

History Tracking Report: 2009 to 2010 Requirements

Accreditation Program: Behavioral Health Care

2009 Chapter: Management of Information

Standard IM.1.10

2009 Standard Text:

The {jc}organization{/2} plans and designs information management processes to meet internal and external information needs.

2009 Standard: IM.1.10

2009 EP: 1

2009 EP Text:

Revision Type: Split

The {jc}organization{/2} bases its information management processes on an assessment of internal and external information needs. The assessment identifies the flow of information throughout {jc}an organization{/5}, including information storage and feedback mechanisms. The assessment identifies the data and information needed: within and among services, or programs; within and among the staff, the administration, and the governance for supporting relationships with outside services and contractors; with licensing, accrediting, and regulatory bodies; with purchasers, payers, and employers; for supporting informational needs between the {jc}organization{/2} and the {jc}patients{/6}; and for participating in research and databases.

2009 Standard: IM.1.10

2009 EP: 1

2009 EP Text:

Revision Type: Split

The {jc}organization{/2} bases its information management processes on an assessment of internal and external information needs. The assessment identifies the flow of information throughout {jc}an organization{/5}, including information storage and feedback mechanisms. The assessment identifies the data and information needed: within and among services, or programs; within and among the staff, the administration, and the governance for supporting relationships with outside services and contractors; with licensing, accrediting, and regulatory bodies; with purchasers, payers, and employers; for supporting informational needs between the {jc}organization{/2} and the {jc}patients{/6}; and for participating in research and databases.

Standard IM.01.01.01

2010 Standard Text:

The organization plans for managing information.

2010 Standard: IM.01.01.01

2010 EP: 1

2010 EP Text:

The organization identifies the internal and external information needed to provide safe, quality care.

2010 Standard: IM.01.01.01

2010 EP: 2

2010 EP Text:

The organization identifies how data and information enter, flow within, and leave the organization.
 Note: The flow of data and information within the organization includes how it moves into and out of storage.

<p>2009 Standard: IM.1.10 2009 EP Text: To guide development of processes for managing information used internally and externally, the {jc}organization{/2} assesses its information management needs based on the following: Its missionIts goalsIts servicesStaff{jc}Patient{/1} safety considerationsQuality of care, treatment, and services Mode(s) of service deliveryResourcesAccess to affordable technologyIdentification of barriers to effective communication among caregivers</p>	<p>2009 EP: 2 Revision Type: Retain</p>	<p>2010 Standard: IM.01.01.01 2010 EP Text: The organization uses the information identified to guide development of processes to manage information.</p>
<p>2009 Standard: IM.1.10 2009 EP Text: The {jc}organization{/2} bases its management, staffing, and material resource allocations for information management on the scope and complexity of care, treatment, and services provided.</p>	<p>2009 EP: 3 Revision Type: Delete:NE</p>	<p>2010 Standard: N/A 2010 EP Text: No EP</p>
<p>2009 Standard: IM.1.10 2009 EP Text: Identified staff participates in assessment, selection, integration, and use of information management systems for clinical/service and {jc}organization{/2} information.</p>	<p>2009 EP: 4 Revision Type: Retain</p>	<p>2010 Standard: IM.01.01.01 2010 EP Text: The organization selects staff to participate in the assessment, selection, integration, and use of information management systems for the delivery of care, treatment, or services.</p>
<p>2009 Standard: IM.1.10 2009 EP Text: The organization has an ongoing process to assess the needs of the organization, programs and services, and individuals for knowledge-based information.</p>	<p>2009 EP: 5 Revision Type: Delete:Redun</p>	<p>2010 Standard: N/A 2010 EP Text: No EP</p>
<p>2009 Standard: IM.1.10 2009 EP Text: The {jc}organization{/2} uses the assessment for knowledge-based information as a basis for planning.</p>	<p>2009 EP: 6 Revision Type: Delete:NE</p>	<p>2010 Standard: N/A 2010 EP Text: No EP</p>

Standard IM.2.10

2009 Standard Text:

Information privacy and confidentiality are maintained.

2009 Standard: IM.2.10

2009 EP: 1

2009 EP Text:

Revision Type: Retain

The {jc}organization{/2} has a written policy(ies) for addressing the privacy* and confidentiality** of information, that is based on and consistent with law or regulation.*Privacy An individual's right to limit the disclosure of personal information.**Confidentiality The safekeeping of data/information so as to restrict access to individuals who have need, reason, and permission for such access.

2009 Standard: IM.2.10

2009 EP: 2

2009 EP Text:

Revision Type: Delete:NE

The {jc}organization{/2}'s policy, including changes to the policy, has been communicated to staff.

2009 Standard: IM.2.10

2009 EP: 3

2009 EP Text:

Revision Type: Retain

The {jc}organization{/2} implements the policy.

2009 Standard: IM.2.10

2009 EP: 4

2009 EP Text:

Revision Type: Retain

The {jc}organization{/2} monitors compliance with the policy.

2009 Standard: IM.2.10

2009 EP: 5

2009 EP Text:

Revision Type: Delete:NE

The {jc}organization{/2} improves privacy and confidentiality of information by monitoring information and developments in technology

Standard IM.02.01.01

2010 Standard Text:

The organization protects the privacy of health information.

2010 Standard: IM.02.01.01

2010 EP: 1

2010 EP Text:

The organization has a written policy addressing the privacy of health information. (See also RI.01.01.01, EP 7)

2010 Standard: N/A

2010 EP Text:

No EP

2010 Standard: IM.02.01.01

2010 EP: 2

2010 EP Text:

The organization implements its policy on the privacy of health information. (See also RI.01.01.01, EP 7)

2010 Standard: IM.02.01.01

2010 EP: 5

2010 EP Text:

The organization monitors compliance with its policy on the privacy of health information. (See also RI.01.01.01, EP 7)

