§709.61. Exceptions to the general standards for free-standing treatment activities.

Due to the nature of this detoxification activity, projects of this kind need not comply with §709.24(a)(2) and (3) (relating to treatment/rehabilitation management).

§709.62. Intake and admission.

(a) The project director shall develop a written plan providing for intake and admission which includes, but is not limited to:

(1) Criteria for admission.

Criteria should include age, sex, physical and/or mental conditions, geographic requirements and nature of the D/A problem. Any special project limitations should also be noted, e.g., serving the handicapped, psychotic, non-English speaking populations.

(2) Treatment methodology.

Examples – individual, group, antabuse, or other medication.

(3) Requirements for completion of treatment.

Requirements for completion of treatment should be viewed from both the project and the client perspectives, etc.

(4) Involuntary discharge/termination criteria.

Examples – involuntary discharges and administrative discharges.

(b) Intake procedures other than initial medical care shall be performed at a time when the immediate physiological effects of drug and alcohol abuse have subsided.

(c) Intake procedures shall include documentation of the following:
(1) Disclosure to the client of criteria for admission, treatment, completion and discharge.

*Disclosure could be documented in initial progress notes, in the consent to treatment, or orientation packet.*

(2) Client orientation to the project which includes, but is not limited to a familiarization with:

*See c (1) above for acceptable documentation of client orientation.*

(i) Project policies, which include the following:

*Project rules and requirements related to treatment.*

(ii) Hours of operation.

(iii) Fee schedule.

(iv) Services provided.

(3) Histories, which include the following:

*Histories should be constructed to collect as much personal information about a client as possible since they form the basis from which the psychosocial evaluation and subsequent treatment plans are formulated.*

(i) Medical history.

*A history documenting the client’s personal medical history, family medical history, and history of illness and symptoms.*

(ii) Drug or alcohol history, or both.

*A history documenting the substances most frequently abused, the length and patterns of use, prior treatment episodes. Include the client’s perception of their effect on his/her social, physical and mental state. It is recommended that any substance abuse history within the family, or that of significant others be noted.*

(iii) Personal history.

*Historical and current personal data including: family, legal, employment/vocational, educational, military, recreational, sexual, and others where appropriate.*
(iv) Consent to treatment.

A consent to treatment form should be signed by the client and staff person at intake. This consent could be integrated with other forms/procedures, e.g., liability determination, preliminary treatment plan, intake and orientation verification.

(v) Physical examination.

The results of the physical examination should be documented according to the following: evidence of injuries, serial neurological examination, an investigation of the organ systems for possibilities of infectious disease, pulmonary, liver, and cardiac abnormalities, dermatologic sequelae of addiction, and concurrent problems. In addition, the physical examination should include a determination of the patient’s vital signs (temperature, pulse, and blood pressure and respiratory rate); an examination of the client’s general appearance, head, ears, eyes, nose, throat (thyroid), chest (including heart, lungs and breasts), abdomen, extremities, skin assessment, and the project physician’s overall impression of the client.

The project should make every effort to utilize results of physicals in determining related medical care needed and the appropriateness of client involvement in all project activities.

It is recommended that the following laboratory tests be completed for each client at admission to a project in addition to the required examination stated in the above paragraph:

- **STAT blood alcohol level**;
- **Complete blood count and differential**;
- **Blood or urine drug screen for the detection of multiple drug use**;
- **Serological test for syphilis**;
- **Routine and microscopic urinalysis**;
- **Liver function profile, e.g., SMA-12, etc.**;
- **Tuberculin skin test, and when positive, a chest X-ray**;
- **When clinically indicated, Australian Antigen HG Ag Testing (HAA testing), EKG; and**,
• When appropriate, pregnancy test and a pap smear.

When a client is readmitted to a project within one year, the physical exam or lab tests should be at the discretion of the physician.

(vi) Psychosocial evaluation.

The evaluation should provide a composite picture of the individual in relationship to the collected historical information in order to identify possible relationships, conditions and causes leading to the client’s current situation.

§709.63. Client records.

(a) There shall be a complete client record on an individual which includes information relative to the client’s involvement with the project. This shall include, but not be limited to the following:

(1) Consent forms.

A copy of any and all consent forms signed by the client while undergoing treatment (intake through discharge) should be maintained in the client record.

(2) Drug and alcohol support plan.

A plan that reflects the project’s efforts to support and motivate the client to seek formal treatment after the detoxification process. This plan should delineate methods the project plans to use to cope with denial, to promote better understanding of chemical dependency and to encourage client participation in formal treatment.

(3) Progress notes.

