Long Term Care
Health Information Practice
And
Documentation Guidelines

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Developed By:
AHIMA/FORE Long Term Care Taskforce

Written By:
Michelle Dougherty, RHIA
HIM Practice Manager, AHIMA

In Partnership With --
Beverly Enterprises
Extendicare Health Services
Genesis Health Ventures
Good Samaritan Society
Harborside Healthcare Corporation
HCR-ManorCare
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1.0 INTRODUCTION

1.1 Purpose And Use of These Guidelines:

Over the past decade, the long term care (LTC) industry has had an increased need for complete and accurate clinical record documentation. Documentation-based survey initiatives, quality indicators, corporate compliance, reimbursement changes and litigation have all had an impact on the industry and the need for properly maintained clinical record systems. The LTC Health Information Practice and Documentation Guidelines were developed to provide a resource to health information professionals and healthcare organizations on the role of the health information practitioners, practice guidelines for establishing and maintaining health information systems, and documentation guidelines specific to long term care.

Federal regulations for nursing facilities and skilled nursing facilities require organizations to maintain their clinical records in accordance with accepted professional standards and practices and to employ or contract with professionals necessary to carry out the regulations.

Just as the LTC industry has seen changes, it is anticipated that these practice guidelines will also be reviewed, revised and updated to adapt to future changes in practice, systems, and regulations.

Note: These guidelines were developed to address federal regulations for LTC facilities. State regulations should be followed if they differ from the practice guidelines.

1.2 Transition From Medical Records To Health Information Management (HIM):

The terms health information and health information management are used throughout this document to represent the medical record and medical record department. In the early 1990’s the American Medical Record Association changed its name to the American Health Information Management Association to better reflect the role the medical record professional. The new terminology recognized the maintenance of clinical information in a variety of formats and the evolution of the role of a medical record director to one whose role is to manage health information beyond the medical record.

1.3 Definition of Long Term Care Facility:

The term long term care (LTC) facility is used throughout the guidelines to represent nursing facilities and skilled nursing facilities. The term resident was used rather than patient to provide consistency with the term used in the federal requirements for long term care facilities.

1.4 Acknowledgements

These guidelines have been developed and made available to health care organizations and health information management professionals through donations to the Foundation of Research and Education in Health Information Management (FORE) by six contributing organizations. In addition to AHIMA, special thanks to -- Beverly Enterprises Extendicare Health Services Genesis Health Ventures Good Samaritan Society Harborside Healthcare Corporation HCR-ManorCare

These guidelines were developed by a taskforce comprised of health information management professionals and specialists with key areas of expertise. Their hard work, dedication, experience and insight were instrumental in creating the LTC Health Information Practice and Documentation Guidelines.
LTC Taskforce Members:
Rhonda Anderson, RHIA, Anderson Health Information Systems, Inc.
Monica Baggio Tormey, RHIA, Corporate Medical Record Consultant, Harborside Healthcare Corporation
Dorothy “Dot” Chapman, RHIA, Health Information Management Consultant, Good Samaritan Society
Joy Howe-Spoto, RN, Director of Clinical Risk Management, Beverly Enterprises
Debbie Johnson, RHIT, AHIMA LTC Section, HIM Consultant, D.A. Johnson Consulting
Carmilla “Kelli” Marsh, RHIA, Vice President of Support Services, Westhaven Services Co.
Judy Moffett, RN, Manager of Automated Clinical Systems, HCR ManorCare
Cheryl Olson, RHIA, Director of Health Information Management, Life Care Centers of America
Sharon Schott, RN, Litigation Support Services National Director, Extendicare Health Services, Inc.
Renae Spohn, RHIA, CPHQ, Quality Improvement Department Director, Good Samaritan Society

LTC Taskforce Coordinator and Project Manager:
Michelle Dougherty, RHIA, HIM Practice Manager, AHIMA

Special thanks to those who reviewed and commented on the LTC Health Information Practice and Documentation Guidelines. The comments received were invaluable in validating and improving the quality of this document.

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These guidelines were developed and made available free of charge via the Internet and AHIMA’s website for use by health care provider organizations and health information management professionals to provide assistance and direction in developing and maintaining health information systems that meet professional practice standards. The guidelines, samples, and examples can be used in development of facility/organization systems, policies and procedures without obtaining special copyright permission.

1.6 Reference to HIM Practice Standards

In section four of this report (Practice Guidelines For LTC Health Information And Record Systems) there are HIM Standards displayed in a box which relate to the section topic. These standards were obtained from the book Health Information Management Practice Standards: Tools for Assessing Your Organization published by AHIMA in 1998. Not all HIM standards published in this book were referenced in this report – only those relevant to LTC.

Example:
4.1.2 Assigning a Medical Record Number

<table>
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<td>The healthcare organization has a policy that requires a separate, unique health record for each resident.</td>
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2.0 ROLE OF THE HEALTH INFORMATION STAFF IN LONG TERM CARE FACILITIES:

In order to maintain quality health information systems, proper staffing and allocation of resources is necessary. The following guidelines provide an outline on the recommended qualifications, responsibilities and functions that would be performed by four different types of positions – 1) a health information consultant, 2) a credentialed health information practitioner working in a facility, 3) a non-credentialed practitioner working in a facility, and 4) a health unit coordinator. As documentation and clinical record systems increase in complexity in response to changes in the industry, HIM professionals and staff provide valuable expertise and help to maintain health information systems that impact quality of care, regulatory, legal, compliance and financial issues.

2.1 JOB QUALIFICATIONS, RESPONSIBILITIES, AND FUNCTIONS OF HEALTH INFORMATION STAFF IN A LTC FACILITY:

2.1.1 Role Of The Credentialed Consultant:

Many long term care facilities have access to a Health Information Consultant to provide professional expertise on health information, documentation and medical record issues. Consultants are usually contracted independent of the organization to support non-credentialed staff or employed at the corporate level. Consultants may also serve as an additional resource to a HIM corporate consultant to assist with state-specific issues, assist with implementation of corporate policies, and procedures. Consultants may also be used for special projects, independent auditing/monitoring services, training, etc. even when a credentialed practitioner is employed by the facility.

**QUALIFICATIONS OF A CONSULTANT:**

The following qualifications are recommended for a consultant in long term care.

- Credentialed as a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT). **Note:** A RHIA (previously a RRA) holds a 4 year bachelor degree. A RHIT (previously an ART) typically has a 2 year associate degree or technical training.
- Experience in long term care preferably as a Director or Coordinator of Health Information Services.
- Knowledge of regulations, survey process, accreditation standards and professional standards of practice pertaining to SNF/NF.
- Understanding of payment systems for SNF/NF including Medicare and Medicaid.
- Knowledge and application of ICD-9-CM coding in long term care.
- Understanding of HCPCS and CPT coding systems.
- Knowledge of documentation and legal issues pertaining to health information.
- Knowledge of quality assurance and ability to apply a quality improvement process to problem solving.
- Superior presentation skills, both oral and written.
- Solid clinical understanding of anatomy, physiology, pathophysiology and clinical/nursing process.
- Ability to teach using a variety of methods.
- Computer skills and understanding of information systems used on long term care with the ability to assist a facility move toward an electronic medical record.
- Supervisory and management skills and experience.
- Organizational skills.
Personal attributes of a qualified consultant should include:

- Ability to perform critical thinking, analysis, and problem solving.
- Leadership abilities preferred with an understanding of how to function within a team.
- Flexibility, creativity, and adaptability in dealing with problems and facility/corporate staff.
- Good communication skills with the ability to provide constructive information while being sensitive to the customer’s needs.

**REPORTING:**

The Health Information Consultant should report to the Administrator or Executive Director of the organization to assure that he/she is aware of findings and recommendations that affect the facility operation and risk factors. The Administrator may choose to delegate direct reporting during a visit to another staff member such as the Director of Nursing Services or the Coordinator of Health Information Services.

**COMMON FUNCTIONS PERFORMED BY A HEALTH INFORMATION CONSULTANT:**

A consultant should be able to perform and train on all of the functions of a Health Information Coordinator as well as many of the functions of the Health Unit Coordinator. The following functions are unique to the role of a consultant.

- Ability to provide assistance and function as a key resource for the development, transition, and maintenance of an electronic medical record.
- Assist with implementation and function as a key resource on the Health Insurance Portability and Accountability Act (HIPAA) including information system security issues and privacy.
- Provide expertise on compliance issues and the integration of clinical documentation and coding with the billing process.
- Develop, implement and monitor health information department policy and procedures and job descriptions. Make recommendations or assist with implementation of corporate policies.
- Provide training and orientation to health information personnel on functions of the department and facility staff on documentation.
- Develop and maintain health information systems and processes that meet regulatory requirements (both state and federal), professional practice standards, legal standards, and management/corporate policy.
- Establish a process for systematically reviewing documentation on an ongoing basis for both quality and quantity of documentation.
- Ability to complete documentation/medical record audits and monitoring with an ability to assess the quality of documentation.
- Ability to recommend corrective actions for findings on medical record audits/monitoring.
- Initiate clinical record systems and indexes.
- Assist with forms development and forms analysis/flow.
- Support compliance process of facility/organization.
- Support quality assurance/quality improvement process of the facility/organization.
- Train staff on quality assurance/quality improvement process related to health information management and appropriate methods for the collection of data.
- Provide resources to the facility on health information, documentation, regulations, standards of practice, etc.
- Develop consultation reports in a timely manner. Communicate findings and recommendations effectively to facility administration and interdisciplinary team members.
- Maintain good communication with facility staff and interdisciplinary team members. Empower facility staff to work independently.
2.1.2 ROLE OF THE CREDENTIALED PRACTITIONER WORKING IN A LONG TERM CARE FACILITY

QUALIFICATIONS OF A CREDENTIALED PRACTITIONER:

A growing trend in the industry is to hire credentialed practitioners to manage the health information department in a facility. Facilities who hire a credentialed practitioner often forego contracting with a consultant or they will utilize a consultant for independent audit and training services. The following list provides the recommended qualifications for a credentialed practitioner working in long term care. If you are hiring a practitioner new to long term care, additional training specific to long term care regulations and documentation will be needed.

- Credentialed as a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT). Note: A RHIA (previously a RRA) holds a 4 year bachelor degree. A RHIT (previously an ART) typically has a 2 year associate degree or technical training.
- Experience in long term care preferred.
- Knowledge of regulations, survey process, accreditation standards and professional standards of practice related to long term care.
- Understanding of payment systems including Medicare and Medicaid.
- Knowledge and application of ICD-9-CM coding appropriate for LTC.
- Understanding of HCPCS and CPT coding systems.
- Knowledge of documentation and legal issues pertaining to health information.
- Computer skills and understanding of information systems used in long term care.
- Supervisory and management skills and experience preferred.
- Basic understanding of the budget and monitoring process.
- Planning and organizational skills.

Personal attributes of a credentialed health information practitioner should include:

- Leadership abilities preferred with an understanding of how to function within a team.
- Ability to provide instruction or guidance and communicate effectively.
- Ability to perform critical thinking, analysis, and problem solving.
- Flexibility, creativity, and adaptability in dealing with problems and staff.
- Good customer service and telephone skills.

REPORTING:

It is recommended that this position report directly to the Administrator or Executive Director in a facility. There are a number of reasons why reporting to the Administrator is important for this position. First, the medical record is a multidisciplinary record. Overall decisions made about the record, use of data and analysis should not be influenced by one discipline over another. Second and most important, full disclosure of audit and quality monitoring findings should be reported to the facility administrator and the quality assurance committee. Many of the functions, data gathering and analysis directly influence administrative and clinical management of the facility.

COMMON FUNCTIONS PERFORMED BY A CREDENTIALED HEALTH INFORMATION PRACTITIONER:

The following functions are recommended for a credentialed health information practitioner and represent the core functions for health information. Facility size, admission and discharge rates, department staffing and other non-HIM responsibilities assigned to the position should all be considered when developing the final job description for a facility. In a facility that also employs health unit coordinators, some of the functions outlined may be managed by this position but performed by the health unit coordinator.


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Supervisory/Management Functions:
- Maintain current policy and procedures and job descriptions for the health information department.
- Manage human resource functions for the department including interviewing, hiring, staff scheduling, performance evaluation, disciplinary actions, and termination.
- Supervise health information staff to assure staff competency and performance.
- Provide guidance, motivation and support to health information staff.
- Monitor department budget as directed.
- Serve as the Privacy Officer under HIPAA and may serve as the Security Officer depending on expertise and facility need.

Quality Monitoring and Quality Assurance Functions:
- Participate in the facility quality assurance committee and process. Optional: Coordinate the facility quality assurance program.
- Maintain a qualitative and quantitative audit/quality monitoring process. Collect and report data from audit findings to QA committee. Report, monitor and follow-up on problems/concerns. Maintain routine audit and monitoring systems (admission, MDS, concurrent, acute problem, discharge) and focus audits on problem areas, QA concerns, Quality Indicator and survey issues.

Health Information Management Functions:
- Maintain security of health information systems and medical records. Assure physical protection is in place to prevent loss, destruction and unauthorized use of both manual and electronic records. For example, assure safeguards are in place such as record sign-out systems, assignment of computer passwords/log-ons, and systems for securing file cabinets and file rooms where overflow and discharge records are stored. Assure systems are in place to maintain confidentiality of both manual and electronic health information.
- Manage the release of information functions for the facility including review and processing of all requests for information.
- Maintain facility policies and standards of practice to assure release of information requests are appropriate and meet legal standards.
- Maintain a forms management system for development, review, and reproduction of facility forms. Maintain a master forms manual.
- Maintain systems for filing, retention and destruction of overflow/thinned records and discharge records.
- Develop systems for retention and destruction of medical records stored in an electronic format.
- Complete facility statistical reports such as monthly facility statistics, daily census, and licensure reports as applicable.
- Participate in meetings and committees such as daily stand-up, administrative/department head, quality assurance/quality improvement, and Medicare documentation review.
- Provide inservice education as applicable on health information issues.
- Provide orientation to new employees on topics such as the medical record organization and content, record completion, confidentiality, documentation standards and error correction procedures.
- Support and assist in carrying out corporate compliance initiatives as assigned by administrator.
- Manage the credentialing process for physicians and other professional staff when applicable.
- Optional: Review MDS validation reports and take appropriate actions to ensure errors are corrected. Retrieve quality indicator reports from HCFA and review findings.

Computerization/Automation:
- Understand all aspects of clinical computer system.
- Participate in decisions related to the computer system including systems selection, planning, and future expansion.
- Provide resources for training on computer system and use of clinical applications.
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- Monitor security of the system such as assuring audit trails and password security are in place. Monitor audit trails and follow up with possible breaches in confidentiality/security.
- Assure ICD-9-CM database utilizes the current version.
- Assure systems are in place to maintain up to date resident-specific information in the clinical information system.
- Complete data entry functions as applicable.
- Optional: Maintain the care plan and MDS schedule and transmit MDS information.

Oversight Records Management Functions:
The following list outlines the records management functions that are the responsibility of the health information department on admission, during the resident’s stay, and upon discharge. Depending on the facility size and department staffing some or all of these functions may be completed by other department staff such as a health unit coordinator.

Admission:
- Complete the appropriate information in the census register.
- Complete and file as applicable the master patient index information (computerized or manual).
- Initiate the inpatient medical record and inhouse overflow file, prepare labels, etc.
- Complete admission checklists and admission audits.
- Complete coding and indexing of admission diagnoses.

During the resident’s stay:
- Conduct concurrent audits/quality monitoring at regular scheduled intervals.
- Code diagnoses at regularly scheduled intervals.
- Thin inhouse records in accordance with the written policy and procedure and file in chart order for discharge in the inhouse overflow file.
- Contact physicians or departments as appropriate when signatures or information is needed before records can be completed.
- Maintain a monitoring system to assure telephone orders and other information is signed or completed by the physician as needed.
- File all incoming clinical information in the inhouse records on a daily basis.
- Monitor timeliness of physician visits on a monthly basis.

Discharge:
- Update discharge information on master patient index (manual or electronic).
- Record appropriate discharge information in the census register.
- Initiate the discharge record control log to monitor discharge record processing status.
- Obtain the discharge clinical record from the nursing station within 24 hours of discharge or death of a resident.
- Assemble record from the nursing station and the overflow file in established discharge order.
- Analyze the record for deficiencies using the discharge record audit/checklist.
- Follow up and monitor discharge record deficiencies including monitoring/mail information to the physician for completion as applicable.
- Maintain discharge record control log.
- File discharge record in incomplete clinical record file until complete and then file the discharge record in the complete file.
- Code and index final diagnoses using the ICD-9-CM code books.
2.1.3 ROLE OF THE NON-CREDENTIALED PRACTITIONER WORKING IN A LONG TERM CARE FACILITY

QUALIFICATIONS OF A NON-CREDENTIALED PRACTITIONER:
The qualifications and skills vary widely for a non-credentialed practitioner coordinating the health information functions in a facility. The basic functions of the health information department warrant the following minimum qualifications for an entry-level practitioner:

Minimum Entry Level:
• High school graduate or equivalent.
• Knowledge of medical terminology.
• Basic computer and typing/data entry skills.
• General office skills including filing, organizing, etc.
• Oral and written communication skills.
• Good customer service and telephone skills.
• Ability to work within a team.
• Empathy for the elderly.

Recommended Additional Qualifications:
• Long term care or healthcare experience preferably as a Coordinator of Health Information in another facility. Training as a Medical Records Secretary or equivalent.
• Experience with ICD-9-CM coding.
• Knowledge of documentation and legal issues.
• Knowledge of regulations, accreditation standards, and professional standards of practice for health information in long term care.
• Understanding of payment systems in long term care.
• Ability to provide instruction or guidance and communicate effectively.
• Supervisory and management skills depending on size of the department.
• Knowledge of the budget process.
• Interest in maintaining professional development and continuing education on health information issues.

REPORTING:

It is recommended that this position reports to the Administrator or Executive Director, however, this may vary depending on the skills and expertise of the individual. If the department is responsible for audit and quality management functions and/or supervises a department reporting to the administrator is imperative.

COMMON FUNCTIONS PERFORMED BY A NON-CREDENTIALED HEALTH INFORMATION PRACTITIONER:
The functions of this position are a subset of those functions outlined in the Credentialed Health Information Practitioner based on training, past experience, and skill level. At a minimum when hiring this position, the non-credentialed practitioner should be able to complete the following functions. The functions in the credentialed health information practitioner list could be completed by this position (depending on skill and experience) under the direction of a credentialed consultant.

Supervisory/Management Functions:
• Maintain current policy and procedures and job descriptions for the health information department.
• Monitor department budget as directed.
Quality Monitoring and Quality Assurance Functions:
- Participate in the facility quality assurance committee and process. Optional: Coordinate the facility quality assurance program.
- Maintain a quantitative audit/quality monitoring process and qualitative. Collect and report data from audit findings to QA committee. Maintain routine audits (admission, MDS, concurrent, acute problem, discharge) and focus audits on problem areas, QA concerns, Quality Indicator and survey issues.

Health Information Management Functions:
- Maintain security of health information systems and medical records. Assure physical protection is in place to prevent loss, destruction and unauthorized use of both manual and electronic records. For example, assure safeguards are in place such as sign-out systems, assignment of computer passwords/log-ons, and systems for securing file cabinets and file rooms where overflow and discharge records are stored.
- Assure systems are in place to maintain confidentiality of both manual and electronic health information.
- Manage the release of information functions for the facility including review and processing of all requests for information. Maintain facility policies and standards of practice to assure release of information requests are appropriate and meet legal standards.
- Maintain a forms management system for development, review, and reproduction of facility forms. Maintain a master forms manual.
- Maintain systems for filing, retention and destruction of overflow records and discharge records.
- Develop systems for retention and destruction of medical records stored in an electronic format under the direction of a consultant.
- Complete facility statistical reports such as monthly facility statistics, daily census, licensure reports as applicable.
- Participate in meetings and committees such as daily stand-up, administrative/department head, quality assurance/quality improvement, Medicare documentation review.
- Support and assist with carrying out corporate compliance initiatives as assigned by administrator.
- Manage the credentialing process for physicians and other professional staff when applicable.

Computerization/Automation:
- Understand all aspects of clinical computer system.
- Provide input into decisions related to the computer system including system selection, planning, and future expansion.
- Monitor security of the system such as assuring audit trails and password security are in place. Monitor audit trails and follow-up with possible breaches in confidentiality/security.
- Assure ICD-9-CM database utilizes the current version.
- Assure systems are in place to maintain up to date resident-specific information in the clinical information system.
- Complete data entry functions as applicable.
- Optional: Maintain the care plan and MDS schedule and transmit MDS information.

Records Management Functions:

Admission:
- Complete the appropriate information in the census register.
- Complete and file as applicable the master patient index information (computerized or manual).
- Initiate the inpatient medical record and inhouse overflow file, prepare labels, etc.
- Complete admission checklists and admission audits.
- Complete coding and indexing of admission diagnoses.
During the resident’s stay:
- Conduct concurrent audits/quality monitoring at regular scheduled intervals.
- Code diagnoses at regular scheduled intervals.
- Thin inhouse records in accordance with the written policy and procedure and file in chart order for discharge in the inhouse overflow file.
- Contact physicians or departments as needed when signatures or information is needed before records can be completed.
- Maintain a monitoring system to assure telephone orders and other information is signed or completed by the physician as needed.
- File all incoming clinical information in the inhouse records on a daily basis.
- Monitor timeliness of physician visits on a monthly basis.

Discharge:
- Update discharge information on master patient index (manual or electronic).
- Record appropriate discharge information in the census register.
- Initiate the discharge record control log to monitor discharge record processing status.
- Obtain the discharge clinical record from the nursing station within 24 hours of discharge or death of a resident.
- Assemble record from the nursing station and the overflow file in established discharge order.
- Analyze the record for deficiencies using the discharge record audit/checklist.
- Follow up and monitor discharge record deficiencies including monitoring/mail information to the physician for completion as applicable. Maintain discharge record control log. File discharge record in incomplete clinical record file until complete and then file the discharge record in the complete file.
- Code and index final diagnoses using the ICD-9-CM code books.

2.1.4 ROLE OF THE HEALTH UNIT COORDINATOR (UNIT CLERK/SECRETARY, HEALTH INFORMATION ASSISTANT):

In addition to a health information manager, some facilities may choose to also hire a health unit coordinator(s) depending on facility size, number of admissions and discharges, or resident acuity level. Although this position is typically found at the nursing station, their functions primary revolve around the monitoring and completion of the record and station management. Since many of the health information functions are performed by the health unit coordinator position, it was critical to address this position under a health information model.

QUALIFICATIONS OF A HEALTH UNIT COORDINATOR:

Minimum Entry Level:
- High school graduate or equivalent.
- Knowledge of medical terminology.
- Basic computer and typing/data entry skills.
- General office skills including filing, organizing, scheduling and tracking.
- Oral and written communication skills.
- Good customer service and telephone skills/etiquette. Tact and warmth when dealing with family and residents.
- Ability to work within a team.
- Empathy for the elderly.

Recommended Additional Qualifications:
- Medical office secretary or health unit coordinator training/certificate (or other applicable course).
- Long term care or healthcare experience preferably as a Health Unit Coordinator.
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- Knowledge of documentation and legal issues.
- Knowledge of regulations, accreditation standards, and professional standards of practice for health information in long term care.
- Experience with transcribing physician orders with knowledge of medications and applicable terminology.

REPORTING:

It is recommended that the health unit coordinator position report to the Manager of Health Information Services to provide consistent application of health information policies throughout the facility. Because of the unique nature of a health unit coordinator, it is important that this position have an indirect reporting relationship with the nurse manager or supervisor for the nursing station.

COMMON FUNCTIONS PERFORMED BY A HEALTH UNIT COORDINATOR:

When this position is utilized in a facility, many of the record management functions are performed by the health unit coordinator along with additional functions unique to coordinating a nursing station. This position provides assistance to the nursing staff by moving non-nursing clerical functions away from nursing allowing them to spend more time with direct patient care. If a facility does not utilize a health unit coordinator position or incorporate their functions in another position, the nursing staff are completing many clerical functions keeping them away from delivery of direct patient care.

Records Management Functions:

When a health unit coordinator position is utilized by a facility, the following records management functions are performed by this position:

Admission:
- Initiate the inpatient medical record and inhouse overflow file, type labels, etc.
- Coordinate admission process.
- Optional: Transcribe admission orders after review by clinical staff with proper education and training.
- Complete admission checklists.

During the resident’s stay:
- Thin inhouse records in accordance with the written policy and procedure and file in chart order for discharge in the inhouse overflow file.
- Maintain the in-house chart appearance and organization.
- Maintain a monitoring system to assure telephone orders and other information is signed or returned by the physician and other professionals.
- File all incoming clinical information in the inhouse records on a daily basis.
- Monitor timeliness of physician visits on a monthly basis in conjunction with the Manager of Health Information Services. Pull charts for physician rounds and transcribe new orders if applicable.
- Track and schedule routine labs.
- Schedule resident appointments and arrange transportation.
- Transcribe vitals, input/output information, per system.
- Prepare paperwork for transfer or referrals.
- Optional: Transcribe physician orders once obtained from clinical staff. (Clinical staff to sign off on transcription).
- Optional: If data-entry is expected in this position for the MDS or care plan, additional time should be allocated.
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Discharge:
- Prepare paperwork for discharge.
- Assemble record from the nursing station and the overflow file in established discharge order.

Nursing Station-Specific Functions:
- Answer telephones at the nursing station.
- Maintain an organized nursing station.
- Stock forms and clerical supplies on the station.
- Maintain station lists.
- Maintain nursing assistant care cards/assignment records.
- Completes station filing of loose reports, policies, etc.

Other Functions:
Additional hours should be allocated to this position if non-health information functions are shared with this position.

2.1.5 EVOLVING ROLE OF HEALTH INFORMATION

As computerization continues to evolve, the role of the HIM practitioner will also change. Although some traditional functions in maintenance of a manual record may be eliminated, new issues will take their place. The HIM role will continue to be responsible for oversight of confidentiality, compliance, privacy and security management programs, ongoing auditing of the electronic medical record, and audit trails. HIM practitioners should be responsible for orientation and ongoing training of clinical staff on the information system, and overall administration of the information system. Even with a computerized record system, many of the routine HIM functions will still need to be carried out.

With the implementation of HIPAA, the HIM practitioner will see new roles as a privacy officer and possibly a security officer. Expertise on code sets will also be necessary for proper coding and reporting under the federal regulation. The HIM role in corporate compliance and billing should also evolve to assure that documentation supports services billed by the facility.

2.2 HEALTH INFORMATION DEPARTMENT STAFFING

Staffing the health information department is based on five critical issues:

- The time requirements for functions under the responsibility of the health information department (see job positions and functions in Sections 2.1.
- Resident acuity and complexity.
- Census based on number of residents in the facility.
- Number of resident exchanges (admission, discharge, hospital transfer and hospital return).
- Availability of information technology.

3.0 HEALTH INFORMATION CONSULTANT SERVICES:

A health information consultant in long term care provides a facility or corporate office with professional expertise on health information, medical records, and documentation based on their education, skills and experience. At a time in the industry when quality of documentation for survey and litigation, coding, confidentiality and security are emerging as critical issues, the consultant is an invaluable resource for a facility. Consultants provide assistance with monitoring potential fraud and abuse issues, assistance with corporate compliance plans, and evaluation of documentation that supports the billing process.
By federal law, facilities are required to provide services that maintain the professional standards of practice. Many States have statutes that specifically require that facilities maintain the services of a consultant – check with your state to determine whether a consultant is mandated.

The section will assist in addressing expectations, performance standards, and utilization of a consultant. The information can be used both by a facility and a consultant to evaluate the quality of the services provided and make changes as necessary. This document is meant to provide a consistent set of expectations and deliverables to assure that both facilities and consultants have a common vision of role and services of a consultant. The specific types of functions and the role of a consultant are outlined in section 2.1.1.

A consultant is often contracted independently with a facility to provide professional expertise in coordination with a non-credentialed practitioner. However, many facilities utilize consultants to augment the services of a credentialed health information practitioner by providing independent audits and assessing the quality of documentation, the adherence to legal and regulatory documentation standards and billing support. In addition, many facilities utilize consultants for inservices and training programs.

3.1 FREQUENCY OF CONSULTANT VISITS:

The role and functions of a consultant should be tailored to the needs of each facility. This chart provides guidelines to align expectations with a recommended frequency for visits, but would not prevent a consultant and facility from mutually agreeing upon other functions during a visit. The frequency of consulting visits that a facility is looking for should directly correlate to responsibility and role of the consultant.

<table>
<thead>
<tr>
<th>Frequency of Visits</th>
<th>General expectations for the role of Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly or More Often</td>
<td>Oversight of HIM department to include health information system evaluation implementation, and monitoring, policy and procedures, assessment and monitoring of documentation; monitoring QI’s, training and inservicing, input into facility QA Committee; assistance with billing and compliance issues, assistance with implementing new systems. The hours budgeted each month must provide the consultant with adequate time to complete the functions listed.</td>
</tr>
<tr>
<td>Quarterly or Semi-Monthly</td>
<td>Assess basic HIM functions and monitors status of key areas in the department – provide new information and spot checking, some troubleshooting of problems/issues with minimal follow-up; minimal audits – not proactive; minimal on-going monitoring; deals with problems identified by facility and HIM department; focus is on a few key areas with facility to follow-up; training or inservices as recommended by facility; Typically quarterly visits are full day visits regardless of size of facility.</td>
</tr>
<tr>
<td>Semiannually or Annually *Generally not recommended</td>
<td>Brief look at the general systems and department functions. No oversight or monitoring of department functions. Address issues identified by the facility. Minimal to no audits. If audits done they would be few in number to provide a snapshot but not representative of facility documentation practices with a comprehensive list of problem areas. Facility may request inservice or training based on problems that they have identified. Typically visits are full days regardless of size of facility.</td>
</tr>
<tr>
<td>Focus Review or PRN Visits</td>
<td>Functions performed specific to the need identified by the facility or per contract. Generally no oversight or monitoring of HIM functions.</td>
</tr>
</tbody>
</table>
Recommended Number Of Visits:
The number of visits should be decided between the consultant and the facility, however, monthly visits are recommended to get the oversight of HIM systems including the department, documentation, quality indicators, coding/reimbursement and compliance. At a minimum it is recommended that facilities contract for no less than quarterly visits.

