UVAHealth

Department:	Health Information Management
Procedure No:	332
Revised Date:	2/2024
Approved By:	Gloria Johnson

A. TITLE: Record Modification

B. PROCEDURE:

Note the following:

The following departmental procedure illustrates how the designated record set's integrity is maintained when revisions or corrections are necessary or when duplicating information. It is applicable to all systems/media identified in Medical Center Policy 0218 unless noted as an exception. Please note that the scope of this procedure is only for changes initiated by the UVA Health Licensed Independent Practitioner (LIP) or staff. Modification requests initiated by the patient are covered in Health System Policy HPA-006.

- The ability to copy and paste is authorized. Authors should note that the risks are significant, including placing information within the incorrect encounter or patient record or entering information that does not reflect the current situation. Those utilizing this functionality assume responsibility for such information once the new note has been electronically signed.
- Duplication of information (e.g. copy and paste) should be minimal and succinct as it also leads to unnecessary voluminous records within the electronic medical record
- All viewing and documentation transactions, including the creation of addendums, corrections, and electronic signatures, are captured and viewable on the audit trail report
- Content errors where these is inaccurate or incomplete information in the original note must be corrected, either directly prior to electronic signature or via addition of an addendum post electronic signature
- The addition of information to provide clarification or to avoid misinterpretation is approved
- When a modification is made to the signed electronic record documentation, the original entry is maintained and accessible
- Corrective entries may be made at any time and should not be delayed once an erroneous entry is identified (e.g. do not need to wait for discharge, etc.)
- Only the author may make a change to their clinical documentation. With that said, other clinicians may add a new note if the author is not available.
- Addendum's are reflected in the original note as well as via the Chart Review – Notes tab

- Addendum's must also be electronically signed
- Entry and signature dates and times are never modified
- Failures to abide by this procedure or unauthorized, inappropriate, or otherwise wrongful efforts to modify medical records may result in discipline; termination of access to medical record systems; termination of employment, medical staff privileges, and/or other relationships with UVA Health; and any and all other legal action deemed appropriate by UVA.

Admitting Diagnosis

Responsible Parties: Bed Control Center (Inpatient) and Physician (Emergency Department)

Inpatient
1. Contact the Bed Control Center
2. Provide the following data elements:
   - Patient name
   - Medical record number (MRN)
   - Dates of Service
   - Correct admitting diagnosis

Emergency Department
1. Do not admit to the Emergency Department
2. See Discharge Diagnosis in ED

Admitting/Attending Physician

Responsible Parties: Bed Control Center (Inpatient) and Patient Access (Ambulatory)

1. Contact Patient Access or the Bed Control Center to have them update the Admitting or Attending Physician in Epic
2. Provide the following data elements:
   - Patient name
   - MRN
   - Admission date or date of service
   - Account number
   - Correct admitting or attending physician name

Allergies

Responsible Party: Author

Special Restrictions or Considerations/Ancillary Systems Affected: Linked to Medication Interaction Alerts

- Deleting allergies entered in error within an encounter that is still open?
  1. Select the patient with allergies entered in error
  2. Select **Encounter**
  3. Select **Allergies**
  4. Select the allergy in error
  5. Review the audit information
  6. Enter comment (if desired)
  7. Select **Delete**
  8. Select **Yes** to delete
- Deleting allergies entered in error via the Allergies Activity Tree?
  1. Select the patient with allergies entered in error
  2. Select **Allergies**
  3. Select **Show Deleted**
  4. Select the ► located in front of each allergy
  5. Review the audit information
  6. Enter comment (if desired)
  7. Select **Delete**
  8. Select **Yes** to delete
- Re-adding allergies that have been incorrectly deleted within the Allergy Activity?
  1. Select **Undelete** (next to the name of the allergy)
  2. Select **Yes**
  3. Enter comment (if desired)
  4. Select **Accept**

Amendment by Patient Request

Responsible Party: Author (as facilitated by HIM)

Special Restrictions or Considerations/Ancillary Systems Affected: HIM will contact the system administrator of ancillary system if applicable

- Encounter Based?
  1. Select **Patient Station**
  2. Enter MRN and select patient
  3. Select the appropriate encounter and double-click. The notes tab will appear on the right hand side of the tool bar at this point.

