SECTION 2: HEALTH INFORMATION MANAGEMENT

2.2 Documentation Rules

POLICY:

1. General Requirements

   a. All handwritten entries should be written legibly in black or blue ink.
   b. The date and time of each entry will be included. Use of military time is preferred.
   c. The signature of the author will follow all entries.
      i. If the author has an assigned unique number; the identification number should be included unless the provider’s name and title display on the document. If the author does not have a unique practitioner identification number, the title should follow the signature.
      ii. Stamped signatures are not allowed without a separate hand written signature.
      iii. Applications with electronic signature capabilities must have the signature system reviewed and approved by the Compliance Office, Information Security Office, Legal Services, and the Health Information Management (HIM) Department to assure that the electronic signature meets acceptable standards.
   d. Patient identification information shall appear on each document contained in the medical record.
   e. Only physicians, other credentialed caregivers and UF or UF Health Shands employees functioning within their designated role (or contracted individuals with an equivalent competency process) are authorized to document in the patient medical record.
      i. Specific charting privileges of non-physician authors will be delineated and supervised by the department head or faculty member to whom the author reports.
      ii. Documentation by Students: Authorized students must document under the direct supervision of a licensed or registered professional. The term “student” includes individuals participating in internship or practicum phases of degree programs affiliated with the UF Health Science Centers and affiliated colleges.
   f. Specific charting privileges of non-physician authors will be delineated and supervised by the department head or faculty member to whom the author reports.

2. General Documentation Requirements:

   a. Electronic Records:
      i. Providers are required to use the current electronic health record (EHR) system to provide readily accessible, timely, and accurate information for ongoing patient care. Providers should not create paper documents for permanent inclusion in a patient’s electronic health record. Providers may not print electronic documents to use during treatment, except in rare emergency situations.
      ii. Logging in to the EHR system constitutes authentication for all entries.
iii. Patient identification information (including name and record number) must be verified before making any entry in a patient’s EHR.

iv. All hand-written notes must be retained and/or scanned into the EHR unless the information is dictated or duplicated in some other area of the health care record.

b. **Electronic Health Record (EHR):** EHR Applications with electronic signature capabilities must have the signature system reviewed and approved by UF’s Legal Services, Information Services and the Privacy Office to ensure that the electronic signature meets required standards.

c. **Additions/Amendments/Corrections** may only be made in health records using approved procedures; documentation should never be deleted, removed, destroyed or obliterated in primary health records.

d. **Copies of Health Records from Other Facilities/Providers,** if they were used to make healthcare decisions about the patient during treatment at UF, may be retained in any convenient, retrievable format in the patient’s primary record, whether in electronic or paper format. Relevant copies should be, but are not required to be, initialed and dated by the patient’s provider prior to adding them to the patient’s record.

e. **Record Duplications and other Errors** that cannot be corrected by individual caregivers and providers should be referred immediately to the UF Health HIM Chart Correction team.

**DEFINITIONS**

1. **Addendum:** Entries added to a health record to provide additional information in conjunction with a previous entry. The addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record.

2. **Amendment:** The formal and deliberate addition of documentation or material to make the original documentation more complete and thereby more accurate. The formal and deliberate alteration of a health record, after the original documentation has been completed and signed by the provider, to make the original information more accurate.

3. **Authentication:** The corroboration that a person is the one claimed; most often refers to an ability to prove authorship, by written signature, initials or computer password.

4. **Availability:** The property that data or information is accessible and useable upon demand by an authorized person.

5. **Correction:** The formal and deliberate alteration, deletion or other modification of documentation to make it more accurate. In electronic records, corrections must be made as addendums; they may also involve removing information from one record and posting it to another within the electronic document management system.

6. **Deletion:** The action of permanently eliminating information that is not viewable in a paper record or tracked in a previous version of an electronic record. UF does not allow permanent deletions of clinical information from any health records.

7. **Documentation:** Evidence, proof, or substantiation that certain actions were completed, information was collected, used or disclosed, or requirements were met. The act of making a record or setting down facts in permanent form.
PROCEDURES

1. Person or entity authentication: Procedures must be implemented to verify that a person or entity seeking access to electronic PHI is the one claimed.

2. Additions/Amendments/Corrections: Use only approved amending and error-correction procedures; never delete, remove, destroy or obliterate parts of the primary record. (See system- and facility-specific procedures.)
   a. Make “late entries” in the health record by entering the current date and time and labeling the entry as a ‘late entry’.
   b. If the documentation error is on paper, make the correction by drawing a single line through the entry, writing "error" above the entry, then initialing and dating the notation. Add the correct information as close to the error as possible, or, if not possible, write “See note on (date)” near the crossed-through error and write an additional note explaining and/or correcting the error.
   c. If the document was originally created in a paper format, and then scanned electronically, the imaged version must be corrected by printing the document, correcting as above (in b.), and then rescanning the document.
   d. If the error is in electronic documentation, follow the error-correction procedures approved and authorized for the EHR documentation system. If needed, enter a new note, title the entry as ‘Late Entry’ or ‘Amendment,’ and document a complete explanation of any previous error with additional or corrected information.

3. Errors in Scanning Documents: If a document is imaged/scanned with a wrong encounter date or to the wrong patient, reprint the scanned document, and then rescan the document to the correct date or patient, and void the incorrectly scanned document. When in doubt, refer the issue to the UF Health HIM Chart Correction team.

4. Co-Signatures: Co-signature of a health record entry signifies acknowledgement by the co-signer that the entry was made appropriately, and implies concurrence with the statements or conclusions contained in the entry. If there is significant disagreement with the conclusion of the author, the cosigner should record such conclusions or expand on the entry as appropriate.

REFERENCES

1. Florida Statues: 456.057 Ownership and Control of Patient Records
2. HIPAA Regulations: 45 CFR § 164.501 Definitions; § 164.526 Right to Request an Amendment

EXHIBITS

None