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

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

Printable version of this page with latest updates

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Purpose And Use of These Guidelines

The long term care (LTC) community requires complete and accurate clinical records and documentation. Documentation-based survey initiatives, quality indicators, quality measures, 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.

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.

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.

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 Service
- 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.

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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.

**Reference to HIM Practice Standards**

In section four of this report (Practice Guidelines for LTC Health Information and Record Systems) there are HIM Standards 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:**

*Assigning a Medical Record Number*
HIM STANDARD:
The healthcare organization has a policy that requires a separate, unique health record for each resident.
Role of the Health Information Staff in Long Term Care Facilities

In order to maintain quality health information systems, properly trained staff 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 to include the following:

1. A Health Information Consultant
2. A credentialed health information practitioner working in a facility
3. A non-credentialed practitioner working in a facility
4. A health unit coordinator

As documentation and clinical record systems increase in complexity in response to the changes in the LTC environment, HIM professionals and staff provide valuable expertise and assistance to maintain health information systems that impact quality of care including regulatory, legal, compliance and financial issues.

Job Qualifications, Responsibilities, and Functions of HIM Staff in a LTC Facility

Role of Credentialed Consultant:

Many long term care facilities have access to a Health Information Management Consultant to provide expertise on manual and automated health information medical record systems issues, documentation requirements, and assistance with the implementation of the electronic health record. Consultants are usually contracted independent of the organization to support non-credentialed staff or they are employed at the corporate level. Consultants may also serve as an additional resource to a HIM corporate consultant to assist with state specific issues, and/or assist with implementation of corporate policies and procedures. Consultants may also be used for special projects, independent auditing/monitoring services, staff 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. Many state licensure bodies require a consultant for a facility which does not have a credentialed person on staff.
• Experience in long term care.
• Knowledge of regulations, survey process, accreditation standards and professional standards of practice pertaining to long term care.
• Understanding of payment systems for SNF/NF including Medicare and Medicaid.
• Knowledge and application of the International Classification of Disease coding in long term care.
• Understanding of the HCPCS and CPT coding systems and how they pertain to reimbursement in long term care.
• Knowledge of documentation and legal issues pertaining to health information.
• Knowledge of quality assurance/improvement and the ability to apply a quality improvement process to problem solving.
• Superior presentation skills, both oral and written. defined/demonstrated how?
• Solid clinical understanding of anatomy, physiology, pathophysiology, and the clinical/nursing process.
• Ability to teach using a variety of methods
• Computer skills and understanding of electronic information systems as used in long term care.
• Ability to assist a facility’s 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 the necessary inter-personal skills 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/facilities needs.

**Reporting:**

The Health Information Management 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. It is advisable that both the Administrator and the Director of Nursing are aware of the findings and recommendations of the Consultant.

**Common Functions Performed by a Health Information Consultant:**

• 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.
• 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 training and orientation to health information personnel on functions of the department and facility staff on documentation and the use of an electronic health information system.
• 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 manual and electronic (via a variety of computer systems) 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 for 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.
Develop educational programs on multiple health information related topics for presentation to clinical staff.
Understand all aspects of clinical computer system.
Provide resources to the facility on health information, documentation, regulations, standards of practice, disease coding, etc.
Ability to provide assistance and function as a key resource for the development, transition, and maintenance of an electronic medical record.
Develop and provide 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 staff to work independently
Be available to address situational problems via email, phone, on-site visits as appropriate

Role of the Credentialed Practitioner Working in a Long Term Care Facility

A growing trend in the LTC 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.

Qualifications of a Credentialed Practitioner:

- 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 bachelors degree. An 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.
- Knowledge of and access to the various entities to obtain revisions to the regulatory/accreditation requirements.
- Understanding of payment systems including Medicare and Medicaid.
- Knowledge and application of the current International Classification of Diseases coding appropriate to long term care.
- Understanding of HCPCS and CPT coding systems and how they pertain to long term care reimbursement.
- Knowledge of documentation and legal issues pertaining to health information.
- Computer skills and understanding of electronic 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 management practitioner should include:

- Leadership abilities preferred with skills 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.
- Empathy for the elderly with ability to be sensitive to resident and family needs/concerns.
Reporting:

It is recommended that this position report directly to the Administrator of 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 the 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 management 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. It should be noted that the majority of facilities may have one HIM staff person in a 'Department', however there are instances when the HIM Director may supervise the Unit Clerks or other staff members outside the confines of the HIM Department.

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 evaluations, disciplinary actions, and terminations.
- Supervise health information staff to assure staff competency and performance.
- Provide guidance, motivation, and support to health information staff.
- Monitor department budget as directed.
- If designated: May serve as the HIPAA Privacy Officer or 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.
- Conduct and maintain routine audits including admissions/re-admission, concurrent/quarterly, MDS, diagnoses, acute problems, and discharge.
- Conduct and maintain focus audits on problem areas, QA concerns, Quality Indicators, Quality Measures, and survey issues.
- Collect and report data from audit findings to QA committee.
- Develop an action plan for identified problems/concerns.

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.
  - Assure facility safeguards are in place such as record sign-out systems, assignment of computer passwords/log-on.
  - Assure systems are in place for securing file cabinets and file rooms where overflow and discharge records are stored.
  - Assure systems are in place to maintain confidentiality/privacy of both manual and electronic health information.
- Manage the release of health 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
regulations.
- Maintain a forms management system for development, review, and reproduction of facility forms.
- Maintain a forms manual and/or electronic templates.
- Maintain systems for filing, retention and destruction of overflow/thinned records and discharge records that are compliant with State, Federal, and HIPAA guidelines.
- 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, PPS, Administrative/department head, Quality Assurance/Quality Improvement, Medicare documentation review, etc. as appropriate.
- Provide in-service 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.
- Provide orientation to new employees regarding facility specific HIPAA privacy and security safeguards.
- Support and assist in carrying out corporate compliance initiatives as assigned by the Administrator/Executive Director.
- 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 and analyze Quality Indicator/Quality Measure reports and other MDS management reports from State MDS submission Website.

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.
- 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/privacy/security per regulations.
- Assure the current International Classification of Diseases.
- 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 management 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 in-house overflow file, prepare labels, etc.
- Optional: May prepare admission records (face sheet) for the medical record.
- Complete admission checklist 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 and update concurrently throughout resident’s stay.
Thin in-house records in accordance with the written policy and procedure and file in chart order for discharge in the in-house overflow file.

Contact physician or departments/disciplines as appropriate when signatures or information is needed before records can be completed.

Maintain a trending and evaluation system that identifies that telephone orders and other information is completed and signed by the physician in a timely manner.

File all incoming clinical information in the in-house records on a daily basis. If electronic, this material may be scanned into the system.

Monitor timeliness of physician visits on a monthly basis to assure compliance with Federal and State regulations.

Report physicians who are out of compliance to facility Administration. (Administrator, Director of Nursing, Medical Director).

**Discharge:**

- Update discharge information on the master patient index (manual or electronic).
- Record appropriate discharge information in the census register (manual or electronic).
- Initiate the discharge record control log to monitor discharge records processing status.
- Obtain the discharge clinical record from the nursing station within 24 hours (or per facility policy) 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 physician for completion as applicable.
- Maintain discharge record control log.
- File discharge record in incomplete clinical record file until completed and then file the discharge record in the complete file.
- Code final diagnoses using the current International Classification of Diseases

**Role of the Non-Credentialed Practitioner Working in a Long Term Care Facility**

**Qualifications of a Non-Credentialed Practitioner Working in a Long Term Care Facility**

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 with the ability to be sensitive to resident and family needs/concerns.

**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 diagnoses coding using the International Classification of Diseases 
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 the 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. These functions should be completed (depending on skill and experience) under the direction of a credentialed consultant. At a minimum when hiring for this position, the non-credentialed practitioner should be able to complete the following functions:

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 qualitative and quantitative audit/monitoring process.
• Conduct and maintain routine audits including admission/re-admission, concurrent/quarterly, MDS, diagnoses, acute problems, and discharge.
• Conduct and maintain focus audits on problem areas, QA concerns, Quality Indicators, Quality Measures, and survey issues.
• Collect and report data from audit findings to QA committee.
• Assist in the development of action plans for identified problems/concerns.

Health Information Management Functions:

• Maintain security of health information systems and medical records.
  o Assure physical protection is in place to prevent loss, destruction, and unauthorized use of both manual and electronic records.
  o Assure facility safeguards are in place such as record sign-out systems, assignment of computer passwords/log-ons.
  o Assure systems are in place for securing file cabinets and file rooms where overflow and discharge records are stored.
  o Assure systems are in place to maintain confidentiality/privacy of both manual and electronic health information.
• Manage the release of health 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
regulations.
- 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 that are compliant with State, Federal, and HIPAA guidelines.
- 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, PPS, Administrative/department head, Quality Assurance/Quality Improvement, Medicare documentation review, etc.
- Support and assist in carrying out corporate compliance initiatives as assigned by the Administrator/Executive Director.
- Manage the credentialing process for physicians and other professional staff when applicable.

**Computerization/Automation:**

- Understand all aspects of clinical computer systems.
- 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/privacy/security.
- Assure disease database utilizes the current version of the International Classification of Diseases.
- 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 in-house overflow file, prepare labels, etc.
- *Optional:* May prepare admission records (face sheet) for the medical record.
- 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 in-house records in accordance with the written policy and procedure and file in chart order for discharge in the in-house overflow file.
- Contact physicians or departments/disciplines as needed when signatures or information is needed before records can be completed.
- Maintain a trending and evaluation system that identifies that telephone orders and other information is completed and signed by the physician in a timely manner.
- File all incoming clinical information in the in-house records on a daily basis. If electronic, this material may be scanned into the system.
- Monitor timeliness of physician visits on a monthly basis to assure compliance with Federal and State regulations.
- Report physicians who are out of compliance to facility Administration. (Administrator, Director of Nursing, Medical Director).

**Discharge:**
• Update discharge information on the master patient index (manual or electronic).
• Record appropriate discharge information in the census register. (Manual or electronic).
• Initiate the discharge record control log to monitor discharge records processing status.
• Obtain the discharge clinical record from the nursing station within 24 hours (or per facility policy) 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 physician for completion as applicable.
• Maintain discharge record control log.
• File discharge record in incomplete clinical record file until completed and then file the discharge record in the complete file.
• Code and index final diagnoses using the current version of the International Classification of Diseases

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 a facility size, number of admissions and discharges, or resident acuity level. Although this position is typically found at the nursing station, their functions primarily revolve around the monitoring and completion of the record and nursing 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.
• Ability to work within a team.
• Empathy for the elderly with the ability to be sensitive to resident and family needs and concerns.

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.
• Knowledge of documentation and legal issues.
• Knowledge of regulations, accreditation standards, and professional practice standards of practice in health information management in long term care.
• Experience with transcribing physician orders with the knowledge of medications and applicable medical terminology.

Reporting:

It is recommended that the health unit coordinator position report to the Manager/Supervisor of Health Information Management 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 resident care. If a facility does not utilize a health unit coordinator position or incorporate their functions in another position, the nursing staff is completing many clerical functions keeping them away from delivery of direct resident 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 in-house 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 in-house records in accordance with the written policy and procedure and file in chart order for discharge in the in-house overflow file.
- Maintain the in-house chart appearance and organization.
- Maintain a monitoring system to assure telephone order and other information is signed or returned by the physician and other professionals in a timely manner.
- File all incoming clinical information in the in-house records on a daily basis. If electronic, this material may be scanned into the system.
- Monitor timeliness of physician visits on a monthly basis in conjunctions 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.

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 sheets.
- Complete station filing of loose reports, policies, etc.
- Assist family, visitors, etc. as needed and appropriate.
Other Functions:
Additional hours should be allocated to this position in non-health information functions are shared with this position,

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. This is particularly relevant with the increased focus of external agencies on the documentation process and compliance with the various Medicare, Medicaid and insurance provider requirements.

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.
AHIMA’s Long-Term Care Health Information Practice & Documentation Guidelines

Health Information Consultant Services

Contents

1. Frequency of Consultant Visits
2. Performance Expectations for a Consultant
3. Consultation Reports
   i. Timeliness of Consultation Reports
   ii. Content of Consultation Reports
   iii. Distribution of the Consultation Report
   iv. Retention of Reports (Facility And Consultant)

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.

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</td>
</tr>
<tr>
<td>Interval</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<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</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.

**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 an change in the schedule is mutually agreed upon.

MAINTENANCE OF A CONTRACT: A written contract should 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.

- PROVIDE TELEPHONE CONSULTATION: Because not all problems can wait until the next consultation visit, the consultant should provide telephone or e-mail consultation as situations arise. Telephone consultation time is equivalent to on-site consultation time. The facility should expect to pay for the time it takes to answer the questions that arise between consultation visits.

### 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.

### 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.

### Content of Consultation Reports

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.

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.

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.

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 there is good rapport and communications between the consultant and your staff?
   _ Yes _ No
Comments:
7. Do you feel that the entrance and exit conference with each visit is:
   __Beneficial __Not Beneficial
   If not, why?
   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 N/A
    Comments:

General Comments, strengths and suggestions:

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AHIMA’s Long-Term Care Health Information Practice & Documentation Guidelines

Practice Guidelines for LTC Health Information and Record Systems

**Record Systems, Organization and Maintenance** - Updated 6/09
1. Maintaining a Unit Record
2. Assigning a Medical Record Number
3. Maintaining Records in a Continuum of Care
4. Defining What is Part of the Medical Record
5. Maintenance of the Chart
6. Identification/Name and Medical Record Number on Pages
7. Common Chart Forms and Thinning Guidelines
   i. Integrating Hospital Records into the Long Term Care Record
   ii. Thinning the Medical Record
8. Maintaining the Overflow Record of Thinned Documents
9. Maintaining a "Soft Chart" or "Shadow Record" and Other Types of Records
10. Forms Control Processes

**Audits and Quality Monitoring** - Updated 11/08
1. Qualitative vs. Quantitative Audits and Monitoring
2. Assessing the Quality of Documentation
3. Routine Audits/Monitoring (Criteria and Timeframes)
4. Focus Audits and Monitoring Systems
5. Integrating Audits/Monitoring into the QA/QI Program
6. Retention of Audits, Checklists, and Monitoring Record
7. Auditing the Electronic Health Record

**Discharge Record Processing** - Updated 6/09
1. Discharge Record Assembly
2. Discharge Record Analysis
3. Timely Completion of a Discharge Record
4. Incomplete and Delinquent Records
5. Maintaining a Control Log for Discharge Records
6. When to Close a Record on Temporary Absence
   i. Closing Records with a Change in Level of Care
   ii. Closing Records with a Payer Change

**Filing and Retrieval** - Updated 6/09
1. Separate Location for Incomplete Records
2. Typical Filing Systems
3. After Hours Retrieval

**Storage Systems** - Updated 6/09
1. Storage System Options
2. Security Issues: Locking Office and Storage Areas
3. Alternative Storage Areas

**Retention** - Updated 6/09
1. Retention Guidelines

**Destruction** - Updated 6/09
1. Acceptable Methods of Destruction
2. Abstracting Documents Prior to Discharge
3. Destruction Logs and Witnesses

**Physical Security of Manual/Paper Records - Updated 6/09**
1. Maintaining a Record Checkout System
2. What To Do If a Record Is Lost, Destroyed or Stolen
3. Disaster Plans

**Confidentiality and Release of Information - Updated 6/09**
1. Identification of Confidential vs. Non-Confidential Information
2. Resident Access to Their Records
3. Confidentiality, Training and Agreements with Employees and Volunteers
4. Resident Identification Boards at Nursing Stations
5. Maintaining an Access/Disclosure Grid for Employees, Contractors and Outside Parties
6. Handling a Request for Medical Records
   i. Review of Authorization for Release of Information
   ii. Preparing a Record for Release
   iii. Turn Around Time for Responding to a Request for Copies of Medical Records
   iv. Copy Fees for Release of Information
   v. Documenting the Release of Information (Accounting of Disclosures)
7. Redisclosure of Health information
   i. Redisclosure Upon Transfer to Another Healthcare Facility
8. Handling Telephone Requests for Information
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10. Responding to a Subpoena or Court Order
11. Removing Original Records from the Facility
12. Notice of Information Practices
13. Designation of a Privacy Officer

**Coding and Reimbursement - Updated 6/09**
1. Training and Resources
2. Frequency of ICD-9-CM Coding
3. Coding and Billing Relationships
4. Investigation of Claim Rejection/Denials Due to Coding
5. Coding Issues Under Consolidated Billing

**Indexes and Registries**
1. Master Patient Index
   i. Maintaining an MPI
   ii. Minimum Content
2. Admission/Discharge Register
3. Disease Index

**Minimum Statistical Reporting**
1. Total Admissions
2. Total Discharges
3. Average Daily Census
4. Total Census Days
5. Length of Stay
6. Percentage of Occupancy

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A medical record must be maintained for every resident in a long term care facility. It is critical that every facility have formalized systems in place for the maintenance of records that are systematically organized and readily accessible. With long term care providers at varying stages of automating their clinical documentation, there may be some portions of a record maintained electronically and some in paper format. This section of the report will deal with maintenance of the paper medical record and special considerations related to maintenance of electronic or hybrid records.

A hybrid record is a system with functional components that include both paper and electronic documents and use both manual and electronic processes. Software products, as well as human and fiscal resources of a facility, vary in the ability to implement and support a fully electronic health record (EHR). Facilities can migrate to an EHR by staggering the automation of various components of the clinical record, such as the MDS, care plan or physician orders, while maintaining the remainder of the record in a paper format. Fully automating a component of clinical documentation entails not only creating the information electronically, but the ability to:

- electronically authenticate, correct, retrieve, and archive the information,
- destroy the electronic information in accordance with record retention policies,
- produce hardcopy output of the electronic information as necessary for litigation or other warranted use, and
- adhere to federal and state requirements for maintaining the privacy and security of protected health information.

Within the facility you must determine if components of your clinical record that are entered into a computer system, such as the MDS or care plan, will be printed and placed in the paper record or only maintained electronically. Either method is acceptable as long as it is in accordance with federal and state laws and regulations, and is consistent with facility policy (see CMS Survey & Certification Memo S&C-04-46 of September 9, 2004).

It is helpful to establish a grid or matrix that identifies all components of the clinical record and whether, for purposes of the legal health record, that component is maintained in electronic or paper format. Such a grid can be useful in ensuring all document types are addressed in planning the transition from hybrid to fully electronic health records. Including the date the information was converted to an electronic format is advantageous as it identifies the specific timeline of the conversion, particularly when it is a staggered conversion process. In addition, the grid can serve as a tool for communicating the paper or electronic status of document types to staff and, therefore, ongoing maintenance of the grid is important.

Recommended content for a facility legal health record grid includes:

- type and name of the document
- media source considered as the legal health record (i.e. paper or electronic)
- software application used to create and maintain the document
An abbreviated sample of a legal health record grid is found below in Table 1.

The AHIMA Practice Brief Series “The Complete Medical Record in a Hybrid EHR Environment” (2003) presents a comprehensive review of issues related to a hybrid record system. The series addresses:

- Managing the Transition (Part I)
- Managing Access and Disclosure (Part II)
- Authorship of and Printing the Health Record (Part III)
- Legal Source Legend (Appendix)

Review of this Practice Brief series is strongly encouraged.

<table>
<thead>
<tr>
<th>Report/Document Types</th>
<th>Media Type for Legal Record: (P)aper/(E)lectronic</th>
<th>Software Application Source for Electronic Document</th>
<th>Start Date for Electronic Storage of Document</th>
<th>Last Date for Routine Printing of Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDENTIFICATION &amp; ADMISSION DOCUMENTATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission Record/Facesheet</td>
<td>P &amp; E</td>
<td>Specify Application</td>
<td>1/1/2005</td>
<td></td>
</tr>
<tr>
<td>Pre-admission Screening (PASARR)</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission Agreement</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLINICAL ASSESSMENTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Admission Assessment</td>
<td>E</td>
<td>Specify Application</td>
<td>2/1/2005</td>
<td>4/1/2005</td>
</tr>
<tr>
<td>Fall Assessment</td>
<td>E</td>
<td>Specify Application</td>
<td>2/1/2005</td>
<td>4/1/2005</td>
</tr>
<tr>
<td>MINIMUM DATA SET AND CARE PLAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDS</td>
<td>E</td>
<td>Specify Application</td>
<td>1/1/2005</td>
<td>3/1/2005</td>
</tr>
<tr>
<td>Care Plan</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Plan Signature Record</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHYSICIAN ORDERS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly Recap</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone Orders</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following practice guidelines establish a baseline for the systems that should be in place for maintaining the clinical record in both paper and electronic formats.

**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 to the facility. This number is retained for each subsequent admission/readmission, and is used for both paper and electronic portions of the record. Though there may be multiple volumes, folders and formats, the patient’s entire medical record is filed as a unit under one number. *(Health Information Management, Huffman)*

In long term care, the record(s) from previous admissions should **may** be brought forward and filed in the same area as the current admission, **if space allows**. Bringing previous records forward provides 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.