2010 Standard: N/A

2010 EP Text:

No EP

<p>2009 Standard: IM.2.10 2009 EP Text: Individuals for whom identifiable clinical/service data and information are maintained or collected are made aware of how the data will be used and whether it will be disclosed.</p>	<p>2009 EP: 6 Revision Type: Delete:Redun</p>	<p>2010 Standard: N/A 2010 EP Text: No EP</p>
<p>2009 Standard: IM.2.10 2009 EP Text: Personal identifiers are removed to the extent possible for uses and disclosures of clinical/service information, consistent with maintaining the usefulness of the information.</p>	<p>2009 EP: 7 Revision Type: Delete:NE</p>	<p>2010 Standard: N/A 2010 EP Text: No EP</p>
<p>2009 Standard: IM.2.10 2009 EP Text: Protected clinical/service information* is used for the purposes identified or as required by law or regulation and not further disclosed without client authorization.*Protected clinical/service information Clinical/service information that contains information such that an individual person can be identified as the subject of that information.</p>	<p>2009 EP: 8 Revision Type: Split</p>	<p>2010 Standard: IM.02.01.01 2010 EP: 3 2010 EP Text: The organization uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. (See also MM.01.01.01, EP 1; RI.01.01.01, EP 7)</p>
<p>2009 Standard: IM.2.10 2009 EP Text: Protected clinical/service information* is used for the purposes identified or as required by law or regulation and not further disclosed without client authorization.*Protected clinical/service information Clinical/service information that contains information such that an individual person can be identified as the subject of that information.</p>	<p>2009 EP: 8 Revision Type: Split</p>	<p>2010 Standard: IM.02.01.01 2010 EP: 4 2010 EP Text: The organization discloses health information only as authorized by the individual served or as otherwise consistent with law and regulation. (See also RI.01.01.01, EP 7)</p>
<p>2009 Standard: IM.2.10 2009 EP Text: The {jc}organization{/2} preserves the privacy and confidentiality of data and information identified as sensitive.</p>	<p>2009 EP: 9 Revision Type: Delete:Redun</p>	<p>2010 Standard: N/A 2010 EP Text: No EP</p>

Standard IM.2.20

2009 Standard Text:

Information security, including data integrity, is maintained.

2009 Standard: IM.2.20

2009 EP: 1

2009 EP Text:

Revision Type: Split

The {jc}organization{/2} has a written policy(ies) for addressing information security, including data integrity* that is based on and consistent with law or regulation. *Integrity In the context of data security, data integrity means the protection of data from accidental or unauthorized intentional change.

2009 Standard: IM.2.20

2009 EP: 1

2009 EP Text:

Revision Type: Split

The {jc}organization{/2} has a written policy(ies) for addressing information security, including data integrity* that is based on and consistent with law or regulation. *Integrity In the context of data security, data integrity means the protection of data from accidental or unauthorized intentional change.

2009 Standard: IM.2.20

2009 EP: 2

2009 EP Text:

Revision Type: Delete:NE

The {jc}organization{/2}'s policy, including changes to the policy, has been communicated to staff.

2009 Standard: IM.2.20

2009 EP: 3

2009 EP Text:

Revision Type: Retain

The {jc}organization{/2} implements the policy.

2009 Standard: IM.2.20

2009 EP: 4

2009 EP Text:

Revision Type: Retain

The {jc}organization{/2} monitors compliance with the policy.

2009 Standard: IM.2.20

2009 EP: 5

2009 EP Text:

Revision Type: Delete:NE

The {jc}organization{/2} improves information security, including data integrity, by monitoring information and developments in technology.

Standard IM.02.01.03

2010 Standard Text:

The organization maintains the security and integrity of health information.

2010 Standard: IM.02.01.03

2010 EP: 1

2010 EP Text:

The organization has a written policy that addresses the security of health information, including access, use, and disclosure.

2010 Standard: IM.02.01.03

2010 EP: 2

2010 EP Text:

The organization has a written policy addressing the integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.

2010 Standard: N/A

2010 EP Text:

No EP

2010 Standard: IM.02.01.03

2010 EP: 5

2010 EP Text:

The organization protects against unauthorized access, use, and disclosure of health information.

2010 Standard: IM.02.01.03

2010 EP: 8

2010 EP Text:

The organization monitors compliance with its policies on the security and integrity of health information.

2010 Standard: N/A

2010 EP Text:

No EP

<p>2009 Standard: IM.2.20 2009 EP Text: The {jc}organization{/2} develops and implements controls to safeguard data and information, including the clinical/case record, against loss, destruction, and tampering.</p>	<p>2009 EP: 6 Revision Type: Retain</p>	<p>2010 Standard: IM.02.01.03 2010 EP Text: The organization protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.</p>	<p>2010 EP: 6</p>
<p>2009 Standard: IM.2.20 2009 EP Text: Controls to safeguard data and information include the following:Policies indicating when the removal of records from the control of the organization is permitted Protection against unauthorized intrusion, corruption, or damageMinimization of the risk of falsification of data and informationGuidelines for preventing the loss and destruction of recordsGuidelines for destroying copies of recordsProtection of records in a manner that minimizes the possibility of damage from fire and water</p>	<p>2009 EP: 7 Revision Type: Split</p>	<p>2010 Standard: IM.02.01.03 2010 EP Text: The organization has a written policy addressing the intentional destruction of health information.</p>	<p>2010 EP: 3</p>
<p>2009 Standard: IM.2.20 2009 EP Text: Controls to safeguard data and information include the following:Policies indicating when the removal of records from the control of the organization is permitted Protection against unauthorized intrusion, corruption, or damageMinimization of the risk of falsification of data and informationGuidelines for preventing the loss and destruction of recordsGuidelines for destroying copies of recordsProtection of records in a manner that minimizes the possibility of damage from fire and water</p>	<p>2009 EP: 7 Revision Type: Split</p>	<p>2010 Standard: IM.02.01.03 2010 EP Text: The organization has a written policy that defines when and by whom the removal of health information is permitted. Note: Removal refers to those actions that place health information outside the organization's control.</p>	<p>2010 EP: 4</p>
<p>2009 Standard: IM.2.20 2009 EP Text: Controls to safeguard data and information include the following:Policies indicating when the removal of records from the control of the organization is permitted Protection against unauthorized intrusion, corruption, or damageMinimization of the risk of falsification of data and informationGuidelines for preventing the loss and destruction of recordsGuidelines for destroying copies of recordsProtection of records in a manner that minimizes the possibility of damage from fire and water</p>	<p>2009 EP: 7 Revision Type: Split</p>	<p>2010 Standard: IM.02.01.03 2010 EP Text: The organization controls the intentional destruction of health information.</p>	<p>2010 EP: 7</p>

2009 Standard: IM.2.20**2009 EP:** 8**2010 Standard:** N/A**2009 EP Text:****Revision Type:** Delete:Redun**2010 EP Text:**

No EP

Policies and procedures, including plans for implementation, for electronic information systems address the following: data integrity, authentication*, non-repudiation**, encryption*** as warranted, and auditability,**** as appropriate to the system and types of information, for example, {jc}patient{/1} information and billing information.*Authentication The validation of correctness for both the information itself and the person who is the author or user of information.**Non-repudiation The inability to dispute a document's content or authorship.***Encryption The process of transforming plain text (readable) into cipher text that is unreadable without a special software key.****Auditability The ability to do a methodical examination and verification of all information activities such as entering and accessing.

