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

Practice Guidelines for LTC Health Information and Record Systems

Audits and Quality Monitoring

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-audting, 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.

	Quantitative Monitoring	*Qualitative Monitoring*
Admit/Return first 24 hours	• Consent to Treatment signed on admission • Transfer Form or Order to Admit Received. • Admission orders transcribed accurately from transfer form.' • All orders required per facility policy are verified or clarified by the attending physician notified. • If transfer form not signed by physician, 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	Physician Orders: • Legible • Follow standards of practice • Abbreviations on approved list • Orders not in conflict • Labs ordered for appropriate screening of specific drugs

	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)	
Admit/Return 24 – 48 hours	• Face sheet or demographic information on record. • Admit – Consent to Treat signed on admission • H&P and Discharge summary requested from hospital if applicable if not sent with resident. • If H&P not completed prior to admission, an exam is scheduled per state requirements. Resident capacity identified. • Advanced directive acknowledgement is completed. A copy of the directive is in the record if applicable, physician orders coincide with resident directives. • Inventory of personal effects is completed if applicable. • Nursing Assessments completed or updated and others assessments required per facility policy are completed immediately upon 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,	• 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

	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 plan. Diagnoses used for therapy used are identified and consistent with		

	reason for admission/Medicare, etc.	
Admit/Return 14-21 days	• 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 • Items that were not complete on the admit and 24-48 hour audits are checked. • 14 day Medicare Recertification has been completed if applicable. • The 2nd step of the PPD/TB test was administered and read (if applicable). • The MDSs (both OBRA/regulatory and PPS if applicable). See the MDS audit criteria for specifics. • Care plan is complete by day 21 (should be available for use by day 21)	
RAI Process	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). • Basic tracking form complete and signed. • All questions on the MDS are appropriately answered. • On admission, MDS Face Sheet completed, signed and dated. • A-3 Assessment Reference date within the proper range. • 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. • Staff signatures include their title, sections completed and date completed. • When a computer print-out of the MDS is placed in the chart,	• The supporting documentation in the medical record is consistent with the MDS scoring. • 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

	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. • Triggered RAPs are identified in section V. • For RAPs triggered, assessment documentation is shown in the location of information column. • 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 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	Verify latest version of MDS software updated per maintenance contract, staff trained	

	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	
MDS Validation Reports	• 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	• 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

	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 being resigned. Nursing noted orders upon return per facility policy.	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

	• Telephone and Fax Orders: All telephone orders are complete, signed and dated. All original telephone orders have been returned within the appropriate time frame. All orders given by a physician has 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	interest from assessment, participation alternation trials if not involved, recognizes behavioral manifestations and plan activities accordingly.

	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 thinning schedule Forms are repaired Chart is cleaned and organized	• Chart has a file order that indicates location of records, i.e., an automated document.
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#:	• Qualitatively and for time saving reasons, consider filing manual discharge

		• 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 TO's have been returned and signed. Facility policy should define how to handle orders that have not 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	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

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

Focus Audits and Monitoring Systems

There are other beneficial audit and monitoring systems, many of which should be in place on an on-going 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.

	Quantitative Monitoring Criteria	*Qualitative Monitoring Criteria*
Acute Problems/24 Hour Board	Review the 24 hour log, Nursing identify new orders via computer, alert log or other system reflective of the computer system. For each	Not only verify that the documentation was done, but also analyze what was documented based on the condition. Does a

(completed daily)	resident and problem identified check to see if corresponding documentation was completed such as nurses note, monitoring record, physician, family, resident notifications, CP upgrade, etc.	note contain information applicable to the problem, should other issues been addressed referrals needed should the documentation have included an assessment or plan? Was plan updated as applicable?
Weights	Implement an on-going monitoring system when weights are recorded to note significant weight loss changes or there is a trend over time.	If a significant weight loss or trend has occurred review the documentation content to determine if the assessment and plan are complete and appropriate and if referrals were approved.
Physician Visits	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.	Content of the progress note addresses or supports resident issues.
Physician Orders	Reviewed and signed by the physician within specified time frame (30 or 60 days).	Diagnosis can be associated with orders; Check for duplication of medications or treatments in treating a diagnosis.
MAR/TAR	Documentation completed at time of administration or within 24 hours if documentation omission occurs.	Reason and results are documented for PRN administration. Self-monitoring identifies who assumed the med/tx documentation if manual, (sign on and off). eHR includes an edit/alert system to remind nurses to complete entries.
Physical Restraints	Assessment completed and reviewed/updated at least quarterly. Consent obtained from resident or responsible party. Physician order obtained.	Reason for restraint is appropriate to justify use.
Skin/Pressure Sore	Assessment completed and reviewed/updated weekly until healed.	Documentation shows improvement or modification of plan if no improvement and follows the criteria for survey guidance on this subject.
Psychotropic, Antipsychotic, and Hypnotic Medication Use	Assessment completed and reviewed/updated at least every 6 months. Physician order obtained. Consent obtained from resident o responsible party.	Diagnosis associated with medication is listed in the federal regulations as appropriate. Continued justification for administration of medication is documented. Annual dose

		reduction considerations are documented.
Lab Result Monitoring	Results of physician orders for all labs are in the medical record.	Documentation reflects that abnormal lab results are communicated with physician.

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 (eg. 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 acces/security grid identifies the persons who access or enter data are equal to the authorizations.
- 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.
    i. Use screen prints to provide instructions on how to retrieve electronic data and how to locate other types of data.
    ii. 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 ensure that all required documentation is ready for the survey entrance conference.
    i. 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.
    ii. 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.
    iii. Certificates of destruction of records and DHS permission to file records offsite should be available.
    iv. 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

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