When a resident is readmitted, all records from previous admissions **should** **may** be pulled forward and maintained in the overflow files, **again, if space allows**. Records from previous admissions **should** **may** be separated from other discharged/closed records to prevent the inadvertent destruction of the record(s) prior to the required medical records retention period (see section 4.6 for discussion of retention...
guidelines). The medical records from previous stays remain in their original file folder and are retained, chronologically, with other records for residents currently in the facility. The records from one discharge to another are not combined into one folder.

If the previous records cannot be brought forward and kept in the same area as the current record, the facility must have a process in place to ensure that previous records are not inadvertently destroyed prior to the required retention period for the record. It is good medical record practice, and beneficial from a clinical perspective, to retain those records from the resident's previous stays, however, facility policy and financial or space requirements may not allow for this practice.

Some software products have been setup to assign a new number with each readmission to the facility. In this situation, the previous records should be brought forward and filed under the latest number assigned to the resident. The software vendor should be queried as to whether there could be a mechanism by which the previous admission could be identified, possibly through the addition of a character to the resident's identifier.

If information from a prior admission(s) is in an electronic format, the information must be viewable upon readmission and staff need to be made aware of its availability.

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:

1. Assign a medical record number only when a resident is admitted. This will prevent numbers from being assigned when the resident is not actually admitted to the facility.
2. If a resident was assigned a number, but was not admitted, make a notation in the admission/discharge register (see section 4.11.2) that the resident was not admitted. Do not reuse the number.
3. Assign numbers chronologically. Each new admission is assigned the next sequential number.
   - Always verify in the master patient index (see section 4.11) that the resident has not been in the facility previously.
   - If a resident has multiple admissions, the facility can assign a modifier to the medical record number to designate each admission, such as 1234-a, 1234-b or 1234-1, 1234-2.
4. When a resident is re-admitted, the original medical record number is used.
   - No additional entry is needed in the medical record number log, but the readmission is noted on the master patient index card.

Special considerations for healthcare campuses or continuums of care (i.e. facilities with nursing home and assisted living components, continuing care retirement communities, etc.):

- How the facility uses the medical record number is a key consideration when assigning numbers in a facility with different care settings. Is the medical record number used for filing sequence (i.e. patient records are filed in numerical sequence based on the medical record number) or is the medical record number only used for purposes of patient identification?
- If the medical record number is used for filing sequence, a separate number should be assigned to each of the different care settings, such as a separate medical record number for the SNF stay and a separate medical record number for the Assisted Living stay. On readmission to either the SNF or AL, the number originally assigned in that setting would be used again.
- If the medical record number is used only for patient identification, the facility may want to consider assigning a single medical record number to be used for records created in any of the different care settings, issuing in essence a “campus” number. A modifier may be used to indicate the specific care setting to which the patient is being admitted. For example, if the resident is being admitted to the Assisted Living portion of the facility, the suffix “AL” may be added to the number to designate the Assisted Living stay, creating the number 1234(AL).

Special considerations for multi-facility organizations:

Accurate identification of customers being served, the frequency of customer use of specific services, and the profitability of such services are strong motivators for corporations to consider adoption of an enterprise identifier. An enterprise identifier is the primary identifier used by the corporation to identify the resident across facilities in the enterprise. It is used at the corporate level to link and identify residents, while the medical record number is still used for identification at the facility level.
General:
Electronic systems should provide fields for medical record numbers that are of adequate length and type (i.e. alphanumeric vs numeric only) to support the numbering convention of the facility. If the system cannot support existing numbering conventions and a new numbering system is initiated, the facility will have to cross-reference the new number on the master patient index and the resident’s medical record folders.

Electronic systems should also have the ability to automatically assign sequential numbers for new admissions and search for prior admissions of the resident to the facility. It is important to remember that the system can only search for prior admissions based on the data available. It may still be necessary to search the manual patient master index for prior admission status if the system data base is of a limited timeframe.

Finally, electronic systems should support collection of demographic information and pre-admission assessments prior to resident admission to the facility. Such pre-admission information should be distinct from “resident” information and would not be associated with a medical record number until such time as the resident is admitted to the facility.

Enterprise Identifiers:
Use of enterprise identifiers requires all facilities to search the corporate database for previous admissions to avoid assigning more that one number to a resident previously admitted within the organization. Effective use of enterprise identifiers hinges on accurate identification of the resident to avoid duplicate, overlap, or overlay entries in the corporate database. The matching algorithm used to determine if the resident exists in the corporate database is critical to avoiding errors in assignment of identifiers. Three types of algorithms are currently available: deterministic, rules-based, and probabilistic. These concepts are discussed in detail in the AHIMA Practice Brief Building an Enterprise Master Person Index from January 2004.

Maintaining Records in a Continuum of Care

For healthcare campuses or continuums it is recommended that separate records are maintained for each of the different care settings. For example, a separate record is maintained for assisted living, one for the NF/SNF, another for home care, a record for outpatients, etc. Creation of a new record is not recommended when a resident changes levels of care within the nursing home, i.e. moves from SNF to NF.

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 ensure continuity of care. Include copies of relevant documentation to facilitate the assessment and care planning process.

Health information staff should be responsible for record management. This includes creation, maintenance, storage, retention, and destruction of the medical records maintained by the campus. The assignment of responsibility helps to ensure 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 or some other mechanism to link all paper, electronic and hybrid records to the resident.

Electronic systems should have the ability to maintain a campus-wide patient master index.

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 types 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. (see Section 4.1 overview)
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. Products are available for cleaning/disinfecting the chart holders (binders). Cleaning is recommended periodically during the stay and upon discharge.

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.

In hybrid or electronic record environments, procedures must be clearly defined regarding how staff are to handle interruptions in the ability to electronically chart due to situations such as power failure or system failure. Issues to address include:

- Is manual charting created during the time the system is down
- If manual charting is created, is it maintained as part of the legal health record
- Is manual charting replicated as a “copy” in the electronic documentation once the system is accessible
- What type of notation is made in the electronic documentation to identify any manual charting created during the system down time.

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

From a legal perspective, each page or individual documents (i.e. shingled telephone order) 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 resident name and number should be placed on both sides of a two-sided form/page because records are frequently copied. Identification information appearing on both sides of a form helps to ensure that the copy is not lost or misplaced. If the back of the form is blank, no identification information is required on the blank side. There should not be documentation on the back of a one-sided form. If, for any reason, documentation is placed on the back of a one-sided form, a label or identifying information must be added and any blank space on the form lined or X’d out to prevent further documentation that may be out of sequence.

Resident identification information can be noted on forms by methods such as writing on the page in permanent ink, stamping by an addressograph, or affixing a printed or manually completed label. Regardless of the method used, identification information should not obscure any content on the form. Resident specific documents printed from a computer system to be filed in the medical record, such as physician orders, care plans, etc., should include resident identification information on each page.

In electronic or hybrid environments, it is important that core resident identification information appear on each screen view of the resident’s clinical information as well as on each page of hard copy output. Again, at a minimum, both the resident name and medical record number should be present.

Common Forms and Thinning Guidelines

HIM STANDARD:
The healthcare organization has a policy that establishes a uniform chart order for health records.

This section outlines common forms found in a long term care record and provides guidelines for thinning the record contents. While form titles listed and the location of the forms in the record may differ from facility practice, the thinning guideline would remain appropriate for the type of documentation identified.

Thinning the medical record is a process of removing documents 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 profession. Federal regulations at 42 C.F.R. § 483.75 (l)(5) require that clinical records 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. Some states may have specific regulations that address what can be thinned from the active record. 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
Section 4.3.6 presents information on considerations related to leaving records “open” versus “closing” records when a resident has been temporarily discharged (such as for hospitalization) and return to the facility is anticipated. If a facility has established a policy to leave the record “open” during temporary discharge, then they will also need to identify practices for thinning of documents such as old admission forms or advance directives from the record which is being continued following readmission.

In a hybrid record, thinning will only apply to documents identified for inclusion in the paper medical record. Electronically stored forms, documents, and information must be retained and accessible as needed for providing care, quality review, survey, etc. The facility needs to have a thorough understanding of any processes for automatically archiving data that have been built into their clinical information system, as well as processes for retrieving the archival information. All components of an electronic record need to reside on the system in accordance with facility retention guidelines.

Clinical information in the electronic system may not be presented in the same format as the hard copy record. In an electronic record, data elements will be sorted and pulled to populate a variety of views, forms or reports. It will become more important to identify data elements that are common to a variety of reports. Duplicative entry of data elements should be eliminated as the database or data dictionary is built and accessible.

**Integrating Hospital Documents into the Long Term Care Record**

Records from a hospital or other healthcare provider (i.e., another LTC facility) 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 active medical record. All other documents sent (copies of progress notes, labs, consults, etc.) should be kept in the active record for 1 month 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 are part of the facility record. 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.

While the federal conditions of participation do not require LTC facilities to obtain a resident History & Physical (see Section 6.8.4), many times state licensure rules or facility policy impose this requirement. A copy of the history and physical from the hospital is commonly accepted as the history and physical on admission to a LTC facility. If the hospital physician is also the attending physician, the hospital H&P should be kept in the active record for 1 month 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 are part of the facility record. 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.

As with paper copies of hospital documents, electronic documents provided upon transfer from the hospital will need to be integrated into the resident’s record. If the legal health record is paper based, the electronic documents should be printed and filed in the record as discussed above. If the legal health record is in electronic format, the electronic information from the hospital should be integrated in a manner such that the source is clearly identified, but the information is retrieved, archived, and destroyed as part of the resident record.

**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 calendar for thinning Only documents that are signed and complete are thinned.

Once the record has been thinned, a notation may 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.

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 for required types and content of documentation and the associated regulatory reference.
| COMMON CHART FORM* | RECOMMENDED THINNING GUIDELINE  
(State Regulations May Be More Stringent And Supersede These Guidelines)** |
|-------------------|-------------------------------------------------------------------------------------------------|
| Identification and Admission Documentation | Current Facesheet  
Most Current  
3 months after admission  
Financial/Administrative file  
Permanent |
- Admission Record/Facesheet  
- Pre-admission Screening (PASARR)  
- Preadmission Assessment/Intake  
- Admission Agreement (new agreement not required on readmission after temporary discharge with return anticipated)  
- Admission Consent |
| History and Physical and Hospital Records | Most Current  
Most Current  
Last Hospital Stay  
Retain pertinent records for 1 month after hospitalization & then thin  
Permanent |
- H&P  
- Hospital Discharge Summary  
- Hospital Transfer Form  
- Other Hospital Records  
(All hospital records received should be retained as part of the facility clinical record)  
- Immunization Records |
| Advance Directives/Legal Documents | Most Current  
Most Current  
Most Current  
Most Current  
Most Current  
Most Current  
Most Current  
Most Current  
Most Current  
Permanent |
- CPR Directive  
- DNR Order from physician  
- Resident Self Determination Act Acknowledgement.  
- Living will  
- Advance Directive  
- Durable Power of Attorney  
- Guardianship/Conservator  
- Legal incapacitation  
- Consents, Acknowledgements  
(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) |
| Clinical Assessments  
(At a minimum, retain most recent assessment plus one previous) | 6 months to 1 year  
6 months to 1 year  
6 months to 1 year  
6 months to 1 year  
6 months to 1 year  
6 months to 1 year |
- Nursing Assessment  
- Wound and Skin Assessments  
- Fall Assessment  
- Bowel and Bladder Assessment  
- Pain Assessment  
- Mini-Mental/Cognitive Exam  
- Restraint Assessment |
| Minimum Data Set and Care Plan | 15 months readily available  
Current care plan  
Current plan  
Current plan |
- MDS  
- Care plan  
- Specialty Care Plans ie: hospice/dialysis  
- Care Plan Signature Records (if used)  
- Care plan recap (if used) |
| Physicians Orders | 3 months  
3 months  
3 months |
- Monthly Recaps or Renewals  
- Telephone Orders  
- Interim orders |
| Protocols or Standing Order Policies (if used) | Current |
| Fax Orders | 3 months |
| **Physician and Professional Progress Notes/Consults** | | |
| Physician Progress Notes | 1 year |
| Cumulative Problem/Diagnosis List | Most recent |
| Annual Exams | Most recent |
| Other specialists/consultation | 1 year |
| Dental Progress Notes/Exams | 1 year |
| Podiatry Progress Notes/Exams | 1 year |
| Psychological Evaluation | Current |
| **Nursing Notes/Interdisciplinary Notes** | | |
| Nursing Notes or Interdisciplinary Notes | 3 months |
| Nursing Summary Forms/Flowsheets | 6 months |
| **Medication, Treatment and Other Flowsheets** | | |
| Monthly Medication and Treatment Records | 3 months |
| Vitals Sign Record | 1 year |
| Weights Record | 1 year |
| Intake and Output Records | 3 months |
| Behavior Monitoring Records | 3 months |
| Other Flow Sheets (Diabetic site rotation, etc) Pharmacist/Drug Reviews Recommendations | 3 months |
| **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 |
| **Activities (Therapeutic Recreation)** | | |
| Progress notes | 6 months to 1 year |
| Assessments | Most Recent |
| **Dietary (Nutrition Services)** | | |
| Progress notes | 6 months to 1 year |
| Assessments | Most Recent |
| **Social Service** | | |
| History | Permanent |
| Progress notes | 6 months to 1 year |
| Assessments | Most Recent |
| **HIPAA Documents** | | |
| HIPAA Requests | Most Current |
| Accounting of Disclosures (if applicable) | Most Current |
| Requests for Amendment | Most Current |
| Requests for Alternative Communication | Most Current |
| Requests for Restriction of Access to PHI | Most Current |
| HIPAA Complaints | Most Current |
| Request to Opt Out of NPP practices | Most Current |
| Authorization to Use and/or Disclose Protected Health | Most Current |
Information

<table>
<thead>
<tr>
<th>Miscellaneous/Legal</th>
<th>Most Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clothing list or Inventory List (If required)</td>
<td></td>
</tr>
</tbody>
</table>

*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.

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 assembly 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 thinned charts). Tabs will make retrieval and filing of documents easier.
- Contents of 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 has been considered the gold standard, but reverse chronological order has now become more widely used and can save a considerable amount of time by eliminating the need to reverse the order of the documents when thinning or closing the record. If reverse chronological order is adopted, the chart order remains the same for active, thinned and discharged/closed records. Either method is acceptable but the facility must define in a policy which of the methods will be used and consistently apply that method.
- Overflow records should be filed alphabetically by resident last name.

**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.

Maintaining a "Soft Chart" or "Shadow Record" and Other Types of Records

Soft charts are resident-specific records maintained by a discipline that contain extra notes, observations and copies of documentation kept in the medical record. This record is not usually integrated with the resident’s legal medical record. The soft chart is often a working duplicate of the medical record but may also contain information that should be in the legal medical record, but is documented in the soft record and never transferred to the legal record.

Soft charts are discouraged. The facility is put at legal risk because a soft record is discoverable in a legal process and could contain contradictory or damaging information. There is potentially a loss of critical information when information is documented in the soft record and never transferred to the legal medical record.

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 ensure that the records are physically secure such as retaining information in locked file cabinets with access by limited staff.
- Develop policies to address the confidentiality of information and documents contained in the record.
- Identify these records on the retention and destruction schedules.
Social Service and Financial Files:
Separate social service and financial files are commonly maintained by long term care facilities. Both of these types of records are acceptable. They contain information that is highly sensitive and often not related to resident care. If your facility uses separate files for these two areas, develop policies 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 and not accessible to other care providers. Policies should also 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.

Communication Records/Shift Worksheets
In a hybrid record, consideration should be given to which staff members have a need for access to different areas within the electronic record. If identified in the development stages, it is easier to identify safeguards that can be built into the electronic portions of the record to deny access based on assigned responsibilities. Access levels can be assigned based on these responsibilities.

In preparing for the electronic record, team members should also consider the possibility of built in “alerts” and “task lists” that can be automatically generated to specific employees. This will enable information to be shared in real time. When possible, entry of information into a specific area should generate or enable the author to generate information to others affected by the action. For example, when a new admission is received, an alert should go to dietary so that they can prepare for the resident’s integration into the nutritional system and plan to include the resident in the meals going forward.

Outpatient Records and Records Maintained by Vendors
In a hybrid record, electronic records maintained by therapy providers must be addressed in facility policies and procedures and the procedures clearly defined for use of electronic signatures.

In the electronic environment, data entry could be mapped to provide pertinent information to all appropriate areas within the electronic record.

Forms Control Processes

HIM STANDARD:
• A procedure has been established to address issues related to the establishment and completion of all health record forms and data entry screens.

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:

• Title, index, and maintain a master of each form.
• Review and approve new forms. New forms should be reviewed for:
  o Content,
  o Potential duplication of information already being captured in another area or form, and
Inclusion of basic identification information on all pages of form: Title of form, resident name, medical record number, page numbers (page x of y) if applicable, form control number if applicable, and revision date.

- Format appropriate for type of chart holder used (i.e. when form is placed in chart holder, information is not presented upside down)
- Review and approve revisions to forms.
- Identify forms which should be deleted or inactivated and ensure that the form is no longer available for use.

In the hybrid environment, the forms committee will still function in the same manner as mentioned in the paper record, but it will also begin to take on the responsibility of guiding the process of building and maintaining the data dictionary to eliminate duplication of entries and appropriate mapping to documents and forms. As facilities move closer to a totally electronic record, the forms committee will transition into this new responsibility.

Note: Also take responsibility for screen design, customized views, report output, understand user interaction with the system.
The content, completion, timeliness and accuracy of medical record documentation has a direct impact on the evaluation of the quality of assessment, planning and delivery of quality services. Documentation has a universal effect on organizational operation, evaluation of care and services, compliance, reimbursement, and survey compliance. 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 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. Some of the alerts and quality assurance monitors may be included in the clinical and administrative software used. The quality monitoring process will focus on the combination of using manual and computerized clinical and billing data as well as standards/requirements.

Establishing the qualitative and quantitative monitoring process is expected to be tailored to the facility, their needs, the services they provide, workflow issues at the facility, survey findings and overall management of the facility. The monitoring process will not remain static but will move from focus to focus based on the Quality Assurance model of the facility.

**Internal Qualitative vs. Quantitative Audits and Monitoring**

There are various types of audits/monitoring systems – qualitative, quantitative and self-monitoring including manual and automated methods. 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 adhere to the standards of practice, qualitative resident care protocols both internal and those prescribed by the regulatory agencies. Qualitative protocols include increased knowledge and skills of the reviewer to evaluate documentation that focuses on the clinical practice and standards. The results or findings from the qualitative monitoring provide the data for quality assurance reviews of the quality of care in relationship to the standards, clinical practices and the regulatory requirements.

Facility staff can be trained and internal systems can be established for self-monitoring to complete quantitative audits which focus on whether a document is complete (all sections of a form), authenticated, or timely. This type of audit is more objective than a qualitative audit.

Increased **self–reliance and self-monitoring** is within the reach of the clinical staff documenting using the following methods:

1. Self-auditing, before you put the pen down look for those clinical interventions, observations or assessment that would demonstrate the quality of care you just provided or planning for the future
2. Look at the automated edits or warning/alerts for inconsistencies of documentation based on the software criteria
3. Set an expectation to periodically run reports to identify areas of deficiencies or information to evaluate the documentation, examples, un-noted orders report, alerts for individuals – to check against the charting planned or just completed
4. Establish shift to shift or person to person monitoring of documentation with a “sign-off” either manual/or electronic to indicate self-monitoring. Some examples are medication and treatment, ADL monitoring, “

On an on-going basis, facilities should have quantitative and qualitative monitoring in place to assure complete and timely records. Admission, concurrent and discharge record monitoring assures that analysis is completed throughout the residents stay. The goal to continuous monitoring throughout a residents 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 documentation problems when it can still impact the resident during their stay while maintaining the integrity of the medical record. 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. Signatures for manual systems shall meet the requirements for a full signature, initials that are referenced by the clinician’s full name including title or via the use of an electronic signature that is defined by the eHR standards.

**External Qualitative and Quantitative Audits**

Audits of health record information may be performed for the licensing and certification process, for legal reviews from licensing boards and for billing reviews.

**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 document on a similar issue.
- Documentation that is missing key elements for the proper assessment or planning of a problem.
- 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 and quantitative analysis of the documentation content of the medical record, identify potential workflow issues and provide feedback and suggestions for resolution.

**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 monthly/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 Quality Assurance process should incorporate the findings into their overall quality management program.

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

<table>
<thead>
<tr>
<th><strong>Quantitative Monitoring</strong></th>
<th><strong>Qualitative Monitoring</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admit/Return first 24 hours</strong></td>
<td><strong>Physician Orders:</strong></td>
</tr>
<tr>
<td>- Consent to Treatment signed on admission</td>
<td>- Legible</td>
</tr>
<tr>
<td>- Transfer Form or Order to Admit Received.</td>
<td>- Follow standards of practice</td>
</tr>
<tr>
<td>- Admission orders transcribed accurately from transfer form.</td>
<td>- Abbreviations on approved list</td>
</tr>
<tr>
<td>- All orders required per facility policy are verified or clarified by the attending physician notified.</td>
<td>- Orders not in conflict</td>
</tr>
<tr>
<td>- If transfer form not signed by physician,</td>
<td>- Labs ordered for appropriate screening of specific drugs</td>
</tr>
</tbody>
</table>
orders are verified by telephone or fax order.
- A diagnosis or reason is identified for admission i.e., diagnosis supports the medical necessity of admission and the billing requirements, each medication, ancillary service, and treatment with billable supplies that are ordered. (Diagnosis in text of order, on diagnosis list, or through supporting physician documentation).
- Orders are transcribed accurately to MAR and TAR.
- All medication orders include the name of the med, dose, frequency, route, and if appropriate the duration. PRN orders should include reasons for administration.
- Admission orders are signed and noted by a nurse as appropriate in accordance with facility procedure.
- An initial nursing assessment/admission note is completed to include i.e., time of admission, how resident was admitted, condition of resident, assessment of major body systems, skin, pain
- Care plan is initiated including primary reason for admission or immediate needs, diet and nursing care.
- Initial Medicare Certification is completed if applicable.
- Allergies are identified and checked for consistency among all the documents.
- Discharge plan is initiated if applicable (i.e. as required by Joint Commission Accreditation).

