The Joint Commission E-dition

Effective Date: August 25, 2014

Program: Ambulatory

Chapter: Record of Care, Treatment, and Services

Overview:

The "Record of Care, Treatment, and Services" (RC) chapter contains a wealth of information about the components of a complete clinical record. A highly detailed document when seen in its entirety, the record of care comprises all data and information gathered about a patient from the moment he or she enters the organization to the moment of discharge or transfer. As such, the record of care functions not only as a historical record of a patient's episode(s) of care, but also as a method of communication between practitioners and staff that can facilitate the continuity of care and aid in clinical decision making.

In many organizations, patient care is episodic. The organization may only see the patient once or twice, depending on the patient's need and the organization's scope of services. For example, a diagnostic imaging center may only see the patient for magnetic resonance imaging (MRI). However, other organizations, such as college-based student health centers, may see a patient for a limited number of visits over a few years. In either case, the patient's episode(s) of care must be carefully documented.

Whether the organization keeps paper records, electronic records, or both, the contents of the record remain the same. Special care should be taken, however, by organizations that are transitioning from paper to electronic systems, as the period of transition can present increased opportunity for errors in recordkeeping that can affect the delivery of safe, quality care.

About This Chapter:

Within this chapter, those responsible for compiling the clinical record can find a comprehensive set of requirements for its contents. The separate components of a complete clinical record are listed and arranged within common groups (demographic, clinical, and additional information). This chapter also contains documentation requirements for screenings, assessments, and reassessments; pre- and postoperative procedures; the

administration of moderate or deep sedation or anesthesia; restraint and seclusion; the clinical procedures themselves; and discharge. Standards provide policies and procedures that guide the compilation, completion, authentication, retention, and release of records.

Chapter Outline:

I. Plan

A. Clinical Record Components (RC.01.01.01)

B. Authentication (RC.01.02.01)

C. Verbal Orders (RC.01.03.01)

D. Audit (RC.01.04.01)

E. Retention (RC.01.05.01)

II. Implement

A. Care, Treatment, or Services (RC.02.01.01, RC.02.01.03, RC.02.01.05,RC.02.01.07) (RC.02.01.09 through RC.02.01.27 are not applicable toambulatory care)

B. Not applicable to ambulatory care (RC.02.02.01)

C. Orders (RC.02.03.07)

D. Not applicable to ambulatory care (RC.02.04.01)

III. Not applicable to ambulatory care (RC.03.01.01 and RC.03.01.03)

EP Attributes Icon Legend:

CMS	CMS Crosswalk	1	EP Criticality level is 1 - Immediate Threat to Health or Safety
A	EP belongs to Scoring Category 'A'	2	EP Criticality level is 2 - Situational Decision Rules
C	EP belongs to Scoring Category 'C'	3	EP Criticality level is 3 - Direct Impact.
M	EP requires Measure of Success	**D**	Documentation is required
ESP-1	EP applies to Early Survey Option	**NEW**	EP is new or changed as of the selected effective date.

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RC.01.01.01: The organization maintains complete and accurate clinical records.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

1 The organization defines the components of a complete clinical record.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.47				A	ESP-1

5 The clinical record contains the information needed to support the patient's diagnosis and condition.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.47 §416.47(b)	M			C	

6 The clinical record contains the information needed to justify the patient's care, treatment, or services.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

7 The clinical record contains information that documents the course and result of the patient's care, treatment, or services.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.47 §416.47(b)	M			C	

8 The clinical record contains information about the patient's care, treatment, or services that promotes continuity of care among providers.
Note: For organizations that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- Coordination of Care		M			C	

9 The organization uses standardized formats to document the care, treatment, or services it provides to patients.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
						A	

11 All entries in the clinical record are dated.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
						C	

12 The organization tracks the location of all components of the clinical record.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.47				A	

13 The organization assembles or makes available in a summary in the clinical record all information required to provide patient care, treatment, or services. (See also MM.01.01.01, EP 1)

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.47	M			C	

14 When needed to provide care, summaries of treatment and other documents provided by the organization are forwarded to other care providers.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.47	M			C	

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RC.01.02.01: Entries in the clinical record are authenticated.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

1 Only authorized individuals make entries in the clinical record.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			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.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
						A	ESP-1

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

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

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.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.49(b)(1)	M			C	

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

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.49(b)(1)				A	

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RC.01.03.01: Documentation in the clinical record is entered in a timely manner.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

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

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
					D	A	ESP-1

2 The organization defines the time frame for completion of the clinical record.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
						A	ESP-1

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

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

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RC.01.04.01: The organization audits its clinical records.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

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

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.47 §416.47(a) §416.47(b)	M			C	

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RC.01.05.01: The organization retains its clinical records.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

1 The retention time of the clinical record is determined by its use and organization policy, in accordance with law and regulation.
Note: For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The Centers for Medicare & Medicaid Services requires the ambulatory surgical center to retain the original or legally reproduced medical record for at least five years, including applicable films, scans, and other images.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.47 §416.47(a) §416.49(b)(1) §416.49(b)(2)			D	A	

