Permanency of Entries

All entries in the medical record must be permanent, regardless of if it is a manual or electronic medical record.

a. Hard-copy medical records: The ink should be blue or black. There should be no colored ink, and ink should be permanent. You should never use erasable ink, water-soluble ink, or pencils.
b. Printers: Laser printers are preferred because ink jet printers use water-soluble ink.
c. Fax copies: Thermal paper will fade over time, so a copy should be made for permanency of the fax.
d. Photocopies: The original documents should be used whenever possible. There are times that you will maintain a copy of a medical record, such as medical records from other facilities.
e. Carbon copy paper (NCR): When the carbon paper is the permanent entry, it needs to be photocopied to ensure permanency. There should be a policy in place to indicate when the documentation was copied and how the original was disposed.
f. Labels: Adhesive labels are an acceptable practice for medical records.
   i. Adhesive should remain permanent shortly after affixation.
   ii. Patient identification should be imprinted on the label.
   iii. Do not place one label on top of another; follow the correction methods for this entry.
   iv. The ink used for the labels must be permanent.

Entries for the Medical Record

a. Abbreviations: Follow the approved abbreviation list for the facility.
b. Continuous entries: Do not skip or leave blanks in the medical record documentation. A new form should not be started until the previous lines are completely filled. If a new sheet is started, then all available lines on the previous page should be crossed out.
c. Completing entries: All fields should be completed. If a field is not applicable, "NA" should be noted.
d. Continuity of entries: All entries should be concurrent. Make sure to avoid contradictions of previous documentation and repetitiveness.
e. Informed consent: This must be carefully documented, if applicable. The informed consent includes an explanation of the risks, as well as the benefits of a specified treatment or procedure. It includes alternatives and evidence of the patient understanding and giving
consent to treatment.
f. Make and sign own entries: Authors must document and sign their own documentation, either hard copy or electronic medical records.
g. Appropriateness of entries: All documentation should pertain to the direct care of the patient.

Error Corrections

a. Draw a thin line through the entry, and ensure the legibility of the inaccurate information.
b. Initial and date the entry.
c. State the reason for the error, in the margin or above the note as permissible.
d. Document the correct information.
e. Do not white-out, black out with a marker, or write over the entry.

Documentation Omissions

Sometimes, entries are made out of sequence or provide additional documentation.

Late Entries

If pertinent information was missed or not written in a timely manner, then a late entry may apply.

a. Label the entry, "late entry."
b. Note the current date and time.
c. Identify the date of the incident that applies to the late entry.
d. If the late entry is because of an omission, validate the source of the additional information, such as information in other parts of the medical record.
e. There is no time limit for a late entry, but it should be done as soon as possible.

Addendum

If another type of late entry is used to provide additional information in conjunction with a previous entry, then an addendum applies.
Medical Record Entries

a. Document the current date and time.
b. Label “addendum,” and state the reason for the addendum, making sure you refer to the source of the original documentation.
c. Identify any sources of documentation to support the addendum.
d. Complete the addendum as soon as possible, following the original documentation.

Clarification

This is a late entry, which provides clarity to avoid incorrect interpretation of information that was previously documented. In this, a clarification applies.

a. Document the current date and time.
b. Label "clarification," and state the reason for the clarification, making sure you refer to the source of the original documentation to be clarified.
c. Complete this clarification note as soon as possible, following the original documentation.