<table>
<thead>
<tr>
<th>Admit/Return 24 – 48 hours</th>
<th>Primary reason for admission, is identified at the time of admission, with initial care plan that reflects those conditions, alerts and risk factors are clear with monitoring at the time of admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face sheet or demographic information on record.</td>
<td></td>
</tr>
<tr>
<td>Admit – Consent to Treat signed on admission.</td>
<td></td>
</tr>
<tr>
<td>H&amp;P and Discharge summary requested from hospital if applicable if not sent with resident.</td>
<td></td>
</tr>
<tr>
<td>If H&amp;P not completed prior to admission, an exam is scheduled per state requirements. Resident capacity identified.</td>
<td></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>
<td></td>
</tr>
<tr>
<td>Inventory of personal effects is completed if applicable.</td>
<td></td>
</tr>
<tr>
<td>Nursing Assessments completed or updated and others assessments required per facility policy are completed immediately upon admission</td>
<td></td>
</tr>
</tbody>
</table>
admission are complete, timely and authenticated. (No missed sections or questions on the assessment without explanation). Note: A Nursing Assessment may be started on admission and completed within 24 hours.

- Admission vital signs, height, and weight are documented.
- Admission paperwork such as consents, consent to treat, privacy statement acknowledgement, bill of rights 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. Complete an initial assessment the use of the restraint and a determination made for the time of re-review. Informed consent has been obtained from the resident or their representative.
- Diagnosis list/other method of diagnosis identification have been started and accurate ICD codes assigned consistent with reason for admission/Medicare.
- 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 assessments 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 plan of treatment/evaluation has been initiated no later than 48 hours. Physician orders have been clarified to include the specific therapy
<table>
<thead>
<tr>
<th>Admit/Return 14-21 days</th>
<th>plan. Diagnoses used for therapy used are identified and consistent with reason for admission/Medicare, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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. This can be accomplished by a self-completion manual document and/or tracked in the eHR with reports provided</td>
</tr>
<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>
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<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>
<tr>
<td>RAI Process</td>
<td>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).</td>
</tr>
<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>When a computer print-out of the MDS is placed in the chart, the signature dates should reflect the date the staff actually completed the sections of the MDS, not the print-out date. If a hand-written version of the MDS is used as an input tool, it is retained in the thin chart.</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</td>
</tr>
<tr>
<td></td>
<td>The supporting documentation in the medical record is consistent with the MDS scoring.</td>
</tr>
<tr>
<td></td>
<td>The RAP note/documentation addresses the following: nature of the condition, complications and risk factors that affect the decision to proceed to care planning, factors that must be considered in developing individualized care plan interventions, need for referrals, whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem identified</td>
</tr>
<tr>
<td></td>
<td>Verify latest version of MDS software updated per maintenance contract, staff trained</td>
</tr>
</tbody>
</table>
days between R2b dates, and annual no more than 366 days from last annual VB2 date).

- Date in VB3 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.

**Significant Change**

- If possible significant change note indicates monitoring to determine need for Full MDS or reason for no new MDS
- Significant change assessment completed within 14 days after significant change in status is noted.
- Basic tracking form completed, signed, dated
- Care Plan Updated

**Readmissions**

- Readmission/Return and Discharge Tracking forms are completed within 7 days of the event.
- Previous face sheet copied and left on prior record, original brought forward to readmission record
- New MDS if significant change is noted upon readmission, if no significant change, same MDS continues
- Significant change Permanent – Full MDS completed within 14 days.
- Previous 15 months MDS copied and brought forward (or may be maintained electronically)

**Abbreviated Assessment**

- Used only for PPS/MDS Assessment
- If admission assessment box is checked (Section A8a), abbreviated assessment for not used.

**MDS Corrections**

- Significant error, correction form completed
- Code 4 entered in AA8a of Correction form
- Printed, signed, dated copy of correction form attached to front of appropriate MDS/Tracking forms
- RAP Triggers recalculated
- Incorrect MDS manually corrected/corrections dated, signed.
- Care Plan updated to reflect changes
- Corrected MDS documents are called to the attention of the business office to assure that adjustment bills are completed if necessary
The validation report is reviewed after each submission and appropriate follow-up is conducted to address errors.

**Concurrent or Quarterly**

- 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.
- Diagnosis List Updated And Coded: Check if new diagnoses have been written on the diagnosis list. Check physicians 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.
- RAI Process: See RAI Audit Criteria
- 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 either updated or rewritten or reprinted if there are too many changes and it is difficult to read/use.
- 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.
- Restorative Program (if applicable): actual treatment time is documented for rehab nursing service delivery record, an assessment has been completed. Progress notes reflect residents status and progress. The care plan reflects restorative program and goals.
- Nursing Documentation: Nurses notes are signed and dated changes in condition i.e., incidents/falls, new behavioral manifestation, new skin condition, condition requiring antibiotics; to include a description of the condition, update of the CP if indicated and documented follow up, ongoing observations re: conditions identified on the CP, and supporting documentation for Medicare coverage completed. Weekly/monthly summary or case mix charting completed as applicable.
- Physician Orders – Renewals: Physician has signed and dated the renewals in the specified timeframe (?) Orders did not expire before check.
- Care Plan Content: All RAPs indicated to proceed to the care plan are addressed on the care plan. Goals are measurable and objective.
- Care Plan and interventions that match the needs of the resident are initiated on admission for the primary reason/s for admission and those high risk areas based on the assessment findings.
- Charting reflects the care plan
- Restorative Program: Progress notes reflect residents status and progress. The care plan reflects restorative program and goals.
- Med/Tx records; if documentation incomplete, the passing of medication/treatment process is an issue. Implement self-monitoring. Develop policies and procedures/tools to accomplish the self monitoring. Pharmacy Committee monitors progress from Pharmacist review.
- The lab results are followed up with the physician to assure orders applicable to the lab results
- Social Services notes reflect evaluation of behavioral issues; follow up on Hx, input from family, visits with resident and social intervention on care plan.
- Dietary/Nutrition percentage evaluated, labs followed up, weights considered, skin condition considered, care plan reflects current resident status.
- Activity documentation reflects resident’s interest from assessment, participation alternation trials if not involved, recognizes behavioral manifestations and plan activities accordingly.
being resigned. Nursing noted orders upon return per facility policy.

- Telephone and Fax Orders: All telephone orders are complete, signed and dated. All original telephone orders have been returned within the appropriate timeframe. All orders given by a physician have a corresponding signed order (TO, fax order, signed physician referral, etc.).

- Physical Restraints: If ordered, current assessment completed, informed consent documented, order matches device in use. Documentation includes alternatives tried before restraint used.

- Psychotropic, Antipsychotic, Antidepressant, Hypnotic medication Monitoring: If ordered, monitoring assessments completed, signed and authenticated. Side effect monitoring completed. Dose reduction documentation or justification on record.

- 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.

- 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, and psychological services are in record when applicable. Physician progress notes reference diagnosis/condition that support medical necessity of admission, principal care/services; and support the evaluation and management current procedural terminology code (CPT). Consults are related to a diagnosis/condition for referral, report includes recommendations that are followed up.

- Vital Sign Records: Vitals completed and recorded in a timeframe consistent with facility policy and state regulation where 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. Referrals are made to dietary and physician. Action follow up. CP reviewed/updated, progress review follow up
on weight also evaluate consistent increase/decrease.

- Medication and Treatment Record: Look for open holes on the MAR/TARs before end of each shift. PRN records signed, reason and result documented. Other flowsheets are complete. If deficiencies found, self monitoring established. Staff is scheduled to complete their documentation and provide self-monitoring systems.

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
Resident Transferred to ER or Acute

- Gather all loose forms, collect the medical record and place in a location that is secure and unavailable for current charting.
- Review the record for completeness of the final transfer note/inter-facility transfer report, current status of the resident at the time of transfer, follow up as needed.
- Check for signatures, time, completeness of the medical record and all loose forms, i.e., ADL sheets, medication/treatment records, therapy records, etc.
- Note: A new record may or may not be initiated on return from the acute hospital. If the resident returns from the Emergency Room the same record will be continued.
- Assure the record is intact.
- Secure the record in a location that is not available to staff who are taking care of current residents.
- Identify how the electronic record is “checked out” when the resident is out to the ER or short term admission to an acute hospital.

Discharge Analysis

- Chart in 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 discharged.
- Physician Discharge Summary completed if required by State law. Physician discharge summary may reference the Interdisciplinary Discharge Summary and Plan of Care; signed by the physician and includes the final diagnosis and prognosis initiated by facility staff. Physician completed, signed and returned within 30 days of discharge unless other timeframe required by State law.
- Discharge Order: Discharge order obtained on 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 / TO’s: All renewals have been returned and signed All TOs have been returned and signed. Facility policy should define how to handle orders that have not
- Qualitatively and for time saving reasons, consider filing manual discharge record in the same order as the inhouse record. For automated records, identify via a slip sheet in the manual record those “record in transition” see the eHR for “specific documentation and specify
been returned.

- Discharge documentation: There is documentation of events leading to discharge or death. Nurse wrote a note at the time of discharge. The note leading to discharge/death includes assessment, observations, intervention and detailed documentation of nursing process that lead to death/discharge (as applicable).
- 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.
- DC 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.

<table>
<thead>
<tr>
<th>Privacy and Security</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Is PHI protected?</td>
<td></td>
</tr>
<tr>
<td>Are destruction processes being followed?</td>
<td></td>
</tr>
<tr>
<td>Is the health record signout process used?</td>
<td></td>
</tr>
<tr>
<td>Are the residents provided with the Notice of Privacy practices on admission?</td>
<td></td>
</tr>
<tr>
<td>Are resident privacy practices available upon request?</td>
<td></td>
</tr>
<tr>
<td>Are computer system precautions in place to prevent inappropriate sharing of PHI?</td>
<td></td>
</tr>
<tr>
<td>Have all employees completed HIPAA training?</td>
<td></td>
</tr>
<tr>
<td>Have all volunteers completed HIPAA training?</td>
<td></td>
</tr>
<tr>
<td>Automated records are available only to staff identified and have access by the Privacy &amp; Security grid.</td>
<td></td>
</tr>
</tbody>
</table>

**Focus Audits and Monitoring Systems**

There are other beneficial audit and monitoring systems, many of which should be in place on an ongoing 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>Acute Problems/24 Hour Board</td>
<td>Review the 24 hour log, Nursing identify new orders via computer, alert log or other system reflective of the computer system. For each resident and problem identified check to see if corresponding</td>
</tr>
<tr>
<td></td>
<td>Not only verify that the documentation was done, but also analyze what was documented based on the condition. Does a note contain</td>
</tr>
<tr>
<td>Description</td>
<td>Information</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Documentation</td>
<td>Documentation was completed such as nurses note, monitoring record, physician, family, resident notifications, CP upgrade, etc.</td>
</tr>
<tr>
<td>Weights</td>
<td>Implement an on-going monitoring system when weights are recorded to note significant weight loss changes or there is a trend over time.</td>
</tr>
<tr>
<td>Physician Visits</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>Physician Orders</td>
<td>Reviewed and signed by the physician within specified time frame (30 or 60 days).</td>
</tr>
<tr>
<td>MAR/TAR</td>
<td>Documentation completed at time of administration or within 24 hours if documentation omission occurs.</td>
</tr>
<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>
</tr>
<tr>
<td>Skin/Pressure Sore</td>
<td>Assessment completed and reviewed/updated weekly until healed.</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. Consent obtained from resident or responsible party.</td>
</tr>
<tr>
<td>Lab Result Monitoring</td>
<td>Results of physician orders for all labs are in the medical record.</td>
</tr>
</tbody>
</table>

### 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 (QA) 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, causation factors identified, system evaluated, 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.

### Role of HIM on the Quality Committee

HIM staff should be a permanent member of the Quality Committee responsible to routinely present results of qualitative and quantitative documentation audits and trending reports of the results. HIM may lead the quality function.

It is critical that the health information coordinator/manager actively participates in the Quality Assurance Committee and process. 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.

Other duties of HIM staff on the Quality Committee are listed as follows:

- Report lost records or portions (hard copy); automation/electronic record breech.
- Recommend filing of incomplete records and electronic record quality assurance processes according to federal and state regulations and policy and procedures.
- Lead quality improvement teams.
- Participate as a member in quality improvement teams.
- Complete compliance audits as necessary.
- Complete state survey plan of current audits as necessary.
- Present the quality monitoring schedule for the year and revised as priorities indicate.
- Participate in writing state survey plans of correction as appropriate.
- Track and trend incomplete documentation.

**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 timeframe 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.

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.

**Auditing the Electronic Health Record**

When transitioning from a paper record to a hybrid record (part paper, part electronic) to an electronic record (paperless), care must be taken to carefully plan an electronic record keeping system that permits performance improvement monitoring as part of an overall system that also supports performance of other required HIM functions. The Health Information Consultant and designee should be involved throughout the planning process to give practical input from an HIM standpoint. Many of the audits can be used to determine edits and alerts within the documentation system.

When you already have an EHR or partial EHR (or if you are planning an EHR) the following should be considered:

- What are the outcomes or expectations from the facility for monitoring documentation?
- Determine which data elements that match the quality indicators and the criteria for evaluating each of these items.
- What reports do you now have and what reports can be written?
- If an error is found in the EHR how do you correct? How do you flag, close, amend and append information. Example: Entered in error and reference the document, date and time.
- Error reports are prepared for follow up; what, who.
- Assignment of follow up and monitoring, correction process in place.
- Method of electronic signatures, what system will be used?
- Will you use an EHR from a computer based system, integration of a document management system, downloading documents such as word/excel, faxed and other documents from other organizations.
- How will you identify records in a variety of databases, can these databases be integrated or do you need to go to different programs to find the information.
- Data entry vs. double entry. When do you have this occur? Consider getting different modules of different systems integrated vs. replacing an entire system.
- Is it possible to redesign forms that eliminate some narrative charting using check boxes instead? Could part or all of a qualitative audit be done using edits or alerts for some parts of the record?
- Audit trail of which entered data vs. the access/security grid identifies the persons who access or enter data are equal to the
Identify tables, menus that can be modified both for documentation and for monitoring.

Reminders, calendaring, assignments, use any notifications that are in the system, look at notifications when the staff sign on if something is due, saves auditing.

Protocols established for documentation, ask questions re: areas not completed that are high priority are identified as required fields/data.

Can quantitative audits be done by using a series of edits? For example, when a signature is missing on a med sheet, when the nurse attempts to sign off at the end of the shift an error report is created prompting to go back and correct the omission.

Can reports be created using electronic auditing that could also be used to trend data suitable for use in the QI process?

As parts of the record change from paper to electronic format, so should the policies and procedures relating to documentation monitoring. The health information consultant and health information designee will need to be trained on how to access information for auditing and their computer access privileges and restrictions updated to reflect the process changes as the record becomes entirely paperless.

**External Audits**

Preparation is the key to having a successful outcome to an external audit. Skilled Nursing Facilities are or may be subject to a number of audits by outside agencies including Licensing and Certification, the OIG (for Corporate Compliance and HIPAA Privacy enforcement), CMS (for HIPAA Security enforcement), a Fiscal Intermediary or other Insurer (Medical review to support billing) or perhaps by the facility’s corporation for compliance reviews.

1. Use a team effort to prepare your responses to each type of review. Knowing what documentation will be needed, where to get it and how to present it to the surveyor or auditor is critical. Training staff on what to retrieve and how to retrieve and presenting it to the surveyor or auditor is an important part of managing the survey or audit process.
   - Use screen prints to provide instructions on how to retrieve electronic data and how to locate other types of data.
   - Train a number of staff members on how to work with a surveyor or auditor in order to make the process as smooth as possible.

2. Use your annual survey, quality indicators, corporate compliance surveys, Quality Assurance Data, monitor trending results, Consultant Reports and Medical Review (Billing) Request Log, etc. to guide you in determining what your problems have been in the past, what your plans of corrections were and what progress you have made in correcting those issues.

3. Use a survey preparation checklist to make sure that all required documentation is ready for the survey entrance conference.
   - The HIM Department may be responsible for printing the HCFA-802 Resident Roster/Sample Matrix and the HCFA-672 Resident Census and Conditions. The HIM Director as well as at least one other designated person should be familiar with how to produce these reports on demand.
   - Have a matrix of which forms are maintained electronically and which are on paper when using a hybrid record. The chart should have a notation that specific documentation is maintained electronically.
   - Certificates of destruction of records and DHS permission to file records offsite should be available.
   - The HIM Policy and Procedure Manual should be available and up to date.

4. Develop a grid that lists the types of possible audits or surveys, a listing of what supporting documentation will be required during the survey or audit and a reference to the location of that documentation.

**Discharge Record Processing**

**HIM Standard:**

- The healthcare organization’s and health information management’s service, whether health records are paper based, hybrid or fully electronic, policies and procedures comply with federal and state regulations and accepted standards of practice to ensure records are accurate, complete and systematically organized.

- The healthcare organization’s and health information management’s service, whether health records are paper based, hybrid or fully electronic, policies and procedures comply with federal and state regulations and accepted standards of practice to ensure records are protected against loss, destruction and unauthorized use.

- The health information management service should implement audit and monitoring systems to ensure the health record is complete prior to final record closure and filing of a discharge record.
Discharge Record Processing

Contents

1. Discharge Record Assembly
2. Discharge Record Analysis
3. Timely Completion of a Discharge Record
4. Incomplete and Delinquent Records
5. Maintaining A Control Log for Discharge Records
6. When to Close a Record on Temporary Absence
   i. Closing Records with a Change in Level of Care
   ii. Closing Records with a Payer Change

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 reattined 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.

In maintaining a unit record, the health 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 initial 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. It is advantageous 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 timeframe. A record should be removed from the nursing 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 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:

<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>
</table>

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 tracking form assessment is completed. If it is indicated on the MDS discharge tracking form 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
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 must 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.

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Filing and Retrieval

Contents

1. Separate Location for Incomplete Records
2. Typical Filing Systems
3. Retrieval
4. Filing

HIM STANDARDS:

- The healthcare organization’s and health information management department’s filing systems, whether paper based, hybrid or fully electronic, 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.
- Every long term care facility should have an established a system for filing and retrieving of their health 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.

Retrieval

Paper Based System
During normal business hours requests for thinned or discharged health records should be coordinated through the HIM staff.

It is recommended that a process be in place to track the locations and holders of the health record. This can be accomplished through a record check out system. A reasonable length of time should be identified for which a record can be checked out.

Hybrid or Electronic System
Appropriate access levels should be given based on the needs of the staff member to perform their job. Completed records upon discharge would be locked and only available as read-only. There should be a limited number of staff members with printing capabilities.

After Hours Retrieval – Paper Based System
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.

After Hours Retrieval – Hybrid or Electronic System
If using a hybrid or electronic health record consider if parts of the electronic health record need to be printed during the duration of the stay or upon discharge. This will depend on how the health record is defined within the organization and electronic storage capabilities.

Filing

Paper based system
Filing of all documents that should be part of the complete health record are added to the discharge record, preferably prior to completion. As with the addition of any document to the record, care should be taken to verify the resident name prior to inserting the document in the record.

Hybrid system
The facility policies and procedures should determine which parts of the record will be paper based and which parts are stored in a data repository. This policy should also determine whether or not additional documents should be added as paper based documents or scanned into the data repository. If documents are added to the electronic portion of the record after this has been completed, these should be added as addendums. Refer to section 4.1 Table 1 Legal Source Legend for the hybrid record.

Electronic record
The facility policies and procedures should allow for the capture of additional material for the electronic record through a system of scanning to the file. If the record has been determined to be complete and additional paperwork is discovered, these documents should be added as addendums.

Separate Location for Incomplete Records

Paper Based System
It is recommended that incomplete paper based health 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 responsible for completing records and also provides for easier monitoring of incomplete records.

Hybrid or Electronic System
If the health record is hybrid or fully electronic, it is recommended that a method be developed to flag incomplete records and determine access to such records. Policies and procedures should also be developed to identify how e-signatures will effect your processing. Determine if the vendor can help with automating the deficiency analysis along with ensuring the application can monitor and track, records or document completion.

If using a hybrid or electronic health record consider if parts of the electronic health record need to be printed during the duration of the stay or upon discharge. This will depend on how the health record is defined within the organization and electronic storage capabilities. Refer to section 4.1 Table 1 Legal Source Legend for the hybrid record.

