The Joint Commission

History Tracking Report: 2010 to 2009 Requirements

Accreditation Program: Behavioral Health Care

2010 Chapter: Record of Care, Treatment, and Services

Standard RC.01.01.01	**Standard IM.6.10**
2010 Standard Text:	**2009 Standard Text:**
The organization maintains complete and accurate clinical/case records.	The {jc}organization{/2} has a complete and accurate {jc}medical record{/8} for {jc}patient{/1}s assessed, cared for, treated, or served.

2010 Standard: RC.01.01.01 **2010 EP:** 1

2010 EP Text:

The organization defines the components of a complete clinical/case record.

2009 Standard: IM.6.10 **2009 EP:** 9

2009 EP Text: **Revision Code:** Split

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.

2010 Standard: RC.01.01.01 **2010 EP:** 4

2010 EP Text:

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

2009 EP Text: **Revision Code:** Split

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.

2010 Standard: RC.01.01.01 **2010 EP:** 5

2010 EP Text:

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

2009 EP Text: **Revision Code:** Split

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.

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2010 Standard: RC.01.01.01 **2010 EP:** 6

2010 EP Text:

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

2009 Standard: IM.6.10 **2009 EP:** 6

2009 EP Text: **Revision Code:** Split

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.

2010 Standard: RC.01.01.01 **2010 EP:** 7

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.

2009 Standard: IM.6.10 **2009 EP:** 6

2009 EP Text: **Revision Code:** Split

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.

2010 Standard: RC.01.01.01 **2010 EP:** 8

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.

2009 Standard: IM.6.10 **2009 EP:** 6

2009 EP Text: **Revision Code:** Split

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.

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.

2009 Standard: IM.6.10 **2009 EP:** 3

2009 EP Text: **Revision Code:** Retain

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

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

2009 EP Text: **Revision Code:** 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.

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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.

2009 Standard: IM.6.60 **2009 EP:** 1

2009 EP Text: **Revision Code:** Retain

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

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)

2009 Standard: IM.6.60 **2009 EP:** 2

2009 EP Text: **Revision Code:** 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.

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Standard RC.01.02.01	**Standard IM.6.10**
2010 Standard Text: Entries in the clinical/case record are authenticated.	**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.
2010 Standard: RC.01.02.01 **2010 EP:** 1 **2010 EP Text:** Only authorized staff make entries in the clinical/case record.	**2009 Standard:** IM.6.10 **2009 EP:** 1 **2009 EP Text:** **Revision Code:** Retain Only authorized individuals make entries in the {jc}medical record{/8}.
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.	**2009 Standard:** IM.6.10 **2009 EP:** 2 **2009 EP Text:** **Revision Code:** Retain The {jc}organization{/2} defines which entries made by non-independent practitioners require countersigning consistent with law or regulation.
2010 Standard: RC.01.02.01 **2010 EP:** 3 **2010 EP Text:** The author of each clinical/case record entry is identified in the clinical/case record.	**2009 Standard:** IM.6.10 **2009 EP:** 4 **2009 EP Text:** **Revision Code:** 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.

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2010 Standard: RC.01.02.01 **2010 EP:** 4

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.
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

2009 EP Text: **Revision Code:** 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.

2010 Standard: RC.01.02.01 **2010 EP:** 4

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.
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:** 5

2009 EP Text: **Revision Code:** Retain

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

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2010 Standard: RC.01.02.01 **2010 EP:** 5

2010 EP Text:

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

2009 Standard: IM.6.10 **2009 EP:** 4

2009 EP Text: **Revision Code:** 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.

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Standard RC.01.03.01

2010 Standard Text:

Documentation in the clinical/case record is entered in a timely manner.

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.

2010 Standard: RC.01.03.01 **2010 EP:** 1

2010 EP Text:

The organization has a written policy that requires timely entry of information into the clinical/case record.

2009 Standard: IM.6.10 **2009 EP:** 8

2009 EP Text: **Revision Code:** Split

he {jc}organization{/2} has a policy on the timely entry of information into the {jc}patient{/1}'s {jc}medical record{/8}.

2010 Standard: RC.01.03.01 **2010 EP:** 2

2010 EP Text:

The organization defines the time frame for completion of the clinical/case record following discharge.

2009 Standard: IM.6.10 **2009 EP:** 9

2009 EP Text: **Revision Code:** Split

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.

2010 Standard: RC.01.03.01 **2010 EP:** 3

2010 EP Text:

The organization implements its policy requiring timely entry of information into the clinical/case record of the individual served.