Standard IM.2.30

2009 Standard Text:

Continuity of information is maintained.

2009 Standard: IM.2.30

2009 EP: 1

2009 EP Text:

The {jc}organization{/2} has a business continuity/disaster recovery plan for its information systems.

Revision Type: Retain

2009 Standard: IM.2.30

2009 EP: 2

2009 EP Text:

For electronic systems, the business continuity/disaster recovery plan includes the following: Plans for scheduled and unscheduled interruptions, which includes end-user training with the downtime proceduresContingency plans for operational interruptions (hardware, software, or other systems failure)Plans for minimal interruptions as a result of scheduled downtimeAn emergency service plan A back-up system (electronic or manual) Data retrieval, including retrieval from storage and information presently in the operating system, retrieval of data in the event of system interruption, and back up of data

Revision Type: Split

2009 Standard: IM.2.30

2009 EP: 2

2009 EP Text:

For electronic systems, the business continuity/disaster recovery plan includes the following: Plans for scheduled and unscheduled interruptions, which includes end-user training with the downtime proceduresContingency plans for operational interruptions (hardware, software, or other systems failure)Plans for minimal interruptions as a result of scheduled downtimeAn emergency service plan A back-up system (electronic or manual) Data retrieval, including retrieval from storage and information presently in the operating system, retrieval of data in the event of system interruption, and back up of data

Revision Type: Split

Standard IM.01.01.03

2010 Standard Text:

The organization plans for continuity of its information management processes.

2010 Standard: IM.01.01.03

2010 EP: 1

2010 EP Text:

The organization has a written plan for managing interruptions to its information processes (paper-based, electronic, or a mix of paper-based and electronic). (See also EM.01.01.01, EP 6)

2010 Standard: IM.01.01.03

2010 EP: 2

2010 EP Text:

The plan for managing interruptions to electronic information systems addresses the following: Scheduled and unscheduled interruptions. (See also IM.03.01.01, EP 1; EM.01.01.01, EP 6)

2010 Standard: IM.01.01.03

2010 EP: 3

2010 EP Text:

The plan for managing interruptions to electronic information systems addresses the following: Training for staff on alternative procedures to follow when systems are unavailable. (See also EM.01.01.01, EP 6)

2009 Standard: IM.2.30

2009 EP: 2

2010 Standard: IM.01.01.03

2010 EP: 4

2009 EP Text:

Revision Type: Split

2010 EP Text:

For electronic systems, the business continuity/disaster recovery plan includes the following: Plans for scheduled and unscheduled interruptions, which includes end-user training with the downtime proceduresContingency plans for operational interruptions (hardware, software, or other systems failure)Plans for minimal interruptions as a result of scheduled downtimeAn emergency service plan A back-up system (electronic or manual) Data retrieval, including retrieval from storage and information presently in the operating system, retrieval of data in the event of system interruption, and back up of data

The plan for managing interruptions to electronic information systems addresses the following: Backup of the electronic information systems. (See also EM.01.01.01, EP 6)

2009 Standard: IM.2.30

2009 EP: 3

2010 Standard: IM.01.01.03

2010 EP: 5

2009 EP Text:

Revision Type: Retain

2010 EP Text:

The plan is tested periodically as defined by the {jc}organization{/2} (or in accordance with law or regulation) to ensure that the business interruption back-up techniques are effective.

The organization's plan for managing interruptions to electronic information systems is tested for effectiveness according to time frames defined by the organization.

2009 Standard: IM.2.30

2009 EP: 4

2010 Standard: IM.01.01.03

2010 EP: 6

2009 EP Text:

Revision Type: Retain

2010 EP Text:

The business continuity/disaster recovery plan is implemented when information systems are interrupted.

The organization implements its plan for managing interruptions to information processes to maintain access to information needed for the care, treatment, or services of the individuals served. (See also IM.03.01.01, EP 1)

Standard IM.3.10

2009 Standard Text:

The {jc}organization{/2} has processes in place to effectively manage information, including the capturing, reporting, processing, storing, retrieving, disseminating, and displaying of clinical/service and non-clinical data and information.

Standard IM.02.02.03

2010 Standard Text:

The organization retrieves, disseminates, and transmits health information in useful formats.

2009 Standard: IM.3.10

2009 EP: 1

2010 Standard: N/A

2009 EP Text:

Revision Type: Delete:Redun

2010 EP Text:

No EP

Information technology field standards or {jc}organization{/2} policies are used and address the following:Uniform data definitionsData capture Data displayData transmission

2009 Standard: IM.3.10

2009 EP: 3

2010 Standard: N/A

2009 EP Text:

Revision Type: Split

2010 EP Text:

No EP

Minimum data sets, terminology, definitions, classifications, vocabulary, and nomenclature, including abbreviations, acronyms, symbols, and dose designations are standardized throughout the {jc}organization{/2}.

2009 Standard: IM.3.10

2009 EP: 3

2010 Standard: IM.02.02.01

2010 EP: 1

2009 EP Text:

Revision Type: Split

2010 EP Text:

The organization uses uniform data sets to standardize data collection throughout the organization.

Minimum data sets, terminology, definitions, classifications, vocabulary, and nomenclature, including abbreviations, acronyms, symbols, and dose designations are standardized throughout the {jc}organization{/2}.

2009 Standard: IM.3.10

2009 EP: 4

2010 Standard: IM.04.01.01

2010 EP: 1

2009 EP Text:

Revision Type: Retain

2010 EP Text:

The organization has processes to check the accuracy of health information. Note: The organization has the flexibility to determine what health information needs to be checked for accuracy and the frequency with which it will be checked.

