



Accreditation Program: Behavioral Health Care  
Record of Care, Treatment, and Services

**Standard RC.01.01.01**

The organization maintains complete and accurate clinical/case records.

**Elements of Performance for RC.01.01.01**

	1.	The organization defines the components of a complete clinical/case record.		<b>A</b>
<b>M</b>	4.	The clinical/case record contains information unique to the individual served, which is used for identification of the individual.		<b>C</b>
<b>M</b>	5.	The clinical/case record contains the information needed to support the diagnosis or condition of the individual served.		<b>C</b>
<b>M</b>	6.	The clinical/case record contains the information needed to justify the care, treatment, or services provided to the individual served.		<b>C</b>
<b>M</b>	7.	The clinical/case record contains information that documents the course and result of the care, treatment, or services provided to the individual served.		<b>C</b>
<b>M</b>	8.	The clinical/case record contains information about the care, treatment, or services provided to the individual served that promotes continuity of care among providers.	<b>3</b>	<b>C</b>
	9.	The organization uses standardized formats to document the care, treatment, or services it provides to individuals served.		<b>A</b>
<b>M</b>	11.	All entries in the clinical/case record are dated.		<b>C</b>
	12.	The organization tracks the location of all components of the clinical/case record.		<b>A</b>
<b>M</b>	13.	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)		<b>C</b>

**Standard RC.01.02.01**

Entries in the clinical/case record are authenticated.

**Elements of Performance for RC.01.02.01**

<b>M</b>	1.	Only authorized staff make entries in the clinical/case record.		<b>C</b>
	2.	The organization defines the types of entries in the clinical/case record made by staff that require countersigning, in accordance with law and regulation.		<b>A</b>
<b>M</b>	3.	The author of each clinical/case record entry is identified in the clinical/case record.		<b>C</b>

**KEY:** **A** indicates scoring category A; **C** indicates scoring category C; **2** indicates situational decision rules apply; **3** indicates direct impact requirements apply; **M** indicates Measure of Success if needed; **D** indicates that documentation is required

- M** 4. 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. **C**  
 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.
- 5. The staff identified by the signature stamp or method of electronic authentication is the only staff who uses it. **A**

**Standard RC.01.03.01**

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

**Elements of Performance for RC.01.03.01**

- 1. **D** The organization has a written policy that requires timely entry of information into the clinical/case record. **A**
- 2. The organization defines the time frame for completion of the clinical/case record following discharge. **A**
- M** 3. The organization implements its policy requiring timely entry of information into the clinical/case record of the individual served. **C**

**Standard RC.01.04.01**

The organization audits its clinical/case records.

**Elements of Performance for RC.01.04.01**

- M** 1. 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. **C**

**Standard RC.01.05.01**

The organization retains its clinical/case records.

**Elements of Performance for RC.01.05.01**

- 1. **D** The retention time of the clinical/case record is determined by its use and organization policy, in accordance with law and regulation. **A**
- 8. Original clinical/case records are not released unless the organization is responding to law and regulation. **A**

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**Standard RC.02.01.01**

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

**Elements of Performance for RC.02.01.01**

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| <b>M</b> | <p>1. The clinical/case record contains the following demographic information:</p> <ul style="list-style-type: none"> <li>- The name, address, date of birth, and sex of the individual served</li> <li>- The name and contact information for the individual's family and any legally authorized representative</li> <li>- The preferred language and any special communication needs of the individual served</li> </ul> <p>Note: Special communication needs may include sign language.</p>   | <b>C</b>   |
| <b>M</b> | <p>2. The clinical/case record of the individual served contains the following clinical information:</p> <ul style="list-style-type: none"> <li>- The reason(s) for admission for care, treatment, or services</li> <li>- The initial diagnosis, diagnostic impression(s), or condition(s)</li> <li>- Any findings of assessments and reassessments</li> <li>- Any allergies to food</li> <li>- Any allergies to medications</li> <li>- Any conclusions or impressions drawn from the medical history and physical examination</li> <li>- Any diagnoses or conditions established during the course of care, treatment, or services</li> <li>- Any consultation reports</li> <li>- Any observations relevant to care, treatment, or services</li> <li>- The response to care, treatment, or services</li> <li>- Any emergency care, treatment, or services provided prior to arrival</li> <li>- Any progress notes</li> <li>- Any medications ordered or prescribed</li> <li>- Any medications administered, including the strength, dose, and route</li> <li>- Any access site for medication, administration devices used, and rate of administration (for intravenous therapy)</li> <li>- Any adverse drug reactions</li> <li>- Treatment goals, plan of care, and revisions to the plan of care, treatment, or services</li> <li>- Orders for diagnostic and therapeutic tests and procedures and their results</li> </ul> | <div style="text-align: center;"><b>3</b></div> <b>C</b> |

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- M** 4. As needed to provide care, treatment, or services, the clinical/case record contains the following additional information: **3** **C**
- 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
22. 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. **A**
27. 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. **A**
- Note: Separate clinical/case records are not needed for family members participating in family therapy or counseling only.

