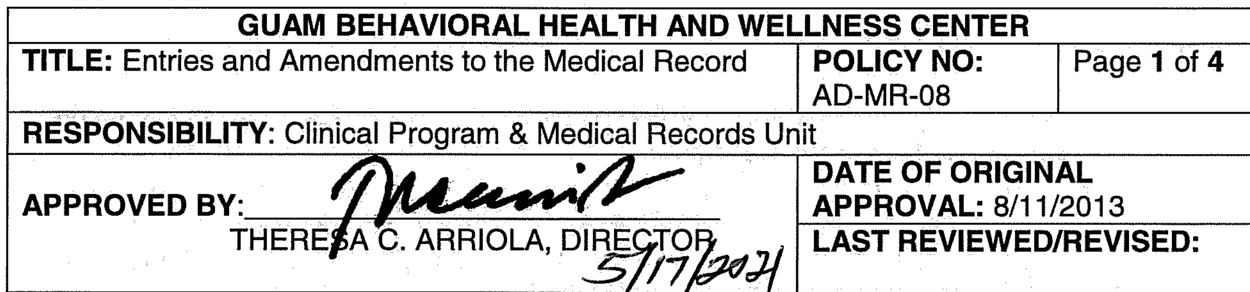

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER		
TITLE: Entries and Amendments to the Medical Record	**POLICY NO:** AD-MR-08	Page **1** of **4**
RESPONSIBILITY: Clinical Program & Medical Records Unit		
APPROVED BY: ______ THERESA C. ARRIOLA, DIRECTOR 5/17/2021	**DATE OF ORIGINAL APPROVAL:** 8/11/2013	
	LAST REVIEWED/REVISED:	

PURPOSE:

To provide guidance on entries to the medical records and on instances in which an amendment and addendum is necessary to support the integrity of the medical record.

POLICY:

A. Guam Behavioral Health and Wellness Center (GBHWC) medical records are a compilation of all documents related to consumer care. All entries are recorded as they occur (real time) or as indicated in the *CL-AP -10 Progress Notes Clinical Documentation Policy* time frames.
   a. All medical records must be maintained in their entirety and no document or entry may be deleted/removed from the record once signed.
   b. Any amendments or late entries shall be in accordance with this policy.
   c. Essential and pertinent hard copy documents should be scanned and uploaded in EHBR/AWARDS as a file whenever possible. The hard copy will be stamped "uploaded."
   d. The medical record may include documents that are transmitted by facsimile machine; provided that the faxed copies are on non-thermal paper and that the faxed copies are dated and authenticated.

B. GBHWC shall ensure that medical records contain accurate, complete, and timely documentation of care that can be utilized by clinicians to provide safe quality patient care and best outcomes.
   a. All attempts to correctly identify patients should be made prior to documenting within the record.
   b. It is strongly recommended that documentation be entered into the electronic health record within specified timeframes (*reference CL-AP-10 Progress Notes Documentation*) however, all late entry documentation is allowed in EBHR/AWARDS within 30 days of the encounter without backdated permission request and if the document has not been signed.

   c. Providers documenting within the EBHR must avoid indiscriminate use of amendments as a means of documentation.
      i. Staff shall seek approval from the immediate supervisor when requesting for permission to amend any record in EHBR/AWARDS.
      ii. Only **strike through options** will be utilized to remove an entry made in error.

   d. All entries in the medical record shall be authenticated in written or electronic form by the person (identified by name and discipline) responsible for providing or evaluating the service provided.

   e. GBHWC uses standardized diagnosis and procedure codes and ensure the standardized use of approved symbols and abbreviations. Only approved

abbreviations listed in the GBHWC Abbreviation and Symbol List (F-ADMR-08.2) as listed in this policy attachment.

i. GBHWC **prohibits** the use of abbreviations in informed consent forms, patient rights, discharge instructions, and other documents patients and families receive *(reference attachment F-ADMR-08.1 Joint Commission do not use abbreviation list*)

C. Knowingly falsifying clinical documents is a felony offense and GBHWC views this offense seriously if it occurs. Examples of falsified records:
   a. Purposely document inaccurate information
   b. Amending records that does not comply with the procedure in this policy or in direct violation of other regulatory body requirements.

D. Staff must be trained and competent in the fundamental documentation practices of this facility and legal documentation standards.

DEFINITIONS:

Amendment: An amendment is an alteration of the health information by modification, correction, addition, or deletion. For the purpose of this policy, the term "amendment" is the overarching term indicating that documentation has been altered. Amendment is made after the original documentation has been completed and signed by the provider (AHIMA, 2012).