The factors that should be considered when deciding on a visit frequency including the bed size of the facility, availability of a corporate health information consultant, state regulations requiring specific HIM services, crisis situations or survey/quality indicator problems, staff turnover, and the performance or expertise of HIM staff.

Indicators for Increase in Consulting Visits:
There are times when an increase in consultation visits may be warranted. The following indicators provide a good rule of thumb to consider additional hours or warrant a focus review. The number of extra visits are variable based on the severity of the problems identified.

- Turnover in health information coordinator position requiring training of new staff. The number of additional visits will vary based on the past experience and performance of the new coordinator hired.
- Survey or quality indicator problems related to quality of care and documentation. Consultants can provide tailored documentation audits, inservices, and plans to assist in analyzing and correcting a problem.
- Reimbursement, coding or corporate compliance issues such as an increase in the number of denials by the fiscal intermediary. Focus audits can help to identify and correct a documentation problem.
- Program changes such as a change in licensure status, new accreditation status (JCAHO), or certification status (NF to SNF).
- Extraneous training needs based on findings from the facility.
- New major regulations or initiatives such as HIPAA, computerization initiatives, etc. that have an impact on health information systems, documentation or reimbursement.

3.2 PERFORMANCE EXPECTATIONS FOR A CONSULTANT

- PROFESSIONALISM: Possess knowledge and understanding of current issues affecting long term care facilities. Possess good communication skills with the ability to establish rapport and motivate staff through positive interaction.
- CONSULTATION REPORT: A type written, professional report is delivered in a timely manner after the consultation visit unless other arrangements are made with the facility. A process should be in place to follow up on past recommendations. (See section 3.3.2 on the content of a consultation report for more details).
- INITIAL EVALUATION: When first contracting with a facility, a consultant should complete a comprehensive evaluation. It is preferred that the consultant have an evaluation checklist such as one published in the Health Information Management Standards of Practice published by AHIMA.
- WORK PLAN: A work plan should be developed for the facility which identifies the areas to be evaluated, when they were evaluated, and when follow-up should occur. It is recommended that a work plan be developed for a calendar year. Developing a work plan can help in managing the expectations of the facility with the number of hours contracted. Set clear expectations with regard to hours available. Clarify facility goals and crosscheck against budgeted hours.
- ENTRANCE CONFERENCE: An entrance conference should be conducted with facility staff to discuss and communicate the work plan for the day. The plan for the day should be agreed upon mutually by the facility and consultant. The consultant should adjust his or her work plan to accommodate facility needs.
- EXIT CONFERENCE: An exit conference should be held with the appropriate staff (such as administration and other staff administration would like to have present). It may not always be
appropriate to have an exit conference with all staff mentioned depending on the sensitivity of the information to be discussed.

- **SCHEDULING VISITS**: Consultation visits should be scheduled in advance during the working hours of the health information coordinator and administration.
- **PROFESSIONALISM**: Consultants should be professional in dress and attitude.
- **CONTRACT HOURS**: Meet assigned contract hours unless a change in the schedule is mutually agreed upon.
- **MAINTENANCE OF A CONTRACT**: A written contract should be signed by both the consultant and the facility. The contract should include the number of hours or visit schedule agreed upon, the scope of services to be provided, the hourly rates and expenses to be charged by the consultant. The contract should contain language that protects the confidentiality of the consultation reports from discovery (i.e. litigation purposes) by placing the report under the quality assurance program. As an example, the following statement could be used: *As part of [facility name] Quality Assurance Program, [consultant name] has been retained to provide oversight of the facility health information systems, conduct audits, etc. [tailor role based on functions performed]. Any reports shall be part of the facility quality assurance documents and considered confidential.*
- **WORK WITH CORPORATE AND FACILITY POLICIES**: A consultant should be mindful of corporate policies related to HIM and assist the facility in adhering to those policies and procedures. If the consultant recommends changes in corporate policy/procedures and the facility concurs, a written report should be made to the corporate contact person with suggested alternatives and valid reasons.
- **EVALUATION OF CONSULTANT SERVICES**: On a routine basis (i.e. annually) the consultant and facility administrator should evaluate the consultant services. A formal mechanism such as a survey sent by the consultant or in a face to face meeting with the facility administrator or their designee can be conducted. *(See the section 3.4 on Evaluating Consulting Services)*
- **ABILITY TO ASSESS THE QUALITY OF DOCUMENTATION**: It is critical that a consultant have the ability to assess the quality of documentation across all disciplines. To do so, the consultant must understand the regulations, clinical standards, legal issues, reimbursement methods and have the ability to apply them to a variety of situations.

### 3.3 CONSULTATION REPORTS

Consultation reports should be provided after each visit to summarize the activities, findings and recommendations. There may be times when the consultant is working on an on-going project in which a written report after each visit is not necessary, but a summary is expected at the end of the project. The consultant and administrator/designee should decide on the expectations for a written report prior to the start of the project.

#### 3.3.1 Timeliness of Consultation Reports

Timely, complete and accurate consultant’s report are a valuable tool for follow-up and monitoring by a facility or corporation. The quality of a consulting service is equally dependent on the quality, content and timeliness of the written report provided after the consultation. A report is considered timely if it is provided to the facility within 7 to 10 working days after the consultation visit was conducted.

It is an advantage for the consultant and the facility to have a report or an abstract/draft report of activities, findings and recommendations prior to leaving the facility on the day of a visit. With the use of laptops or pre-printed reporting worksheets, a consultant should strive to provide some documentation on the day of the visit before leaving the facility.
3.3.2 Content of Consultation Reports

I. Demographics: Each consultation report should include the following basic information: Name and address of the facility, date of consultation visit, and consultants name, credentials and title.

II. Statement of Activities: It is suggested to start a report with a concise statement of the activities performed during the consultation visit. This can be in the form of a brief narrative summary, bulleted list or a pre-printed checklist form with activities identified. This summary will give the administrator a document that can be reviewed and summarized quickly.

III. Summary of Findings, Recommendations, and Follow-up: Provide a written summary of key findings, recommendations and follow-up activities or direction necessary. It is not necessary to describe every activity performed during the visit, but to focus on the key findings in which there are recommendations and/or follow-up. The report should direct the facility and provide guidance on what the facility is to do -- an action plan format may work well for this section of the report. The report should be written in language that is understandable to the reader.

IV. Attachments or Appendixes: This section should include either a copy of the audit tools or a summary of the audit findings and any copies of resources provided such as forms, regulations, etc.

V. Report Footer: A statement such as the following should be included in the consultation report to protect the confidentiality of the consultation report and audit findings. As part of {facility name} Quality Assurance Program, {consultant name} has been retained to provide oversight of the facility health information systems, conduct audits, etc. {tailor role based on functions performed}. Any reports shall be part of the facility quality assurance documents and considered confidential.

If the facility or corporation requests a specific format or specific forms for the consultation report, their request should be accommodated if possible.

Note: When summarizing audits of patient records, the patient name should not be included in the report. The medical record number should be referenced.

3.3.3 Distribution of The Consultation Report

Upon initiation of the contract, the consultant and administrator should decide to whom the consultant’s reports should be sent. It is often necessary to send two copies of the report – one to the administration/director of nursing services and one to the health information coordinator.

If the corporate office requests copies of reports to assist in their monitoring of the HIM problem areas, a copy of the report should be sent to the appropriate corporate person.

3.3.4 Retention of Reports (Facility And Consultant)

As a general rule, facilities should retain the consultation reports for a minimum of 2 years unless state law or corporate policy specifies a different time frame. Consultants should retain a copy of their reports for a minimum of 7 years or the state-specific statute of limitations for business records.

3.4 EVALUATING CONSULTING SERVICES

To assure that the customer (the facility or corporation) is satisfied with the services provided, it is recommended that a consultant incorporate some type of formal evaluation for feedback from the client. Feedback is essential to maintaining, improving, and growing a consulting business. One possible method would be to send out a questionnaire on an annual basis evaluating the services that they are providing. If the consultant does not have a process, the facility administrator should implement an evaluation and discuss their comments with the consultant during a consultation visit.
Sample 1: Consulting Service Evaluation:

The following questionnaire provides a baseline for an evaluation of services.

1) In general, do you feel that the services provided by your consultant have been helpful?:
   __ Strongly Agree    __ Agree     __ No Opinion     __ Disagree     __ Strongly Disagree
   Comments:

2) Are the reports you receive helpful?
   __ Strongly Agree    __ Agree     __ No Opinion     __ Disagree     __ Strongly Disagree
   Comments:

3) Are the reports you receive understandable?
   __ Strongly Agree    __ Agree     __ No Opinion     __ Disagree     __ Strongly Disagree
   Comments:

4) Are the reports you receive returned promptly?
   __ Strongly Agree    __ Agree     __ No Opinion     __ Disagree     __ Strongly Disagree
   Comments:

5) Do you feel that the frequency of on-site visits are made regularly and as needed according to contract?
   __ Strongly Agree    __ Agree     __ No Opinion     __ Disagree     __ Strongly Disagree
   Comments:

6) Do you feel that the entrance and exit conference with each visit is:
   __ Beneficial __ Not Beneficial
   If not, why?
   Comments:

7) Do you feel that the entrance and exit conference with each visit is:
   __ Yes __ No
   Comments:

8) If asked, would you recommend this consultant to other long term care facilities?
   __ Yes __ No
   If not, please explain:
   Comments:

9) Do you feel that the consultant keeps you up to date with changes and brings new ideas to your facility?
   __ Yes __ No
   Comments:

Recommendations for Improvement:

General Comments:
Sample 2: Consulting Service Evaluation:

Use the following scale to rate your health information consulting services in the past year.
Scoring: Excellent = 4   Good = 3   Fair = 2   Poor = 1  Not Applicable = N/A

(Circle the score. Please provide comments and suggestions if score is less than three.)

1. Provides quality training and direction to the health information designee.
   Score: 4   3   2   1   N/A
   Comments:

2. Assesses the quality of the health information designee’s job duties and makes recommendations.
   Score: 4   3   2   1   N/A
   Comments:

3. Keeps us informed of new regulations and provides updates.
   Score: 4   3   2   1   N/A
   Comments:

4. Provides “quality” inservices to meet our needs.
   Score: 4   3   2   1   N/A
   Comments:

5. Identifies and prioritizes problem areas for action (identifies our strengths and weaknesses).
   Score: 4   3   2   1   N/A
   Comments:

6. Written reports clearly identify problems.
   Score: 4   3   2   1   N/A
   Comments:

7. Written reports include realistic recommendations directed to solve identified problems.
   Score: 4   3   2   1   N/A
   Comments:

8. Consultant reports are timely.
   Score: 4   3   2   1   N/A
   Comments:

9. Follows up on prior reports.
   Score: 4   3   2   1   N/A
   Comments:

10. Assists during survey and with plan of correction if requested.
    Score: 4   3   2   1   N/A
    Comments:

11. Exits with Administrator/Director of Nursing Services.
    Score: 4   3   2   1   N/A
    Comments:

12. Health Information Department policy and procedure manual is rated as:
    Score: 4   3   2   1   N/A
    Comments:
13. I have a good rapport with my consultant.
   Score: 4 3 2 1 N/A
   Comments:

   Score: 4 3 2 1 N/A
   Comments:

15. Overall rating of medical records consulting services.
   Score: 4 3 2 1
   Comments:

General Comments, strengths and suggestions:
4.0 PRACTICE GUIDELINES FOR LTC HEALTH INFORMATION AND RECORD SYSTEMS

4.1 RECORD SYSTEMS, ORGANIZATION AND MAINTENANCE:

A medical record must be maintained for every resident in a long term care facility. With varying levels of automation, there may be some records maintained electronically and some in paper format. This section of the report will deal with maintenance of the paper medical record.

It is critical that every facility have formalized systems in place for the maintenance of their records. Records should be systematically organized and readily accessible. The following practice guidelines establish a baseline for the systems that should be in place for maintaining the record systems in a facility.

4.1.1. Maintaining a Unit Record

A unit record and unit numbering system is recommended for long term care facilities. With a unit record, the patient is assigned a medical record number on the first admission which is retained for all subsequent admissions/readmissions. The patient’s entire medical record is thus filed together as a unit under one number (there may be multiple volumes and folders). (Health Information Management, Huffman)

In long term care, the record from previous admissions should be brought forward to be filed with the current admission. All records from previous admissions are pulled forward and usually maintained in the overflow files. It is best to separate the past records for a current admission from the discharge record files so the chart is not inadvertently filed in storage and destroyed.

Bringing previous charts forward will provide the most comprehensive picture of the resident’s medical history and therapy. The previous records should be readily accessible to staff for use in the assessment and care planning process.

The medical records from previous stays remain in their original file folder and are retained chronologically with other records for residents currently admitted to the facility. The records from one discharge to another are not combined into one folder.

4.1.2. Assigning a Medical Record Number

HIM STANDARD:
• The healthcare organization has a policy that requires a separate, unique health record for each resident.

Each resident admitted to the long term care facility should be assigned a unique medical record number. The following are general rules to follow when assigning medical record numbers:

• Assign a medical record number only after a resident is admitted. This will prevent numbers from being assigned when the resident is not actually admitted to the facility.
• Assign numbers chronologically. Each new admission is assigned the next sequential number. Exception: For any subsequent admissions, reassign the previous medical record number. You may use a modifier to the medical record number to designate multiple admissions. For example: 1234 – a or 1234 – 1. Always verify in the master patient index that the resident had not been in the facility before.
• If a resident was assigned a number, but was not admitted, make a notation in the admission/discharge register that the resident was not admitted.
4.1.3. Maintaining Records in a Continuum of Care:

For healthcare campuses or continuums it is recommended that separate records are kept for each of the different care settings. For example, a separate record is maintained for assisted living, a record for the NF/SNF, a record for home care, etc. However, it is not recommended to create different records for a change in level of care such as from NF to SNF.

When transferring between care settings (i.e. assisted living to SNF), it is recommended that an interdisciplinary transfer form or discharge instructions be completed to assure continuity of care. Include copies of relevant documentation to facilitate the assessment and care planning process.

Health information staff should oversee record management, storage, retention, and destruction for the medical records maintained by the campus to assure that the medical records for each of the care settings are maintained in an organized and systematic filing and retrieval system.

To assist with tracking medical record numbers/campus numbers, admissions, discharges and transfers there should be a campus-wide master patient index maintained or another mechanism to link all records to the resident.

4.1.4. Defining What is Part of the Medical Record

The medical record in a long term care facility reflects the multi-disciplinary approach to assessment, care planning and care delivery. The medical record includes but is not limited to the following type of information: Resident identification, admission/readmission documentation, advance directives and consents, history and physical exams and other related hospital records, assessments, MDS, care plan, physicians orders, physician and professional consult progress notes, nursing documentation/progress notes, medication and treatment records, reports from lab, x-rays and other diagnostic tests, rehabilitation and restorative therapy records, social service documentation, activity documentation, nutrition services documentation, and other miscellaneous records including correspondence and administrative documents.

Facility policy should specifically outline in the format of a chart order the exact documents and records that will be considered part of the medical record. If portions of the record will be retained in an electronic medical record system, policies should differentiate between those records that will be paper-based and those that are electronic.

4.1.5. Maintenance of the Medical Record

It is critical that both the active record and the overflow records are maintained in a systematically organized fashion. This means that all records have an established chart order or order of filing that is followed. All records (records on the nursing station, overflow records, and discharge records) should be readily accessible, maintained in an organized chart order, filed in an easily retrievable manner, and maintained in folders or chart holders sufficient in size for the volume of the record. The chart holders and folders should be kept neat, clean and orderly.

It is recommended that a chart order or order of filing with thinning guidelines be kept in the record and at the nursing station to direct staff to the proper location of forms.

4.1.6. Identification (Name and Number) on pages of the Medical Record

From a legal perspective, each page or individual documents (i.e. shingled telephone orders) in the medical record should contain resident identification information. At a minimum, both the resident name and medical record number should be on each form. If labels/label paper is used, resident identification information must be included on the label. The name and number should be placed on both sides of a page because records are frequently copied and both sides may not be included. The name of the form should
also be printed on both sides of a two-sided form.

For example, identification information can be written on the page in permanent ink, stamped using an addressograph, or affixed with a label placed. Resident specific information printed from a computer system to be filed in the medical record should include resident identification information on each page.

**4.1.7. Common Forms and Thinning Guidelines**

<table>
<thead>
<tr>
<th>COMMON CHART FORM*</th>
<th>THINNING GUIDELINE**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identification and Admission Documentation</strong></td>
<td></td>
</tr>
<tr>
<td>Admission Record/Facesheet</td>
<td>Current Facesheet</td>
</tr>
<tr>
<td>Pre-admission Screening (PASARR)</td>
<td>Permanent</td>
</tr>
<tr>
<td>Preadmission Assessment/Intake</td>
<td>3 months after admission</td>
</tr>
<tr>
<td>Admission Agreement</td>
<td>Financial/Administrative file</td>
</tr>
<tr>
<td>Admission Consent</td>
<td>Permanent</td>
</tr>
<tr>
<td><strong>History and Physical and Hospital Records</strong></td>
<td></td>
</tr>
<tr>
<td>H&amp;P</td>
<td>Most Current</td>
</tr>
<tr>
<td>Hospital Discharge Summary</td>
<td>Most Current</td>
</tr>
<tr>
<td>Hospital Transfer Form</td>
<td>Last Hospital Stay</td>
</tr>
<tr>
<td>Other Hospital Records</td>
<td>Retain pertinent records for 3 months after hospitalization &amp; then thin</td>
</tr>
<tr>
<td>(All hospital records received should be retained)</td>
<td></td>
</tr>
<tr>
<td>Immunization Records</td>
<td>Permanent</td>
</tr>
<tr>
<td><strong>Advance Directives/Legal Documents</strong></td>
<td></td>
</tr>
<tr>
<td>CPR Directive</td>
<td>Most Current</td>
</tr>
<tr>
<td>Resident Self Determination Act Acknowledgement.</td>
<td>Most Current</td>
</tr>
</tbody>
</table>

This section outlines the common chart forms found in a long term care record. The titles, location in the record may be different, but the thinning guideline would remain consistent for the type of documentation contained. Thinning the medical record is a process of removing records older than a certain date and moving them into a secondary record known as the overflow record.

The establishment of thinning guidelines is a standard of practice for the long term care industry. Federal regulations require clinical records to include (1) sufficient information to identify the resident; (2) a record of the resident’s assessment; (3) the plan of care and services provided; (4) the results of any pre-admission screening conducted by the State; and (5) progress notes. 42 C.F.R. § 483.75 (l)(5). Check licensure rules to determine if state law delineates a specific thinning guideline.

The goal of the thinning guideline is to retain documentation in the resident’s chart that reflects the current plan of care and services provided. Unless required by state regulations, it is not necessary to keep the original assessment or progress notes in the record. The overflow record should be easily accessible for review of admission documentation.

By listing a form in the following chart order, we are identifying documents commonly found in the medical record. This should not be interpreted as a recommendation or requirement that the form be a mandatory part of the long term care record. See section 6.0 on content of documentation to address the type of documentation and the associated regulatory reference.
### LTC Health Information Practice and Documentation Guidelines

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living will</td>
<td>Most Current</td>
</tr>
<tr>
<td>Advance Directive</td>
<td>Most Current</td>
</tr>
<tr>
<td>Durable Power of Attorney</td>
<td>Most Current</td>
</tr>
<tr>
<td>Guardianship/Conservator</td>
<td>Most Current</td>
</tr>
<tr>
<td>Legal incapacitation</td>
<td>Most Current</td>
</tr>
<tr>
<td>Consents, Acknowledgements</td>
<td>Most Current</td>
</tr>
<tr>
<td>(For example, Physical Restraints Consent, Admission Consents, Consent to Treat, Consent to Photograph, MDS Consent, MDS Acknowledgement, Release of Information Consent, Release of Responsibility/Leave of Absence)</td>
<td>Most Current</td>
</tr>
</tbody>
</table>

### Clinical Assessments
(At a minimum, retain most recent assessment plus one previous)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Assessment</td>
<td>6 months to 1 year</td>
</tr>
<tr>
<td>Wound and Skin Assessments</td>
<td>6 months to 1 year</td>
</tr>
<tr>
<td>Fall Assessment</td>
<td>6 months to 1 year</td>
</tr>
<tr>
<td>Bowel and Bladder Assessment</td>
<td>6 months to 1 year</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>6 months to 1 year</td>
</tr>
<tr>
<td>Mini-Mental/Cognitive Exam</td>
<td>6 months to 1 year</td>
</tr>
<tr>
<td>Restraint Assessment</td>
<td>6 months to 1 year</td>
</tr>
</tbody>
</table>

### Minimum Data Set and Care Plan

<table>
<thead>
<tr>
<th>Component</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDS</td>
<td>15 months readily available</td>
</tr>
<tr>
<td>Care plan</td>
<td>Current care plan</td>
</tr>
<tr>
<td>Specialty Care Plans ie: hospice/dialysis</td>
<td>Current plan</td>
</tr>
<tr>
<td>Care Plan Signature Records (if used)</td>
<td>Current plan</td>
</tr>
<tr>
<td>Care plan recap (if used)</td>
<td>Current plan</td>
</tr>
</tbody>
</table>

### Physicians Orders

<table>
<thead>
<tr>
<th>Orders</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computerized Recaps or Renewals</td>
<td>3 months</td>
</tr>
<tr>
<td>Telephone Orders</td>
<td>3 months</td>
</tr>
<tr>
<td>Interim orders</td>
<td>3 months</td>
</tr>
<tr>
<td>Protocols or Standing Order Policies (if used)</td>
<td>Current</td>
</tr>
<tr>
<td>Fax Orders</td>
<td>3 months</td>
</tr>
</tbody>
</table>

### Physician and Professional Progress Notes/Consults

<table>
<thead>
<tr>
<th>Notes/Consults</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Progress Notes</td>
<td>1 year</td>
</tr>
<tr>
<td>Cumulative Problem/Diagnosis List</td>
<td>Most recent</td>
</tr>
<tr>
<td>Annual Exams</td>
<td>Most recent</td>
</tr>
<tr>
<td>Other specialists/consultation</td>
<td>1 year</td>
</tr>
<tr>
<td>Dental Progress Notes/Exams</td>
<td>1 year</td>
</tr>
<tr>
<td>Podiatry Progress Notes/Exams</td>
<td>1 year</td>
</tr>
<tr>
<td>Psychological Evaluation</td>
<td>Current</td>
</tr>
</tbody>
</table>

### Nursing Notes/Interdisciplinary Notes

<table>
<thead>
<tr>
<th>Notes</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Notes or</td>
<td>3 months</td>
</tr>
<tr>
<td>Interdisciplinary Notes</td>
<td>6 months</td>
</tr>
<tr>
<td>Nursing Summary Forms/Flowsheets</td>
<td>3 months</td>
</tr>
</tbody>
</table>

### Medication, Treatment and Other Flowsheets

<table>
<thead>
<tr>
<th>Flowsheets</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Medication and Treatment Records</td>
<td>3 months</td>
</tr>
<tr>
<td>Vitals Sign Record</td>
<td>1 year</td>
</tr>
<tr>
<td>Weights Record</td>
<td>1 year</td>
</tr>
<tr>
<td>Intake and Output Records</td>
<td>3 months</td>
</tr>
<tr>
<td>Behavior Monitoring Records</td>
<td>3 months</td>
</tr>
</tbody>
</table>
Other Flow Sheets (Diabetic site rotation, etc) 3 months
Pharmacist/Drug Reviews Recommendations 1 year

**Lab, X Rays, and Special Reports**
Lab Reports (frequently ordered) 3 months
Annual or interim Lab Reports 1 year
X-Ray Reports 1 year
Special Diagnostic Tests 1 year

**Rehabilitative Therapy (PT, OT, SLP)**
Therapy Evaluation Most Recent
Therapy Certification/Recertification 3 months
Progress Notes 3 months
Discharge Summary Most Recent
Therapy Screen Most Recent
*Once therapy is discontinued thin therapy information for that discipline except the evaluation and discharge summary.

**Rehab Nursing**
Rehab Screen Most Recent
Rehab Nursing Assessment Most Recent
Progress Notes/Treatment Records 3 months

**Social Service, Dietary (Nutrition Services), and Activities (Therapeutic Recreation)**
History Permanent
Progress notes 6 months to 1 year
Assessments Most Recent

**Miscellaneous**
Clothing list or Inventory List (If required) Most Current

*Common Chart Forms* – The chart forms and location are not meant to represent a recommended chart order or forms. Chart order and the types of forms used are facility-specific. The forms named represent common types of documentation found in a long term care record.

**Thinning Guidelines** – These guidelines are recommendations and provide a baseline. Each facility should adapt and develop thinning guidelines that meet the needs of their resident population and staff needs.

4.1.7.1. Integrating Hospital Documents into the Long Term Care Record

Hospital or another healthcare providers (i.e. another LTC facility) records that are sent with a resident to provide information for continued care and treatment should be retained by the facility. It is recommended that pertinent information such as the history and physical, discharge summary, and transfer form be kept in the medical record. All other records sent (copies of progress notes, labs, consults, etc.) should be kept for 3 months in the record to provide information when establishing the current plan of care and treatment and then thinned and retained in the resident’s overflow record. The records provided on admission, readmission, or return from the hospital should never be destroyed. See section 4.9.7.1 of this report for guidance on how to handle release of information or redisclosure of hospital and other healthcare provider documents.

A copy of the history and physical from the hospital is commonly accepted as the history and physical on admission to a LTC facility. When necessary, physicians are expected to update the H&P or to write a progress note that documents the resident’s current condition on admission.
4.1.8  Thinning the Medical Record

Each facility should develop a schedule for thinning the medical records. It is generally recommended that records are thinned quarterly and as needed. Using the MDS/care conference schedule and thinning after the care conference can provide a calendar for checking the chart to determine if thinning is needed.

Once the record has been thinned a notation should be made in the record. For example, a label can be placed in the inside cover of the chart that states the date the record was thinned. The records thinned from the chart should be filed in the overflow record immediately to assure that resident records are always accessible and easily retrievable.

4.1.9  Maintaining the Overflow Record of Thinned Documents

The overflow record is considered part of the resident’s active medical record. The overflow records which contain the documentation thinned from the chart must be systematically organized (a chart order should be established) and readily accessible. Because it is not always possible to keep all documentation in the chart holder at the nursing station, the thinned information is generally kept in the HIM department.

Standards for maintaining the overflow medical record:

SYSTEMATICALLY ORGANIZED:

• For ease in locating documents a chart order should be developed for overflow records. It is recommended that the overflow chart order be the same as the discharge chart order to facilitate quick reassembling upon discharge. All like forms should be filed together (i.e. all nurses notes together in date order). Use index tabs if desired to indicate the sections of the chart (index tabs from an office supply company work well in thin charts). Tabs will make retrieval and filing of documents easier.

• Records should be maintained in date order. Facility policies should define if forms will be filed in chronological or reverse chronological order. Filing in chronological order is considered the gold standard, but reverse chronological would be acceptable defined in facility policy and consistently applied to all overflow records.

READILY ACCESSIBLE:

• Overflow records should be filed in a location that is secure and readily accessible.

• When overflow records are removed a chart locator or tracking system must be used to identify the individual removing the chart, the date, and the location.

4.1.10  Maintaining a “Soft Chart” or "Shadow Record" and Other Types of Records:

Soft charts are resident-specific records that are maintained by a discipline that contains extra notes, observations and copies of documentation kept in the medical record. The record is not usually integrated with the resident’s legal medical record. The soft chart is often a working duplicate of the medical record.

Soft charts are generally not recommended. The facility has legal risks because this type of record is discoverable in a legal process and could contain contradictory or damaging information. There is potentially a loss of critical information that should be documented in the medical record, but it is not.

If facility administration approves the use of soft charts, policies should be developed to manage the records with the same structure and organization as the resident’s legal medical record. The following systems should be developed for each type of soft chart:

• Implement systems to assure that the records are physically secure such as retaining information in locked file cabinets with access by limited staff.
LTC Health Information Practice and Documentation Guidelines

- Policies should be developed to handle the confidentiality of information and documents contained in the record.
- Records should be identified on the retention and destruction schedules.

**Social Service and Financial Files:**

Both social service and financial files are commonly maintained by long term care facilities. Both of these type of records are acceptable. They contain information that is highly sensitive and often not related to resident care. Policies must be developed to define what information is retained in each type of record. There is a risk with a social service file that information which should be documented in the medical record is kept only in the social service record. Along with guidelines to define what is contained in the file, policies should define security, confidentiality, retention and destruction.

