

## **B122**

### **§482.61(c)(1)(iii) The specific treatment modalities utilized;**

#### **Guidance §482.61(c)(1)(iii)**

This requirement refers to all of the planned treatment modalities used to treat the patient during hospitalization. Having identified the problems requiring treatment, and defining outcome goals to be achieved, appropriate treatment approaches must be identified.

Modalities include all of the active treatment measures provided to the patient. It describes the treatment that will be provided to the patient. It describes the treatment that will be provided by various staff.

A daily schedule of unit activities does not, in itself, constitute planned modalities of treatment. It is expected that when a patient attends various treatment modalities/activities, it is a part of individualized planning with a specific purpose and focus for that patient.

Simply “naming” modalities (i.e., individual therapy, group therapy, occupational therapy, medication education) is not acceptable. The focus of the treatment must be included.

Simply “stating” modality approaches (i.e., “set limits,” “encourage socialization,” “discharge planning as needed”) is not acceptable. Modality approaches must be specifically described in order to assure consistency of approach.

Observation of staff implementing treatment, both in structured and non-structured settings, is a major criterion to determine whether active treatment is being provided in accordance with planned treatment.

It must be clear to you that the active treatment received by the patient is internally consistent and not simply a series of disconnected specific modalities delivered within certain scheduled intervals.

#### **Probes §482.61(c)(1)(iii)**

Are qualified staff observed following the methods, approaches and staff intervention as stated?

Can staff explain the focus of the modality they have provided?

Are observed treatment methods, approaches and interventions from all disciplines included in the plan?

Do the pieces of the treatment plan work together to achieve the greatest possible gain for the patient?

Does the hospital integrate its activities, therapies, treatments, and patient routines to work for the patient's therapeutic interest first, and its own convenience second?

Do the disciplines present at observed treatment planning meetings represent all of the patient's needs?

If the patient attends treatment planning, how do the staff prepare the patient to participate?

If the patient does not attend, what reasons do staff give to explain the absence?

Is there a process to enable staff to reach a consensus regarding how treatment will be carried out?

Is the patient included in the decision-making, whenever possible?

Are the final decisions regarding treatment approaches defined clearly by the end of the discussion?

How does the patient get to know his/her treatment regime?

How does the treatment team encourage the patient to accept responsibility for engaging in the treatment regime, rather than accepting it passively?

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## **B123**

### **§482.61(c)(1)(iv) The responsibilities of each member of the treatment team; and**

#### **Guidance §482.61(c)(1)(iv)**

There are no "correct" number of staff who comprise the treatment team. The disciplines involved in the patient's treatment depend upon the problems to be treated, the short-term and long-range goals and the treatment approaches and modalities used to achieve the goals.

The intent of the regulation is to insure that each individual on the treatment team who is primarily responsible for ensuring compliance with particular aspects of the patient's individualized treatment program is identified. Identification of the staff should be recorded in a manner that includes the name and discipline of the individual. If other professionals or paraprofessionals provide care, the facility has the latitude to decide the manner with which it will identify them on the treatment plan.

The patient, as well as family/significant others, should be aware of the staff responsible for various aspects of treatment.

**Probes §482.61(c)(1)(iv)**

Are staff who are designated in the treatment plan observed carrying out treatment activities and therapies? Is the information in the plan consistent with surveyor observations?

Are the patients able to name the staff responsible for implementing their treatment? Is this information consistent with the treatment plan?

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**B124**

**§482.61(c)(1)(v) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.**

**Guidance §482.61(c)(1)(v)**

When the progress and treatment notes are reviewed, the content of the notes must relate to the treatment plan. The notes must indicate what the hospital staff is doing to carry out the treatment plan and the patient's response to the interventions.

**Probes §482.61(c)(1)(v)**

Are the treatment notes relative to the identified problems?

Are the treatment notes indicative of the patient's response to treatment?

Do the progress notes relate to specific patient problems or progress?

