

Amendments, Corrections, and Deletions in the Electronic Health Record Toolkit

American Health Information
Management Association
2009

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Foreword

A key component to health information management (HIM) is the handling of amendments, corrections, and deletions. Although these are not new concepts for HIM professionals, their management does change when working with an electronic health record (EHR).

When, and if, a clinical provider determines that documentation within the EHR is inaccurate or incomplete, organizations must have established policies and procedures to guide the provider in making corrections within the body of the record. HIM professionals should ensure that these policies and procedures support and maintain the integrity of the record.

Traditional practices within the paper record support a single-line strike-through of the original documentation. However, these practices will not necessarily transfer to an electronic environment, and new practices should be evaluated against organizational policy and specific system limitations.

This toolkit is designed to provide guidance to HIM professionals when addressing amendment, correction, and deletion functionality in an EHR.

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Introduction

Healthcare organizations must have a health record that is created and developed to meet the requirements of a legal business record. As such, it must be maintained in a manner that is consistent with state and federal requirements.

From an EHR standpoint there are guidelines and standards that provide HIM professionals direction when creating and managing this functionality. Both the American Society for Testing Materials (ASTM) and Health Level Seven (HL7) provide guidelines for technical requirements. Further guidance can be sought from state, federal, and accrediting body requirements as well as individual organizational requirements found within organizational medical staff rules, regulations, and bylaws. HIM professionals should have a fundamental understanding of all these documentation requirements in order to appropriately guide their organizations in managing this function in the EHR.

Organizational processes defined in this toolkit may be different depending on reports versus direct data entry documentation and draft documents versus final. It is an important distinction for organizations to develop policies and procedures regarding these different processes in order to ensure the integrity of the health record.

Note: For the purpose of this toolkit the authors have made the assumption that if the electronic health system is utilized for direct data entry that the applicable of electronic signature is used by the provider.

Issues Today

EHRs may not provide an easy distinction between original and edited text. The edited text can often occur with little or no versioning or track-changes functionality. These changes often occur without the knowledge of the HIM professional or other care providers.

As clinical providers become more comfortable with electronic documentation and editing capabilities it is a possibility that changes to record documentation can occur on a regular basis without oversight. System functionality regarding changes may be developed within an application of the EHR (e.g., progress note). It is not necessarily a product of poor application architecture, but rather a design feature to meet the requests of clinical providers to edit health information. The ability to control the use of this functionality and the extent of its usage is imperative in order to ensure the integrity of the health record.

Organizations should understand the functionality of their EHR systems and provide clinical providers with guidance. The electronic processes by which these functionalities are made will most likely vary from vendor to vendor. Not all will handle this functionality in the same way, even with ASTM and HL7 guidelines and CCHIT

certification. However, there are some essential elements that should be present in vendor systems to accommodate these functionalities.

Key Terms and Guiding Principles

Although the terms *amendments*, *corrections*, and *deletions* are often used interchangeably, they do not refer to the same actions. The intent of this toolkit is to provide some clarity regarding these terms and guidelines for managing this functionality within the EHR.

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).

Amendments

An amendment is documentation meant to *clarify* health information within a health record. An amendment is made after the original documentation has been completed by the provider. All amendments should be timely and bear the current date of documentation.

Case Scenario 1: A patient presents to a private care physician for a regular physical exam. The patient has been seen in the past for high blood pressure and is returning for an exam prior to a medication refill prescription. The physician documents in the note that the patient is a 64-year-old female and signs the note. The nurse reads the note and realizes that the patient is only 42 years old. An amendment is added to the record correcting the patient's age.

Case Scenario 2: A patient is admitted to the hospital. As a part of the admissions process the physician completes a history and physical. The physician receives the document via the transcription system, voice recognition, or direct entry into the EHR and electronically signs the document. After signing, the physician realizes that he

incorrectly indicated the patient was a 72-year-old white female. The patient is in fact a 72-year-old white *male*.” The physician now presents to the HIM department asking for a correction to be made to the history and physical.

Concerns: The physician is making amendments to a signed document, and several risky practices may occur. Because of system limitations the physician may be making the amendment by altering the original document rather than by completing an amendment per appropriate procedures. The system may not have safeguards in place to ensure that once a document is signed it cannot be altered. This would create version control issues, and HIM professionals, at face value, would not know what the original document is. Sometimes the risk is incurred because “it has always been done this way” and the organization has not taken into account fundamental HIM principles.