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

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
						A	

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RC.02.01.01: The clinical record contains information that reflects the patient's care, treatment, or services.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

1 The clinical record contains the following demographic information:
- The patient’s name, address, phone number, and date of birth and the name of any legally authorized representative
- The patient’s sex, height, and weight
- The legal status of any patient receiving behavioral health care services
- The patient’s language and communication needs

Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the clinical record.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- Disparities in Care, Health Equity	§416.47(b)(1)	M			C	

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, EPs 1 and 4; 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, and route
- 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 (See also PC.01.03.01, EP 1)
- Orders for diagnostic and therapeutic tests and procedures and their results

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- Diagnostic Imaging	§416.47(b)(2) §416.47(b)(5) §416.52(a)(2) §416.49(b)(1)	M	3		C	

4 As needed to provide care, treatment, or services, the clinical record contains the following additional information:
- Any advance directives

Note: For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization documents in a prominent place in the clinical record whether or not the patient has advance directives in place.
- Any informed consent (See also RI.01.03.01, EP 13)
- Any documentation of clinical research interventions distinct from entries related to regular patient care, treatment, or services (See also RI.01.03.05, EPs 4-6)
- Any records of communication with the patient, such as telephone calls or e-mail
- Any referrals or communications made to internal or external care providers and community agencies
- Any patient-generated information

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- FSA Direct Impact EPs	§416.50(c)(3) §416.47(b)(7)	M	3		C	

21 The clinical record of a patient who receives urgent or immediate care, treatment, or services contains the following:
- The time and means of arrival
- Indication that the patient left against medical advice, when

applicable
- Conclusions reached at the termination of care, treatment, or services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, or services
- A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment, or services

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- Coordination of Care		M			C	

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RC.02.01.03: The patient's clinical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

1 The organization documents in the patient's clinical record any operative or other high-risk procedure and/or the administration of moderate or deep sedation or anesthesia.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- FSA Direct Impact EPs	§416.47(b)(6)		3		A	

2 A licensed independent practitioner involved in the patient's care documents the provisional diagnosis in the clinical record before an operative or other high-risk procedure is performed.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

5 An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.
Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the organization.
Note 2: If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- FSA Direct Impact EPs		M	3		C	

6 The operative or other high-risk procedure report includes the following information:
- The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
- The name of the procedure performed
- A description of the procedure
- Findings of the procedure
- Any estimated blood loss
- Any specimen(s) removed
- The postoperative diagnosis

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.47(b)(4) §416.52(c)(2)	M	3		C	

7 When a full operative or other high-risk procedure report cannot be entered immediately into the patient's clinical record, a note is entered immediately. This note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- FSA Direct Impact EPs		M	3		C	

8 The clinical record contains the following postoperative information:
- The patient's vital signs and level of consciousness (See also PC.03.01.05, EP 1; PC.03.01.07, EP 1)
- Any medications, including intravenous fluids and any administered blood, blood products, and blood components
- Any unanticipated events or complications (including blood transfusion reactions) and the management of those events

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP

- FSA Direct Impact EPs	§416.47(b)(6)	M	3	C

9 The clinical record contains documentation that the patient was discharged from the recovery phase of the operation or procedure either by the licensed independent practitioner responsible for his or her care or according to discharge criteria. (See also PC.03.01.07, EP 4)

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

10 The clinical record contains documentation of the use of approved discharge criteria that determine the patient's readiness for discharge. (See also PC.03.01.07, EP 4)

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

11 The postoperative documentation contains the name of the licensed independent practitioner responsible for discharge.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§416.52(c)(2)	M			C	

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RC.02.01.05: The clinical record contains documentation of the use of restraint.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

1 The organization documents the use of restraint in the clinical record, including the following:
- Orders for use
- Results of patient monitoring
- Reassessment
- Unanticipated changes in the patient's condition

(See also PC.03.02.03, EP 1; PC.03.02.07, EPs 1 and 2)

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

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RC.02.01.07: The clinical record contains a summary list for each patient who receives continuing ambulatory care services.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

1 A summary list is initiated for the patient by his or her third visit.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

2 The patient's summary list contains the following information:
- Any significant medical diagnoses and conditions
- Any significant operative and invasive procedures
- Any adverse or allergic drug reactions
- Any current medications, over-the-counter medications, and herbal preparations

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

3 The patient's summary list is updated whenever there is a change in diagnoses, medications, or allergies to medications, and whenever a procedure is performed.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

4 The summary list is readily available to practitioners who need access to the information of patients who receive continuing ambulatory care services in order to provide care, treatment, or services.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

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RC.02.03.07: Qualified staff receive and record verbal orders.

Rationale: Not applicable.

Introduction: Not applicable

Elements of Performance

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

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
					D	A	ESP-1

2 Only authorized staff receive and record verbal orders.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
			M			C	

3 Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
						C	

4 Verbal orders are authenticated within the time frame specified by law and regulation.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
						C	