**Communication Records/Shift Worksheets:**

Communication and Shift Records are a common form of communication between nursing staff working on different shifts. They usually contain multiple residents on one page and are not considered a formal part of the medical record. These records are acceptable but standards should be in place to assure that the medical record also reflects the resident’s condition, nursing observations, and assessment that are often found in the communication records. It is critical that the medical record contain the same information as the worksheets on condition, observation and assessments.

Facility policy should establish retention and destruction procedures. Determine where the reports will be stored, how they will be collected, how long they will be retained, and when they will be destroyed. In absence of a state law, it is recommended that shift reports be retained for 30 days and then destroyed.

**Outpatient Records and Records Maintained by Vendors:**

When vendors such as a therapy provider is contracted with a facility, it is acceptable for the company to maintain their own medical record. The facility must ensure that the vendor providing outpatient services through the facility has appropriate policies in place to deal with security, confidentiality, retention and destruction.

If facility staff is providing outpatient services, the facility must develop and manage the record systems and procedures to assure security, confidentiality, retention and destruction. If the facility employs the therapists, it is not recommended that they have a separate therapy chart (soft chart). All documentation should be maintained in the medical record.

**4.1.11 Forms Control Processes**

<table>
<thead>
<tr>
<th>HIM STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>A procedure has been established to address issues related to the completion of all health record forms and data entry screens.</td>
</tr>
</tbody>
</table>

A process should be in place to review and approve new or revised forms. There should be a formal process such as a forms committee to carry out the following functions:

- Forms should be titled and indexed. A master of each form should be maintained.
- Review and approve new forms. New forms should be reviewed for content, potential duplication of information already being documented, and inclusion of basic identification information: Title of form, resident name, medical record number, page numbers (page x of y) if applicable, form control number if applicable, and revision date.
- Review and approve revisions to forms.
Identify forms which should be deleted or inactivated and assure that the form is no longer available for use.

4.2 AUDITS AND QUALITY MONITORING

The content, completion, timeliness and accuracy of medical record documentation is extremely important in a long term care facility. Documentation has a far-reaching effect on most aspects of the organization’s operation. The quality and type of care and services delivered to the resident are determined in part through documentation. On-going planning and assessment rely heavily on the quality and accuracy of the documentation in the chart. The medical record is also used to determine survey compliance, reimbursement, and serve as a source document for legal proceedings.

Proactive (concurrent) monitoring of the completion, timeliness and accuracy of the medical record documentation is critical. Both the need for good documentation and risk factors hindering quality support the importance of on-going, scheduled audits and monitoring for every resident’s medical record.

4.2.1 Qualitative vs. Quantitative Audits and Monitoring

There are two broad types of audits – qualitative and quantitative. Qualitative audits look at the quality of documentation assessing adherence to clinical practice guidelines, evaluating consistency in charting, and adherence to regulations, standards and interpretations. This type of audit is usually completed by a staff member or consultant who has professional training, education or experience. Qualitative audits are more subjective than quantitative. The auditor tries to determine if the proper care was delivered based on the documentation.

Facility staff can be trained to complete quantitative audits which focus on whether a document is complete (all sections of a form), authenticated, or timely rather than what the documentation states. A training process is necessary to help staff understand what they are to look for and why. This type of audit is more objective than a qualitative audit. Staff can usually determine if an audit element is in place or not (similar to a yes – no question).

On an on-going basis, facilities should have quantitative monitoring in place to assure complete and timely records. Admission, concurrent and discharge record monitoring assures that analysis is completed throughout the resident’s stay. The goal to continuous monitoring throughout a resident’s stay is to identify problems or omissions when correction is possible. Analyzing the record on discharge makes it virtually impossible to legally and ethically address or correct most documentation problems or omissions. For example, if an assessment is not completed on admission nothing can be done on discharge, but if it is found during an admission audit the assessment can still be completed in order for the facility to provide appropriate care and services for the resident.

4.2.2 Assessing the Quality of Documentation

When completing a qualitative audit, the reviewer should have the ability to assess the following issues, identify strengths and weaknesses, and provide suggestions to correct future documentation discrepancies.

- Consistency in documentation between progress notes, assessments, care plans, etc.
- Duplication or redundancy in documentation.
- Contradiction in documentation without a clear reason for the differences. This may occur between two disciplines or within one discipline such as nursing where multiple staff members chart on a similar issue.
- Documentation that is missing key elements for the proper assessment or planning of a problem.
LTC Health Information Practice and Documentation Guidelines

- Documentation reflects application of appropriate practice guidelines, standards, regulations, reimbursement rules, and clinical protocols across all disciplines.
- Understanding of the reason for all types of documentation in a long term care record and the underlying guidelines, standards, regulations, or clinical practice protocols.

A health information consultant should have the ability to provide a qualitative analysis of the documentation and content of the medical record and provide feedback and suggestions for problems identified.

4.2.3 Routine Audits/Monitoring (Criteria and Timeframes)

Every long term care facility should have systems in place for monitoring completion of their documentation on an on-going basis. At a minimum, records should be reviewed on admission and hospital return, concurrently on a quarterly basis, and upon discharge/death. Not all audit findings will be correctable. For findings that cannot be corrected, the information should be gathered for training/retraining, system evaluation and improvement.

The criteria in the following table can be used to develop and tailor audit and monitoring tools.

<table>
<thead>
<tr>
<th>Quantitative Monitoring Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit/Return first 24 to 48 hours:</td>
</tr>
<tr>
<td>- Transfer form or order to admit received.</td>
</tr>
<tr>
<td>- Admission orders transcribed accurately from transfer form.</td>
</tr>
<tr>
<td>- All orders required per facility policy are verified or clarified by the attending physician notified.</td>
</tr>
<tr>
<td>- If transfer form not signed by physician, orders are verified by telephone or fax order.</td>
</tr>
<tr>
<td>- A diagnosis or reason is identified for each medication, ancillary service, treatment with billable supplies that are ordered. (Diagnosis in text of order, on diagnosis list, or through supporting physician documentation).</td>
</tr>
<tr>
<td>- Admission orders are signed and noted by a nurse as appropriate in accordance with facility procedure.</td>
</tr>
<tr>
<td>- Orders are transcribed accurately to medication administration record (MAR) and treatment administration record (TAR).</td>
</tr>
<tr>
<td>- All medication orders include the name of the medication, dose, frequency, route, and if appropriate the duration. PRN orders should include reasons for administration.</td>
</tr>
<tr>
<td>- An initial care plan is implemented including diet and nursing care.</td>
</tr>
<tr>
<td>- Admission note is completed including time of admission, how resident was admitted, and condition of resident.</td>
</tr>
<tr>
<td>- Initial Medicare Certification is completed if applicable.</td>
</tr>
<tr>
<td>- Allergies are identified.</td>
</tr>
<tr>
<td>- Discharge plan is initiated if applicable (i.e. as required by Joint Commission Accreditation)</td>
</tr>
<tr>
<td>- Face sheet or demographic information on record.</td>
</tr>
<tr>
<td>- H&amp;P and Discharge summary requested from hospital if applicable and if not sent with resident.</td>
</tr>
<tr>
<td>- If H&amp;P not completed prior to admission, an exam is scheduled per state requirements.</td>
</tr>
<tr>
<td>- Advanced directive acknowledgement is completed. A copy of the directive is in the record if applicable, physician orders coincide with resident directives.</td>
</tr>
<tr>
<td>- Inventory of personal effects is completed if applicable.</td>
</tr>
<tr>
<td>- Nursing Assessments and others required per facility policy are completed</td>
</tr>
</tbody>
</table>
immediately upon admission are complete, timely and authenticated (e.g. skin
assessment, fall assessment, etc.). (No missed sections or questions on the
assessment without explanation).

- Admission vital signs, height, and weight are documented.
- Admission paperwork such as admission consents including the consent for use of
  protected health information, bill of rights acknowledgement, advanced directive
  acknowledgement etc. Are completed per facility policy.
- PASARR documentation on record or review scheduled.
- Admission PPD read or TB test ordered. If not, documentation indicates if
  contraindicated or previously completed within an acceptable timeframe.
- Although it is not recommended to accept an order for restraints on admission, if
  physical restraints are ordered upon admission the order should include the type of
  physical restraint/device, the reason for use, the frequency of use and the
  restrictions for use. An initial assessment should have been completed for the use
  of the restraint. Informed consent has been obtained from the resident or their
  representative.
- Diagnosis list has been started and ICD-9-CM codes assigned.
- Labs, x-rays, consultation visits, etc. that were ordered upon admission have been
  scheduled.
- Assessments and monitoring records were initiated or completed per facility
  policy: Common forms include skin risk, fall risk, bowel & bladder monitoring,
  intake and output records, self-administration of meds, pain assessments,
  interdisciplinary assessments (dietary, activities, social service, chaplain),
  teaching/resident education plans, oral/dental assessment, restorative nursing
  assessments.
- If therapy has been ordered, the therapy plan of treatment/evaluation has been
  initiated no later than 48 hours. Physician orders have been clarified to include
  the specific therapy plan.

<table>
<thead>
<tr>
<th>Admit/Return 14-21 days</th>
<th>The assessments listed in the 24-48 hour audit that were not initiated in that time frame should be audited during the 14-21 day audit.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Items that were not complete on the admit and 24-48 hour audits are checked.</td>
</tr>
<tr>
<td></td>
<td>14 day Medicare Recertification has been completed if applicable.</td>
</tr>
<tr>
<td></td>
<td>The 2nd step of the PPD/TB test was administered and read (if applicable).</td>
</tr>
<tr>
<td></td>
<td>The MDSs (both OBRA/regulatory and PPS if applicable). See the MDS audit criteria for specifics.</td>
</tr>
<tr>
<td></td>
<td>Care plan is complete by day 21 (should be available for use by day 21)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RAI Process</th>
<th>The RAI process should be audited by someone independent of the process to assure compliance with completion and timeliness timeframes. Recommend auditing each MDS (OBRA/Regulatory and PPS).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic tracking form complete and signed.</td>
</tr>
<tr>
<td></td>
<td>All questions on the MDS are appropriately answered.</td>
</tr>
<tr>
<td></td>
<td>On admission, MDS Face Sheet completed, signed and dated.</td>
</tr>
<tr>
<td></td>
<td>A-3 Assessment Reference date within the proper range.</td>
</tr>
<tr>
<td></td>
<td>R2b date and dates of staff completing the MDS are not prior to the A-3 date. Staff dates cannot be after the R2b date.</td>
</tr>
<tr>
<td></td>
<td>Staff signatures include their title, sections completed and date completed.</td>
</tr>
<tr>
<td></td>
<td>Triggered RAPs are identified in section V.</td>
</tr>
<tr>
<td></td>
<td>For RAPs triggered, assessment documentation is shown in the location of information column.</td>
</tr>
<tr>
<td></td>
<td>Date in VB2 is no later than day 14 after the start of the assessment period. (Admission no later than day 14, quarterly no more than 92 days between R2b dates, and annual no more than 366 days from last annual VB2 date).</td>
</tr>
</tbody>
</table>
LTC Health Information Practice and Documentation Guidelines

- Date in VB4 is no more than 7 days after VB2.
- RAP documentation/assessments are completed prior to VB2.
- If a RAP is identified to be care planned, the issue is addressed on the resident’s plan of care.
- Re-admission/Return and Discharge Tracking forms are completed within 7 days of the event.
- Significant change assessment completed within 14 days after significant change in status is noted.
- Corrected MDS documents are called to the attention of the business office to assure that adjustment bills are completed if necessary.

### MDS Validation Reports
- The validation report is reviewed after each submission and appropriate follow-up is conducted to address errors.

<table>
<thead>
<tr>
<th>Concurrent or Quarterly</th>
<th>Admission Record/Face Sheet: Check if any changes have been made on the face sheet page or any areas are inaccurate. Reprint a new face sheet if there are changes or inaccuracies.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diagnosis list updated and coded: Check if new diagnoses have been written on the diagnosis list. Check physician’s orders, progress notes, referrals, etc. to see if the physician has documented any new diagnoses. Code new diagnoses, input into the computer, and print a new list.</td>
</tr>
<tr>
<td></td>
<td>RAI Process: See RAI Audit Criteria</td>
</tr>
<tr>
<td></td>
<td>Care plan current and complete: Care conference held within 7 days of the MDS (either quarterly or full). All those in attendance signed the attendance record. Care plan is rewritten or reprinted if there are too many changes and it is difficult to read/use.</td>
</tr>
<tr>
<td></td>
<td>Nursing Assessment and Monitoring: Assessments completed per policy. All entries are signed and dated. Monitoring records are completed and authenticated – no open holes or breaks in documentation.</td>
</tr>
<tr>
<td></td>
<td>Restorative Program (if applicable): Actual treatment time is documented for rehab nursing service delivery record, an assessment has been completed. Progress notes reflect resident's status and progress. The care plan reflects restorative program and goals.</td>
</tr>
<tr>
<td></td>
<td>Nursing Documentation: Nurses notes are signed and dated. Follow-up charting complete for incidents/falls. Medicare charting completed when applicable Weekly/monthly summary or case mix charting completed as applicable.</td>
</tr>
<tr>
<td></td>
<td>Physician Orders – Renewals: Physician has signed and dated the renewals in the specified time frame. Orders did not expire before being resigned. Nursing noted orders upon return per facility policy.</td>
</tr>
<tr>
<td></td>
<td>Telephone and Fax Orders: All telephone orders (TO's) are complete, signed and dated. All original telephone orders have been returned within the appropriate time frame. All orders given by a physician have a corresponding signed order (TO, fax order, signed physician referral, etc.).</td>
</tr>
<tr>
<td></td>
<td>Physical Restraints: If ordered, current assessment completed, informed consent documented, order matches device in use. Documentation includes alternatives tried before restraint used and the symptom being treated.</td>
</tr>
<tr>
<td></td>
<td>Psychotropic, antipsychotic, hypnotic medication monitoring: If ordered, monitoring assessments completed, signed and authenticated. Side effect monitoring completed. Dose reduction documentation or justification on record.</td>
</tr>
<tr>
<td></td>
<td>Physician Visits: Visits are made timely. Progress notes written or dictated notes sent back and filed. Notes are authenticated and dated. Required NP/PA and physician visits alternate.</td>
</tr>
</tbody>
</table>
LTC Health Information Practice and Documentation Guidelines

- Physician referrals are complete and noted by the nurse receiving. Orders on physician referral have been verified with the attending if appropriate and transcribed accurately.
- Documentation of consults for dental, vision, podiatry, audiology/hearing aid, hospice, and psychological services are in record when applicable.
- Vital Sign Records: Vitals completed and recorded in a time frame consistent with facility policy and state regulation when applicable.
- Weights recorded monthly or per facility policy/state regulation where applicable. Changes in weight (5% in 30 days/10% in 6 mo.) noted in record for possible significant change assessment.
- Medication and Treatment Record (MAR/TAR): Look for open holes on the MAR/TARs. PRN records signed, reason and result documented. Other flowsheets are complete. All flowsheets and MAR/TARs have resident name, MR#, month and year identified on every page.
- Pharmacist review conducted monthly.
- Medication disposal/destruction records are complete. Documentation signed and dated.
- Labs: All orders for labs (routine and stat) have a corresponding lab report in chart. Labs are noted and dated by nursing. Lab results are communicated to physician.
- Social Service Documentation: Each quarter a progress note or assessment form is completed at the time of care conference noting changes to be made to the care plan. Updates are completed on the Social History. Entries on all documentation are signed and dated.
- Dietary/Nutrition Documentation: Each quarter a progress note or assessment form is completed at the time of care conference noting changes to be made to the care plan. Intake monitoring records are completed as appropriate. All entries are signed and dated.
- Activity Documentation: Each quarter a progress note or assessment form is completed at the time of care conference noting changes to be made to the care plan. All entries are signed and dated.
- Rehabilitation Documentation (PT, OT, SLP): Documentation for each therapy is filed together (all PT doc. together, etc.) For residents currently treated, service delivery record are completed, treatment time documented, signed and dated, progress notes are written at least every seven days, the physician plan of care/evaluation/cert/recert has been completed and signed by the therapist and physician. A current physician order is on record matching the current treatment plan.
- Chart Thinned: The chart is thinned per thinning schedule. Forms are repaired. Chart is cleaned and organized.

**Discharge Analysis**

- Chart is placed in discharge chart order per facility policy.
- All Forms have Name/MR#.
- Discharge Plan of Care or Discharge Instructions or Transfer Form: All sections are completed, signed, and dated by appropriate discipline(s). Resident received a copy of discharge plan/instructions which has been written in layman’s terms.
- Recap of stay documented for planned discharge.
- Physician Discharge Summary completed if required by State law. Initiated by facility staff. Physician completed, signed and returned within 30 days of discharge unless other time frame required by State law.
- Discharge Order: Discharge order obtained for the day of discharge. Order
included discharge destination, if meds sent when transferring to another facility include statement in order. Order upon death states to release the body or documentation of physician notification on record. Discharge order has been signed, dated and returned by the physician.

- Orders: Renewals / Telephone Orders (TO’s): All renewals have been returned and signed. All TO’s have been returned and signed. Facility policy should define how to handle orders that have not been returned.
- Discharge documentation: There is documentation of events leading to discharge or death: Nurse wrote a note reflecting date and time of discharge, the resident’s disposition, condition of the resident at discharge, where discharged to, and the individual taking responsibility for the resident.
- Disposition of medications documented per facility policy.
- Disposition of Personal Belongings: Inventory of personal belongings completed on discharge; or documentation of belongings sent with resident or picked up by the family documented in notes.
- Discharge Diagnoses coded and indexed per facility policy.
- MDS Discharge Tracking form completed within 7 days of discharge.

DEATH ONLY:

- Nurses notes reflect physician notification
- Nurses notes reflect family notification
- Mortician Receipt completed.

4.2.4 Focus Audits and Monitoring Systems

There are other beneficial audit and monitoring systems, many of which should be in place on an on-going basis. Focus audits should be implemented based on the needs and issues of a facility. The following table lists the common monitoring and focus audits found in long term care facilities.

<table>
<thead>
<tr>
<th>Quantitative Monitoring Criteria</th>
<th>Qualitative Monitoring Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Problems/24 Hour Board</strong> (completed daily)</td>
<td>Review the 24 hour or acute problem board each day. For each resident and problem identified check to see if corresponding documentation was completed such as nurses note, monitoring record, etc.</td>
</tr>
<tr>
<td><strong>Weights</strong></td>
<td>Implement an on-going monitoring system when weights are recorded to note significant weight loss changes.</td>
</tr>
<tr>
<td><strong>Physician Visits</strong></td>
<td>Monitoring system to assure that physician visits are made and documented every 30 days for the first three visits and then every 60 days thereafter. Assure dictation is returned if applicable.</td>
</tr>
<tr>
<td><strong>Physician Orders/ Renewals</strong></td>
<td>Reviewed and signed by the physician within specified time frame. Renewal of orders completed timely (i.e., 30 or 60 days).</td>
</tr>
</tbody>
</table>

Not only verify that the documentation was done, but also analyze what was documented. Does a note contain information applicable to the problem, should other issues be addressed? If an assessment or plan was documented was it appropriate? Should the documentation have included an assessment or plan?

If a significant weight loss has occurred review the documentation content to determine if the assessment and plan are complete and appropriate.

Content of the progress note addresses or supports resident issues.

Diagnosis can be associated with orders; Check for duplication of medications or treatments in treating a diagnosis.
LTC Health Information Practice and Documentation Guidelines

<table>
<thead>
<tr>
<th>MAR/TAR</th>
<th>Documentation completed at time of administration or within 24 hours if documentation omission occurs.</th>
<th>Reason and results are documented for PRN administration.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Restraints</td>
<td>Assessment completed and reviewed/updated at least quarterly. Consent obtained from resident or responsible party. Physician order obtained.</td>
<td>Reason for restraint is appropriate to justify use.</td>
</tr>
<tr>
<td>Skin/Pressure Sore</td>
<td>Assessment completed and reviewed/updated weekly until healed.</td>
<td>Documentation shows improvement or modification of plan if no improvement.</td>
</tr>
<tr>
<td>Psychotropic, Antipsychotic, and Hypnotic Medication Use</td>
<td>Assessment completed and reviewed/updated at least every 6 months. Physician order obtained.</td>
<td>Diagnosis associated with medication is listed in the federal regulations as appropriate. Continued justification for administration of medication is documented. Dose reduction efforts are documented.</td>
</tr>
<tr>
<td>Lab Result Monitoring</td>
<td>Results of physician orders for all labs are in the medical record.</td>
<td>Documentation reflects that abnormal lab results are communicated with physician.</td>
</tr>
</tbody>
</table>

4.2.5 Integrating Audits/Monitoring into the QA/QI Program

In order for an audit and monitoring program to be effective the data collected should be managed, analyzed, and reported. Findings from both focus audits/monitoring and on-going systems should be reported at the Quality Assurance Committee meeting. Trends or problem areas should be identified and action taken to correct the negative finding. Using a quality improvement process, the problems identified through the audit should be analyzed, measures taken to correct the problem, and further monitoring to determine compliance.

It is recommended that audit findings are plotted or graphed over time to show potential negative trends, the result of improvement efforts, or results of on-going monitoring. Not every audit or monitoring criteria warrants reporting and graphing. Facility administration, health information practitioners and the QA committee should determine which audit criteria are appropriate for on-going reporting and graphing.

It is critical that the health information coordinator/manager actively participates in the quality assurance committee and process. If this is not possible due to level of staffing and level of expertise, it is acceptable to have other clinical staff assist in the collection of audit data and in the analysis and reporting process to the QA committee. Once on-going audit and monitoring processes are established, there is a system in place that can be adapted to the changing needs of the facility. For example, if a potential problem area is identified on the quality indicator report, the audit tools can be adapted to monitor related documentation issues as one method to analyze a possible problem. The elements of an effective audit and quality monitoring system include flexibility to adapt to the changing needs of the facility, formal reporting and correction methods, and administrative acknowledgement of the importance of proactive monitoring systems.

4.2.6 Retention of Audits, Checklists, and Monitoring Records

If checklists are placed on the chart, it is acceptable to leave them on the record, but only for the time frame defined on the tool and then it should be removed (e.g. An admission checklist that is completed by day 7 should be removed right after the 7th day). It is not recommended the audit forms be left in the chart even discharge audit tools.
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The retention policies for the facility should define how long audits, checklists, and monitoring records should be retained based on the need and further use for the information. Generally, once the tool is completed and the findings are used for statistical analysis where applicable, the checklists/audit forms can be destroyed. If an audit is used in conjunction with a survey correction plan or monitoring a quality indicator, adjust the retention schedule appropriately.

4.3 DISCHARGE RECORD PROCESSING

Processing of discharge records is an important aspect in management of record systems. For all records including discharge records it is the responsibility of the long term care facility to protect the records from loss, destruction and unauthorized use. Prior to final filing of a discharge record, audit and monitoring systems should assure that the record is complete. This section reviews the fundamental processes that should be in place when managing discharge records.

4.3.1 Discharge Record Assembly

Discharge assembly is the process of pulling together all medical records for a resident upon discharge and assembling the medical record into one combined chart (which can have multiple volumes) in the established discharge chart order. The established order provides for a discharge record that is systematically organized. It is recommended that a discharge chart order or order of filing be placed in each record to facilitate location and retrieval of information.

Pulling Records from Multiple Locations:
When assembling the discharge record pull records from all locations. For example, all overflow records for the resident, therapy records not yet filed in the chart, records kept in a separate notebook/cardex such as the MDS or care plan, records that are not kept in the chart such as an individual resident’s sign-out log kept in a sign-out book, and other records that have not yet been filed in the chart.

Discharge Chart Order:
Place the records in discharge chart order. Facility policy should define a specific discharge chart order that is used consistently for all discharge records. It is recommended that the discharge chart order remain the same as the in-house chart order to eliminate unnecessary time moving sections of the chart around. The only change that is recommended for the discharge chart order is to place the discharge documentation (discharge plan of care, transfer form, etc) at the front of the chart behind the face sheet/admission record. If there are records not normally kept in the chart during the resident stay, but filed on discharge, they should be added to the discharge chart order.

The key to the assembly process is to establish one consistent chart order and date order for the forms and follow it consistently through all discharge records to establish systematically organized records that facilitate ease in retrieval of information. The following are the accepted methods for organizing discharge records.

- Charts placed in discharge chart order running in chronological order.
- Charts placed in discharge chart order running in reverse-chronological order.
- Another approach when used systematically may reduce staff time yet allow for an organized record by placing the active chart in discharge chart order and maintain as volume one of the discharge record (either chronological or reverse chronological date order). The overflow records become the subsequent volumes of the discharge chart. A chart order or order of filing is placed at the front of volume one. The overflow records are placed in a defined chart and date order to use this method for assembling discharge records.
**Date Order for Discharge Records:**
There are two acceptable methods for the order of filing chart forms -- chronological date order (oldest records filed first) or reverse chronological date order (most recent records filed first). It is considered technically correct to file the discharge medical records in chronological order by form on the chart order (for example, all nurses notes kept together in chronological order, all physician orders recaps in chronological order, etc.)

If defined by facility policy and consistently applied through the discharge record, forms could be filed in reverse-chronological order. If using a reverse-chronological order, all records in the discharge chart and on the discharge chart order should follow this organization.

**Fastening Discharge Records:**
To prevent loss or destruction of individual records, it is recommended that all discharge records be fastened in some manner. The most common methods include:

- Two-pronged metal fasteners. If using a standard file folder, the prong should fasten the records to the file folder.
- Specialty fastener rubber bands that are used for record storage. They have a life-span equal to the retention period for the medical records and fasten the records around both the length and width of the pages.
- Pocket accordion folders in combination with a metal fastener or rubber band fastener. If using a metal fastener, it should not be fastened to the file folder since records must be lifted out of the pocket folder for review.

**Discharge Record Folders and Labeling:**
Discharge records should be placed in file folders that are labeled with resident identification information. The type of file folder used should be dictated by the storage method used for filing. For example, if using shelf filing the file folder should have a side tab to place resident identification information. If using drawer style file cabinets, the file folder used should have a top tab for resident identification information.

At a minimum the discharge record file folder should be labeled with the following information: Resident full name, admission date, discharge date, medical record number and volume number. Other information which could be include on the label is the physician name and the discharge disposition (discharged home, another nursing home, expired, etc.). The number of volumes should be included on all discharge records even if there is only one record and should note both the volume number of that folder and the total volumes for that record (volume 1 of 2, etc.). It is recommended that a label with the discharge year be placed on the file folder to be used as a reference in the retention and destruction process.

Other information and labels can be placed on the file folder to aid in filing and locating a record. Depending on how sophisticated of a filing system is used, color coded labels with information such as the first three letters of the last name or numbers in the medical record number provide additional assurances that records are filed correctly and can be located easily.

In maintaining a unit record, the medical records from a previous stay should be pulled forward and kept with the current admission. Once the resident has been discharged from their most recent admission, the records from previous stays should be filed with the last admission. Do not integrate the records from a previous stay with the last admission. Keep the previous records in their file folders. Relabel the folder with the year from the most recent discharge. File the records from the previous stay in chronological order behind the last volume of the most recent stay.
4.3.2 Discharge Record Analysis

The process of analyzing a discharge record entails completing an audit of required discharge documentation before it is filed with the other discharge records. When completing discharge analysis the following steps should be completed:

- Initiate a discharge audit form to record audit findings and deficiencies.
- Check all pages of the medical record for resident name and medical record number. This will assure that a document if separated from the record can be traced back to the correct resident. Make sure that all documents belong to the correct resident.
- Complete a discharge audit focusing on those elements outlined in discharge analysis in section 4.2.3 Audits and Quality Monitoring.
- Note on the discharge audit those items that are missing or incomplete. Note items that have been mailed or are waiting return.

If the discharge audit is kept on the incomplete record, it should be removed before filing it with the other completed discharge records or when the record is requested by an outside party.

4.3.3 Timely Completion of a Discharge Record

**HIM STANDARD:**
- Written policies on record completion are in place and are consistent with accreditation standards, regulatory requirements, and medical staff guidelines.

Records should be assembled, analyzed, and completed within 30 days of discharge unless state law specifies another time frame. A record should be removed from the station as soon as possible after discharge. Records should be removed within 24 – 48 hours, but no more than 72 hours after discharge. The initial assembly and analysis should take place within 5 days of discharge. This leaves the remaining time to follow up on deficiencies and track documents that are being mailed and still allow for timely completion of the discharge record.

4.3.4 Incomplete and Delinquent Records

**HIM STANDARD:**
- Written policies outline the organization’s standards for the timely and accurate reporting of delinquent records.

Upon discharge analysis, records that have specific deficiencies that can be completed by a health care provider are considered incomplete. Once the audit has been completed, the providers should be notified of the incomplete records. They should be informed of the expectation to complete these records within a specific timeframe (within the 30 day or state-specific timeframe for timely completion of discharge records). Records should be monitored within the 30 day period to assure deficiencies are completed. If records have been mailed and were not returned in a timely manner follow up requests should be made for their return in time to meet the 30 day deadline.

Once an incomplete medical record remains so after a defined period of time (over 30 days or over the state-defined timeframe), the medical record is considered delinquent. A long term care facility can develop a quality assurance monitor by calculating the delinquent record rate or reporting the number of delinquent records each month. To calculate the delinquent record rate divide the total number of delinquent records by the average number of discharges in a defined period. For example, if there are 30 total delinquent records and the average number of discharges for a 30-day period is 45 then the delinquent record rate is 67%.
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An on-going quality improvement process should be used to monitor the types of deficiencies in discharge records and the reasons for records to become delinquent, identify the causes for the deficiencies and delinquencies, and then implement corrective measures. The number of delinquent records, delinquent record rate and reasons for delinquency can be reported at the Quality Assurance Committee meetings. Completing a run chart with the number of delinquent records and delinquent record rate each month can show a pattern over time. When records cannot be completed, a process should be established to review and approve of records to be filed with the other discharge records as incomplete.