Addendum**:** Is an optional feature available for the group notes in AWARDS and used when additional information is needed to support the original document at the time of the entry. (Foothold Technology, 2015)

Late Entry: An addition to the health record when a pertinent entry was missed or was not written in a timely manner. The late entry should bear the current date, time, and should reference the original date of the actual encounter (AHIMA, 2012).

PROCEDURE:

A. General Documentation/Entry Guidelines in Paper Medical Record & EBHR/AWARDS
   1. All documentation and entries in the medical record, both paper and electronic, must be identified with the consumer's full name (last, first, middle initial), date of birth, and unique GBHWC medical record number.
   2. Two patient identifiers must be on every page (patient name, account number, date of birth, etc.) front and back if two-sided.
   3. Entries in medical record shall be time stamped as to the date and time it was entered, the date must be documented as MM/DD/YYYY, and time in 24 hr. format (military time).
   4. Charting time as block (i.e., 7-3) especially for narrative notes is not advised.
      a. Narrative documentation should reflect the actual time the entry was made.
      b. For certain types of flow sheets such as a daily nursing flow sheet, recording time as a block could be acceptable.
   5. A co-signature is only needed if the staff making an entry is being supervised by a clinician who is ensuring they are properly delivering the service (i.e., supervising staff co-signing for interns, etc.).

B. Documentation guideline Paper Chart
   1. All handwritten entries must be in black or blue ink using a ballpoint pen.
   2. Write legibly.
   3. If there is unused space within a document (i.e., progress note) a line must be drawn from the end of the entry to the end of the unused space.
   4. Any blank spaces on forms must be "X'ed" out or the word "Deferred" must be written in the areas left blank.
   5. Every required space shall be filled on forms or flow sheets. "Not applicable" or "N/A" should be noted rather than leaving the space blank.
   6. There shall be no documentation on the back of a one-sided form.
   7. There shall be no crowding or writing in the margins.

C. Procedure for Making a Late Entry to;
   1. Hand written medical record documentation
      i. New entry MUST be identified as late entry.
      ii. Date and time when entry was made; do not try to give the appearance that the entry was made on a previous date or an earlier time.
      iii. Identify or refer to the date and incident for which the late entry is written.
      iv. Reference the date when the original entry was made on the late entry.
      v. If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get the information to write the late entry, i.e., use of supporting documentation on other facility worksheets or forms).
      vi. When using late entries, document as soon as possible. There is no time limit to writing a late entry; however, the more time that passes, the less reliable the entry becomes.

   2. Electronic Health Record documentation:
      i. Entering the late documentation still follows procedure for original entry.
      ii. New entry MUST be identified as late entry at the top of the note.
      iii. Late entry that is beyond the standard window of documentation will require backdated data entry permission.

D. Procedure for Amendments to;
   1. Hand Written Medical Record
      i. Draw a single line through the incorrect information so that it is still readable and legible.
      ii. Write the word "ERROR" besides the entry that was stricken.
      iii. Place the date and your initials besides the word "ERROR"
      iv. Enter the correct information or note N/A if not applicable.

   2. Electronic Health Record
      i. Amendment to progress notes is found in the progress notes module.
      ii. Amendments to progress note can only be done by the writer of the original note.
      iii. The existing note should also be locked or e-signed for the note amendment feature to be displayed.
      iv. Writer opens progress note, and shall enter the same note type, service type, location, date, time, consumer, writer, face to face selection, of an already existing note.
      v. Writer enters amended note in the text box
      vi. Writer can choose the strike through feature to strike through the original note text.

vii. The Amendment feature also has options to copy and paste the text from the original note.
viii. Amended progress note should be signed once completed.

REFERENCE(S):

American Health Information Management Association. (2012). *Amendments in the electronic health record toolkit.* Chicago: AHIMA.

RELATED POLICY (IES):

SUPERSEDES: Title; Policy No.; Effective Date/signature date; Approving individual's name

ATTACHMENT(S):

F-ADMR-08.1 Do not Use Abbreviation List
F-ADMR-08.2 Approved Abbreviation List

The Joint Commission.

Official "Do Not Use" List

The Joint Commission
FACT SHEET

- This list is part of the Information Management standards
- Does not apply to preprogrammed health information technology systems (i.e. electronic medical records or CPOE systems), but remains under consideration for the future

Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols and dose designations from the software.

Official "Do Not Use" List

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I	Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO_4 and $MgSO_4$	Confused for one another	

[1] Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Development of the "Do Not Use" List

In 2001, The Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations. A year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "Do Not Use" List to meet that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01.

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For more information

- Contact the Standards Interpretation Group at 630-792-5900.
- Complete the Standards Online Question Submission Form.

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REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

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Policy No: AD-MR-08
Initiated by: Medical Records

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