4. Select the **Note** tab
5. Create the note
- Documentation Only?
  1. Select the **red Epic drop down box** at the top left side of the screen
  2. Select **Patient Care**
  3. Select **Encounter**
  4. Enter MRN and select patient
  5. Select **New**
  6. Populate all red stop sign fields
  7. Select documentation in the appropriate field

Care Plans (Interdisciplinary Plan of Care)

Responsible Party: Author

Note: Authors may not delete a template, but are able to delete the elements of the template

1. Select **IPOC** (Interdisciplinary Plan of Care)
2. Highlight the problem to be corrected
   - Delete entire problem?
     1. Select **Delete Problem**
     2. Select the appropriate reason for modification
     3. Select **Accept**
   - Modify problem?
     1. Select **Modify Problem**
     2. Select **Add Goal, Edit Problem,** or **Add Intervention**
     3. Edit, delete, or add intervention
     4. Select **Yes** (you will not be prompted for a Yes command if you are deleting a goal or intervention

Charge Capture (Charge Modification)

Responsible Party: Charging Department

Radiology

Note: Radiology utilizes CodeRyte for billing
1. Contact the following:
   - Charge Modifications –Coding Supervisor at 4-9326
   - System Operations –Billing Manager at 4-9328

Chief Complaint

Responsible Party: Author

Note: Document the Chief Complaint as reported by the patient

1. Select **Chief Complaint**
2. Highlight the incorrect Chief Complaint
3. Select **Yes** to delete
4. Enter correct Chief Complaint
5. Select **Erroneous Entry**

Diagnosis Associated with an Order

Responsible Party: Author

Modification Procedure:

Note: If the encounter is closed, the only modification option is to addend the note. See
          Problem List section to correct a diagnosis that has been added to the Problem List.

1. Select **Order Entry**
2. Select **Diagnosis**
3. Select **Remove Dx**
   o Order not signed? Assign a new diagnosis
   o Order signed, but not released? Select **Yes** to message that diagnosis has associations

Discharge Diagnosis in ED

Responsible Party: Author

Note: The Discharge Diagnosis displays in the After Visit Summary (AVS). IMO or ICD-9
codes do not display in the AVS.

1. Select the **Description Field** (free text field)
2. Edit/Delete the Discharge Diagnosis

Discharge Writer/Discharge Instruction

Responsible Party: Author

Special Restrictions or Considerations/Ancillary Systems Affected: Contact the patient, instruct them to disregard/destroy the incorrect discharge instructions, and provide a corrected copy.

Note: If text in the Discharge Writer has not been reviewed, it may be deleted. The ED neither closes encounters nor utilizes Discharge Writer as it is inpatient functionality.

1. Select **Update** to edit the text
2. Delete all text
3. Replace text with a note stating **Erroneous Entry**
4. Select **Discharge Writer** to view the audit trail/signatures of authors
5. Select **Show History**

Document Associated with Incorrect Patient Encounter/Visit

Responsible Parties: Author, HIM, & Epic Help Desk

- Direct Entry into Epic?
  1. Author Copy/Paste the information to the correct patient
  2. Delete the original document under the incorrect patient
- Media Manager Import?
  1. E-mail the CL HIM Doc Import distribution group (if the image is linked to a flowsheet, the end Author must remove the image first)
- Transcribed document?
  1. Contact HIM at either 4-5136 or via e-mail at CL HIMDATA
  2. Provide the following data elements:
     - Patient name
     - MRN
     - Date of Service
     - Account numbers
  3. HIM will "soft-delete" the document, which means that it will be marked as a deleted document, but will be available for audit tracking purposes
  4. Please note that in many cases, direct entry notes into Epic cannot be deleted or soft deleted and the only option is to enter an addendum that an incorrect entry has been made on that patient and to disregard

Documentation Flowsheets*

Responsible Party: Author

1. Select the appropriate **Flowsheet**
2. Locate the entry in error
3. Delete, replace, or correct the entry
4. Select **Add Comment** within the field
5. Note the **Reason for Modification**
6. Select **File**
7. Select **Show Audit** to view the modification details (date, time, and Author record)
8. Author will also need to remove any incorrect images that are linked