4.3.5 Maintaining A Control Log for Discharge Records

It is important to maintain a monitoring system or control log for managing the completion of discharge records. The following table can be used to track records through the process:

<table>
<thead>
<tr>
<th>Discharge Date</th>
<th>Resident Name</th>
<th>Assembled</th>
<th>Analyzed</th>
<th>Coded</th>
<th>Completed</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.3.6 When to Close a Record on Temporary Absence

Facility policy should define when a record will be closed upon a temporary absence and when it will remain open. Federal law does not dictate when records must be closed and when they remain open on a temporary absence. Most state laws do not address this issue, however, if there is a specific state statute follow the regulation. A temporary absence would be such events as a temporary leave of absence with or without a paid bed hold or a transfer/discharge to the hospital with the expectation of return with or without a paid bed hold.

Long term care facilities should determine how they will handle closing records upon a temporary absence and consistently apply the policy in their facility. A good rule of thumb to help decide when to keep a record open upon a temporary absence is how the MDS discharge tracking form is completed. If it is indicated on the MDS discharge tracking form that the resident is not anticipated to return the chart should be closed and the resident discharged. If it is anticipated that the resident will return, facility policies should define whether the record will remain open or be closed. Facility policies should specify how each of the following situations will be handled and consistently applied. Policies may be different for each type of temporary discharge and/or by payer type.

- Hospitalization with paid bed hold
- Hospitalization with out paid bed hold
- Leave of absence with paid bed hold
- Leave of absence without paid bed hold
- Other types of temporary absences as defined by facility policy

There are advantages and disadvantages to each option outlined below.

- **Keeping a Record Open Upon Discharge for a Temporary Absence:** One option is to keep the record open during a temporary absence rather than closing the record on the discharge/transfer date. The advantage to keeping the record open is to minimize the time in readmitting and reassessing the resident. The information prior to the temporary absence continues to be available rather than in another record that is less accessible. The disadvantage of leaving the record open is the lack of consistency between the admission and discharge date, the financial record, and the medical record.

If the record remains open, policies should define the maximum length of time a record will remain open. Some payers such as Medicaid may define a bed hold period which can be followed in
developing a time frame on keeping a record open. In absence of a state or payer specific guideline, keep a record open for no more than 14 days. If the resident has not returned within a 14 day period, the chart should be closed. The discharge date is the date the resident left the facility.

When the chart remains open, the medical record should be removed from the nursing station or flagged for an absence or leave. This will help prevent staff from charting when the resident is no longer in the facility. A common practice is to redline the chart with a hospitalization. The pages in the record used for cumulative or on-going documentation such as progress notes, orders, flowsheets, or medication and treatment records are lined with a red pen with the hospital dates noted. This provides a visual break or flag in the record.

Upon return from a temporary absence, facility policy should also define the documentation to be completed when the resident returns. The reason for the discharge will affect the type of documentation to be completed. A return from a 5 day leave of absence will probably not require the same type of reassessment as a return from a 5 day hospital stay. When the resident is readmitted, all of the current assessments and care plan should be reviewed and updated, a readmission physical assessment completed, an assessment for significant change in condition, readmission/assessment notes written by all disciplines, and new physician orders initiated.

- **Closing the Record with a Temporary Absence:** Another option is to close the record upon the discharge date for the temporary absence. Closing the record keeps the admission and discharge dates consistent with the financial record and medical record. If the record is closed, records from the last stay must be brought forward to the new record to assure access to important clinical information and provide continuity of care.

When pulling documentation forward to the new record a copy of the following documentation should be made and placed in the new medical record: last MDS (if resident was expected to return from the temporary absence, the MDS schedule should resume not start over), advanced directives, social history, immunization records, leisure interest survey, copy of last progress notes, preadmission screening documentation (PASARR).

### 4.3.6.1 Closing Records with a Change in Level of Care

The medical record should not be closed when there is a level of care change between NF and SNF – the same record should remain active through the level of care change. If a long term care provider offers services in a variety of licensure settings, organization policies should define how transfers between different levels of care will be handled. Transfers between similar levels like NF and SNF should not result in the closure of records. Major changes in level of care such as a transfer between an assisted living facility to a SNF should result in the records being closed if the resident does not anticipate returning to their previous living situation. If a resident anticipates a return, organization policies can determine if records will remain open, the maximum length of time records will remain open, or if they will be closed.

### 4.3.6.2 Closing Records with a Payer Change

The medical record should not be closed upon change in payer such as a change from Medicare to private funds. A change in payment status does not warrant separating the medical records into different stays. The financial office should have mechanisms to track dates of coverage by individual payers.
### 4.4 FILING AND RETRIEVAL

**HIM STANDARDS:**

- The healthcare organization’s and health information management department’s filing systems, policies, and procedures comply with federal and state regulations and accepted standards of practice to ensure that all health records and resident-identifiable data are well organized and readily available for resident care, research, education, and other authorized uses.
- Policies and procedures exist to facilitate the prompt, consistent, uniform, and efficient filing of all health records and resident-identifiable data.
- The filing system is designed and implemented to ensure the safety, security, and accuracy of health records and resident-identifiable data.
- Policies and procedures exist to facilitate the prompt, consistent, uniform, and efficient retrieval of all health records and resident-identifiable data, and the policies and procedures ensure that confidentiality is maintained and that retrieval is performed only by authorized persons.
- The retrieval system is designed and implemented to ensure that safety, security, and accuracy of health records and resident-identifiable data; to keep track of the locations and holders of health records and resident-identifiable data removed from files; to follow up at appropriate intervals on the return of health records and data; and to identify health records and data to be converted to alternative medium moved to inactive storage, or destroyed.

Every long term care facility should have established a system for filing and retrieving of their medical records. The sophistication of the filing system is dependent on the volume of filing, admissions, discharges, and requests for records. Only trained staff should have access to the records and perform the filing and retrieval functions.

#### 4.4.1 Separate Location for Incomplete Records

It is recommended that incomplete medical records be kept in a separate location in the department rather than integrated with all of the discharge medical records. An incomplete record area facilitates ease in retrieval for staff who are completing records and also provides for easier monitoring of incomplete records.

#### 4.4.2 Typical Filing Systems

There are many acceptable methods for filing medical records ranging from the simple (alphabetical filing) to the complex (terminal digit filing). The type of system selected is based on facility-specific factors such as the volume of filing, admissions, discharges, requests for records, filing space, storage (open shelf filing vs. file cabinets) and security concerns. The following are the most common filing systems used in long term care for discharge records and overflow records:

- **Records are filed alphabetically by discharge year.** This method is commonly used when there is limited space in the health information department to retain more than one year of discharge records. Alphabetical filing provides the easiest for retrieval of records. Special systems are not required to locate a resident’s record. This method offers the least security since anyone could locate a resident record.
- **Records are filed alphabetically with multiple years integrated together.** A color-coded label is placed on the tab of the folder to indicate the discharge year. When there is adequate storage in the health information department, multiple years of records are integrated and filed alphabetically.
- **Records are filed numerically by medical record number by discharge year.** Records are filed by medical record number in numeric order for a single discharge year. This method offers better security than alphabetic filing because the medical record number must be known to locate a record. Access is more difficult for supervisory staff who must access records when the health information department is closed.
LTC Health Information Practice and Documentation Guidelines

- Records are filed numerically by medical record number with multiple years integrated together. A color-coded label is placed on the tab of the folder to indicate the discharge year. Multiple years of discharges are integrated together and filed by medical record number when there is more filing space in the health information office.

4.4.3 After Hours Retrieval

Every facility should have a process in place for after hour retrieval of records in case of an emergency. Because evening and night shift staff may have to complete deficient discharge records or have access to an overflow record, the supervisor should have keys to access the department and be trained in retrieval, the sign-out process, and other security measures. Department procedures should track who has keys to the department and documentation of their training on filing and retrieval procedures.

4.5 STORAGE SYSTEMS:

**HIM STANDARD:**
- Policies and procedures exist to facilitate the storage of both active and inactive health records and resident-identifiable data and are evaluated periodically to ensure that health records and data are well organized, are kept confidential and secure, and are readily available for resident care, research, education, and other authorized uses.
- The storage system is designed and implemented to ensure the safety, security, and accuracy of health records and resident identifiable data.
- When storage plans are developed, consideration is given to the amount of space needed and available, the expected future demand for storage space, the costs of various storage alternatives and associated personnel, and the healthcare organization’s health record and data retention policies.

Long term care facilities must invest in adequate storage systems and storage space for their medical records. The storage methods and systems must be secure and protect the confidentiality of resident information. The storage system and space must be adequate to protect the physical integrity of the record and prevent loss, destruction, and unauthorized use.

4.5.1 Storage System Options:

Medical record storage systems should be of professional quality to house and protect the medical records. Office supply and medical record file and storage vendors offer various products ranging from simple file cabinets to mobile file storage systems. The most common found in long term care are open shelf filing shelves (with or without locking doors) or metal drawer file cabinets. The storage method selected is dependent on the security of the health information office and the amount of storage. If the office is to be shared with another staff member or department not in health information, the shelves or file cabinets must be lockable and kept locked when ever health information staff are not in attendance.

The goal in each facility should be to keep accessible as many years as possible of discharge records.

- **Open shelf filing:** Open shelf filing is a common filing method for medical records in various practice settings in health care. Open shelf filing allows for easy access to files. The file folders used with open shelf filing must have side tabs for viewing demographic information for identification.

If medical record files are retained in the health information office that is not shared with other staff or in a separate locked file room, open shelf filing without lockable doors is acceptable. The office should always be locked when staff is not in attendance. If the office is shared, the open shelf filing should have doors that are lockable. When the health information staff member is out of the office, all medical records should be in locked files.
• **File cabinets:** Two, four or five drawer metal file cabinets are also commonly used in long term care facilities. File cabinets work well when there are few discharges in a year and storage space is minimal. Because file cabinets are bigger and bulkier than open shelf filing, they are not the optimal choice for large storage rooms or offices with a large volume of discharge medical records.

Locked file cabinets should be used when the health information office is shared with another staff member. The cabinets should be locked whenever the health information staff is not in the office.

### 4.5.2 Security Issues: Locking of Office and Storage Areas

The health information office and storage areas must be kept secure at all times if medical records are filed and stored in that area. If the office is only used for health information staff, open shelf filing can be used in the office.

When health information staff leaves the office, all doors or access to the office must be locked. The office should not be unattended when there are records on open shelving. If the office is not to be locked, then all filing shelves or file cabinets must be locked. No records should be out in the open and left unattended.

If the office is to be shared with another staff member or department not in health information, the shelves or file cabinets must be lockable and kept locked whenever health information staff are not in attendance.

Storage areas outside of the health information office should be locked with access limited to only those who need access. Health information department policies should identify who has keys and training on access, security, and the log-out process for records.

### 4.5.3 Alternative Storage Areas

When there is not enough room in the health information office to store all discharge medical records for the defined retention period, it is necessary to locate alternative storage. Optimally the storage should be in the facility to facilitate retrieval, but when storage space is limited it may be necessary to utilize storage space outside of the facility. When an alternative storage space is needed, the space selected must be secure and must protect the records from damage, loss or destruction.

Storage rooms must be organized allowing for ease in location and retrieval of records and documents. Similar documents should be retained together. One method for tracking the location of documents that are retained is to maintain an index log for records/documents (other than personnel files and medical records) which identifies the contents of different storage containers and locations. A log would contain information on the box number and a description including dates of items in the box.

• **Storage Boxes:** When it becomes necessary to store inactive discharge records and other resident-specific documents, storage boxes may be used. Storage boxes should not be considered for recent years of discharge records when records are accessed more frequently. Storage boxes purchased should be of adequate quality and durability for record/document storage purposes.

If storage boxes are used they must be adequately labeled with the content of the box, the year, and the year the records may be destroyed (per facility retention guidelines). It is recommended that similar types of documents are kept together in a storage box to facilitate ease in destruction.

When storage boxes are used, they should not be stacked on top of each other. Boxes should be placed on shelves to facilitate easy retrieval of records and documents. Boxes should be placed off the floor and below sprinkler heads following state fire safety standards. In absence of a standard, boxes should be at least 18" off of the floor and 18" below sprinkler heads.
• **Storage Rooms**: If storage rooms are used for medical records and other confidential records, they should be kept organized with adequate shelving, lighting and security. Multiple use storage rooms in which multiple staff members have access or keys must have a separate area that is caged and locked to protect the security of confidential records and documents. The storage room environment should not cause damage to the records and documents (such as moisture or rodents). It is acceptable to use storage boxes, but it would be optimal to use metal files or cabinets.

• **Storage Buildings/Sheds/Rented Storage**: When storage buildings or sheds are used for confidential documents, records and documents must be secure and protected from loss or destruction. The same standards apply to storage buildings, sheds and rented storage that applies for storage rooms within a facility. If multiple staff have access to the shed and store items, the records and documents must be placed in a separate locked area with access by select staff. The storage building must protect records from the elements such as moisture and rodents. The storage area must be organized to facilitate location and retrieval of information. Although it is acceptable to use storage boxes, it is optimal to use metal cabinets or files.

    *In some states prior approval is required from the Department of Health for use of off-site storage.*

• **Storage Companies**: If a storage company is selected, they should have written policies on the security and safety of confidential records and documents. If using a storage company there should be a written contract or agreement in place outlining the storage companies responsibility in securing documents, protecting documents from loss or destruction, and outlining how facilities will access records and the time frame for obtaining records. The long term care facility should have a list of all resident medical records and other documents retained at the storage company and have mechanism to access to those records in an emergency situation.

### 4.6 RETENTION

#### HIM STANDARD:

• The healthcare organization’s and health information management department’s health record and data retention systems, policies, procedures, and specified periods of retention comply with federal and state regulations; certification, licensure and accepted standards of practice.

• The retention system is designed and implemented to ensure the safety, security, and accuracy of health records and resident-identifiable data, and it considers the needs of all legitimate users of health records and resident-identifiable data.

• Health information management department provides assistance to other departments in developing retention schedules for their records, data, indexes, and reports.

Facility policy should define a specific retention schedule for different types of records based on federal and state law and professional practice standards. The policy should be consistently applied and records destroyed after the retention period has expired. Storage areas should be organized and storage boxes labeled with the content, year of documents, and year records/documents can be destroyed.

#### 4.6.1 Retention Guidelines

The following retention schedule outlines federal guidelines and recommended retention guidelines. If State law requires a different retention period, the more stringent between federal and state must be followed. After considering the required retention period, every facility should define in policy their specific retention period not to be less than the period defined by state or federal law.
## LTC Health Information Practice and Documentation Guidelines

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Federal Regulation</th>
<th>AHIMA Recommended Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Record</td>
<td>(F515) 5yrs after discharge when there is no requirement by state law; For minors, 3 years after the resident reaches legal age as defined by state law. Medicare residents – 5 years after the month the cost report is filed (HIM 12 Medicare Manual).</td>
<td></td>
</tr>
<tr>
<td>Financial Record</td>
<td>Medicare residents – 5 years after the month the cost report is filed. (HIM 12 Medicare Manual)</td>
<td></td>
</tr>
<tr>
<td>Master patient index</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Admission/Discharge Register</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Disease Index</td>
<td>10 Years</td>
<td></td>
</tr>
<tr>
<td>OSHA Records/Employee Medical Records</td>
<td>Duration of employment plus 30 years</td>
<td></td>
</tr>
<tr>
<td>Accounting of Disclosure Information (Release of Information Log)</td>
<td>6 years (HIPAA Privacy Rule)</td>
<td></td>
</tr>
</tbody>
</table>

### 4.7 DESTRUCTION

**HIM STANDARD:**
- The healthcare organization’s and health information management department’s health record and data destruction systems, policies, and procedures comply with federal and state regulations and accepted standards of practice.
- Policies and procedures exist to facilitate the destruction of health records and resident-identifiable data.
- The destruction system is designed and implemented to ensure the security and confidentiality of the health records and resident identifiable data being destroyed.

Every long term care facility should have a policy and procedure established to destroy records or confidential documents that are beyond their retention period. At least annually, every facility should review the documents on the retention guideline and destroy records as appropriate. It is recommended that the Executive Director/Administrator be notified and approve of records/documents to be destroyed.

#### 4.7.1 Acceptable Methods of Destruction

Records containing resident-identifiable data must be destroyed in a manner that makes it impossible to reconstruct and read the information. Records and resident information cannot be disposed of in the garbage containers without some type of shredding or obliteration. Acceptable methods used today include shredding, incineration; and pulverization. If facility staff are used to shred records, the health information staff should oversee the process. If the records are destroyed off-site through a destruction company, a certificate should be obtained attesting to destruction of records.

#### 4.7.2 Abstracting Documents Prior to Discharge

Unless required by state law it is not necessary to abstract documents out of the record to retain on a permanent basis. The master patient index card and the destruction logs contain basic demographic information and are to be retained on a permanent basis.
4.7.3 Destruction Logs and Witnesses

In addition to written policies and procedures on retention and destruction, it is recommended that a facility maintain documentation of the records/documents that are destroyed and the dates information was destroyed. Two types of destruction logs are recommended. One log should be used to reference when different types of documents were destroyed, when they were destroyed and who they were destroyed by.

Sample Destruction Log (Multiple types of documents)

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Facility Retention Period</th>
<th>Dates Destroyed</th>
<th>Person Authoring Destruction</th>
<th>Destroyed By and Witnessed By</th>
<th>Destruction Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Medical Records</td>
<td>7 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing Records</td>
<td>7 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease Index</td>
<td>10 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When medical records are destroyed, documentation of the destruction process and individual records destroyed must be in place. There are a number of methods that can be used to document records that have been destroyed. A destruction log is a common process used to document the resident’s name and the minimal demographic information for records that are destroyed. The destruction log also must contain the date of destruction, method of destruction, who destroyed the records and the witness, and a statement that the records were destroyed in the normal course of business. The medical record destruction log should be retained with the destruction log shown above.

Sample Medical Record Destruction Log (Individual Resident Records)

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Medical Record No.</th>
<th>Admission Date</th>
<th>Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of Destruction: __________ Destroyed By: __________ Witness: __________

If an off-site record storage company or destruction company destroy records, they should supply a certificate of destruction that is signed and witnessed and includes a list of the items destroyed, the date of destruction and method of destruction. The LTC facility should have a written agreement with the destruction company detailing their procedures and their security measures.

4.8 PHYSICAL SECURITY OF MANUAL/PAPER RECORDS

HIM STANDARD:

- When the healthcare organization uses a manual record-tracking system, out guides and/or requisition slips are used consistently to indicate records removed from the files.
- Training on the organization’s record-tracking system is provided to all healthcare employees empowered to request access to health records.

4.8.1 Maintaining a Record Checkout System

One of the most important physical security measures that must be in place in every long term care facility is a record sign-out system (log-out and/or outguides) for all types of medical records. Not only do the systems have to be in place, but they must also be enforced to be effective. Health information staff should monitor the sign-out practices and assure that records are returned promptly.
• **Active Records**: Outguides or a sign-out system must be in place on all nursing stations. Charts should not leave the unit without being signed out. Outguides work well because they are placed in the chart rack where the chart was removed. The authorized person who took the record must be identified along with the date and location.

• **Overflow Records**: Regardless of where overflow records are located in the facility, there must be a sign-out process to identify when a record has been removed, who took the record, and where it is located.

• **Discharge Records**: A sign-out system must be in place when a record is removed from the health information department or record storage area.

### 4.8.2 What to do if a Record is Lost, Destroyed or Stolen:

Even with the best preventative systems in place medical records, in full or in part, can be inadvertently lost, destroyed, or stolen. To limit or minimize the harm, systems must be in place and enforced which protect the records.

When records are lost or missing, an exhaustive search should be conducted to locate the documents or records. Once records are found, evaluate the system failure that resulted in the loss of records and implement corrective measures to prevent it from occurring again.

After an exhaustive search for lost records or in situations where the records are known to be destroyed or stolen, the next step is to reconstruct the record if possible.

Reconstruct the information by:

- Reprinting documents from any databases, such as the facility clinical computer system (MDS, care plans, etc), pharmacy (current physician orders), laboratory, and radiology databases or data backup services.
- Retranscribe documents from the dictation system if used (check with attending physician for copies of dictated progress notes).
- Obtaining copies from recipients of previously distributed reports/documents, such as those sent to physician's offices, hospital, other healthcare facilities, or the business office.
- Obtain copies of reports generated by a healthcare facility (hospital) that relate to the resident’s stay (history and physical, discharge summary, emergency room reports, etc.).
- If the current record is missing, have staff complete baseline assessments for the resident, complete a comprehensive assessment and a new care plan. Have each discipline write a summary note with the resident history and progress over the course of their stay. Verify physician orders with attending physician and have reconstructed orders signed.

If unable to reconstruct part or all of a resident's health information, document the date, the information lost, and the event precipitating the loss in the resident's record. When appropriate, document what and how information was reconstructed. Authenticate the entry as per facility policy. When information is disclosed that would have normally included the missing portion, include a copy of the entry documenting the loss of that information.
4.8.3 Disaster Plans

HIM STANDARD:
- A disaster plan for recovering health records damaged by fire, flood, or other destructive events is in place.
- The disaster plan includes provisions for recovering healthcare records on different types of storage media.
- The disaster plan includes provisions for a backup system to provide the healthcare organization’s staff necessary access to health records during emergency situations.

Every long term care facility should have a disaster plan in place to deal with unexpected events and outline how health information/medical records will be protected from damage. A well thought out disaster plan will minimize disruption, ensure stability, and provide for orderly recovery when faced with an unforeseen event.

A plan should be in place to deal with water damage (flood, sewage back-up, sprinkler damage, etc), fire, power failures (electronic medical records and clinical information systems), resident evacuation, and other natural disasters common to your area such as a hurricane or tornado.

AHIMA has the following practice brief on disaster planning which details the steps to take in preparing for potential adverse events.

**Research**
- Perform a literature search on disasters and disaster planning relative to medical records or health information. Search the archives of your favorite health information listservs or Web sites. Check the Internet to see if other health organizations have posted disaster plans on their Web sites. Collect sample health information disaster plans from peers.
- Talk to colleagues who have experienced the types of disasters your facility could expect.
- Contact several fire/water/storm damage restoration companies to determine the services available in your area and obtain any instructional information they can provide. Services may include document, electronic media, and equipment restoration as well as storage. These companies can often be located in the yellow pages under "fire/water damage restoration" or in the Disaster Recovery Yellow Pages.
- Determine to what extent the facility's insurance covers the costs associated with moving health information, operating elsewhere, recovering damaged information, or lost revenue secondary to the inability to restore information. In addition, determine whether your insurer offers consultation and advice on disaster planning. Many insurers provide this at little or no cost to their clients.

**Drafting the Plan**
- List the various types of disasters that might directly impair the operation of the facility, such as fire, explosion, tornado, hurricane, flood, earthquake, severe storm, bioterrorism, or extended power failure.
- List your department's core processes. For example, at a large hospital, the core processes might be maintenance of a correct master patient index (MPI), assembly, deficiency analysis, coding, abstracting, release of information, transcribing dictation, chart tracking, locating and provision, and generating birth certificates.
- Correlate the disaster plan/recommendations to the facility disaster plan mandated under Life/Safety codes.
- Make sure facility insurance policy addresses record restoration in case of damage.

For each plausible disaster and core process, generate a contingency plan. The document might include:
- facility name
- department name
LTC Health Information Practice and Documentation Guidelines

• contingency plan originator
• date
• the major function being addressed, such as chart tracking and location and provision
• the disaster being considered, such as a hurricane
• assumptions about the disaster, such as how will the disaster affect utilities; staffing and the ability of staff to report to work; security of health information and the facility itself; hardware and software; equipment and supplies; other departments; and residents presenting to the facility for treatment
• description of the existing process used for the major function being addressed
• an if/then scenario stating what will happen if a specific function cannot be performed
• interdependencies, such as which processes depend on the provision of certain information or services
• solutions and alternatives, including steps that can be taken to minimize damage or disruption before the disaster, ensure stability, or provide for orderly recovery
• the limitations and benefits of each solution or alternative
• activities that will need to be performed before the disaster in order to make this alternative possible, such as equipment acquisition, implementation of back-up systems, and development of disaster-related forms, materials, procedures, and staff training
• the names of the individuals responsible for performing these activities
• a list of individuals and departments with phone numbers to be contacted or notified relative to the disaster and implementation of this particular contingency plan

Implementing the Plan

• Perform the preparatory activities listed in each of the contingency plans.
• Share the preliminary plans with the facility's safety officer and risk manager.
• Develop written agreements with potential disaster recovery vendors or alternative service providers and locations as needed.
• Provide staff with the training and tools necessary to implement the plan.
• Test the plan.
• Reevaluate and revise the plan and corresponding procedures based on the input of staff, the safety officer, and the risk manager, and on simulated disaster trials.
• Include disaster training as part of staff orientation.
• Measure staff competency by asking staff to describe or demonstrate their roles and responsibilities during specific disasters. Include competencies in staff performance standards.
• Conduct drills at least semiannually.
• Review and update the plan at least annually.
• Repeat training and test competencies at least annually.

Restoring Damaged Records

In the event records are damaged in an actual disaster, contact a fire/water/storm damage restoration company. If services are contracted, the contract must provide that the business partner will:

• specify the method of recovery
• not use or further disclose the information other than as permitted or required by the contract
• use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the contract
• report to the contracting organization any inappropriate use or disclosure of the information of which it becomes aware
• ensure that any subcontractors or agents with access to the information agree to the same restrictions and conditions
• indemnify the healthcare facility from loss due to unauthorized disclosure
• upon termination of the contract, return or destroy all health information received from the contracting organization and retain no copies
• specify the time that will elapse between acquisition and return of information and equipment
• authorize the contracting entity to terminate the contract if the business partner violates any material term of the contract

To the extent records cannot be reconstructed by the damage restoration company, reconstruct the information by:
• reprinting documents from any undamaged databases, such as admission, transcription, laboratory, and radiology databases or data backup services
• retranscribing documents from the dictation system
• obtaining copies from recipients of previously distributed copies, such as physicians' offices, other healthcare facilities, or the business office

If unable to reconstruct part or all of a resident's health information, document the date, the information lost, and the event precipitating the loss in the resident's record. When appropriate, document what and how information was reconstructed. Authenticate the entry as per facility policy. When information is disclosed that would have normally included the missing portion, include a copy of the entry documenting the loss of that information.

Create and retain a record of the disaster event and a list of resident records affected, with recovery efforts, successes, and failures. This will allow for easy retrieval of general information regarding the past event should any legal or accreditation issues arise.

Post Disaster
Following the disaster, meet with staff and allow them the opportunity to:
• evaluate departmental performance and identify opportunities for improvement
• begin the grieving and healing process that may follow emotionally charged disasters

Disaster Plan Practice Brief prepared by: Gwen Hughes, RHIA Professional Practice Division

4.9 CONFIDENTIALITY AND RELEASE OF INFORMATION

<table>
<thead>
<tr>
<th>HIM STANDARD:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The medium in which resident-identifiable data and healthcare information are stored, whether paper based or computer based, is the property of the healthcare organization and is maintained to serve the resident, the healthcare professional, and the healthcare organization in accordance with legal, accrediting, licensing, regulatory, and ethical standards.</td>
</tr>
<tr>
<td>• Resident-identifiable data and healthcare information, regardless of the medium in which they are stored, belong to the resident and are protected accordingly.</td>
</tr>
<tr>
<td>• Confidentiality policies and procedures specify that resident-identifiable data and healthcare information are used within the healthcare organization only for the purposes for which the data and information were collected.</td>
</tr>
<tr>
<td>• Disclosure of resident-identifiable data and healthcare information is restricted to those individuals who possess knowledge of applicable federal and state laws and regulations and training in the legal ramifications of subpoenas and court orders.</td>
</tr>
</tbody>
</table>

One of the most critical roles of the health information department is to monitor and apply regulations, professional practice standards, and facility procedures for protecting resident confidentiality, information security, and release of information. A comprehensive policy and procedure on confidentiality and release of information must be in place in all long term care facilities. The following guidelines provide direction on common issues related to confidentiality and release of information. The guidelines take into consideration federal laws and professional practice standards, but not individual state regulations. If there is a state specific law with more stringent requirements, follow the laws of your state.

Version 1.0 August 2001

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Federal Regulation: 42 C.F.R. § 483.75 (4) states: The facility must keep confidential all information contained in the residents’ records, regardless of the form or storage method of the records, except when release is required by – (i) transfer to another health care institution; (ii) law; (iii) third party payment contract; or (iv) the resident.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires healthcare facilities and payers who utilize standardized transactions (such as electronic billing) to comply with the Standards for Privacy of Individually Identifiable Health Information (HIPAA Privacy Rule). The HIPAA privacy rule became final on April 14, 2001 with compliance required by April 14, 2003. This section refers to various components of the privacy rule, but does not go into full detail on all requirements. It is recommended that health information practitioners obtain a copy and review the entire HIPAA privacy rule. Copies can be obtained through the Administrative Simplification website at http://aspe.os.dhhs.gov/admnsimp/.