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**B125**

**§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.**

**Guidance §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.

### **Probes §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?

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## **§482.61(d) Standard: Recording Progress**

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### **B126**

**§482.61(d) Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the patient as specified in §482.12(c),**

#### **Guidance §482.61(d)**

Refer to [§482.61\(c\)\(2\)](#) Guidance for clarification between treatment notes and progress notes. The recording of progress is evidence of individual patient performance. Specifically, the progress notes recorded by the professional staff, or others responsible for the patient's treatment, must give a chronological picture of the patient's progress or lack of progress towards attaining short and long-range goals outlined in the individual treatment plan. Progress notes should relate to the goals of the treatment plan. Notes that state, "patient slept well" or "no complaints" constitute observations and do not indicate how the patient is responding to treatment and progressing towards set goals. Frequency alone does not determine the adequacy of progress notes. Expect to see greater frequency when patients are more acutely ill and/or in a crisis of some kind. Notes should be dated and signed (signature and title or discipline).

**Probes §482.61(d)**

Are the physicians who are significantly involved in **active treatment** modalities/interventions actually documenting progress?

Do the progress notes relate to the goals of the treatment plan? Do they include precise statements of progress?

Is there a correlation between what is observed by the surveyor and what is described in the notes?

Do the notes give a clear picture of the patient's progress or lack thereof, during the course of hospitalization?

In reviewing the patient's progress, are aftercare/discharge plans being evaluated?

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**B127**

**§482.61(d) nurse**

**Probes §482.61(d)**

Are the nurses who are significantly involved in **active treatment** modalities/interventions actually documenting progress?

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**B128**

**§482.61(d) social worker**

**Probes §482.61(d)**

Are the social workers that are significantly involved in **active treatment** modalities/interventions plan actually documenting progress?

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**B129**

**§482.61(d) when appropriate, others significantly involved in **active treatment** modalities.**

**Probes §482.61(d)**

Are staff from other disciplines, i.e., rehabilitative therapy and psychology, which are significantly involved in **active treatment** modalities/interventions actually documenting progress?

The discharge summary and/or plan should contain information about the status of the patient on the day of discharge, including psychiatric, physical and functional condition.

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## **B136**

### **§482.62 Condition of Participation: Special Staff Requirements for Psychiatric Hospitals**

**The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning.**

#### **Guidance §482.62**

The purpose of this Condition of Participation is to ensure that the psychiatric hospital is adequately staffed with qualified mental health professionals and supportive staff to carry out an intensive and comprehensive active treatment program and to protect and promote the physical and mental health of the patients.

Through observation, interview and record review determine if numbers and/or deployment of qualified staff is a concern. Review incident reports, medication error reports, patient and staff injury reports, for indications that staffing is an issue.

Adequate numbers are defined to mean the numbers, and deployment, of staff with qualifications to evaluate, plan, implement and document active treatment.

Do not look at numbers alone. The hospital is responsible for organizing its available staff and administrative duties along with patient appointments, treatment plan meetings, treatment sessions, activities, materials, equipment and patient assignments to wards and groups in such a way that results in patients achieving the maximum therapeutic benefit.

#### **Survey Procedure §482.62**

Assess the adequacy of the Special Staffing Condition by:

1. Observing sampled patients and others during structured sessions and in unstructured settings. You should be able to observe behavioral evidence of a rational organization of resources.
2. Next, interview patients and staff to determine whether or not necessary treatment modalities and other services are being provided in a timely manner.

3. Next review the medical records of patients in the sample to ascertain if necessary **active treatment** assessments, treatments, evaluations and activities have been conducted and documented.
4. Also, review other records such as restraint and seclusion records, incident reports, medication error reports, reports of patient/staff injuries, etc., to determine the extent to which staffing levels or deployment contributed to negative patient outcomes.
5. Evaluate all outcome data in light of the success or failure observed during the survey relevant to each patient receiving **active treatment**, and achieving desired outcomes of care. This is the primary basis for evaluating the adequacy of the hospital's staffing under this Special Condition.