Typical Filing Systems

Paper Based System
There are many acceptable methods for filing health records ranging from the simple (alphabetical to the complex (terminal digit filing). The resident record can also be filed by room number on each unit for active residents. 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 overflow records and discharge records. Overflow records are filed alphabetically, with all forms organized in reverse chronological order based on the facility’s active chart order. Overflow files can be subdivided with chart dividers to facilitate efficient file and retrieval of information. Subdividing the overflow files also enhances record assembly upon discharge.

Discharge records are filed alphabetically by discharge year. This method is commonly used when there is limited space in the
Discharge 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. This method does require some movement of the records to allow for adequate space of filing additional records within the existing system.

Discharge records are filed numerically by health record number by discharge year. Records are filed by health record number in numeric order for a single discharge year. This method offers better security than alphabetic filing because the health record number must be known to a record. Access is more difficult for supervisory staff who must access records when the health information department is closed. 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 health record number when there is more filing space in the health information office.

**Hybrid System**

When a medical record is both paper based and electronic combined, the policies and procedures should reflect the parts of the record stored in each medium. Also, the policies and procedures should reflect which documents should be scanned for inclusion in the electronic portion of the record prior to completion. If a portion of the record is paper based, a reference to the location of the electronic portion should be added to this chart. (Refer to section 4.1 Table 1 - Legal Source Legend for the hybrid record.)

**Electronic Record**

The fully electronic record would be available in a variety of formats. The electronic system should be able to separate the active from the inactive record within the data base.

**Retrieval**

**Paper Based System**

During normal business hours requests for thinned or discharged health records should be coordinated through the HIM staff.

It is recommended that a process be in place to track the locations and holders of the health record. This can be accomplished through a record check out system. A reasonable length of time should be identified for which a record can be checked out.

**Hybrid or Electronic System**

Appropriate access levels should be given based on the needs of the staff member to perform their job. Completed records upon discharge would be locked and only available as read-only. There should be a limited number of staff members with printing capabilities.

**After Hours Retrieval – Paper Based System**

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.

**After Hours Retrieval – Hybrid or Electronic System**

If using a hybrid or electronic health record consider if parts of the electronic health record need to be printed during the duration of the stay or upon discharge. This will depend on how the health record is defined within the organization and electronic storage capabilities.

**Filing**

**Paper based system**

Filing of all documents that should be part of the complete health record are added to the discharge record, preferably prior to
completion. As with the addition of any document to the record, care should be taken to verify the resident name prior to inserting the document in the record.

**Hybrid system**
The facility policies and procedures should determine which parts of the record will be paper based and which parts are stored in a data repository. This policy should also determine whether or not additional documents should be added as paper based documents or scanned into the data repository. If documents are added to the electronic portion of the record after this has been completed, these should be added as addendums. Refer to section 4.1 Table 1 Legal Source Legend for the hybrid record.

**Electronic record**
The facility policies and procedures should allow for the capture of additional material for the electronic record through a system of scanning to the file. If the record has been determined to be complete and additional paperwork is discovered, these documents should be added as addendums.

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Storage Systems

Contents

1. Storage System Options
2. Security Issues: Locking of Office and Storage Areas
3. Alternative Storage Areas

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.
• Storage systems need to address the hardware equipment that operates the electronic information systems. This area may be referred to as the wiring closet, server room etc. Large organizations may refer to this area as the data center. Generally, the servers, cables and other equipment that operate electronic information systems must be stored in a designated area with appropriate physical safeguards and access limited to authorized employees.
• Long term care facilities must invest in adequate storage systems and storage space for their health records and hardware that operate electronic information systems. The storage methods and systems must be secure and protect the confidentiality of resident information maintained both in paper and electronic format. The storage system and space must be adequate to protect the physical integrity of the record and hardware equipment and prevent loss, destruction, and unauthorized use.

Storage System Options

Health record storage systems should be of professional quality to house and protect the health records. Office supply and health 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 systems (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 whenever 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 health 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 health 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 health 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.

**Security Issues: Locking of Office and Storage Areas**

The health information office and storage areas must be kept secure at all times if health 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 is 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 and access to the information processing area.

Storage areas that house the electronic information systems hardware need to have appropriate physical safeguards in place to protect the hardware and prevent unauthorized access. Appropriate physical safeguards may include access controls (locks, token, biometric controls) raised flooring, dry pipe sprinklers, temperature controls and a back-up electrical source/generator.

**Alternative Storage Areas**

When space is not adequate in the health information office to store all discharge health 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 health 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 health 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 company’s responsibility in securing documents, protecting documents from loss or destruction, and outlining how facilities will access the records and the time frame for obtaining records. Additionally, business associate language must be incorporated into the main contract or attached as an addendum. The long term care facility should have a list of all resident health records and other documents retained at the storage company and have mechanism to access those records in an emergency situation.

• **Redundant/Back up Information Sites:** When a redundant electronic information system is utilized, this should be housed in a location that is a reasonable distance away from the primary information processing area. Policies and procedures should address specific positions that may access the storage media, retention time periods for the backed-up information and appropriate destruction practices.

• **Storage of Back-up Media:** If an electronic information system is utilized, the information is generally backed-up on a regular basis. Back up media may include tapes, CDs, diskettes or other some other type of storage medium. Special precautions must be implemented to ensure the safeguarding and availability of storage media.
  - Storage media should be stored at an off-site location or at a different, secure location within the campus.
  - If the media is stored off-site a bonded company should be utilized. An appropriate contract should be obtained and business associate language incorporated into the contract or attached as an addendum. The selected company should be located in a location that is a reasonable distance away from the primary information processing area.

• Policies and procedures should address specific positions that may access the storage media, retention time periods for the backed-up information and appropriate destruction practices.
Retention

Contents

1. Retention Guidelines

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.

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.

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Federal Regulation</th>
<th>State Regulations</th>
<th>AHIMA Recommended Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health 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 (CMS Skilled Nursing Facility Manual – Pub 12)</td>
<td>See Exhibit A AHIMA Practice Brief Table 4: State Laws or Regulations Pertaining to Retention of Health Information</td>
<td>10 years based on False Claims Act (31 USC 3729-3733) Section 3731: Statute of Limitations; a claim of fraud can be made up to 10 years from the date of violation, materials must be made available for inspection which includes financial and health records</td>
</tr>
<tr>
<td>Financial Record</td>
<td>Medicare residents – 5 years after the month the cost report is filed. (CMS Skilled Nursing Facility Manual – Pub 12)</td>
<td>Refer to above recommendation 10 year retention period</td>
<td></td>
</tr>
<tr>
<td>Master Patient Index</td>
<td>Permanent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission/Discharge Register</td>
<td>Permanent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSHA Records/ Employee Medical Records</td>
<td>Duration of employment plus 30 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIPAA Related Documents (i.e. Accounting of Disclosure, Request for Amendment, Requested Restrictions, etc.)</td>
<td>6 years (HIPAA Privacy Rule) or length of record retention if documents kept in the medical record – whichever is longer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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 protected health information stored in paper or electronic format using an acceptable method of destruction after the appropriate retention period.
- Destruction of any record involved in an open investigation, audit or litigation is not permitted.
- The destruction system is designed and implemented to ensure the security and confidentiality of the health records and protected health information being destroyed.

Every long term care facility should have a policy and procedure established to destroy records or confidential documents, whether in paper or electronic format, that are beyond their retention period. Destruction should be done at least annually based on a proper written retention schedule that encompasses federal and state regulations. The policies and procedures and the destruction schedule should demonstrate that records are destroyed in the normal course of business, as consistency and documentation are key components of record management. A destruction program that documents both appropriate retention and destruction of documents protects the facility/organization from legal liability. 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. (See Retention section)

Acceptable Methods of Destruction - Paper-based Records

Paper-based records containing resident-identifiable data must be destroyed in a manner that makes it impossible to reconstruct and read the information. Records and protected health information cannot be disposed of in the garbage containers without some type of shredding or obliteration. Documents awaiting destruction should be housed in secure collection containers, with specific attention to location of the container and the locking capabilities. Acceptable methods used today include shredding, incineration pulping and pulverization.

In addition to the records maintained for a specific retention period, there are other documents that should be destroyed after their usefulness has ended. These secondary or incidental documents include duplicates, carbon copies, misprints, worksheets and documents containing billing statements.

On-Site: The health information management staff should oversee any shredding of documents at the facility. Cross cut shredders have a higher degree of security than strip-shred. Destruction companies do offer on-site services where trucks with industrial shredders come to the facility to perform the service. A business associate agreement with the destruction company should detail the location of the destruction, method of destruction and require proof of destruction.
Off-Site: If the records are destroyed off-site through a destruction company, a business associate agreement should detail the safeguarding practices while the PHI is in transit, time that will elapse between acquisition and destruction, method of destruction and require proof of destruction.

Note: Some states might require notification prior to destruction of health records and also might require the use of only approved destruction companies. Check specific state laws prior to setting up destruction program.

Acceptable Methods of Destruction - Electronic Records and Information:

Like paper-based records, electronically stored resident-identifiable data, such as MDS/RAI, MPI, Dietary, or other documents, must be destroyed in a manner that makes it impossible to reconstruct and read the information. Acceptable methods used today include digital sanitation and physical destruction.

Digital sanitation or overwriting is the most common, cost-effective process for destruction of data without rendering the hard drive useless. Overwriting replaces existing data on a hard drive with meaningless data in such a way that the original data cannot be recovered. (Keating, Angie Singer. “Destroying Data the DoD Way: Military Standards Help Ensure compliance for Electronic Data Security.” *Journal of AHIMA* 76, no.7 (July-August 2005): 54-55.62.)

Degaussing is another destruction method and this uses a process that erases the data by changing the magnetic alignment to random patterns that renders the previous data unrecoverable.

Physical destruction requires damaging the medium so that it is unusable in a computer and the data is no longer retrievable.

Methods of destruction and disposal should be reassessed periodically based on current technology, accepted practices, and the availability of timely and cost-effective destruction/disposal services.

If a service is used for disposal, the vendor should provide a Certificate of Destruction indicating the following:

- Computers and media that were decommissioned have been disposed of in accordance with environmental regulations, as computers and media may contain hazardous materials.
- Data stored on the decommissioned computer or media was destroyed per the previously stated method(s) prior to disposal. (AHIMA Workgroup on Electronic Health Records Management. “The Strategic Importance of Electronic Health Records Management. Appendix A: Issues in Electronic Health Records Management” *Journal of AHIMA* 75, no.9 (October 2004): web extra.)

Computer Data and Media 2

Workstations, laptops, and servers use hard drives to store a wide variety of information. PHI may be stored on a number of areas on a computer hard drive. Simply deleting these files or folders containing this information does not necessarily erase the data.

To ensure that all PHI has been removed, utility software that overwrites (digital sanitation) the entire disks drive must be used. Remember, total data destruction does not occur until the backup tapes have been overwritten.

If the computer is being redeployed internally or disposed of due to obsolescence, the utility software must be run against the computer's hard drive, after which the hard drive may be reformatted and a standard software image loaded on the reformatted drive.

If the computer is being disposed of due to damage and is not possible to run the utility to overwrite the data, then the hard drive must be removed from the computer and physically destroyed.

Other Storage Devices 2

Compact disks, diskettes and backup tapes containing PHI must be shredded, pulverized or otherwise physically destroyed before disposal.
**PDAs**
Any PDA or other electronic device that does not have a hard drive must be reset to factory defaults prior to reuse

**Abstracting Paper Documents and Electronic Data Prior to Discharge**

Unless required by state law it is not necessary to abstract paper documents or electronic data out of the record to retain on a permanent basis. The master patient index and the destruction logs (manual or electronic) contain basic demographic information and are to be retained on a permanent basis.

**Destruction Logs and Witnesses**

Destruction Logs: 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 date information was destroyed. Two types of destruction logs are recommended. These logs should be maintained permanently.

1. **Clinical Record Destruction Log** - When clinical 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 log is a common process used to document the resident's name and the minimal demographic information for records that are destroyed. This log should contain the following information:
   - Resident Name
   - Medical Record Number
   - Admission Date
   - Discharge Date
   - Date of Destruction
   - Method of Destruction
   - Destroyed by
   - Witness

2. **Destruction Log for All Other Types of Documents** - A log should be used to reference when different types of documents were destroyed, when they were destroyed and who they were destroyed by. Some examples of the elements that might be recorded in this log include:
   - Document Name
   - Facility Retention Period
   - Dates Destroyed
   - Method of Destruction
   - Destroyed by
   - Witnesses/Authorization
   - Destruction Date

**Certificate of Destruction** - 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 business associate agreement with the destruction company detailing their procedures, document insurance coverage and their security measures. If the specific items destroyed are not included on the certificate, then the certificate should be linked to this information to create an audit trail. (i.e. type of record destroyed, year, box numbers, etc.) This could be as simple as filing the certificate of destruction with the destruction logs. The certificate of destruction should be maintained permanently.

**Sources:**
AHIMA Practice Brief, “Destruction of Patient Health Information” (updated November 2002).
Inadvertent Destruction of Records

There are two types of situations in which records could be inadvertently destroyed. The first type is natural or man-made disasters, and would include flood, fire, hurricanes, tornadoes and explosions. The second type are provider induced disasters or disasters caused by negligence. Some examples of provider induced disasters are records destroyed by water due to storing the records on the floor, medical records lost or destroyed by computers or records inadvertently thrown away/destroyed.

If records are destroyed in either of the above situations, a risk assessment investigation should be conducted and documented as part of the Quality Assurance Committee which includes information about what caused the destruction and an action plan. See Section 4.8.2 (lost records)

If records requested by The Centers for Medicare & Medicaid Services (CMS) have been destroyed, then there is a procedure established to determine if the circumstances of the destruction was unforeseen and should not count as a “no documentation error”. Refer to the CMS web site for additional information and instructions. (e.g. the MLN Matters article: The Comprehensive Error Rate Testing (CERT) Process for Handling a Provider’s Allegation of Medical Record Destruction #SE0547)

Also check for state specific requirements for handling lost or destroyed records.
AHIMA's Long-Term Care Health Information Practice & Documentation Guidelines

Physical Security of Manual/Paper Records

Contents

2. Maintaining Security of Electronic Record Access
3. What to do if a Record is Lost, Destroyed or Stolen
4. Disaster Plans

HIM STANDARD:

- When the healthcare organization maintains all or portions of the record electronically they must have a security plan with policies and procedures that delineate how the facility will safeguard the premises, the exterior and interior of the building from unauthorized physical access and the software and equipment therein from unauthorized physical access, tampering, and theft. The software must have a method of tracking access.

- When the healthcare organization uses a manual record system they likewise must have protections of the record, including a manual record-tracking system, out guides and/or requisition slips are used consistently to indicate records removed from the files.

- When the healthcare organization maintains portions of the record electronically, a system shall be used to indicate in the paper record that specific documentation is maintained elsewhere, and how to access that documentation. Electronic access shall be granted based on assigned access privileges.

- The process for accessing manual and electronic records shall be known by employees who would have such access or may be requested to identify methods of accessing and tracking both the manual and electronic health records


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.

Maintaining Security of Electronic Record Access

HIM STANDARD:
When the healthcare organization uses electronic record access control procedures for verifying access authorization, regular review of audit logs, system activity, access reports, and security incident tracking reports are used consistently to monitor for intrusion or any unauthorized access.

Training on the organization’s electronic record security is provided to all healthcare employees empowered to request or who may receive requests to access to health records.

Facilities with electronic records or hybrid (partially electronic) records must establish policies and procedures for verifying access authorizations before granting physical access, which include documented instructions for validating the access privileges of an individual before granting those privileges. Need-to-know (Minimum Necessary) procedures for personnel access should be defined so that a user shall have access only to the data needed to perform a particular function. Need-to-know is also a criterion for removal of user accounts included in the requirements for termination procedures. Staff members should not be allowed access to information beyond the scope of their current job functions.

A computer role based access grid should be established that delineates both the access privileges and limitations based on the employee’s position. Access privileges must be able to be changed as changes in the system, applications or forms are implemented or changes in access needs for individuals or classes of employees change.

Information must also be classified to indicate what level of access control is indicated.

For example:

- **Public** = No restrictions on access; Examples brochures, Notice of Privacy Practices
- **Internal** = Access by employees only, based on need to know; Examples: policies and procedures
- **Confidential** = Role based Access only; Protected Health Information;
- **Sensitive** = Role Based Assigned Access only ; HIV test results, Psychiatric or Alcohol Abuse

The **Workstation** is another integral part of electronic record physical security. HIPAA Security requires that the facility have a policy and guidelines on workstation use (documented instructions and procedures delineating the proper functions to be performed, the manner in which those functions are to be performed, and the physical attributes of the surroundings of a specific computer terminal site or type of site, dependent upon the sensitivity of the information accessed from that site).” Users should be guided as to unauthorized viewing. The policy might show that users need to log off when they leave the workstation unattended during their shift and before they end their shift for the day. As an alternative to logging off, password-protected screensavers could also be used to secure an unattended workstation.

The physical attributes of the workstation site must also be addressed. Some examples of this may be:

- Locking cage to enclose CPU case when left unattended
- Locking room where the workstation is located when not in use
- Protecting all removable media (e.g. diskettes, CD-ROMs, backup tapes, etc.) from unauthorized use
- Prohibiting the practice of writing down User IDs and/or Passwords where others can find and/or use them.

Workstation sites that have access to sensitive data and/or workstation sites that are in a public area may need extra physical attribute policies to maximize the security of the site. Special consideration must also be given to protection of information stored in portable devices such as laptop computers and PDAs that guard against theft, loss or unauthorized use.

Other considerations for control of physical access to electronic records include but are not limited to:

- **Equipment control:** Bringing hardware and software into and out of a facility and maintaining a record of that equipment including, but not limited to, the marking, handling, and disposal of hardware and storage media.
- **Facility security plan:** A plan to safeguard the premises and the exterior and interior of the building from unauthorized physical access and the equipment therein from unauthorized physical access, tampering, and theft.
- **Physical access authorization verification:** Access authorization verification must include instructions for validating the
access privileges of an entity before granting those privileges.

- Maintenance records: The process for the documentation of repairs and modifications to the physical components of a facility, such as hardware, software, walls, doors, and locks.
- Personnel access need-to-know procedures: Procedures must ensure that a user has access only to the data he or she needs to perform a particular function.
- Visitor sign-in and escort procedures: Escort procedures must include procedures governing the reception and hosting of visitors, “if appropriate”.
- Testing and revision: Procedures for restricting program testing and revision to formally authorized personnel.
- Scanned documents or other specialized program of record management must have the same level of access privileges to prevent unauthorized physical access and the equipment therein from unauthorized physical access, tampering, and theft.

**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 to 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.
- Go to your computer backup system or your corporate server or backup of your automated document management system back (imagining, etc.)
- Retranscribe documents from the dictation system if used (check with attending physician or consultant for copies of dictated progress notes or consultative reports).
- Obtaining copies from recipients of previously distributed reports/documents, such as those sent to a physicians’ 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.

**Disaster Plans**

HIM STANDARD:

- A disaster plan for recovering health records damaged by fire, flood, or other destructive events in is place.
- The disaster plan includes revisions for recovering healthcare records on different types of storage media.
- The disaster plan includes provisions for a backup system, offsite access such as hosting, corporate storage and retrieval, to provide the healthcare organization’s staff necessary access to health records during emergency situations.
The disaster plan must outline alternative procedures to be utilized for continuity of care during the emergency and the procedure when there is restoration of the automated system.

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.

For each plausible disaster and core process, generate a contingency plan. The document might include:

- facility name
- department name
- 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
- inter-dependencies, 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

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Confidentiality and Release of Information

Contents
1. Identification of Confidential vs. Non-confidential Information
2. Resident Access to Their Records
3. Confidentiality Training and Agreements with Employees and Volunteers
4. Resident Identification Boards at Nursing Stations and Other Facility Locations
5. Maintaining an Access/Disclosure Grid for Employees, Contractors and Outside Parties
6. Handling a Request for Health Information contained in the Designated Record Set
7. Handling Telephone Requests for Information
8. Transmitting Resident Information via Facsimile
9. Responding to a Subpoena or Court Order
10. Removing Original Records from the Facility
11. Notice of Information Practices
12. Designation of a Privacy Officer

HIM STANDARD:

- The medium in which protected health 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.
- Residents’ protected health information, regardless of the medium in which they are stored, belong to the resident and are protected accordingly.
- Confidentiality policies and procedures specify that protected health information is used within the healthcare organization only for the purposes for which the data and information were collected.
- Disclosure of protected health 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.

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 set of policies and procedures to comply with the Health Insurance Portability and Accountability (HIPAA) privacy and security rules in regards to 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 or that allows greater privacy protections, follow the laws of your state.

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 healthcare institution; (ii) law; (iii) third party payment contract; or (iv) the resident.

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/admsimp/](http://aspe.os.dhhs.gov/admsimp/).

Identification of Confidential vs. Non-confidential Information

HIM STANDARD:

- Residents’ protected health information is 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, sexual or physical abuse, HIV/AIDS, abortion, and adoption.

