POLICY MANUAL

Subject: Clinical Documentation Timeframes **Effective Date**: 6/22/1998

Initiated By: Cinde Stewart Freeman
PI Director

Approved By: Billie Alexander Avery
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Review Dates: 02/11 Committee
2/14 Committee, 4/15 Committee

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07/13 WRPC, 10/13 SG, 2/14 CH

POLICY: Cumberland Heights has established timeframes for completion of specific clinical documentation. This is done in order to enhance treatment effectiveness, facilitate the utilization process, and assist with timely discharge planning as well as to ensure completion of the medical record.

PROCEDURE:

Adult Residential Programs

1. The initial substance abuse assessment is completed by the Admissions counselor at time of admission with the Triage being completed by a licensed nurse. If unable to do so at admission, the Admissions counselor completes the substance abuse assessment within 24 hours.

2. The Biopsychosocial and Treatment Plans are completed by day five (5) of treatment. The initial Treatment Plan Review is completed within the first week and weekly thereafter.

3. A Discharge Summary is completed on all patients discharging by entering the Discharge Summary of the Electronic Medical Record. This is completed within 5 days of discharge.

4. Continuing Care Plans are completed for those patients who are discharging. A copy of this plan is given to the patient at the time of discharge. Continuing Care Planning begins at time of admission.

Youth Residential Programs

1. The initial substance abuse assessment is completed by the Admissions counselor at time of admission with the Triage being completed by a licensed nurse. If unable to do so at admission, the Admissions counselor completes the substance abuse assessment within 24 hours.

2. The Biopsychosocial and Treatment Plans are completed by day five (5) of treatment. The initial Treatment Plan Review is completed within the first week and weekly thereafter.

3. Discharge summaries are completed within 5 days of discharge.

4. Continuing Care Plans are completed for those patients who are discharging. A copy of this plan is given to the patient at the time of discharge. Continuing Care Planning begins at time of admission

Intensive Outpatient

1. The initial substance abuse assessment is completed by the Admissions counselor at the time of admission.

2. The initial Treatment Plan is completed in orientation.

3. The Biopsychosocial is completed by session seven (7) for direct admits or an update is completed by session (5) for transfers. The Master Treatment Plan is completed by session (7) and reviewed by treatment team every two weeks with possible revisions documented at that time.

4. Discharge summaries are completed within 5 days after discharge.

5. Continuing Care Plans are due at the time of discharge.

Nursing (for residential patients only)

1. A nursing assessment is completed at time of admission. If unable to do so at admission, the nurse completes the assessment within 24 hours of admission.

2. The registered nurse initiates an Initial Treatment Plan within 24 hours of admission.

3. For patients in the residential programs, a registered nurse develops treatment planning for psychiatric and medical needs as appropriate.

4. See related nursing policy for detoxification assessment and management documentation standards, as well as for rehabilitation assessment and management documentation standards.

5. At the time of discharge or transition, a continuing care plan for physical health issues is completed with a copy given to the patient.