The Joint Commission

History Tracking Report: 2009 to 2010 Requirements

Accreditation Program: Long Term 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.

Standard IM.01.01.01

2010 Standard Text:

The organization plans for managing information.

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 departments, 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.

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.

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 departments, 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.

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.

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2009 Standard: IM.1.10 **2009 EP:** 2 **2010 Standard:** IM.01.01.01 **2010 EP:** 3

2009 EP Text: **Revision Type:** Retain

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

2010 EP Text:

The organization uses the information identified to develop processes to manage information.

2009 Standard: IM.1.10 **2009 EP:** 3 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:NE

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.

2010 EP Text:

No EP

2009 Standard: IM.1.10 **2009 EP:** 4 **2010 Standard:** IM.01.01.01 **2010 EP:** 4

2009 EP Text: **Revision Type:** Retain

Identified staff participates in assessment, selection, integration, and use of information management systems for clinical/service and {jc}organization{/2} information.

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, and services.

2009 Standard: IM.1.10 **2009 EP:** 5 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:Redun

The {jc}organization{/2} has an ongoing process to assess the needs of the {jc}organization{/2}, departments, and individuals for knowledge-based information.

2010 EP Text:

No EP

2009 Standard: IM.1.10 **2009 EP:** 6 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:NE

The {jc}organization{/2} uses the assessment for knowledge-based information as a basis for planning.

2010 EP Text:

No EP

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Standard IM.2.10

2009 Standard Text:

Information privacy and confidentiality are maintained.

Standard IM.02.01.01

2010 Standard Text:

The organization protects the privacy of health information.

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.

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)

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.

2010 Standard: N/A

2010 EP Text:

No EP

2009 Standard: IM.2.10 **2009 EP:** 3

2009 EP Text: **Revision Type:** Retain

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

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)

2009 Standard: IM.2.10 **2009 EP:** 4

2009 EP Text: **Revision Type:** Retain

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

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)

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

2010 Standard: N/A

2010 EP Text:

No EP

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2009 Standard: IM.2.10 **2009 EP:** 6 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:Redun **2010 EP Text:**

Individuals for whom identifiable health data and information are maintained or collected are made aware of how the data will be used and whether it will be disclosed.

No EP

2009 Standard: IM.2.10 **2009 EP:** 7 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:NE **2010 EP Text:**

Personal identifiers are removed to the extent possible for uses and disclosures of health information, consistent with maintaining the usefulness of the information.

No EP

2009 Standard: IM.2.10 **2009 EP:** 8 **2010 Standard:** IM.02.01.01 **2010 EP:** 3

2009 EP Text: **Revision Type:** Split **2010 EP Text:**

Protected health information* is used for the purposes identified or as required by law or regulation and not further disclosed without {jc}patient{/1} authorization.*Protected health information Health information that contains information such that an individual person can be identified as the subject of that information.

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)

2009 Standard: IM.2.10 **2009 EP:** 8 **2010 Standard:** IM.02.01.01 **2010 EP:** 4

2009 EP Text: **Revision Type:** Split **2010 EP Text:**

Protected health information* is used for the purposes identified or as required by law or regulation and not further disclosed without {jc}patient{/1} authorization.*Protected health information Health information that contains information such that an individual person can be identified as the subject of that information.

The organization discloses health information only as authorized by the resident or as otherwise consistent with law and regulation. (See also RI.01.01.01, EP 7)

2009 Standard: IM.2.10 **2009 EP:** 9 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:Redun **2010 EP Text:**

The {jc}organization{/2} preserves the privacy and confidentiality of data and information identified as sensitive.

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Standard IM.2.20	**Standard IM.02.01.03**
2009 Standard Text: Information security, including data integrity, is maintained.	**2010 Standard Text:** The organization maintains the security and integrity of health information.

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.

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.

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.

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.

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.

2010 Standard: N/A
2010 EP Text:
No EP

2009 Standard: IM.2.20 **2009 EP:** 3
2009 EP Text: **Revision Type:** Retain
The {jc}organization{/2} implements the policy.

2010 Standard: IM.02.01.03 **2010 EP:** 5
2010 EP Text:
The organization protects against unauthorized access, use, and disclosure of health information.

2009 Standard: IM.2.20 **2009 EP:** 4
2009 EP Text: **Revision Type:** Retain
The {jc}organization{/2} monitors compliance with the policy.

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.

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.

2010 Standard: N/A
2010 EP Text:
No EP

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2009 Standard: IM.2.20 **2009 EP:** 6 **2010 Standard:** IM.02.01.03 **2010 EP:** 6

2009 EP Text: **Revision Type:** Retain **2010 EP Text:**

The {jc}organization{/2} develops and implements controls to safeguard data and information, including the clinical record, against loss, destruction, and tampering.

The organization protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.

2009 Standard: IM.2.20 **2009 EP:** 7 **2010 Standard:** IM.02.01.03 **2010 EP:** 3

2009 EP Text: **Revision Type:** Split **2010 EP Text:**

Controls to safeguard data and information include the following:Policies indicating when the removal of records is permittedProtection 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

The organization has a written policy addressing the intentional destruction of health information.

2009 Standard: IM.2.20 **2009 EP:** 7 **2010 Standard:** IM.02.01.03 **2010 EP:** 4

2009 EP Text: **Revision Type:** Split **2010 EP Text:**

Controls to safeguard data and information include the following:Policies indicating when the removal of records is permittedProtection 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

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.