Encounter Diagnosis

Responsible Party: Author

- Open Encounter
    1. Edit the diagnosis as instructed
- Closed Encounter
    1. Select **Patient Care**
    2. Select **Addendum**
    3. Select **Patient**
    4. Select **Visit to Addend**
    5. Select **Order Entry**
    6. Make modifications/remove
    7. Select **Yes** to the question "Remove the following diagnosis?"
    8. Select **Yes** to the question "This encounter has associations – Are you sure?"
    9. Sign the addendum

Error Created by Another Author

Responsible Parties: Authors

1. Author will contact the author of the documentation error for modification.
2. Modification required to a data element within an encounter? The encounter will be closed and the modification will be performed via an addendum.

Follow Up/Disposition

Responsible Party: Author

Special Restrictions or Considerations/Ancillary Systems Affected: Contact patient with changes if the AVS has been distributed or if the documentation was placed in the incorrect patient record and the patient has already been discharged

Ambulatory
1. Open the encounter or addendum
2. Select **Follow-Up** in the visit navigator
3. Make modifications
4. Select **Close** to save changes
5. Enter a comment stating what was changed and if the patient has been notified of the change in the Progress Notes section (may also enter a comment for an addendum)

Inpatient
- This functionality is not utilized in the inpatient setting.

Emergency Department
1. Select the **Disposition in Follow-Up** activity
2. Select the correct disposition button if you select a disposition in error and only need to replace OR
3. Highlight the incorrect disposition in **Category Selection**
4. Select **Delete** if you selected a disposition in error and do not intend to replace
5. Select **Close**

Disposition Comments
1. Select the **Comments** section and make modifications
2. Select **Close**

Follow-Up Information
1. Highlight the **Provider Name**
2. Select **Delete** if the provider entered is incorrect
3. Deselect **Incorrect**
4. Select **Correct** if the how or when is incorrect
5. Select **Delete** if changing incorrect comments

Histories

Responsible Party: Author

Note: Histories are to be documented within the History Activity. An audit trail of deletions/revisions details the versions of changes within the History Activity. Changes are not saved until the Author exits the History Activity screen.

- Medical/Surgical History
  1. Select **Chart**
  2. Select the patient in question
  3. Select **History**
  4. Select **Medical or Surgical History**
  5. Select and make the modification within the appropriate row
  6. Select **Yes** to the deletion warning
  7. Enter pertinent comments regarding the modification
  8. Enter reason for deletion or revision of history in the comment section in the row to be corrected
  9. Exit the **History Activity** to save the comment
- Family History/Family Status (do not make changes within the Family History worksheet)
  1. Select and make the modification within the appropriate row
  2. Follow process as defined in the Medical/Surgical History section
- Substance and Sexuality
  1. Select the appropriate radio button
  2. Manually delete additional details (such as pack/day, years, etc.) if changing from a positive to negative response
  3. Exit the **History Activity**
- ADL and Other Concerns (No option to delete, but may make changes)
  1. Select and make changes within the appropriate section
  2. Enter comment (if desired)
  3. Exit the **History Activity**
- Social History (Free text box with no audit or deletion capabilities)
  1. Select and makes changes within the free text fields. Marital status may not be edited in this field.
  2. Enter reason for modification, author name, date, and time for each entry
  3. Exit the **History Activity**
- Socioeconomic History
  1. Select and makes changes within the free text fields. Marital status may not be edited in this field.
  2. Enter reason for modification, author name, date, and time for each entry
  3. Exit the **History Activity**

- Specialty
  - Birth History (Both free text and drop down fields with no audit capability)
    1. Select and makes changes
    2. Exit the **History Activity**
- Obstetrics
  1. Select and make the modification within the appropriate row (which will automatically calculate)
  2. Enter reason for modification, author name, date, and time for each entry
  3. Exit the **History Activity**

Home Medications/Medication Documentation

Responsible Party: Author

Special Restrictions or Considerations/Ancillary Systems Affected: If the modification is not made prior to the patient admission, the admitting provider will need to evaluate if this medication should be continued during the inpatient stay during the medication reconciliation process.

