

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).