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### **§482.62(a) Standard: Personnel**

**§482.62(a) The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:**

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#### **B137**

##### **§482.62(a)(1) Evaluate Patients**

##### **Probes §482.62(a)(1)**

Is there adequate staff to assure that the admission work-ups (assessment, diagnostic data gathering) are completed in a timely manner?

Is there evidence that there is continuing evaluation of the patient's progress and response to treatment?

Are evaluations delayed or absent?

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#### **B138**

##### **§482.62(a)(2) Formulate written individualized, comprehensive treatment plans;**

##### **Guidance §482.62(a)(2)**

Staffing must be sufficient so that members of the patient's treatment team and others responsible for evaluation and assessment can contribute their respective data for consideration in the formulation of the treatment plan.

## Probes §482.62(a)(2)

Was there sufficient discipline participation at the treatment team meeting to assure formulation of a treatment plan that meets the patient's individualized needs?

What problems prevent staff members from attending treatment meetings? Do they relate to staffing?

Are the assessments/evaluations absent or delayed to the extent that they are not useful to the treatment team for the purpose of planning individualized treatment?

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## B139

§482.62(a)(3) Provide **active treatment** measures;

Guidance §482.62(a)(3)

→ **Active treatment** occurs when the patient receives treatment interventions that are delivered under the direction of a physician, and which are specific to patient strengths, disabilities, and problems identified in the treatment plan. Treatment interventions and other services are furnished in accordance with accepted standards of professional practice. Although the **active treatment** process must be identifiable in documentation, it must be first and foremost observable and evident in daily practice.

Treatment interventions need to be individualized, in that the patient receives assistance with resolving or ameliorating the problems/circumstances that led to hospitalization. Expect to see treatment focused on the unique needs of individual patients. For example, several patients may be referred to "Anger Management Group," but the focus of discussion and therapeutic intervention may differ depending on the individual patient's particular issue regarding managing anger.

Whether structure must be imposed by staff or whether the patient can direct his or her own activities for periods of time (without staff supervision), is based on the patient's ability to engage in constructive, appropriate behavior (without engaging in harm to self or others). Be certain that the patient's time on the unit is maximized toward the further development of appropriate desired outcomes, including but not limited to leisure and recreation. ←

Probes §482.62(a)(3)

Through observation, interviews and record reviews, can you determine that patients receive **active treatment**?

Is the distribution of staff consistent with particular patient needs? Is appropriate staffing sufficient to carry out treatment plans?

Does the patient attend therapies that are relevant to the identified problems that brought the patient to the hospital?

Are staff absences and/or vacancies preventing the patient from receiving active treatment? Are patients not attending therapeutic activities off the unit because there is no staff to escort them? Are therapeutic groups not available on the unit for patients who are not able to go off the unit?

Are patients observed not engaged in activities while staff attend to administrative tasks?

Are active treatment sessions or activities carried out at discrete time intervals exclusively? Or is active treatment implemented as the patient's needs emerge during the course of the day, as well?

Does a review of quality assurance data reveal a pattern of serious incidents occurring on particular shifts and/or days of the week?

What do patients report to the surveyor are their treatment modalities?

Do patient interviews indicate that patients believe the treatment being provided is helpful?

Does the scheduling of activities and their content relate directly to the patient's treatment objectives or are the activities/content generalized, non-therapeutic "time-fillers"?

Can staff describe how their activities relate to the patient's treatment objectives?

At any point in time, in any of the patient's experiences in the hospital is the thrust of the patient's treatment plan observable during the staff and/or patient interactions?

Is there a consistent, observable pattern of evidence that hospital staff provide, reinforce and otherwise implement measures to achieve active treatment objectives?

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## **B140**

### **§482.62(a)(4) Engage in discharge planning;**

#### **Guidance §482.62(a)(4)**

The patient together with all relevant professionals caring for the patient should be expected to participate in the discharge planning process. Staffing should be sufficient to facilitate this outcome, to the maximum extent possible.