Long-Term Care Survey Alert

MESSY OR INCOMPLETE RECORDS COULD MEAN FAILING MARKS

Its 11 p.m. the night before the survey: Do you know where your residents records are?

Survey citations at F514 (records must be accurate, comprehensive and accessible) are rapidly rising toward the top 10 deficiencies. So its time to make sure clinical records are available, organized, current and that they tell a consistent and accurate story about each residents care and condition.

As a first step, take a good look at the records kept on the unit. If theyre several inches thick with papers sticking out, surveyors might assume, correctly or not, that your facility is disorganized.

"The cleaner the chart, the less chance the survey team is going to find problems or inconsistencies, or just get irritated and confused," advises **Gene Larrabee**, principal of **Primus Care** in Valparaiso, IN.

On the other hand, a too-thin chart might make surveyors wonder if your staff is going a little light on the documentation or hiding something in the medical records closet.

Thus, you have to know what you are doing when you cull residents files, cautions **Beth Klitch**, principal of **Survey Solutions** in Columbus, OH. "You never want to obfuscate the record so that surveyors cant find a potential problem that you know is there."

Klitch suspects that the rise in F514 citations could reflect that surveyors are having a harder time locating all residents records during surveys. Surveyors also hand out the tag for incorrect MDS entries and outdated care plans.

Establish Thinning Policies

To ensure records are current and complete, establish facility policies for thinning records that incorporate state requirements and the **American Health Information Management Associations** long-term care health information practice and documentation guidelines. AHIMAs guidelines include federal requirements and clearly spell out what should be in the residents medical record.

For example, AHIMA recommends using the calendar for the MDS/care planning meeting as a time to determine whether the residents record needs to be thinned. Larrabee also advises thinning records every 90 days when the facility performs the quarterly resident assessment.

To meet federal requirements and AHIMA guidelines, your facility should have 15 months worth of the residents MDSs readily available.

Physician orders and nursing notes should go back three months, including nursing summary forms and flow sheets. Clinical assessments (nursing, pain, wound, restraints, cognitive) should include the most recent assessment and one previous one, spanning six months to a year. (See the complete list of what needs to be included in the chart at www.ahima.org/infocenter/index.html.)

The AHIMA recommends that the facility maintain a copy of the thinning guidelines in the residents record and at the nursing station. These guidelines should also direct staff (or surveyors, if they are looking) to the overflow records. Once the file has been thinned, make a notation inside it and immediately file the removed documents in the residents overflow record. The guidelines suggest placing a label on the inside cover of the charts documenting the date you thinned them.

The overflow record is considered part of the residents active medical record and should be systematically organized using a standardized chart order, AHIMA explains. Your facility can file the overflow records in the health information department as long as they are readily available if surveyors or residents request them.

Conduct Chart Audits

Survey experts also advise facilities to perform regular audits of charts to see that they meet state and AHIMA guidelines. Look for inconsistencies and examples of poor documentation, which signals a need for inservices or one-on-one coaching.

Focus on two key areas that surveyors are directed to examine when they sample records to determine compliance with F514:

Is there enough record documentation for staff to conduct care programs and to revise the program, as necessary, to respond to the changing status of the resident as a result of interventions?

How is the clinical record used in managing the residents progress in maintaining or improving functional abilities and psychosocial status?