2009 Standard: IM.2.20 **2009 EP:** 7 **2010 Standard:** IM.02.01.03 **2010 EP:** 7

2009 EP Text: **Revision Type:** Split **2010 EP Text:**

Controls to safeguard data and information include the following:Policies indicating when the removal of records is permittedProtection 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

The organization controls the intentional destruction of health information.

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2009 Standard: IM.2.20 **2009 EP:** 8 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:Redun

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.

2010 EP Text:

No EP

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Standard IM.2.30	**Standard IM.01.01.03**
2009 Standard Text: Continuity of information is maintained.	**2010 Standard Text:** The organization plans for continuity of its information management processes.

2009 Standard: IM.2.30	**2009 EP:** 1	**2010 Standard:** IM.01.01.03	**2010 EP:** 1
2009 EP Text:	**Revision Type:** Retain	**2010 EP Text:**	
The {jc}organization{/2} has a business continuity/disaster recovery plan for its information systems.		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)	

2009 Standard: IM.2.30	**2009 EP:** 2	**2010 Standard:** IM.01.01.03	**2010 EP:** 2
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: Scheduled and unscheduled interruptions. (See also IM.03.01.01, EP 1; EM.01.01.01, EP 6)	

2009 Standard: IM.2.30	**2009 EP:** 2	**2010 Standard:** IM.01.01.03	**2010 EP:** 3
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: Training for staff and licensed independent practitioners on alternate procedures to follow when systems are unavailable. (See also EM.01.01.01, EP 6)	

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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)
Note: A backup system can be electronic or manual.

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 resident care, treatment, and services. (See also IM.03.01.01, EP 1)

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Standard IM.3.10	**Standard IM.02.02.03**
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.	**2010 Standard Text:** The organization retrieves, disseminates, and transmits health information in useful formats.

2009 Standard: IM.3.10 **2009 EP:** 1	**2010 Standard:** IM.02.02.03 **2010 EP:** 1
2009 EP Text: **Revision Type:** Retain	**2010 EP Text:**
Information technology industry standards or {jc}organization{/2} policies are used and address the following:Uniform data definitionsData capture Data displayData transmission	The organization has written policies addressing data capture, display, transmission, and retention.

2009 Standard: IM.3.10 **2009 EP:** 3	**2010 Standard:** N/A
2009 EP Text: **Revision Type:** Split	**2010 EP Text:**
Minimum data sets, terminology, definitions, classifications, vocabulary, and nomenclature, including abbreviations, acronyms, symbols, and dose designations are standardized throughout the {jc}organization{/2}.	No EP

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:**
Minimum data sets, terminology, definitions, classifications, vocabulary, and nomenclature, including abbreviations, acronyms, symbols, and dose designations are standardized throughout the {jc}organization{/2}.	The organization uses uniform data sets to standardize data collection throughout the organization.

2009 Standard: IM.3.10 **2009 EP:** 4	**2010 Standard:** IM.04.01.01 **2010 EP:** 1
2009 EP Text: **Revision Type:** Split	**2010 EP Text:**
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.	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. Examples of health information to be checked include the information collected from a resident, his or her family, and a transferring organization.

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2009 Standard: IM.3.10 **2009 EP:** 4 **2010 Standard:** IM.04.01.01 **2010 EP:** 3

2009 EP Text: **Revision Type:** Split **2010 EP Text:**

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.

The organization implements its processes to check the accuracy of health information.

2009 Standard: IM.3.10 **2009 EP:** 5 **2010 Standard:** IM.02.02.03 **2010 EP:** 2

2009 EP Text: **Revision Type:** Retain **2010 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.

The organization's storage and retrieval systems make health information accessible when needed for resident care, treatment, and services. (See also IC.01.02.01, EP 1)

2009 Standard: IM.3.10 **2009 EP:** 6 **2010 Standard:** IM.02.02.03 **2010 EP:** 12

2009 EP Text: **Revision Type:** Retain **2010 EP Text:**

Data and information are retained for sufficient time to comply with law or regulation.

The organization retains data and information for time frames consistent with law and regulation.

2009 Standard: IM.3.10 **2009 EP:** 7 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:NE **2010 EP Text:**

Knowledgeable staff and tools are available for collecting, retrieving, and analyzing data and their transformation into information.

No EP

2009 Standard: IM.3.10 **2009 EP:** 8 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:Redun **2010 EP Text:**

Data are organized and transformed into information in formats useful to decision makers.

No EP

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2009 Standard: IM.3.10 **2009 EP:** 9 **2010 Standard:** IM.02.02.03 **2010 EP:** 3

2009 EP Text: **Revision Type:** Retain

Dissemination of data and information is timely* and accurate.*Timely Defined by organization policy and based on the intended use of the information.

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.

2009 Standard: IM.3.10 **2009 EP:** 10 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:Redun

Data and information are disseminated in standard formats and methods to meet user needs and provide for retrievability and interpretation.

2010 EP Text:

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Standard IM.4.10

2009 Standard Text:	**2010 Standard Text:**
The information management system provides information for use in decision making.	No Standard

2009 Standard: IM.4.10 **2009 EP:** 1 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:NE **2010 EP Text:**

2009 EP Text	2010 EP Text
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	No EP

2009 Standard: IM.4.10 **2009 EP:** 2 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:NE **2010 EP Text:**

2009 EP Text	2010 EP Text
To support clinical 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.	No EP

2009 Standard: IM.4.10 **2009 EP:** 3 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:NE **2010 EP Text:**

2009 EP Text	2010 EP Text
Comparative performance data and information are used for decision making, when available.	No EP

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Standard IM.5.10

2009 Standard Text:

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

Standard IM.03.01.01

2010 Standard Text:

Knowledge-based information resources are 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.

