

# AHIMA's Long-Term Care Health Information Practice and Documentation Guidelines

Please note:

Portions of these guidelines are under revision to reflect regulatory and practice changes.

## INTRODUCTION

- Purpose and Use of These Guidelines
- Transition from Medical Records to Health Information (HIM)
- Definition of Long Term Care Facility
- Acknowledgements
- Copyright and Use of Report
- Reference to HIM Practice Standards

## ROLE OF HEALTH INFORMATION STAFF IN LONG-TERM CARE FACILITIES

- Job Qualifications, Responsibilities, and Functions of Health Information Staff in a Long-Term Care Facility
  - Role of the Credentialed Consultant
  - Role of the Credentialed Practitioner Working in a Long Term Care Facility
  - Role of the Non-Credentialed Practitioner Working in a Long Term Care Facility
  - Role of the Health Unit Coordinator (Unit Clerk/Secretary, Health Information Assistant)
  - Evolving Role of Health Information
- Health Information Department Staffing

## HEALTH INFORMATION CONSULTANT SERVICES

- Frequency of Consultant Visits
- Performance Expectations for a Consultant
- Consultation Reports
  - Timeliness of Consultation Reports
  - Content of Consultation Reports
  - Distribution of the Consultation Reports
  - Retention of Reports (Facility and Consultant)
- Evaluating Consulting Services

## PRACTICE GUIDELINES FOR LTC HEALTH INFORMATION AND RECORD SYSTEMS

- Record Systems, Organization and Maintenance
  - Maintaining a Unit Record
  - Assigning a Medical Record Number
  - Maintaining Records in a Continuum of Care

- Defining What is Part of the Medical Record
- Maintenance of the Medical Record
- Identification (Name and Number) on Pages of the Medical Record
- Common Forms and Thinning Guidelines
  - Integrating Hospital Documents into the Long Term Care Record
  - Thinning the Medical Record
- Maintaining the Overflow Record of Thinned Documents
- Maintaining a "Soft Chart" or "Shadow Record" and Other Types of Records
- Forms Control Processes
- Audits and Quality Monitoring
  - Internal Qualitative vs. Quantitative Audits and Monitoring
  - Assessing the Quality of Documentation
  - Routine Audits/Monitoring (Criteria and Timeframes)
  - Focus Audits and Monitoring Systems
  - Integrating Audits/Monitoring into the QA/QI Program
  - Retention of Audits, Checklists, and Monitoring Record
  - Auditing the Electronic Health Record
- Discharge Record Processing
  - Discharge Record Assembly
  - Discharge Record Analysis
  - Timely Completion of a Discharge Record
  - Incomplete and Delinquent Records
  - Maintaining a Control Log for Discharge Records
  - When to Close a Record on Temporary Absence
    - Closing Records with a Change in Level of Care
    - Closing Records with a Payer Change
- Filing and Retrieval
  - Separate Location for Incomplete Records
  - Typical Filing Systems
  - Retrieval
  - Filing
- Storage Systems
  - Storage System Options
  - Security Issues: Locking of Office and Storage Areas
  - Alternative Storage Areas
- Retention
  - Retention Guidelines
- Destruction

- Acceptable Methods of Destruction - Paper-based Record
- Abstracting Paper Documents and Electronic Data Prior to Discharge
- Destruction Logs and Witnesses
- Physical Security of Manual/Paper Records
  - Security Measures for Record Check Out—Manual
  - Maintaining Security of Electronic Record Access
  - What To Do If a Record Is Lost, Destroyed or Stolen
  - Disaster Plans
- Confidentiality and Release of Information
  - Identification of Confidential vs. Non-Confidential Information
  - Resident Access to Their Records
  - Confidentiality Training and Agreements with Employees and Volunteers
  - Resident Identification Boards at Nursing Stations and other Facility Locations
  - Maintaining an Access/Disclosure Grid for Employees, Contractors and Outside Parties
  - Handling a Request for Health Information Contained in the Designated Record Set
    - Consent for Use and Disclosure of Protected Health Information
    - Redisclosure upon Transfer to Another Healthcare Facility
  - Handling Telephone Requests for Information
  - Transmitting Resident Information via Facsimile
  - Responding to a Subpoena or Court Order
  - Removing Original Records from the Facility
  - Notice of Information Practices
  - Designation of a Privacy Officer
- Coding and Reimbursement
  - Training and Resources
  - Frequency of ICD-9-CM Coding
  - Coding and Billing Relationships
  - Investigation of Claim Rejection/Denials Due to Coding
  - Coding Issues Under Consolidated Billing
- Indexes and Registries
  - Master Patient Index
    - Maintaining an MPI
    - Minimum Content
  - Admission/Discharge Register
  - Disease Index
- Minimum Statistical Reporting
  - Total Admissions

- Total Discharges
- Average Daily Census
- Total Census Days
- Length of Stay
- Percentage of Occupancy
- Electronic Patient Records (on hold)