4.9.1 Identification of Confidential vs. Non-confidential Information

**HIM STANDARD:**
- Resident-identifiable data and healthcare information are regarded as confidential and made available only to users authorized within the healthcare organization, users authorized by the resident or his/her legal representative, and users authorized by law.
- Confidentiality policies and procedures differentiate between confidential and non-confidential data and information.
- Policies and procedures address the heightened level of confidentiality provided to healthcare information related to behavioral health, substance abuse treatment, HIV/AIDS, abortion, and adoption.

The confidentiality/release of information policy should define what information is considered non-confidential and may be disclosed without an authorization and that which is considered confidential. State law may define non-confidential information. Federal law restricts disclosure of information related to drug and alcohol abuse treatment. Under the HIPAA privacy rule, disclosure of directory information is permitted without a consent or authorization as long as the resident has had an opportunity to agree or restrict its use. Directory information may be disclosed to individuals who ask for the resident by name. Healthcare facilities are under no obligation to disclose even non-confidential information, policies should define the facility practice. The resident population should be considered when deciding what is considered non-confidential. Special consideration may be given to celebrities, facilities who treat HIV/AIDS residents, behavioral health facilities, etc. Under the HIPAA privacy rule,

- Non-confidential or directory information is considered to be common knowledge such as name of the resident, location in the facility (room number), their condition described in general terms (critical, stable, good, fair, transferred, treated and released, or expired) and religious affiliation.
- Confidential information is information made available during the course of a confidential relationship between the resident and healthcare professional. Confidential information includes – but is not limited to – all clinical data and the resident’s address on discharge. Confidential information may be disclosed only when the resident, or the resident’s legal representative, gives written authorization, or when federal or state law, subpoena, or court order requires such disclosure.

Facility policies should give direction to staff on releasing non-confidential and confidential information. Since these situations often occur at the receptionist desk or at the nursing station, staff should receive special training in dealing with requests and deciding what is acceptable to release and what is not.
4.9.2 Resident Access to Their Records

HIM STANDARD:

- Subject only to specific legal constraints (such as those governing minors and persons adjudicated incompetent), a resident or his/her legal representative has access to and is provided photocopies of his/her health record upon written request with reasonable notice and payment of a reasonable fee.
- Policies and procedures have been established to enable the resident to review, amend, or correct his/her health record.

By federal law, residents or their legal representative in a long term care facility have the right to access their medical records. Facility policies should provide guidance on who is considered a legal representative based on State law (i.e. guardian, conservator, durable power of attorney, etc.) Facility procedures should also outline how each request – whether a review of the medical record or request for photocopies – will be handled.

C.F.R. § 483.10(b)(i) states that “the resident or his or her legal representative has the right, upon oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays).” In the event the resident or the representative wants a copy of the medical records, the facility is required to make copies, after 2 working days advance notice, “at a cost not to exceed the community standard.” 42 C.F.R. § 483.10(b)(ii).

Under the HIPAA privacy rule, the resident has the right of access to inspect and obtain a copy of their protected health information in a designated record set (medical record) as long as the information/record is maintained. The facility must act on the request no later than 30 days after receipt. If records or information are not maintained on-site, the facility has up to 60 days to act on the request. The federal regulation for nursing homes (483.10(b)(i)) requires a more stringent time frame and should be followed when acting on a request by the resident/legal representative to access records.

Steps In Handling A Request To Access/View Medical Records:

- When a request is made by the resident or another party to view the medical record, those requests should be directed to the health information coordinator. Selecting one person or a department to handle requests will help to assure that the policy is carried out uniformly and information isn’t inappropriately disclosed or withheld.
- If the requestor has the legal authority to view the record, a meeting should be set up within the 24 hours required by law. If the requestor cannot accommodate a meeting within the 24 hour time frame, the review should be set up at a mutually agreed upon time. Since the resident or their legal representative have the right to review their records under federal law, it is not necessary to get approval from their attending physician.
- Prior to the meeting, the record should be reviewed. All records from another facility (i.e. hospital from a prior stay or another nursing home) should be removed.
- During the meeting, a staff member should be in attendance at all times. The staff member can be from the health information department or a designee such as nursing or social service. The staff member present at the meeting is there to answer questions and to assure that the record is not altered in any way or documents removed/destroyed. The resident/legal representative should be allowed to review and read the record without intervention from the staff member present.
- If copies are requested during this meeting, a release of information form should be signed with the specific documents and dates listed. The facility’s copy charge policy should be disclosed to the resident/legal representative at the time of the request. By law, the copies must be made within 2 working days of the request.
Steps In Handling A Request for Copies of Medical Records:

See the sections on Handling a Request for Medical Records and Copy Fees for Medical Records. The request for copies should be put in writing on a Release of Information form and signed by the resident or legal representative (for tracking purposes). The request should specifically state what records are to be copied. Review the copy fee policy with the resident/legal representative and if known, the estimated cost to fulfill the request before copies are made. To comply with the federal regulation, the copies must be made within 2 business days.

4.9.3 Confidentiality Training and Agreements with Employees and Volunteers

HIM STANDARD:
- Education and training programs provided to members of the healthcare organization as a whole and to specific departments address the confidentiality of resident-identifiable data and healthcare information.
- Confidentiality policies and procedures are incorporated into new employee orientations and routinely reviewed as part of each employee’s ongoing education.
- Education and training programs on confidentiality address the responsibilities of staff to protect the resident’s right to privacy.
- Confidentiality agreements are signed by everyone connected with the healthcare organization who may have access to confidential healthcare information and resident-identifiable data, and the agreements are updated annually.
- Agreements with home-based employees state that the employees assume the same responsibility as regular employees for maintaining the confidentiality of all resident-identifiable data and healthcare information within their control.
- Education and training programs provided to members of the healthcare organization as a whole and to specific departments address the release of resident-identifiable data and healthcare information.

Long term care facilities should have confidentiality training programs in place for all employees and volunteers. Training should be provided at the time of hire and reviewed annually with employees/volunteers. Training should address the employees responsibility in maintaining the resident’s privacy, the facility’s confidentiality and release of information policies, common situations which an employee may face which could result in a breach of confidentiality, and the consequences if a breach occurs or policy is not followed. All employees should have some basic training on their responsibility. Staff who handle requests for information should have additional training to address the situations they will face in their position.

Under HIPAA, facilities must train all members of its workforce on their policies and procedures related to the privacy rule. The training should be based on employee's function within the facility. Training for the entire workforce must be completed by the compliance date (April 14, 2003 at the latest). After the compliance date, all new members of the workforce must be trained within a reasonable period of time. Retraining must occur when there is a policy or procedure change that affects an employee's job. The facility must document that training was provided.

In addition to training, long term care facilities should have employees, students, and volunteers sign a confidentiality agreement at the time of employment after they have received training. Facility policies should address the frequency for obtaining updates to the agreement (i.e. annually after training). It is not recommended that confidentiality statements/agreements be incorporated into employee handbooks where the employee signs a blanket statement at the end. With the privacy requirements in the Health Insurance Portability and Accountability Act (HIPAA), it is recommended that confidentiality agreements should be separate and above the employee handbook to stress the importance of maintaining resident privacy and the potential action if privacy is breached.
Employee/Student/Volunteer Nondisclosure Agreement

[Name of healthcare facility] has a legal and ethical responsibility to safeguard the privacy of all residents and to protect the confidentiality of their health information. In the course of my employment/assignment at [healthcare facility], I may come into possession of confidential resident information, even though I may not be directly involved in providing resident services.

I understand that such information must be maintained in the strictest confidence. As a condition of my employment/assignment, I hereby agree that, unless directed by my supervisor, I will not at any time during or after my employment/assignment with [name of healthcare facility] disclose any resident information to any person whatsoever or permit any person whatsoever to examine or make copies of any resident reports or other documents prepared by me, coming into my possession, or under my control, or use resident information, other than as necessary in the course of my employment/assignment.

When resident information must be discussed with other healthcare practitioners in the course of my work, I will use discretion to ensure that such conversations cannot be overheard by others who are not involved in the resident’s care.

I understand that violation of this agreement may result in corrective action, up to and including discharge.

[Signature and date of employee, student, or volunteer]

4.9.4 Resident Identification Boards at Nursing Stations and Other Facility Locations

It is common to find boards at the nursing station or in other areas of the facility that are viewable to the public and identify resident-specific information considered confidential. These boards have been used to identify the nursing assistant they are assigned to, clinical information for communication to other shifts, census information, etc. As a general rule, the only resident boards that should be viewable to the public provide directory information (room number). Other communication boards viewable to the public, other residents or staff members who do not have a need to know, should not be in a location where confidential information is viewable.

4.9.5 Maintaining an Access/Disclosure Grid for Employees, Contractors and Outside Parties

HIM STANDARD:

- With regard to access to resident-identifiable data and healthcare information, the healthcare organization’s and health information management department’s policies differentiate among levels of authorized users within the healthcare organization, users within the healthcare organization’s provider network, and third-party users external to the healthcare organization and its provider network.
- Contracts for services external to the healthcare organization state that the companies providing the services assume responsibility for maintaining the confidentiality of all resident-identifiable data and healthcare information within their control.
- Policies and procedures identify when disclosure of resident-identifiable data and healthcare information may be made without the resident’s consent and differentiate between mandatory disclosure (for example, reporting of child abuse) and permissive disclosure (for example, access by healthcare staff).
- Policies and procedures define those circumstances that require resident authorization and those that do not before resident-identifiable data and healthcare information may be disclosed.
Policies and procedures identify those communicable diseases and other public health threats that require reporting to the appropriate governmental agency and the mechanism by which the reporting is to be done.

Part of the facility policies on confidentiality should be an access grid that outlines which employees and contractors are considered authorized users of the medical record and any restrictions or limitations on what can be accessed. The grid should identify the authorized user by department and position and the limitations on access to information. If subcontractors are used for certain services (billing service, laundry, dietary, etc.), language needs to be included in the contracts outlining the employee’s responsibility to maintain resident confidentiality and their authority to access the medical record.

### Employee/Contractor Access to Medical Records

<table>
<thead>
<tr>
<th>Position</th>
<th>Access to Records Granted</th>
<th>Scope/Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator/Executive Director</td>
<td>Yes</td>
<td>No limitations</td>
</tr>
<tr>
<td>Director of Nursing Services</td>
<td>Yes</td>
<td>No limitations</td>
</tr>
<tr>
<td>RAI Coordinator</td>
<td>Yes</td>
<td>Full access to records but only residents on their case load</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>Yes</td>
<td>Full access to records but only residents on their case load</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>Limited</td>
<td>Care plan and NAR flowsheets only</td>
</tr>
<tr>
<td>Health Information Services</td>
<td>Yes</td>
<td>No limitations</td>
</tr>
<tr>
<td>Health Information Consultant</td>
<td>Limited</td>
<td>As directed by the facility</td>
</tr>
<tr>
<td>Business Office Manager</td>
<td>Limited</td>
<td>Access only to clinical information required for billing purposes</td>
</tr>
<tr>
<td>Director of Laundry</td>
<td>Limited</td>
<td>Access only to information necessary to do job</td>
</tr>
<tr>
<td>Laundry Staff</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Pastor</td>
<td>Limited</td>
<td>Access only to information necessary to do job and only for those residents requesting pastoral services</td>
</tr>
<tr>
<td>Receptionist</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

This table is not all-inclusive and is for discussion/illustration purposes only. Positions, access and scope should be determined by each facility. No recommendations are made through this illustration.

A second access grid should also be developed for access to clinical information computer systems. The grid would serve the same purpose of outlining who has access to the system and what screens or programs are available to the position.

### Employee/Contractor Access to Clinical Information Computer System

<table>
<thead>
<tr>
<th>Position</th>
<th>Access to System</th>
<th>Scope/Limitations*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator/Executive Director</td>
<td>Yes</td>
<td>Billing and Clinical</td>
</tr>
<tr>
<td>Director of Nursing Services</td>
<td>Limited</td>
<td>Clinical Only</td>
</tr>
<tr>
<td>RAI Coordinator</td>
<td>Limited</td>
<td>Clinical Only</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>Limited</td>
<td>Clinical Only</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Health Information Services</td>
<td>Yes</td>
<td>Billing and Clinical</td>
</tr>
<tr>
<td>Health Information Consultant</td>
<td>Limited</td>
<td>Access as directed by facility</td>
</tr>
<tr>
<td>Business Office Manager</td>
<td>Yes</td>
<td>Billing and Clinical</td>
</tr>
<tr>
<td>Director of Laundry</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Laundry Staff</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
*As computer systems access control becomes more sophisticated, the scope and limitation should be more specific to the specific programs and screens in the system.

In addition to an access grid for employees and contractors, a grid should be included which outlines access to records by other types of providers, agencies or third-party users. This grid should outline whether a release of information form is required to be signed before information is disclosed or released and when reporting/disclosure is mandatory by law. Both federal and state regulations need to be incorporated into the facility policy and procedure and access grid.

The federal regulation (42 CFR § 483.75(4)) requires that the facility must keep confidential all information contained in the residents’ records, regardless of the form or storage method of the records, except when release is required by – (i) transfer to another health care institution; (ii) law; (iii) third party payment contract; or (iv) the resident.

The disclosure grid should outline access by the following individuals/entities and whether an authorization from the resident is required to release information.

*Completion of this grid should be based on state applicable state and local laws the following are guidelines

<table>
<thead>
<tr>
<th>Requestor or Outside Party</th>
<th>Authorization Required</th>
<th>Copy Charges Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accrediting Agencies (JCAHO, CARF)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Attorney</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Attorney for Facility/Corporation</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Courts of Law (Court Order)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Employer of Resident</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Family members</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Federal, State, and Local Government, and Voluntary Welfare Agencies</td>
<td>No – when reporting is required by law</td>
<td>No – when reporting is required by law</td>
</tr>
<tr>
<td>Funeral Homes</td>
<td>No – when releasing remains</td>
<td>No</td>
</tr>
<tr>
<td>Health Department</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Healthcare Practitioners</td>
<td>No - for continuity of care purposes when involved in residents care and treatment</td>
<td>No – for continuity of care and continued treatment. Yes – if not involved in care and treatment</td>
</tr>
<tr>
<td>Healthcare Providers (hospitals, LTC facilities, home health agencies, etc.)</td>
<td>No – for continuity of care purposes</td>
<td>No – for continuity of care purposes</td>
</tr>
<tr>
<td>Insurance Companies and Third Party Payers</td>
<td>No – for third party payment purposes</td>
<td>No – for third party payment purposes</td>
</tr>
<tr>
<td>Insurance Companies for Facility/Corporation</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Law Enforcement Officials</td>
<td>Dependent on state law</td>
<td></td>
</tr>
<tr>
<td>Medical Examiner/Coroner</td>
<td>No – if reporting is required by law</td>
<td></td>
</tr>
<tr>
<td>Ombudsman</td>
<td>Dependent on state law</td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>No – if project is approved by facility</td>
<td>No – if project is approved by facility</td>
</tr>
<tr>
<td>Residents</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
4.9.6 Handling a Request for Medical Records

HIM STANDARDS:
• Every request for healthcare information includes a valid authorization to disclose confidential resident-identifiable data and healthcare information.

All request for information should be handled by the health information department to assure uniform application of the facility policy and adherence to applicable laws and practice standards. When a request for information is made, the following issues should be considered before releasing information:

• Is an authorization to release information required to be signed by the resident or their legal representative?
• What is the nature of the information requested.
• Is the information considered confidential or non-confidential?
• What is the purpose of the request?
• What is the authority of the person or agency requesting the information?
• Are there any revocations or notices to withhold information on file?

Consent for Use and Disclosure of Protected Health Information:
Under the HIPAA privacy rule, the facility must obtain the resident's consent prior to using or disclosing protected health information to carry out treatment, payment, or health care operations (review the privacy rule for specifics on exceptions and requirements). Once the consent is signed, the facility may disclose information without additional authorizations for treatment purposes, to obtain payment for services, and for activities related to facility operations.

4.9.6.1 Review of Authorization for Release of Information

When a request for information is made that requires an authorization to release information, the authorization form should be reviewed to determine if it is complete. Many states have specific laws governing the content of the authorization. HIPAA also established minimum requirements for the content of an authorization form. In absence of state law requiring additional information, an acceptable authorization to release information should include all of the following:

• Be in writing or be given via computer (facsimiles or copies may be accepted if the LTC facility’s policy allows them). Under HIPAA, the authorization must be written in plain language.
• Be addressed to the LTC facility or the facility’s health information management professional.
• Specifically identify the resident (the resident’s full name, address and date of birth to assure proper identification), and
• Identify the individual or entity authorized to receive the information.
• Identify the health information authorized for disclosure (for example, specify the medical record documents and dates).

If a request for “all medical record information” or “any and all records” is made, contact the requesting party and clarify which documents are needed. Identify the estimated number of pages and the estimated copy charges. Often the requestor has specific documents in mind to serve the purpose of the request. If all records are requested and the authorization is valid, copy and send all information.

• Specify the date, event, or condition upon which the authorization will expire unless revoked earlier.
• Indicate that the resident, or the resident’s legal representative, can revoke the authorization.

The authority to grant an authorization may reside with the resident, if competent or an emancipated or mature minor; a legal guardian or parent on behalf of a minor; or the executor of the estate or an individual appointed by the probate court, if the resident is deceased.

If the resident is incompetent or cannot authorize the disclosure, the following individuals may serve
as the resident’s legal representative, in order of priority: legal guardian or attorney ad litem; agent named in a directive, durable power of attorney for health care, or other durable power of attorney; or next of kin, in the following order: spouse from a marriage recognized by law, adult son or daughter, father or mother, adult brother and sister. State law may determine this order which could vary from state to state.

- A statement that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the HIPAA privacy rule.
- Be signed or authenticated by the resident or the resident’s legal representative (if someone other than the resident has given authorization, that individual must indicate his or her relationship to the resident or legal authority).
- Be dated sometime following the resident’s admission. Unless state law provides otherwise, no more than six months should elapse between the date of signature on the authorization and the date the information is requested.

Reference: Release and Disclosure: Guidelines Regarding Maintenance and Disclosure of Health Information. Mary Brandt, MBA, RHIA, CHE.

4.9.6.2 Preparing a Record for Release

All information requested and authorized must be copied. The copier should be adjusted to assure that all documentation is readable (adjust copier shading). Make sure that the resident’s name and medical record number are on every page in the record and both sides of a double sided form (such as the nurses notes). If shingled pages are used in the record (i.e. telephone order slips), each individual shingle must be copied. If the entire discharge record is requested, number the pages of the record prior to copying.

If there is the potential for the record to be used in a legal proceeding involving the facility, the health information practitioner should notify administration and the facility legal counsel per facility/corporate policy. In many cases, it is in the facilities best interest to keep a duplicate copy of the record sent to an requesting attorney. This will provide a record for the facility’s legal counsel on what was sent for review.

A duplicate copy of records may also be kept for records sent to the Fiscal Intermediary upon a request for medical review. The duplicate copy will provide a record of the documents used in the Medicare determination.

4.9.6.3 Turn Around Time for Responding to a Request for Copies of Medical Records

The maximum turnaround time to respond to a valid request for information accompanied by a valid authorization is 30 days unless otherwise required by state law. When a resident or their legal representative requests copies of their medical record, copies must be made within 2 working days.

4.9.6.4 Copy Fees for Release of Information

HIM STANDARD:
- A reasonable and justifiable fee structure reflects the actual labor and photocopying expenses involved in releasing resident-identifiable data and healthcare information as permitted by law.

In the event the resident or the representative wants a copy of the medical records, the facility is required to make copies. Facility policies should state the copy fee rates charged. The federal regulations imply that a copy fee may be charged but “at a cost not to exceed the community standard.” 42 C.F.R. § 483.10(b)(ii). Some states have laws that dictate the maximum copy fees a health care provider can charge. AHIMA has published a summary of state law copy charges in a practice brief that is available at the following web address: http://www.ahima.org/journal/pb/99.01.html
For those states that do not have a specific law governing copy fees, an amount not to exceed the community standard can be charged. The community standard can be determined by reviewing photocopy charges from the post office, library, or local copy center.

Under the HIPAA final privacy rule, LTC facilities can charge a reasonable cost-based fee if the individual requests a copy of their protected health information (medical record) or agrees to a summary or explanation. The reasonable, cost-based fee can only include the cost of:

- Copying, including the cost of supplies for and labor of copying, the medical record requested by the individual.
- Postage, when the individual has requested the copy, or the summary or explanation be mailed; and
- Preparing an explanation or summary of the medical record if agreed to by the individual.

### 4.9.6.5 Documenting the Release of Information (Accounting for Disclosures)

The signed authorization form should be retained as part of the resident’s medical record. On the form, make a notation stating the information disclosed, the staff member disclosing/copying the information, and the date the information was sent to the requesting party.

Facilities can also choose to maintain a release of information log to document all requests and disclosure. The log can also be used as a tracking tool to monitor incoming requests and completion dates.

**Sample Release of Information Log**

<table>
<thead>
<tr>
<th>Date Received</th>
<th>Requested By/Sent To:</th>
<th>Resident Name:</th>
<th>Information Copied/Sent &amp; Purpose:</th>
<th>Copied/Released By:</th>
<th>Copy Charge</th>
<th>Date Sent:</th>
</tr>
</thead>
</table>

Under HIPAA, residents have the right to request an accounting of disclosures (releases) for the previous six years from the date of the request. Facilities must start a tracking process for disclosures by April 14, 2003. The accounting does not need to include disclosures made to carry out treatment, payment and health care operations, disclosures made to the resident, or disclosures from the facility directory. The accounting of disclosures must include:

- The date of the disclosure.
- The name of the entity or person who received the information/records and, if known, the address.
- A brief description of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure; or, in lieu of a statement, a provide a copy of the written authorization or written request for disclosure.

Facilities must retain the information required for the accounting, the written accounting provided to the resident, and the titles of the persons responsible for receiving and processing the requests for an accounting.

### 4.9.7 Redisclosure of Health Information

**HIM STANDARD:**

- The healthcare organization’s and health information management department’s policies and procedures identify the circumstances that require the inclusion of a redisclosure notice with the release of resident-identifiable data and healthcare information.

Long term care facilities will often have records from other health care providers, such as a hospital or another nursing facility, as part of their records. Redisclosure is the process of releasing records that were provided to the facility from a previous facility for continuity of care purposes.
LTC Health Information Practice and Documentation Guidelines

HIPAA does not prohibit redisclosure of health information/ medical records and requires facilities to protect the privacy of records that were received from another facility. State regulations should be reviewed for any restrictions in redisclosure. Unless otherwise required by state law or regulation, AHIMA recommends the following:

In general, health care providers should:
• redisclose to other health care providers protected health information when it is necessary to assure the health and safety of the patient
• redisclose requested health information to patients when necessary, but after first encouraging the patient to obtain the most complete and accurate copies from the originating healthcare provider
• redisclose protected health information when necessary to comply with a valid consent and notice of privacy practices
• redisclose protected health information when necessary to comply with a valid authorization or legal process

Reference: Practice Brief - Redisclosure of Health Information (2001) Gwen Hughes, RHIA.

4.9.7.1 Redisclosure upon Transfer to Another Healthcare Facility

If the hospital or another facility’s records provide important information for the continued care of the resident, those records should be sent to the next facility/agency that will be providing care. A LTC facility should send the most recent hospital history and physical report and discharge summary upon transfer to another facility if the information provides insight into the resident’s current health status or would be beneficial in the continued diagnosis and treatment. Other documents should be redisclosed based on the content and relevance to the resident’s continued care and treatment.

4.9.8 Handling Telephone Requests for Information

When a request for a resident’s health information is received by telephone, the person receiving the request must decide if they have the authority to handle the request, decide whether information can be disclosed without an authorization, and verify that the individual has a right to receive the information. With the exception of requests related to the resident’s current care and treatment, telephone requests should be directed to the health information department.

Telephone requests can be honored without an authorization if they meet the specifications in the federal regulations – when needed for a transfer to another health care institution (for continuity of care purposes), when required by law, for third party payment, or when requested by the resident (including the legal representative). The call should be returned to verify the identity of the individual requesting information if they are not known to the health information department/facility staff handling the request.

Under HIPAA, the Consent for Use and Disclosure of Personal Health Information signed by the resident would cover telephone release in certain situations. The consent would cover requests made for treatment purposes, for payment purposes, or facility operation provided that the resident did not request a restriction.

4.9.9 Transmitting Resident Information via Facsimile

HIM STANDARD:
• Policies and procedures establish the circumstances under which transmission of resident-identifiable data and healthcare information by facsimile machine is appropriate (such as when the original document or mail-delivered photocopies will not serve the purposes of the requestor).
LTC Health Information Practice and Documentation Guidelines

When the fax machine is used to release or transmit resident health information, safeguards must be in place to protect the resident’s confidentiality. If a LTC facility uses the fax machine to transmit information, they must have a policy and procedure in place directing staff on the proper procedures.

- A fax cover letter must always be used when sending resident information. The cover letter should indicate whom the fax is sent to, whom it is from, the number of pages, and a confidentiality statement. A facility should never send resident information (whether medical record documents or a narrative summary/notes) without a cover sheet.
- The fax cover letter should provide specific directions on the steps to take if the fax was sent to the wrong location/person.
- Preprogram fax numbers into the machine whenever possible to minimize the chance of entering an incorrect fax number resulting in a misdirected fax.
- If faxing is used to correspond with the physician and a response is needed, maintain a monitoring system to assure that a response is received. If an immediate response is needed or the resident’s condition requires immediate intervention, the telephone should be used to contact the physician rather than the fax machine.
- Some type of verification process should be in place to assure that the fax was transmitted. Verification may vary from a report generated by the fax machine to a call back from the receiving party. The type of verification used should be dependent on what was sent and who it was sent to.
- Facility policy should outline the types of information that cannot be faxed.

4.9.10 Responding to a Subpoena or Court Order

It is critical that state law is followed in processing a subpoena. The following provide general guidelines in handling a subpoena when it is received. Facility policies should be tailored to specific state statutes.

- Check that the subpoena is signed by a representative of the court (usually the Clerk of Court).
- If a subpoena is received, notify facility administration and the facility legal counsel per facility policy. Some corporate offices require that the corporate legal department be notified and approve the release before records are sent.
- Review the entire medical record to make sure that all sections in the record are present and in the proper sequence. For a discharge record, do not make any alterations in the record or allow anyone else to make additions, corrections, or deletions after the subpoena has been received.
- Number the pages of the record (including shingled copies), verify that the records all belong to the correct resident, and check that the resident name and medical record number are on all pages including both sides of forms. Make the requested copy after approval from administration/legal counsel if required by facility policy. Make a second copy for facility use/legal counsel.
- If the record is for a discharge resident and for litigation purposes, the records should be removed from the storage/filing area and placed in a locked location until the litigation process is complete.
- Deliver the copy of the record to the location listed on the subpoena.
- Upon return from court, write a note on the subpoena identifying by whom the subpoena was answered, the date and time, the attorney’s name, and note that a copy of the medical records was left with the court.
- If the original record is requested, contact the Clerk of Court to determine if a copy is acceptable. If the original is required for court --
  - Create a Receipt for Medical Records and keep one copy for the facility and one for the person accepting the record on behalf of the court. Include on the receipt an inventory of the medical record content. For example, nurses notes – 20 pages, physician orders – 10 pages, total pages – 30.
  - Place the original record in a folder with the receipt and label as the “Original Medical Record.”
  - Deliver both the original record and the copy to the location listed on the subpoena.
  - Remain with the original record at all times until you are sworn in.
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- Request the Court Official to review the copy to see if they will accept the copy in place of the original. If the Judge or Hearing Officer refuses to accept the copy in place of the original, leave the original record. Request that the original record be returned to the facility when the case is completed.
- Obtain a signature of the original copy of the Receipt for Medical Records from the Clerk of Court. Keep the original copy of the receipt.
- Leave the copy of the receipt with the record held by the Court.
- Upon return from court, write a note on the subpoena identifying by whom the subpoena was answered, the date and time, the attorney’s name, and that the original medical record was left with the court.
- File the subpoena and the signed receipt in the resident/resident's medical record file folder until the record is returned.
- After the record is returned, check the record against the receipt to make sure that all pages are present. Reassemble the record in proper order, if necessary. Note the date returned on the receipt/subpoena and file the original record in the permanent file.

4.9.11 Removing Original Records from the Facility

HIM STANDARD:
- Original health records may not be physically removed except in accordance with the healthcare organization’s policies.

The original medical record should never be removed from the facility. Facility policies should specifically address removal of records and prohibit any employee, contractor or agent from removing resident medical records (in full or in part) from the facility. When records are requested for legal proceedings, it is acceptable to submit a copy of the original. If the original record is specifically requested for a legal proceeding, every effort should be made to submit a copy. For example, contact the court requesting that a copy versus the original be submitted or go to court with the original record and a copy. Request that the copy be placed into evidence rather than the original record. If the original must be placed into evidence, then the copy can be used by the facility.

If it is absolutely necessary to remove the original record, measures should be in place to physically protect the original. One possible method is to utilize the storage bags with plastic locks that can be purchased through medical record supply companies. The bag can be locked at the facility and the lock broken once at the destination. If the original record does have to be removed from the facility, it should always stay in the custody of a facility representative who takes full responsibility for its safe-keeping.

