

**CHAPTER 37**

**COMMUNITY MENTAL HEALTH SERVICES ACT**

**Authority**

N.J.S.A. 30:9A-10

**Source and Effective Date**

R.1995 d.596, effective October 26, 1995.  
See: 27 N.J.R. 2666(a), 27 N.J.R. 4715(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 37, Community Mental Health Services Act expires on October 26, 2000.

**Chapter Historical Note**

Chapter 37, Community Mental Health Services Act, was originally filed prior to September 30, 1969. Chapter 37 was amended by R.1974 d.69, effective March 21, 1974. See: 6 N.J.R. 66(b), 6 N.J.R. 151(a). Amendments were made at N.J.A.C. 10:37-6.3, formerly "Definitions," and N.J.A.C. 10:37-7.3, formerly "System of per capita allocation" by R.1976 d.133, effective May 4, 1976. See: 8 N.J.R. 119(b), 6 N.J.R. 286(b). Former Subchapter 12, "Conditions governing state grants for construction assistance for community mental health facilities," was adopted as new rules by R.1977 d.482, effective December 23, 1977. See: 9 N.J.R. 531(a), 10 N.J.R. 63(d). Chapter 37 was repealed and replaced with new rules by R.1980 d.479, effective November 3, 1980. See: 12 N.J.R. 580(a), 12 N.J.R. 704(g). Pursuant to Executive Order No. 66(1978), Chapter 37 was readopted by R.1985 d.605, effective November 4, 1985. See: 17 N.J.R. 2222(a), 17 N.J.R. 2894(a). Pursuant to Executive Order No. 66(1978), Chapter 37 was readopted by R.1990 d.591, effective November 2, 1990. See: 22 N.J.R. 2915(a), 22 N.J.R. 3620(a). Subchapter 12, Children's Partial Care Programs, was adopted as new rules by R.1993 d.355, effective July 19, 1993. See: 25 N.J.R. 669(a), 25 N.J.R. 3209(a). Subchapter 9, Quality Assurance, and Subchapter 10, Site Review and Certification, were adopted as new rules by R.1993 d.412, effective August 16, 1993. See: 25 N.J.R. 2193(a), 25 N.J.R. 3782(a). Pursuant to Executive Order No. 66(1978), Chapter 37 was readopted as R.1995 d.596, effective October 26, 1995. See: Source and Effective Date. See, also, section annotations.

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**APPENDIX A CONTINUUM OF MENTAL HEALTH SETTINGS**

**SUBCHAPTER 1. INTRODUCTION AND PURPOSE**

**10:37-1.1 Introduction and purpose**

(a) Since the enactment of the Community Mental Health Services Act in 1957, there has been a broad expansion of public funding sources administered by the State and utilized to support community mental health services. In addition to grant-in-aid, there are funds from Title XX of the Federal Social Security Act, State Community Care and Screening purchase of service contracts, the State Capital Improvement Program and two State-funded demonstration community mental health centers. This amended chapter represents an integration of these multiple funding sources and the minimal requirements that are applicable to all of them. These requirements are conceptually based upon the Division's four operating principles: Normalization, Level of Functioning, Advocacy and Unified Services, which are described in a companion document titled "Principal Statement." Within the context of these principles, however, the Division encourages innovative implementation and a variety of comprehensive service models, developed in response to local needs and talents.

(b) Wherever the "Department" is cited, the term shall refer to the New Jersey Department of Human Services; wherever the "Division" is cited, it shall refer to the New Jersey Division of Mental Health and Hospitals. Subsequent to a period of public review and comment, this chapter shall become effective on November 3, 1980; it will be incorporated into guidelines for the Division's ongoing site visit, monitoring, program development and evaluation activities for community mental health grants and contracts. Compliance with this chapter shall be required one year from its effective date, as of July 1, 1981. It is anticipated that total compliance will necessitate, in some instances, a reorganization of service components and priorities by participating agencies. It is for that reason that the Department is extending the implementation and compliance deadline for one year, in order to allow for local phase-ins and for technical assistance to be provided by the county mental health boards and the Division.