Practice Guidelines: The organization should have a procedure that specifies how this process will be completed so that the integrity of the record remains intact and in compliance with documentation standards. The organization should also complete due diligence when selecting a system to understand the system capabilities and functions.

The system should have the functional capabilities to lock a record from any further editing once the final signature has been applied. Each organization should develop guidelines regarding dual signatures, such as residents and attending physicians. In these cases, organizational policy will dictate when the report and visit note is locked. If the system has already been implemented, HIM professionals should be proactive in addressing a system issue that does not lock the record after final signature and request modifications from the vendor.

The organization may choose to lock the record from provider editing but, in the case of an amendment, allow this documentation privilege to specific staff. In the case scenarios above, the amendment is limited to a change in the patient’s age or sex. Asking the provider to complete an addendum may seem inappropriate. The organization instead, may allow for the HIM professional to unlock the report, add the correct age into the document, and then lock the report. In the case of amendments, the provider should re-sign the new report.

Another key practice would be ensuring that the correct age does not erase the incorrect information. The new information should stand out from the original. The system may show the new information in bold, underlined, italics, or in a different color so that it is easily identified. The system should also provide tracking functionality to indicate when the change was made and by whom.

Organizational policies and procedures should ensure that documents created in the source system, such as the transcription system, are not utilized for release of information. Amendments can be made by direct entry or through dictation.

Note: *Some organization may choose to implement policies and procedures that do not allow amendments. In that case, any clarification would require an addendum.*

See appendix B for a sample amendment policy (page 15).

Corrections

A correction is a *change* in the information meant to clarify inaccuracies after the original electronic document has been signed or rendered complete.

Case Scenario 1: A patient presents to the hospital for a planned surgery. The patient has been given a pre-admission account for all pre-operative blood work and radiology. On the day of surgery the provider dictates the history and physical with the date of pre-operative blood work as the admission date and encounter number, and applies a final signature. The report does not connect to the admission in the EHR due to the incorrect admission date and the HIM Department must correct the admission date and encounter number in order for the report to cross the interface and connect appropriately in the EHR.

Case Scenario 2: A patient presents to the hospital for a planned surgery. The patient has been given a pre-admission account for all pre-operative blood work and radiology. On the day of surgery the provider dictates the history and physical with the date of pre-operative blood work as the encounter number, *but does not apply a final signature*. The report has connected to the EHR because the admission date was correct; however the encounter number is still incorrect. Because the report does not have a final signature, the provider identifies the incorrect encounter number and corrects it. After the correction the report is final signed.

Concerns: There are many different ways to enter a correction within the EHR, and it may depend on the specific system the organization has implemented (e.g., the initial documentation has a single line through it, or the original documentation appears in a different color). The way corrections are processed will often depend on whether or not the report or documentation has been signed.

As stated above, once a report has been signed, it should be locked from any future editing. The concern in the first case scenario is that the report has already been final signed, thus locking the report and keeping the report from crossing the interface. If the operating room nurses are searching for a history and physical in the EHR there would not be anything to view, possibly affecting the start of the surgical procedure. There should be a way for the appropriate organizational staff to correct the date and encounter in order for the report to cross the interface.

In case scenario 2, the incorrect information is changed prior to the application of the final signature. Corrections made prior to obtaining a final signature may not be considered “corrections” at all. Depending on the system and organizational policy, corrections made prior to final signature may not be indicated in any way, and HIM professionals may have no way of knowing that these documentation changes were entered into the record. The organization should clearly define how edits prior to the application of final signatures are processed.

Practice Guidelines: The organization should have a clear policy and procedure regarding its system’s abilities regarding corrections. In addition, the organization should clearly define who can “unlock” a document once it has been signed. Only one individual or department should have the ability to unlock a report, and the functionality should be carefully monitored and audited. This toolkit recommends that the HIM professional be assigned the “unlock” function within the EHR; however, the choice will depend on the organization.

The policy and procedure outlines the organization’s definitions of corrections made to a signed document as well as corrections made before the document is signed. The processes need not be the same; they should, however, indicate who is responsible for making the corrections in both scenarios. Corrections 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.