Quality control systems are used to monitor data content and collection activities. The method used provides for timely and economical data collection with the degree of accuracy, completeness, and discrimination necessary for their intended use.The method used minimizes bias in the data and regularly assesses the data's reliability, validity, and accuracy. Those responsible for collecting and reviewing the data are accountable for information accuracy and completeness.

<p>2009 Standard: IM.3.10 2009 EP Text: Storage and retrieval systems are designed to support {jc}organization{/2} needs for clinical/service and {jc}organization{/2}-specific information. Storage and retrieval systems are designed to balance the ability to retrieve data and information with the intended use for the data and information. Storage and retrieval systems are designed to balance security and confidentiality issues with accessibility. Systems for paper and electronic records are designed to reduce disruption or inaccessibility during such times as diminished staffing and scheduled and unscheduled downtimes of electronic information systems.</p>	<p>2009 EP: 5 Revision Type: Retain</p>	<p>2010 Standard: IM.02.02.03 2010 EP Text: The organization's storage and retrieval systems make health information accessible when needed for care, treatment, or services of the individual served.</p>	<p>2010 EP: 2</p>
<p>2009 Standard: IM.3.10 2009 EP Text: Data and information are retained for sufficient time to comply with law or regulation.</p>	<p>2009 EP: 6 Revision Type: Retain</p>	<p>2010 Standard: IM.02.02.03 2010 EP Text: The organization retains data and information for time frames consistent with law and regulation.</p>	<p>2010 EP: 12</p>
<p>2009 Standard: IM.3.10 2009 EP Text: Knowledgeable staff and tools are available for collecting, retrieving, and analyzing data and their transformation into information.</p>	<p>2009 EP: 7 Revision Type: Delete:NE</p>	<p>2010 Standard: N/A 2010 EP Text: No EP</p>	
<p>2009 Standard: IM.3.10 2009 EP Text: Data are organized and transformed into information in formats useful to decision makers.</p>	<p>2009 EP: 8 Revision Type: Delete:Redun</p>	<p>2010 Standard: N/A 2010 EP Text: No EP</p>	
<p>2009 Standard: IM.3.10 2009 EP Text: Dissemination of data and information is timely* and accurate.*Timely Defined by organization policy and based on the intended use of the information.</p>	<p>2009 EP: 9 Revision Type: Retain</p>	<p>2010 Standard: IM.02.02.03 2010 EP Text: The organization disseminates data and information in useful formats within time frames that are defined by the organization and consistent with law and regulation.</p>	<p>2010 EP: 3</p>
<p>2009 Standard: IM.3.10 2009 EP Text: Data and information are disseminated in standard formats and methods to meet user needs and provide for retrievability and interpretation.</p>	<p>2009 EP: 10 Revision Type: Delete:Redun</p>	<p>2010 Standard: N/A 2010 EP Text: No EP</p>	

Standard IM.4.10

2009 Standard Text:

The information management system provides information for use in decision making.

2010 Standard Text:

No Standard

2009 Standard: IM.4.10

2009 EP: 1

2010 Standard: N/A

2009 EP Text:

Revision Type: Delete:NE

2010 EP Text:

No EP

The {jc}organization{/2} has the ability to collect and aggregate data and information to support care, treatment, and service delivery and operations, including the following: Individual care, treatment, and services and care, treatment, and service delivery Decision makingManagement and operationsAnalysis of trends Performance comparisons over time throughout the {jc}organization{/2} and with other organizations Performance improvement Infection control{jc}Patient{/1} safety

2009 Standard: IM.4.10

2009 EP: 2

2010 Standard: N/A

2009 EP Text:

Revision Type: Delete:NE

2010 EP Text:

No EP

To support clinical/service decision making, information found in the {jc}patient{/1} record is: Readily accessibleAccurateCompleteOrganized for retrieval of dataTimely**Timely Defined by organization policy and based on the intended use of the information.

2009 Standard: IM.4.10

2009 EP: 3

2010 Standard: N/A

2009 EP Text:

Revision Type: Delete:NE

2010 EP Text:

No EP

Comparative performance data and information are used for decision making, when available.

Standard IM.5.10

2009 Standard Text:

Knowledge-based information resources are readily available, current, and authoritative.

2009 Standard: IM.5.10

2009 EP: 2

2009 EP Text:

Revision Type: Consolidate

The {jc}organization{/2} provides access to knowledge-based information resources* needed by staff in any of the following forms: print, electronic, Internet, or audio. *Examples of knowledge-based information resources include current texts; periodicals; indexes; abstracts; reports; documents; databases; directories; discussion lists; successful practices; equipment and maintenance user manuals; standards; protocols; practice guidelines; clinical trials and other resources.

2009 Standard: IM.5.10

2009 EP: 3

2009 EP Text:

Revision Type: Consolidate

Knowledge-based information resources are available to clinical/service staff, through electronic means, after-hours access to an in-house collection, or other methods.

2009 Standard: IM.5.10

2009 EP: 4

2009 EP Text:

Revision Type: Delete:Redun

The {jc}organization{/2} has a process for providing access to knowledge-based information resources when electronic systems are unavailable.

Standard IM.03.01.01

2010 Standard Text:

Knowledge-based information resources are available, current, and authoritative.

2010 Standard: IM.03.01.01

2010 EP: 1

2010 EP Text:

The organization provides access to knowledge-based information resources. (See also IM.01.01.03, EPs 2 and 6)

2010 Standard: IM.03.01.01

2010 EP: 1

2010 EP Text:

The organization provides access to knowledge-based information resources. (See also IM.01.01.03, EPs 2 and 6)

2010 Standard: N/A

2010 EP Text:

No EP

Standard IM.6.10

2009 Standard Text:

The {jc}organization{/2} has a complete and accurate {jc}medical record{/8} for {jc}patient{/1}s assessed, cared for, treated, or served.

2009 Standard: IM.6.10

2009 EP: 1

2009 EP Text:

Revision Type: Retain

Only authorized individuals make entries in the {jc}medical record{/8}.

2009 Standard: IM.6.10

2009 EP: 2

2009 EP Text:

Revision Type: Retain

The {jc}organization{/2} defines which entries made by non-independent practitioners require countersigning consistent with law or regulation.

2009 Standard: IM.6.10

2009 EP: 3

2009 EP Text:

Revision Type: Retain

Standardized formats are used for documenting all care, treatment, and services provided to {jc}patients{/6}.