Definition:
Protected Health Information (Individually Identifiable Health Information) is information that is a subset of health information, including demographic information collected from an individual, and (1) is created or received by a healthcare provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual that (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

The confidentiality/release of information policy should define what information is considered non-confidential and may be disclosed without a HIPAA compliant authorization and that which is considered confidential. The policy should contain information that is maintained in both paper and electronic format. 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 resident’s 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 (only available to members of the clergy).
- 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.\(^1\)

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.

**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, restrict access to or correct his/her health record.

**Definition:**

*Designated Record Set* means (1) a group of records maintained by or for a covered entity that is (i) the medical records and billing records about individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, and case or medical management record system maintained by or for a health plan; or (iii) used, in whole or in part, by or for the covered entity to make decisions about individuals. (2) The term record means any item, collection or grouping of information that includes protected health information and is maintained, collected, used or disseminated by or for a covered entity.

By federal law, residents or their legal representative in a long term care facility have the right to access their designated record set. 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).

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 current resident/legal representative to access records. The HIPAA Privacy Rule timelines can be followed when responding to requests from former residents or their legal representatives.

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 as long as the information/record is maintained. The privacy rule allows facilities to provide the record in a more timely manner to respond to requests to inspect or obtain copies. The facility may follow the privacy rules in this event when responding to requests from former residents. 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. If the facility is unable to respond within the 30 or 60 days, the facility may have one time extension of no more than 30 days. The facility must notify the requesting party in writing of the reason/s for the delay and the date when the request will be completed. Again, the facility is only allowed one time extension.

**Steps In Handling A Request To Access/View Designated Record Set:**

When a request is made by the resident or another party to view information within the designated record set, 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 for a current resident. 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 to ensure that is complete, accurate and organized. This also helps the facility to become familiar with the content and identify any potential areas of concern. Facility policy should address how to handle re-disclosure of protected health information received from another facility (i.e. hospital from a prior stay or another nursing home).

If components of the designated record set are maintained electronically in a hybrid medical record, determine how access will be provided to the electronic components of the medical record.

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, an authorization to use or disclose health 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.

**Steps in Handling A Request for Copies of Designated Record Set:**

See the sections on Handling a Request for Medical Records and Copy Fees for Medical Records. The request for copies must be documented on a HIPAA compliant authorization 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, provide the estimated cost to fulfill the request before copies are made.

**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 residents’ protected health 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 and their responsibilities to safeguard protected health information.

Confidentiality agreements are signed by everyone connected with the healthcare organization who may have access to confidential healthcare information and resident-identifiable data. It is recommended that 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 residents’ protected health 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 residents’ protected health information.

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**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]

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**Resident Identification Boards at Nursing Stations and Other Facility Locations**

Communication boards may be used to communicate within a facility and may contain protected health information. Common uses of communication boards include staff assignments, sharing information with other shifts, census information, etc. These communication boards that contain residents’ protected health information must be in an area that is not viewable to residents, unauthorized staff members or the public. As a general rule, the only resident communication boards that should be viewable to the public provide directory information (room number).

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

**HIM STANDARD:**

- With regard to access to residents’ protected health 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 must include business associate language that state that the companies providing the services assume responsibility for maintaining the confidentiality of all protected health information within their control.
• Policies and procedures identify when disclosure of protected health information may be made without the resident’s authorization 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 prior to disclosure of information and those that do not require resident authorization.

• 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.

**Definition:**

Minimum necessary means that when a facility uses or discloses protected health information or requests protected health information from another covered entity, the facility must make a reasonable effort to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Part of the facility policies on minimum necessary and confidentiality should be an access grid that outlines which employees and contractors are considered authorized users of the information contained in the designated record set 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, 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 designated record set.

<table>
<thead>
<tr>
<th>Employee/Contractor Access to Protected Health Information</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 documentation 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>Therapy Staff</td>
<td>Yes</td>
<td>Access to records but only to those residents on their case load/receiving therapy treatment</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.

<table>
<thead>
<tr>
<th>Employee/Contractor Access to Clinical Information Computer System</th>
<th>Access to System</th>
<th>Scope/Limitations*</th>
<th>Read Only or Read/Write</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator/Executive Director</td>
<td>Yes</td>
<td>Billing and Clinical</td>
<td>Read/Write</td>
</tr>
<tr>
<td>Director of Nursing Services</td>
<td>Limited</td>
<td>Clinical Only</td>
<td>Read/Write</td>
</tr>
<tr>
<td>RAI Coordinator</td>
<td>Limited</td>
<td>Clinical Only</td>
<td>Read/Write</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>Limited</td>
<td>Clinical Only</td>
<td>Read/Write</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Information Services</td>
<td>Yes</td>
<td>Billing and Clinical</td>
<td>Read/Write</td>
</tr>
<tr>
<td>Health Information Consultant</td>
<td>Limited</td>
<td>Access as directed by facility</td>
<td>Read Only</td>
</tr>
<tr>
<td>Business Office Manager</td>
<td>Yes</td>
<td>Billing Limited</td>
<td>Read/Write</td>
</tr>
<tr>
<td>Director of Laundry</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy Staff</td>
<td>Limited</td>
<td>Clinical Only</td>
<td>Read/Write</td>
</tr>
<tr>
<td>Pastor</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptionist</td>
<td>Limited</td>
<td>Demographics Only</td>
<td>Read Only</td>
</tr>
<tr>
<td>Maintenance</td>
<td>No</td>
<td></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.

*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 the designated record set by other types of providers, agencies or third-party users. This grid should outline whether an authorization to use or disclose health 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 to protected health information 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 applicable federal and state laws the following are guidelines:

<table>
<thead>
<tr>
<th>Disclosure Grid</th>
<th>Authorization Required</th>
<th>Copy Charges Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requestor or Outside Party</td>
<td></td>
<td></td>
</tr>
<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>Family members with demonstrated involvement in care</td>
<td>No – for verbal updates related to involvement in care</td>
<td>No</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/hospice 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>Dependent on Research Project &amp; IRB Approval/Waiver</td>
<td>No – if project is approved by facility</td>
</tr>
<tr>
<td>Residents</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The column “Copy Charges Allowed” should be reviewed carefully and compared to the requirements in the privacy rule and any other applicable state of federal regulations. While is may be acceptable to charge for copies, facilities may exercise discretion and judgment when determining whether or not to charge a resident, his/her legal representative or other requesting party for copies.

**Handling a Request for Health Information contained in the Designated Record Set**

**HIM STANDARDS:**

Requests for healthcare information require a valid (HIPAA compliant) authorization to disclose protected health information, unless the disclosure is required for treatment, payment or healthcare operations.

All requests 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 use or disclose health 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:**

The HIPAA privacy rule does not require the facility to obtain the resident's consent prior to using or disclosing protected health information to carry out treatment, payment, or health care operations. The HIPAA Privacy Rule states that your facility may choose to obtain consent. The decision to obtain consent should be defined in the facility’s policies and procedures.

**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. The privacy rule allows for redisclosure of resident’s protected health information. Your facility should have a policy in place to ensure redisclosure is handled in a consistent manner. 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. Refer to the Frequently Asked Questions available on the Office For Civil Rights web site at [http://www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa) for additional information regarding this topic.

1. Unless otherwise required by state law, incorporate in your own facility’s designated record set the health information generated by other healthcare providers needed for patient diagnosis and treatment.
2. Become knowledgeable about and implement organizational compliance with federal and state laws and regulations that address redisclosure. Any redisclosure must comply with federal and state laws and regulations.
3. Consult with legal counsel when federal and state redisclosure requirements differ and it’s unclear which should prevail.
4. Develop facility policies and procedures that address redisclosure. Be sure to include the requirement that prior to disclosure, the disclosing staff member verify the authority of the person to receive the information.
5. Modify existing authorization forms to incorporate required language in the HIPAA final privacy rule.
6. In general, healthcare providers should:
   - Redisclose to other healthcare providers PHI when it is necessary to ensure 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 PHI when necessary to comply with a valid authorization
   - Redisclose PHI when necessary to comply with a legal process. Only redisclose PHI located within your legal health record (the designated record set). Note that you may be compelled by the legal discovery process to release additional individually identifiable health information if access to the information is deemed necessary for the stated purpose.
7. Ask legal counsel to review draft policies and procedures prior to implementation.
8. Educate staff on new or revised policies and procedures relative to redisclosure.
9. Implement policies and procedures and monitor compliance.
10. When in doubt about a potential redisclosure, consult legal counsel.
11. When asked to certify or testify about the authenticity of redisclosed health information, state that the information was received from another healthcare facility’s medical record through normal business practices, your facility received the information in good faith, and that you cannot knowledgeably speak about the record-keeping practices of the originating organization.
12. Modify existing certification forms when indicated.


**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, other types of telephone requests should be directed to the health information management department.

Telephone requests can be honored without an authorization if they are for the purposes of treatment, payment or health care operations. This may occur when a resident’s protected health information is 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).

Regardless of the situation, if the caller’s identity is unknown, steps should be taken to verify the caller’s identity. This can be accomplished by requesting the caller’s name, address and, if applicable, company information. The facility staff member should look up the information, verify that it is accurate and return the call based on the information looked up.

**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).

When the fax machine is used to release of 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. If a facsimile transmission fails to reach the recipient, check the internal logging system of the facsimile machine to obtain the number to which the transmission was sent. If the sender becomes aware that a fax was misdirected, contact the receiver and ask that the material be returned or destroyed. Investigate misdirected faxes as a risk management occurrence or security incident; include the accidental disclosure of patient health information in the accounting of disclosures log. Mitigate the accidental disclosure and determine the need to contact the patient, organization’s legal counsel, and risk management carrier.
- Preprogram fax numbers into the machine whenever possible to minimize the chance of entering an incorrect fax number resulting in a misdirected fax. Request that frequent recipients notify your facility of any fax number changes.
- Place fax machines in secure areas.
- 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. For instance, it may not be appropriate to fax highly sensitive information (HIV/AIDS status, drug or alcohol abuse information, etc.).
- Establish guidelines to address retention of information transmitted via facsimile and whether it should become part of the patient’s health record (e.g., is the document part of a designated record set or a business record?).
- Take precautions to preserve the quality of faxed documents. Fax copies may fade and may need to be photocopied. Extra precautions are necessary when thermal paper is used to ensure legible copies are retained as long as the medical record is retained.
- Include in your organization’s notice of information practices uses and disclosures of individually identifiable health information made via fax machine or software where appropriate (see the AHIMA practice brief “Notice of Privacy Practices”).
Responding to a Subpoena or Court Order

It is critical that state law is followed in processing a subpoena. In addition, the privacy rule has specific requirements that must be met prior to responding to a subpoena. (Refer to the privacy rule 42 C.F.R. § 164.512 (e).) The following provide general guidelines in handling a subpoena when it is received. Facility policies should be tailored to specific state statutes and the privacy rule. Generally, your facility should work with legal counsel to ensure a subpoena is valid and your facility responds appropriately.

- Check that the subpoena is signed by a representative of the court (usually the Clerk of Court).
- Determine if satisfactory assurances are received with the subpoena. Contact your facility’s legal counsel to ensure appropriate satisfactory assurances have been received or a qualified protective order is present or requested.
- 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.
- If the entire medical record is requested, number the pages of the original medical 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.
- 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.

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.

Notice of Information Practices

The HIPAA privacy rule requires facilities to provide the resident with a Notice of Information Practices also referred to as a Notice of Privacy Practices. This Notice must describe how the facility uses or discloses residents’ protected health information, the resident’s rights with respect to his/her PHI, and the facility’s legal duties under the privacy rule. The notice must be provided at the time of admission to the facility. 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)
A good faith effort must be made to obtain acknowledgement of receipt of the Notice. If your facility is unable to obtain acknowledgment, document actions taken to obtain acknowledgement and why you were unable to obtain acknowledgement.

If a resident is admitted in an emergency situation, provide the Notice as soon as reasonably practicable after the emergency situation.

The Notice must be posted in your facility; in addition, you must have copies of the Notice available for interested parties (perspective residents, visitors, family members, etc.) to have upon request.

If your organization maintains a public Web site, the Notice must be posted on the Web site.

Changes to the Notice:
- Content (material changes) to the Notice cannot be implemented prior to the effective date of the revised Notice.
- Your facility’s Notice should include a statement that it reserves the right to make changes to the Notice and how an updated Notice can be obtained. This will allow the facility to make changes to the Notice without having to redistribute the Notice to current residents. If your Notice does not contain this type of statement, it must provide an updated Notice to current residents.

A copy of each version of your facility’s Notice must be retained for six years from the date it was last in effect.

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’s published model position description for the Privacy Officer
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 accuracy and retrievability of pertinent information.
- The director of the health information management department supervises or monitors any diagnosis 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 non-health information management staff who assign or analyze diagnoses codes.

Regulatory Requirements:

Under the federal Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Sets Standard (TCS), Subpart J, medical data code sets were adopted as the following code sets standards:

2. *ICD-9-CM, Volume 3, Procedures*, is to be used only for reporting procedures for hospital inpatients, and is, therefore, not used by long-term care facilities.
4. *Code on Dental Procedures and Nomenclature*
5. The combination of *Health Care Financing Administration Common Procedure Coding System (HCPCS)*, as maintained and distributed by HHS, and *Current Procedural Terminology, Fourth Edition (CPT-4)*, as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to Physician services, Physical and occupational therapy services, Radiologic procedures, Clinical laboratory tests, Other medical diagnostic procedures, Hearing and vision services, and Transportation services including ambulance.
6. *HCPCS* for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to Medical supplies, Orthotic and prosthetic devices, and Durable medical equipment.

Source: 45 CFR §162.1002(a)

Adherence to the code sets listed in Section (a) has been adopted under HIPAA for all healthcare settings, including long-term care. Long-term care facilities should also be aware of the code sets in Sections (e) and (f) that have an impact on nursing facility reimbursements. (See Coding and Billing Relationships)

In February 2005, the Centers for Medicare and Medicaid Services (CMS) published MLN Matters Number MM3664 that revised the Medicare Claims Processing Manual (Pub.100-04, Chapter 6 (SNF Inpatient Part A Billing), Section 30 (Billing SNF PPS Services)), to include the following *ICD-9-CM* coding guidance for SNFs:
Principal Diagnosis Code - SNFs enter the ICD-9-CM code for the principal diagnosis in FL 67. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA), including any applicable guidelines regarding the use of V codes. The code must be the full ICD-9-CM diagnosis code, including all five digits where applicable.

Other Diagnosis Codes Required The SNF enters the full ICD-9-CM codes for up to eight additional conditions in FLs 68-75. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-9-CM guidelines.

In CMS’s RAI User’s Manual, Section I, Disease Diagnoses, of the MDS 2.0, there is further guidance that reinforces that coding staff in long-term care facilities should refer to official coding guidance in assigning and reporting code numbers (Section I1, Coding) and that V codes may be used if they affect the resident’s current ADL status, mood and behavior status, medical treatments, nursing monitoring, or risk of death (Section I3, Coding). In Sections I1 and I2, Process, it clearly states that a physician diagnosis is required to code the MDS.

The coding process in long term care facilities primarily involves the use of the ICD-9-CM 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 has adequate training and resources to accurately and completely assign diagnoses codes.

In a long term care facility, diagnoses 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-04. In HIPAA’s Transaction and Code Sets, ASC X12N837 is used to identify this claim format. Assignment of diagnoses codes on the face sheet/admission record and diagnosis/problem list is not mandated by regulation, but is highly recommended. Reporting codes on the MDS and UB-04 are required.

Training and Resources

HIM STANDARD:

- Competent, credentialed clinical coders are recruited, hired and retained.
- Health information management employees who perform diagnosis 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 or biannual basis as the classification systems are revised.

In the Office of Inspector General’s Compliance Program Guidance for Nursing Facilities, it states “The OIG recommends that a nursing facility, through its policies and procedures, take all reasonable steps to ensure compliance with the Federal health care programs when submitting information that affects reimbursement decisions. A key component of ensuring accurate information is the proper and ongoing training and evaluation of the staff responsible for coding diagnoses and regular internal audits of coding policies and procedures. With the arrival of consolidated billing and the next edition of the coding manuals, it will be even more critical that knowledgeable individuals are performing these coding tasks.

The risk areas associated with billing and cost reporting have been among the most frequent subjects of investigations and audits by the OIG. In addition to facing criminal sanctions and significant monetary penalties, providers that have failed to adequately ensure the accuracy of their claims and cost report submissions can have their Medicare payments suspended (42 CFR 405.371), be excluded from program participation (42 U.S.C. 1320a-7(b)), or, in lieu of exclusion, be required by the OIG to execute a corporate integrity agreement (CIA).” Federal Register/Vol. 65, No. 52/March 16, 2000, p. 14296

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 guidance, 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 annually or biannually). 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 annually or biannually either by the vendor or by health information staff to reflect current, up-to-date diagnostic codes.
- Current CPT Code books (updated annually or as required).
- Current HCPCS code books (updated annually or as required).
- 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. Go to Publications link at www.ahima.org
- The LTC facility should have a copy of the ICD-9-CM Official Guidelines for Coding and Reporting available on the Center for Disease Control website.
- Coders should be aware of and abide by the Standards of Ethical Coding.
- ICD-9-CM Coding Training Modules developed by the LTC Consortium are available to the public at The American Health Care Association website.
- All LTC facilities may 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 that is necessary for adherence to the transaction and code set standards required by the (HIPAA). Ordering information is available through the American Hospital Association at www.ahaonlinestore.org

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. Many facilities utilize a document for the listing of diagnoses, often titled Diagnosis List, that is initiated upon admission. It includes the diagnoses, ICD-9-CM codes, with the date of initial entry (admission). As the resident’s treatments and cares are documented in the health record, diagnoses are updated, added and resolved in physician documentation. As diagnoses are updated during the resident’s stay, it is beneficial to maintain
the Diagnosis List by adding and resolving diagnoses with the applicable dates and assigning the ICD-9-CM codes. This process is often coordinated with the MDS assessment process when nursing staff identifies new diagnoses, while updating resolved conditions, as noted in physician documentation, and routes 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.

As residents may remain in long term care facilities for extended periods of time, the diagnosis listing can become extensive with numerous updates. If the inclusion of diagnoses is required on the face sheet/admission record, it may be time consuming and difficult in the limited space to update this information on a concurrent basis. If possible, it may be helpful to indicate “Admission Diagnoses” with the diagnoses listed on this admission document while maintaining an up-to-date listing on the Diagnosis List. If the face sheet/admission record must be current, staff should develop a procedure for maintaining this document. Another consideration is that this face sheet/admission record document containing diagnoses may routinely be copied to provide resident information to appropriate individuals, agencies, or vendors. With HIPAA’s requirement of “minimum necessary,” routinely disclosing resident diagnoses via this document may no longer be desired or appropriate. Establishing policies and procedures for using and disclosing information on this document will insure compliance with state and federal regulations. See Section 4.9 Confidentiality and Release of Information. For documentation issues related to coding, see Section 6.8

**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.

With the implementation of HIPAA’s Transaction and Code Sets standards, both health care providers and payers must utilize the specified code sets and follow the official coding guidelines established for each code set when submitting electronic transactions (i.e. electronic billing/claim submission). Payers are no longer able to set their own rules for reporting diagnoses that conflict with official policy.

ICD-9-CM codes on a billing claim form usually provide 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).

**Reporting Principal and Additional Diagnoses:**

In the ICD-9-CM Official Guidelines for Coding and Reporting, in Section II, Selection of Principal Diagnosis, “The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as ‘that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.’” This definition and other data elements were published in the Federal Register on July 31, 1985. As the guidelines go on to explain, the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; rehab facilities; nursing homes, etc.). Since the publication of this definition in 1985, the reporting of reimbursement and diagnostic data on the UB-04 (ASC X12N837) has been required for healthcare settings other than just hospitals. Section III, Reporting Additional Diagnoses also includes the application of this definition.

This definition of principal diagnosis does not supersede the guidance related to LTC in Coding Clinic 4th Qtr 1999. In fact, these instructions appear to be very similar. In this Coding Clinic, the “first listed diagnosis” (principal diagnosis) can be interpreted to follow the UHDDS definition above: the condition after study to be chiefly responsible for the admission to the nursing home. Unlike the acute care hospital setting, the resident may remain in the nursing home for months and even years. As ongoing data regarding diagnoses needs to be reported to payers and to other regulatory bodies, it may be necessary to submit additional UB-04 (ASC X12N837) claim forms for specific time periods (usually monthly) throughout a resident’s stay. Even
though the UHDDS definition for principal diagnosis is “admission-focused,” since it was developed for short-term, acute-care hospitals, there is a logical transition to apply the same concept for the resident that continues to stay in the facility -- the diagnosis chiefly responsible for the resident remaining in the nursing home.

There may be instances when the reason for a Medicare Part A services may not be the same as the reason the resident is in the facility (principal diagnosis). For example, a resident who is permanently living in the facility due to the residuals following a CVA may go to the hospital for pneumonia and returns to the facility. In this case, the principal diagnosis would be the code for the residual(s) of the CVA followed by the additional diagnosis of pneumonia.