- Home medications/Medication documentation section has been closed or has been documented on the incorrect patient?
  1. Discontinue the medication either via Visit Navigator or Medications Activity
  2. Select the appropriate discharge reason
  3. Enter comment (if desired)
- Medication discontinued in error?
  1. Add medication back via Visit Navigator
  2. Enter the original information (e.g. start date, provider, etc.)

Immunizations/Injections (Rx)

Responsible Party: Author

Special Restrictions or Considerations/Ancillary Systems Affected: Contact the Pharmacy department.

Note: For immunizations, orders populate the Immunization/Injection Activity with incomplete administrations of immunizations. Deleting an immunization linked to an order will also delete the order.

Ambulatory – Open Encounter
1. Locate the incorrectly ordered immunization under the Incomplete Administrations in the Immunizations Activity
2. Select Delete
3. Select Yes to the question "Are you sure you want to delete this immunization?"
4. View the deleted immunizations by selecting the Show Deleted button

Ambulatory – Closed Encounter
1. Locate the incorrect immunization in the Imms/Inj Activity under Administration History
2. Select Delete
3. Select Yes to the question "Are you sure you want to delete this immunization?"
4. View the deleted immunizations by selecting the Show Deleted button

Emergency Department/Inpatient
1. Select Medication Activity
2. Locate the ID order
3. Select Discontinue
4. Select Ordered in Error as the reason for the modification

Ordered Wrong Patient – Injection Administered to Wrong Patient
1. Document that the injection was administered in error
2. Complete a quality report in QR Track
3. Submit a new order for the correct patient and administer according to procedure

Ordered Correct Patient – Injection Administered to Wrong Patient
1. Re-dispense medication to the correct patient
2. Document the administration in the wrong patient's record
   a. Enter the immunization under **Imms/Injections – Historical**
   b. Add a comment to document the unintended administration
   c. Add a progress note to document the unintended administration
3. Complete a quality report in QR Track

Historical Immunizations
1. Select the blue hyperlink date within the Imms/Inj Activity
2. Enter comments to reflect why the error occurred within the comments field
3. Select Accept to save
4. Select Delete to remove the immunizations

Letters

Responsible Party: Author

- General Letters (not ED)
    4. Letter has been "Accepted" (has a status of Open), but has not been marked as "Sent"
        1. Enter a letter comment (located in the upper right hand corner of the letter template window) and describe the reason for deleting the letter
        2. Select **Accept**
        3. Highlight the letter in the **Letters Activity**
        4. Select **Delete**
        5. Select **Yes** to the question "Are you sure you want to delete this letter?" The status will change to "Deleted" at this point.
    5. Letter has been marked as "Sent"
        1. Select **Void**
        2. Enter **Erroneous Entry** in the comments section
        3. Contact the patient to notify of the amended information
        4. Document the communication in a telephone encounter or addend the current progress note
- ED Letters
    1. Utilize the Communication Manager to create/send ED to PCP letter
    2. Utilize the Letters Activity for other letters
    3. See above for directions regarding Letters Activity

Medical Administration Record (MAR)

Responsible Party: Author

Note: The cancelled administration will appear on the MAR, but the text will appear in strike-through font. If the Author hovers the cursor over the text, a tool tip will reflect the reason for cancellation. Refer to the Medication Orders procedure for additional detail.

- Medication administration documented in the incorrect patient record while utilizing the MAR
    1. Enter correct information in the MAR section in the correct patient's record
    2. Select the incorrect entry in the MAR section
    3. Select the **Edit** check box
    4. Select **Yes** to the question "Are you sure you want to edit?"
    5. Modify the Action Code to **Cancelled Entry**
    6. Enter **Erroneous Entry** in the comments section
    7. Select **Accept**

Medication Orders

Responsible Party: Author

Note: Modification will discontinue the original order and create a new order. The Author will need to communicate the modification to the person administering the order to ensure that the original order is not acted upon. The Author will not need to contact the Pharmacy unless the medication is being specially prepared as changes will be reflected in the verification queue. Refer to the Immunizations/Injections (Rx) and Medication Administration Records (MAR) procedure for additional detail.

