

Chapter Outline

Chapter: Record of Care, Treatment, and Services (RC) Program: Behavioral Health Care

SII Chapter Outline: RC

- I. Plan
 - A. Clinical/Case Record Components (revised RC.01.01.01)
 - B. Authentication (revised RC.01.02.01)
 - C. Timeliness (revised RC.01.03.01)
 - D. Audit (revised RC.01.04.01)
 - E. Retention (revised RC.01.05.01)

- II. Implement
 - A. Care, Treatment, or Services (revised RC.02.01.01, RC.02.01.05) (revised RC.02.01.03, RC.02.01.07, RC.02.01.09, RC.02.01.11, RC.02.01.13, RC.02.01.15, RC.02.01.17, RC.02.01.19, RC.02.01.21, RC.02.01.23, RC.02.01.25, RC.02.01.27 are not applicable to Behavioral Health Care)
 - B. Not applicable to Behavioral Health Care (revised RC.02.02.01)
 - C. Orders (revised RC.02.03.07)
 - D. Discharge Information (revised RC.02.04.01)

- III. Foster Care
 - A. Agency Documentation (revised RC.03.01.01, RC.03.01.03)

Revised Chapter

Record of Care, Treatment, and Services

Behavioral Health Care Accreditation Program

Revised Standard RC.01.01.01

The [organization] maintains complete and accurate clinical/case records.

Revised Elements of Performance for RC.01.01.01

1. The organization defines the components of a complete clinical/case record.
5. The clinical/case record contains the information needed to support the diagnosis and condition of the individual served.
6. The clinical/case record contains the information needed to justify the care, treatment, or services of the individual served.
7. The clinical/case record contains information that documents the course and result of the care, treatment, or services of the individual served.
8. The clinical/case record contains information about the care, treatment, or services of the individual served that promotes continuity of care among providers.
9. The organization uses standardized formats to document the care, treatment, or services it provides to individuals served.
11. All entries in the clinical/case record are dated.
12. The organization tracks the location of all components of the clinical/case record.

Revised Standard RC.01.02.01

Entries in the clinical/case record are authenticated.

Revised Elements of Performance for RC.01.02.01

1. Only authorized staff make entries in the clinical/case record.
2. The organization defines the types of entries in the clinical/case record made by nonindependent practitioners that require countersigning, in accordance with law and regulation.
3. The author of each clinical/case record entry is identified in the clinical/case record.
4. Entries in the clinical/case record are authenticated by the author. Information introduced into the clinical/case record through transcription or dictation is authenticated by the author.
Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.
Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.
5. The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it.

Revised Standard RC.01.03.01

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

Revised Elements of Performance for RC.01.03.01

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

Revised Standard RC.01.04.01

The [organization] audits its clinical/case records.

Revised Elements of Performance for RC.01.04.01

1. According to a time frame it defines, the organization reviews its clinical/case records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.

Revised Standard RC.01.05.01

The [organization] retains its clinical/case records.

Revised Elements of Performance for RC.01.05.01

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

Revised Standard RC.02.01.01

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

Revised Elements of Performance for RC.02.01.01

1. The clinical/case record contains the following demographic information:
 - The name, address, and date of birth of the individual served
 - The sex of the individual served
 - The preferred language and any special communication needs of the individual served (See also MM.01.01.01, EP 3)Note: Special communication needs may include sign language.
2. The clinical/case record of the individual served contains the following clinical information:
 - The reason(s) for admission for care, treatment, or services
 - The initial diagnosis, diagnostic impression(s), or condition(s)
 - Any findings of assessments and reassessments (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 medical history and physical examination
 - Any diagnoses or conditions established during the course of care, treatment, or services
 - Any consultation reports
 - Any observations relevant to care, treatment, or services
 - The response to care, treatment, or services
 - Any emergency care, treatment, or services provided prior to arrival
 - Any progress notes
 - Any medications ordered or prescribed
 - Any medications administered, including the strength, dose, and route
 - Any access site for medication, administration devices used, and rate of administration (for intravenous therapy)
 - Any adverse drug reactions
 - Treatment goals, plan of care, and revisions to the plan of care (See also PC.01.03.01, EP 1 and 23)
 - Orders for diagnostic and therapeutic tests and procedures and their results
4. As needed to provide care, treatment, or services, the clinical/case record contains the following additional information:
 - Any advance directives
 - Any informed consent (See also RI.01.03.01, EP 13)
 - Any documentation of protective services
 - Any documentation of consent by the individual served, family, or guardian for admission; care, treatment, or services; evaluation; continuing care; or research
 - Any records of communication with the individual served, such as telephone calls or e-mail
 - Any documentation of involvement in care, treatment, or services by the individual served and, when necessary, his or her family
 - Any information on unusual occurrences, such as complications; accidents or injuries to the individual served; procedures that place the individual served at risk or cause pain; other illnesses or conditions that affect care, treatment, or services; and the death of the individual served
 - Any indications for and episodes of special procedures