2. Consider the range of services available within that Service Area and identify:

- i. The service needs of that client; and
- ii. The least restrictive setting available to meet those needs.

3. Consider alternatives in the following sequence:

i. Natural support systems: The client's living arrangement and the people who usually provide support to him/her in crisis. If no such people are readily identified, the staff may help the client to develop a natural support network with someone with whom there seems to be good potential for supportive contact.

(1) If the natural support system is unable to meet the client's needs in a timely manner, formal community services should be explored and used.

ii. Community services: These services should be explored and arranged as follows:

(1) Generic services/community supports: Income maintenance, housing, health, transportation, etc., shall be arranged when necessary, with the mental health Program Element acting as advocate and service procurer. In the cases of DYFS clients who are children, the primary advocate and service procurer/coordinator should be the DYFS worker.

(2) Mental health services: If the client's needs cannot be met by his/her natural environment or by the generic services available in the Service Area and client need dictates, the client shall be provided with local community mental health services, either by the intake agency, or through alternative arrangements with other mental health Program Element providers in the Service Area. The least restrictive alternative, i.e., ambulatory Outpatient Program Elements, should be emphasized over more restrictive, i.e., inpatient alternatives, as appropriate.

iii. Division of Youth and Family Services (DYFS) residential network: Residential services provided directly and through contract by DYFS are appropriate for placement of children whose natural support setting is no longer sufficient to maintain a child in his/her home. Mental Health support services shall be provided, as needed, by mental health providers.

iv. Institutional: Local, inpatient units in general hospitals should be emphasized over less local settings, such as a county hospital. County psychiatric hospitals shall be the preferred setting, rather than a Regionalized State hospital, in Service Areas where General Hospital inpatient units are not available. The community mental health agency in that Service Area shall then work with the Hospital to maximize the therapeutic benefit of the IPU stay while also beginning discharge planning as quickly as possible.

#### Case Notes

Right to treatment in least restrictive setting. See *Scott v. Plante*, 641 F.2d 117 (3rd Cir.1981) certiorari granted, vacated 102 S.Ct. 3474, 458 U.S. 1101, 73 L.Ed.2d 1362, on remand 691 F.2d 634. In re Hospitalization of Patterson and Bohuk, 156 N.J.Super. 91, 98, 383 A.2d 467 (App.Div.1978), certification denied, 77 N.J. 469, 391 A.2d 484 (1978).

#### 10:37-6.50 through 10:37-6.52 (Reserved)

#### 10:37-6.53 Medication counseling

(a) All State funded Mental Health Program Elements using medication as a therapeutic modality shall regularly provide counseling services aimed at informing clients about medication(s). Medication counseling shall be included within the service plan of each client for whom psychotropic medication has been prescribed.

(b) As part of their medication counseling, such clients shall receive an individual written medication information fact sheet for each prescribed medication. The Division shall, if requested by an agency, supply a standard format for these fact sheets. Clients shall also have the opportunity to participate in a planned program of self-medication which shall teach clients to administer their own prescribed medication dosage and to report side effects promptly. Explanations shall also include:

1. Types of medication prescribed;
2. Name of medication(s), dosage(s), and time to take medication(s);
3. Effects of medication(s), including expected benefits, risks, and side effects;
4. Prescriptions;
5. Whom to go to with questions (e.g., physician, nurse, pharmacist);
6. Reimbursement options for medication purchases;
7. Reasons for regular medical check-ups at recommended intervals.

(c) Medication counseling should occur whenever a different psychotropic medication is prescribed. Counseling may be provided by any member of the treatment team, or by a community or consulting pharmacist; however, counseling should be coordinated with the physician prescribing the client's medications.