2010 Standard: IM.03.01.01 **2010 EP:** 1

2010 EP Text:

The organization provides access to knowledge-based information resources 24 hours a day, 7 days a week. (See also IM.01.01.03, EPs 2 and 6)

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.

2010 Standard: IM.03.01.01 **2010 EP:** 1

2010 EP Text:

The organization provides access to knowledge-based information resources 24 hours a day, 7 days a week. (See also IM.01.01.03, EPs 2 and 6)

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.

2010 Standard: N/A

2010 EP Text:

No EP

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Standard IM.6.10	**Standard RC.01.02.01**
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 Text:** Entries in the clinical record are authenticated.

2009	2010
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}.	**2010 Standard:** RC.01.02.01 **2010 EP:** 1 **2010 EP Text:** Only authorized individuals make entries in the clinical record.
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.	**2010 Standard:** RC.01.02.01 **2010 EP:** 2 **2010 EP Text:** The organization defines the types of entries in the clinical record made by nonindependent practitioners that require countersigning, in accordance with law and 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}.	**2010 Standard:** RC.01.01.01 **2010 EP:** 9 **2010 EP Text:** The organization uses standardized formats to document the care, treatment, and services it provides to residents.
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.	**2010 Standard:** RC.01.01.01 **2010 EP:** 11 **2010 EP Text:** All entries in the clinical record are dated.

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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.

2010 Standard: RC.01.02.01 **2010 EP:** 3

2010 EP Text:

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

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.

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

2010 EP Text:

Entries in the clinical record are authenticated by the author. Information introduced into the clinical 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 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.

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

2010 EP Text:

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

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2009 Standard: IM.6.10 **2009 EP:** 5

2009 EP Text: **Revision Type:** Retain

The author authenticates either by written signature, electronic signature, or computer key or rubber stamp the following: The history and physical examinationMedication ordersPractitioner ordersDischarge summary

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

2010 EP Text:

Entries in the clinical record are authenticated by the author. Information introduced into the clinical 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

2009 EP Text: **Revision Type:** Split

The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; 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:** 4

2010 EP Text:

The clinical record contains information unique to the resident, which is used for resident identification.

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

2009 EP Text: **Revision Type:** Split

The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; 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 record contains the information needed to support the resident’s diagnosis and condition.

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

2009 EP Text: **Revision Type:** Split

The {jc}medical record{/8} contains sufficient information to identify the {jc}patient{/1}; support the diagnosis/condition; 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:** 6

2010 EP Text:

The clinical record contains the information needed to justify the resident’s care, treatment, and services.

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2009 Standard: IM.6.10 **2009 EP:** 6 **2010 Standard:** RC.01.01.01 **2010 EP:** 7

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; 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 record contains information that documents the course and result of the resident's care, treatment, and services.

2009 Standard: IM.6.10 **2009 EP:** 6 **2010 Standard:** RC.01.01.01 **2010 EP:** 8

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; 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 record contains information about the resident’s care, treatment, and services needed to provide continuity of care among providers.

2009 Standard: IM.6.10 **2009 EP:** 8 **2010 Standard:** RC.01.03.01 **2010 EP:** 1

2009 EP Text: **Revision Type:** Split **2010 EP Text:**

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

The organization has a written policy that requires timely entry of information into the clinical record. (See also PC.01.02.03, EP 1)

2009 Standard: IM.6.10 **2009 EP:** 8 **2010 Standard:** RC.01.03.01 **2010 EP:** 3

2009 EP Text: **Revision Type:** Split **2010 EP Text:**

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

The organization implements its policy requiring timely entry of information into the resident’s clinical record. (See also PC.01.02.03, EP 2)

2009 Standard: IM.6.10 **2009 EP:** 9 **2010 Standard:** RC.01.01.01 **2010 EP:** 1

2009 EP Text: **Revision Type:** Split **2010 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.

The organization defines the components of a complete clinical record. (See also RC.01.04.01, EP 1)

2009 Standard: IM.6.10 **2009 EP:** 9 **2010 Standard:** RC.01.03.01 **2010 EP:** 2

2009 EP Text: **Revision Type:** Split **2010 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.

The organization defines the time frame for completion of the clinical record, which does not exceed 30 days after the resident’s discharge.

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2009 Standard: IM.6.10 **2009 EP:** 12 **2010 Standard:** RC.01.04.01 **2010 EP:** 1

2009 EP Text: **Revision Type:** Consolidate

{jc}Medical record{/8}s are reviewed on an ongoing basis at the point of care.

2010 EP Text:

The organization conducts an ongoing review of clinical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. (See also RC.01.01.01, EP 1)

2009 Standard: IM.6.10 **2009 EP:** 13 **2010 Standard:** RC.01.04.01 **2010 EP:** 1

2009 EP Text: **Revision Type:** 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.

2010 EP Text:

The organization conducts an ongoing review of clinical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. (See also RC.01.01.01, EP 1)

2009 Standard: IM.6.10 **2009 EP:** 14 **2010 Standard:** RC.01.05.01 **2010 EP:** 1

2009 EP Text: **Revision Type:** 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 EP Text:

The retention time of the clinical record is determined by its use and organization policy, in accordance with law and regulation.
Note: State law and regulation may address different retention time frames for clinical records for minors.

