LOMA LINDA UNIVERSITY MEDICAL CENTER

OPERATING POLICY

CATEGORY:	MEDICAL RECORDS	**CODE:**	D-12
		EFFECTIVE:	08/2018
SUBJECT:	CORRECTION OF MISTAKEN ENTRIES AND OMISSIONS IN THE MEDICAL RECORD	**REPLACES:**	09/2015
		PAGE:	1 of 6

A. CHANGES BY HEALTHCARE PERSONNEL

1. Each correction in the medical record shall be dated, timed, and signed (electronic or actual signature) by the individual making the correction. Although a full signature corresponding to the correction is preferred, the use of initials shall be acceptable if there is a corresponding reference signature in the document.

1.1 The individual who made the clinical data entry in the medical record shall be the one to make the correction whenever possible. If for any reason, this is not possible, the matter shall be referred to the manager or director/designee.

1.2 Staff of the Health Information Management (HIM) Department may correct inaccurate documentation regarding incorrect admission and discharge dates, medical record numbers, and patient names, if there is no ambiguity in the documentation.

a. Scanned Documents:
   1) If a document is scanned with a wrong encounter date, the scanned document shall be moved to the correct encounter.
   2) If a document is scanned to the wrong patient, a copy of the document will be moved to the correct patent and the incorrect document shall be "Filed in Error" on the incorrect patient.

b. Note Mover Tool:
   1) Move electronically created notes using the Note Mover tool in LLEAP from an incorrect encounter date to the correct encounter.
   2) If moving from an incorrect patient to the correct patient, the note shall be printed and scanned to the incorrect patient and marked "Filed in Error" before moving the note to the correct patent.

c. Note Type Change Tool:
   1) The Note Type Change Tool shall be used to change the note type for incorrectly titled electronically created documents.

d. Chart Correction Users:

1) HIM leadership that oversee chart correction staff have separate, unique user names and passwords to perform other chart correction function, for example copying documents to a separate encounter when the two encounters must maintain the documentation (i.e. consents, H&Ps, etc.)

1.3 When HIM does not have access to back-end electronic tools to perform some chart corrections activities, HIM staff shall work in collaboration with Information Services to update the patient record.

2. Correction of one's own mistaken entry or omission shall, immediately upon discovery, be corrected as follows:

2.1 Electronic Documentation – Direct Online Data Entry

a. In general, correcting an error in an electronic/computerized medical record should follow the same basic principles as corrections to the paper record.

b. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.

c. When correcting or making a change to a signed entry, the original entry must be retrievable; the current date and time shall be entered, and the person making the change identified.

2.2 On paper records

a. When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible. Draw a single line through the discovered mistaken entry so that the underlying documentation is still legible. Enter the current date, time, and signature (initials if signature is elsewhere on the page) adjacent to the mistaken entry. If documentation has become damaged due to an unforeseen extenuating circumstance such as a spill, re-create the documentation and attach the prior record.

b. Whether correcting a prior entry or adding further information associated with an omission, enter the correct information as a new entry as close to the original entry as possible. Provide the current date, time, and signature with this entry.

2.3 Documents that are created electronically must be corrected by one of the following mechanisms (see also 1.2 above):

a. Adding an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the

date created, and the electronic signature of the individual making the addendum.

b. Preliminary reports and documents are available for patient care as a part of the medical record. Until they are authenticated they are not part of the legal medical record. Once authenticated, the final report will become part of the legal medical record.

c. Once a transcribed document is final, it can only be corrected in the form of an addendum affixed to the final copy as indicated above. The amended version must be reviewed and signed by the provider.

d. Sometimes it may be necessary to re-create a document (e.g., wrong work type). If it was originally posted to the incorrect patient record, it shall be marked as "in error" and copied over to the correct patient record while the "In Error" document remains as part of the incorrect patient record ensuring the integrity of the medical record.

3. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:

3.1. Identify the new entry as a "late entry"

3.2 Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time. The entry must be signed.

NOTE: For electronic entries, the system will automatically date and time each new entry

3.3 Identify or refer to the date and circumstance for which the late entry or addendum is written.

3.4 When making a late entry, document as soon as possible. The longer the interval of time that has lapsed, the less reliable the entry becomes.

4. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.

4.1 Document the date and time on which the addendum was made.

NOTE: For electronic entries, the system will automatically date and time each new entry

4.2 When making an addendum, complete it as soon as possible after the original note.

5. Errors or omissions that are discovered which have been entered by another person shall be corrected as follows:

    5.1 The person who made the original entry shall be notified.

        a. If for any reason contact is not successful, or it is not possible for the individual who authored the mistaken entry to make corrections, the matter shall be referred to the appropriate manager or director for follow up.

        b. Once notified, the individual who made the original entry shall be asked to correct the entry as outlined in A.2.

        c. Exceptions shall be allowed as described in A.1.1,1.2, and 1.3.

    5.2 If a paper document has been incorrectly stamped with another patient's name and there is documentation for both patients on that page, the correction shall be made as follows:

        a. Make a copy of the page

        b. For each patient, draw a line through the portion of the documentation that does not apply to the patient, and place it in the chart in the appropriate section. Do not attempt to erase or otherwise obliterate the documentation that was entered in error.

    5.3 Any other alteration of another's entry in the medical record shall be prohibited regardless of reason or method.

6. Under no circumstances shall any correction(s) be made to a patient's medical record where litigation has been threatened (record sequestered), unless authorized by Risk Management in consultation with the LLUMC Office of Legal Counsel.

B. CHANGES REQUESTED BY PATIENTS

1. In the event that a patient exercises his or her right to request that a change or correction be made to his/her medical record, he or she shall submit the request in writing with a reason to support the change.

    1.1 The request may be denied for any of the following reasons:

        a. The record was not created by LLUMC

        b. The information in the record is accurate and complete

c. The information is not part of the designated record set for which the patient requests amendment.

d. The patient does not have the legal right to access the protected health information for which the request for amendment is being submitted.

e. The PHI would not be available for inspection under the HIPAA Privacy Rule § 164.524 (reference Policy Personal Access to Records (P-6)).

1.2 If the request is for clinical data and does not meet the criteria in B.1.1.a-e, requests for changes in clinical documentation shall be forwarded to the respective attending physician for discussion with the patient before any changes/corrections are made. If the attending physician is not available, the request for change to the clinical record shall be discussed with the clinical department head.

2. If the request is granted:

2.1 The appropriate person shall create an addendum and make an entry into the medical record documenting that the change was made at the request of the patient. The "Patient Request Form" shall become a permanent part of the medical record.

2.2 The HIM Department shall inform the patient of the accepted amendment.

2.3 The HIM Department shall provide the amendment to:

a. Persons identified by the patient as having received PHI regarding the subject of the amendment, and

b. Persons, including business associates, to whom LLUMC has disclosed PHI regarding the subject of the amendment.

3. If the request for changes/corrections is denied:

3.1 The physician or other person authorized to deny the request for changes shall document on the "Patient Request Form" the reason for denial and that documentation shall be a permanent part of the medical record.

3.2 The process of patient disagreement and rebuttal shall be managed through the HIM Department.

4. The patient's request for amendment shall be acted upon within 60 days of the written request.

   Note: A one-time 30-day extension shall be allowed if the patient is given reason for the delay.

APPROVERS: Hospital Executive Leadership, LLUMC Chief Executive Officer, LLUMC Chief Nursing Officer, LLUMC Medical Staff President and Chair of MSEC