#### 10:37-6.54 Psychotropic medication

(a) Definition: "Psychotropic medication" shall include medications which exercise direct effect upon the central nervous system and are capable of modifying behavior and/or mood. Drugs included, within the context of these regulations and guidelines, are:

1. Anti-psychotics;
2. Anti-depressants;

3. Agents for control of mania and depression, such as lithium;
4. Anti-anxiety agents;
5. Anti-parkinsonian agents;
6. Psychomotor stimulants.

(b) Requirements and procedural guidelines:

1. Clients shall have the right to refuse medication and to be free from unnecessary or excessive medication.

2. Medication shall not be used as punishment, for the convenience of staff, as a substitute for other appropriate treatment, nor in quantities that interfere with the client's total treatment program.

3. All medication shall be prescribed for specified periods of time; initial prescriptions shall be written with a termination date not to exceed 30 days.

4. Medications shall be prescribed only on a written order of a physician or by emergency phone order, provided that the physician countersigns the order within 24 hours.

5. When possible, before prescribing medication an individual's drug history should be obtained and should include consideration of the use of all drugs by the client, a medical history, as well as the presence of any drug allergies. Communication shall occur between the physician treating the behavioral disorder and other physicians who may be treating other diseases in the same client, to avoid serious drug interactions.

6. All medication prescriptions should be correlated with a physical examination of the client. Outpatient programs should encourage clients to obtain such an examination from their private physician or a neighborhood health clinic. Inpatient physical examinations and related laboratory work-ups should be ordered.

7. For those clients on long-term therapy with neuroleptic agents, particular attention should be paid to signs of tardive dyskinesia. This risk appears to be greatest in elderly clients, especially females, children, people with organic brain syndrome and retarded adults.

8. Progress notes and/or a checklist for citing medication reactions should be in each client's chart. This documentation should be completed on admission, updated on the appearance of abnormal signs, and notes made each time the medication is reviewed.

9. Target symptoms and behavioral problems to be treated should be recorded in the client's record, as a baseline against which the client's clinical condition is evaluated. Effects of medication on the target symptoms and behavior should be reviewed and recorded regularly, as specified by J.C.A.H. or more often if clinically indicated.

10. Adequacy of initial dosage should be cautiously and individually determined.

11. A psychotropic drug should be administered for a sufficient period of time to determine its clinical effectiveness before shifts in medication occur. In general, a period of three to six weeks may be required before significant improvement in clinical behavior is observed, unless, in acute cases, the client's management problems are so severe that a change in medication in shorter periods is necessary.

12. Dosage should be gradually reduced to the minimum maintenance dose after the desired clinical result is obtained and the client's condition has stabilized.

13. In the use of anti-psychotic and anti-depressant drugs, a drug-free period (two days, a week, etc.) may be established for clients where this is possible or desirable.

14. The continuing use of anti-anxiety agents is not generally justifiable because their effectiveness is short-lived. Only that anxiety which markedly interferes with human performance should be drug treated and then only with drugs that are not tolerance or dependence forming.

15. If dosage levels significantly in excess of the maximum listed in the AMA Drug Evaluation, Physician's Desk Reference, or in ASHP Formulary Services are used, the medical rationale shall be documented in the client's clinical record. Such documentation must include the process of informed consent given by the client or his/her guardian.

16. The use of psychotropic drugs in children, should be carefully scrutinized given that generally, long-term toxicity studies pertinent to the growing child are unavailable. In those situations where the manufacturer and/or the Food and Drug Administration do not recommend certain dosage levels, or where a specific medication is not approved for children, in spite of its apparent clinical effectiveness, the physician should seek a second opinion in writing from a qualified child psychiatrist, pediatrician, or clinical pharmacologist. Written consent must be secured from the parents or guardians.

17. Generally, only one psychotropic drug should be prescribed at one time. Combinations do not permit the identification of the offending drug, if side effects occur. Drug consultations may be indicated when combined medications are used.

