

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.