

## 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).