Long-term Care by the Book: AHIMA Releases Practice Standards

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by Deborah A. Johnson, RHIT

Often, when HIM professionals attempt to uphold standards of practice in their facility, they are asked, "where does it say that I can't do this?" or "show me where it says...". A report recently issued by a task force of HIM professionals is meant to provide that reference-and assist in providing support for legal documentation practices.

The lack of "official" standards is a common problem in many care settings, but it is particularly troublesome in long-term care. Federal nursing home regulations require facilities to "maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized."[1] But what is the industry standard for such documentation?

Last year, in an initiative spearheaded by AHIMA, a task force of HIM professionals in long-term care worked to answer this question. The result is the report "Long-term Care Health Information Practice and Documentation Guidelines," a manual of practice guidelines available to all HIM professionals, nursing facilities, and long-term care organizations free of charge.

Getting It in Writing

Although many manuals, policies, procedures, and books have been written on the subject, until recently true health information practice and documentation standards had yet to emerge. To complicate matters, many "standards of practice" are quoted, but few are available in writing.

The task force, a group of professionals from diverse areas in long-term care including representatives from AHIMA's Long Term Care Section, HIM consultants and practitioners, as well as nurses specializing in risk management, litigation, insurance, and IT, came together to provide an official, comprehensive reference to clarify such practice standards in writing.

A Question of Clarity

The task force's report provides direction in many areas. In addition to providing specific practice standards, it includes clarifications and examples for each standard. These examples are meant to provide guidance in various situations, as reflected, for example, in the standard for acceptable methods of record destruction.

For example, the HIM standard is:

- the healthcare organization's and HIM 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 patient-identifiable data
- the destruction system is designed and implemented to ensure the security and confidentiality of the health records and patient-identifiable data being destroyed

The manual then provides clarification regarding acceptable methods of destruction-such as shredding, incineration, and pulverization. Furthermore, it is specified that records and patient information cannot be disposed of in garbage containers without some type of shredding or obliteration.

Although these issues may appear to be basic ones for HIM professionals, this clarification is helpful to the practitioner who is new to the field or to administrators who may not be familiar with standards of practice.

Other issues, such as authentication, pre-dating and back-dating, documenting errors and omissions, and documentation timeliness, are also addressed.

A Handy Reference

In addition to stating and clarifying standards, the report includes such practical guidance as:

- guidance on organizing and maintaining record systems, audits and quality monitoring, storage, retention, and destruction, confidentiality and release of information, and coding and reimbursement
- standards for authentication, dating, signature legends, permanency of entries, legibility, timeliness, acceptable media, handling corrections, errors, omissions, and late entries
- clarification of the minimum content of the medical record, Medicare documentation, physician documentation and orders, and discharge documentation
- a checklist for HIM policy and procedures

"Long-term Care Health Information Practice and Documentation Guidelines" will be available online at AHIMA's Web site, http://www.ahima.org/, free of charge. The report will also be furnished to a number of nursing home organizations and industry trade organizations as professional practice guidance. AHIMA members in long-term care are encouraged to forward information about "Long-term Care Health Information Practice and Documentation Guidelines" to facility practitioners and administration.

Note

1. Code of Federal Regulations ß483.75(1).

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