Note: *Organizations require policies for instances in which the wrong patient’s name is in the report but the information is on the correct patient. The document should be retracted, and a correct copy without the wrong patient’s name should be placed in the record. Just lining through a wrong patient name and adding the correct name is not enough. Every time the record is released, a HIPAA privacy violation would occur.*

See appendix C for a sample correction policy (page 16).

Deletions

A deletion is the action of ***eliminating information*** from previously closed documentation without substituting new information.

Case Scenario 1: A patient is admitted to a behavioral health facility. As a part of her counseling process the therapist meets with the patient, enters the counseling note in the EHR, and final signs the note. The note includes a sentence that the patient is suicidal. Upon review, the therapist realizes that this sentence was intended for a different patient. The rest of the documentation within the note was accurate. System functionality does not allow for the elimination of one sentence; instead it shows a strike through line, which is inappropriate in this case. The entire document needs to be retracted and a corrected copy created without the incorrect sentence.

Concern: In the scenario above the provider is requesting the removal of information from a signed document within the health record. In order to accomplish this, the information must be stricken from the record and should not be seen on the final report. However, since the report has been signed and is considered “locked” from editing, there is no way to remove the information within the electronic system.

Practice Guidelines: It is recommended that total elimination of information should never occur. If the organization allows information to be deleted, it requires clear policies and procedures to ensure the integrity of the health record, and it should monitor and

audit this functionality. Organizations that allow this functionality should carefully review clinical actions taken based on initial documentation.

Note: The ability to delete and retract information within the EHR is dependent on the system. Organizations should carefully review both functionalities within their system and apply appropriate policies and procedures.

See appendix D for a sample deletion and retraction policy (page 17).

Late Entries

A late entry only applies to documentation within the EHR that is entered after the point of care.

Case Scenario: A nurse on the general medical/surgical floor completes an intake assessment for a new patient to the unit. She is called away to care for an emergency with another patient and forgets to document the assessment within the electronic record at the end of her shift. The next day, she reports for her shift and enters the information at that time.

Concerns: Visit documentation was not completed in a timely manner, requiring the clinical provider to document information about the visit as a late entry or after the visit is locked. In order to place the documentation in the proper place in the EHR the visit may have to be “unlocked.” In addition, the late entry may not be readily identifiable. It may or may not appear in the correct chronological order.

Practice Guidelines: Any clinical provider documenting within the health record may need to enter a late entry. The organization should clearly define how this process occurs within their system. Tracking and trending within the electronic record will be dependent on the system; the organization should clearly understand this process. In addition, specific policies and procedures should guide clinical care providers on how to correctly make a late entry within the health record. The author should document within the entry that it is a late entry.

Typically late entries apply to direct documentation only; for example, physician orders, progress notes or nursing assessments. Dictated report such as history and physicals, although dictated outside of organizational time frames, would not be considered a late entry.

Note: Some systems may not have late entry functionality. The late entry is shown as an addendum.

Retractions (see also Deletions)

A retraction is the action of ***correcting information that was incorrect, invalid or made in error***, by preventing display or hiding the entry or documentation from future general views.

Case Scenario: A physician is seeing patient John S. Doe in the ED. The patient has a birth date of 12/12/89. However, when the physician pulls up the patient record, he inadvertently selects John S. Doe with a birth date of 12/29/87 and documents his findings. He signs the report before realizing that he has documented on the wrong patient. The document is now locked from editing. The physician calls the HIM department to have the entry retracted from the incorrect entry and placed in the correct chart.

Concern: The physician is requesting to eliminate information from a signed document within the health record. In order to accomplish this, the information must be stricken from the incorrect record and should not be seen on the final record, or any printed versions of the record. However, since the report has been signed and is considered “locked” from editing, the physician no longer has access to remove the information within the electronic system.

Practice Guidelines: The organization should have a clearly defined process that indicates how, and in what manner, signed reports are to be handled. In the example above, the information was placed in the wrong patient’s record. Depending on the organization’s electronic system, locked reports may require specific interventions to retract information; e.g., only the HIM department personnel can unlock a report, thus creating a user audit trail of instances where information was altered. In addition, the organization should develop guidelines for making these types of entries.

Retractions 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. This information should still be available in the background, but will not display in the regular record view or be released upon request for the record. It is important to consider that while this information may be in the “background” of the electronic health record, it should not be reproduced on any printed versions of the record. If the record is requested for litigation or patient care purposes, the system should keep the retracted information from printing as a part of the legal health record. The organization should clearly define who is responsible for ensuring that this information is retracted from the legal health record as well as who is responsible for managing the information contained in the background of the record version.

