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.

- 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

- 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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