2009 Standard: IM.6.10 **2009 EP:** 15 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:NE

Clinical records are retained for five years from the resident's discharge date when there is no requirement in state law.

2010 EP Text:

No EP

2009 Standard: IM.6.10 **2009 EP:** 16 **2010 Standard:** N/A

2009 EP Text: **Revision Type:** Delete:NE

Clinical records of minors are retained for three years after the resident reaches legal age under the law.

2010 EP Text:

No EP

2009 Standard: IM.6.10 **2009 EP:** 17 **2010 Standard:** RC.01.05.01 **2010 EP:** 8

2009 EP Text: **Revision Type:** 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.

2010 EP Text:

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

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2009 Standard: IM.6.10 **2009 EP:** 19

2009 EP Text: **Revision Type:** Retain

In the event of a change in the organization’s ownership, residents’ clinical records remain the organization’s property and are transferred to the new owner unless otherwise indicated by law.

2010 Standard: RC.01.05.01 **2010 EP:** 6

2010 EP Text:

The residents’ clinical records remain the organization’s property and are transferred to the new owner, in the event of a change in the organization's ownership, unless otherwise indicated by law.

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Standard IM.6.20

2009 Standard Text:

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

Standard RC.02.01.01

2010 Standard Text:

The clinical record contains information that reflects the resident's care, treatment, and services.

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: Care, treatment, and services provided to the resident before his or her arrival, if any Documentation and findings of assessments*Initial medical assessment and conclusions or impressions drawn from medical history and physical examinationDiagnosis, diagnostic impression, or conditionsReason(s) for admission or care, treatment, and services Goals of the care and care plan Orders for care treatment and service as required by law or regulation Diagnostic and therapeutic ordersDiagnostic and therapeutic procedures, tests, and resultsProgress notes made by authorized individuals Reassessments and plan of care revisionsRelevant observations 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 dischargeRelevant diagnoses/conditions established during the course of care, treatment, and services*See the “Provision of Care, Treatment, and Services ” chapter in this manual.

2010 Standard: RC.02.01.01 **2010 EP:** 2

2010 EP Text:

The clinical record contains the following clinical information:
- The reason(s) for admission for care, treatment, and services
- Any observations relevant to care, treatment, and services
- Any progress notes made by authorized individuals
- Any orders, including medications ordered or prescribed, and diagnostic and therapeutic orders
- Any allergies to medications
- Any medications administered, including the strength, dose, and rate
- Any medication administration devices used, including access site or route
- Any adverse drug reactions
- Any medications dispensed or prescribed on discharge
- Any assessment findings (See also PC.01.02.01, EP 1)
- Any consultation reports
- Any food allergies

2009 Standard: IM.6.20 **2009 EP:** 2

2009 EP Text: **Revision Type:** Retain

{jc}Medical record{/8}s contain, as applicable, the following demographic information: Resident’s name, address, date of birth, religion, marital status, social security number, gender, and the name of any legally authorized representative Resident’s legal statusThe {jc}patient{/1}’s language and communication needs.

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

2010 EP Text:

The clinical record contains the following demographic information:
- The resident’s name, address, date of birth, and the name of any legally authorized representative
- The resident’s sex
- The resident’s language and communication needs

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

2009 EP Text: **Revision Type:** Retain

{jc}Medical record{/8}s contain, as applicable, the following information: Evidence of known advance directives Evidence of informed consent when required by organization policy Orders, renewal of orders, and documentation that resuscitative services are to be withheld or life-sustaining treatment withdrawn Discharge plan, or the reason for lack of an ongoing plan when discharge potential does not exist Referrals or communications made to external or internal care providers and community agencies Physician's summary and the resident's final diagnosis when the resident is admitted from either a hospital or another health care organization

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

2010 EP Text:

As needed to provide care, treatment, and services, the clinical record contains the following additional information:
- Any advance directives (See also RI.01.05.01, EP 11)
- Orders, renewal of orders, and documentation that resuscitative services are to be withheld or life-sustaining treatment withdrawn
- Any informed consent, when required by organization policy (See also RI.01.03.01, EP 13)
- Any records of communication with the resident, such as telephone calls or e-mail
- Any resident-generated information (for example, choices, habits, routine)
- Referrals or communication made to external or internal care providers and community agencies
- Any physician's summary and final diagnosis when the resident is admitted either from a hospital or from another health care organization
- The discharge plan or the reason for lack of an ongoing plan when discharge potential does not exist

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Standard IM.6.50	**Standard RC.02.03.07**
2009 Standard Text: Designated qualified staff accept and transcribe verbal or telephone orders from authorized individuals.	**2010 Standard Text:** Qualified staff receive and record verbal orders.

2009 Standard	2009 EP	Revision Type	2009 EP Text	2010 Standard	2010 EP	2010 EP Text
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	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	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	3	Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders.
IM.6.50	3	Retain	When required by law or regulation, verbal or telephone orders are authenticated within the specified time frame.	RC.02.03.07	4	Verbal orders are authenticated within the time frame specified by law and regulation.

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Standard IM.6.60	**Standard RC.01.01.01**
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.	**2010 Standard Text:** The organization maintains complete and accurate clinical records.

