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

Practice Guidelines for LTC Health Information and Record Systems

Discharge Record Processing

Processing of discharge records is an important aspect in management of health record systems. This section reviews the fundamental processes that should be in place when managing discharge records.

Discharge Record Assembly

Discharge assembly is the process of gathering all health records for a resident upon discharge and assembling the health 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.

Accessing Records from Multiple Locations:

When assembling the discharge record access health 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. For those facilities which maintains the health record in both the electronic and hard copy format (hybrid record). a determination should be made as to whether the electronic record is to be printed and incorporated into the existing hard copy record. Although this would appear to negate the purpose of an electronic record, there may be factors which dictate the printing of the record. If the information is to be reatined in an electronic format, a notice should be placed in the closed hard copy records identifying the presence of an electronic component of the record.

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 health 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. Whichever format is utilized, this should be clearly identified in the policy and the discharge chart order form (previous recommendation is that a copy of the discharge chart order be placed in the closed record.)

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. Care should be used when applying the hole punch for the prongs so the hole does not go through an area of staff documentation, e.g. flow sheets).
- 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, health record number and volume number. Other information which could be included 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 health record number provide additional assurances that records are filed correctly and can be located easily.

It is advanatgeous to bring forward the resident's previous admissions, if any, and file these records with the current admission. However, given the lack of space in most facilities this may not be practical. The resident index should clearly identify the dates of the resident's previous admissions and these should be available for the staff to review, if requested. The records from the resident's previous admission should not be integrated with the current admission record. Data should not be 'canabalized' and brought forward.

Discharge Record Analysis

HIM Standard:

- The facility has a process for analyzing a discharge record whether hard copy, hybrid or an electronic health record (EHR) by completing an audit of required discharge documentation before it is filed as a complete discharge record or before it is moved to an inactive resident data base within the data repository.

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 health record for resident name and health 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.
- For hybrid records, identify portions of the record that are maintained within the data repository and not printed as a hard copy record Refer to section 4.1 Table 1 Legal Source Legend for the hybrid record. A copy of this type of legend or similar documentation should be placed within the discharge record
- Identify on the discharge audit those items that are missing or incomplete. Identify 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.

Timely Completion of a Discharge Record

HIM STANDARD:

- Written policies on record completion comply with 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 nursing station as soon as possible after discharge 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 allows the remaining time to follow up on deficiencies and track documents that are mailed for completion and/or signature and still allow for timely completion of the discharge record.

Incomplete and Delinquent Records

HIM STANDARD:

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

Upon completion of the discharge analysis, records that have specific deficiencies that can be completed by a health care provider are considered incomplete. After 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. If the deficiency/ies have not been addressed within 5 days of 30 day deadline, the Medical Director, Administrator, and Director Nursing should be notified for follow-up action/s.

After an incomplete health record remains open after a defined period of time (over 30 days or over the state-defined timeframe), the health 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%.

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 running 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. A permission to file an incomplete record form should be filed in the health record which identifies the reason the record is filed as incomplete. The form should contain at a minimum the following information: Resident Name, Case Number, Admit and Discharge Date, Statement similar to the following; “The following portion(s) of the record are incomplete due to:, signature of HIM staff, signature of Administrator.

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:

Discharge Date	Resident Name	Assembled	Analyzed	Coded	Completed	Miscellaneous

When to Close a Record on Temporary Absence

HIM Standard:

The facility will have a policy which defines health record closure or maintaining an open record upon the resident's temporary leave of absence (LOA).

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 (e.g. home visit, vacation with the family, etc.) 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 assessment is completed. If it is indicated on the MDS discharge assessment 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 without 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 health 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 health record should be removed from the nursing station or flagged for an absence or leave. If the software system provides an application for identifying the resident as temporary LOA, the resident's EHR portion of the record should be directed to this file at the time of daily census. This will help prevent staff from charting when the resident is no longer in the facility. A common practice is to redline the hard copy 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 temporary LOA 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 health record. If the record is closed, certain portions of the records from the last stay should be copied and the copies 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 at a minimum should be made: most recent 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). The facility can further define additional information as determined by the interdisciplinary team to bring forward upon closing the health record during a temporary LOA.

Closing Records with a Change in Level of Care

The health 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.

Closing Records with a Payer Change

The health 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 health records into different stays. The financial office should have mechanisms to track dates of coverage by individual payers.