2009 Standard: IM.6.10

2009 EP: 4

2009 EP Text:

Revision Type: Split

{jc}Medical record{/8} entries* are dated, the author identified and, when necessary according to law or regulation or {jc}organization{/2} policy, authenticated, either by written signature, electronic signature, or computer key or rubber stamp**. *For paper-based records, counter-signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulations or organization policy. For electronic records, electronic signatures will be date-stamped. **Authentication is shown by written signatures or initials, rubber-stamp signatures, or computer key. Authorized users of signature stamps or computer keys sign a statement assuring that they alone will use the stamp or key.

Standard RC.01.02.01

2010 Standard Text:

Entries in the clinical/case record are authenticated.

2010 Standard: RC.01.02.01

2010 EP: 1

2010 EP Text:

Only authorized staff make entries in the clinical/case record.

2010 Standard: RC.01.02.01

2010 EP: 2

2010 EP Text:

The organization defines the types of entries in the clinical/case record made by staff that require countersigning, in accordance with law and regulation.

2010 Standard: RC.01.01.01

2010 EP: 9

2010 EP Text:

The organization uses standardized formats to document the care, treatment, or services it provides to individuals served.

2010 Standard: RC.01.01.01

2010 EP: 11

2010 EP Text:

All entries in the clinical/case record are dated.

2009 Standard: IM.6.10

2009 EP: 4

2010 Standard: RC.01.02.01

2010 EP: 3

2009 EP Text:

Revision Type: Split

2010 EP Text:

The author of each clinical/case record entry is identified in the clinical/case record.

{jc}Medical record{/8} entries* are dated, the author identified and, when necessary according to law or regulation or {jc}organization{/2} policy, authenticated, either by written signature, electronic signature, or computer key or rubber stamp**. *For paper-based records, counter-signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulations or organization policy. For electronic records, electronic signatures will be date-stamped. **Authentication is shown by written signatures or initials, rubber-stamp signatures, or computer key. Authorized users of signature stamps or computer keys sign a statement assuring that they alone will use the stamp or key.

2009 Standard: IM.6.10

2009 EP: 4

2010 Standard: RC.01.02.01

2010 EP: 4

2009 EP Text:

Revision Type: Split

2010 EP Text:

Entries in the clinical/case record are authenticated by the author. Information introduced into the clinical/case record through transcription or dictation is authenticated by the author.

{jc}Medical record{/8} entries* are dated, the author identified and, when necessary according to law or regulation or {jc}organization{/2} policy, authenticated, either by written signature, electronic signature, or computer key or rubber stamp**. *For paper-based records, counter-signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulations or organization policy. For electronic records, electronic signatures will be date-stamped. **Authentication is shown by written signatures or initials, rubber-stamp signatures, or computer key. Authorized users of signature stamps or computer keys sign a statement assuring that they alone will use the stamp or key.

Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.

Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.

2009 Standard: IM.6.10

2009 EP: 4

2010 Standard: RC.01.02.01

2010 EP: 5

2009 EP Text:

Revision Type: Split

2010 EP Text:

The staff identified by the signature stamp or method of electronic authentication is the only staff who uses it.

{jc}Medical record{/8} entries* are dated, the author identified and, when necessary according to law or regulation or {jc}organization{/2} policy, authenticated, either by written signature, electronic signature, or computer key or rubber stamp**. *For paper-based records, counter-signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulations or organization policy. For electronic records, electronic signatures will be date-stamped. **Authentication is shown by written signatures or initials, rubber-stamp signatures, or computer key. Authorized users of signature stamps or computer keys sign a statement assuring that they alone will use the stamp or key.

2009 Standard: IM.6.10

2009 EP: 5

2010 Standard: RC.01.02.01

2010 EP: 4

2009 EP Text:

Revision Type: Retain

2010 EP Text:

The author authenticates either by written signature, electronic signature, or computer key or rubber stamp the following: The history and physical examination Evaluations and assessments Progress notes Medication orders Discharge summary

Entries in the clinical/case record are authenticated by the author. Information introduced into the clinical/case record through transcription or dictation is authenticated by the author.

Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.

Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.

2009 Standard: IM.6.10

2009 EP: 6

2010 Standard: RC.01.01.01

2010 EP: 4

2009 EP Text:

Revision Type: Split

2010 EP Text:

The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; and service; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.

The clinical/case record contains information unique to the individual served, which is used for identification of the individual.

2009 Standard: IM.6.10

2009 EP: 6

2010 Standard: RC.01.01.01

2010 EP: 5

2009 EP Text:

Revision Type: Split

2010 EP Text:

The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; and service; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.

The clinical/case record contains the information needed to support the diagnosis or condition of the individual served.

2009 Standard: IM.6.10

2009 EP: 6

2010 Standard: RC.01.01.01

2010 EP: 6

2009 EP Text:

Revision Type: Split

2010 EP Text:

The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; and service; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.

The clinical/case record contains the information needed to justify the care, treatment, or services provided to the individual served.

<p>2009 Standard: IM.6.10 2009 EP Text: The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; and service; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.</p>	<p>2009 EP: 6 Revision Type: Split</p>	<p>2010 Standard: RC.01.01.01 2010 EP Text: The clinical/case record contains information that documents the course and result of the care, treatment, or services provided to the individual served.</p>
<p>2009 Standard: IM.6.10 2009 EP Text: The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; and service; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.</p>	<p>2009 EP: 6 Revision Type: Split</p>	<p>2010 Standard: RC.01.01.01 2010 EP Text: The clinical/case record contains information about the care, treatment, or services provided to the individual served that promotes continuity of care among providers.</p>
<p>2009 Standard: IM.6.10 2009 EP Text: A concise discharge summary* providing information to other caregivers and facilitating continuity of care includes the following: The reason for care, treatment, and services Significant findings Procedures and care, treatment, and services provided The client's condition at discharge Information provided to the client and family, as appropriate * Exceptions to the discharge summary: When individuals are seen for minor problems or interventions as defined by the clinical staff, a final progress note may be substituted for the discharge summary. When individuals are transferred to a different level of care within the {jc}organization{/2}, and the caregivers change, a transfer summary may be substituted for the discharge summary. When the caregivers are the same, a progress note may be used.</p>	<p>2009 EP: 7 Revision Type: Retain</p>	<p>2010 Standard: RC.02.04.01 2010 EP Text: The clinical/case record contains the following: - A concise discharge summary that includes the reason for acceptance for care, treatment, or services - The care, treatment, or services provided - The condition at discharge of the individual served - Information provided to the individual served and his or her family (for example, written discharge instructions, medication regimen, follow-up care) Note 1: A discharge summary is not required when individuals served are seen for brief interventions, as defined by the clinical staff. In these instances, a final progress note may be substituted for the discharge summary. Note 2: When individuals served are transferred to a different program within the organization, and staff change, a transfer summary may be substituted for the discharge summary. If the staff do not change, a progress note may be used.</p>
<p>2009 Standard: IM.6.10 2009 EP Text: he {jc}organization{/2} has a policy on the timely entry of information into the {jc}patient{/1}'s {jc}medical record{/8}.</p>	<p>2009 EP: 8 Revision Type: Split</p>	<p>2010 Standard: RC.01.03.01 2010 EP Text: The organization has a written policy that requires timely entry of information into the clinical/case record.</p>

