

Addendums

An addendum is 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 health record.

Case Scenario 1: A patient presents to the outpatient department for a chest x-ray and sputum culture. The patient was referred from their primary care physician for a long-term cough. The resident physician provides the initial interpretation of the x-ray film and states “pneumonia” and signs the report. Seven days later the sputum culture indicates a streptococcal infection. The physician returns to his original note and completes an addendum to indicate the infection.

Case Scenario 2: A patient presents to the emergency department (ED) and states that she fell down the stairs fracturing her arm. The ED physician completes his documentation as such in the ED note. After further discussion and follow up the patient admits that her spouse pushed her down the stairs. The ED physician creates an amendment to the original ED note clarifying the nature of the accident.

Concern: There are two concerns with this practice: (1) the original report has already been final signed by the provider; and (2) the new information actually changes information within the EHR. The new information has the ability to affect the treatment of the patient. In the first scenario the infection may require a change in antibiotics or treatment. In the second case the additional information may require additional reporting to protective services or law enforcement.

In order to promote timely patient care the new information must be connected to the original note. Both the original and addendum should be signed by the provider. The addendum is providing additional information to the original signed documents, and in order for the additional information to have meaning it should be connected to the original report.

Practice Guidelines: Organizations should clearly define for providers that once a document has been final signed the only way to correct or revise documentation is to provide an addendum. The organization should have a specific policy and procedure addressing how addendums are made in the health record. The policy and procedure includes information as to where the additional information is located within the body of the original report and the requirement that the addendum include a separate signature, date, and timed entry. The procedure indicates who is responsible for entering addendums into the EHR. If the addendum is generated through a transcription system, the interface is monitored to ensure that the addendum is correctly merged with the original report. HIM professionals have the ability to track and trend addendums within the EHR and provide appropriate follow up as needed.

In addition, the organization should clearly define what type of information is considered an addendum. In the case scenarios above, the new information clearly affects the treatment of the patient. These scenarios may also indicate a concern with the legal health record. In each, the added information provides additional clinical information pertinent to the continuum of care.

Organizations also may choose to define how extensive an addendum can be. If the provider is correcting entire paragraphs of documentation and editing extensive information, the organization may choose to have the first report retracted from the EHR and ask the provider to redictate or redocument a new report. In either case, the original version should remain a part of the EHR.

Addendums should be made in the source system or where the documentation was originally created, as well as in any long term medical record or data repository system. Under legal advisement, the organization should have processes in place to forward the addendums to any other place where the information has been sent to ensure that providers have the most up to date information.

See appendix A for a sample addendum policy (page 14).