2009 Standard:	**2009 EP:**	**Revision Type:**	**2009 EP Text:**	**2010 Standard:**	**2010 EP:**	**2010 EP Text:**
IM.6.60	1	Retain	The {jc}organization{/2} has a process to track the location of all components of the {jc}medical record{/8}.	RC.01.01.01	12	The organization tracks the location of all components of the clinical record.
IM.6.60	2	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.	RC.01.01.01	13	If the clinical record is not maintained as a single entity, the organization has a system that allows staff to access information needed to provide care, treatment, and services to residents. (See also MM.01.01.01, EP 1)

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Standard IM.6.70

2009 Standard Text:

Clinical record documentation includes the provision of and response to the activities program at least quarterly.

Standard RC.02.01.09

2010 Standard Text:

Clinical record documentation includes the provision of and response to the activities program at least quarterly.

2009 Standard: IM.6.70 **2009 EP:** 1

2009 EP Text: **Revision Type:** Split

The provision of and response to the activities program based on the interdisciplinary care plan are documented at least quarterly in the clinical record.

2010 Standard: RC.02.01.09 **2010 EP:** 1

2010 EP Text:

The activity providers document the provision of activities to the resident based on the interdisciplinary care plan at least quarterly in the clinical record.

2009 Standard: IM.6.70 **2009 EP:** 1

2009 EP Text: **Revision Type:** Split

The provision of and response to the activities program based on the interdisciplinary care plan are documented at least quarterly in the clinical record.

2010 Standard: RC.02.01.09 **2010 EP:** 2

2010 EP Text:

The activity providers document the resident's response to the activities program based on the interdisciplinary care plan at least quarterly in the clinical record.

2009 Standard: IM.6.70 **2009 EP:** 2

2009 EP Text: **Revision Type:** Retain

The activity providers document in the clinical record and report to the charge nurse changes in the resident’s response to the activity program .

2010 Standard: RC.02.01.09 **2010 EP:** 3

2010 EP Text:

The activity providers document in the clinical record any report given to the primary nurse of changes in the resident’s response to the activity program.

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Standard IM.6.80

2009 Standard Text:

Clinical record documentation includes the provision of and response to nutrition care services at least quarterly.

Standard RC.02.01.11

2010 Standard Text:

Clinical record documentation includes the provision of and response to nutrition care services at least quarterly.

2009 Standard: IM.6.80 **2009 EP:** 1

2009 EP Text: **Revision Type:** Split

The provision of and response to nutrition care services based on the interdisciplinary care plan is documented at least quarterly in the clinical record.

2010 Standard: RC.02.01.11 **2010 EP:** 1

2010 EP Text:

The provision of nutrition care services is documented at least quarterly in the clinical record.

2009 Standard: IM.6.80 **2009 EP:** 1

2009 EP Text: **Revision Type:** Split

The provision of and response to nutrition care services based on the interdisciplinary care plan is documented at least quarterly in the clinical record.

2010 Standard: RC.02.01.11 **2010 EP:** 2

2010 EP Text:

The resident's response to nutrition care services based on the interdisciplinary care plan is documented at least quarterly in the clinical record.

2009 Standard: IM.6.80 **2009 EP:** 2

2009 EP Text: **Revision Type:** Retain

Documentation includes the current status and changes in the resident's nutritional status, including the following information: The resident's acceptance of prescribed dietsThe resident's food and fluid consumptionSignificant weight loss or gain consistent with law or regulationHydration statusThe resident's ability to eat independently The resident's ability to use adaptive devices for eating Current status and changes in the resident's physical or behavioral condition, including symptoms Summary of the resident's condition, which includes the extent to which nutritional goals included in the interdisciplinary care plan are achieved

2010 Standard: RC.02.01.11 **2010 EP:** 3

2010 EP Text:

Clinical record documentation includes the following information regarding nutrition care services:
- The resident's understanding of prescribed diets
- The resident's food consumption and nutrient status
- The resident's fluid consumption and hydration status
- Significant weight changes, in accordance with law or regulation
- The resident's ability to eat with or without adaptive devices
- Current status and changes in the resident's physical or behavioral status that affect nutrition (for example, the ability to function with or without natural teeth or dentures)
- Summary of the resident's nutritional status, including the extent to which nutritional goals included in the interdisciplinary care plan are affected or achieved

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Standard IM.6.90

2009 Standard Text:

Clinical record documentation includes the provision of and response to nursing care.

Standard RC.02.01.13

2010 Standard Text:

Clinical record documentation includes the provision of and response to nursing care.

2009 Standard: IM.6.90 **2009 EP:** 1

2009 EP Text: **Revision Type:** Split

The provision of nursing care that is based on the interdisciplinary care plan and the resident’s response to this care are documented in the clinical record.

2010 Standard: RC.02.01.13 **2010 EP:** 1

2010 EP Text:

The provision of nursing care that is based on the interdisciplinary care plan is documented in the clinical record.

2009 Standard: IM.6.90 **2009 EP:** 1

2009 EP Text: **Revision Type:** Split

The provision of nursing care that is based on the interdisciplinary care plan and the resident’s response to this care are documented in the clinical record.

2010 Standard: RC.02.01.13 **2010 EP:** 2

2010 EP Text:

The resident's response to the nursing care that is based on the interdisciplinary care plan is documented in the clinical record.