If the provider selects the wrong patient chart in EHR, documents visit information, and then realized he or she is in the wrong chart, before signing the visit the provider will need to delete all information entered into this patient chart and select the correct patient chart and begin his or her documentation over again in the correct patient chart. The provider can copy and paste information into correct patient chart rather than type all of the information over again.

If the provider has already signed the visit before he or she realized they are in the wrong patient chart, then the provider will be asked to alert HIM and place an addendum in the record stating that entry was in error. The provider can copy and paste the information keyed into the wrong patient chart and copy it back into the correct patient chart if a policy is in place to do so.

Retractions are different from corrections in that they change the main point of the original documentation. A correction will leave the original documentation intact along with the revision.

See appendix D for a sample deletion and retraction policy (page 17).

Associated Terms

Additional terms factor into the guidance provided within this toolkit. The definitions of these terms are important to understanding the context. For the purpose of this toolkit, the following definitions apply.

Completion: the process of *completing an entry* in the health record by applying the provider's signature, either electronic or manual. Once the signature is applied, the entry is considered complete and the only opportunity to make changes is through an amendment or addendum to that entry. Organizational policy should define documentation points required for completing an entry and how long documents are available in an incomplete status.

Direct documentation: *text entries* made into the health record; e.g., progress notes, nursing notes, physician orders. The process where entries made directly into the health record are automatically authenticated as a result of the author logging into the system.

Electronic Signature: any electronic process signifying an approval to terms, and/or documentation presented in electronic format. Electronic signatures frequently also have the added benefit of ensuring the integrity of the signed document to signify that (1) the document has not been changed since it was signed and (2) the signer cannot 'repudiate' or claim that they did not sign the document. Electronic signatures encompass a broad gamut of technologies and methodologies, ranging from an "I agree" button in a click-thru agreement to an electronic tablet which accepts a handwritten signature to a *digital signature* cryptographically tied to a digital ID or certificate.

Final Signature: The process of applying the responsible provider's electronic signature to documentation. Once applied, the documentation is considered complete. See **Completion**.

Information: changes made to entries within a health record that can be either direct documentation or transcribed reports; e.g., a deletion can be made to either a progress note (direct documentation) or a dictated operative note (report).

Locked: The process by which health record entry is complete and any changes to the entry must be made through an amendment.

Provider: Any staff member providing care to a patient who has privileges to treat and document within a health record.

Reports: Refers to transcribed reports; e.g., history and physical or operative note, not generated within the electronic health record.

Versioning: Refers to the storage and management of previous versions of a piece of information, documentation or documents for security, diagnostics and interest.

Record Completion Guidelines

Organizations should have clearly defined policies on when and how a record and its individual components (e.g., dictated reports, progress notes, orders, etc.) are considered complete. System functionality should be evaluated to determine whether or not the end-user functionality to add information or make corrections can be removed at a certain point in time (e.g., 24 hours after discharge). Any changes that need to be made after this point in time should be handled on a case by case basis and the documentation functionality temporarily reactivated for that specific record. Once that has been established further policies and procedures surrounding how alterations within the record are made should be established.

It is important for organizations to utilize the audit trail function of the EHR system in order to identify and trend the utilization of these functionalities. Report should be generated by provider and type in order to provide education to individuals who may be utilizing it incorrectly.

Appendix A

Sample Addendum Policy

Making Addendums within the Health Record

PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the instances in which an addendum is necessary to support the integrity of the health record.

POLICY: Providers documenting within the EHR must avoid indiscriminate use of addendums as a means of documentation. All attempts to correctly identify patients and their medical conditions should be made prior to documenting within the record.

DEFINITION: Addendums are significant clinical corrections or changes in information to a signed report or direct entry documentation. (INSERT APPLICABLE STATE LAW AS REFERENCE)

PROCEDURE:

PROVIDER:

1. If the provider determines that additional information is appropriate, the provider is responsible for ensuring the total content of their documentation.
2. The provider should complete an addendum which includes the following information:
 - a. Patient name
 - b. Date of service
 - c. Account number
 - d. Medical record number
 - e. Original report that the addendum is to be attached to
 - f. Date, time, and signature of the addendum

DEPARTMENT (INSERT DEPARTMENT NAME):

1. Review each addendum for appropriateness prior to attaching it to the original report
2. Attach to original report
3. Ensure the addendum has a separate date, time, and signature line

See Also:

Amendment Policy

Correction Policy

Deletion/Retraction Policy

Appendix B

Sample Amendment Policy

Amendments to Health Information in the Electronic Record

PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the instances in which an amendment is necessary to support the integrity of the health record.