There may also be situations when a Medicare service (e.g. therapy) is focused on a secondary condition of the resident’s and not the principal diagnosis. As noted in Section 4.10 under Regulatory Requirements, the Medicare Claims Processing Manual includes directions for following ICD-9-CM coding guidance. CMS indicates that SNFs are to follow the official coding guidelines for the principal diagnosis, including applicable V codes. For other diagnosis codes, it stated that CMS does not have any additional requirements for the reporting or sequence of the codes beyond those contained in the ICD-9-CM guidelines.

As per this direction, CMS does not provide instruction for the sequence in which facilities are to list additional ICD-9 codes. For example: diabetes mellitus does not have to be listed before Alzheimer’s disease; COPD before urinary tract infection.

The ICD-9 classification system does have sequencing requirements for related diagnoses as directed in guidance in the ICD-9-CM codebook and the ICD-9-CM Official Guidelines for Coding and Reporting as diagnoses may require more than one code number to correctly identify the condition. Examples of guidance includes:

- Multiple Codes for Single Condition [Section I.B.9.]: Instructions in the Alphabetical Index or Tabular List identify need for additional codes (“Use additional code,” “Code first underlying condition”)

Example: Alzheimer’s dementia (331.0, 294.10)

- Late effects [Section I.B.12.]: Guidance includes residual conditions (late effect) and indicates that the condition that remains (late effect) is sequenced first unless otherwise instructed (cause of late effect is usually listed second).

Example: Paralysis of left leg due to old poliomyelitis (344.30, 138)

- Etiology/Manifestation [I.A.6.]: “Code first”, “Use additional code”, and “In diseases classified elsewhere” notes indicate requirement to code underlying or associated condition(s). Code title in italics is always sequenced second. Example: Diabetes mellitus is the most common etiology/manifestation combinations.

Examples: Diabetic ulcer (250.60, 707.1); diabetis chronic kidney disease (250.40, 583.81)

Complete data based on accurate ICD-9-CM coding is needed for:

- Acuity management by diagnosis
- Planning, Program management
- Resource utilization
- Internal data quality controls-diagnosis triggers quality indicators and quality measures (QIs/QMs)
- Reimbursement of services and care provided (UB04, Medicare Review- i.e. RAC, CERT, PCA)
- Education
- Research

Risks of inaccurate coded data include:

- Non-compliance with federal regulations for coding and billing
- Incomplete or inaccurate data submissions on MDS and UB
- Impaired or delayed cash flow due to denied or delayed claims
- Increased labor costs due to “work around” system to follow official guidance
- time consuming and inefficient use of staff time
- Inaccurate legal health record
- Medical necessity NOT accurately reflected
- Inaccurate clinical picture

**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 or 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 Medicare fiscal intermediary (FI) or other payer. The facility staff may need to explain the guidance within the ICD-9-CM code book and the ICD-9-CM Official Guidelines for Coding and Reporting. If discrepancies remain on the reporting of the diagnoses codes, ask for the FIs coding advice in writing and keep a written log of phone calls, discussion, and recommendations. If they will not put their recommendations in writing, obtain the staff name and write a letter back to the FI or payer summarizing the advice received. Keep a copy of the letter with facility logs.

**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), was ordered by the physician, and was medically necessary.

**ICD-10-CM Coding Classification**

In January 2009 the U.S. Department of Health and Human Services (HHS) announced two rules for the adoption of the ICD-10-CM and ICD-10-PCS code sets and the version of the standards for certain electronic health care transactions, under the authority of HIPAA (5010/D.0). AHIMA, along with its alliance partners, worked with members of Congress and government organizations to support the adoption of ICD-10-CM as many countries around the world have adopted ICD-10 including Canada and Australia.

The ICD-9-CM has become an obsolete (developed in the early 1970s) code set due to its lack of expansion and inability to capture health care data that reflects disease, procedure, and technology terminology specific to meet today’s healthcare data needs. ICD-9 is also no longer supported by the World Health Organization. ICD-9 contains only 17,000 codes by contrast to the 155,000 specific codes that will accommodate new diagnoses and procedures. (ICD-10-PCS is the procedural classification and will not be used in LTC nursing homes.)

Significant changes in ICD-10-CM include expansion to approximately 68,000 available diagnosis codes. The diagnosis codes will be 3-7 characters in length: digit 1 is alphabetic; digits 2 and 3 are numeric; digits 4-7 are alpha or numeric. The system restructures chapters and categories, provides greater specificity of diagnoses, includes laterality for specific conditions, and has the flexibility for adding new codes. The specificity in ICD-10-CM will improve coding accuracy and the richness of data for analysis and the accuracy of data used for medical research. It will also support interoperability and the exchange of health data between other countries and the U.S. (Currently ICD-9-CM does not support interoperability because it is not used by other countries.)

Updated versions of current HIPAA electronic transaction standards require the use of the ICD-10 codes sets for claims, remittance advice, eligibility inquiries, referral authorization, and other widely used transactions. The current standard, version 4010/4010A1 of the American Standards Committee X12 group, cannot accommodate the much larger ICD-10 code sets. Under the transaction standards final rule, covered entities must comply with Version 5010 (for some health care transactions) and Version D.0 (pharmacy transactions) on January 1, 2012. Covered entities must comply with the standard for the Medicaid pharmacy subrogation transaction (Version 3.0) on Jan. 1, 2012. However, for Version 3.0, small health plans have an additional year and must comply on Jan. 1, 2013. These updated versions will replace the 4010/4010A1 versions of the current standard, will
promote greater use of electronic transactions, and will accommodate the use of the greatly expanded ICD-10 code sets. The ICD-10 code set rule sets the compliance date at Oct. 1, 2013.

Fact Sheet for both rules are available.

The Federal Rules can be accessed:
- Electronic health care transactions – Version 5010 of the X12 standard
- ICD-10-CM and ICD-10-PCS medical code set standards

The adoption of ICD-10-CM will require significant time, effort, and financial commitment to implement this redesigned classification system. HIM professionals will also have the opportunity to coordinate, communicate, and assist in the planning and implementation of this system. HIM professionals will be required to continue to obtain ongoing training to maintain coding skills. Ongoing information and training seminars are available at AHIMA at http://www.ahima.org/icd10/

Coding and the EHR

Currently, there is limited ‘encoder-type’ software to assist with code determination in nursing homes. Coding software in nursing homes is usually the ICD-9-CM library of codes in the system. This ‘library’ often contains the entire code book of the category, subcategory, and subclassification codes without notations as to the need for assigning codes to the highest level of specificity (4th or 5th digits) or to the requirements for proper sequencing. The library also may not contain include and exclude notes or other directional information that is needed for correct code assignment.

The software system must allow the coder to properly sequence codes for the entire Diagnosis List as required within the ICD classification system. If the system only allows staff to indicate the proper sequence, for instance, the first ten (10) diagnosis codes, the remaining codes will most likely be listed in numerical order. Without proper sequencing, the information will be confusing and misunderstood. In addition, improper sequencing of codes creates compliance issues, as the system would not allow staff to follow HIPAA’s requirements for proper use of the ICD-9-CM Code Book and the ICD-9-CM Official Guidelines for Coding and Reporting. Staff should carefully review all codes directly interfaced to the claim form to insure the accuracy and applicability for that claim. See Section 4.10.3 above

As facilities develop and implement the electronic record, staffs using the software systems need to be aware of how the system is installed and utilized within the facility. Issues include:

- ICD code library:
  - Updates affecting diagnostic data, including ICD codes, should be available and able to be implemented on the effective date;
  - The pros and cons to customizing your ICD library:  1) Updates may remove individual customization;  2) Time taken to ‘free-text’ diagnostic language may be beneficial to staff’s understanding of the diagnosis versus utilizing the codebook language, which may not be specific.
- As information is entered into the system, particularly physician orders, it may be necessary to code diagnoses on a concurrent basis.
  - Determine staff member that will assign codes on a concurrent basis
  - Insure staff member(s) are trained in accurate code assignment
- Staff should be aware of the way the software system organizes data from different points of entry. Staff needs to also understand how updates affecting clinical data impact on current functions and processes.

It is critical as electronic health record systems are developed, expanded, and updated that facilities work with software vendors to maintain systems at a current level.

CCI Edits: The CMS developed the National Correct Coding Initiative (NCCI) to promote correct coding, to eliminate improper coding, and to ensure proper payments in Part B claims. Therapy services provided in SNFs are now included in this CCI edit process within the outpatient code editor (OCE). The purpose of the edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. This will require facilities to assign the correct code(s), particularly for therapy services, from the Current Procedural Terminology (CPT) Manual for the appropriate medical diagnosis to reflect the services being provided and billed. Complete and accurate documentation will continue to be required to support these services.

‘Computer-assisted Coding’ is a tool that is being developed to automate the assignment of certain diagnosis codes from clinical documentation within an electronic system. Automation tools are being developed that allow computer software to assist in the translation of natural language processes (NLP) to extract pertinent data and terms from text documents and convert them into a set of medical codes. This information would then be reviewed and edited by coding professionals to assist in determining the code assignment. As EHRs become more fully developed, utilization of these tools is expected, particularly in the hospital setting.


LOINC code set (Logical Observation Identifiers Names and Codes) is an electronic database that provides a set of universal names and ID codes identifying laboratory and clinical (vital signs, intake/output, EKG, cardiac echo, imaging, etc.) test results. The purpose is to allow the exchange of clinical data, primarily laboratory, between compatible computing environments for clinical care, outcomes management, and research.

Indexes and Registries

Contents

1. Master Patient Index (MPI)
   i. Maintaining an MPI
   ii. Minimum Content
2. Disease Index

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. The disease index is optional unless required by state law.

Master Patient Index (MPI)

HIM Standard
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.

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).

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.

**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 is [available online](#).
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.

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 advantages of using a computerized system is that diagnoses are updated continually through a residents 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.

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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.

**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.

**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.

**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:** Sum of the Daily Census for each day of the month
- 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.

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

**Total Census Days**

The sum of the daily census for a given period for each day in the month.

**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**:
  - Total length of stay for discharges (for facility or for a unit) in a one month period
  - 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.

**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.

<table>
<thead>
<tr>
<th>Formula:</th>
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<tbody>
<tr>
<td>Sum of the daily census for the month</td>
</tr>
<tr>
<td>Total bed count days in the month</td>
</tr>
<tr>
<td>(bed count x number of days in the month)</td>
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</table>

**Electronic Patient Records (On Hold)**

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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:

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

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.

<table>
<thead>
<tr>
<th>Guidelines for Defining the Health Record for Legal Purposes</th>
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</thead>
<tbody>
<tr>
<td><strong>LEGAL HEALTH RECORD</strong></td>
</tr>
<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</td>
</tr>
</tbody>
</table>
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.

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 and Renewals
- Consent for treatment forms
- Consultation reports
- Physical therapy, Speech therapy, and Occupational therapy records
- Email containing patient-provider or provider-provider communication
- Graphic records
- Intake/output records
- Nursing and other discipline assessment
- Care plan
- Minimum data sets
- Practice guidelines or protocols/clinical pathways that imbed patient data
- Telephone orders
- Advanced Directives
- Discharge instructions, plan of care, etc.

**PATIENT - IDENTIFIABLE SOURCE DATA**

An adjunct component of the legal business record as defined by the organization. Often maintained in a separate location or database, these secondary records are provided the same level of confidentiality as the legal business record. The information is usually retrievable upon request.

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.
<table>
<thead>
<tr>
<th>DERIVED DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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 &quot;medical record.”)</strong></td>
</tr>
</tbody>
</table>

| **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 |

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

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Legal Documentation Standards

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22. Appropriateness of Entries – Keep Documentation Relevant to Resident Care

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

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).

**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.

**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).

**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.

**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.

**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.

**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.
**Countersignatures**

Countersignatures should be used as required by state law (i.e. graduate nurses who are 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 and physician assistants. It is important to know state licensure and professional practice regulations for a NP/PA to determine if countersignatures are required.

**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).

**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.

**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.

**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.

**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.

**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 turnover 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.

**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.

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.

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.

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.

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. 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.
- 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).

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.

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.

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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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).

**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.

**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.

**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.
Legal Guidelines for Handling Corrections, Errors, Omissions, and other Documentation Problems

Content

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2. Handling Omissions in Documentation
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4. Documenting Care Provided by a Colleague
5. Resident Amendments to their Record

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.

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.

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.

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.

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
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.

**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.

**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.

**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 and treatments 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."

**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 11:05 am. 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.

**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 for 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 to support a requested amendment. 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.

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AHIMA’s Long-Term Care Health Information Practice & Documentation Guidelines

PDF version of this section

Documentation in the Long Term Care Record updated 10/2010

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6. DOCUMENTATION IN THE LONG TERM CARE RECORD
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   2. Purpose of Clinical Records
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   5. Documentation Systems/Formats

Documentation in long-term care has become increasingly complex as the resident’s clinical needs and decision making 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. Those data elements with an F-tag association are placed in numerical order. Those data elements without an associated F-tag follow in alphabetic order. 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, CARF), 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. Each facility will need to establish their own documentation guidelines.

1. Federal Regulations Pertaining to Clinical Records:

Federal regulation (F514) requires that a 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 provides 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. Facilities must always consider State regulations for clinical records and documentation, as they may be more stringent than the Federal regulations.

2. Purpose of the Documentation

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 plans of care identified to meet the resident’s identified condition/s, 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. While the main purpose of the record is to provide continuity of care, there are other reasons including clinical, administrative, financial, regulatory and legal

3. Elimination of Duplication/Redundant Information when Evaluating/Implementing a Documentation System:
One of the most significant problems found in many documentation systems is duplicate or redundant information that is collected in the medical record. Not only is this inefficient, but it potentially creates conflicts and contradiction in the documentation that leads to confusion and could possibly create errors in care and treatment as well as diminishing 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 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 to facilitate the interdisciplinary team approach rather than segregating assessments and documentation into department-specific documents that do not work together but increase the likelihood of contradictions. In addition, it is important when evaluating EHR systems to look for ways to eliminate duplication. EHR systems have great potential for streamlining the documentation process.

Documentation Content in a Long Term Care Record:

Admission Record (F157):
Every clinical record should have a face sheet or admission record that provides demographic information, responsible party and contacts 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. The old face sheet is filed in the overflow folder. Some states have specific field requirements for face sheets such as diagnoses as well as demographic information. The state regulations should be reviewed for this information.

Assessments:
It is important to recognize that there are two types of assessments which are referenced, i.e. the Resident Assessment Instrument (RAI) which is the mandated assessment tool (under the Federal Omnibus Budget Reconciliation Act) and those assessments which are required by the nursing facility and/or corporate structure, e.g. Nursing Assessment, Pain Assessment, Elopement Assessment, Dietary Assessment, Social Service Assessment, etc. 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 a narrative assessment. Many “assessments” collect information or identify a condition. To be complete, they should also include conclusions, recommendations, recommended interventions. To be an assessment rather than just a data collection tool, the following elements should be in place:
1. Data Collection - data is collected relevant to the issue being assessed.
2. Evaluation - the assessor interprets the data.
3. Conclusion - the assessor comes to a decision as to the clinical conclusions based on the data collected. (Review the state specific practice standards to define who can complete the assessment.)
4. Conclusion -- the assessor interprets and documents their conclusions based on the data collected
5. Plan -- recommendations and follow-up based on resident goals and standards of practice.

Integrating Facility Assessments with Resident Assessment Instrument (RAI) Process:
As LTC facilities evaluate their documentation system, one goal should be to create an interdisciplinary assessment process that uses the Resident Assessment Instrument (RAI) as the assessment rather than a supplement. With the regulatory required Minimum Data Set (MDS) and Care Area Assessments (CAAs) as the base assessment tools, other assessments would collect information that supplements and/or supports the comprehensive assessment rather than readdress it. The Centers for Medicare and Medicaid Services (CMS) position has always been that the MDS is a source document, not requiring additional documentation support. However, various entities both state and private agencies, have identified that supportive documentation is necessary. The Resident Assessment Instrument includes assessments required by the Omnibus Reconciliation Act of 1987 (OBRA) and those required by the Prospective Payment System (PPS). Those residents who are in the facility less than 14 days may not have a Resident Assessment Instrument but will have an Entry Record as a minimum.

OBRA REQUIRED
- Admission (Comprehensive)
- Significant Change (Comprehensive)
- Quarterly Assessment
- Annual (Comprehensive)
Significant Correction to Prior Comprehensive Assessment
Significant Correction to Prior Quarterly Assessment

Prospective Payment Required
- 5 day Assessment
- 14 day Assessment
- 30 day Assessment
- 60 day Assessment
- 90 day Assessment
- Other Medicare Required Assessment (OMRA)
- Readmission/Return
- Start of Therapy (SOT)
- End of Therapy (EOT)
- End of Therapy revised (EOT-r)
- Start and End of Therapy
- Change of Therapy (COT)

Other required records/assessments
- Entry record
- Discharge Assessment return anticipated
- Discharge Assessment return not anticipated
- Death in Facility

Types of Assessments (Facility required) and Requirements:

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

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 an additional purpose in providing supporting documentation for the MDS. However, with the changeover to the RUGs IV system and the MDS 3.0, services provided prior to admission do not assist in the financial determination but are still reflected on the MDS itself. 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.

Admission Assessment:

An admission or readmission assessment typically incorporates items that would be considered a nursing assessment and 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, CAAs and care plan process is completed.

Fall Assessment (F323-F324):

The facility must identify each resident at risk for accidents and/or falls and adequately care plan and implement procedures to prevent accidents. Due to the time allowed in completing the RAI, it is recommended that the risk for falls be assessed on admission/readmission. Risk factors may include:

- diagnosis
- fall history
- unsteady gait
- age
- assistance for balance, transfer, walking, wandering
\begin{itemize}
  \item denial of physical limitation
  \item orthostatic hypotension
  \item urinary frequency or incontinence
  \item infection
  \item medications
  \item sensory impairments
  \item footwear
  \item confusion/dementia
  \item delirium or sedation
  \item sleep disorders
  \item impulsive behavior or poor judgment
\end{itemize}

Likewise the physical environment may increase the risks of falls. This may include lack of non-slip surfaces, unfamiliar objects in a walkway and improper lighting.

The care plan should include the risk factors and the interventions to be implemented to try to prevent falls or other accidents. Based on the assessment findings interventions may include but are not limited to:
\begin{itemize}
  \item assistive devices; such as walker, cane, or wheelchair
  \item assistances with ambulation
  \item non-slip footwear
  \item strength building exercises
  \item eyeglasses
  \item pain management
  \item adequate fluids
  \item toileting schedule
\end{itemize}

The fall risk should be reassessed with
\begin{itemize}
  \item Each MDS
  \item With change in condition, and
  \item after each fall or "near" fall
\end{itemize}

The Care Plan should be reviewed after each fall and revised to include a different intervention to try to prevent another fall.

Skin Assessment (F314):

Based on the comprehensive assessment the facility must ensure that a resident who enters the facility without a pressure ulcer does not develop pressure ulcers unless the individual’s clinical condition demonstrates they are unavoidable. Residents must receive the necessary treatment and services to promote healing, prevent infection, and prevent new or increasing stage of pressure ulcers from developing. The resident’s skin condition must be reviewed for each MDS including the discharge assessment. Although not a requirement, it is advisable that documentation regarding the resident’s skin condition be provided when the resident departs and returns from a leave of absence, e.g. home visits, out with the family, etc. This provides information as to the presence of absence of bruises and the like which may be determined to be facility acquired if not documented the injury was sustained while out of the facility.

The documentation must support
\begin{itemize}
  \item the promotion of the prevention of pressure ulcer development.
  \item the promotion of the healing of pressure ulcers and infections.
  \item the prevention of the development of additional pressure ulcers.
\end{itemize}

Tools/Documents for the identification and documentation of resident’s at risk or with existing pressure ulcers
\begin{itemize}
  \item Medical Findings (H&P and Discharge Summary)
  \item Skin Assessment – visual examination of the skin on admission
  \item Standardized Skin at Risk Assessment such as the Braden or Norton Plus
  \item Laboratory Work
  \item Intake and Output Totals
  \item Resident Assessment Instrument
  \item Dietician Evaluation
\end{itemize}

Skin at Risk Assessment
The RAI (Resident Assessment Instrument) is the only regulatory required assessment tool and is used to identify risk factors that may be removed or modified. It also identifies a resident who has multi-system organ failure or an end of life condition or who is rejecting care and promotes identification and evaluation of potential alternatives.

Survey guidelines under F314 refer to a Standardized Risk Assessment such as the Braden Scale or Norton Plus Scale that provides a systematic assessment to identify the degree of risk. The assessment is usually completed:
- on admission
- weekly for four weeks after admission/readmission
- quarterly
- with a significant change

The early identification of the risk areas facilitates the prompt implementation of an individualized Care Plan with interventions to stabilize, reduce, or remove the risk factors. Risk Factors include:
- impaired/decreased mobility and decreased functional ability
- co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus
- drugs, such as steroids that may affect wound healing
- impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency
- resident refusal of some aspect of care and treatment
- cognitive impairment
- exposure of skin to urinary and fecal incontinence
- under nourished, malnutrition, and hydration deficit
- weight loss, decline in appetite, cause of decline, medical diagnoses
- a healed ulcer
- pressure points and tissue tolerance
- observation of positioning and pressure sites and devices that may cause pressure

The care plan should include the risk factors and the interventions to be implemented to try to reduce or eliminate risk factors related to skin at risk and/or pressure ulcers. Based on the assessment findings interventions may include but are not limited to:
- protective/preventative Skin Care
- turning and repositioning
- pressure relieving devices on beds and chairs
- encourage ambulation/movement and time out of bed
- nutritional approaches that are specifically designed for adequate nutrition
- pain management
- adequate fluids
- supportive surfaces and pressure redistribution

Actual Skin Problems/Pressure Ulcer

A complete review of the resident’s skin must be completed on admission to establish a baseline. In addition there must be an on-going system in place to assess the condition of the skin. This should occur prior to a resident being transferred to another facility, upon resident readmission/return from another facility, prior to the resident leaving the facility for an overnight (or longer) visit with family/friends, and upon return. In addition there should be a routine monitoring for skin conditions which could occur, for example, at the time of the resident’s shower/bath. Nursing assistants can report observations to the nurse, the charge nurse, nursing supervisor, etc. who would then assess for any abnormal findings.

