Setting the Standard in Assisted Living

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by Michelle Dougherty, RHIA

Have you found yourself in the position of developing or reviewing health information and documentation policies for an assisted living facility? If so, you know that it is not easy to find resources or standards for this growing industry. However, both the Joint Commission on Accreditation of Healthcare Organizations and the Rehabilitation Accreditation Commission (CARF) have developed accreditation standards for assisted living.

CARF already has an accreditation process in place, and the Joint Commission will begin accrediting facilities this summer. If an assisted living facility is a component of an organization already accredited under hospital or long-term care standards, compliance with assisted living standards is not effective until January 2001.

Assisted living facilities should develop systems in core health information practices including confidentiality, release of information, management of information, and medical records. Accreditation standards provide an excellent road map to tailoring practices to the assisted living environment. Here's a handy Q & A on some of the most frequently asked questions in this area.

Q: What is assisted living?

A: To develop policies for assisted living, it is important to understand the scope of care and services provided by this type of facility. The focus of an assisted living facility is to provide a safe environment while allowing the resident as much freedom and independence as possible.

Assisted living facilities are often apartment-like settings with common areas for activities, socialization, and meals. There usually is not a nursing station but there is an office for the staff who coordinate and supervise the services provided.

There are a number of free-standing assisted living facilities, but a current trend in healthcare is to provide assisted living as part of a healthcare campus offering a full continuum of services as the resident's healthcare needs change.

Q: What are the confidentiality, access, and ROI standards?

A: A Joint Commission standard and fundamental HIM practice is to have systems in place to respect and protect the residents' rights to confidentiality of health and personal information. This information should not be readily visible to outsiders or posted in public areas of the facility. Medical and financial records should be maintained in a secure location to protect from a possible breach, loss, or destruction of records.

The Joint Commission also has a standard requiring assisted living facilities to give residents access to their medical and financial records in a timely manner. Copies of records should be provided in a time frame that meets the resident's need for the information, though the intent statement in the standard does not address copy fees. As with any standard, applicable or more stringent state and federal laws would take precedence.

The assisted living facility should only release records that have been authorized by the resident or legal representative or when required by law. When a patient is transferred to another healthcare setting, appropriate information should be made available. The standard's intent statement on confidentiality indicates that the resident should be informed of the type of information released to another setting.

Q: What are the management of information standards?

A: The Joint Commission draft standards for information management (IM) are similar to IM standards for other healthcare settings. The goal is to recognize information as an asset to be used in planning, management, and improving resident

outcomes. The standards in the IM chapter are fundamental to an HIM professional, but can be a risk area to many assisted living facilities that have established medical record and information systems without awareness of these practice standards.

An assisted living facility should have developed IM processes to meet the needs of the organization. In addition, systems in place should protect confidentiality. If the information is computerized, passwords, audit trails, and other security measures should be in place. For all records (paper or electronic), safeguards should be in place to protect the information from loss, destruction, and tampering.

A medical record should be maintained on every resident in a systematic and organized manner. Where relevant, standardized terms (e.g., abbreviation lists) and methods for collecting information are included. The facility should define which care givers can access and may document in the records.

Q: What information should the medical record contain?

A: The medical record for each assisted living resident should contain demographic information, safety measures required, documentation of services provided, current medication profile if medication assistance is provided, assessment, reassessment, and changes in status. When services are ordered by a physician, orders must be maintained in the record and authenticated. There should be documentation supporting services provided by all healthcare professionals, whether they are internal staff or external referrals. Upon discharge, transfer, or referral, the assisted living facility provides appropriate information to the receiving facility.

Q: How often should assessments and service planning be conducted?

A: Whether choosing assisted living accreditation or not, the Joint Commission standards provide an excellent baseline for assessment, reassessment, and service planning. Within 72 hours of resident admission, a standardized assessment of needs and services should be conducted. The assessment should contain information on health, nutrition, physical, activity and socialization, cognitive, functional, and spiritual needs. In addition, the resident's current daily routine, immunization status, decision-making capacity, and service preferences should also be included.

Reassessment should be completed whenever there is a noticeable change in a resident's health, psychosocial, cognitive, or functional status or resident supports. In the absence of applicable laws or regulations, reassessments should be conducted at least every six months.

Additionally, each resident should have a specific service plan, based on an assessment of the resident's needs, preferences, and daily routines. The plan should be reviewed and revised periodically to reflect changes and the current services provided. Each facility can determine its own schedule for completion and review of the service plan. A good rule of thumb is to develop, review, and revise the service plan after completing the assessments/ reassessments and as changes occur.

Whether you are planning for an accreditation survey or developing documentation and HIM procedures, state regulations and standards used by accreditation organizations provide an excellent source of information and sound foundation for practice.

References

Joint Commission on Health Care Accreditation assisted living accreditation standards are available at www.jcaho.org/standard/asst_livg/al_mpfrm.html.

Rehabilitation Accreditation Commission assisted living information is available at www.carf.org/CARF/AssistedLiv.htm.

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