**Standard RC.02.01.05**

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

**Elements of Performance for RC.02.01.05**

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| <b>M</b> | <p>3. The organization documents the use of restraint and/or seclusion for behavioral health purposes in the clinical/case record, including the following:</p> <ul style="list-style-type: none"> <li>- Each episode of restraint and/or seclusion</li> <li>- The circumstances that led to the use of restraint and/or seclusion</li> <li>- Consideration or failure of nonphysical interventions</li> <li>- The rationale for the type of physical intervention used</li> <li>- Written orders for the use of restraint and/or seclusion</li> <li>- Each verbal order received from a licensed independent practitioner</li> <li>- Each in-person evaluation and reevaluation of the individual served</li> <li>- Each 15-minute assessment of the status of the individual served</li> <li>- Continuous monitoring of the individual served</li> <li>- Any preexisting medical conditions or any physical disabilities that would place the individual served at greater risk during restraint and/or seclusion</li> <li>- Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint and/or seclusion</li> <li>- 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</li> <li>- That the individual served was notified of the use of restraint and/or seclusion</li> <li>- Behavior criteria for discontinuing restraint and/or seclusion</li> <li>- 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</li> <li>- Assistance provided to the individual served to help him or her meet the behavior criteria for discontinuing the use of restraint and/or seclusion</li> <li>- Debriefing the individual served with staff following an episode of restraint and/or seclusion</li> <li>- Any injuries the individual served sustained and the treatment for these injuries</li> <li>- The death of the individual served while in restraint or seclusion</li> </ul> | <b>C</b> |
| 4.       | <p>The method(s) used to document restraint and/or seclusion facilitates the collection and analysis of data for performance improvement activities.</p>  | <b>A</b> |





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**Standard RC.02.03.07**

Qualified staff receive and record verbal orders.

Note: Verbal orders may include medication, laboratory tests, dietary, or restraint and seclusion.



**Elements of Performance for RC.02.03.07**





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| 1.  |  The organization identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation. | <b>A</b> |
|  | 2. Only authorized staff receive and record verbal orders.  | <b>C</b> |
|  | 3. Documentation of verbal orders includes the date and the names of staff who gave, received, recorded, and implemented the orders.  | <b>C</b> |
|  | 4. Verbal orders are authenticated within the time frame specified by law and regulation.   | <b>C</b> |

**Standard RC.02.04.01**

The organization documents the discharge information of the individual served.

**Elements of Performance for RC.02.04.01**

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|  | 3. The clinical/case record contains the following: <ul style="list-style-type: none"> <li>- A concise discharge summary that includes the reason for acceptance for care, treatment, or services</li> <li>- The care, treatment, or services provided</li> <li>- The condition at discharge of the individual served</li> <li>- Information provided to the individual served and his or her family (for example, written discharge instructions, medication regimen, follow-up care)</li> </ul> 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.<br>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. |  <b>C</b> |
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**Standard RC.03.01.01**

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.

**Elements of Performance for RC.03.01.01**

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| 1.          | <p><b>D</b> For foster care: The agency defines in writing, and in accordance with law and regulation, the following:</p> <ul style="list-style-type: none"> <li>- Who has what level of access to information (for example, individuals served, family of origin, guardians, attorneys, foster parents)</li> <li>- The circumstances under which information may be released</li> <li>- The length of time records are kept</li> <li>- The individual served, family of origin or adoptive family, and foster family</li> <li>- The right of the individual served, family of origin or adoptive family, and the foster family to confidentiality and accessibility of information</li> </ul>     | A |
| 2.          | <p>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.</p> | A |
| 3.          | <p>For foster care: The agency implements its processes for accessing information, maintaining confidentiality of information, and for children/youth, maintaining a current life book.</p>  | A |
| <b>M</b> 4. | <p>For foster care: Information maintained by the agency includes the following:</p> <ul style="list-style-type: none"> <li>- 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</li> <li>- Contracts, correspondence, incident reports, and placement and other records or reports needed for the continuity of care</li> </ul>                       | C |

**Standard RC.03.01.03**

For foster care: The agency maintains foster family information.

**Elements of Performance for RC.03.01.03**

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| 1. | <p>For foster care: The foster family record contains copies of licensing certificates and reports.</p>  | A |
| 2. | <p>For foster care: The foster family record contains the application to provide foster care, references, background checks, and all assessment reports.</p> | A |
| 3. | <p>For foster care: The foster family record contains correspondence, including records of compliments and complaints.</p>                                   | A |

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- 4. For foster care: The foster family record contains evidence of training. A
- 5. For foster care: Foster family records are retained in accordance with law and regulation and organizational policy. A

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