4.9.12 Notice of Information Practices

The HIPAA privacy rule requires facilities to provide the resident with a notice of the uses and disclosures of protected health information, the resident's rights, and the facility's legal duties. The notice should be provided before services are delivered (usually in conjunction with signing the Consent for Use and Disclosure of Protected Health Information). The notice must be written in plain language and contain the following elements: (See HIPAA privacy rule for specifics under each section)

- Header: "This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully."
- Uses and disclosures
- Separate statements for certain uses or disclosures
- Individual rights
- Covered entity's duties (facility's duties)
- Complaints
- Contact information
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- Effective date
- Other optional information as described in the HIPAA privacy rule

If there are changes to the notice it must be promptly revised and distributed.

4.9.13 Designation of a Privacy Officer

HIPAA requires the designation of a privacy official who is responsible for the development and implementation of the policies and procedures of the facility related to the privacy rule. The facility must also designate a contact person or office who is responsible for receiving complaints related to the facility's privacy practices. The privacy official and contact person does not have to be the same individual. The rule does not require specific training or expertise. AHIMA has published a model position description for the Privacy Officer available at http://www.ahima.org/infocenter/models/PrivacyOfficer2001.htm

4.10 CODING AND REIMBURSEMENT

HIM STANDARD:
- The healthcare organization’s diagnosis and procedure coding guidelines for all resident types are based on current ICD-9-CM, CPT and HCPCS classification systems to ensure the retrievability of pertinent information.
- The director of the health information management department supervises or monitors any diagnosis and procedure coding done outside the department to ensure the complete and accurate description of resident services.
- The director of the health information management department (or a designee) provides training and/or consultation to staff outside the department who assign or analyze diagnoses and/or procedure codes.

The coding process in long term care facilities primarily involves the use of the ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) system for assignment of a diagnostic code to diagnoses, diseases, and conditions for a resident. ICD-9-CM coding is a key function for health information practitioners in a facility. It is critical that health information staff have adequate training and resources to accurately and completely assign diagnosis codes.

In a long term care facility, diagnosis codes are generally assigned on the face sheet/admission record, on the diagnosis/problem list, on the MDS, and for billing purposes on the UB-92. Assignment of diagnosis codes on the face sheet/admission record and diagnosis/problem list is not mandated by regulation, but are highly recommended. Reporting codes on the MDS and UB-92 are required.

4.10.1 Training and Resources

HIM STANDARD:
- Competent, credentialed clinical coders are recruited, hired and retained.
- Health information management employees who perform diagnosis and procedure coding functions attend educational programs related to their responsibilities, including orientation, on-the-job training, in-service education, and external educational opportunities.
- ICD-9-CM, CPT and HCPCS coding books and computer software are updated on an annual basis as the classification systems are revised.

Training:

The health information practitioner in a facility should be trained on the proper use of the ICD-9-CM system. Ideally, this training should be through a formal course or program. If staff who code do not have access to a formal training course, at a minimum, they should attend a comprehensive coding workshop.
have current resource materials available, and access to a trained, credentialed HIM consultant/professional for questions and clarification.

Under consolidated billing for Medicare, CPT and HCPCS codes are utilized to reflect services and supplies. LTC facilities should have health information staff who have basic training and an understanding of the CPT and HCPCS coding system.

Although coding should be completed by trained coders, if other staff (such as a MDS nurse, biller, or Medicare nurse) use the ICD-9-CM coding system, they should also be trained in the correct coding process, official coding rules, and standards of ethical coding.

**Resources:**

- Current ICD-9-CM Code Books (code books are updated each year in October. New code books or updates must be purchased). All staff who code must have access to current code books. The ICD-9-CM database used for clinical and financial computer information systems must also be updated each year either by the vendor or by health information staff.
- Current CPT Code books (updated annually).
- Current HCPCS code books (updated annually).
- If staff who complete coding have not been through formal coding training, coding resource books for ICD-9-CM and CPT/HCPCS should be available. Basic coding handbooks are available through AHIMA and other coding vendors. AHIMA publishes a long term care resource for coding that will assist staff in the coding process. (Insert URL and book title)
- The LTC facility should have a copy of the Official Coding Rules available on the Center for Disease Control website. Under the Health Insurance Portability and Accountability Act (HIPAA), LTC facilities will be required to follow the official coding guidelines for ICD-9-CM. The guidelines are available at www.cdc.gov/nchs/data/icdguide.pdf.
- All LTC facilities should subscribe to Coding Clinic, a quarterly newsletter published by the Official Office for ICD-9-CM coding. The newsletter provides official coding advice from the Cooperating Parties which is necessary for adherence to the transaction and code set standards required by the Health Insurance Portability and Accountability Act (HIPAA). Subscription information is available at www.icd-9-cm.org.
- Coders should be aware of and abide by the Standards of Ethical Coding available at www.ahima.org/infocenter/index.html (under AHIMA Guidelines).

**4.10.2 Frequency of ICD-9-CM Coding**

As a general rule of thumb, facilities should have a process to review the record, assign new ICD-9-CM codes, and report them on the diagnosis/problem list in the following timeframes:

**Minimum Coding Frequency:**

- **Admission/Readmission:** Each time a resident is admitted, readmitted, or returns from a hospital stay, the physician documentation (physician orders, history and physical, physician signed transfer form, hospital records, etc.) should be reviewed and diagnosis codes reported in the medical record. The diagnoses should be coded and reported in time to be used in completion of the MDS.
- **Quarterly/Per MDS Schedule:** At a minimum, the resident’s medical record should be reviewed on a quarterly basis to coincide with the MDS schedule. The physician progress notes, orders, referrals/consultation reports, etc. should be reviewed for new diagnoses or resolved diagnoses.
- **Discharge:** To complete the disease index information (if one is being maintained) and have a record of all pertinent diagnoses, the medical record should be reviewed and new diagnoses coded and reported for billing and other record keeping purposes.
Concurrent Coding:

Health information staff can also opt to code the record on a concurrent basis. As diagnoses are added or resolved during the resident’s stay, they are coded and reported in the medical record and updated in the information system. This type of process is usually dependent on nursing staff identifying new diagnoses in physician documentation and routing the information to the health information staff for coding. Another concurrent process is to assign codes based on the physician order entry into the clinical computer system. Concurrent coding helps to assure that the medical record and information system have up to date information on diagnoses at all times.

For documentation issues related to coding, see Section 6.8

4.10.3 Coding and Billing Relationships

The health information professional should be well versed and involved in the coding or monitoring process in a long term care facility and understand the link to the billing cycle. Billing staff must also recognize that accurate and complete ICD-9-CM, CPT, and HCPCS codes are necessary in accurate billing.

The Health Insurance Portability and Accountability Act (HIPAA) contains regulations pertaining to transaction and code set standards for the health care industry. The law requires that both health care providers and payers utilize specific code sets and follow the official coding guidelines established for each code set when submitting electronic transactions (i.e. electronic billing/claim submission). Payers will no longer be able to set their own rules for reporting diagnoses that conflict with official policy.

ICD-9-CM codes on a billing claim form usually provides information on the medical necessity of the services billed. Each code number represents a specific disease or condition for the resident that must be supported by physician documentation. An inaccurate diagnosis code used to justify services billed could potentially be considered fraudulent if the resident does not have the diagnosis used to justify the services utilized and billed.

CPT and HCPCS codes represent services or supplies. When a CPT or HCPCS code is reported on a claim form, the facility is indicating that the specific service or supply represented by the code was provided and medically necessary. It is important that all services and supplies represented by the CPT or HCPCS codes be supported by documentation in the medical record regardless of whether it is a Medicare part A claim (where all services are lumped together under one revenue code) or a Medicare part B claim (where each item is line item billed per service and per day).

4.10.4 Investigation of Claim Rejection/Denials due to Coding

Communication must be established and maintained between the billing and health information staff when billing claims are rejected or denied for coding reasons. It is not appropriate for the billing staff to change the code without knowledge of the resident’s current condition just to get a claim paid. Health information staff should be consulted to determine the reason for the rejection of denial such as an invalid code, lack of 4th or 5th digits, or improper sequencing. The reason for the denial/rejection should be investigated and the resident’s record reviewed prior to resubmission. If necessary, consult with the fiscal intermediary. If requesting direction on coding, ask for coding advice in writing and keep a written log of phone calls, discussion, and recommendations. If the fiscal intermediary will not put their recommendations in writing, obtain the staff name and write a letter back to the FI summarizing the advice received. Keep a copy of the letter with facility logs.
4.10.5 **Coding Issues Under Consolidated Billing**

Under consolidated billing (both Medicare part A and part B), health information and billing staff must be concerned with the accuracy of the vendor invoices received and billed under the facility’s provider number. When a vendor bills the facility for services provided to a Medicare resident, they should provide the CPT/HCPCS code and date of service. To assure accuracy, the facility should have a process to review vendor invoices prior to billing Medicare. The goal of the review process is to assure that the service or supply was provided (based on medical record documentation), physician ordered, and medically necessary.

4.11 **Indexes and Registries**

There is a minimum of three indexes or registries that every long term care facility should maintain. Indexes or registries provide baseline information in a retrievable format and are fundamental components in managing a facility’s health information. At a minimum, every long term care facility should maintain a master patient index (MPI), and admission and discharge register.

4.11.1 **Master Patient Index (MPI)**

<table>
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<th>HIM Standard</th>
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<tr>
<td>• The computer-based patient record system is supported by the organization-wide master patient index or other resident identification mediation service that ensures accurate and timely resident identification.</td>
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</table>

The master patient index (MPI) is a valuable reference for basic demographic information and resident activity (i.e. admission and discharge dates) within one source. The MPI is an index maintained separately from the resident’s medical record. It is used to identify that a resident had a stay in the facility, the dates of the stay and other important data in an easily retrievable format (i.e. alphabetically or through name searches).

4.11.1.1 **Maintaining an MPI**

An index can be maintained manually or as part of a computerized system. Because the information in the MPI is important for tracking resident stays in an organization, the MPI should be retained on a permanent basis. Information on the MPI should be updated with changes throughout the residents’ stay.

Most long term care facilities maintain the MPI alphabetically. If the MPI is computerized, facility staff should be able to retrieve the information by resident name and by medical record number.

**Maintaining a Manual MPI:**

There is no required form or format for the MPI. The most common manual format for an MPI is the use of index cards. The index cards are completed on admission and updated with changes throughout the resident’s stay. The index cards are typically filed alphabetically in long term care facilities.

Another common method for maintaining a MPI is to use a copy of the admission record (face sheet). On admission the face sheet is printed, kept updated throughout the residents’ stay and on discharge, the discharge date and disposition are documented. The face sheets are maintained alphabetically and retained on a permanent basis.

There are a variety of methods for filing the MPI information including separating the current admissions from the discharges or integrating the current admissions with previous discharges. For facilities that have decades of MPI information, it may be necessary to separate some of the MPI cards. For example, to
manage the volume of information MPI cards from the 1960’s, 1970’s, 1980’s may be separated, maintained alphabetically and filed together.

**Maintaining a Computerized MPI:**

Many computer systems have the MPI information readily available through the demographic and census program. It is not necessary to have a manual index if the information is computerized, however, it is critical that the information be available on a permanent basis. There are MPI programs available for other health care settings, but they are not commonly used in the long term care setting at this time unless the facility is attached to a hospital or part of an integrated delivery system.

Computerized MPI information has many advantages for an organization including ease in access and retrieval. Because of current limitations in software programs available in the long term care industry, consider the following before moving to a fully computerized MPI:

- Does your system have the capability to retain the core MPI elements on a permanent basis? If not, a manual system should be considered to back up the computerized system.
- If you change computer systems, how will you access the MPI information in the old system? Will the new system allow for transfer of the core MPI elements from the previous software? If not, the MPI information from the previous system should be printed out and maintained manually or data entered into the new system.

Some computer systems will have a report that allows for an MPI card or sheet to be printed. The most common reasons for printing a hard copy include:

- Continuation of a manual system. Many facilities have decades of MPI information available in a manual format and see advantages to continuing this type of system particularly as a back up to the computerized system.
- If resident and MPI information has to be purged from the computer system because of memory/storage limitations the MPI information should be maintained manually.
- Manual systems are maintained when there are questions about the long term viability of the computer system and concerns that the system won’t be available for retrieval of information.

It is possible to maintain a partially automated and partially manual MPI system. There should be a clear point in time when all MPI information is maintained in the computer system rather than manually. Proper safeguards must be in place to prevent from loss or destruction of the computerized MPI information.

**Retention:**

The MPI should be retained on a permanent basis to provide historical access to basic resident information and dates of stay in an organization.

**4.11.1.2 Minimum Content**

The content or format of the MPI may vary from health care facility. At a minimum, the MPI in a long term care facility should contain the following data elements:

- Medical record number
- Resident name (legal name including surname, given name, middle name or initial, name suffixes (Junior, IV), and prefixes (Father, Doctor).
- Date of Birth (day, month, and year)
- Gender
- Address
• Alias or previous name (other names patient is known including nicknames, maiden name, previous
name that was legally changed)
• Social security number
• Admission/Readmission date(s)
• Discharge/Transfer date(s)
• Resident disposition (resident’s intended care setting following discharge or died)

There are many other data elements such as attending physician, marital status, emergency contact that can
be included in a facility MPI. The list provides the minimum content, but should not be considered all-
inclusive. Other data elements should be added to meet the needs of the facility/organization. AHIMA has
published a practice brief with additional core elements to the MPI. This practice brief can be reviewed at

4.11.2 Admission/Discharge Register

An admission and discharge register (or census register) lists chronologically all admissions and discharges
by date. This type of register can be maintained either manually or on a computer system. Some states
require a specific format such as a bound book which continues to be the most common format used for this
type of register.

If there are multiple care settings on a long term care campus (i.e. assisted living and a long term care
facility –NF/SNF), admission and discharge information should be maintained for each setting. The
campus must determine if one census register will be maintained for the campus or if each setting will
maintain their own register. If one is maintained, the register must clearly indicate the care setting.

Minimum Content:

At a minimum, the admission/discharge register should contain the following information:

Admissions:
• Admission date
• Resident name
• Medical record number
• Where admitted from

Discharges:
• Discharge date
• Resident name
• Medical record number
• Where discharged to/discharge disposition

Optional Information:
• Transfer and return dates (bedhold information)
• Pay source (on admission and on discharge)
• Discharge length of stay
• Attending physician

Register Format:

Unless required by state law, facilities can determine the format and content of the admission/discharge
register to meet their needs. This type of register can be very helpful in compiling statistical
information/reports for a facility. The following are two examples of the most common formats used for
recording admission and discharge activity:
For each month, admissions are recorded on one page/side of the register and discharges on the opposing page. Both the admissions and discharges are listed chronologically.

For each month, list chronologically all activity integrating admissions and discharges and sequencing them in date and time order. This method gives you a picture of the activity each day whether it was an admission or a discharge.

Retention:

The admission/discharge register should be retained on a permanent basis to provide a historical record of activity in the long term care facility.

4.11.3 Disease Index

HIM Standard:

- The integrity of a disease index is maintained.
- Disease indexes are used to provide cross-reference for locating health records of all patient types for the purposes of epidemiological and biomedical studies; health services research; and statistical research on occurrence rates, ages, sex, complications, and associated conditions; as well as continuous quality improvement/total quality management activities.

The maintenance of a disease index may be required by state regulation. In the absence of such a requirement, the maintenance of a disease index is optional for long term care facilities. The decision to maintain a disease index should be based on facility/corporate need for diagnostic information. Disease or diagnosis information can be a valuable tool in understanding the population served by the facility, for evaluating special programs offered, or to assist with planning for the future programs such as an Alzheimer’s or rehab unit. If a long term care facility decides to maintain a disease index, either a manual or computerized format can be used to provide access to diagnostic information on the resident population.

Content:

The most common purpose for a disease index in a long term care facility is to identify or provide access to resident(s) who have a certain disease/diagnosis based on an ICD-9-CM diagnosis code.

At a minimum, a disease index report should include:

- Resident’s name and medical record number
- Attending physician
- Admission date
- Discharge date
- Discharge length of stay
- ICD-9-CM diagnosis codes present during the resident’s stay. *(For reporting or planning purposes, it can be helpful to identify the primary diagnosis for which treatment was received.)*

Optional Information:

- Resident’s age or date of birth
- Resident’s sex

Format:

There is not a specific format required for a disease index unless dictated by state law. Either a manual or computerized index can be maintained. Forms supplies for the long term care industry have sample forms that can be used for maintaining the disease index.
Since disease indexes have primarily been maintaining manually, the availability of reports through the clinical information system have been overlooked as a means for maintaining the index. If a clinical information system collects diagnostic information and provides reporting capabilities by resident and by diagnosis code the system may have the capability of serving as a disease index. The advantage of using a computerized system is that diagnoses are updated continually throughout a resident’s stay minimizing the need to additional staff time in maintaining the index.

If using an automated system, the software should have the capability to report diagnoses for discharged residents as well as current residents. To get access to disease index information, the system should have the capability of searching the resident database by diagnosis code (i.e. 428.x) and by a range of diagnosis codes (801 – 899). The system should be able to identify the specific resident(s) who has been assigned the code(s) queried with a specific date range identified.

Retention:

Unless otherwise specified by state law, the recommended retention period for a disease index is 10 years.

4.12 Minimum Statistical Reporting

Each facility should determine their need for statistical information and the frequency in reporting. The health care data collected and reported can be very valuable in evaluating, monitoring and planning for facility operation and management.

This section outlines statistical data commonly collected by long term care facilities – the calculation and reporting of the statistical data may be completed by various staff in the LTC facility. Typically the information is collected and reported to administration on a monthly basis. The data should also be compiled throughout the year providing year-to-date compilation.

Statistical data should be compiled routinely and reported in a manner that allows review and analysis of the information over time (i.e. the current month and year-to-date). The use of spread sheets can be very helpful in compiling, reporting, and graphically depicting statistical data. The statistical data can be helpful to administration, the facility quality assurance/quality improvement committee, and corporate office staff.

The following statistical formulas are shown for a monthly reporting period.

4.12.1 Total Admissions: Each month the total number of new admissions or readmission is reported. This number should not reflect residents who were out on a bed hold or temporary leave of absence.

4.12.2 Total Discharges: Each month the total number of discharges is reported excluding residents who were transferred/discharge on bed hold or left for a temporary leave of absence.

4.12.3 Average Daily Census: To calculate the average daily in-house census in a month, add the daily census for each day of the calendar month and divide the total by the number of days in a month. Each census day begins at 12:00am and ends at 11:59 p.m. Because Medicare uses the midnight census hour as a cut-off for determining a Medicare day, this standard is generally used by the industry.

Formula: \[
\text{Average Daily Census} = \frac{\text{Sum of the Daily Census for each day of the month}}{\text{Total number of days in the month}}
\]

This formula can be adopted for any period of time. For example, to calculate the average daily in-house census for a year, add the daily in-house census for each day of the year and divide by the number of days in the year.

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When a resident is both admitted and discharged in one census day, they are usually counted in the daily census.

4.12.4 **Total Census Days**: The sum of the daily census for a given period for each day in the month.

4.12.5 **Length of Stay**: To calculate the length of stay for a resident admission, total the number of days the resident has been in the facility. Count the day of admission but not the day of discharge. Typically, bed hold days or temporary leaves are not subtracted from the total length of stay for a resident.

**Average Length of Stay**: The average length of stay is calculated by adding the total length of stay for each discharged resident in the month and dividing by the number of discharge residents in a month. The average length of stay can be calculated for the entire facility or by specialty unit/program. When there are short-term stay or dementia units, calculating a separate average length of stay can be helpful in accurately reporting the average length of stay for that specific population.

Formula: 
\[
\text{Total length of stay for discharges (for facility or for a unit) in a one month period} \\
\frac{\text{Number of discharges in the month}}{\text{Number of discharges in the month}}
\]

**Discharge Days or Length of Stay**: The discharge days also known as the length of stay is the total number of calendar days a resident is in the facility from admission to discharge. When calculating the length of stay, count the day of admission but not the day of discharge. Days when the resident is not in the facility due to a temporary leave of absence or bed hold are not subtracted from the length of stay. If a resident is admitted and discharged on the same day, one discharge day is assigned.

**Total Length of Stay**: The total length of stay is the sum of the length of stay/discharge days for a given population and discharged during a specified period. Usually the total length of stay is calculated for the entire facility, but could also be calculated by unit particularly when there are short-term or dementia units.

4.12.6 **Percentage of Occupancy**: The percentage of occupancy is calculated by adding the daily census for each day of the month and dividing by the total bed count days. The total bed count is the number of beds available multiplied by the number of days in the month.

Formula: 
\[
\text{Sum of the daily census for the month} \\
\frac{\text{Total bed count days in the month}}{\text{(bed count x number of days in the month)}}
\]

4.13 **ELECTRONIC PATIENT RECORDS (On Hold)**
5.0 LEGAL DOCUMENTATION STANDARDS

This section will review the legal documentation standards for entries in and maintaining the medical record. In today’s healthcare environment health information is collected in various formats – paper-based, electronic resident records, and computerized resident databases. The legal documentation standards have mainly applied to a paper medical record, however, most are also applicable to documentation in an electronic medical record as well. This section is divided into three topics and will address the following issues:

1) Purpose of the medical record and definition of the legal medical record 
2) Legal documentation standards that apply to medical records 
3) Proper methods for handling errors, omissions, addendum, and late entries.

5.1 Purpose and definition of the Legal Medical Record*

A patient’s health record plays many important roles:
1. It provides a view of the resident’s health history - In other words, it provides, a record of the resident’s health status including observations, measurements, history and prognosis, and serves as the legal document describing the health care services provided to the patient. The medical record provides evidence of the quality of resident care by –
   • Describing the services provided to the resident
   • Providing evidence that the care was necessary
   • Documenting the resident’s response to the care and changes made to the plan of care
   • Identifying the standards by which care was delivered
2. Documenting adherence to company standards and procedures
3. It provides a method for clinical communication and care planning among the individual healthcare practitioners serving the resident.
4. It provides supporting documentation for the reimbursement of services provided to the resident.
5. It is a source of data for clinical, health services, outcomes research as well as public health purposes.
6. It serves as a major resource for healthcare practitioner education.
7. It serves as the legal business record for a health care organization and is used in support of business decision-making.

There is not a one-size-fits-all definition of the legal record since laws and regulations governing the content vary by practice setting and by state. However, there are common principles to be followed in creating a definition. The following table “Guidelines for Defining the Health Record for Legal Purposes” breaks down the health record into four categories to provide guidelines for assisting health care organizations in defining the content of their legal record.

Guidelines for Defining the Health Record for Legal Purposes

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<thead>
<tr>
<th>LEGAL HEALTH RECORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>The legal business record generated at or for a healthcare organization. This record would be released upon request.</td>
</tr>
<tr>
<td>The legal health record is the documentation of the healthcare services provided to an individual in any aspect of healthcare delivery by a healthcare provider organization. The legal health record is individually identifiable data, in any medium, collected and directly used in and/or documenting health care or health status. The term includes records of care in any health-related setting used by healthcare professionals while providing patient care services, for reviewing patient data or documenting observations, actions, or instructions. Some types of documentation that comprise the legal health record (see examples listed below) may physically exist in separate and multiple paper-based or electronic/computer-based databases. Typically this includes records that are considered part of the active, overflow, and discharge chart.</td>
</tr>
</tbody>
</table>
The legal health records EXCLUDES health records that are NOT official business records of a healthcare provider organization (even though copies of the documentation of the healthcare services provided to an individual by a healthcare provider organization are provided to and shared with the individual). Thus, records such as Personal Health Records (PHRs) that are patient controlled, managed, and populated would not be part of the legal health record.

Copies of PHRs that are patient owned, managed, and populated by the individual but are provided to a healthcare provider organization(s) should be considered part of the legal health record. Such records are then used by healthcare provider organizations to provide patient care services, review patient data or document observations, actions or instructions. This includes patient owned, managed and populated "tracking" records, such as medication tracking records and glucose/insulin tracking records.

Examples of documentation found in the legal health record:
- Records of history and physical examination
- Multidisciplinary progress notes/documentation
- Immunization record
- Problem list
- Medication profile, Physician Orders, Telephone Orders and Renewals
- Consent for treatment forms
- Consultation reports
- Physical therapy, Speech therapy, and Occupational therapy records
- Email containing patient-provider or provider-provider communication
- Nursing and other discipline assessment
- Care plan
- Minimum data sets
- Practice guidelines or protocols/clinical pathways that imbed patient data
- Advanced Directives
- Discharge instructions, plan of care, etc.

PATIENT - IDENTIFIABLE SOURCE DATA

Patient-identifiable source data are data from which interpretations, summaries, notes, etc. are derived. Source data should be accorded the same level of confidentiality as the legal health record. These data are increasingly captured in multimedia form. For example, the videotape recording of the encounter would not represent the legal health record but rather would be considered source data. In the absence of documentation, (e.g., interpretations, summarization, etc.), the source data should be considered part of the legal health record.

Examples of patient-identifiable source data:
- Diagnostic films and other diagnostic images from which interpretations are derived
- Electrocardiogram tracings from which interpretations are derived
- Audio of dictation
- Analog and digital patient photographs for identification purposes only
- Videos of procedure
## ADMINISTRATIVE DATA

Provided the same level of confidentiality as the legal health record, however, the data is not considered part of the legal health record (such as in response to a subpoena for the "medical record.")

- Administrative data are patient-identifiable data used for administrative, regulatory, and payment (financial) purposes

Examples of administrative data:
- Authorization forms for release of information
- Correspondence concerning requests for records
- Event history/audit trails
- Protocols/clinical pathways, practice guidelines and other knowledge sources that do not imbed patient data
- Patient-identifiable claim
- Patient-identifiable data reviewed for quality assurance or utilization management
- Death Certificates
- Patient identifiers (e.g., medical record number, biometrics)

## DERIVED DATA

Provided the same level of confidentiality as the legal health record, however, the data is not considered part of the legal health record (such as in response to a subpoena for the "medical record.")

- Derived data are data derived from patient records that are aggregated so that there are no means to identify patients.

Examples of derived data:
- Best practice guidelines created from aggregate patient data
- Anonymous patient data for research purposes
- ORYX report
- OASIS report
- MDS report
- Survey/Accreditation reports
- Public health records
- Statistical reports

* Source: Definition of the Legal Medical Record AHIMA’s Legal Medical Record Task Force

## 5.2 LEGAL DOCUMENTATION STANDARDS

This section outlines the specific guidelines and standards that will assist with maintaining a legally sound medical record regardless of format.

### 5.2.1 Defining Who May Document in the Medical Record:

Anyone documenting in the medical record should be credentialed and/or have the authority and right to document as defined by facility policy. Individuals must be trained and competent in the fundamental documentation practices of the facility and legal documentation standards. All writers should be trained in and follow their facility/company standards and policies for documentation (i.e. following timeframes for documentation).

### 5.2.2 Linking each entry to the resident; Resident Identification on Every Page/Screen

Every page in the medical record or computerized record screen must be identifiable to the resident by name and medical record number. Resident name and number must be on every page including both sides of the pages, every shingled form, computerized print out, etc. When double-sided forms are used, the resident name and number should be on both sides since information is often copied and must be identifiable to the resident. Forms both paper and computer generated with multiple pages must also have the resident name and number on all pages.
5.2.3 Date and Time on Entries

Every entry in the medical record must include a complete date -- month, day and year and have a time associated with it. Time must be included in all types of narrative notes even if it may not seem important to the type of entry -- it is a good legal standard to follow. Charting time as a block (i.e. 7-3) especially for narrative notes is not advised. Narrative documentation should reflect the actual time the entry was made. For certain types of flowsheets such as a treatment record, recording time as a block could be acceptable. For example, a treatment that can be delivered any time during a shift, could have a block of time identified on the treatment record with staff signing that they delivered the treatment during that shift.

For assessment forms where multiple individuals are completing sections, the date and time of completion should be indicated as well as who has completed each section (Exception: MDS).

5.2.3.1 Timeliness of Entries

Entries should be made as soon as possible after an event or observation is made. An entry should never be made in advance. If it is necessary to summarize events that occurred over a period of time (such as a shift), the notation should indicate the actual time the entry was made with the narrative documentation identifying the time events occurred if time is pertinent to the situation.

5.2.3.2 Pre-dating and back-dating

It is both unethical and illegal to pre-date or back-date an entry. Entries must be dated for the date and time the entry is made. (See section on late entries, addendum, and clarifications). If pre-dating or back-dating occurs it is critical that the underlying reason be identified to determine whether there are system failures. The cause must be evaluated and appropriate corrective action implemented.

5.2.4 Authentication of Entries and Methods of Authentication

Every entry in the medical record must be authenticated by the author -- an entry should not be made or signed by someone other than the author. This includes all types of entries such as narrative/progress notes, assessments, flowsheets, orders, etc. whether in paper or electronic format. There are various acceptable methods for authentication of an entry. Each facility must identify the proper and acceptable method of authentication for the type of entry taking into consideration state regulations and payer requirements.

5.2.4.1 Signature

Entries are typically authenticated by a signature. At a minimum the signature should include the first initial, last name and title/credential. A facility can choose a more stringent standard requiring the author’s full name with title/credential to assist in proper identification of the writer. If there are two people with same first initial and last name both must use their full signatures (and/or middle initial if applicable). Facility policies should define the acceptable format for signatures in the medical record.

5.2.4.2 Countersignatures

Countersignatures should be used as required by state law (i.e graduate nurse who is not licensed therapy assistants, etc.). The person who is making the countersignature must be qualified to countersign. For example, licensed nurses who don’t have the authority to supervise should not be countersigning an entry for a graduate nurse who is not yet licensed).

