

Retractions (*see also* Deletions)

A retraction is the action of ***correcting information that was incorrect, invalid or made in error***, by preventing display or hiding the entry or documentation from future general views.

Case Scenario: A physician is seeing patient John S. Doe in the ED. The patient has a birth date of 12/12/89. However, when the physician pulls up the patient record, he inadvertently selects John S. Doe with a birth date of 12/29/87 and documents his findings. He signs the report before realizing that he has documented on the wrong patient. The document is now locked from editing. The physician calls the HIM department to have the entry retracted from the incorrect entry and placed in the correct chart.

Concern: The physician is requesting to eliminate information from a signed document within the health record. In order to accomplish this, the information must be stricken from the incorrect record and should not be seen on the final record, or any printed versions of the record. However, since the report has been signed and is considered “locked” from editing, the physician no longer has access to remove the information within the electronic system.

Practice Guidelines: The organization should have a clearly defined process that indicates how, and in what manner, signed reports are to be handled. In the example above, the information was placed in the wrong patient’s record. Depending on the organization’s electronic system, locked reports may require specific interventions to retract information; e.g., only the HIM department personnel can unlock a report, thus creating a user audit trail of instances where information was altered. In addition, the organization should develop guidelines for making these types of entries.

Retractions 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. This information should still be available in the background, but will not display in the regular record view or be released upon request for the record. It is important to consider that while this information may be in the “background” of the electronic health record, it should not be reproduced on any printed versions of the record. If the record is requested for litigation or patient care purposes, the system should keep the retracted information from printing as a part of the legal health record. The organization should clearly define who is responsible for ensuring that this information is retracted from the legal health record as well as who is responsible for managing the information contained in the background of the record version.

If the provider selects the wrong patient chart in EHR, documents visit information, and then realized he or she is in the wrong chart, before signing the visit the provider will need to delete all information entered into this patient chart and select the correct patient chart and begin his or her documentation over again in the correct patient chart. The provider can copy and paste information into correct patient chart rather than type all of the information over again.

If the provider has already signed the visit before he or she realized they are in the wrong patient chart, then the provider will be asked to alert HIM and place an addendum in the record stating that entry was in error. The provider can copy and paste the information keyed into the wrong patient chart and copy it back into the correct patient chart if a policy is in place to do so.

Retractions are different from corrections in that they change the main point of the original documentation. A correction will leave the original documentation intact along with the revision.

See appendix D for a sample deletion and retraction policy (page 17).