2009 Standard: IM.6.10 **2009 EP:** 8

2009 EP Text: **Revision Code:** Split

he {jc}organization{/2} has a policy on the timely entry of information into the {jc}patient{/1}'s {jc}medical record{/8}.

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Standard RC.01.04.01

2010 Standard Text:

The organization audits its clinical/case records.

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.

2010 Standard: RC.01.04.01 **2010 EP:** 1

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.

2009 Standard: IM.6.10 **2009 EP:** 12

2009 EP Text: **Revision Code:** Consolidate

{jc}Medical record{/8}s are reviewed on an ongoing basis.

2010 Standard: RC.01.04.01 **2010 EP:** 1

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.

2009 Standard: IM.6.10 **2009 EP:** 13

2009 EP Text: **Revision Code:** Consolidate

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.

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Standard RC.01.05.01

2010 Standard Text:

The organization retains its clinical/case records.

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.

2010 Standard: RC.01.05.01 **2010 EP:** 1

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.

2009 Standard: IM.6.10 **2009 EP:** 14

2009 EP Text: **Revision Code:** Retain

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.

2010 Standard: RC.01.05.01 **2010 EP:** 8

2010 EP Text:

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

2009 Standard: IM.6.10 **2009 EP:** 17

2009 EP Text: **Revision Code:** Retain

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

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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.

Standard IM.6.20

2009 Standard Text:

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

2010 Standard: RC.02.01.01 **2010 EP:** 1

2010 EP Text:

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:** 2

2009 EP Text: **Revision Code:** Retain

{jc}Medical record{/8}s 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 representativeLegal status of clientsThe {jc}patient{/1}'s language and communication needs.

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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:** 1

2009 EP Text: **Revision Code:** 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.

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2010 Standard: RC.02.01.01 **2010 EP:** 4

2010 EP Text:

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

2009 EP Text: **Revision Code:** Split

{jc}Medical record{/8}s 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 involvedInformation 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 researchIndications 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 emailClient-generated information (for example, information entered into the record over the Web or in previsit computer systems)

2010 Standard: RC.02.01.01 **2010 EP:** 22

2010 EP Text:

When a person with intellectual disabilities, or his or her family or advocate, is unable or unwilling to participate in planning of care, treatment, or services, it is documented in the clinical/case record.

2009 Standard: PC.4.100 **2009 EP:** 8

2009 EP Text: **Revision Code:** Retain

Inability or unwillingness to participate in planning is documented in the clinical/case record.

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2010 Standard: RC.02.01.01 **2010 EP:** 27

2010 EP Text:

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.

2009 Standard: IM.6.20 **2009 EP:** 3

2009 EP Text: **Revision Code:** Split

{jc}Medical record{/8}s 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 involvedInformation 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 researchIndications 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 emailClient-generated information (for example, information entered into the record over the Web or in previsit computer systems)

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Standard RC.02.01.05

2010 Standard Text:

The clinical/case record contains documentation of the use of restraint and/or seclusion.

2010 Standard: RC.02.01.05 **2010 EP:** 3

2010 EP Text:

The organization documents the use of restraint and/or seclusion for behavioral health purposes in the clinical/case record, including the following:
- Each episode of restraint and/or seclusion
- The circumstances that led to the use of restraint and/or seclusion
- Consideration or failure of nonphysical interventions
- The rationale for the type of physical intervention used
- Written orders for the use of restraint and/or seclusion
- Each verbal order received from a licensed independent practitioner
- Each in-person evaluation and reevaluation of the individual served
- Each 15-minute assessment of the status of the individual served
- Continuous monitoring of the individual served
- Any preexisting medical conditions or any physical disabilities that would place the individual served at greater risk during restraint and/or seclusion
- Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint and/or seclusion
- That the individual served and/or his or her family was informed of the organization’s policy on the use of behavioral restraint and/or seclusion
- That the individual served was notified of the use of restraint and/or seclusion
- Behavior criteria for discontinuing restraint and/or seclusion
- That the individual served was informed of the behavior criteria he or she needed to meet in order for restraint and/or seclusion to be discontinued
- Assistance provided to the individual served to help him or her meet the behavior criteria for discontinuing the use of restraint and/or seclusion
- Debriefing the individual served with staff following an episode of restraint and/or seclusion
- Any injuries the individual served sustained and the treatment for these injuries
- The death of the individual served while in restraint or seclusion

Standard PC.12.170

2009 Standard Text:

{jc}Medical record{/8}s document that the use of restraint or seclusion is consistent with {jc}organization{/2} policy.

