



Accreditation Program: Long Term Care
Record of Care, Treatment, and Services

Standard RC.01.01.01

The organization maintains complete and accurate clinical records.

Elements of Performance for RC.01.01.01

	1.	The organization defines the components of a complete clinical record. (See also RC.01.04.01, EP 1)	A
M	4.	The clinical record contains information unique to the resident, which is used for resident identification.	C
M	5.	The clinical record contains the information needed to support the resident's diagnosis and condition.	C
M	6.	The clinical record contains the information needed to justify the resident's care, treatment, and services.	C
M	7.	The clinical record contains information that documents the course and result of the resident's care, treatment, and services.	C
M	8.	The clinical record contains information about the resident's care, treatment, and services needed to provide continuity of care among providers.	3 C
	9.	The organization uses standardized formats to document the care, treatment, and services it provides to residents.	A
M	11.	All entries in the clinical record are dated.	C
	12.	The organization tracks the location of all components of the clinical record.	A
M	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)	C

Standard RC.01.02.01

Entries in the clinical record are authenticated.

Elements of Performance for RC.01.02.01

M	1.	Only authorized individuals make entries in the clinical record.	C
	2.	The organization defines the types of entries in the clinical record made by nonindependent practitioners that require countersigning, in accordance with law and regulation.	A
M	3.	The author of each clinical record entry is identified in the clinical record.	C
M	4.	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.	C

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

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

Standard RC.01.03.01

Documentation in the clinical 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 record. (See also PC.01.02.03, EP 1) **A**
2. The organization defines the time frame for completion of the clinical record, which does not exceed 30 days after the resident's discharge. **A**
- M** 3. The organization implements its policy requiring timely entry of information into the resident's clinical record. (See also PC.01.02.03, EP 2) **C**

Standard RC.01.04.01

The organization audits its clinical records.

Elements of Performance for RC.01.04.01

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

Standard RC.01.05.01

The organization retains its clinical records.

Elements of Performance for RC.01.05.01

1. **D** 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. **A**
6. 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. **A**
8. Original clinical records are not released unless the organization is responding to law and regulation. **A**

Standard RC.02.01.01

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

Elements of Performance for RC.02.01.01

- | | | |
|----------|--|------------|
| M | <p>1. The clinical record contains the following demographic information:</p> <ul style="list-style-type: none"> - 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 | C |
| M | <p>2. The clinical record contains the following clinical information:</p> <ul style="list-style-type: none"> - 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 | 3 C |
| M | <p>4. As needed to provide care, treatment, and services, the clinical record contains the following additional information:</p> <ul style="list-style-type: none"> - 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 | 3 C |

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

Standard RC.02.01.05

The clinical record contains documentation of the use of restraint.

Elements of Performance for RC.02.01.05

- | | | | |
|--|----|---|----------|
| | 2. | The use of restraint, including the trial of alternatives to restraint, is documented in the clinical record. (See also PC.03.02.09, EP 5; PC.03.02.13, EP 1) | A |
|--|----|---|----------|

Standard RC.02.01.09

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

Elements of Performance for RC.02.01.09

- | | | | |
|----------|----|---|----------|
| M | 1. | The activity providers document the provision of activities to the resident based on the interdisciplinary care plan at least quarterly in the clinical record. | C |
| M | 2. | 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. | C |
| M | 3. | 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. | C |

Standard RC.02.01.11

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

Elements of Performance for RC.02.01.11

- | | | | |
|----------|----|---|----------|
| M | 1. | The provision of nutrition care services is documented at least quarterly in the clinical record. | C |
| M | 2. | The resident's response to nutrition care services based on the interdisciplinary care plan is documented at least quarterly in the clinical record. | C |
| M | 3. | Clinical record documentation includes the following information regarding nutrition care services: <ul style="list-style-type: none"> - 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 | C |

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

Standard RC.02.01.13

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

Elements of Performance for RC.02.01.13

- | | | |
|----------|---|----------|
| M | 1. The provision of nursing care that is based on the interdisciplinary care plan is documented in the clinical record. | C |
| M | 2. The resident's response to the nursing care that is based on the interdisciplinary care plan is documented in the clinical record. | C |
| M | 3. 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. | C |

Standard RC.02.01.15

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

Elements of Performance for RC.02.01.15

- | | | |
|----------|--|----------|
| M | 1. The provision of medical treatment and care is documented in the clinical record. | C |
| M | 2. The resident's response to medical treatment and care is documented in the clinical record. | C |
| M | 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 | C |
| M | 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. | C |
| M | 5. Documentation in the resident's clinical record includes progress notes recorded by the physician at each visit. | C |
| M | 6. Upon the resident's discharge, documentation in the resident's clinical record includes the complete transfer form and the discharge summary. | C |
| M | 7. If the resident dies in the organization, the course of events leading up to the resident's death is documented. | C |

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 | 8. 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. | C |
| M | 9. Clinical record documentation includes significant changes, as determined by the organization, in the resident's condition, care, treatment, and services. | C |

Standard RC.02.01.17

Clinical record documentation includes the provision of and response to rehabilitation services.

Elements of Performance for RC.02.01.17

- | | | |
|----------|--|----------|
| M | 1. Documentation in the clinical record describes the provision of rehabilitation services that are based on the interdisciplinary care plan and includes the following: <ul style="list-style-type: none"> - Reason for admission or referral to rehabilitation services - Rehabilitation treatments, modalities, or procedures provided - The resident's involvement in rehabilitation services | C |
| M | 2. 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. | C |
| M | 3. 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. | C |
| M | 4. Documentation in the clinical record includes a rehabilitation discharge plan. | C |

Standard RC.02.01.19

Clinical record documentation includes the provision of and response to social services.

Elements of Performance for RC.02.01.19

- | | | |
|----------|--|----------|
| M | 1. Documentation in the clinical record describes the provision of social services, including the following: <ul style="list-style-type: none"> - 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 | C |
|----------|--|----------|

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 | 2. | Documentation in the clinical record describes the response to social services, including the following: | C |
| | | - 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. | |

Standard RC.02.01.21

Clinical record documentation includes resident education.

Elements of Performance for RC.02.01.21

- | | | | |
|----------|----|--|----------|
| M | 1. | The provision of resident education is documented in the clinical record. | C |
| M | 2. | The resident's response to education is documented in the clinical record. | C |

Standard RC.02.01.25

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

Elements of Performance for RC.02.01.25

- | | | | |
|----------|----|---|----------|
| M | 1. | The clinical record includes information from external resources who provide treatment to the resident. | C |
|----------|----|---|----------|

Standard RC.02.01.27

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

Elements of Performance for RC.02.01.27




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

Standard RC.02.03.07

Qualified staff receive and record verbal orders.

Elements of Performance for RC.02.03.07



- | | | | |
|--|----|--|----------|
| | 1. | D The organization identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation. | A |
|--|----|--|----------|





- | | | |
|---|--|----------|
|  | 2. Only authorized staff receive and record verbal orders. | C |
|  | 3. Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders. | C |
|  | 4. Verbal orders are authenticated within the time frame specified by law and regulation. | C |

Standard RC.02.04.01

The organization documents the resident's discharge information.

Elements of Performance for RC.02.04.01

- | | | |
|---|--|----------|
|  | 1. The organization documents in the clinical record the discharge information it provides to the resident and to the receiving organization. | C |
|  | 2. The resident's discharge information includes the following: <ul style="list-style-type: none"> - 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 | C |

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