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).