Practitioners who are asked to countersign should do so carefully. If there is a procedure involved, there should be some observation (i.e. view treatment or view dressing) to assure that it was done properly.

The federal regulations for long term care facilities do not require countersignatures for nurse practitioners.
LTC Health Information Practice and Documentation Guidelines

and physician assistants. It is important to know state licensure and professional practice regulations for a NP/PA to determine if countersignatures are required.

5.2.4.3 Initials

Any time a facility chooses to use initials in any part of the record for authentication of an entry there has to be corresponding full identification of the initials on the same form or on a signature legend. Initials can be used to authenticate entries such as flow sheets, medication records or treatment records, but should not be used in such entries as narrative notes or assessments. Initials should never be used where a signature is required by law (for example, on the MDS).

5.2.4.4 Fax Signatures

The acceptance of fax signatures is dependent on state, federal, and reimbursement regulations. Federal regulations for nursing facilities do not prohibit the use of fax signatures. Unless specifically prohibited by state regulations or facility policy, fax signatures are acceptable. When a fax document/signature is included in the medical record, the document with the original signature should be retrievable.

5.2.4.5 Electronic/Digital Signatures

Electronic signatures are acceptable if allowed by state, federal, and reimbursement regulations. The federal regulations for nursing facilities allow for the use of electronic signatures when computerized medical records are maintained rather than a hard copy except for the MDS (HCFA currently requires the facility to retain a hard copy of the MDS signatures). State regulations and payer policies must be reviewed to assure acceptability of electronic signatures when developing facility policies.

If electronic signatures are used in the medical record, the software program/technology should provide assurance that the following standards are met:

- **Message Integrity:** The message sent or entry made by a user is the same as the one received or maintained in the system.
- **Non-Repudiation:** Assurance that the entry or message came from a particular user. It will be difficult for a party to deny the content of an entry or creating it.
- **Authentication:** Confirms the identity of the user and verifies that a person really is who he says he is.

5.2.4.6 Rubber Stamp Signatures:

Rubber stamp signatures are acceptable if allowed by state, federal and reimbursement regulations. Federal regulations for nursing facilities allow for the use of rubber stamp signatures by physicians provided that the facility authorizes their use and has a statement on file indicating that the physician is the owner of the stamp and attested that they will be the only one using the signature stamp (F386).

From a reimbursement perspective, some fiscal intermediaries have local policies prohibiting the use of rubber stamp signatures in the medical record even though federal regulation allows for their use. Facility policies should define if rubber stamp signatures are acceptable and define the circumstances for their use after review of state regulations and payer policies.
5.2.4.7 Authenticating Documents with Multiple Sections or Completed by Multiple Individuals:

Some documentation tools particularly assessments are set up to be completed by multiple staff members at different times. As with any entry, there must be a mechanism to determine who completed information on the document. At a minimum, there should be a signature area at the end of the document for staff to sign and date. Staff who have completed sections of the assessment should either indicate the sections they completed at the signature line or initial the sections they completed.

5.2.5 Signature Legends

A signature legend may be used to identify the author and full signature when initials are used to authenticate entries. Each author who initials an entry must have a corresponding full signature on record. There are three types of acceptable signature legends:

1) Signature Legend on the Original Document: A signature legend can be included on the actual form where the initials are used. The legend would include the authors initials and their full signature and title.

2) One Master Signature Legend per Resident Record: A separate signature legend form can be kept with staff initials and signatures for each resident’s record. The legend should include the initials, full signature and title. A process must be implemented to obtain staff signatures with each new admission as well as a process for new staff to sign the signature legends for all current residents.

3) One Facility Master Signature Legend with Copies for Resident Records: Another acceptable method for maintaining a signature legend is to keep one master for the facility and make copies of the original for the resident’s record. During the resident’s stay a copy of the legend must be available (for example, posted at station or kept at the front of the medication and treatment book). At the time of discharge, a copy of the signature legend must be incorporated in the record. The discharge record must include a copy of the master signature legends maintained and updated by the facility during the resident’s stay. At a minimum the signature legend should contain the initials, full signature and title of staff.

If master signature forms are to be used, there must be systems in place to assure all staff who initial entries sign the legend on an on-going basis. If staff turn over is high new master signature legends should be completed on a regular basis (i.e. once a year). With each update of the master signature legend there should be a date indicating implementation and revision.

5.2.6 Permanency of Entries

All entries in the medical record regardless of form or format must be permanent (manual or computerized records).

For hard copy/paper records facilities should document in blue or black ink only. No other colored ink should be used in the event that any part of the record needs to be copied. The ink should be permanent (no erasable or water-soluble ink should be used). Never use a pencil to document in the medical record.

5.2.6.1 Printers

When documentation is printed from a computer for entry in the medical record, the print must be permanent. For example, a laser printer would be used rather than an ink jet printer because the ink is water-soluble.
5.2.6.2 Fax Copies

When fax records are maintained in the medical record the assurance must be made that the record will maintain its integrity over time. For example, if thermal paper is used for the receipt of a fax that will become part of the medical record, a copy must be made for filing in the medical record since the print on thermal paper fades over time.

5.2.6.3 Photo Copies

The medical record should contain original documents whenever possible. There are times when it is acceptable to have copies of records and signatures particularly when records are sent from another health care facility or provider.

5.2.6.4 Carbon Copy Paper (NCR)

If there is a question about the permanency of the paper (i.e. NCR, carbon paper) when the carbon paper is the permanent entry it needs to be photocopied. Policy should indicate when items are copied and how the original is disposed. At times carbon copies of documents (i.e. TO’s ) may be used on a temporary basis and the original will replace the carbon – this is considered an acceptable practice.

5.2.6.5 Use of Labels in the Medical Record

The use of adhesive labels in the medical record is an accepted practice in the health care industry including long term care. Labels or label paper (adhesive-backed paper) are used for a variety of reasons including, but not limited to, resident demographics, transcription of dictated progress notes, printing of physician orders for telephone orders, medication or treatment records.

There are a number of advantages to using labels: 1) they are often computer generated and usually typed providing a readable record/document such as progress notes; 2) when used in the physician order transcription process within an clinical computer system they can help to reduce or eliminate transcription errors by printing the order in a consistent format for all areas of the record (telephone order, medication/treatment record, physician order sheets); and 3) when demographic labels are used in the record, it is more likely that complete resident identification information will be provided on each page of the record rather than relying on staff to write in the demographic information.

When labels are used in the record, there are a number of issues or concerns that must be considered and addressed before implementation. Facility policies and practices should address how and where labels will be used as well as the following issues:

- If labels are to be used in the medical record, selection of a label vendor and/or type of label requires careful consideration. Because the labels lose their adhesiveness over time, facilities must select a vendor and labels that offer a guarantee on the length of time the labels will retain their adhesiveness. The length of time should be consistent with the average length of stay for residents in the facility plus the retention period for medical records after discharge. A guarantee of 10 years should be adequate for most facilities. The label should also be considered permanently adhesive shortly after being affixed to the backing sheet (some labels do not adhere permanently for 24 hours after placing it on a backing sheet allowing for possible removal).
- Basic resident identification information should be included on each label should it become dislodged from the backing sheet to assure that the label/entry can always be tracked to the proper resident’s record. If the label paper is used for documentation such as a progress note or order, the date and signature should also be included on the label.
- If an error was made on a label, another label should never be placed over the original. Proper error correction procedures should be used for the entry.
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- Labels must never be placed over other documentation in the medical record. This would be the equivalent of using whiteout or blacking out an entry in the record and is not acceptable.
- Consideration should be given to the type of file folder used to house overflow and discharge records. Although not a requirement, using a pocket folder could help to contain any labels that may have become dislodged from the backing sheet over time.
- When labels are computer-generated, the printer ink must be permanent (i.e. a laser printer is permanent vs. an ink jet printer which is usually water-soluble).

5.2.7 Specificity

In writing entries use language that is specific rather than vague or generalized. Do not speculate when documenting -- the record should always reflect factual information (what is known vs. what is thought or presumed) and be written using factual statements.

Examples of generalizations/vague words: Resident doing well, appears to be, confused, anxious, status quo, stable, as usual.

5.2.8 Objectivity

Chart the facts and avoid the use of personal opinions when documenting. By documenting what can be seen, heard, touched and smelled entries will be specific and objective. Describe signs and symptoms, use quotation marks to quote the resident, and document the resident’s response to care.

5.2.9 Completeness

Document all facts and pertinent information related to an event, course of treatment, resident condition, response to care and deviation from standard treatment (including the reason for it). Make sure entry is complete and contains all significant information. If the original entry is incomplete, follow guidelines for making a late entry, addendum or clarification.

5.2.10 Use of Abbreviations

Every facility should set a standard for acceptable abbreviations to be used in the medical record (develop a facility-specific abbreviation list). Only those abbreviations approved by the facility should be used in the medical record. When there is more than one meaning for an approved abbreviation, facilities chose one meaning or identify the context in which the abbreviation is to be used.

5.2.11 Legibility

All entries in the medical record must be legible. Illegible documentation can put the resident at risk. Readable documentation assists other caregivers and helps to assure continuation of the resident’s plan of care. If entry cannot be read, the author should rewrite the entry on next available line, define what the entry is for referring back to the original documentation and legibly rewrite the entry. Example: “Clarified entry of (date)” and rewrite entry; date and sign. The entry rewritten must be the same as the original.

5.2.12 Continuous Entries

In manual records, document entries on the next available space – do not skip lines or leave blanks. There must be a continuous flow of information without gaps or extra space between documentation. A new form should not be started until all previous lines are filled. If a new sheet was started, the lines available on the previous page must be crossed off. If an entry is made out of chronological order it should be documented as a late entry.
5.2.13 Completing all Fields

Some of the questions or fields on documentation tools such as assessments, flow sheets, checklist documents may not be applicable to the resident. All fields should have some entry made whether it applies to the resident or not. If a field is not applicable, an entry like “N/A” should be made to show that the question was reviewed and answered. Fields left blank may be suspect to tampering or back-dating after the document has been completed and authenticated. If the documentation will be reported by exception (e.g. documenting only on shifts where a behavior occurs), there should be a statement on the form indicating how charting will be completed.

5.2.14 Continuity of Entries – Avoiding Contradictions

All entries should be consistent with the --
- Concurrent entries
- Other parts of the medical record – the assessments, care plan, physician’s orders, medication and treatment records, etc.
- Other facility document – incident reports, twenty-four hour reports, nursing service shift reports, etc.

Ongoing treatments and conditions (feeding tube, vent, trach, catheter, etc.) should be noted as continuing. Avoid repetitive (copy cat or parrot) charting. The current entry should document current observations, outcomes/progress.

If an entry is made that contradicts previous documentation, the new entry should elaborate or explain why there is a contradiction or why there has been a change.

5.2.15 Condition Changes

Every change in a resident’s condition or significant resident care issues must be noted and charted until the resident’s condition is stabilized or the situation is otherwise resolved. Documentation that provides evidence of follow-through is critical.

5.2.16 Document Informed Consent

Informed consent should be carefully documented whenever applicable. An informed consent entry should include an explanation of the risks and benefits of a treatment/procedure, alternatives to the treatment/procedure, and evidence that the resident or appropriate legal surrogate understands and consents to undergo the treatment/procedure.

5.2.17 Admission/Discharge Notes

The resident’s initial admission note and discharge summary should fully and accurately describe the resident’s condition at the time of admission and discharge, respectively. Documentation should include the method/mode of arrival/discharge, resident’s response to admission/discharge and physical assessment. When discharging a resident, take special care in documenting resident education when applicable including instructions for self-care, and that the resident/responsible party demonstrated an understanding of the self-care regimen.
5.2.18 Notification or Communications

If notification to the resident’s physician or family is required, or a discussion with the resident’s family occurs regarding the care of the resident, all such communication (including attempts at notification) should be charted. Include the time and method of all communications or attempts. The entry should include any orders received or responses, the implementation of such orders, if any, and the resident’s response. Messages left on answering machines should be limited to a request to return call and does not meet the definition of notification.

5.2.19 Delegation

The charge nurse is responsible for ensuring that all entries by nursing assistants (CNA, NAR, etc.) are complete and consistent with the remainder of the record. All entries by nursing assistants should be reviewed by the charge nurse at the end of the shift. The charge nurse is responsible for all delegated nursing acts, as allowed by state/federal requirements, including charting of such care in the resident’s medical record (i.e. flowsheets).

5.2.20 Incidents

When an incident occurs, document the facts of the occurrence in the progress notes. Do not chart that an incident report has been completed or refer to the report in charting.

5.2.21 Make and Sign Own Entries

Authors must always make and sign their own entries (both manual and computerized records). An author should never make an entry or sign an entry for someone else or have someone else make or sign an entry for them.

5.2.22 Appropriateness of Entries – Keep Documentation Relevant to Resident Care

The medical record should only contain documentation that pertains to the direct care of the resident. Do not let emotions show up in charting. Charting should be free from jousting statements that blame, accuse, or compromise other care givers, the resident, or his/her family. The medical record should be a compilation of factual and objective information about the resident. The record should not be used to voice complaints (about other care givers, departments, physicians or the facility), family fights, fights between disciplines, gripes, staffing issues, vendor issues, etc.

5.3 LEGAL GUIDELINES FOR HANDLING CORRECTIONS, ERRORS, OMISSIONS, AND OTHER DOCUMENTATION PROBLEMS

There will be times when documentation problems or mistakes occur and changes or clarifications will be necessary. Proper procedures must be followed in handling these situations.

5.3.1 Proper Error Correction Procedure:

When an error is made in a medical record entry, proper error correction procedures must be followed.

• Draw line through entry (thin pen line). Make sure that the inaccurate information is still legible.
• Initial and date the entry.
• State the reason for the error (i.e. in the margin or above the note if room).
• Document the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line/space documenting the current date and time and referring back to the incorrect entry.
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Do not obliterate or otherwise alter the original entry by blacking out with marker, using white out, writing over an entry, etc.

Correcting an error in an electronic/computerized medical record systems should follow the same basic principles. The system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated. When correcting or making a change to an entry in a computerized medical record system, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted. In situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected.

5.3.2 Handling Omissions in Documentation

At times it will be necessary to make an entry that is late (out of sequence) or provide additional documentation to supplement entries previously written.

5.3.2.1 Making a Late Entry

When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the medical record.

- Identify the new entry as a “late entry”
- Enter the current date and time – do not try to give the appearance that the entry was made on a previous date or an earlier time.
- Identify or refer to the date and incident for which late entry is written
- If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get information to write late entry). For example, use of supporting documentation on other facility worksheets or forms.
- When using late entries document as soon as possible. There is not a time limit to writing a late entry, however, the more time that passes the less reliable the entry becomes.

5.3.2.2 Entering an Addendum

An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident. With an addendum, additional information is provided, but would not be used to document information that was forgotten or written in error. When making an addendum –

- Document the current date and time.
- Write “addendum” and state the reason for the addendum referring back to the original entry.
- Identify any sources of information used to support the addendum.
- When writing an addendum, complete it as soon after the original note as possible.

5.3.2.3 Entering a Clarification

Another type of late entry is the use of a clarification note. A clarification is written to avoid incorrect interpretation of information that has been previously documented. For example, after reading an entry there is a concern that the entry could be misinterpreted. To make a clarification entry –

- Document the current date and time.
- Write “clarification”, state the reason and refer back to the entry being clarified.
- Identify any sources of information used to support the clarification.
- When writing a clarification note, complete it as soon after the original entry as possible.
5.3.3 Omissions on Medication, Treatment Records, Graphic and other Flowsheets

It is considered willful falsification and illegal to go back and complete and/or fill-in signature “holes” on medication and treatment records or other graphic/flow records in the medical record. Facility protocol should establish procedures for documenting a late entry when there is total recall and other supporting information to prove that a medication or treatment was administered. Some states have established time frames in which the omissions can be completed if the practitioner recalls administering the medication or treatment such as no more than 24 hours should go by in which a practitioner is allowed to complete a medication, treatment, graphic or flow record and only when there is a clear recollection of administering the medication, treatment or information pertinent to a flow/graphic record.

Facilities should use concurrent monitoring (self-monitoring, shift-to-shift review, etc.) to assure that the documentation is complete and timely for all medications and treatments administered. When systemic problems are identified corrective action should be implemented. If an omission is older than 24 hours or the staff member does not have a clear recollection or there is not supporting documentation (i.e. worksheets, narcotic records, drug delivery records, initialed punch cards, etc.), the record should be left blank. At no time should the records be audited after a period of time (i.e. end of month) with the intent of identifying omissions and filling in “holes.”

5.3.4 Documenting Care Provided by a Colleague

Documentation must reflect who performed the action. If it is absolutely necessary to document care given by another person, document factual information. For example, if a call is received from a nurse from the previous shift who indicates that he/she forgot to chart something in the record, enter the date and time of the telephone call and note: “At 16:00 Louise Jackson, R.N., called to report that at 11:00 this morning, Mr. Smith indicated he had a headache and requested Tylenol. Tylenol 650mg p.o. was given by Ms. Jackson at 11:05am. Ms. Jackson stated that Mr. Smith verbalized he was free of pain at 12:00 noon.” (Signed by Penelope E. Olson, RN). Also place initials on the medication record as follows: “PEO for LJ.” When Louise returns to work, she should review your note for accuracy and countersign it. She should also place her initials by your entry on the medication record. If there is not adequate room on the medication record, the initials are entered on the medication record and the entry is circled. On the back of the medication record document the above entry.

5.3.5 Resident Amendments to Their Record

LTC facilities should have policies to address how a resident or their legally responsible party can enter amendments into their medical record. A separate entry (progress note, form, typed letter, etc.) can be used for resident amendment documentation. The amendment should refer back to the information questioned, date, and time. The amendment should document the information believed to be inaccurate and the information the resident/responsible party believes to be correct. At no time should the documentation in question be removed from the chart or obliterated in any way. The resident cannot require that the records be removed or deleted.

Under HIPAA, the resident has the right to request an amendment as long as the record(s) is maintained by the facility. The facility may require a resident to make the request for an amendment in writing and provide a reason. The facility must act on the individual's request for an amendment no later than 60 days after receipt (a 30 day extension may be granted if the resident is notified). Once the amendment request has been reviewed, the facility must inform the resident if the amendment was granted in whole or in part. If all or a portion of the amendment request was denied, the facility must provide the resident with a written reason for the denial. The resident has the right to make a written statement of disagreement with the denial that will become part of the medical record. The facility can also document a rebuttal statement. When disclosing information pertaining to the disagreement, the written statement by the resident and the rebuttal by the facility must be included.
6.0 DOCUMENTATION IN THE LONG TERM CARE RECORD

Documentation in long term care has become increasingly complex as the resident’s clinical needs have become more complex, regulations and surveys more stringent, documentation–based payment systems implemented, and litigation/legal challenges have increased.

This section creates a foundation for documentation by addressing the minimum content as required by federal regulation for long term care facilities and fundamental practice standards, but generally does not outline specific content. The tag number for the Federal Condition of Participation is referenced where applicable. This section also addresses common documentation issues and concerns and establishes guidelines or provides recommendations on how to handle common problem areas.

As long term care facilities establish or review their documentation system, the practice guidelines and federal regulations identified below must be taken into consideration. In addition to the federal regulations and professional practice standards, it is imperative to review and incorporate state regulations, accreditation requirements (i.e., JCAHO), and payer requirements into the documentation systems established.

Because documentation systems should be created to meet the needs and unique practices of a long term care facility or organization, this section does not recommend a specific system. Instead, minimum requirements are established, issues to consider are discussed, and guidelines are provided to assist facilities with implementing or evaluating a documentation system while retaining flexibility in how it can be created.

6.0.1 Federal Regulations Pertaining to Clinical Records:

Federal regulation (F514) requires that the facility “must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.”

The guidelines in this document provide the foundation for “professional standards and practices” as established by AHIMA for clinical records/health information systems. Other professional organizations may have additional standards in dealing with documentation unique to a specific discipline.

6.0.2 Purpose of the Documentation.

On a fundamental level, a complete record contains an accurate and functional representation of the actual experience of the individual in the facility. It must contain enough information to show that the facility knows the status of the individual, has adequate plans of care and provides sufficient documentation of the effects of the care provided. Documentation should provide a picture of the resident and their response to treatment, changes in condition and changes in treatment.

6.0.3 Elimination of Duplication/Redundant Information when Evaluating/Implementing a Documentation System:

One of the most significant problems found in many documentation systems is the duplication or redundant information that is collected in the medical record. Not only is this inefficient, but it creates conflicts and contradiction in the documentation that leads to confusion and diminishes the credibility of the record. A common problem found in long term care records is the duplication of information that is collected on different assessments and between the disciplines. To address this issue, long term care facilities should evaluate their entire documentation system looking at the data elements collected by all disciplines and eliminating areas of duplication.
One method to use in evaluating duplication is to create a data dictionary or a list of documentation elements collected in the entire documentation system, identify where it is collected (i.e. what form), how often, and by whom. Once it is known where information is collected and areas of overlap are identified, decisions can be made on elimination of duplicative information. When working with different disciplines, the goal should be creating a system that works together as an interdisciplinary team rather than segregating assessments and documentation into department-specific documents that don’t work together but increase the likelihood of contradictions.

6.1 DOCUMENTATION CONTENT IN A LONG TERM CARE RECORD:

6.1.1 Admission Record:

Every clinical record should have a face sheet or admission record that provides demographic information, responsible party and contacts (F157), financial and insurance information, and contact information for outside professionals involved in the resident’s care (i.e. attending physician, alternate physician, etc.). The face sheet should be kept up to date as changes occur.

6.2 Assessments:

Assessments are critical to the documentation system in a long term care record. It is important to recognize that assessments can be documented in a variety of ways but typically fall into two groups – completion of an assessment form or documenting an assessment narratively. Many “assessments” collect information or identify a condition. To be complete, they should also include conclusions, recommendations and interventions. To be an assessment rather than just a data collection tool, the following elements should be in place:

1) Evaluation -- data is collected relevant to the issue being assessed.
2) Conclusion -- the assessor interprets and documents their conclusions based on the data collected
3) Plan -- based on the type of assessment, there should be a plan with recommendations and follow-up.

6.2.1 Integrating Assessments with RAI Process:

As LTC facilities evaluate their documentation system, the goal should be to create an interdisciplinary assessment process that uses the RAI as the foundation rather than a supplement. With the MDS and RAPS as the main assessment tools, other assessments would collect information that supplements the comprehensive assessment rather than readdress it.

6.2.2 Types of Assessments and Requirements:

The following assessments represent those required by federal regulation or those that have become a standard of practice in the industry. Although many of the assessments are completed on a separate form, the format may vary or the assessment may be documented in narrative notes.

6.2.2.1 Preadmission Assessment:

Completion of a preadmission assessment is not required by federal regulation, but is commonly completed to determine the needs of the resident and assure that the facility has adequate resources and expertise to provide care. As Medicare reimbursement moved to a prospective payment system partially based on services delivered prior to admission, the preadmission assessment has taken on a new purpose in providing supporting documentation for the MDS. If the information from the preadmission assessment is used to support other documents in the record including the MDS, it should be incorporated into the legal medical record and meet legal documentation requirements (completed in ink, authenticated, and dated).
6.2.2.2 Admission Assessment:
An admission or readmission assessment typically incorporates items that would be considered a nursing assessment or physical examination. Although there is not a federal regulation to perform an admission assessment, professional practice standards for the industry indicate that an admission assessment should be completed. State regulations may provide specific detail on information to collect such as vital signs, a review of systems, pain, etc. The purpose of the admission assessment is to collect baseline information on the resident and assist with initiating an initial admission care plan until the MDS, RAPS and care plan process is completed.

6.2.2.3 Fall Assessment:
(F324) Based on the comprehensive assessment, the RAI incorporates a fall risk assessment into the MDS and RAPS. The facility must identify each resident at risk for accidents and/or falls and adequately care plan and implement procedures to prevent accidents. On admission/readmission, due to the time delay in completing the RAI, it is recommended that the risk for falls be assessed (i.e. could be incorporated into admission assessment or work the RAP early) and appropriate action taken. The RAI can be used to assess fall risk at times thereafter (quarterly, annually, significant change in condition and significant correction). Another type of assessment should be completed after a fall. A post-fall assessment should assess the circumstances of a fall, draw conclusions about the cause of a fall, and implement a plan if appropriate. This type of assessment may be completed in the narrative notes or on a separate form.

6.2.2.4 Skin Assessment:
(F314) Based on the comprehensive assessment the facility must ensure that a resident who enters the facility without a pressure sore does not develop pressure sores unless the individual’s clinical condition demonstrates they are unavoidable. An assessment of current skin status upon admission/readmission is recommended to serve as a baseline. A resident having pressure sores must receive the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

6.2.2.5 Bowel and Bladder Assessment:
(F316) Based on the comprehensive assessment the facility must ensure that a resident who enters without a catheter is not catheterized without medical justification, a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

6.2.2.6 Physical Restraint Assessment:
(F221) Prior to a physical restraint being used an assessment must be completed to determine whether a restraint is necessary and if so, the least restrictive device to treat the resident’s medical symptom(s). Prior to a restraint being applied, the facility must assess the resident’s bed mobility, ability to transfer between positions, ability to transfer to and from bed or chair, and ability to stand and transfer to the toilet and so forth. Once a restraint is applied, the facility must reassess its use on a periodic basis. The facility should use the Physical Restraint RAP to evaluate the appropriateness of restraint use. (Transmittal 20 - revisions to Appendix PP of the State Operation Manual effective 9/2000)

6.2.2.7 Self-Administration of Medication:
(F176) The interdisciplinary team must determine that it is safe for the resident to self administer drugs before the resident may exercise that right. Appropriate notation of these determinations should be placed in the resident’s care plan. If the resident chooses to self-administer drugs this decision should be made by the time the care plan is completed within seven days of the completion of the comprehensive assessment and then on an on-going basis.

6.2.2.8 Nutrition Assessment:
(F325) The resident must maintain acceptable parameters of nutritional status taking into account the residents clinical condition or other appropriate intervention when there is a nutritional problem. The nutrition assessment should address these issues and include identification of the factors that put the resident at risk for malnutrition. Evidence of review of the RAP for Nutritional status should be present to
assess the causal factors for decline, potential for decline or lack of improvement for residents at risk. The individual goals of the plan of care must be periodically evaluated and if not met alternative approaches should be considered or attempted.

6.2.2.9  Activities/Recreation/Leisure Interest Assessment:
(F248) The resident’s activity program should occur within the context of each resident’s comprehensive assessment and care plan. Clinical records and activity attendance records should reflect individual resident history, interests and preferences indicated by the comprehensive assessment and consistent with the intent of the RAI/care plan process. Outcomes/responses to activities interventions are identified in the reassessment of the resident.

6.2.2.10 Social Service:
(F250) It is the responsibility of the facility to identify the medically related social service needs of the resident and assure that the needs are met by the appropriate discipline. Clinical records should reflect how facility staff implement social service interventions; evidence of monitoring the resident’s progress in improving physical, mental and psychosocial functioning; goal attainment been evaluated and the care plan changed accordingly. Evidence should support that social services interventions successfully address residents’ needs and link social supports, physical care and physical environment with residents’ needs and individuality.

6.2.2.11 Mental and Psychosocial Functioning:
(F319) Based on the comprehensive assessment the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem. (F320) For a resident whose assessment does not reveal a mental or psychosocial adjustment difficulty, there is not a pattern of decreased social interaction and/or increased withdrawn, angry or depressive behaviors, unless the resident’s clinical condition demonstrates that such a pattern is unavoidable.

6.2.2.12 Restorative/Rehab Nursing Assessment:
(F317) Based on the comprehensive assessment the facility ensures that a resident who enters without limited range of motion does not experience a reduction in range of motion unless the resident’s clinical condition indicates that it is unavoidable. (F318) A resident with limited range of motion, receives appropriate treatment and services to increase range of motion and/or to prevent further decline.

6.3  Resident Assessment Instrument (RAI) - MDS and RAPS
(F274) Each facility must complete a comprehensive assessment which is based on a uniform data set. Facilities must use their State specified RAI (which includes both the MDS, utilization guidelines and the RAPS) to assess newly admitted residents within 14 days, conduct annual reassessment, assess those residents who experience a significant change in status or when completing a significant correction of a prior full assessment. No less than once every quarter (92 days), facilities must review the comprehensive assessment to assure that the resident’s assessment is accurate and reflects the resident’s current status.

A comprehensive assessment must be completed within 14 days after the facility has determined that there has been a significant change in the resident’s physical or mental condition (F274). A significant change is defined as a major decline or improvement in the resident status that will not normally resolve itself without further intervention by staff or by implementing standard disease related clinical interventions, that has an impact on more than one area of the resident’s health status and requires interdisciplinary review of the plan of care or both.

The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or RAPS. The facility is also responsible for addressing the resident’s needs from the moment of admission.
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The MDS is also used to determine the reimbursement level under the prospective payment system for Medicare Part A residents in a SNF. Based on the MDS scoring, a Resource Utilization Group (RUG) is assigned which determines the per diem payment. While on Medicare Part A, the PPS MDS schedule includes a 5, 14, 30, 60, and 90 day assessment. An OMRA (Other Medicare Required Assessment) may also be completed in specific situations. In addition to Medicare, some states may also use the MDS to determine reimbursement.

6.4 Care Plan:

The care plan is the foundation that provides direction to the interdisciplinary team and staff on providing care and treatment to the resident. The care plan should be the central focus for on-going documentation of the residents care, condition, and needs.