- Modifications/Deletions to unsigned orders?
  1. Modify order as appropriate OR
  2. Delete any orders placed in error
- Modifications/Deletions to signed orders on the correct patient where the order has not been acted upon?
  1. Select **Medications Activity**
  2. Highlight the medication in error
  3. Select **Modify** or **Discontinue**
  4. Enter the reason for modification or discontinuation
  5. Select **Accept**
  6. Enter the correct order per normal procedure
- Modifications/Deletions for signed orders on the correct patient where the order has been acted upon?
  1. Complete a quality report in QR Track
  2. One time order?
     a. Note the event in the patient's progress notes
     b. Select **Medications Activity**
     c. Enter **Erroneous Activity**
     d. Select **Accept**
  3. Ongoing order?
     a. Select **Medications Activity**
     b. Select the appropriate **Reason for Discontinuation**
     c. Select **Accept**
- Modifications/Deletions for signed orders on the incorrect patient where the order has not been acted upon?
  1. Select **Medications Activity**
  2. Select the appropriate **Reason for Discontinuation**
  3. Select **Accept**
  4. Enter the correct order on the correct patient per normal procedure

- Modifications/Deletions for signed orders on the incorrect patient where the order has been acted upon?
  1. Complete a quality report in QR Track
  2. One time order?
     a. Note the event in the patient's progress notes
     b. Select **Medications Activity**
     c. Enter **Erroneous Activity**
     d. Select **Accept**
  1. Ongoing order?
     a. Select **Medications Activity**
     b. Select the appropriate **Reason for Discontinuation**
     c. Select **Accept**
  2. Enter the correct order on the correct patient per normal procedure
- Modifications/Deletions for orders on the correct patient, but the incorrect encounter?
  1. Select **Medications Activity**
  2. Select the appropriate **Reason for Discontinuation**
  3. Select **Accept**
  4. Locate the correct encounter
  5. Re-enter the medication order utilizing the same ordering date, ordering provider, authorizing provider, and communicator
  6. Enter the verbal order type if the order was verbal
  7. Contact Pharmacy to verify the order

MyChart™ Change Requests

Responsible Parties: HIM & Ambulatory

- Demographic changes (e.g. address, name, etc.) are corrected/modified in Epic by HIM (with verification of name changes)
- Clinical information may be requested via completion of an HIM Amendment Request form (See Amendment by Patient Request section)

Notes Entered via Notes Activity

Responsible Party: Author

Note: The addended note will be available for viewing in Chart Review. To see the original document, select Previous Versions. Notes that have been signed may not be deleted.

- Note Unsigned?
  o Correct a Note

1. Select **Notes Activity**
2. Select the note to be corrected
3. Select **Addendum**
4. Make modifications as needed
5. Select **Accept**
- o Delete a Note
    1. Select **Notes Activity**
    2. Select the note to be corrected
    3. Select **Addendum**
    4. Highlight and delete the original text that automatically reflects in the Addendum box
    5. Enter reason for deleting the note
    6. Select **Accept**
    7. Highlight the entire note
    8. Click the **Delete key**
    9. Select **Yes** to the question "Are you sure you want to delete the document?"
- Note Signed?
    - o Correct a Note – Enter an Addendum
        1. Select **Patient Care** on the toolbar
        2. Select **Addendum**
        3. Enter correct information
        4. Select **Closed Encounter**
        5. Scroll to the Progress Notes section
        6. Select the **Edit** check box
        7. Select **Yes** to the question "Are you sure you want to edit?"
        8. Select **Accept**

Notes Entered via Transcription

Responsible Party: Author

- Unsigned Note?
    - o Correct a Note
        1. Select the Transcription folder in your InBasket
        2. Open the note in question
        3. Make modifications
        4. Sign the note
    - o Delete a Note
        1. Select the Transcription folder in your InBasket
        2. Open the note in question
        3. Select the Reject button

- Signed Note?
    3. Correct a Note – Enter an Addendum
        - See the Notes Entered via Notes Activity procedure to enter an addendum via Epic. Otherwise, utilize the telephone dictation system to dictate an addendum.
    4. Delete a Note
        - Notes that have been signed may not be deleted