2009 Standard: IM.6.90 **2009 EP:** 2

2009 EP Text: **Revision Type:** Retain

Documentation includes the following: Medications and treatment given and untoward reactionsNursing care providedCurrent status and changes in the resident’s physical or behavioral condition, including symptomsSummary by licensed nursing staff of the resident’s condition, which includes the extent to which nursing goals included in the interdisciplinary care plan are achieved, at least quarterly or more often if the resident's condition warrantsNote: In determining the frequency of preparing a summary of the residents condition, consideration should be given to residents with complex needs or short lengths of stay.

2010 Standard: RC.02.01.13 **2010 EP:** 3

2010 EP Text:

Clinical record documentation includes the following information regarding nursing care:
- Medications and treatment given and untoward reactions
- Nursing care provided
- Current status and changes in the resident’s physical or behavioral condition, including symptoms
- Summary by licensed nursing staff of the resident’s condition, which includes the extent to which nursing goals included in the interdisciplinary care plan are achieved, at least quarterly or more often if the resident's condition warrants

Note: In determining the frequency of preparing a summary of the residents condition, consideration should be given to residents with complex needs or short lengths of stay.

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Standard IM.6.100	**Standard RC.02.01.15**
2009 Standard Text: Clinical record documentation includes the provision of and response to medical treatment and care.	**2010 Standard Text:** Clinical record documentation includes the provision of and response to medical treatment and care, and changes in the resident's condition.

2009 Standard	2009 EP	Revision Type	2009 EP Text	2010 Standard	2010 EP	2010 EP Text
IM.6.100	1	Split	The provision of medical treatment and care and the resident's response to medical treatment and care are documented in the clinical record.	RC.02.01.15	1	The provision of medical treatment and care is documented in the clinical record.
IM.6.100	1	Split	The provision of medical treatment and care and the resident's response to medical treatment and care are documented in the clinical record.	RC.02.01.15	2	The resident's response to medical treatment and care is documented in the clinical record.
IM.6.100	2	Retain	Documentation in the resident's clinical record includes, before or on admission, the submission of the following:Admitting diagnosisCurrent medical findingsDiet prescribedThe resident's functional status	RC.02.01.15	3	Documentation in the resident's clinical record includes, before or on admission, the following: - Admitting diagnosis - Current medical findings - Diet prescribed - The resident's functional status
IM.6.100	3	Retain	Documentation in the resident's clinical record includes medical observations and recommendations made after the initial medical assessment, as well as progress notes that are reported at the time of observation and that describe significant changes in the resident's condition.	RC.02.01.15	4	Documentation in the resident's clinical record includes medical observations and recommendations made after the initial medical assessment, as well as progress notes that are reported at the time of observation and that describe significant changes, as defined by the organization, in the resident's condition.
IM.6.100	4	Retain	Documentation in the resident's clinical record includes progress notes recorded by the physician at each visit.	RC.02.01.15	5	Documentation in the resident's clinical record includes progress notes recorded by the physician at each visit.

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2009 Standard: IM.6.100 **2009 EP:** 5

2009 EP Text: **Revision Type:** Retain

Upon the resident's discharge, documentation in the resident's clinical record includes the completion of the transfer form when appropriate, the discharge summary, and the resident's clinical record.

2010 Standard: RC.02.01.15 **2010 EP:** 6

2010 EP Text:

Upon the resident's discharge, documentation in the resident's clinical record includes the complete transfer form and the discharge summary.

2009 Standard: IM.6.100 **2009 EP:** 6

2009 EP Text: **Revision Type:** Retain

If the resident expires in the organization, the course of events leading up to the resident's death is documented.

2010 Standard: RC.02.01.15 **2010 EP:** 7

2010 EP Text:

If the resident dies in the organization, the course of events leading up to the resident's death is documented.

2009 Standard: IM.6.100 **2009 EP:** 7

2009 EP Text: **Revision Type:** Retain

Documentation in the resident's clinical record includes evidence that the attending physician has reviewed the consulting physician's orders for consistency with the overall care plan.

2010 Standard: RC.02.01.15 **2010 EP:** 8

2010 EP Text:

Documentation in the resident's clinical record includes evidence that the attending physician has reviewed the consulting physician's orders for consistency with the interdisciplinary plan of care.

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Standard IM.6.110	**Standard RC.02.01.17**
2009 Standard Text: Clinical record documentation includes the provision of and response to rehabilitation services.	**2010 Standard Text:** Clinical record documentation includes the provision of and response to rehabilitation services.

2009 Standard: IM.6.110 **2009 EP:** 1
2009 EP Text: **Revision Type:** Split
The provision of rehabilitation services that are provided based on the interdisciplinary care plan and the resident's response to these services are documented in the clinical record.

2010 Standard: RC.02.01.17 **2010 EP:** 1
2010 EP Text:
Documentation in the clinical record describes the provision of rehabilitation services that are based on the interdisciplinary care plan and includes the following:
- Reason for admission or referral to rehabilitation services
- Rehabilitation treatments, modalities, or procedures provided
- The resident's involvement in rehabilitation services

2009 Standard: IM.6.110 **2009 EP:** 1
2009 EP Text: **Revision Type:** Split
The provision of rehabilitation services that are provided based on the interdisciplinary care plan and the resident's response to these services are documented in the clinical record.

2010 Standard: RC.02.01.17 **2010 EP:** 2
2010 EP Text:
Documentation in the clinical record describes the resident's response to rehabilitation services, including the progress toward treatment goals as described in the interdisciplinary care plan.

