas: informed consent, confidentiality, privacy, and security. Expect to see detailed policies and procedures regarding the therapeutic use of restrictions, such as visitors, mail, and phone calls. Seclusion and restraint policies and procedures must address patient protection and safety while in a restricted setting.

Clarification of the types of notes found in the medical record.

Treatment notes are recordings in the medical record that indicate provision of, and a patient's response to, a specific modality. This modality may be drug therapy, individual, family, marital, or group therapy, art therapy, recreational therapy, and any specialized therapy ordered by the physician or anyone credentialed by the facility, in accordance with the State law, to write orders in the medical record.

A combined treatment and progress note may be written.

Progress notes are recordings in the medical record that are written by persons directly responsible for the care and active treatment of the patient. Progress notes give a chronological picture of how the patient is progressing toward the accomplishment of the individual goals in the treatment plan. These are frequently shift notes, weekly notes, or monthly notes.

Survey Procedures §482.61(c)(2)

Does the patient know his/her diagnosis?

What did the patient contribute to the formulation of the treatment plan? Goals of treatment?

If the patient receives medication, does the patient understand the reason for the medication? The name of the medication? The dose prescribed? The time of administration? The desired effects? The potential side effects?

If medication is changed, is there a rationale for the change?

Are staff members recording their observations relative to the patient's response to the treatment modalities, including medication?

Is there evidence that the patient was afforded the opportunity to participate in his/her plan of care?

What progress has the patient made? Has the patient achieved his/her optimal level of functioning? If not, why? Are these reasons/barriers reflected in the current treatment plan? Do treatment and progress notes support these insights?

Does the observed status of the patient in the various treatment modalities correspond to the progress note reports of status?

Do all treatment team members document their observations and interventions so that the information is available to the entire team?

If a restrictive procedure is used (e.g., restraint and/or seclusion), is there evidence that attempts were made systematically to treat the patient in the least restrictive manner?

Is there evidence that the rights of the patient were protected while in the restrictive setting in accordance with Federal and State law and accepted standards of practice?