AHIMA's Long-Term Care Health Information Practice and Documentation Guidelines

Legal Documentation Standards

Legal Guidelines for Handling Corrections, Errors, Omissions, and Other Documentation Problems

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There will be times when documentation problems or mistakes occur and changes or clarifications will be necessary. Proper procedures must be followed in handling these situations.

Proper Error Correction Procedure

When an error is made in a medical record entry, proper error correction procedures must be followed.

- Draw line through entry (thin pen line). Make sure that the inaccurate information is still legible.
- Initial and date the entry.
- State the reason for the error (i.e. in the margin or above the note if room).
- Document the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line/space documenting the current date and time and referring back to the incorrect entry.

Do not obliterate or otherwise alter the original entry by blacking out with marker, using white out, writing over an entry, etc.

Correcting an error in an electronic/computerized medical record systems should follow the same basic principles. The system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated. When correcting or making a change to an entry in a computerized medical record system, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted. In situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected.

Handling Omissions in Documentation

At times it will be necessary to make an entry that is late (out of sequence) or provide additional documentation to supplement entries previously written.

Making a Late Entry

- When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the medical record.
- Identify the new entry as a "late entry"
- Enter the current date and time – do not try to give the appearance that the entry was made on a previous date or an earlier time.
- Identify or refer to the date and incident for which late entry is written
- If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get information to write late entry). For example, use of supporting documentation on other facility worksheets or forms.
- When using late entries document as soon as possible. There is not a time limit to writing a late entry, however, the more time that passes the less reliable the entry becomes.

Entering an Addendum

An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident. With an addendum, additional information is provided, but would not be used to document information that was forgotten or written in error. When making an addendum --

- Document the current date and time.
- Write "addendum" and state the reason for the addendum referring back to the original entry.
- Identify any sources of information used to support the addendum.
- When writing an addendum, complete it as soon after the original note as possible.

Entering a Clarification

Another type of late entry is the use of a clarification note. A clarification is written to avoid incorrect interpretation of information that has been previously documented. For example, after reading an entry there is a concern that the entry could be misinterpreted. To make a clarification entry –

- Document the current date and time.
- Write "clarification", state the reason and refer back to the entry being clarified.
- Identify any sources of information used to support the clarification.
- When writing a clarification note, complete it as soon after the original entry as possible.

Omissions on Medication, Treatment Records, Graphic and other Flowsheets

It is considered willful falsification and illegal to go back and complete and/or fill-in signature

"holes" on medication and treatment records or other graphic/flow records in the medical record. Facility protocol should establish procedures for documenting a late entry when there is total recall and other supporting information to prove that a medication or treatment was administered. Some states have established time frames in which the omissions can be completed if the practitioner recalls administering the medication and treatmen such as no more than 24 hours should go by in which a practitioner is allowed to complete a medication, treatment, graphic or flow record and only when there is a clear recollection of administering the medication, treatment or information pertinent to a flow/graphic record.

Facilities should use concurrent monitoring (self-monitoring, shift-to-shift review, etc.) to assure that the documentation is complete and timely for all medications and treatments administered. When systemic problems are identified corrective action should be implemented. If an omission is older than 24 hours or the staff member does not have a clear recollection or there is not supporting documentation (i.e. worksheets, narcotic records, drug delivery records, initialed punch cards, etc.), the record should be left blank. At no time should the records be audited after a period of time (i.e. end of month) with the intent of identifying omissions and filling in "holes."

Documenting Care Provided by a Colleague

Documentation must reflect who performed the action. If it is absolutely necessary to document care given by another person, document factual information. For example, if a call is received from a nurse from the previous shift who indicates that he/she forgot to chart something in the record, enter the date and time of the telephone call and note: "At 16:00 Louise Jackson, R.N., called to report that at 11:00 this morning, Mr. Smith indicated he had a headache and requested Tylenol. Tylenol 650mg p.o. was given by Ms. Jackson at 11:05am. Ms. Jackson stated that Mr. Smith verbalized he was free of pain at 12:00 noon." (Signed by Penelope E. Olson, RN). Also place initials on the medication record as follows: "PEO for LJ." When Louise returns to work, she should review your note for accuracy and countersign it. She should also place her initials by your entry on the medication record. If there is not adequate room on the medication record, the initials are entered on the medication record and the entry is circled. On the back of the medication record document the above entry.

Resident Amendments to their Record

LTC facilities should have policies to address how a resident or their legally responsible party can enter amendments into their medical record. A separate entry (progress note, form, typed letter, etc.) can be used for resident amendment documentation. The amendment should refer back to the information questioned, date, and time. The amendment should document the information believed to be inaccurate and the information the resident/responsible party believes to be correct. At no time should the documentation in question be removed from the chart or obliterated in any way. The resident cannot require that the records be removed or deleted.

Under HIPAA, the resident has the right to request an amendment for as long as the record(s) is maintained by the facility. The facility may require a resident to make the request for an amendment in writing and provide a reason to support a requested amendment. The facility must act on the individual's request for an amendment no later than 60 days after receipt (a 30 day extension may be granted if the resident is notified). Once the amendment request has been reviewed, the facility must inform the resident if the amendment was granted in whole or in part. If all or a portion of the amendment request was denied, the facility must provide the resident with a written reason for the denial. The resident has the right to make a written statement of disagreement with the denial that will become part of the medical record. The facility can also document a rebuttal statement. When disclosing information pertaining to the disagreement, the written statement by the resident and the rebuttal by the facility must be included.