18. Because of potential serious toxicity, lithium should be used only after a complete history, physical examination and laboratory assessment of the client. The procedural requirements which follow are being actively studied and may be amended at a later time.

i. Essential components of the work-up needed before lithium use include:

(1) History of previous use of lithium, with particular attention to evidences of lithium sensitivity;

(2) A Medical history, with attention given to evidence of cardiac, renal or thyroid disease;

(3) Appropriate laboratory tests confirming adequate kidney functioning;

(4) Cardiac evaluation, such as an electrocardiogram; and

(5) Appropriate thyroid assessment, as indicated by history and physical, including appropriate laboratory studies.

ii. Maintenance procedures required with the use of lithium:

(1) The physician should evaluate the client for clinical signs and symptoms of drug efficacy and for any side effects.

(2) APA guidelines for laboratory work shall be followed.

19. A scheduled formal review of each client's drug treatment plan shall be conducted on a regular basis dependent on client needs. The physician and direct care personnel should be involved in the review. Results of these reviews and new treatment recommendations shall be recorded in the client's record at intervals in conformance with J.C.A.H.

20. Clinical psychopharmacology consultants should be designated for the purpose of helping in-house staff with ongoing medication problems (dosages, new drugs, new reactions, drug interactions, etc.), as well as developing in-house training seminars to discuss chemotherapy, to include staff responsible for all mental health Program Elements.

21. Consent requirements: Psychotropic medication may be administered to an adult client only after he/she has given voluntary consent to that specific medication. Consent to a specific medication shall remain effective as long as the client is receiving services, unless it is revoked by the client.

i. A client is considered to have given consent to medication only after:

(1) A treatment team member has discussed with the client the nature of his/her condition, the anticipated benefits of the medication prescribed and the risks and side effects of such medication.

(2) A treatment team member has provided the client with a consent form and medication fact sheet for the medication prescribed, and has offered to answer questions. Upon request, the Division may supply a standard fact sheet format for agency distribution to clients.

(3) The client has given written or oral consent to the medication or, by affirmative behavior, has given evidence of his/her willingness to accept the medi-

cation. The client's consent or behavior must be documented by a treatment team member on the consent form.

22. Revocation of consent: A client may revoke consent to a specific medication by stating or writing to any physician or nurse that he/she does not wish to take that medication.

i. Each such refusal to take a specific medication shall be documented on the consent form, and in the client's record.

ii. If the client subsequently indicates a willingness to consent to such medication, he/she may do so, pursuant to the procedures in (b)21i(3) above.

23. Emergency exceptions to consent requirements:

i. Psychotropic medication may be administered to a voluntary or involuntary client without written consent, and despite oral refusals, if a psychiatrist certifies that the medication is necessary to prevent a substantial likelihood of imminent, serious harm to the client or others.

ii. The administration of psychotropic medication in such an emergency shall be documented in the client's record.

24. Additional requirements for administration of medication may be forthcoming from the Division, given pending court cases involving issues directly related to the administration of medication.

25. Concerning voluntary patients/clients: When a voluntary patient/client refuses medication and the treating physician feels that medication is essential to that individual's care, the physician has the right to submit written notice to the patient/client and relieve him/herself of further medical responsibility for the care of that individual. The program should, however, attempt to link the client with other program staff or agencies which can meet the client's critical life support needs.

#### Case Notes

Right to refuse medication. See *Rennie v. Klein*, 476 F.Supp. 1294 (D.N.J.1979) stay denied in part, granted in part 481 F.Supp. 552, modified, remanded 653 F.2d 836, certiorari granted, vacated 102 S.Ct. 3506, 458 U.S. 1119, 73 L.Ed.2d 1381, on remand 720 F.2d 266 (decided on statutory grounds.)