2009 Standard: PC.12.170 **2009 EP:** 3

2009 EP Text: **Revision Code:** Retain

The {jc}medical record{/8} contains the following documentation: That the {jc}patient{/1} and/or family was told of the {jc}organization{/2}'s policy on restraint Any pre-existing medical conditions or any physical disabilities that would place the {jc}patient{/1} at greater risk during restraint and seclusion Any history of sexual or physical abuse that would place the {jc}patient{/1} at greater psychological risk during restraint or seclusionEach episode of use The circumstances that led to restraint or seclusion Consideration or failure of non-physical interventions The rationale for the type of physical intervention selected Notification of the {jc}patient's{/9} family, as appropriate Written orders for use Behavior criteria for discontinuing restraint or seclusion Informing the {jc}patient{/1} of behavior criteria for discontinuing restraint or seclusion Each verbal order received from a licensed independent practitioner Each in-person evaluation and reevaluation of the {jc}patient{/1}15-minute assessments of the {jc}patient's{/9} status Assistance provided to the {jc}patient{/1} to help him or her meet the behavior criteria for discontinuing restraint or seclusionContinuous monitoring Debriefing of the {jc}patient{/1} with staff Any injuries and treatment for these injuries Any deaths

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2010 Standard: RC.02.01.05 **2010 EP:** 4

2010 EP Text:

The method(s) used to document restraint and/or seclusion facilitates the collection and analysis of data for performance improvement activities.

2009 Standard: PC.12.170 **2009 EP:** 4

2009 EP Text: **Revision Code:** Retain

Documentation is done in a manner that allows for data to be collected and analyzed for performance improvement activities (such as a restraint and seclusion log).

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Standard RC.02.03.07	**Standard IM.6.50**
2010 Standard Text:	**2009 Standard Text:**
Qualified staff receive and record verbal orders. Note: Verbal orders may include medication, laboratory tests, dietary, or restraint and seclusion.	Designated qualified staff accept and transcribe verbal or telephone orders from authorized individuals.

2010 Standard:	**2010 EP:**	**2010 EP Text:**	**2009 Standard:**	**2009 EP:**	**Revision Code:**	**2009 EP Text:**
RC.02.03.07	1	The organization identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation.	IM.6.50	1	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.
RC.02.03.07	2	Only authorized staff receive and record verbal orders.	IM.6.50	1	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.
RC.02.03.07	3	Documentation of verbal orders includes the date and the names of staff who gave, received, recorded, and implemented the orders.	IM.6.50	2	Retain	Verbal or telephone orders are dated and identifies the names of the individuals who gave, received, and implemented the order.
RC.02.03.07	4	Verbal orders are authenticated within the time frame specified by law and regulation.	IM.6.50	3	Retain	When required by law or regulation, verbal or telephone orders are authenticated within the specified time frame.

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Standard RC.02.04.01

2010 Standard Text:

The organization documents the discharge information of the individual served.

2010 Standard: RC.02.04.01 **2010 EP:** 3

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.

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:** 7

2009 EP Text: **Revision Code:** Retain

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 findingsProcedures and care, treatment, and services provided The client's condition at dischargeInformation 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.

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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.

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.

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

2009 Standard: IM.6.270 **2009 EP:** 1

2009 EP Text: **Revision Code:** 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

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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:** 3

2009 EP Text: **Revision Code:** 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.

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.

2009 Standard: IM.6.270 **2009 EP:** 2

2009 EP Text: **Revision Code:** 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.

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2010 Standard: RC.03.01.01	**2010 EP:** 4	**2009 Standard:** IM.6.270	**2009 EP:** 4
2010 EP Text:		**2009 EP Text:**	**Revision Code:** Retain

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 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

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Standard RC.03.01.03	**Standard IM.6.280**
2010 Standard Text: For foster care: The agency maintains foster family information.	**2009 Standard Text:** The agency maintains foster family information.

2010 Standard	2010 EP	2010 EP Text	2009 Standard	2009 EP	Revision Code	2009 EP Text
RC.03.01.03	1	For foster care: The foster family record contains copies of licensing certificates and reports.	IM.6.280	1	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
RC.03.01.03	2	For foster care: The foster family record contains the application to provide foster care, references, background checks, and all assessment reports.	IM.6.280	1	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
RC.03.01.03	3	For foster care: The foster family record contains correspondence, including records of compliments and complaints.	IM.6.280	1	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
RC.03.01.03	4	For foster care: The foster family record contains evidence of training.	IM.6.280	1	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

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2010 Standard: RC.03.01.03   **2010 EP:** 5

2010 EP Text:

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

2009 Standard: IM.6.280   **2009 EP:** 2

2009 EP Text: **Revision Code:** Retain

Record retention complies with law or regulation.

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