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

Legal Documentation Standards that Apply to Medical Records

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).

acility 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 nurse who is not licensed therapy assistants, etc.). The person who is making the countersignature must be qualified to countersign. For example, licensed nurses who don't have the authority to supervise should not be countersigning an entry for a graduate nurse who is not yet licensed).

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

The federal regulations for long term care facilities do not require countersignatures for nurse practitioners 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 turn over is high new master signature legends should be completed on a regular basis (i.e. once a year). With each update of the master signature legend there should be a date indicating implementation and revision.

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.
