AHIMA Offers Tips, Tools for Auditing in Long-term Care

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Once upon a time, the role of the medical records department in a long-term care (LTC) facility was to file and assemble discharge records. Those days are long gone. Today, it is critical for HIM practitioners to focus on the content and quality of the documentation in the medical record.

Auditing and analyzing documentation are increasingly important for HIM professionals in LTC. Earlier this year, to assist HIM practitioners and LTC facilities, AHIMA developed a new set of comprehensive practice guidelines. These can be downloaded from AHIMA's Web site (www.ahima.org). The following excerpt from "Long-Term Care Health Information Practice and Documentation Guidelines" focuses on the audit and quality monitoring process and includes recommended time frames and audit criteria important in an LTC setting.

4.2 Audits and Quality Monitoring

he content, completion, timeliness, and accuracy of medical record documentation are extremely important in a long-term care facility. Documentation has a far-reaching effect on most aspects of the organization's operation. The quality and type of care and services delivered to the resident are determined in part through documentation. Ongoing planning and assessment rely heavily on the quality and accuracy of the documentation in the chart. The medical record is also used to determine survey compliance and reimbursement and serve as a source document for legal proceedings.

Proactive (concurrent) monitoring of the completion, timeliness, and accuracy of the medical record documentation are critical. Both the need for good documentation and the risk factors hindering quality support the importance of ongoing, scheduled audits, and monitoring for every resident's medical record.

4.2.1 Qualitative Versus Quantitative Audits and Monitoring

here are two broad types of audits-qualitative and quantitative. 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 are more subjective than quantitative. The auditor tries to determine if the proper care was delivered based on the documentation.

Facility staff can be trained to complete quantitative audits that focus on whether a document is complete (all sections of a form), authenticated, or timely rather than what the documentation states. A training process is necessary to help staff understand what to look for and why. This type of audit is more objective than a qualitative audit. Staff can usually determine if an audit element is in place or not (similar to a yes/no question).

On an ongoing basis, facilities should have quantitative monitoring in place to assure complete and timely records. Admission, concurrent, and discharge record monitoring assures that analysis is completed throughout the resident's stay. The goal to continuous monitoring throughout a resident's 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 most documentation problems or omissions. 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.

4.2.2 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 chart 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

An HIM professional should have the ability to provide a qualitative analysis of the documentation and content of the medical record and provide feedback and suggestions for problems identified.

4.2.3 Routine Audits/Monitoring (Criteria and Time Frames)

Every long-term care facility should have systems in place for monitoring completion of its documentation on an ongoing basis. At a minimum, records should be reviewed on admission and hospital return, concurrently on a 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.

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

4.2.4 Focus Audits and Monitoring Systems

here 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.

4.2.5 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 ongoing systems should be reported at the quality assurance committee 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, measures should be taken to correct the problem, and further monitoring continued 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 ongoing 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 ongoing reporting and graphing.

It is critical that the HIM professional actively participates in the quality assurance committee and process. If this is not possible due to level of staffing and level of expertise, it is acceptable to have other clinical staff assist in the collection of audit data and in the analysis and reporting process to the QA committee. Once ongoing audit and monitoring processes are established, a system is 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.

4.2.6 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 time frame defined on the tool and then it should be removed (e.g., an admission checklist that is completed by day seven should be removed right after the seventh day). It is not recommended that audit forms be left in the chart-even discharge audit tools.

he 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.

For the complete text to the "Long-Term Care Health Information Practice and Documentation Guidelines," visit AHIMA's Web site at www.ahima.org/.

Tables

Quantitative Monitoring Criteria

Monitoring and Focus Audits

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