(F279) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be provided to attain or maintain the resident’s highest practicable physical, mental and psychosocial well-being; any services that would otherwise be required but are not provided due to the resident’s exercise of rights including the right to refuse treatment. The care plan must reflect intermediate steps for each outcome objectives if identification of those steps will enhance the resident’s ability to meet his/her objectives. Facility staff will use these objectives to monitor resident progress. Facilities may need to prioritize their care plan interventions. This should be noted in the clinical record or on the plan of care.

The care plan must be prepared by an interdisciplinary team that includes the attending physician, a registered nurse with the responsibility for the resident and other appropriate staff and disciplines as determined by the resident’s needs and to the extent practicable the participation of the resident, the residents family or the resident’s legal representative. There should be evidence that the care plan is periodically reviewed by a team of qualified persons after each assessment and as the resident’s status changes.

6.4.1 Timeliness:

(F280) A comprehensive care plan must be completed within 7 days of completion of the comprehensive assessment. Completion or updating of the care plan should follow the comprehensive assessment since the assessment provides the foundation or analysis of a problem resulting in the goals and interventions on the care plan. The care plan is reviewed and updated after each scheduled comprehensive assessment – admission, quarterly reviews, annually, and with a significant change in condition.

6.4.2 Care Conference:

(F280) In completion of the care plan, the professional disciplines must work together to provide the greatest benefit to the resident. The mechanics of how the interdisciplinary team meets its responsibilities in developing an interdisciplinary care plan (e.g. a face-to-face meeting, teleconference, written communication) is at the discretion of the facility. The facility should encourage residents, surrogates, and representatives to participate in care planning including encouraging attendance at care planning conferences.

6.4.3 Admission/Interim Care Plan:

Upon admission, a brief initial care plan should be developed to carry through until the resident’s comprehensive assessment and care plan have been developed. The care plan should address the primary reason for admission and treatment and the resident’s most immediate care needs. Usually the plan includes clinical and/or rehab needs and nutritional needs.
6.4.4 Integrating Acute Problems into the Care Plan:
When temporary or acute problems arise, the facility documents an assessment of the problem and implements a plan. It is at the facilities discretion on how the acute problem is incorporated into the care plan. The acute problem can be incorporated into the comprehensive care plan or could be documented on a separate acute or temporary care plan form. If an acute care plan is used, there must be documentation of the problem, interventions and conclusion.

6.4.5 Timeliness of Completion of Care Plan:
The comprehensive care plan should be in the medical record within 7 days after completion of the comprehensive assessment. For example, if the care conference is held 7 days after the completion of the comprehensive assessment, the updated care plan would be on the record or available for staff to use on that day.

6.4.6 Authenticating Changes to Care Plan:
Since the care plan is a key document that should be kept up to date at all times, changes are frequently made. Each time there is a change made on the care plan, staff making the change must follow proper legal documentation guidelines and authenticate and date the entry. This includes making a new entry, changing, or discontinuing an entry.

6.5 Narrative Charting and Summaries:

6.5.1 Admission/Readmission Note:
It is a standard of practice to write a note at the time of admission that documents the date and time of admission, how transported, the reason for admission, and the resident’s condition. State regulations may have specific requirements for admission documentation and the time frame for completion.

6.5.2 Content of Narrative Charting:
A complete record contains an accurate and functional representation of the actual experience of the individual in the facility. It must contain enough information to show that the facility knows the status of the individual, has adequate plans of care and provides sufficient documentation of the effects of the care provided. Documentation should provide a picture of the resident’s, including response to treatment, change in condition and changes in treatment. Good practice indicates that for functional and behavioral objectives the clinical record should document change toward achieving care plan goals.

6.5.3 Monthly Summary Charting:
Federal regulations do not require the completion of a summary note, however, some states may require a summary per licensure or reimbursement regulations. Typically summary documentation provides a mechanism to provide an update of the resident’s status.

The summary note should be based on the care plan. If there are changes in the resident’s status from the previous summary or not reflected in the care plan, the summary should describe the resident’s status, the reason for the change, and the updates made to the care plan.

If flowsheets or checklists are used, they should contain an area for narrative documentation to supplement the check boxes, all fields should be completed, if a section does not apply the writer should indicate that is not applicable. When using a flowsheet or checklist, the care plan should still be the basis for the documentation. If there is a change from the previous summary or a change not reflected in the care plan, a note should be written explaining the reason for the change and the updates made to the care plan.

The use of a monthly summary note or flowsheet should not preclude staff from maintaining documentation throughout the month that reflects any changes in condition or status.
6.5.4 Integrated vs. Disciplinary Progress Notes:
Either integrated or disciplinary progress notes may be used at the facility discretion. There are advantages and disadvantages to each type of progress note. With integrated progress notes, all disciplines document on one progress note form found in one section of the medical record. Disciplinary progress notes separate narrative notes on different forms based on department or discipline.

6.6 Medicare Documentation:
Medicare documentation must provide an accurate, timely and complete picture of the skilled nursing or therapy needs of the resident. Documentation must justify the clinical reasons and medical necessity for Medicare part A coverage, the skilled services being delivered, and the on-going need for coverage. Documentation along with data gathered from observation and interviews should support the MDS used to determine the Resource Utilization Group (RUG payment level) for the Medicare recipient. The medical record must also support the ancillary services provided to the resident and billed to Medicare by documenting that the services were both delivered and medically necessary.

Note: Some Fiscal Intermediaries (FI) and other payers may have specific local medical review policies pertaining to MDS and other supporting documentation, content and format. When developing documentation systems for Medicare, check with your payers to determine any specific requirements.

6.6.1 Skilled Nursing/Therapy Charting:
The medical record must prove that the resident needed and received skilled services on a daily basis (either nursing or therapy). Medicare charting may be more frequent if necessitated by the resident’s condition. The content of the documentation is specific to the clinical reasons for coverage and services delivered and should be objective and measurable. Medicare worksheets can be helpful in focusing charting to the specific service delivered, related clinical issues, and the resident’s response to care. When therapy services are justifying Medicare coverage, nursing documentation should be consistent with therapy documentation addressing how skills learned in therapy are applied on the nursing unit.

The methods for charting can vary based on the reason for Medicare coverage and the services delivered – documentation can be written narratively, captured on flow records or graphics, charting by exception, through structured notes like SOAP, etc.

In addition to documenting daily skilled services, the medical record should also contain documentation supporting the reason for coverage/non-coverage.

6.6.2 Supporting Documentation for the MDS:
Since the MDS is the basis for determining the payment/RUG class, the medical record documentation should support the answers on the MDS within the time frame established by the assessment reference date.

Note: Some case-mix states will stipulate the specific source document that is allowable in supporting the MDS data and/or additional State specific documentation requirements.

The following are examples of types of supporting documentation for the MDS.

6.6.3 Therapy Treatment Time:
The individual and group therapy treatment minutes for each resident must be documented in the medical record for all dates in which services were delivered. The treatment minute documentation is then used to complete and support the MDS and RUG level. In addition to treatment time, the RAI manual requires that the physician order must include a statement of the frequency, duration, and scope of treatment.
6.6.4 ADL Charting:
The ADL section of the MDS has an impact on all RUG payment categories for Medicare. The documentation in the medical record should provide support for the scoring on the MDS along with observation and interviews. A facility may utilize ADL charting to collect information from all three shifts during the 7 day observation period. If the staff member assessing the ADL status and completing the MDS disagrees with the supporting documentation, a clarification note can be written documenting the rationale for the ADL scoring on the MDS.

6.6.5 Mood and Behavior Documentation:
Mood and possibly behavior scoring on the MDS can impact the Medicare RUG payment category. Because these sections on the MDS requires the reporting of the frequency of the mood or behavior problem, the medical record should provide supporting documentation which quantifies the frequency reported.

6.6.6 Hospital Documentation:
Certain services provided in the hospital are documented on the MDS and will impact the RUG class/payment category. It is important to obtain supporting documentation from the hospital to justify the MDS. A preadmission assessment that captures hospital services and dates of delivery could also be used to support the MDS. When used in this manner, the preadmission assessment should be considered part of the resident’s permanent record and meet the legal documentation standards.

6.6.7 Medicare Certification/Recertification:
Each resident on Medicare must have a Medicare part A certification/recertification completed and signed by a physician knowledgeable of the residents care and treatment. The certification/recertification should include the reason for Medicare coverage and skilled services delivered. Certifications are required upon admission, on or prior to day 14, and then every 30 days thereafter while the resident continues to be Medicare part A covered.

6.7 Rehabilitative Therapy Documentation – (On Hold)

6.8 Physician Documentation:

6.8.1 Physician Progress Notes:
(F386) Progress notes must be written, signed and dated with each visit (at least every 30 days for the first 90 days after admission, and at least once every 60 days thereafter). Progress notes should contain information pertaining to the following issues:

- Each physician visit should include an evaluation of the resident’s condition, treatment and a review of, and a decision about, the continued appropriateness off the resident’s condition and current medical regime.
- Progress notes should reflect the continuity of care in maintaining or improving a resident's mental and physical functioning status.
- Progress notes should indicate the resident’s progress or problems in maintaining or improving their mental and physical functioning status.
- Progress notes identify primary risk factors and causal factors contributing to clinical conditions, functional decline, deterioration or potential for, and lack of improvement and whether avoidable or unavoidable.
- Progress notes clinically validate need for medical intervention or justification for decisions regarding care.
- The physician should review the resident’s total program of care, including medications and treatments at each visit.
6.8.2 Dictated Progress Notes:
If a physician dictates a progress note, a brief note should be entered into the record at the time of the visit stating that dictation will follow. If there has been an acute change in the resident’s condition, the physician should write a note for the medical record in addition to the dictated progress note. The dictated progress note should be received by the facility and filed in the medical record within 7 days. The facility should have a monitoring system to assure that dictated notes are received within the appropriate time period.

6.8.3 NP/PA Documentation:
Federal regulations allow a NP/PA working with a physician to make every other required physician visit after the initial visit. The NP/PA must write a progress note at the time of the visit and should follow the same guidelines for content as defined above. The federal regulations do not require countersignature by the attending physician, however, state law usually defines the NP/PA authority and should be reviewed to determine if countersignatures are required.

6.8.4 History and Physical:
Federal regulations do not require the completion of a history and physical at the time of admission or on a periodic basis thereafter. Facility policies requiring a H&P should be developed based on state regulations and applicable accreditation standards.

6.8.5 Other Professional and Consultation Records/Notes:
If the resident requires a consultation with a specialist, the medical record should contain documentation of the visit, progress note, and recommendations. For consultations that occur out of the facility, a separate referral/consultation record can be sent to the physician to obtain documentation for the resident’s long term care record.

6.8.6 Documenting Resident Diagnoses:
The medical record contain a record of the resident’s medical diagnoses. The diagnosis/problem list should include the on-set date for the diagnosis if known (if on-set date not known, use the date from physician supporting documentation), a statement of the diagnosis/condition, the applicable ICD-9-CM code, and resolve date.

6.8.6.1 Supporting Documentation for Diagnoses:
The diagnoses recorded in the resident’s medical record must be supported by physician documentation. Supporting documentation includes written progress notes, transfer forms, hospital documentation (i.e. H&P, discharge summary), consultation reports, etc. that have been signed by the physician. If a more specific diagnosis is needed, the physician must be consulted and provide supporting documentation. Clinical staff (i.e. nursing or therapy) can not diagnosis or determine a more specific diagnosis without consulting with the physician and obtaining supporting documentation.

6.8.6.2 Resolving Diagnoses:
On a regular basis (i.e. quarterly with each care conference, at the time of physician visits, etc.), the diagnosis/problem list should be reviewed and diagnoses resolved that are no longer current. If a diagnosis has resolved the physician must provide supporting documentation that the diagnosis is no longer active unless the condition is self-limiting such as a UTI or URI.

6.9 Physician Orders:

6.9.1 Admission Orders:
(F271) At the time a resident is admitted, the facility must have physician orders for the resident’s immediate care. The orders should include at a minimum dietary, drugs (if necessary), and routine care to maintain or improve the resident’s functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan.
6.9.2 **Content of an Order:**
A physician order should include the drug or treatment and a correlating medical diagnosis or reason. For a medication order, the route, dosage, frequency, strength, and reason for administration should be documented in the text of the order. For parenteral or enteral nutrition therapy include all required components – fluid, amount, flow rate, pump/gravity/bolus use, etc. For some orders such as antibiotics, a stop date is also necessary.

6.9.3 **Physician Order Recaps/Renewals:**
On a regular basis (often 30 days or as required by state law), the current set of physician orders are compiled for the attending physician to review and renew. F386 requires the physician to review the orders at the time of the physician visit.

The current orders should be recapped on a physician order record, signed and dated by the physician or their designee. Physician order recap or renewal should not be completed via a review of the medication and treatment records with a blanket statement to renew all orders. After the physician has reviewed and renewed the orders, a nurse should review the orders for changes and note the signed orders.

6.9.4 **Telephone Orders:**
Orders received by telephone should be countersigned by the physician within the required time frame as defined by state law. In absence of a state law, facility policy should define the time frame for countersignature (e.g. 14 days). Federal regulations do not specify a timeframe for countersignature by the physician.

6.9.5 **Fax Orders:**
(F386) Orders received and signed via fax may be accepted until the original is provided. At that time, the fax copy may be destroyed. When fax is used as a means of communication with the physician, both the physician’s office and the facility should retain the fax documents as part of the resident’s medical record. The physician’s office should be able to produce the order with the original signature upon request. All faxed information must be clearly identified with the resident’s name and medical record number.

6.9.6 **Standing Order Policies:**
Standing order policies should be used with discretion. Legend drugs should not be included on standing orders nor should standing orders be used in place of notification to the physician of a change in status. *(Note: Some States do not allow the use of standing orders.)*

6.9.7 **Authentication/Obtaining Signatures:**
Orders must be countersigned within the required period of time usually determined by state law or facility policy. Federal regulations do not define a time period in which telephone orders are to be authenticated. All orders must be signed by the authorizing physician. No physician will authorize through their signature an order that was given/written by another physician. Various methods for authenticating orders is acceptable – see legal documentation section for acceptable methods.

6.9.8 **Transcription of Orders and Noting Orders:**
Transcription of orders, such as telephone orders, is a responsibility of professional nurses (RN, LPN/LVN per scope of practice defined by State law/practice acts), but can be delegated to a trained individual if allowed by state law or practice acts. If the transcription process is delegated, the nurse still must sign off on the order and retain responsibility for accurate transcription. When a telephone or fax order is transcribed into the medical record, it should be transcribed verbatim as given from the physician.

Physician orders (recaps/renewals, telephone/verbal, or fax orders, etc.) are to be noted by a licensed nurse by writing “noted”, dating and signing with name and title.
6.9.9 Contacting the physician to obtain an order:
Nurses, therapists or other professionals designated to take orders must first contact the physician to obtain the order. Each resident’s medical care must be supervised by a licensed physician (F385). Licensed nurses are not authorized to independently write physician orders without the explicit direction of or by the attending physician. It is not acceptable to write a telephone order, implement the order and then send the order for signature without contacting the physician. The exception would be for a nurse practitioner or physician assistant who have the authority by law and scope of practice to write orders on behalf of a physician.

6.9.10 Discontinuing an order when a new order is obtained:
When a physician changes a physician order that is currently in place, the original order must be discontinued first and a new order written that reflects the change.

6.9.11 Updating/changing physician order recaps/renewals after they have been signed:
Once the physician has signed the physician order recap/renewals changes or updates may not be made to the signed document. For example, new orders should not be added to the recap after the physician has signed the document.

6.9.12 Processing physician orders after hospitalization – “resume previous orders”:
Upon a return from a hospital stay or readmission, when an order to “resume all previous orders” is given, the attending physician should be contacted to review the previous orders to assure that they are still appropriate and would not conflict with any new orders. Some states may not allow the use of "resume all previous order" statements.

6.9.13 Verification of hospital orders with attending physician:
All hospital orders should then be reviewed and authorized by the resident’s attending physician at the time of admission or within a reasonable timeframe per facility policy.

6.9.14 Accepting orders from a NP/PA:
Orders should only be accepted from a nurse practitioner or physician assistant if state law allows the NP or PA to give orders or prescribe and the attending physician has given authorization through a scope of care agreement. Both the scope of care agreement with the attending physician and a copy of the NP/PA’s license should be kept on file by the facility.

6.9.15 Accepting orders from Specialists or Consultants:
As a general rule orders from a physician other than the attending (specialist, consulting physician, etc.) should be reviewed with the attending physician prior to implementation unless the attending physician has given previous written direction to accept the specialist/consultant order(s).

6.10 Pharmacy Drug Review:
(F428) A review of the resident’s drug regimen is required to be completed on a monthly basis by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician and the Director of Nursing. The reports made by the pharmacist must be acted upon.

6.11 Antipsychotic Drug Therapy:
(F330) At a minimum, the medical record should include documentation of the specific condition, as diagnosed and documented in the clinical record, which necessitates the use of antipsychotic drugs. When antipsychotic drugs are used, the clinical record should contain documentation that the resident has specific conditions found under the Guidance to Surveyors in the federal regulations.
6.11.1 Dose Reduction Schedules and Documentation:
(F331) For residents who receive antipsychotic drugs, the record should contain documentation of efforts to gradually reduce the dosage and behavioral interventions, unless clinically contradicted, in an effort to discontinue these drugs. If clinically contraindicated, documentation by the physician should provide justification as to why the drug must continue to be used and also why the dose of the drug is clinically appropriate. The justification should include a diagnosis (along with description of symptoms), a discussion of the differential psychiatric and medical diagnoses, a description of the justification for the choice of a particular treatment or treatments, and a discussion of why the present dosage is necessary to manage the symptoms of the resident. The information does not have to be found in the physician’s progress notes, but must be included as part of the resident’s clinical record.

6.12 Medication and Treatment Records:
Medication and treatment records are derived from the physician orders and document the delivery of ordered services.

6.12.1 Starting new Medication/Treatment Records Upon Readmission/Hospital Return:
To eliminate possible errors in transcription or administration of medications and treatments, new medication and treatment records should be initiated with a return from the hospital rather than continuing on the previous record. The new medication and treatment records would be based on the new orders received after hospitalization.

6.13 Flow Sheets/Flow Records:
Although flow sheets or records are generally not recommended for completion of summary or narrative charting, they are helpful tools in recording many clinical data or service delivery.

6.13.1 Service Delivery Records:
ADL Flowsheets and NAR Flowsheets: There is not a federal requirement to maintain ADL flowsheets or Nursing Assistant flowsheets to document delivery of resident care services. Their use should be based on facility/company standards or State requirements. If ADL/NAR flowsheets are used, it is best if they are tailored to the resident’s care plan.

ADL flowsheets can be either documented by nursing after consultation with direct care staff or by the nursing assistant providing care. If the nursing assistant completes the flowsheet, there should be a system to monitor completion every shift.

An acceptable alternative to using ADL/NAR flowsheets in supporting delivery of resident care is to implement a facility policy indicating that the resident’s care plan and the facility standard of care will be followed. Exceptions to the standard or deviations must be documented in the medical record. In this method NAR Flowsheets would not be necessary. ADL flowsheets to record resident assistance levels may still be helpful in providing supporting documentation for the MDS.

Scoring on the ADL flowsheets should be consistent with the scoring on the MDS to increase consistency in data collection and assessment.

6.13.2 Other Clinical Flow Records:
There are many different clinical flow sheets used to assist in data collection and assessment. Examples of clinical flowsheets include injection site rotation, intake and output, pressure ulcer flowsheets, Medicare flowsheets etc. Facility discretion rather than federal regulations usually dictate when clinical flowsheets are used. Flow records can be for 7 day, 14 days or monthly depending on facility policy.
6.14 Labs and Special Reports:

All laboratory, radiology, and diagnostic services must be ordered by the attending physician (F504, F510). A report of findings for all laboratory, radiology or special diagnostic services must be retained in the medical record. When a report is received, a nurse must review the results, note the findings, initial and date the report, and make an entry in the medical record. The physician must be promptly notified of results of laboratory findings (F505) and findings from radiology/other diagnostic services (F512). If there are abnormal lab results but the physician decides not to treat, a notation should be made in the medical record (i.e. nurses notes) documenting the decision and reason.

6.15 Consents, Acknowledgements and Notices:

6.15.1 Informed Consent for Use of a Restraint:
(F221) When a restraint is being considered for a resident, the facility must obtain informed consent from the resident or their legal surrogate/representative. The facility must explain the potential risks and benefits of using a restraint, the risks and benefits of not using a restraint, and alternatives to restraint all within the context of the resident’s condition and circumstances. Informed consent should include an explanation of how the restraint would treat the resident’s medical symptoms, assist the resident in attaining/maintaining his or her highest practicable level of physical or psychological well-being, and explain the negative outcomes of restraint use.

6.15.2 Consent, Notice and Authorization to Use/Release Clinical Records:
(F164) Prior to the release of personal or clinical records an authorization must be obtained. See section 4.9 on confidentiality and release of information. Under the HIPAA final privacy rule, LTC facilities must obtain a Consent for Use and Disclosure of Protected Health Information prior to delivery of services. In addition to the consent, the facility must provide the resident a written Notice of Privacy Practices. When information must be disclosed outside of the scope of the consent form, the resident or their legal representative must sign an authorization for to grant the release. (The consent form covers disclosure for treatment, payment, and healthcare operation purposes or when required by law.)

6.15.3 Notice of Bedhold Policy and Readmission:
(F205) The nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bedhold policy under the state plan, if any, during which the resident is permitted to return and resume residence in the nursing facility. The bedhold policy is usually given to the resident and family/responsible party at the time of admission. In addition, (F205) requires that the facility provide a bedhold notice at the time of transfer.

6.15.4 Notice of Legal Rights and Services:
(F156) Prior to or upon admission the facility must provide a written description of the resident’s legal rights and the items and services provided to the resident.

6.15.5 Notice Before Transfer:
(F203) Before a facility discharges or transfers a resident, a notice must be given to the resident or family member/responsible representative which includes:
- A copy of the facility bed hold policy
- The reason for transfer/discharge
- Effective date of transfer/discharge
- Location to which the resident is transferred or discharged
- Statement that the resident has the right to appeal the action to the state
- Name, address and telephone number of the state long term care ombudsman
- For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals
• For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

6.15.6 Notice prior to change of room or roommate:
(F247) A notice must be given to the resident prior to a change in room or roommate.

6.16 Advance Directives

(F155-156) The resident has the right to formulate advanced directives. The facility must inform and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and, at the individual’s option, formulate an advance directive. A written description of the facility’s policies to implement advanced directives and applicable state laws must be provided to the resident or representative. A copy of the advanced directive should be retained in the medical record.

6.16.1 DNR Order vs. Advance Directives:
Physician orders for a DNR status should be consistent with the advance directives of the resident. In the absence of a state law, the facility should obtain the resident’s advance directives prior to a code status/resuscitation order from the physician.

6.17 Discharge Documentation:

6.17.1 Discharge Order:
(F202) The resident’s physician must document that a transfer or discharge is necessary. This documentation is usually obtained via a physician order prior to discharge or transfer.

6.17.2 Discharge Note:
As a standard, a brief narrative note should be written at the time of discharge, including the date and time of discharge, the resident’s disposition, condition of the resident at discharge, where discharged to, and the individual taking responsibility for the resident.

6.17.3 Discharge Summary:
(F283 and F284) For planned discharges (i.e. discharges home or to another facility), federal regulations require that the facility complete a recapitulation of the resident’s stay, a final summary of the resident’s status based on the comprehensive assessment, and a post-discharge plan of care. The post-discharge plan of care serves as discharge instructions for a resident discharging home or as the transfer form for a resident discharging to another health care facility.

Minimum content for the post-discharge plan of care includes a description of the resident and family’s preference for care, how the resident and family will access the services, and how care should be coordinated if continuing treatment involves multiple care givers. Specific resident needs after discharge, such as personal care, sterile dressings, and therapy, as well as a description of resident/care giver education needs to enable the resident/care giver to meet needs after discharge.

6.17.4 Transfer Form:
As a standard, a transfer form should be completed when transferring the resident to the hospital or to another health care facility.

6.17.5 Physician’s Discharge Summary vs. Discharge Record:
Federal regulations do not require the completion of a physician’s discharge summary. State regulations should be reviewed to determine the physician’s responsibility for documentation upon discharge. At a minimum, a discharge record should be completed which includes the date and time of discharge, disposition, final diagnoses and where discharge location.
7.0 CHECKLIST OF HIM POLICY AND PROCEDURES

The following list provides an example of the types of policy and procedures that may be included in a manual for health information services. The titles and content of the policy and procedures may vary by facility or corporation. Some of the policy and procedures are listed more than once for cross-referencing purposes. (References: AHIS Resident Record Manual, Life Care Medical Record Manual, Kelli Marsh, RHIA – Clinical Record Policy and Procedures Manual)

Abbreviations
Access, to Automated/Computerized Records
Access to Records (Release of Information) by Resident and by Staff
Admission/Discharge Register
Admission Procedures
- Facility Procedures – Establishing/Closing the Record
- Preparing the Medical Record
- Preparing the Master Patient Index Card
- Re-Admission – Continued Use of Previous Record
- Re-Admission – New Record
Amendment of Clinical Records
Audit Schedule
Audit and Monitoring System
- Audit/Monitoring Schedule
- Admission/Readmission Audit
- Concurrent Audit
- Discharge Audit
- Specialized Audits (examples)
  - Change in Condition
  - MDS
  - Nursing Assistant Flow Sheet
  - Psychotropic Drug Documentation
  - Pressure Sore
  - Restrictive Device/Restraint
  - Therapy
Certification, Medicare
Chart Removal and Chart Locator Log
Clinical Records, Definition of Records and Record Service
General Policies
- Access to Records
- Automation of Records (See also computerization)
- Availability
- Change in Ownership
- Completion of Records
- Confidentiality
- Indexes
- Ownership of Records
- Permanent and Capable of Being Photocopied
- Retention
- Storage of Records
- Subpoena
- Unit Record
Purpose/General Instructions for Keeping Clinical records, Completing and Correcting Records
Willful Falsification/Willful Omission
Closing the Record
Coding and Indexing, Disease Index
Committee Minutes Guidelines

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Computerization and Security of Automated Data/Records
Confidentiality – See Release of Information
Consulting Services for Clinical Records and Plan of Service
Content, Record *(the list provided is not all inclusive and should be tailored to the facility/corporation)*
- General
- Advanced Directives
- Transfer Form/Discharge Plan of Care
- Discharge Against Medical Advice
- Physician Consultant Reports
- Medicare Certification/Recertification
- Physician Orders/Telephone Orders
- Physician Services Guidelines and Progress Notes
- Physician History and Physical Exam
- Discharge Summary
- Interdisciplinary Progress Notes

Copying/Release of Records - General
Correcting Clinical Records
Data Collection/Monitoring
Definition of Clinical Records/Health Information Service
Delinquent Physician Visit
Denial Letters, Medicare
Destruction of Records, Log
Disaster Planning for Health Information
Discharge Procedures
- Assembly of Discharge Record
- Chart Order on Discharge
- Completing and Filing Master Patient Index Card
- Discharge Chart Audit
- Notification of Deficiencies
- Incomplete Record File
- Closure of Incomplete Clinical Record

Emergency Disaster Evacuation
Establishing/Closing Record
Falsification of Records, Willful
Fax/Facsimile, Faxing
Filing Order, Discharge (Chart Order)
Filing Order, Inhouse (Chart Order)
Filing System
Filing System, Unit Record
Forms Management
Forms, Release of Information
Forms, Subpoena
Guide to Location of Items in the Health Information Department
Guidelines, Committee Minutes
Incomplete Record File
Indexes
- Disease Index and Forms for Indexing
- Master Patient Index
- Release of Information Index/Log

Inservice Training Minutes/Record
Job Description:
- Health Information Coordinator
- Health Unit Coordinator
- Other Health Information Staff (if applicable)
LTC Health Information Practice and Documentation Guidelines

Late Entries
Lost Record – Reconstruction
Master Patient Index
Medicare Documentation
  - Certification and Recertification
  - Medicare Denial Procedure and Letter
  - Medicare Log
Numbering System
Ombudsman, Review/Access to Records
Omission, Willful
Order of Filing, Discharge
Order of Filing, Inhouse
Organizational Chart for Health Information Department
Orientation/Training of Health Information Department
Outguides
Physician Visit Schedule, Letters, and Monitoring
Physician Visits, Delinquent Visit Follow-up
Quality Assurance
  - Health Information participation
  - QA Studies and Reporting
Readmission – Continued Use of Previous Record
Readmission – New Record
Recertification, or Certification (Medicare)
Reconstruction of Lost Record
Refusal of Treatment
Release of Information
  - Confidentiality
  - Confidentiality Statement by Staff
  - Copying/Release of Records – General
  - Faxing Medical Information
  - Procedure for Release – Sample Letters and Authorizations
  - Redisclosure of Clinical Information
  - Resident Access to Records
  - Retrieval of Records (sign-out system)
  - Subpoena
  - Witnessing Legal Documents
Requesting Information
  - From Hospitals and Other Health Care Providers
  - Request for Information Form
Retention of Records and Destruction after Retention Period
  - Example Statement for Destruction
  - Retention Guidelines
Retrieval of Records
Security of Automated Data/Electronic Medical Records
  - General Procedures
  - Back-up Procedures
  - Passwords
Sign-out Logs
Storage of Records
Telephone Orders
Thinning
  - In house Records
  - Maintaining Overflow Record
Unit Record System