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22. When a person with intellectual disabilities, family, or advocate is unwilling to participate in planning of care, treatment, or services, this is documented in the clinical/case record.
 27. When more than one member of the family is receiving care, treatment, or services, a separate clinical/case record is maintained for each family member involved.
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Revised Standard RC.02.01.05

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

Revised Elements of Performance for RC.02.01.05

3. The organization documents the use of restraint and/or seclusion for behavioral health purposes in the clinical/case record, including the following:
 - Each episode of restraint and/or seclusion
 - The circumstances that led to the use of restraint and/or seclusion
 - Consideration or failure of nonphysical interventions
 - The rationale for the type of physical intervention used
 - Written orders for the use of restraint and/or seclusion (See also PC.03.03.13, EPs 1-3)
 - Each verbal order received from a licensed independent practitioner (See also PC.03.03.17, EP 1)
 - Each in-person evaluation and reevaluation of the individual served
 - Each 15-minute assessment of the status of the individual served (See also PC.03.03.07, EP 5)
 - Continuous monitoring of the individual served (See also PC.03.03.25, EPs 1 and 2)
 - Any pre-existing medical conditions or any physical disabilities that would place the individual served at greater risk during restraint and/or seclusion
 - Any history of sexual or physical abuse that would place the [patient] at greater psychological risk during restraint and/or seclusion
 - That the individual served and/or his or her family was informed of the organization's policy on the use of behavioral restraint and/or seclusion
 - That the individual served was notified of the use of restraint and/or seclusion
 - Behavior criteria for discontinuing restraint and/or seclusion
 - That the individual served was informed of the behavior criteria he or she needed to meet in order for restraint and/or seclusion to be discontinued
 - Assistance provided to the individual served to help him or her meet the behavior criteria for discontinuing the use of restraint and/or seclusion
 - Debriefing the individual served with staff following an episode of restraint and/or seclusion (See also PC.03.03.29, EP 1)
 - Any injuries the individual served sustained and the treatment for these injuries
 - The death of the individual served, should this occur while he or she is under the care of the organization
4. The method(s) used to document restraint and/or seclusion facilitates the collection and analysis of data for performance improvement activities.

Revised Standard RC.02.03.07

Qualified staff receive and record verbal orders.

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

Revised Elements of Performance for 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.
 2. Only authorized staff receive and record verbal orders.
 3. Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders.
 4. Verbal orders are authenticated within the time frame specified by law and regulation.
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Revised Standard RC.02.04.01

The [organization] documents the discharge information of the individual served.

Revised Elements of Performance for RC.02.04.01

3. The clinical/case record contains the following:
 - A concise discharge summary that includes the reason for acceptance for care, treatment, or services
 - The care, treatment, or services provided
 - The condition at discharge of the individual served
 - Information provided to the individual served and his or her family

Note 1: A discharge summary is not required when individuals served are seen for brief interventions, as defined by the clinical staff. In these instances, a final progress note may be substituted for the discharge summary.

Note 2: When individuals served are transferred to a different program within the organization and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

Revised Standard RC.03.01.01

The agency defines and maintains child- and family-specific information for continuity of care and initiation of improvement in its performance.

Revised Elements of Performance for RC.03.01.01

1. The agency defines in writing and in accordance with law and regulation, the following:
 - Who has what level of access to information (for example, children, family of origin, guardians, attorneys, foster parents)
 - The circumstances under which information can may be released
 - The length of time records are kept
 - The child, family of origin, foster family, and the adoptive family
 - The child, family of origin, foster family, and the adoptive family's rights to confidentiality and accessibility of information .
2. The agency implements its processes for accessing information, maintaining confidentiality of information, and maintaining a current life book.
3. The agency has a plan to maintain a current life book for the child, or a similar way or providing such information.
Note: This chronological record of a child's life is created by the child or the caregivers. Items in this book follow the child and will reflect significant life events, up to and including the present placement. The information may include developmental milestones, school information, placement records and reasons for moves, family history, awards and achievements, relationships, goals, information about and descriptions of birth parents and siblings (for example, family tree, pictures), and information about foster families.
4. Information maintained by the agency includes the following:
 - Case records that include social and legal information, family of origin history, school reports, incident reports (for example, behavior problems, illness, injuries) medical and dental records and history, birth and developmental history, immunization records, placement authorization, case plan, progress reports, school information, and family of origin and foster care contacts.
 - Contracts, correspondence, incident reports, and placement and other records or reports needed for the continuity of care.

Revised Standard RC.03.01.03

The agency maintains foster family information.

Revised Elements of Performance for RC.03.01.03

1. The foster family record contains copies of licensing certificates and reports.
2. The foster family record contains the application to provide foster care, references, background checks, and all assessment reports.
3. The foster family record contains correspondence including records of compliments and complaints.
4. The foster family record contains evidence of training.
5. Foster family records are retained in accordance with law and regulation and organizational policy.