CAROLINA FAMILY HEALTH CENTERS, INC.
POLICY

MANUAL: Volume II	**SUBJECT POLICY:** Corrections, Amendments and Deletions to Health Information in the Electronic Health Record System
NUMBER: HIT-102 **Page 1 of 2**	**EFFECTIVE DATE:** September 2013
SECTION: Health Information Technology **REFERENCE PROCEDURE:** HIT-102.01	**REVIEWED:** 04/15, 08/17
RESPONSIBILITY: Chief Operating Officer	**APPROVAL:** APPROVED
CEO APPROVAL: APPROVED **DATE:** 8-22-17	**BOARD APPROVAL:** **DATE:** 8-22-17

I. PURPOSE

The purpose of this policy is to provide guidance for making corrections, amendments, and deletions in the electronic health record (EHR) system at Carolina Family Health Centers, Inc. (CFHC, Inc.) to support the integrity of the health record. 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.

II. POLICY

Providers documenting within the EHR system must avoid indiscriminate use of amendments or deletions as a means of documentation. All attempts to correctly identify patients and link their visit properly should be made prior to documenting within the record.

The EHR system will save the original document in addition to recording the date, time and electronic signature of the individual making the correction, amendment, or deletion. Typically, staff should not amend other's notes; however, this may be appropriate for the supervision of students or mid-level providers.

NOTE: Deletion of health information should never occur if the record is part of an ongoing litigation against CFHC, Inc. The patient's chart will be flagged by the Chief Operating Officer if there is litigation against CFHC, Inc. or maybe put on a litigation hold. Refer to *EXEC-102 Claims Management.*

III. DEFINITIONS

A correction is a means of clarifying health information. Corrections are needed when demographic data or other clinical data is entered incorrectly. A correction will take place before the final provider signature is obtained. Corrections to the document after the final signature will be made through the amendment process.

NOTE: Updating demographic data or past medical, family, social and surgical history should be performed at each patient visit and is not the same as correcting data that has been entered incorrectly.

An **Amendment** is a means of clarifying or changing health information in a note after the final signature has been obtained.

A **Deletion** is an action of ***eliminating information*** from a signed document without substituting new information.

A **Retraction** is an action of ***correcting information that was incorrect, invalid, or made in error*** to a signed document. This could be handled through the amendment process but may require a document to be deleted and replaced with the correct information.