#### 10:37-6.55 through 10:37-6.72 (Reserved)

#### 10:37-6.73 Scope and purpose

(a) A written record shall be maintained for each client served. The record shall:

1. Describe the client's status at service initiation, a comprehensive needs assessment, services provided and progress made, and the client's functional ability and status at the time of discharge from a Program Element, with followup/transfer or additional linkages noted as part

of Individual Service Plan (ISP). (See Article VIII of this subchapter.)

2. Substantiate that the assessment process served as the basis for the service plan.
3. Serve as a basis for service coordination, implementation, evaluation, quality assurance, and training.
4. Be current and accurate.
5. Facilitate the determination of the client's problems and the service which is being provided at any specified time.
6. Provide documentation of the staff's having followed regulations concerning client rights. (See N.J.A.C. 10:37-4.5.)
7. Provide documentation of the involvement of the client, parents, siblings, school personnel, employer, friends, community agencies and other significant figures involved in the client's service/treatment plan.

#### 10:37-6.74 Required contents for all records

(a) The contents of the record shall contain the following information:

1. The identifying and other data indicated on the Division's Unified Services Transaction Form for enrolled and terminated clients. (See Article XIV of this subchapter.)
2. Comprehensive assessment and evaluation (see Division's Service Dictionary for detailed description) of client needs, including level of functioning and a natural support resource inventory for all clients.
3. A social, psychological, and/or a psychiatric mental status evaluation, as needed.
4. Individual service plan with updated revisions. (See Article VIII of this subchapter.)
5. Clinical diagnosis based on the clinical evaluation of the client.
6. Client and/or family consent for a service initiation, record sharing, evaluation, and/or research, as necessary.
7. Utilization Review Committee meeting notes which include the attendees, recommendations made, and actions taken.
8. Medications (see Article X of this subchapter).
9. Laboratory or other diagnostic procedures.
10. Unusual incidents, occurrences (see Article XIX of this subchapter) such as:
  - i. Treatment complications;
  - ii. Accidents or injuries;
  - iii. Morbidity;

iv. Death of a client; and

v. Procedures placing the client at risk or causing pain/harm. (See Article XIX of this subchapter.)

11. Correspondence related to the client and signed, dated notations of relevant contacts regarding the client's service/treatment.

12. Discharge or transfer summary in addition to the discharge plan which shall also be developed with the client and completed within 30 days of last service.

13. The record shall contain documentation of procedures that place clients at risk or in pain including, but not limited to restraint, seclusion; and/or behavior modification using painful stimuli. Such records shall document the justification for the use of the procedure, attempts of staff to provide alternatives, the specific procedures employed, the required authorization, and the measures taken to protect the client's safety and rights.

14. All entries in the record shall be legibly signed and dated.

#### 10:37-6.75 Inpatients records: supplementary content requirements

(a) Inpatient records in State, county, and State funded general hospital psychiatric units shall include all information cited above. Additional information necessary to meet State licensure and federal accreditation shall also include:

1. Results of evaluations and services: Psychological testing, educational and socio-vocational evaluations, pathology and clinical laboratory examinations, radiology examinations, psychiatric and other medical treatment, and any other diagnostic or therapeutic procedure performed.

2. Psychiatric evaluation: Mental status, psychodynamics, sociodynamics, precipitating stress, premorbid personality, tentative diagnosis, a treatment plan, prognosis based on that plan, and subsequent modifications of the plan.

3. Physical examination if performed, shall include pertinent findings.

4. Admission notes: All additions to the history and subsequent changes in the physical findings.

5. Progress notes: Written by medical staff members or other individuals who have been granted clinical privileges, nursing staff, the interdisciplinary treatment team members, consultants, community liaison staff, and/or ancillary service staff.

6. Progress notes: By staff cited in (a)5 above, documenting the treatment plan, a pertinent chronological report of the client's functional abilities and clinical condition, changes in each condition and the results of service/treatment. Progress notes should include only pertinent, meaningful observations and information.