

Guiding Principles

Although the terms *amendments*, *corrections*, and *deletions* are often used interchangeably, they do not refer to the same thing. Organizations should have clearly defined policies, procedures, and practices to ensure that the integrity of the health information remains intact, regardless of how and when information is clarified. Organizations must ensure that clarifications or changes to health information are consistent with state and federal rules and regulations, medical staff bylaws, and accrediting body requirements. ***Once the signature has been placed the document should be considered locked from any editing.*** The intent of this toolkit is to provide further clarity for organizations and providers regarding the key terms listed above and practice guidelines below.

Signed Reports

Once a report has been signed by the dictating provider no further edits should be allowed. Any additions, corrections, or deletions should be applied through an addendum. The addendum should be included within the original report and identified as such. The addendum should include a new signature line that the provider must sign in addition to the signature that has already been placed at the end of the original document. Each organization should develop policies and procedures regarding this practice. Organizations should also address issues such as dual signatures (e.g. resident and attending physicians). In these cases, organizational policy will dictate when the report and visit note are locked from editing.

The organization may choose to lock the record from provider editing, but in some cases allow this documentation privilege to specific staff within the organization. In cases where the correction 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 HIM professionals to unlock the report, add the correct age into the document, and then lock the report. In this case, the provider should still be required to resign the new report. Another key practice would be to ensure that the correct age does not erase the incorrect information. The new information should stand out from the original. The system functionality 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 (e.g., the transcription system) are not utilized for release of information.

Key Recommendations:

- Require addendums to any document that has been final signed.
- Ensure that addendum information is added to each report in the same manner (e.g., at the top of every report).
- Require a new signature for the addendum by the provider.
- Develop policies and procedures to address minor corrections.

Unsigned Reports

Once a report has been dictated, it is usually either printed or electronically sent to the electronic health record (EHR). If it is printed for a manual signature, the report should be considered draft until it is manually signed. If the report is sent to the EHR, it should automatically populate in the provider's electronic signature queue. Unsigned reports, by nature are considered draft documents; in other words, the documentation has not been validated or confirmed by the provider. In these cases, providers may consider the documents to be available for editing. It is up to each organization to define the extent of editing that can occur on an unsigned report and who should perform the editing function. In the paper world, it may be the transcriptionist who edits based on the physician's handwritten corrections. In the electronic environment, it is recommended that providers edit their own transcribed reports within the EHR system.

The distribution of unsigned transcribed reports should not be considered a best practice. Distribution methods can include e-mail or faxing the paper copy, as well as viewing the unsigned report within the EHR. However, in order to facilitate continuity of care it is recognized that the distribution of unsigned documents is necessary to coordinate clinical care. Organizations should clearly define how this process is handled in their policies and procedures. All unsigned reports should be clearly marked as draft. Immediately upon application of the provider signature the report should convert to a final status.

Key Recommendations:

- Organizations should define unsigned reports as draft documents.
- If utilizing electronic signature capabilities in the EHR, draft documents should automatically populate in the provider's queue.
- Once signed a report should immediately convert to a final status.
- Providers should be responsible for making their own edits to draft documents.

Distribution

Distribution of reports is inherent to the continuity of care. In the paper world, reams of paper are printed, followed by a mailing of the document to the dictating provider as well as any copy providers on the report. This process can create volumes of workload for the clerical staff. As organizations move toward an EHR some pieces of the process can be automated, thus saving clerical time. However, organizations still need to define how the distribution of reports will be handled. For the purposes of this toolkit, distribution of reports is the process of making the reports viewable to providers. That process may be viewing a draft document within the EHR, or some organizations may choose to still mail or autofax transcribed documents.

Organizations must first define when the distribution of reports will occur, either prior to signature, after final signature, or a combination of both. An organization that chooses to distribute an unsigned report should have certain safeguards in place to redistribute reports that have been edited prior to final signature. The transcription system or module may have the capabilities to autofax or print to network printers. The transcriptionist

would choose the applicable method of distribution once the report has been transcribed, thus distributing an unsigned report. The report should clearly indicate it is a draft document. System capabilities should be in place to flag any report that is edited prior to final signature. The system should allow the physician to edit and append the final signature to the report, and it should also then prompt the appropriate HIM personnel (e.g., transcription supervisor) that an edit has been made and prompt the personnel to resend the report to the provider(s).

Some organizations may choose to discontinue printing or autofaxing reports once the EHR has been implemented, choosing instead to have providers view the information within the EHR itself and eliminating the paper processes associated with distribution. In these cases, draft documents should be clearly identified within the EHR so that all clinical providers (e.g., physicians, nurses, or consultants) understand that the report has not been validated. The organization should ensure that edits clearly stand out within the document (e.g., different font, color of text).

Key Recommendations:

- Organizations must define when distribution occurs.
- If unsigned reports are distributed, safeguards should be put in place to notify providers of changes made to draft documents.
- Organizations may choose to discontinue paper distribution after EHR implementation.

Record Completion Guidelines

Organizations should have clearly defined policies on when and how a record and its individual components (e.g., dictated reports, etc.) are considered complete. Health records may be incomplete for a variety of reasons (e.g., lack of dictated report or lack of signature on a verbal order). Upon discharge, the record is reviewed by clerical staff to ensure that all required reports and signatures are on the record before marking the record as complete.

As organizations implement EHRs, it does not necessarily mean that the providers will comply with record completion activities. If a provider has difficulty completing his or her records in a paper environment, the implementation of an EHR alone will not correct the issue. In the area of transcribed reports, providers must still apply the final signature. Applying an electronic signature still requires a provider to log into the system, enter his or her unique PIN number, and apply the final signature. It should never be an automatic process. Record completion should be consistent with all state, federal, and accrediting body rules and regulations.

Organizations should clearly define when individual reports are considered complete. Upon application of the final signature a report should be considered complete, and any revisions or corrections considered addendums. However, when viewing the entire health record, the organization should consider it complete when all defined components of the record are included within the body of the record and final signature applied.

Key Recommendations:

- Organizational policy should clearly define when an entire record is considered complete in accordance with all state, federal, and accrediting body rules and regulations.
- Organizational policy should clearly define that a report within the entire record is complete upon application of the final signature.
- Dictated reports within the EHR should automatically populate in a provider's electronic signature queue.
- Applying electronic signatures should never be an automatic process within the EHR.