UCONN HEALTH

POLICY NUMBER 2013-01
December 16, 2014

POLICY: ERROR CORRECTIONS, ADDENDA, AMENDMENTS AND DELETIONS IN THE LEGAL HEALTH RECORD

PURPOSE:
To provide a process for making corrections or modifications to the legal health record (LHR) so as to support and maintain the integrity of the health record.

The legal health record may exist in paper/written form, electronic form, or both. Any method of creating an entry into the legal health record must be evaluated against the standards of this document for the methods it uses to create corrections, addenda, amendments and deletions. The Health Information Management Committee (HIM) is responsible for evaluating methods of entry into and correction of the legal health record for the adequacy of their compliance with this policy. The owners of other systems, including electronic systems, are responsible for assessing their system against these standards and reporting their compliance to the Health Information Management Committee.

It is recognized that not all systems will be capable of managing error corrections as outlined in this policy due to system limitations, thus the HIM Committee will have responsibility to determine what is considered adequate process in these circumstances.

DEFINITIONS:
Addendum:
New documentation used to **add** information to an original entry. Addendums should be timely and bear the current date and reason for the additional information being added to the medical record.

Amendment:
Separate documentation meant to **clarify** an entry in the medical record. An amendment is made after the original documentation has been completed by the provider/author. All amendments should be timely and bear the current date of documentation. This policy covers provider initiated amendments, not patient initiated amendments as required under the HIPAA Privacy law, outlined in UConn Health Policy 2003-17C Patient Right to Amend His/Her Medical/Dental/Research and/or Billing Record.

Correction:
A **change** in the information meant to clarify inaccuracies after the original document has been signed or rendered complete.

Deletion:
Action of **eliminating information** from previously closed documentation without substituting new information. Requests for deletions must be reviewed by the Director of Health Information

Management and Risk Management. Deletions are rare, however, if a situation warrants, deletions can be made if approved.

Signed:
A method applied to documentation to identify the writer of entry, professional designation, and the date and time of the entry.

Wrong chart:
When an entry has been made in error in a document belonging to another patient or when a document has been added in error to a collection of documents belonging to another patient.

PROCEDURE:
For **ERROR CORRECTIONS** to entries in the medical record:

1. Errors should be corrected by the person who made the initial entry. If that is not possible the author's supervisor or authorized designee may make the correction in extenuating circumstances as an addendum to the record.

2. In a paper record, draw a line through the erroneous information in the document in a fashion that makes it clear that it is an error, but does not obliterate or reduce the ability to read that erroneous information. Sign or initial, date and time the entry. If only initials are used, there must be a corresponding entry on the Signature Identification Sheet available in the record for reference.

3. All electronic systems will, at a minimum, address error corrections via the addendum or amendment process. If the electronic system does not provide for marking of the original error, the process for amendments must be strictly adhered to.

4. The information marked by the correction and any subsequent corrected entry must identify the person making the correction.

5. The correct information should be located as adjacent to the original entry as possible, maximizing the likelihood that a user accessing the record will see the correction and locate the correct information.

6. In electronic systems, the reason for the correction should be part of the marking of the original entry or the corrected entry or both.

7. Any edits or additions done to a completed/signed document must be labeled as an addendum and must reference the entry the addendum is linked to.

8. Do not discard or replace handwritten notes which may contain an erroneous entry.

9. All entries must accurately reflect the date and time at which they were made and signed. Never add notes after the fact without accurately authenticating, dating and referencing the original entry.

10. If the document was originally created in a paper format and then scanned electronically, the electronic version should be corrected by printing the documentation from the electronic medical record, correcting as above and re-scanning the document. Please contact the Health Information Department to obtain printed version for correction.

11. If the error is made in an electronic system and the error was made real time and has not been signed, the correction can be made real time and then saved. Additional action is not warranted since the original documentation was not made final.

12. It must be immediately visible to a user that a correction has been made, indicating who made the correction and when the correction was signed.

WRONG CHART ENTRIES:

1. The correction of an entry made in the wrong patient's medical record follows the same basic principles noted above.
2. When the sole issue is that identifying information was in error leading to the wrong chart entry, the correction to the identifying information may be made by supervisory personnel. All other entries and corrections are made and signed by the individual responsible for the entry.

ADDENDA:

1. An addendum is used to add information to the legal health record after the time of their occurrence. They must clearly state the time period they address, and their signature must include the time the entry was created.
2. The addendum should include a clear notice of its purpose to add information concerning an earlier time period to the record.
3. An addendum is the only way to properly add to an entry which has been finalized and signed.
4. It must be immediately visible to a user that an addendum has been made, and clearly indicates who made the addendum and when the addendum was signed. Once a document has been finalized with signature, paper or electronic, the only way to correct or revise that documentation is to provide an addendum. There is no time limit as to when an addendum can be written.

AMENDMENTS:

1. An amendment is used to clarify information within the legal health record after the time of their occurrence. They must clearly state the data and the time period that they address, and their signature must include the date and time the entry was created.
2. The amendment should include a clear notice of its purpose to clarify information concerning an earlier time period to the record.
3. An amendment is the only way to properly clarify an entry which has been finalized and signed.
4. It must be immediately visible to a user that an amendment has been made, and clearly indicates who made the amendment and when the amendment was signed.

DELETIONS:
The total elimination of information/documentation after signature should rarely occur and will require the prior approval of the Director of HIM and Clinical Risk Manager.

Deletions should never occur if the record is part of any ongoing litigation, however, in cases where they are warranted such as mis-filed information in a paper or electronic medical record the following will occur:

1. Identify erroneous information.
2. Report it immediately to the Director of HIM and Clinical Risk Manager.
3. The HIM Director and/or the Clinical Risk Manager will determine if record is involved in litigation or may have potential to be involved in litigation. If so the Clinical Risk Manager and HIM Director will determine appropriateness of the corrective action.
4. The HIM Director and/or the Clinical Risk Manager will compare provider request of erroneous documentation to corrected documentation.
5. The HIM Director and/or the Clinical Risk Manager will ensure that appropriate changes are made in documentation whether paper based, or to the host system as well as the legal health record if the information is electronic.
6. A review will be done by the HIM Department to ascertain whether there were any releases completed during the time the entry remained in the incorrect patient record. If so, corrected information will be re-released accordingly. As appropriate, the Privacy Officer will be notified if documentation was released inappropriately.

Elena Albini (Signed) 1/6/15

Elena Albini, R.H.I.A **Date**
Director of Health Information Management

Jeffrey Geoghegan (Signed) 1/2/15

Jeffrey Geoghegan **Date**
Interim Chief Financial Officer

Andrew Agwunobi (Signed) 1/14/15

Andrew Agwunobi, M.D., MBA **Date**
Interim Executive Vice President for Health Affairs

New Policy: 4/9/2013
Policy Replaces HAM Policy 12-016 Error Correction in Medical Record Documentation
Revised 12/16/14