Long-Term Care Survey Alert

Documentation: Use These 5 Guidelines for Audit-Proof Record Corrections

Documentation clarifications can be a big help --if you use them wisely.

With the plethora of government entities poring over more and more of your patient records, it may be time to use a valuable weapon: documentation corrections and additions. But overuse of late entries may do more harm than good.

"Record tampering undermines a clinician's credibility in the event of litigation," warns a guidebook on medical documentation by the University of North Texas. "It is important not to jeopardize the integrity of a patient's medical record by using a questionable correction method."

Rumor: Some healthcare staff believe they are not allowed to make corrections to a medical record if someone else (i.e., a supervisor) asks them to do so.

Truth: It is perfectly OK for a clinician to make changes to the record at another person's request, notes consultant **Judy Adams** in Chapel Hill, N.C. That is, as long as the clinician actually remembers the information, or reads notes or other written information that triggers their memory of the additional information, adds Washington, D.C.-based attorney **Elizabeth Hogue.**

Often such correction requests will be made of staff in the course of internal quality reviews, notes regulatory consultant **Rebecca Friedman Zuber** in Chicago, Ill. Examples can include corrections made during initial supervisory review of the assessment and plan of care or during quarterly record reviews, Zuber says.

5 Steps to Successful Record Additions

Late entries will help you only if they are completed according to the rules, experts agree. Follow these steps to make sure your corrections will pass muster during review:

1. Cross out, don't black out. If you are correcting an incorrect statement in the record, you should draw a line through the statement and put the word "error" next to it, Zuber counsels. Then sign or initial it (depending on your agency's policy) and put the date.

Plus: "The original information must still be readable and included in the record," Adams tells **Eli**. Use just a single line to cross it out.

2. Don't forget the title. The cardinal sin of making corrections is failing to note the late entry. Be sure to clearly mark the correction or supplementation as a late entry, Adams advises.

3. Include a date and signature. Any late entry should include its date, Hogue says.

"This means no back dating," Zuber stresses.

And corrections or additions to documentation should be made by the documentation's original author, experts agree. That person should sign the correction as well as dating it. There's "no making it look like the entry was made by the original writer if it wasn't," Zuber cautions. In rare cases, another person can make a documentation change, Zuber allows. But the record should clearly indicate who made the entry and "coordination of that person's input with the original writer should be documented in the late entry."

4. Don't be stingy. It's a good idea to jot down the purpose of the entry -- for example, clarification, Adams suggests.

5. Consider these issues for computer records. When you correct an electronic record, remember that the original information must remain in the record, advises the University of Michigan Health System in its medical documentation policy. And "in situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected."

Note: UNT's guidebook is at www.hsc.unt.edu/policies/QuAssure/Clinical%20Documentation&ComplianceManual042704.pdf. The U of M policy, which includes guidance on corrections, late entries, addendums/clarifications, and more is online at http://www.med.umich.edu/newclinicians/med_rec.html (search for "correction").