## **LEGAL DOCUMENTATION STANDARDS**

- Purpose and Definition of the Legal Medical Record
- Legal Documentation Standards that Apply to Medical Records
  - Defining Who May Document in the Medical Record
  - Linking Each Entry to the Resident
  - Date and Time on Entries
    - Timeliness of Entries
    - Pre-dating and Back-dating
  - Authentication of Entries and Methods of Authentication
    - Signature
    - Countersignatures
    - Initials
    - Fax Signatures
    - Electronic/Digital Signatures
    - Rubber Stamp Signatures
    - Authenticating Documents with Multiple Sections or Completed by Multiple Individuals
  - Signature Legends
  - Permanency of Entries
    - Printers
    - Fax Copies
    - Photo Copies
    - Carbon Copy Paper (NCR)
    - Use of Labels in the Medical Record
  - Specificity
  - Objectivity
  - Completeness
  - Use of Abbreviations
  - Legibility
  - Continuous Entries
  - Completing All Fields
  - Continuity of Entries – Avoiding Contradictions
  - Condition Changes
  - Document Informed Consent

- Admission/Discharge Notes
- Notification or Communications
- Delegation
- Incidents
- Make and Sign Own Entries
- Appropriateness of Entries – Keep Documentation Relevant to Patient Care
- Legal Guidelines for Handling Corrections, Errors, Omissions, and Other Documentation Problems
  - Proper Error Correction Procedure
  - Handling Omissions in Documentation
    - Making a Late Entry
    - Entering an Addendum
    - Entering a Clarification
  - Omissions on Medication, Treatment Records, Graphic and Other Flowsheets
  - Documenting Care Provided by a Colleague
  - Resident Amendments to their Record

## **DOCUMENTATION IN THE LONG TERM CARE RECORD**

- Federal Regulations Pertaining to Clinical Records
- Purpose of Clinical Records
- Elimination of Duplication/Redundant Information when Evaluating/Implementing a Documentation System:
- Documentation Content in a Long Term Care Record
  - Admission Record
- Assessments
  - Integrating Facility Assessments with Resident Assessment Instrument (RAI) Process
  - Types of Assessments and Requirements
    - Preadmission Assessment
    - Admission Assessment
    - Fall Assessment
    - Skin Assessment
    - Skin at Risk Assessment
    - Actual Skin Problems/Pressure Ulcer
    - Bowel and Bladder Assessment
    - Physical Restraint Assessment
    - Self-Administration of Medication
    - Nutrition Assessment
    - Activities/Recreation/Leisure Interest Assessment
    - Social Service
    - Mental and Psychosocial Functioning

- Restorative/Rehab Nursing Assessment
  - Rehabilitation Services
- Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) and Care Area Assessment (CAA)
- Care Plan
  - Timeliness
  - Care Conference
  - Admission Care Plan
  - Integrating Acute Problems Into the Care Plan
  - Timeliness of Completion of Care Plan
  - Authenticating Changes to Care Plan
- Narrative Charting and Summaries
  - Admission/Readmission Note
  - Content of Narrative Charting
  - Nursing and/or Interdisciplinary Summary Charting
  - Integrated vs. Disciplinary Progress Notes
- Medicare Physician Certification
  - Skilled Nursing/Therapy Charting
  - Supporting Documentation for the MDS
  - Therapy Treatment Time
  - Activities of Daily Living (ADL) Charting
  - Mood and Behavior Documentation
  - Hospital Documentation
  - Medicare Certification/Recertification
- Rehabilitative Therapy Documentation
- Physician Documentation
  - Physician Progress Notes
  - Dictated Progress Notes
  - Nurse Practitioner (NP)/Physician Assistant (PA) Documentation
  - History and Physical
  - Other Professional and Consultation Records/Notes
  - Documenting Resident Diagnoses
    - Supporting Documentation for Diagnoses
    - Resolving Diagnoses
  - Final Progress Note/Discharge Note/Summary
- Physician Orders
  - Admission Orders
  - Content of an Order
  - Physician Order Recaps/Renewals

- Telephone Orders
- Fax Orders
- Standing Order Policies
- Authentication/Obtaining Signatures
- Transcription of Orders and Noting Orders
- Contacting the Physician to Obtain an Order
- Discontinuing an Order When a New Order is Obtained
- Updating/Changing Physician Order Recaps/Renewals After They Have Been Signed
- Processing Physician Orders After Hospitalization "Resume Previous Orders"
- Verification of Hospital Orders with Attending Physician
- Accepting Orders From a Nurse Practitioner (NP)/Physician Assistant (PA)
- Accepting Orders from Specialists or Consultants
- Pharmacy Drug Review
- Antipsychotic Drug Therapy
  - Dose Reduction Schedules and Documentation
- Medication and Treatment Records
  - Starting new Medication/Treatment Records Upon Readmission/Hospital Return
- Flow Sheets/Flow Records
  - Service Delivery Records
  - Other Clinical Flow Records
- Labs and Special Reports
- Consents, Acknowledgements and Notices
  - Informed Consent for Use of a Restraint
  - Consent, Notice and Authorization to Use/Release Clinical Records
  - Notice of Bedhold Policy and Readmission
  - Notice of Legal Rights and Services
  - Notice Before Transfer
  - Notice Prior to Change of Room or Roommate
- Advance Directives
  - DNR Order vs. Advance Directives
- Discharge Documentation
  - Discharge Order
  - Discharge Note
  - Discharge Summary
  - Transfer Form
  - Physician's Discharge Summary vs. Discharge Record
  - Post Discharge Plan of Care

## Agreements

- [BIPA Forms](#)
  - [Generic Notice](#)
  - [Detailed Notice of Termination of Medicare Benefits](#)
- [Documentation Systems/Formats](#)

## CHECKLIST OF HIM POLICY AND PROCEDURES

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