Orders

Responsible Party: Author

<u>Ambulatory</u>
- Order Entered, but Not Signed?
    1. Select **Order Entry**
    2. Select **Remove**
- Order Result Status Has Not Reached In Progress?
    1. Select **Order Entry**
    2. Select **Open Order**
    3. Highlight the order in question
    4. Select **Cancel**
    5. Enter reason for cancellation
    6. The order will remain, but the text will appear in strike-through font
- Order Has Been Released?
    - Laboratory
        - Contact the Medical Laboratories
    - Radiology
        - Contact Coding Supervisor at 4-9326
- Incorrect Order Performed on the Correct Patient?
    1. Enter the correct order
    2. Complete a quality report in QR Track
    3. Contact Coding Supervisor at 4-9326
    4. Contact the Medical Laboratories
    5. The unintended order will remain
- Incorrect Order Performed on the Incorrect Patient?
    1. Enter the correct order on the correct patient
    2. Complete a quality report in QR Track
    3. Contact Coding Supervisor at 4-9326
    4. The unintended order will remain

<u>Inpatient</u>
- Order Entered, but Not Signed?
  1. Select **Order Entry**
  2. Select **Remove**
- Order Has Been Signed?
  1. Select **Orders Management**
  2. Highlight the order in question
  3. Select **D/C**
  4. Enter comment
  5. Select **Accept**
- Order Has Been Released?
  o See Orders – Ambulatory section
- Incorrect Order Performed on the Correct Patient?
  o See Orders – Ambulatory section
- Incorrect Order Performed on the Incorrect Patient?
  o See Orders – Ambulatory section

<u>Emergency Department</u>
- Nurse: Trackboard Orders Report?
  1. Select the **Discontinue hyperlink**, which will open the Discontinue Orders window
  2. Enter **Author Authentication** (Epic password)
  3. Select reason for discontinuation
  4. Verify all fields and adjust as needed in the Provider Box
     ▪ The ordering physician will pre-populate
     ▪ Enter additional comments, if appropriate
  5. Select **Accept**. The order will change to Discontinued Orders to be Acknowledged
  6. Select the **Acknowledged/Discontinued hyperlink**
  7. Enter **Author Authentication** (Epic password)
- Doctor: Trackboard Orders Report?
  1. Select the **Discontinue hyperlink**, which will open the Discontinue Orders window
  2. Select reason for discontinuation
  3. Select **Accept**
- Other Orders?
  o See Orders – Ambulatory section

Patient Education/Learning Assessment

Responsible Party: Author

Note: Deleted Title, Topic or Teaching Points may be tracked in Education Review. They will appear in a strike-through font. It is not possible to delete a single element within a row. The entire row must be deleted. One may only delete their own entry(ies).

Inpatient
- Learning Assessment
    5. No modifications may be made if the assessment has been filed. The Author must create a new assessment.
- Unresolved Education – Details of Specific Teaching Points
    o Filed (with a status of Active)?
        1. Highlight the item in question
        2. Select **Delete**
    o Not Filed?
        1. Highlight the item in question
        2. Select **Delete, Edit, or Add**
- Unresolved Education – Entire Title or Topic Teaching Point
    1. Highlight the item in question
    2. Select **Remove**
    3. Select **Reason**
- Reactivate a Title, Topic or Teaching Point
    1. Select **Manage Education**
    2. Select the check box for the item to be reactivated
    3. Select **Re-Activate**. They will change to an Unresolved status at this point.
- Incorrect Patient
    1. Highlight the item in question
    2. Select **Remove**
    3. Select **Reason**
    4. Enter **Erroneous Entry** in the comments section

Ambulatory
- Learning Assessment
    1. Select the encounter or addendum
    2. Select **Learning Assessment**
    3. Make modifications
    4. Select **Mark As Reviewed**
- Teaching Documentation
    1. Select the encounter or addendum

2. Select **Teaching Documentation**
3. Make modifications
4. Select **Mark As Reviewed**

Patient Instructions

Responsible Party: Author

Note: The addended note will be available for viewing in Chart Review. To see the original document, select Previous Versions.