The documentation of Assessment and Treatment of Pressure Ulcers include:
- identification of the skin’s condition upon admission.
- monitor on an on-going basis throughout the resident’s stay.
- factors that influence the development of the pressure ulcer
- potential for development of additional pressure ulcers
- potential for deterioration of existing pressure ulcers
- Description of ulcer
- Stage of ulcer including if ulcer is unstageable
- Dimensions
- Characteristics of ulcer
- Color of skin surrounding ulcer
- Evidence of infection
- Potential complications
- Presence of pain
- Progress toward healing
- Dressings and treatments
- Description of skin surrounding dressings when dressing does not need to be changed.
- Monitoring on an on-going basis for the presence of complications, change in status of dressing, or a change in the level of pain.

Documentation weekly or with each dressing change can be recorded in a narrative format in the progress notes, on the reverse side of the Treatment Record, or on a specific flow sheet. This charting includes:

- date and time of documentation
- location
- stage – including if unstageable
- dimensions and presence of undermining or tunneling/sinus tract
- exudate, if present (purulent/serous, color, odor, and approximate amount)
- pain, if present (nature, and frequency, episodic or continuous, relief obtained after treatment)
- wound bed: color and type and characteristic of tissues (granulation or necrosis)
- description of wound edges and surrounding tissue (rolled edges, redness, hardness/induration, maceration)
- signs of infection
- response to treatment
- resident’s non-compliance with treatment plan, if applicable
- notify physician of lack of healing or adverse response to treatment

If interventions were either not applicable or not feasible, there should be sufficient documentation from staff and the practitioner of clinically valid reasons why the interventions were not implemented. The total plan of care needs to be re-evaluated to determine if this was isolated or requires revised approaches.

The MDS 3.0 and CAAs require the use of validated instruments to describe the healing of a pressure ulcer. Clinicians must use the National Pressure Ulcer Advisory Panel guidelines. However, the clinicians may use the Pressure Ulcer Scale for Healing (NPUAP-PUSH) tool. The NPUAP always refers to a healed pressure ulcer as a healed ulcer at the deepest stage of its development (e.g., a healed Stage IV or a healing Stage IV). The NPUAP-PUSH tool documents pressure ulcer healing consistent with the healing process, describes a healing pressure ulcer in terms of three ulcer characteristics, and assigns a numeric value to the characteristics: length (cm) x width (cm), exudate amount, and type of tissue (closed with epithelium; new pink, shiny epithelial tissue; clean, pink or beefy red, shiny, moist granulation tissue; slough tissue; or necrotic, eschar tissue). If a pressure ulcer fails to show some evidence of progress toward healing within 2-4 weeks, the pressure ulcer (including potential complications) and the resident’s overall clinical condition should be reassessed. Re-evaluation of the treatment plan including determining whether to continue or modify the current interventions is also indicated. Results may vary depending on the resident’s condition and interventions/treatments used. The complexity of the resident’s condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain the current regimen, should document the rationale for continuing the present treatment (for example, why some, or all, of the plan’s interventions remain relevant despite little or no apparent healing).

Skin problems/ulcers are listed on the resident’s Care Plan. The interventions and the implementation of these interventions are critical and may include preventative measures. Interventions to treat pressure ulcers may include:

- protective/preventative skin care
- turning and repositioning
- pressure relieving devices on beds and chairs
- nutritional supplements
- pain management
- adequate fluids
- supportive surfaces and pressure redistribution
- treatments as ordered by physician
- short term placement of catheter

Bowel and Bladder Assessment (F315):
Based on the comprehensive assessment the facility must ensure that a resident who enters without a catheter is not catheterized without medical justification and a resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Assessment
The Admission Nursing Assessment identifies the status of the resident such as:

- continence status as described by resident or by observation
- risks or conditions that may affect continence.
- use of medication that may affect continence.
- environmental factors that might facilitate or impede the ability to access to the toilet, type of clothing, ambulation status and devices, use of restraints, and use of siderails.
- dietary preference.
- hydration status; skin turgor, mucous membranes, weight loss
- if catheter present; medical justification for catheter, type and size of catheter, potential for removal, color of urine, flow of urine.

The continence of the resident is usually determined over a period of time, for example, 72 hours. Once the assessment has been completed, the type of urinary incontinence (stress, urge, overflow, mixed, functional or transient), should be determined by the practitioner. Since the type of incontinence is a diagnosis, it can only be determined by the practitioner.

Over the following week, or when the catheter is removed additional data is gathered to include:

- cognitive status
- patterns of incontinent episodes
- voiding patterns
- fluid intake and hydration status
- toileting ability

Based on the initial assessment and the evaluation of ability and patterns, an individualize toileting program is developed for the resident and entered under interventions on the Care Plan. Intervention may include:

- routine incontinence care
- a scheduled toileting program
- habit training, prompted voiding, or
- formal bladder or bowel retraining program.

Progress notes for bladder/bowel retraining programs are usually recorded weekly until the resident has reached the goal or the program is discontinued. Restorative nursing toileting programs that may help the resident regain the ability to toilet self and reduce incontinent are summarized during and/or at conclusion of each assessment reference period.

Physical Restraint Assessment (F221):

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms. The state specific regulations must be referenced to determine if there are any specific requirements related to the use of restraints.

The goal of a facility is to be as restraint free as appropriate. Prior to the use of a physical restraint an assessment must be completed to determine whether a restraint is clinically necessary and 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. The assessment should all include all interventions tried before the use of a restraint was considered. If the nursing staff have determined that a restraint may be appropriate, the practitioner should be contacted and an order for a Physical Therapy/Occupational Therapy evaluation be obtained for the use of the restraint and for the least restrictive device to be used. Once the evaluation has been completed, the recommendations are relayed to the physician for the appropriate order.

The order needs to include the following:

- Type of restraint to be used
- Duration (ex – while in wheelchair, while unattended, to be removed when resident is sitting at the table, removed at least every 2 hours)
- Diagnosis/medical justification for use.

It should be noted that the interpretive guidelines clarify that the justification of the use of the restraint cannot be based on the request of the family, for safety of the resident, and/or for the convenience of staff.

Once the order has been received, the resident/legal representation must be contacted and a consent for use obtained; after the risks and benefits have been explained to the resident/legal representative.

The restraint/device is included in the resident’s Care Plan with the medical symptoms for which the restraint is used. The interventions may include

- method of application
- schedule for release and repositioning
- a plan to reduce the need for the restraint
alternatives to the restraint, such as lowering the bed, mattress on floor, bed alarms,

Though many state regulations may mandate additional requirements, the facility must reassess the use of the restraint at least quarterly. To evaluate the appropriateness, the facility may use the Physical Restraint CAA to evaluate the appropriateness of restraint use; a form designed for this use or records a narrative note.

Self-Administration of Medication (F176):

If the resident requests to self-administer medications, the interdisciplinary team must determine that it is safe for the resident to self-administer drugs before the resident may exercise that right. The assessment may include:

- cognitive status
- manual dexterity
- eyesight

If it is determined the resident is a suitable candidate for a self-medication program, the physician is contacted for an order. The Care Plan will reflect the self-medication program and goals. Flowsheets or narrative notes will reflect the resident's progress in the program.

Nutrition Assessment (F325):

The facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels; unless the resident's clinical condition demonstrates that this is not possible. The facility must ensure the resident receives a therapeutic diet when there is a nutritional problem. In addition, the resident must be interviewed to determine food preferences and food allergies that are taken into account when meeting the resident's needs.

The Nutrition Assessment should address these issues and include identification of the factors that put the resident at risk for malnutrition. The Nutritional Assessment may require the expertise of a Registered Dietitian. State regulations may mandate a dietitian’s assessment of all residents with identified nutritional problems.

Evidence of review of the CAA for Nutritional status should be present to assess the status of the nutritional needs, the causal factors for decline, and potential for decline or lack of improvement for residents at risk.

The nutritional problem or medically related condition is recorded on the resident's Care Plan.

The interventions may include

- therapeutic diet
- altered texture of diet
- fluid restrictions
- altered fluid consistency
- periodic review by dietitian
- laboratory work

The problem and goals of the Care Plan is reviewed at least quarterly and with significant change using a progress note or reassessment form.

Activities/Recreation/Leisure Interest Assessment (F248):

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests, and the physical, mental, and psychosocial well-being of each resident. With the implementation of the MDS 3.0 Assessment, the resident's preferences for activities of leisure are evaluated with every comprehensive MDS. Much of this information may be obtained through the resident interview process. The facility should use an Activity Assessment that includes

- resident's lifelong interests
- spirituality
- life roles
- occupation
- relationships
- goals
- strengths
- needs
- activity pursuit patterns and preferences

The Assessment need not duplicate information from other sources, such as the RAI, including the CAAs, assessments by other disciplines, observation, and resident and family interviews. Other sources of relevant information include interviews with the resident or family. The
ongoing program of activities should match the skills, abilities, needs, and preferences of each resident with the demands of the activity and the characteristics of the physical, social, and cultural environments. Many facilities are implementing other methods of structuring the environment. These programs such as the Eden Program and Pioneer Network are resident centered. They change the types and locations of activities; however, the interests of resident are central to the programs and related documentation. Care planning involves identification of the resident’s interests, preferences, and abilities; and any issues, concerns, problems, or needs affecting the resident’s involvement/engagement in activities. Information may also be found in the resident’s Care Plan, a separate Activity Plan or on the Activity Participation flow sheet. Activity goals related to the comprehensive care plan should be based on measurable objectives and focused on desired outcomes (e.g., engagement in an activity that matches the resident’s ability, maintaining attention to the activity for a specified period of time, expressing satisfaction with the activity verbally or non-verbally), not merely on attendance at a certain number of activities per week. Progress notes reflect the resident’s participation in the Activity Care Plan, preference for specific activities, interactions with other residents, and progress toward goals should be documented during and/or at conclusion of each assessment reference period.

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 must reflect the social history of the resident and assessment of the emotional, financial, mental, and psychosocial needs.

- Cultural background
- Family dynamics and family support, significant others
- Role in community
- Loss and grief
- Financial concerns
- Support of fraternal organizations or community
- Prior living arrangements

The Care Plan addresses these issues as needs or strengths and interventions to support the goal:

- Visits with clergy
- Visits from fraternal organizations
- Visits with social worker
- Family visits
- Hospice intervention
- Community support
- Mood and behavior issues
- mental health counseling
- Discharge planning

Progress notes which reflect the resident’s emotion, financial, psychosocial needs, and progress toward goals should be documented during and/or at conclusion of each assessment reference period. A significant change such as a new diagnosis requires a review of the psychosocial needs and a review of the Care Plan. Discharge planning conferences should be arranged, if indicated, to discuss discharge plans, especially if the resident requires ongoing care or a change in their living arrangements on discharge.

Mental and Psychosocial Functioning (F319-F320):

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 withdrawal, anger or depressive behaviors, unless the resident’s clinical condition demonstrates that such a pattern is unavoidable. Assessments used to identify mental and psychosocial functioning include, but not limited to:

- RAI (through the use of the BIMS, PHQ9, and CAMS obtained in the interview process)
- Folstein Mini-mental Status
- Geriatric Depression Scale,
- Cornell Depression Assessment
- ADAS-Cog (Alzheimer Disease Assessment Scale-Cognitive)
- Behavioral Pathology in Alzheimer's Disease Rating Scale (BEHAVE-AD)
- Blessed Test
- CANTAB - Cambridge Neuropsychological Test Automated Battery
- CERAD (The Consortium to Establish a Registry for Alzheimer's Disease) Clinical and Neuropsychological Tests
Restorative/Rehab Nursing Assessment (F317-F318):

The facility must provide care and services to attain or maintain the resident’s highest level of independent function. Based on the assessment the facility ensures that a resident who enters without limited range of motion, functional activities of daily living does not experience a decrease in their functional status unless the resident’s clinical condition indicates that it is unavoidable.

Assessments may include:

- The RAI
- Screens and recommendations by physical, occupational, speech therapists,
- Range of motion
- Bed mobility, transfer, and ambulation
- Self-feeding capabilities
- Bladder/bowel status
- ADL assessments; grooming, dressing, toileting, hygiene, bathing
- Communication

The Care Plan must include the functional deficit, measurable goals, and the restorative training program. The nurse in charge of the nursing restorative program must record progress notes addressing the progress toward goals during and/or at conclusion of each assessment reference period. The state regulations may address the frequency of documentation of the review of the resident’s progress. Many facilities document the resident’s progress at least quarterly.

Rehabilitation Services (F406):

The physical, occupation, and speech therapists perform evaluations based on the physician orders. The format of these evaluations is based on their professional standards of practice and will address the resident’s physical function in the specific area. The medical diagnosis that supports the medical necessity for skilled therapy services must be provided by the physician either in current documentation in the record or documentation of a newly identified diagnosis made by the physician.

Once the evaluation is complete, the therapist or nurse will notify the physician and obtain an order for the program as outlined by the therapists. Some therapists inform the physician of the program by sending or faxing a copy of the evaluation. Any skilled services must be certified as necessary by the physician/nurse practitioner/physician assistant.

For residents covered by Part B therapy, the physician/nurse practitioner/physician assistant must certify the resident for the services and follow the resident every 30 days as long as the resident is covered by Part B Medicare. At the end of the services the facility must provide the resident with the Notice of Exemption from Non-coverage.

The time spent in therapy and the progress of the resident during this time may be documented on a daily documentation form. Many facilities may use separate log sheets to document the time spent in therapy. These logs should be part of the clinical record. The therapist must include in the note the level of participation of the resident in the program as defined in the plan of treatment. The therapist must write a discharge summary when the program is discontinued.

Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) and Care Area Assessment (CAA) (F272-F278):

Each facility must complete a comprehensive assessment that is based on a uniform data set. Facilities must use the MDS, and the CAAs to assess newly admitted residents within 14 days. Using the Assessment Reference Date (ARD) as the base, the facility staff must conduct an annual assessment (no more than every 366 days after last full assessment or more than 92 days after the last quarterly), assess those residents who experience a significant change in status (F274) or when completing a significant correction of a prior full assessment (within 14 days). No less than once every quarter (92 days), facilities must conduct a State specific quarterly review of the resident’s status. With implementation of the MDS 3.0, the scheduling the subsequent MDS assessment is based on the assessment reference date (ARD) of the previous assessment. (RAI 2-15 to 2-16)

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’s 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 CAAs. The facility is also responsible for addressing the resident’s needs from the moment of admission. 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 assessment schedule includes a 5, 14, 30, 60, and 90-day assessment. An OMRA (Other Medicare Required Assessment) may also be completed in specific situations for example after all therapies are discontinued but the resident is still receiving skilled nursing services such as wound care. Under the MDS 3.0 requirements, residents who opt to receive Hospice benefits must have a significant change assessment completed when benefits are initiated and on discharge from hospice. In addition to Medicare, many states also use the MDS to determine reimbursement for Medicaid. For complete information on the RAI/MDS schedule for both OBRA and PPS assessments, refer to Chapter 2 of the RAI User’s Manual.

Care Plan (F279):

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 the on-going documentation of the residents care, condition, and needs. 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; and 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 resident’s 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.

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. This review must take place within 7 days of completion of the assessment. The care plan must be kept up to date. At any given time; the resident’s care plan should reflect the care the resident is receiving.

Care Conference (F280):

In completing a 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, and 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.

Admission 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. The plan may include self-care deficits, mobility status, nutritional needs, skin conditions, and clinical and/or rehab needs.

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.

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 and/or the quarterly assessment. For example, if the care conference were 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

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.

Narrative Charting and Summaries:
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. The narrative note should not repeat information already included in the nursing assessment. The narrative note should provide supplemental information. State regulations may have specific requirements for admission documentation and the time frame for completion.

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 staff 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, including what the resident said or did observations and/or assessments by staff, communications with practitioners and legal representative/s and the resident's representative, response to interventions/treatment. Good practice indicates that for functional and behavioral objectives the clinical record should document change toward achieving care plan goals.

Nursing and/or Interdisciplinary 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 (i.e. monthly, weekly, or periodic summary). If used, the summary documentation provides a mechanism to update 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 it is not applicable. When using a flow sheet 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 flow sheet does not preclude staff from maintaining documentation throughout the month that reflects any changes in condition or status.

Integrated vs. Disciplinary Progress Notes:
Either integrated or disciplinary progress notes may be used according to the facility's policies and procedures. 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 the narrative notes on different forms based on the specific department or discipline performing the documentation. The integrated progress notes may help to facilitate interdisciplinary communication.

Medicare Physician Certification:
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 coverage, the skilled services being delivered, and the ongoing 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. The certification for Medicare services can be signed by the Nurse Practitioner or the Physician Assistant working with the physician. However, the attending physician must complete the initial medical assessment (H&P) and sign the admission orders.

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, it is advisable to check with your payers to determine any specific documentation requirements. Some states also provide payment to nursing facilities for services provided based on the RUGs system. These state agencies may also have additional documentation requirements to determine payment and/or support the data on the MDS. External auditing agencies may be used to determine whether the facility documentation is compliant with these requirements.

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).
Documentation may be more frequent if necessitated by the resident’s condition. Those residents receiving skilled services must show evidence in the documentation of the need for daily skilled services being rendered. 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 in a narrative format, captured on flow records or graphics, through structured documentation systems such as SOAP, FOCUS, PIE, etc. In addition to documenting daily skilled services, the medical record should also contain documentation supporting the reason for coverage/non-coverage.

Supporting Documentation for the MDS:
The Centers for Medicare and Medicaid Services has identified that the RAI/MDS is a source document and does not require supportive documentation, however they have identified that some entities may require additional documentation requirements specific to supporting 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.

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 assignment level. In addition to treatment time, the RAI manual requires that the physician order for therapy services must include a statement of the frequency, duration, and scope of treatment.

Activities of Daily Living (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 based on observations and interviews, a clarification note can be written documenting the rationale for the ADL scoring on the MDS.

Mood and Behavior Documentation:
Mood and behavior scoring on the MDS will affect the Medicare RUG payment category. Because these sections on the MDS require the reporting of the frequency of the mood or behavior problem, the medical record should provide supporting documentation that quantifies the frequency reported.

Hospital Documentation:
With the implementation of the MDS/CAA 3.0 and RUGs IV, the services provided prior to the resident’s admission to the nursing facility cannot be calculated into the RUG assignment. However, the MDS 3.0 does identify those services prior to admission; therefore 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.

Medicare Certification/Recertification:
Each resident on Medicare must have a Medicare part A certification/recertification completed and signed by a physician knowledgeable of the resident’s care and treatment. Depending upon the individual state’s practice standards for Nurse Practitioners and Physician Assistant, the Nurse Practitioner and/or Physician Assistant may sign the certification. The certification/recertification must include the reason for Medicare coverage and the skilled services to be delivered. Certifications are required upon admission, on or prior to day 14, and then every 30 days thereafter, from the date of the previous signature, while the resident continues to be Medicare part A covered. It should be noted that signature stamps are not acceptable for the Medicare certification and the date of the signature must be completed by the physician at the time of signing the certification form. The facility staff may document the specific reasons for the Medicare services being provided but cannot sign and/or date the certification. The certification may be recorded in various formats as long as it contains the specific certification terminology. There is no Federal requirement for a specific form to document the certification.

(Effective with items and services furnished on or after January 1, 2011, §3108 of the Affordable Care Act has added physician assistants (PAs) to the existing authority for physicians, nurse practitioners (NPs), and clinical nurse specialists (CNSs) to perform the required initial...
Rehabilitative Therapy Documentation
Rehabilitation Services are provided at the order of the attending physician to improve the physical functioning of the resident, hopefully to allow them to return to the community. The Rehabilitation Services Assessment should be performed within a reasonable time after the order is received. Once services have been initiated, a progress note must be documented within 14 days and then at least every 30 days as long as the resident is receiving therapy services. The attending physician must certify the assessment and plan of care documented by the therapists. Most therapists utilize a specific government generated form (HCFA 700) for this purpose. This form includes the assessment of the resident’s functional status, the plan of care going forward and a location for the physician’s signature certifying the need for and approval of therapy services. Once the resident has reached their goal a therapy discharge summary is completed. One of the requirements under the PPS system is a calculation of the number of days and minutes of therapy. The clinical record must reflect these dates and times, usually completed through a flow record, whether electronic or in hard copy. Many therapists include a notation as to what the resident’s performance level was for the therapy session as well. In addition, a weekly summary is frequently documented as well. Regardless of the format for documentation, the therapy documentation must support the information identified on the MDS.