2009 Standard: IM.6.110 **2009 EP:** 2
2009 EP Text: **Revision Type:** Split
Documentation describes the following: The resident's and family's perception of and involvement in rehabilitation servicesReason for the referral to rehabilitation services or admission for medically complex servicesRehabilitation treatments, modalities, or procedures providedThe resident's response to treatmentThe resident's involvement in rehabilitation servicesThe resident's progress toward treatment goals

2010 Standard: RC.02.01.17 **2010 EP:** 1
2010 EP Text:
Documentation in the clinical record describes the provision of rehabilitation services that are based on the interdisciplinary care plan and includes the following:
- Reason for admission or referral to rehabilitation services
- Rehabilitation treatments, modalities, or procedures provided
- The resident's involvement in rehabilitation services

2009 Standard: IM.6.110 **2009 EP:** 2
2009 EP Text: **Revision Type:** Split
Documentation describes the following: The resident's and family's perception of and involvement in rehabilitation servicesReason for the referral to rehabilitation services or admission for medically complex servicesRehabilitation treatments, modalities, or procedures providedThe resident's response to treatmentThe resident's involvement in rehabilitation servicesThe resident's progress toward treatment goals

2010 Standard: RC.02.01.17 **2010 EP:** 2
2010 EP Text:
Documentation in the clinical record describes the resident's response to rehabilitation services, including the progress toward treatment goals as described in the interdisciplinary care plan.

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2009 Standard: IM.6.110	2009 EP: 3	2010 Standard: RC.02.01.17	2010 EP: 3
2009 EP Text:	**Revision Type:** Retain	**2010 EP Text:**	
Assessment of rehabilitation achievement and estimates of further rehabilitation potential are entered at least weekly.		Documentation in the clinical record includes a summary of rehabilitation achievement and estimates of further rehabilitation potential at time frames defined by the organization in accordance with law and regulation, or more often if the resident's condition warrants.	

2009 Standard: IM.6.110	2009 EP: 4	2010 Standard: RC.02.01.17	2010 EP: 4
2009 EP Text:	**Revision Type:** Retain	**2010 EP Text:**	
Documentation includes a progress report and reassessment, including the following: Summary of the resident’s condition, which includes the extent to which rehabilitation goals included in the interdisciplinary care plan are achieved, every two weeks for the first quarter, every month for the second quarter, and quarterly thereafter or more frequently when a resident’s condition changes Estimates of the resident’s further rehabilitation potentialDischarge plan		Documentation in the clinical record includes a rehabilitation discharge plan.	

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Standard IM.6.120	**Standard RC.02.01.19**
2009 Standard Text: Clinical record documentation includes the provision of and response to social service interventions.	**2010 Standard Text:** Clinical record documentation includes the provision of and response to social services.

2009 Standard: IM.6.120	**2009 EP:** 1	**2010 Standard:** RC.02.01.19	**2010 EP:** 1
2009 EP Text:	**Revision Type:** Split	**2010 EP Text:**	
The provision of and the resident's response to social service interventions are documented in the clinical record.		Documentation in the clinical record describes the provision of social services, including the following: - Summary of the resident's problems and condition - Specified goals related to social services, including discharge planning - Services provided - Referrals to outside agencies, resources, or individuals	

2009 Standard: IM.6.120	**2009 EP:** 1	**2010 Standard:** RC.02.01.19	**2010 EP:** 2
2009 EP Text:	**Revision Type:** Split	**2010 EP Text:**	
The provision of and the resident's response to social service interventions are documented in the clinical record.		Documentation in the clinical record describes the response to social services, including the following: - Outcomes of services provided - The extent to which social services goals are achieved, as described in the interdisciplinary care plan. This documentation occurs at least quarterly or more often if the resident's condition warrants. - Follow-up actions or recommendations of outside agencies, resources, or individuals Note: In determining the frequency of preparing a summary, consideration should be given to residents with complex needs or short lengths of stay.	

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2009 Standard: IM.6.120 **2009 EP:** 2

2009 EP Text: **Revision Type:** Split

Documentation of social service interventions includes the following: Specified goals related to social services, including discharge planning, that are an integral part of the interdisciplinary care planServices provided and their outcomesSummary of the resident’s problems, services provided, goals, and condition, which includes the extent to which social services goals included in the interdisciplinary care plan are achieved, at least quarterly or more often if the resident’s condition warrantsReferrals to outside agencies, resources, or individuals, as well as follow-up actions or recommendations of outside agencies, resources, or individualsNote: In determining the frequency of preparing a summary, consideration should be given to residents with complex needs or short lengths of stay.

2010 Standard: RC.02.01.19 **2010 EP:** 1

2010 EP Text:

Documentation in the clinical record describes the provision of social services, including the following:
- Summary of the resident’s problems and condition
- Specified goals related to social services, including discharge planning
- Services provided
- Referrals to outside agencies, resources, or individuals

2009 Standard: IM.6.120 **2009 EP:** 2

2009 EP Text: **Revision Type:** Split

Documentation of social service interventions includes the following: Specified goals related to social services, including discharge planning, that are an integral part of the interdisciplinary care planServices provided and their outcomesSummary of the resident’s problems, services provided, goals, and condition, which includes the extent to which social services goals included in the interdisciplinary care plan are achieved, at least quarterly or more often if the resident’s condition warrantsReferrals to outside agencies, resources, or individuals, as well as follow-up actions or recommendations of outside agencies, resources, or individualsNote: In determining the frequency of preparing a summary, consideration should be given to residents with complex needs or short lengths of stay.