<p>2009 Standard: IM.6.10 2009 EP Text: he {jc}organization{/2} has a policy on the timely entry of information into the {jc}patient{/1}'s {jc}medical record{/8}.</p>	<p>2009 EP: 8 Revision Type: Split</p>	<p>2010 Standard: RC.01.03.01 2010 EP Text: The organization implements its policy requiring timely entry of information into the clinical/case record of the individual served.</p>
<p>2009 Standard: IM.6.10 2009 EP Text: The {jc}organization{/2} defines a complete record and the timeframe within which the record is completed after discharge, not to exceed 30 days after discharge.</p>	<p>2009 EP: 9 Revision Type: Split</p>	<p>2010 Standard: RC.01.01.01 2010 EP Text: The organization defines the components of a complete clinical/case record.</p>
<p>2009 Standard: IM.6.10 2009 EP Text: The {jc}organization{/2} defines a complete record and the timeframe within which the record is completed after discharge, not to exceed 30 days after discharge.</p>	<p>2009 EP: 9 Revision Type: Split</p>	<p>2010 Standard: RC.01.03.01 2010 EP Text: The organization defines the time frame for completion of the clinical/case record following discharge.</p>
<p>2009 Standard: IM.6.10 2009 EP Text: {jc}Medical record{/8}s are reviewed on an ongoing basis.</p>	<p>2009 EP: 12 Revision Type: Consolidate</p>	<p>2010 Standard: RC.01.04.01 2010 EP Text: According to a time frame it defines, the organization reviews its clinical/case records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.</p>
<p>2009 Standard: IM.6.10 2009 EP Text: The review of {jc}medical record{/8}s is based on {jc}organization{/2}-defined indicators that address the presence, timeliness, readability (whether handwritten or printed), quality, consistency, clarity , accuracy , completeness, and authentication of data and information contained within the record.</p>	<p>2009 EP: 13 Revision Type: Consolidate</p>	<p>2010 Standard: RC.01.04.01 2010 EP Text: According to a time frame it defines, the organization reviews its clinical/case records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.</p>
<p>2009 Standard: IM.6.10 2009 EP Text: The retention time of {jc}medical record{/8} information is determined by the {jc}organization{/2} based on law or regulation, and on its use for {jc}patient{/1} care, treatment, and services, legal, research, operational purposes, and educational activities.</p>	<p>2009 EP: 14 Revision Type: Retain</p>	<p>2010 Standard: RC.01.05.01 2010 EP Text: The retention time of the clinical/case record is determined by its use and organization policy, in accordance with law and regulation.</p>

2009 Standard: IM.6.10**2009 EP:** 17**2010 Standard:** RC.01.05.01**2010 EP:** 8**2009 EP Text:****Revision Type:** Retain**2010 EP Text:**

Original {j}medical record{/8}s are not released unless the {j}organization{/2} is responding appropriately to laws or regulations, court orders, or subpoenas.

Original clinical/case records are not released unless the organization is responding to law and regulation.

Standard IM.6.20

2009 Standard Text:

Records contain {jc}patient{/1}-specific information, as appropriate to the care, treatment, and services provided.

2009 Standard: IM.6.20

2009 EP: 1

2009 EP Text:

Revision Type: Retain

{jc}Medical record{/8}s contain, as applicable, the following clinical/case information: Emergency care, treatment, and services provided to the client before his or her arrival, if any Documentation and findings of assessments*Conclusions or impressions drawn from medical history and physical examinationDiagnosis, diagnostic impression, or conditionsReason(s) for admission or care, treatment, and services Goals and objectives of the client's care, treatment, and services Diagnostic and therapeutic ordersDiagnostic and therapeutic procedures, tests, and resultsProgress notes made by authorized individuals, and used as the basis for care, treatment, and services, and habilitation plan development and review Reassessments and plan of care revisionsRelevant observations Response to care, treatment, and services provided Consultation reportsAllergies to foods and medicinesMedications ordered or prescribedDosages of medications administered (including the strength, dose, or rate of administration), administration devices used, access site or route, known drug allergies, and adverse drug reactionsMedications dispensed or prescribed on discharge Relevant diagnoses/conditions established during the course of care, treatment, and services*See the "Provision of Care, Treatment, and Services " chapter in this manual.

Standard RC.02.01.01

2010 Standard Text:

The clinical/case record contains information that reflects the care, treatment, or services provided to the individual served.

2010 Standard: RC.02.01.01

2010 EP: 2

2010 EP Text:

The clinical/case record of the individual served contains the following clinical information:

- The reason(s) for admission for care, treatment, or services
- The initial diagnosis, diagnostic impression(s), or condition(s)
- Any findings of assessments and reassessments
- Any allergies to food
- Any allergies to medications
- Any conclusions or impressions drawn from the medical history and physical examination
- Any diagnoses or conditions established during the course of care, treatment, or services
- Any consultation reports
- Any observations relevant to care, treatment, or services
- The response to care, treatment, or services
- Any emergency care, treatment, or services provided prior to arrival
- Any progress notes
- Any medications ordered or prescribed
- Any medications administered, including the strength, dose, and route
- Any access site for medication, administration devices used, and rate of administration (for intravenous therapy)
- Any adverse drug reactions
- Treatment goals, plan of care, and revisions to the plan of care, treatment, or services
- Orders for diagnostic and therapeutic tests and procedures and their results

2009 Standard: IM.6.20

2009 EP: 2

2010 Standard: RC.02.01.01

2010 EP: 1

2009 EP Text:

Revision Type: Retain

2010 EP Text:

Medical records contain, as applicable, the following demographic information: Client's name, address, date of birth, sex, race or ethnic origin, next of kin, education, marital status, employment, and the name and phone number of any legally authorized representative. Legal status of clients. The patient's language and communication needs.