- Open Encounter?
  1. Select **Patient Instruction**
  2. Make modifications as necessary
- Closed Encounter?
  1. Select **Patient Care**
  2. Select **Addendum**
  3. Locate patient
  4. Select the closed encounter to addend
  5. Select **Patient Instructions**
  6. Make modifications as necessary
  7. Sign and Route the addended document

Problem List

Responsible Party: Author

- Correct problems that may have been entered, resolved, or deleted in error?
  1. Select **Chart**
  2. Select **Problem List Activity**
  3. Select **Full Comments**
  4. Select **My View Options**
  5. Select **Resolved** and **Deleted**
  6. Print the screen for use as a reference
- Review problems and correct as follows:
  - Delete incorrectly added problems (Noted date during incorrect encounter date)
    a. Select **Name of Problem**
    b. Enter **Error – Problem resolved in error on (<u>date of resolution</u>). Added back on (<u>today's date</u>)** in the comments section
    c. Select **Accept**
  - Add back incorrectly resolved problems (Resolved within incorrect encounter date)

a. Select **Name of Problem**
b. Select **Past Updates**
c. Close the **View Changes** window
d. Select **Undelete**
e. Enter **Problem deleted in error on (<u>date of original deletion</u>). Added back on (<u>today's date</u>)** in the comments section
f. Select **Accept**
- Add problems to correct patient
  a. Select **Chart**
  b. Select the correct patient (aka Target patient)
  c. Select **Problem List Activity**
  d. Select **Show Deleted and Resolved**
  e. Select **Full Comments**
  f. Select **My View Options**
  g. Select **Resolved** and **Deleted**
  h. Review problems added on the source patient in comparison to problems shown on the target patient
- Add problems if applicable using the screen print of the source patient
  a. Add problem ICD-9 or 10
  b. Add any comments that were recorded previously
  c. Enter **Added to patient problem list on date diagnosis established** in the comments section

Patient with Multiple Medical Record Numbers

Responsible Party: HIM

1. Contact HIM at 4-5136 or via e-mail at CL HIMDATA
2. Provide the following data elements:
   - Patient name
   - MRNs
   - Date of birth
3. Continue documenting under the medical record number assigned to the current visit unless notified to use another by HIM

Results

Responsible Parties: Medical Laboratories & Radiology

<u>Laboratory Results</u>
1. Contact the Medical Laboratories

2. Provide the following data elements:
   - Patient name
   - MRN
   - Date of birth
   - Result in question
3. The Medical Laboratories will append a comment to the results that are modified.

Radiology Results
1. Contact Radiology
2. Provide the following data elements:
   - Patient name
   - MRN
   - Date of birth
   - Result in question

Retail Prescriptions

Responsible Party: Author

- Incorrect drug was ordered or order was entered on the incorrect patient?
  1. Enter the medication on the correct patient
  2. Highlight the medication in question in the incorrect patient's record
  3. Select **Discontinue**
  4. Enter the reason of **Ordered in Error** for discontinuation
  5. Locate the medication script (if one was printed) and place it in the recycling bin
  6. Contact the Pharmacy to ensure that the erroneous prescription is not dispensed

Telephone Encounters

Responsible Party: Author

- Contacts
  1. Select **Telephone/Refill Encounter** or **Addendum**
  2. Select the **Contacts** section of the encounter
  3. Select **Delete** to delete a contact OR
  4. Select **Edit** to edit a contact
- Disposition
  1. Select **Telephone/Refill Encounter** or **Addendum**
  2. Select the **Disposition** section of the encounter
  3. Select **Delete** to delete a disposition OR

4. Select **Edit** to edit a disposition

Vitals

Responsible Party: Author

<u>Inpatient</u>
- Please refer to the Flow Sheet procedure for further information

<u>Ambulatory</u>
- Open Encounter?
  - Correct the entry
- Closed Encounter
  1. Select **Patient Care**
  2. Select **Addendum**
  3. Enter the correct information
  4. Select **Closed Encounter**
  5. Select **Vitals**
  6. Make modifications as necessary
  7. **Sign** and **Route** the addended document

C. RELATED DOCUMENTS:

- HPA-003 Policy - Amendment of Medical and Billing Records
- Medical Center Policy 0094 – Documentation of Patient Care (Electronic Medical Record)
- Medical Center Policy 0201 – Patient Identification
- Medical Center Policy 0218 – Definition, Characteristics, Authentication, and Maintenance of the Medical Record and Designated Record Set

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