

Appendix C

Sample Correction Policy

Making Corrections in the Electronic Health Record

PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the instances in which a correction is necessary to support the integrity of the health record.

POLICY: Providers documenting within the EHR must avoid indiscriminate use of corrections as a means of documentation. All attempts to correctly identify patients and their medical conditions should be made prior to documenting within the record.

DEFINITION: A correction is a means of clarifying health information to a dictated report or direct data entry. (DEFINE IF THIS POLICY APPLIES TO INFORMATION PRIOR TO FINAL SIGNATURE, AFTER FINAL SIGNATURE, OR BOTH. ORGANIZATIONS CAN ALSO CHOOSE TO DEFINE CORRECTIONS AS CHANGES TO DEMOGRAPHIC INFORMATION.)

PROCEDURE:

PROVIDER:

1. Identify correct patient and encounter prior to documenting within the health record
2. Ensure that the proper format is utilized (e.g., dictated report or direct data entry)
3. Review documentation prior to executing signature
4. Edit document as appropriate
5. Ensure documentation is complete and accurate
6. Apply signature

See also:

Addendum Policy

Amendment Policy

Deletion/Retraction Policy