Physician Documentation:

Physician Progress Notes: (F386)
The Following is based on the AMDA (American Medical Directors Association) Position Statement: "Role of the Attending Physician in the Nursing Home” effective March 2003.
Progress notes must be written, signed and dated each time a physician visits a resident. The frequency of each visit is based on a joint physician-facility-developed protocol that is consistent with applicable state and federal regulations (AMDA). Per federal regulations, the resident must be seen at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. (F387) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required (F387). The subsequent physician visit schedule is established based on the resident’s date of admission.. Progress notes should provide documentation to explain medical decisions, enable effective care and should include:
(Per AMDA guidelines):
- An evaluation of the resident’s condition, current status and goals.
- Progress of resident’s response to the treatment regime.
- Status of any acute episodes of illness since the last visit
- Relevant information about significant ongoing, active, or potential problems including reasons for changing or maintaining current treatments or medications
- Plan for addressing relevant medical issues
- Provide diagnoses related to resident problems and interventions (including medications and diagnostic studies)
- Analysis of significant tests and medical rationale for subsequent interventions or decision not to intervene based on those results when the basis for such decisions is not readily apparent
- Documentation of ethical issues and end of life decisions

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. At a minimum, the physician should identify the resident’s diagnosis and/or reason for admission. 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 frame. Each dictated note should reflect the date dictated and date typed, including the physician’s signature (manual or electronic).

Nurse Practitioner (NP)/Physician Assistant (PA) Documentation (F388; F390):
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. Federal regulations allow the physician and nurse practitioner to alternate the required visits, after the initial visit by the attending physician.
History and Physical:
Although there is not a Federal regulation which requires the completion of a history and physical at the time of admission or on a periodic basis thereafter, facility policies requiring an H&P should be developed based on state regulations and applicable accreditation standards. The Federal requirements mandate that the H&P must be performed and documented by the attending physician. The physician must assess a new admission in a timely fashion (based on a joint physician-facility-developed protocol) and document the results of that assessment and plan of care in the medical record. The note should include information to support the admission to the facility in determining the level of care:

- History and Physical
- An assessment of Current condition or issues
- Treatment goals and plan of care
- Rehabilitation potential
- Diagnoses

Other Professional and Consultation Records/Notes:
If the resident requires a consultation with a specialist, services in an emergency room or a specialty center such as dialysis center, the medical record must 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. Findings and Recommendations of the consultant must be communicated to the Attending Physician. Facility policy will determine this procedure. If the nurse calls the physician with this information, then the nurse will document results of that communication. Some facilities require physician’s to sign off on consultant reports.

Documenting Resident Diagnoses:
The medical record contains a record of the resident’s medical diagnoses. The diagnosis 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, the applicable ICD-9-CM code, and resolve date. If a section is included on the Diagnosis list containing source document where diagnosis signed by physician was found, then physician will not need to sign Diagnosis List. The MDS 3.0 requires that the physician must document the resident’s diagnosis/es within 60 days of the assessment reference date. This documentation can be found in the H&P, progress notes, physician orders, etc. If the diagnosis list is used to support the use of the diagnosis on the MDS, the physician must verify the diagnoses. The diagnoses identified on the MDS not only must be documented within the previous 60 days but must be considered active during the past 7 days. Whether the diagnosis is ‘active’ is determined by whether the condition is being monitored, treated, etc. during the previous 7 days.

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) cannot diagnose or determine a more specific diagnosis without consulting with the physician and obtaining supporting documentation. This is frequently documented through the use of a verbal order.

Resolving Diagnoses:
On a regular basis (i.e. quarterly with each care conference, at the time of physician visits, etc.), the diagnosis 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 (Urinary Tract Infection) or URI (Upper Respiratory Infection).

Final Progress Note/Discharge Note/Summary F283:
As determined by facility policy, the physician’s final note should include a recapitulation of the resident’s stay, final diagnosis, rehabilitation potential and prognosis, if appropriate, and disposition of the resident.

In the event of the resident’s death, the physician must complete and sign the Death Certificate as defined by State protocol. It should be noted that the requirements regarding the completion and registering of birth and death certificates are governed by state law therefore each state may have differences in the requirements.

Physician Orders: Admission Orders: (F271)
At the time a resident is admitted, the facility must have physician orders for the resident’s immediate care. These orders should include, at a minimum, the resident’s diet, medications (if necessary), and routine care to maintain or improve the resident’s functional abilities until the staff can conduct a comprehensive assessment and develop a comprehensive interdisciplinary care plan. At the time that the transfer orders are confirmed with the attending physician, the physician may add or delete some of the orders provided via the transfer document. These should be documented, as appropriate, following documentation standards.
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 of administration, 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.

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.

Telephone Orders:
Orders received by telephone should be countersigned by the physician within the required time frame as defined by state law. There should be indication that the verbal order was read back and verified with the physician. 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.

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. As identified in the Interpretative Guidelines, 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 unless the physician returns the original signed fax to the facility. All faxed information must be clearly identified with the resident's name and medical record number. It should be noted that some older fax machines utilize paper which can deteriorate in time. This should be photocopied and the photocopy placed on the resident's record.

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.)

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 timeframe in which telephone orders are to be authenticated, however, state regulations frequently address the timeframe necessary for signature of the order. 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, NP and PA countersignature.

Transcription of Orders and Noting Orders:
Transcription of orders, such as telephone orders, is a responsibility of professional nurses (RN, LPN/LVN per the 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.

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 create/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 has the authority by law and scope of practice to write orders on behalf of a physician.

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.
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.

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.

Verification of hospital orders with attending physician:
All hospital orders should be reviewed and authorized by the resident's attending physician at the time of admission or shortly there after.

Accepting orders from a Nurse Practitioner (NP)/Physician Assistant (PA):
Orders should only be accepted from a nurse practitioner or physician assistant if the state practice acts 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.

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).

Pharmacy Drug Review: (F428. F431)
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. Documentation in the record must reflect the physician's response to the recommendations made by the pharmacist.

Antipsychotic Drug Therapy (F329):
At a minimum, the medical record documentation should include documentation that supports the assessment of the condition, identifies the specific condition as diagnosed including the statement of the manifestation. The assessment should include the documentation of the behavioral manifestation, signs and symptoms, identification of underlying causes(s) including adverse consequences of medications. The assessment should clearly identify the medical necessity for the use of the psychoactive drug/s, including the consideration of the resident's risk/benefits, total treatment plan and other medications/conditions. As part of the assessment, risk benefits. Non-pharmacological interventions (such as behavioral interventions) are considered, evaluated and used when indicated, instead of, or in addition to, medication) Physician orders for psychoactive drug therapy should include the reason for the medication which should be related to the diagnosis/specific condition based on assessment. The physician order or documentation in another location in the medical record should identify the manifestation to be monitored.

Residents receiving psychoactive drug therapy should receive continuous monitoring and assessment which includes:
- Evaluation of a resident’s signs and symptoms, in order to identify the underlying cause(s), including adverse consequences of medications;
- Frequency and monitoring of the medication to identify effectiveness and adverse consequences will be carried out to include periodic planned evaluation of progress, review of adverse consequences, continued need at least quarterly, unless regulations specify otherwise

If psychopharmacological medications are used as an emergency measure, adjunctive approaches, such as behavioral interventions and techniques should be considered and implemented as appropriate. Longer term management options should be discussed with the resident and/or representative(s)

Dose Reduction Schedules and Documentation (F329):
For residents who receive antipsychotic drugs, the record should contain documentation of the interdisciplinary behavioral interventions, the documentation of the evaluation of the data related to the behavior/s and medication side effects as well as the efforts to gradually reduce the medication dosage unless contraindicated.

Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a gradual dose reduction in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a gradual dose reduction must be attempted annually, unless clinically contraindicated. If clinically contraindicated, documentation by the physician should provide justification as to why the drug must continue to be used and 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.

Medication and Treatment Records:
Medication and treatment records (MARs and TARs) are derived from the physician orders and document the delivery of ordered services. Nurses place their initials in the blocks of the MARs and TARs form when medication or treatment has been administered. Based on physician orders, there should be no gaps noted in this documentation. Also, the medical record should contain a legend that matches staff initials with full signature and credential. Some facilities choose to do this as a separate master list as opposed to legends on each form in the medical record. This Master Signature List should be updated with new staff hires. Each master list however must then be filed in each resident’s medical record.

Any medications or treatments given on a PRN (as needed) basis must be initialed, and information pertaining to the need for the PRN, documented either on the back of the MAR/TAR or elsewhere in the chart as defined by facility policy. Separate nurses’ note may also be required. For electronic records; the Medication and Treatment Records may only have the initials on the MAR/TAR either on view or print. The legal medical record must be able to be identified with the electronic system to verify the initials against the full name, title and effective dates.

Narcotics will require additional tracking and logging procedures.
Nurses will circle or otherwise indicate which medications or treatments were NOT administered. This would then require a documented explanation as to why the order could not be carried out. Facilities utilizing electronic medication administration records (e-MARs) may have the ability to perform audit functions at the end of med passes to insure that all required documentation is in place.

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 should be based on the new orders received after hospitalization.

Flow Sheets/Flow Records:
Although flowsheets or records are not recommended to replace summary or narrative charting, they are helpful tools in recording many clinical data or service delivery.

Service Delivery Records:
ADL (Activities of Daily Living) Flowsheets and NAR (Nursing Assistant Record) Flowsheets:
There is no federal requirement to maintain ADL flowsheets or Nursing Assistant flowsheets to document delivery of resident care services however they may be used to provide supportive documentation for the coding on the MDS. 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 flowsheets, there should be a system to monitor completion every shift. Unless utilizing an electronic care tracking program, flow sheets are the easiest way to document amount of care rendered to the resident. ADL scores are critically important to scoring the ADL section of the MDS correctly and consequently for maximizing reimbursement. Scoring on the ADL flowsheets should be consistent with the scoring on the MDS to increase consistency in data collection and assessment.

ADL flow charts a part of electronic legal health record will include a system for verifying initials, full name and title, dates of entries on view and print.

Other Clinical Flow Records:
There are many different clinical flowsheets 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.

Labs and Special Reports: (F504, F510)
All laboratory, radiology, and diagnostic services must be ordered by the attending physician (F504, F510). Orders for labs, x-rays and other diagnostic tests should include specific tests and the rationale for the diagnostic test requested. The rationale should be either an established diagnosis or current signs/symptoms. One should not accept rule out statements for the rationale. A report of the findings for all laboratory, radiology or special diagnostic services must be retained in the medical record. The physician must be promptly notified of the results of the laboratory findings (F505) and findings from radiology or other diagnostic services (F512). When labs or studies are received, a nurse must review the report and notify the physician of any abnormal results as dictated by facility policy. The nurse will then initial and date the report and note any communication or orders from the physician (if using an EHR, the system should have an electronic equivalent to the nurse initials and date to signify review). The physician will document the clinical significance of the abnormal findings, especially if it establishes a new
diagnosis. If there are abnormal lab results but the physician decides not to treat the resident, a notation should be made in the clinical record (i.e. nurses notes) documenting the physician’s decision and reason for this decision.

Consents, Acknowledgements and Notices:

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. In the case of a resident who is incapable of making a decision, the legal surrogate or representative may exercise the right based on the same information that would have been provided to the resident.

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, the facility must provide the resident with a written Notice of Privacy Practices. In addition, the facility must provide the resident with a Privacy Act Statement which describes the collection and use of the Resident Assessment Instrument information. (See RAI Users Manual Chapter 1-14)

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. It should be noted that the bedhold status of the resident does not impact the completion of the Discharge Assessment nor should it impact whether the resident’s record is closed or remains ‘open’. The timing of the closure of the clinical record is determined by the facility’s policy, e.g. the chart remains open for ‘X’ days after the resident is admitted to the hospital. In cases of emergency transfer, notice “at time of transfer” means the family, surrogate, or representative are provided with written notification within 24 hours of the transfer. The requirement is met if the resident’s copy of the notice is sent with other papers accompanying the resident to the hospital.

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.

Notice Before Transfer (F203):
Before a facility involuntarily discharges or transfers a resident, an Advance 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.

Notice prior to change of room or roommate (F247):
The resident must be notified prior to a change in the resident’s room or roommate and this notification should be documented in the clinical record. Following the room change, the clinical record should include documentation related to the resident/s adjustment to the room or roommate change. The facility staff should make every reasonable effort to accommodate the resident’s preferences.

Advance Directives (F155-156):
The resident has the right to formulate an advanced directive. 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. Some states have chosen to utilize the Physician Orders for Life Sustaining Treatment (POLST) or Medical Orders for Life Sustaining Treatment (MOLST) as the approved method for documenting the resident’s wishes for treatment. This is a specific format for documenting the individual’s wishes for end of life care. The form is to be accepted by all health care providers.

DNR Order vs. Advance Directives:
Physician orders for a DNR status must be consistent with the advance directives of the resident. Some states utilize the MOST/POLST forms to document the resident’s wishes. 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.

Discharge Documentation:
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.

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, instruction, or training provided, where discharged to, and the individual taking responsibility for the resident.

Discharge Summary (F283 and F284):
For planned discharges (i.e. discharges home or to another facility), federal regulations require that the facility complete a discharge summary that includes: (1) recapitulation of the resident’s stay, (2) a final summary of the resident’s status based on the comprehensive assessment, and (3) 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. The format for these documents is not mandated. Depending on facility policy, a copy if the summary may be given to the resident when discharged from the facility.

Transfer Form:
A transfer form must be completed when transferring the resident to the hospital or to another health care facility. This transfer forms should include the resident’s status, reason for transfer, medications, etc. Date elements that should be contained in a Transfer form would include, but not limited to, the following:
- Basic demographic information
- Financial information (Medicare number, Medicaid number)
- Next of kin and/or responsible party contact information (name, address, phone, relationship)
- Facility’s name, address, phone number and contact person
- Code status of the resident
- Description of the problem, condition of the resident necessitating the transfer
- Medications and when they were last provided
- Functional status of the resident

Many facilities will also send copies of information from the clinical record with the resident to the accepting facility. Some of these items may include, but not limited to, copies of the current orders, medication record, last 3 days of nurse’s notes, most recent physician note, advanced directive, power of attorney, etc. The original of the Transfer form should be sent with the resident to accepting facility while the copy (carbon) would be retained in the clinical record.

Physician's Discharge Summary vs. Discharge Record:
Federal regulations do not require the completion of a physician’s discharge summary for every discharge. However, State regulations should be reviewed to determine the physician’s responsibility for documentation upon discharge. Some states may identify the content of the discharge summary as well as the timeline and responsibility for completion. At a minimum, a discharge record should be completed which includes the date and time of discharge, disposition, prognosis and rehabilitation potential (if applicable), final diagnoses, cause of death and to where the resident was discharged.

The RAI 3.0 requires that a Discharge Assessment be completed within 14 days of the resident’s discharge from the facility. If the resident expires in the facility, a Death in Facility record must be completed. If the resident is discharged in less than 14 days from admission, the record may contain only the Entry Record. Any portion of the MDS which has been completed should be part of the clinical record and a notation
written identifying why the MDS was not completed.

Post Discharge Plan of Care (F284):
There must be a plan for the resident’s treatment, if necessary, after their discharge home. This may include visits by a home health agency, outpatient rehabilitation or care provided by the family. This plan should be documented in laymen’s terms, including the medications to be received by the resident. The original of this information is provided to the resident with a verbal explanation of the care needs. The resident and/or responsible party should sign the form verifying that the information has been provided and their understanding of the information. A copy of this information is retained on the clinical record. The accrediting standards require a follow-up contact with the resident and/or responsible party to verify that the resident is progressing as anticipated.

Admission Agreement
Upon admission an Admission Agreement which would contain a Consent to Treat must be completed, signed and dated by the patient or legal representative and a representative of the facility. The patient should receive a copy; the original will be placed in medical record.

Financial Agreement
Upon admission a Financial Agreement which identifies the financial obligations of the resident with regard to the stay in the facility and changes which could be incurred, including terms of payment and any interest rate or late charges on overdue accounts. The Financial Agreement must be signed by the patient or his legal representative. The patient should receive a copy, the original will be placed in the medical record (or business office files).

BIPA Forms

Generic Notice
Two days prior to termination of Medicare Benefits, a Notice of Termination of Benefits (Generic notice) must be completed, issued to the patient or their legal representative, and signed and dated by the patient (representative) and the facility staff member. A corresponding progress note should be documented in the medical record which identifies the person who was notified and that they understood the implication of the notice and their right to appeal the notice. A copy should be given to the patient. The original should be maintained in the medical record. The physician should be notified of patients being terminated from Medicare benefits.

Detailed Notice of Termination of Medicare Benefits
On the occasion that a patient or their representative appeals the decision to terminate Medicare Benefits a “Detailed Notice” will be completed and issued to the patient. This notice will contain the specific reason or rationale, based on the Medicare Criteria for Skilled Services, why the patient no longer qualifies for Medicare Benefits. A copy of this notice will be sent along with copies of the record as requested by the QIO for review. A copy will be retained in the Medical Record.

Documentation Systems/Formats
Most facilities utilize the narrative format when documenting in the clinical record, though this is only one of the many options available. It is important to utilize a system which provides the information to meet the needs of the facility and allow the staff to document efficiently and effectively. Following is a brief overview of the formats available. As this is an overview, more detailed information on each system should be researched through various resources, e.g. Charting Made Incredibly Easy, Mosby’s Surefire Documentation, etc.

- **NARRATIVE**: Used in the majority of institutions, narrative charting is essentially staff recording data using progress notes, with flow sheets supplementing the notes. Narrative charting does not follow a specific outline and follows the thought process of the staff member documenting.

- **PROBLEM ORIENTED MEDICAL RECORD (POMR)**: Used in many health care institutions, the POMR system follows a problem list format, identifying all areas impacting the patient/resident, both positive and negative. The notes and all documentation refer back to the problem list, utilizing the “SOAP” (Subjective, Objective, Assessment, Plan), SOAPIE (Intervention, Evaluation) and/or SOAPIER (Revision) format.

- **PROBLEM/INTERVENTION/EVALUATION (PIE)**: Organizes information according to the residents’ problems to simplify the documentation system. Utilizing flow sheets which have been designed for daily documentation supplemented with structured narrative documentation. This system also integrates the care plan into the daily documentation.

- **FOCUS**: Organized into patient centered topics, the FOCUS system encourages integrating assessment data to evaluate the resident’s condition on an ongoing basis. Utilized principally in acute care settings, it is best used where the procedures are repetitive. Progress notes are written utilizing the DAR (data, action, response) format.
• CHARTING BY EXCEPTION (CBE): Developed by nurses, this system requires the development and use of practice standards or protocols for each body system. The forms utilized in the documenting are developed following the specific guidelines. Developing the standards and forms eliminates the need to document in narrative format standard nursing care. Staff would check off those areas on the flow sheet through which the resident has met the established standard/protocol and then writes a narrative note when the resident’s condition deviates from the established standard.

• FLOW SHEET, ASSESSMENT, CONCISE, TIMELY (FACT): Developed to help eliminate irrelevant data, repetitive notes and inconsistencies and to reduce the amount of time required to document. Flow sheets are designed to address the redundant activities in caring for a resident. The narrative documentation utilizes the DAR format of the FOCUS charting system.

• CORE: this system focuses on the nursing process. Specifically the CORE framework uses the data base, care plan, flow sheets, progress notes and discharge summary to chart the resident’s needs and progress. Progress notes follow the DAE (data, action, evaluation/response) for each problem.
Health Information Policy & Procedure Checklist

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. The policies and procedures should reflect the Health Insurance Portability and Accountability Act (HIPAA), requirements of the electronic health record as well as any state regulations and legal requirements. The (*) will denote areas where it is suggested the policy and procedure include HIPAA and electronic records requirements. The (** will identify electronic record requirements.

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**
- 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, Tracking of access to the electronic record/audits.**
Clinical Records, Definition of Legal Electronic Health Records, Designated Record Set and Health Information/Record Service*
Electronic Health Record (e HR) Planning, Training, Implementation and Quality Assurance process* (sample tools).
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 and/or ability to provide a chronological clinical record.
Retention
Storage of Records Manual Onsite, Automated Record Storage including Hosting
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
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). If an electronic health record is used, include a description of system items related to the below and the content requirements – any special instructions for automated portions of the record, standards, requirements.

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 and e HR monitoring of visits
Denial Letters, Medicare
Destruction of Records, Log, Manual or electronic
Disaster Planning for Health Information
Discharge Procedures (Including the hybrid record)

Assembly of Discharge Record
Chart Order on Discharge
Completing and Master Patient Index
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 (Including the e HR)**
Guidelines, Committee Minutes
Incomplete Record File**
Indexes
  - ICD Disease Data and reporting**
  - 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)**
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**
  - Defining the Quality Assurance Process/monitoring**
  - Health Information participation
  - QA Studies and Reporting
Readmission – Hybrid 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 Process/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, Manual Onsite and Offsite, Automated Record Storage including Hosting**, *
Telephone Orders**
Thinning
  • In house Records
  • Maintaining Overflow Record
Unit Record System

References:

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