Correcting and Amending Entries in a Computerized Patient Record (1999)

The information in this practice brief has been updated. The most recent information is available here.

There are a variety of recognized standards for correcting and amending entries in a computerized patient record. However, two that stand out are the Federal Rule of Evidence 803 (6) and the Uniform Business Records as Evidence Act—both of which apply to computer- and paper-based records. According to the *Comprehensive Guide to Electronic Health Records,* published by Faulkner & Gray, the Federal Rule of Evidence makes it possible to use medical records "as records of regularly conducted activity" in federal criminal and civil cases. The Uniform Business Records as Evidence Act, adopted by some states, also makes medical records admissible as evidence in federal criminal trials and civil cases. While not all states have signed on to the Uniform Business Records legislation, many states, as well as the federal government, allow for the use of medical records in court—either under the business record exception or a variation of that exception, which specifically covers medical records.

Laying the Foundation

To convince courts to allow medical records into evidence, some basic facts must be proven:

- "The record was made in the regular course of business. The regular course of business is nothing more than doing business in accordance with one's usual habit or custom
- The record was kept in the regular course of business
- The record was made at or near the time of the matter recorded
- The record was made by a person within the business with knowledge of the acts, events, conditions, opinions or diagnoses appearing in it"[1]

The Comprehensive Guide to Electronic Health Records states that under these business or medical records exceptions to the hearsay rule, computerized business or medical records are admissible if they meet two requirements: meeting the foundation requirements of the business or medical records exception and showing the accuracy and trustworthiness of the records. The burden of the second requirement is placed upon the party offering the computerized records. Fulfilling the requirements necessitates the following information:

- "the type of computer used and its acceptance as standard and efficient equipment
- its method of operation
- the competency of its operators
- the method and circumstances of preparation of the record, including:
    - the sources of information on which it is based
    - the procedures for entering information into and retrieving information from the computer
    - the controls and checks used, as well as the tests made to ensure the accuracy and reliability of the record

- the information has not been altered."[2]

Making the Correction

Correcting information in a computerized record is essentially the same as correcting information in a paper record. When correcting an error on paper, the provider should draw a line through the original entry in such a way that the original entry remains legible. The provider should not alter the original record in any way by trying to erase or remove the incorrect information. The provider should print the word "error" at the top of the entry, and sign, date, and time it. The reason for the change should be indicated as well as the discipline of the person making the correction. *The Comprehensive Guide to Electronic Health Records* states, "Correcting computerized records also involves maintaining the original, incorrect entry and adding a correction."[3]

Where to Look

Standards organizations such as the American Society for Testing and Materials (ASTM) and Health Level 7 (HL7) have published guidelines that address the correction and amendment of computerized patient record entries.

ASTM Guidelines[4]

In section 8, the signature attributes section, three types of authentication methods are introduced and defined.

8.2.2.15 Addendum Signature: "The signature on a new amended document of an individual who has corrected, edited, or amended an original health information document. An addendum signature can either be a signature type or a signature sub-type." (Signature types and signature sub-types are defined in section 8.1 of the signature attributes section of the E1762).

The ASTM standard states that "any document with an addendum signature shall have a companion document that is the original document with its original, unaltered content, and original signatures. A computer code attribute shall be used to reference the original document to the new document. Whether the original unaltered document is displayed each time the addendum is viewed is left to the individual facility's discretion. However, the original, unaltered document must remain as part of the computerized patient record and the system must permit access to the original document on demand."

8.2.2.16 Modification Signature: "The signature on an original document of an individual who has generated a new amended document."

The standard states that "the original document shall reference the new document via an additional signature purpose. This is the inverse of an addendum signature and provides a pointer from the original to the amended document."

8.2.2.17 Administrative (Error/Edit) Signature: "The signature of an individual who is certifying that the document is invalidated by an error(s), or is placed in the wrong chart."

The standard states that "an administrative (error/edit) signature must include an addendum to the document and therefore shall have an addendum signature sub-type. This signature is reserved for the highest health information system administrative classification, since it is a statement that the entire document should no longer be used for patient care, although for legal reasons the document must remain part of the permanent patient record."

HL7 Guidelines[5]

This section identifies and defines the types of errors and corrections that occur in the appropriate computer messages, which in turn should be used to communicate corrections and addenda. The elements utilized for document addendum notification are outlined and defined in sections 9.4.5 through 9.4.11.

HL7 offers scenarios for each of the following situations:

- creating an addendum—"Author dictates additional information as an addendum to a previously transcribed document. A new document is transcribed. This addendum has its own new unique document ID that is linked to the original

document via the parent ID. Addendum document notification is transmitted. This creates a composite document."

- correcting errors discovered in a document that has not been made available for patient care—"Errors, which need to be corrected, are discovered in a document. The original document is edited, and an edit notification is sent."

- correcting errors discovered in the original document that has been made available for patient care—"Errors discovered in a document are corrected. The original document is replaced with the revised document. The replacement document has its own new unique document ID that is linked to the original document via the parent ID. The availability status of the original document is changed to 'obsolete' but the original document should be retained in the system for historical reference. Document replacement notification is sent."

- notification of a cancelled document—"When the author dictated a document, the wrong patient identification was given, and the document was transcribed and sent to the wrong patient's record. When the error is discovered, a cancellation notice is sent to remove the document from general access in the wrong patient's record. In these cases, a reason should be supplied in the cancellation message. To protect patient privacy, the correct patient's identifying information should not be placed on the erroneous document that is retained in the wrong patient's record for historical reference. A new document notification and content will be created using a TO2 (original documentation notification and content event) and sent for association with the correct patient's record."

Internet Connections

Both ASTM's and HL7's Web pages can be easily accessed by using the Internet Connections option on AHIMA's Web site. Or go directly to these sites:

- ASTM: www.astm.org

- HL7: www.hl7.org

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Related AHIMA Practice Briefs

(available in the AHIMA Library, AHIMA's online body of knowledge)

- Electronic Signatures (October 1998)
- Managing Multimedia Medical Records: A Health Information Manager's Role (February 1998)

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Notes

1. *Comprehensive Guide to Electronic Health Records.* New York, NY: Faulkner & Gray, Inc., 1999.

2. Ibid.

3. Ibid.

4. American Society for Testing Materials. 1999 Annual Book of ASTM Standards, Vol. 14.01. Healthcare Informatics Computerized Systems and Chemical and Material Information. West Conshohocken, PA: 1999. ASTM Designation E1762-99—Standard Guide for Authentication of Health Care Information; Section 8—Signature Attributes.

5. Health Level Seven, Version 2.3. Ann Arbor, MI: 1997. Available online at http://www.hl7.org/Library/standards_non1.htm#HL7 Version 2.3.

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