The clinical/case record contains the following demographic information:

- The name, address, date of birth, and sex of the individual served
- The name and contact information for the individual's family and any legally authorized representative
- The preferred language and any special communication needs of the individual served

Note: Special communication needs may include sign language.

2009 Standard: IM.6.20

2009 EP: 3

2010 Standard: RC.02.01.01

2010 EP: 4

2009 EP Text:

Revision Type: Split

2010 EP Text:

Medical records contain, as applicable, the following information: Evidence of known advance directives when indicated. Evidence of informed consent. Documentation of protective services when provided. Documentation of client and, as appropriate, family involvement in the care, treatment, and services. When more than one member of the family is receiving care, treatment, and services, a separate record is maintained on each family member involved. Information on unusual occurrences, such as care, treatment, and service complications, accidents or injuries to the client, procedures that place the client at risk or cause pain, other illnesses or conditions that affect care, treatment, and services, and the client's death. Documentation of client, family, or guardian consent for admission, care, treatment, services, evaluation, continuing care, or research. Indications for and episodes of special procedures. Referrals or communications made to external or internal care providers and community agencies. Records of communication with the client regarding care, treatment, and services, for example, telephone calls or email. Client-generated information (for example, information entered into the record over the Web or in previsit computer systems).

As needed to provide care, treatment, or services, the clinical/case record contains the following additional information:

- Any advance directives
- Any informed consent (See also RI.01.03.01, EP 13)
- Any documentation of protective services
- Any documentation of consent by the individual served, family, or guardian for admission; care, treatment, or services; evaluation; continuing care; or research
- Any records of communication with the individual served, such as telephone calls or e-mail
- Any documentation of involvement in care, treatment, or services by the individual served and, when necessary, his or her family
- Any information on unusual occurrences, such as complications; accidents or injuries to the individual served; procedures that place the individual served at risk or cause pain; other illnesses or conditions that affect care, treatment, or services; or the death of the individual served
- Any indications for and episodes of special procedures

2009 Standard: IM.6.20**2009 EP:** 3**2010 Standard:** RC.02.01.01**2010 EP:** 27**2009 EP Text:****Revision Type:** Split**2010 EP Text:**

Medical records contain, as applicable, the following information:
Evidence of known advance directives when indicated
Evidence of informed consent
Documentation of protective services when provided
Documentation of client and, as appropriate, family involvement in the care, treatment, and services
When more than one member of the family is receiving care, treatment, and services, a separate record is maintained on each family member involved
Information on unusual occurrences, such as care, treatment, and service complications, accidents or injuries to the client, procedures that place the client at risk or cause pain, other illnesses or conditions that affect care, treatment, and services, and the client's death
Documentation of client, family, or guardian consent for admission, care, treatment, services, evaluation, continuing care, or research
Indications for and episodes of special procedures
Referrals or communications made to external or internal care providers and community agencies
Records of communication with the client regarding care, treatment, and services, for example, telephone calls or email
Client-generated information (for example, information entered into the record over the Web or in previsit computer systems)

When more than one member of the family is receiving individual care, treatment, or services, a separate clinical/case record is maintained for each family member.

Note: Separate clinical/case records are not needed for family members participating in family therapy or counseling only.

Standard IM.6.50

2009 Standard Text:

Designated qualified staff accept and transcribe verbal or telephone orders from authorized individuals.

Standard RC.02.03.07

2010 Standard Text:

Qualified staff receive and record verbal orders.
 Note: Verbal orders may include medication, laboratory tests, dietary, or restraint and seclusion.

2009 Standard: IM.6.50

2009 EP: 1

2009 EP Text:

Revision Type: Split

Qualified personnel are identified, as defined by {jc}organization{/2} policy and in accordance with law or regulation, and authorized to receive and record verbal or telephone orders.

2010 Standard: RC.02.03.07

2010 EP: 1

2010 EP Text:

The organization identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation.

2009 Standard: IM.6.50

2009 EP: 1

2009 EP Text:

Revision Type: Split

Qualified personnel are identified, as defined by {jc}organization{/2} policy and in accordance with law or regulation, and authorized to receive and record verbal or telephone orders.

2010 Standard: RC.02.03.07

2010 EP: 2

2010 EP Text:

Only authorized staff receive and record verbal orders.

2009 Standard: IM.6.50

2009 EP: 2

2009 EP Text:

Revision Type: Retain

Verbal or telephone orders are dated and identifies the names of the individuals who gave, received, and implemented the order.

2010 Standard: RC.02.03.07

2010 EP: 3

2010 EP Text:

Documentation of verbal orders includes the date and the names of staff who gave, received, recorded, and implemented the orders.

2009 Standard: IM.6.50

2009 EP: 3

2009 EP Text:

Revision Type: Retain

When required by law or regulation, verbal or telephone orders are authenticated within the specified time frame.

2010 Standard: RC.02.03.07

2010 EP: 4

2010 EP Text:

Verbal orders are authenticated within the time frame specified by law and regulation.

Standard IM.6.60

2009 Standard Text:

The {jc}organization{/2} provides access to relevant information from a {jc}patient's{/9} record as needed for use in {jc}patient{/1} care, treatment, and services.

2009 Standard: IM.6.60

2009 EP: 1

2009 EP Text:

Revision Type: Retain

The {jc}organization{/2} has a process to track the location of all components of the {jc}medical record{/8}.

2009 Standard: IM.6.60

2009 EP: 2

2009 EP Text:

Revision Type: Retain

The {jc}organization{/2} uses a system to assemble required information or make available a summary of information relative for {jc}patient{/1} care, treatment, and services provided.

Standard RC.01.01.01

2010 Standard Text:

The organization maintains complete and accurate clinical/case records.

