The clinical record contains information that reflects the patient's care, treatment, or services.

**Element(s) of Performance for RC.02.01.01**
2. The clinical record contains the following clinical information:
- The patient's initial diagnosis, diagnostic impression(s), or condition(s)
- Any findings of assessments and reassessments (See also PC.01.02.01, EP 1; PC.03.01.03, EPs 1 and 8)
- Any allergies to food
- Any allergies to medications
- Any conclusions or impressions drawn from the patient's medical history and physical examination
- Any diagnoses or conditions established during the patient's course of care, treatment, or services
- Any consultation reports
- Any progress notes
- Any medications ordered or prescribed
- Any medications administered, including the strength, dose, route, date and time of administration
- Any access site for medication, administration devices used, and rate of administration
- The patient's response to any medication administered
- Any adverse drug reactions
- Plans for care and any revisions to the plan for care
- Orders for diagnostic and therapeutic tests and procedures and their results

Note 1: When rapid titration of a medication is necessary, the organization defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation.

Note 2: For the definition and a further explanation of block charting, refer to the Glossary.
- Any access site for medication, administration devices used, and rate of administration
- The patient's response to any medication administered
- Any adverse drug reactions
- Plans for care and any revisions to the plan for care
- Orders for diagnostic and therapeutic tests and procedures and their results
Glossary definition for block charting: A documentation method that can be used when rapid titration of medication is necessary in specific urgent/emergent situations defined in organizational policy. A single “block” charting episode does not extend beyond a four-hour time frame. If a patient’s urgent/emergent situation extends beyond four hours and block charting is continued, a new charting “block” period must be started. The following minimum elements must be documented in each block charting episode:

- Time of initiation of the charting block
- Name(s) of medications administered during the block
- Starting rates and ending rates of medications administered during the charting block
- Maximum rate (dose) of medications administered during the charting block
- Time of completion of the charting block
- Physiological parameters evaluated to determine the administration of titratable medications during the charting block