2010 Standard: RC.02.01.19 **2010 EP:** 2

2010 EP Text:

Documentation in the clinical record describes the response to social services, including the following:
- Outcomes of services provided
- The extent to which social services goals are achieved, as described in the interdisciplinary care plan. This documentation occurs at least quarterly or more often if the resident’s condition warrants.
- Follow-up actions or recommendations of outside agencies, resources, or individuals

Note: In determining the frequency of preparing a summary, consideration should be given to residents with complex needs or short lengths of stay.

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Standard IM.6.130	Standard RC.02.01.21
2009 Standard Text: Clinical record documentation includes the provision of education and its effectiveness.	**2010 Standard Text:** Clinical record documentation includes resident education.

2009 Standard	2009 EP	Revision Type	2009 EP Text	2010 Standard	2010 EP	2010 EP Text
IM.6.130	1	Split	The provision of and the resident's response to education are documented in the clinical record.	RC.02.01.21	1	The provision of resident education is documented in the clinical record.
IM.6.130	1	Split	The provision of and the resident's response to education are documented in the clinical record.	RC.02.01.21	2	The resident's response to education is documented in the clinical record.

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Standard IM.6.140

2009 Standard Text:

Clinical record documentation includes significant changes in the resident's condition, care, and treatment.

Standard RC.02.01.15

2010 Standard Text:

Clinical record documentation includes the provision of and response to medical treatment and care, and changes in the resident's condition.

2009 Standard: IM.6.140 **2009 EP:** 1

2009 EP Text: **Revision Type:** Retain

Clinical record documentation includes significant changes in the resident's condition, care, and treatment.

2010 Standard: RC.02.01.15 **2010 EP:** 9

2010 EP Text:

Clinical record documentation includes significant changes, as determined by the organization, in the resident's condition, care, treatment, and services.

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Standard IM.6.150

2009 Standard Text:

Treatment provided to the resident by off-site sources is documented in the clinical record.

Standard RC.02.01.25

2010 Standard Text:

Treatment provided to the resident by external resources is documented in the clinical record.

2009 Standard: IM.6.150 **2009 EP:** 1

2009 EP Text: **Revision Type:** Retain

Clinical record documentation includes treatment provided to the resident by off-site sources.

2010 Standard: RC.02.01.25 **2010 EP:** 1

2010 EP Text:

The clinical record includes information from external resources who provide treatment to the resident.

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Standard IM.6.160

2009 Standard Text:

Effects of medications on residents, and associated pharmacist evaluation and physician consultation, are documented.

Standard RC.02.01.27

2010 Standard Text:

Effects of medications on residents, and associated pharmacist evaluation and physician consultation, are documented in the clinical record.

2009 Standard: IM.6.160 **2009 EP:** 1

2009 EP Text: **Revision Type:** Split

Clinical records include documentation of the following: Resident's response to medications Pharmacist's evaluation and consultation with the physician The need for additional laboratory monitoringNote: Documentation can be included in the resident's clinical record or in another location such as the pharmacist's report.

2010 Standard: RC.02.01.27 **2010 EP:** 1

2010 EP Text:

Clinical records include documentation of the resident's response to medications. (See also MM.07.01.01, EPs 1 and 2)

2009 Standard: IM.6.160 **2009 EP:** 1

2009 EP Text: **Revision Type:** Split

Clinical records include documentation of the following: Resident's response to medications Pharmacist's evaluation and consultation with the physician The need for additional laboratory monitoringNote: Documentation can be included in the resident's clinical record or in another location such as the pharmacist's report.

2010 Standard: RC.02.01.27 **2010 EP:** 2

2010 EP Text:

Clinical records include documentation of the clinical or consultant pharmacists' findings, conclusions, and recommendations (for example, additional laboratory monitoring) resulting from monitoring of the medication regimen.

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Standard IM.6.170	**Standard RC.02.04.01**
2009 Standard Text: Discharge information provided to the resident or to the family, as appropriate and permissible, and/or to the receiving organization is documented.	**2010 Standard Text:** The organization documents the resident's discharge information.

2009 Standard: IM.6.170 **2009 EP:** 1	**2010 Standard:** RC.02.04.01 **2010 EP:** 1
2009 EP Text: **Revision Type:** Retain	**2010 EP Text:**
Clinical record documentation includes discharge information provided to the resident and/or to the receiving organization.	The organization documents in the clinical record the discharge information it provides to the resident and to the receiving organization.

2009 Standard: IM.6.170 **2009 EP:** 2	**2010 Standard:** RC.02.04.01 **2010 EP:** 2
2009 EP Text: **Revision Type:** Retain	**2010 EP Text:**
Discharge information includes the following: Medical findings, diagnosis(es), and treatment ordersSummary of the care, treatment, and services provided and progress toward achieving goalsDiet orders and medication ordersBehavioral status, ambulation status, nutrition status, and rehabilitation potentialThe resident's physical and psychosocial statusNursing information useful in resident careAdvance directivesReferrals provided to the residentThe reason for transfer, discharge, or referralPhysician's orders for the resident's immediate careInstructions given to the resident before dischargeThe referring physician's name The physician who has agreed to be responsible for the resident's medical care and treatment, if other than the referring physician	The resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring licensed independent practitioner's name, and the name of the licensed independent practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring licensed independent practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge

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