Deleting Errors in the EHR

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Many types of documentation errors can occur in electronic health records (EHRs), such as incorrectly recording the sex of a patient, documenting in the wrong patient record, and incorrectly identifying the ordering physician on a laboratory report.

It is important to address errors in documentation as soon as possible. If patients are transferred to another facility, the erroneous information may be sent with them, causing potential treatment concerns. If the documentation error occurs in the history and physical, care during the entire stay could be jeopardized.

When errors occur, clinical care providers may be inclined to delete the erroneous information to avoid adversely affecting the care of the patient. Correcting errors in documentation is also important in mitigating risk to the organization or physician. However, the health record is a legal document that records the events, decisions, and outcomes of a patient visit. For this reason, completely eliminating documentation from the record is not recommended.

As a result organizations should have clearly defined policies and procedures for correcting documentation errors within the EHR. These policies and procedures will help support sound documentation practices so that a legal health record is available for each patient.

Assessing System Functionality

AHIMA defines a deletion as the act of eliminating information from previously closed documentation.1 Organizations should clearly define the difference between open (unsigned) and closed (signed) documentation within the EHR in organizational policy as well as the audit process that will be followed for each type of correction of information.

In a paper record, authors may correct inaccurate documentation with a single-line strikethrough, then date and initial the entry. This will leave the original documentation intact. In the EHR, how authorized users change documentation-as well as how the changes are tracked and how they are displayed-will depend on the system or module.

It is recommended that the incorrect information in EHR systems be removed from view but remain within the system so that it may be retrieved through versioning documents or metadata if required.

During the vendor evaluation process, HIM and IT professionals should carefully review both deletion and retraction functionality within EHR systems and modules. It is imperative that HIM professionals are part of the evaluation process for any EHR component to ensure that the product meets all legal health record requirements.

Organizations should avoid systems with the capability to totally eliminate information within the health record. These systems place the organization at risk in terms of legal hold requirements, accurate documentation, and patient safety.

If system capabilities do allow for the total elimination of information, HIM and IT professionals should ensure that appropriate audit trails are available within the system. Audit trails ensure that the organization can track all entries and deletions within a record. They should be monitored on a routine, defined basis by the appropriate personnel.

Incorrect utilization of deletion functionality should result in immediate follow-up and education. In addition, audit trails can be considered a part of an organization's metadata and therefore applicable in litigation. Without context, the audit trail will have little value for the organization. Audit trails should include the name of the user, the application triggering the audit, the workstation, the specific document, a description of the event (e.g., deletion), and the date and time.

Record Maintenance and Legality

All health records must be maintained in accordance with state and federal record-keeping guidelines. HIM professionals should review their state guidelines for potential deletion requirements. For example, in Maryland individuals do not have the right to have information deleted from their medical record.[2]

A note of caution: the term deletion found within state or federal record-keeping guidelines can refer to the act of destroying a record once it has met the statute of limitations for record retention. HIM professionals should ascertain the definition of deletion when reviewing their state guidelines.

The Occupation Safety and Health Act of 1970 allows a medical records custodian to make certain deletions. In these instances, the custodian is allowed to delete specific information related to a family member, personal friend, or others who have provided confidential information regarding an employee's health status.

In addition to the rules cited above, the HIPAA privacy rule allows individuals to request an amendment to their health records. In these instances, the covered entity has the right to review, investigate, and potentially refuse the patient's request.

HIPAA also requires the covered entity to append information in the health record, not delete it. If accepted, a covered entity must then inform the individual that the amendment was made and make reasonable efforts to notify others with whom the amendment needs to be shared.

Training and Accountability

Once the organization has established policies and procedures on deletions, the final crucial step is training and education. Organizations should define key personnel to receive training, such as nursing, physician, and HIM staffs.

Even if the organization implements a policy that states the complete obliteration of information will not occur, appropriate training of personnel is required to educate on the importance of accurate, timely clinical documentation as well as the ramifications of errors in documentation. End users who have privileges to document within the EHR must be held accountable for every entry made, including errors.

As the stewards of health information, HIM professionals are charged with certifying a health record as accurate and complete. As such, proper information management is imperative in the EHR to ensure accurate and timely documentation.

For more guidance on amendments, corrections, and deletions, read the AHIMA toolkit "Amendments, Corrections, and Deletions in the Electronic Health Record," available online at www.ahima.org/resources/infocenter/ehr.aspx.

Notes

1. AHIMA. "Amendments, Corrections, and Deletions in the Electronic Health Record: An American Health Information Management Association Toolkit." 2009.
2. Maryland Attorney General. "How to Get and Use Your Medical Records." Available online at www.oag.state.md.us/consumer/edge88.htm.

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