2010 Standard: RC.01.01.01

2010 EP: 12

2010 EP Text:

The organization tracks the location of all components of the clinical/case record.

2010 Standard: RC.01.01.01

2010 EP: 13

2010 EP Text:

The organization assembles or makes available in a summary in the clinical/case record all information required to provide care, treatment, or services to the individual. (See also MM.01.01.01, EP 1)

Standard IM.6.270

2009 Standard Text:

The agency defines and maintains child- and family-specific information for continuity of care and initiation of improvement in its performance.

2009 Standard: IM.6.270

2009 EP: 1

2009 EP Text:

Revision Type: Retain

The agency defines the following: Who has what level of access to information: children, family of origin, guardians, attorneys, foster parents What is required to release information, for example, written consent Length of time records are kept, for example, in accordance with law

2009 Standard: IM.6.270

2009 EP: 2

2009 EP Text:

Revision Type: Retain

The child, family of origin, foster family, and the adoptive family have a right to confidentiality and access to information in accordance with law or regulation.

2009 Standard: IM.6.270

2009 EP: 3

2009 EP Text:

Revision Type: Retain

The agency has a plan to maintain a current life book* for the child, as appropriate, or a similar way of providing such information. *This chronological record of a child's life is created by the child or the caregivers. Items in this book follow the child and will reflect significant life events, up to and including the present placement. The information can include developmental milestones, school information, placement records and reasons for moves, family history, awards and achievements, relationships, goals, information and descriptions of birth parents and siblings (family tree, pictures), and information about foster families.

Standard RC.03.01.01

2010 Standard Text:

For foster care: The agency defines and maintains information specific to the individual served and his or her family for continuity of care and initiation of improvement in its performance.

2010 Standard: RC.03.01.01

2010 EP: 1

2010 EP Text:

For foster care: The agency defines in writing, and in accordance with law and regulation, the following:

- Who has what level of access to information (for example, individuals served, family of origin, guardians, attorneys, foster parents)
- The circumstances under which information may be released
- The length of time records are kept
- The individual served, family of origin or adoptive family, and foster family
- The right of the individual served, family of origin or adoptive family, and the foster family to confidentiality and accessibility of information

2010 Standard: RC.03.01.01

2010 EP: 3

2010 EP Text:

For foster care: The agency implements its processes for accessing information, maintaining confidentiality of information, and for children/youth, maintaining a current life book.

2010 Standard: RC.03.01.01

2010 EP: 2

2010 EP Text:

For foster care: The agency has a plan to maintain a current life book for the child, or a similar way of providing such information.
 Note: This chronological record of a child's life is created by the child or the caregivers. Items in this book follow the child and will reflect significant life events, up to and including the present placement. The information may include developmental milestones, school information, placement records and reasons for moves, family history, awards and achievements, relationships, goals, information about and descriptions of birth parents and siblings (for example, family tree, pictures), and information about foster families.

2009 Standard: IM.6.270

2009 EP: 4

2009 EP Text:

Information maintained by the agency includes the following: Case records include social and legal information, family history, school reports, incident reports (behavior problems, illness, injuries), medical and dental records and history, birth and developmental history, immunization records, placement authorization, case plan, progress reports, school information, and family contacts Contracts, correspondence, incident reports, and placement and other records or reports needed for the continuity of care

Revision Type: Retain

2010 Standard: RC.03.01.01

2010 EP: 4

2010 EP Text:

For foster care: Information maintained by the agency includes the following:
 - Case records that include social and legal information, family of origin history, school reports, incident reports (for example, behavior problems, illness, injuries), medical and dental records and history, birth and developmental history, immunization records, placement authorization, case plan, progress reports, school information, and family of origin and foster care contacts
 - Contracts, correspondence, incident reports, and placement and other records or reports needed for the continuity of care

2009 Standard: IM.6.270

2009 EP: 5

2009 EP Text:

The agency also has the ability to collect and aggregate data and information for performance improvement activities.

Revision Type: Delete:NE

2010 Standard: N/A

2010 EP Text:

No EP

Standard IM.6.280

2009 Standard Text:

The agency maintains foster family information.

2009 Standard: IM.6.280

2009 EP: 1

2009 EP Text:

Revision Type: Split

The agency maintains foster family records that include the following: The application form Placement history Background checks Performance approval Licensing Approval certificate Re-certification reports Contacts with references Pertinent correspondence Letters or records of compliments or complaints Learning needs assessment and training

2009 Standard: IM.6.280

2009 EP: 1

2009 EP Text:

Revision Type: Split

The agency maintains foster family records that include the following: The application form Placement history Background checks Performance approval Licensing Approval certificate Re-certification reports Contacts with references Pertinent correspondence Letters or records of compliments or complaints Learning needs assessment and training

2009 Standard: IM.6.280

2009 EP: 1

2009 EP Text:

Revision Type: Split

The agency maintains foster family records that include the following: The application form Placement history Background checks Performance approval Licensing Approval certificate Re-certification reports Contacts with references Pertinent correspondence Letters or records of compliments or complaints Learning needs assessment and training

2009 Standard: IM.6.280

2009 EP: 1

2009 EP Text:

Revision Type: Split

The agency maintains foster family records that include the following: The application form Placement history Background checks Performance approval Licensing Approval certificate Re-certification reports Contacts with references Pertinent correspondence Letters or records of compliments or complaints Learning needs assessment and training

Standard RC.03.01.03

2010 Standard Text:

For foster care: The agency maintains foster family information.

2010 Standard: RC.03.01.03

2010 EP: 1

2010 EP Text:

For foster care: The foster family record contains copies of licensing certificates and reports.

2010 Standard: RC.03.01.03

2010 EP: 2

2010 EP Text:

For foster care: The foster family record contains the application to provide foster care, references, background checks, and all assessment reports.

2010 Standard: RC.03.01.03

2010 EP: 3

2010 EP Text:

For foster care: The foster family record contains correspondence, including records of compliments and complaints.

2010 Standard: RC.03.01.03

2010 EP: 4

2010 EP Text:

For foster care: The foster family record contains evidence of training.

2009 Standard: IM.6.280

2009 EP: 2

2010 Standard: RC.03.01.03

2010 EP: 5

2009 EP Text:

Record retention complies with law or regulation.

Revision Type: Retain

2010 EP Text:

For foster care: Foster family records are retained in accordance with law and regulation and organizational policy.