POLICY: Providers documenting within the EHR must avoid indiscriminate use of amendments as a means of documentation. All attempts to correctly identify patients and their medical conditions should be made prior to documenting within the record.

DEFINITION: An amendment is a means of clarifying health information to a dictated report or direct data entry after the final signature has been obtained. (INSERT APPLICABLE STATE LAW AS REFERENCE)

PROCEDURE:

PROVIDER:

1. Identify the correct report or direct data entry in need of clarification.
2. Notify (INSERT APPROPRIATE DEPARTMENT) of the need for an amendment.
3. Complete amendment.
4. Forward amendment to (INSERT APPROPRIATE DEPARTMENT) for inclusion in original document.

DEPARTMENT:

1. Locate original document.
2. Attach amendment to original document.
3. Ensure amendment is dated, timed, and signed. If amendment is not, forward to provider for completion.
4. Attach document in source system as well as electronic health record, if appropriate.
5. Track and trend amendments and report potential violations to (INSERT APPROPRIATE COMMITTEE OR DEPARTMENT).

See also:

Addendum Policy

Correction Policy

Deletion/Retraction Policy

Appendix C

Sample Correction Policy

Making Corrections in the Electronic Health Record

PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the instances in which a correction is necessary to support the integrity of the health record.

POLICY: Providers documenting within the EHR must avoid indiscriminate use of corrections as a means of documentation. All attempts to correctly identify patients and their medical conditions should be made prior to documenting within the record.

DEFINITION: A correction is a means of clarifying health information to a dictated report or direct data entry. (DEFINE IF THIS POLICY APPLIES TO INFORMATION PRIOR TO FINAL SIGNATURE, AFTER FINAL SIGNATURE, OR BOTH. ORGANIZATIONS CAN ALSO CHOOSE TO DEFINE CORRECTIONS AS CHANGES TO DEMOGRAPHIC INFORMATION.)

PROCEDURE:

PROVIDER:

1. Identify correct patient and encounter prior to documenting within the health record
2. Ensure that the proper format is utilized (e.g., dictated report or direct data entry)
3. Review documentation prior to executing signature
4. Edit document as appropriate
5. Ensure documentation is complete and accurate
6. Apply signature

See also:

Addendum Policy

Amendment Policy

Deletion/Retraction Policy

Appendix D

Sample Deletion/Retraction Policy

Making Deletions/Retractions within the Health Record

PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the instances in which a deletion or retraction of information is necessary to support the integrity of the health record.

POLICY: Providers documenting within the EHR must avoid indiscriminate use of deletion and retraction functionality as a means of documentation. All attempts to correctly identify patients and their medical conditions should be made prior to documenting within the record.

Note: Deletion or retraction of information should never occur if the record is a part of any ongoing litigation.

(ADD IF APPROPRIATE FOR THE ORGANIZATION: The total elimination of information/documentation after final signature should never occur. For instances in which the deletion function is utilized to this end, prior approval/notification must be obtained.)

DEFINITIONS:

A deletion is the action of *eliminating information* from a signed document without substituting new information.

A retraction is the action of *correcting information that was incorrect, invalid, or made in error* to a signed document. (INSERT APPLICABLE STATE LAW AS REFERENCE)

PROCEDURE:

PROVIDER:

1. Identify erroneous information
2. Contact (INSERT APPROPRIATE DEPARTMENT NAME) and identify erroneous information as well as correct information

DEPARTMENT (INSERT DEPARTMENT NAME):

1. Locate appropriate record.
2. Verify patient.
3. Determine if record is involved in litigation. If record is involved in litigation, refer request to risk management department.

4. Compare provider request of erroneous documentation to corrected documentation.
5. Apply appropriate changes in documentation to the host system as well as any long term storage systems, if appropriate.
6. Maintain request for deletion/retraction.
7. Report trends to (INSERT ORGANIZATIONAL COMMITTEE).

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