There should be a progress note after each significant client contact.

All progress notes should be dated and signed by the individual making the entry.

Progress notes should include data, assessment and plans relative to treatment.

• The data should include information presented by the client during the counseling session, counselor observations and information about the client from other sources.
• The assessment is the interpretative statement(s) based upon both new and previous information and includes the counselor’s analysis of and conclusions regarding the client’s current situation or status.

• The plan (strategies) should reflect the counselor’s actions to be taken in light of the evaluation and indicate the direction of treatment and include action steps, counselor plan(s) and client assignments or tasks.

• If group sessions are conducted, individual notes need not be written for each client. One group note will suffice provided that it includes a comment relative to each individual’s response or participation in the group session.

(4) Medication records.

All medications being taken by a client whether prescribed by the project’s physician or the client’s private physician should be recorded in the chart indicating the name of the drug, dosage, and frequency of use.

[Note: Where projects act as custodians of a client’s medication, a log should be maintained including: the client name, type of medication, amount, time and date, and staff signature. Refer to section on Medication Control.]

(5) Record of services provided.

This should be a chronological listing (separate from progress notes) of the various specific services provided to the individual client. This listing should also include the date, the provider(s), and the duration of the service.

(6) Aftercare plan, if applicable.

A plan for clients to follow after they leave formal treatment. It is the client’s individual plan for the future, including an identification of the client’s personal goals and objectives. It should focus on sustaining and building on the progress achieved during treatment and should have input from all significant persons, especially the client. The plan should include:

• The client’s future goals with time frames.

• A description of the services that can be provided by the project after discharge, if necessary.

• The method and frequency of continuing contact to provide client support.

• Criteria for re-entry into the project.
• Provision for the periodic re-evaluation and termination of the plan.

Aftercare plans are not required where clients have left treatment against project advice or refuse to participate in an aftercare plan. Plans are also not required if a client is being referred to another facility for further treatment. In this case, follow-up should suffice. This action should be documented in the client record.

(7) Discharge summary.

Within one week after discharge, there should be entered into the client’s case record a discharge summary describing the reasons for treatment, services offered, response to treatment and client’s status or condition upon discharge.

(8) Follow-up information.

When a client has been discharged and referred to an outside resource, the project should, with the written consent of the client and within one week from the day the referral is to be completed, attempt to determine from the resource the disposition of the referral. Once the attempt has been made and documented, a project may consider its obligation to the individual fulfilled.

Where clients are not referred after discharge, some attempt should be made to follow-up the ex-client’s progress and status in accordance with the agency’s written policy.

(9) Verification that work done by the client at the project is an integral part of the client’s drug and alcohol support plan.

Exception – Client’s cleaning of personal living space.

(10) Documentation of special dietetic needs, if applicable.

(b) The project shall develop and maintain client records on standardized project client record forms.

§709.64. Project management services.

(a) The inpatient nonhospital project shall have written policies and procedures for its dietetic services which shall include, but not be limited to the following:

(1) Purchasing of food and equipment.

(2) Receiving, storing and preserving of food stuff.

(3) Proper preparation of food.
(4) Safety and sanitation, including the preparation, handling and storage of foods; the care and cleaning of dishes, utensils and work area.

(5) Personal hygiene for those in food preparation areas.

(6) Special dietary needs.

(b) The project shall develop a written plan that delineates specific service planning and counseling approaches used to promote client interest in participating in necessary treatment, following the detoxification process.

The plan should include specific methods of client management and counseling designed to cope with denial, promote better understanding of chemical dependence and to encourage client continuation in additional treatment.

(c) The project shall assist the client in obtaining the following supportive services when necessary:

Examples of documentation may include letters of agreement/understanding, referral log, progress notes, etc.

(1) Medical/dental.

(2) Psychiatric.

(3) Legal.

   e.g., court representation, bail services, legal assistance.

(4) Economic.

   e.g., housing, income, food supplements, general medical assistance, transportation.

(5) Educational.

(6) Vocational.

(7) Recreational/social.

   e.g., organized group activities, games, arts and crafts.

(d) The project shall develop a written client aftercare policy.

The policy should indicate the staff members responsible for the aftercare plan, when and how it is to be developed and the format to be used.
(e) The project shall develop a written client follow-up policy.

The policy should note who is responsible, method and frequency of contact and the manner of documentation.

(f) The project shall develop a written plan providing for outreach services which shall include, but not be limited to:

(1) Identifying persons in need of project services.

(2) Alerting persons and their families to the availability of project services.

(3) Encouraging persons to utilize the service delivery system.