DELETING SIGNED MEDICAL RECORD ENTRIES ERRONEOUSLY ENTERED IN THE WRONG PATIENT CHART PROCEDURE:

Charting errors are typically not deleted but corrected by creating a time stamped addendum. However, in the exceptional case of a signed entry in the wrong patient chart, a separate procedure is followed. In the event that a clinician or nurse signs an encounter erroneously entered on the wrong patient, the following actions must be taken on the day that the error is recognized.

1. **Mitigate harm.** The first priority is to check to see if either patient involved in the documentation error suffered any harm as quickly as possible. This might include inappropriate injections, vaccinations, filled prescriptions, surgical procedure or radiation exposure, phlebotomy, lab tests, referrals or a delay in timely provision of these services to the correct patient. Taking timely action to mitigate harm is essential once the error is recognized.

2. **File an Incident Report.** After insuring the safety of both of the involved patients, an Incident Report will be initiated and forwarded to the Assistant to the Director for logging and review by the Risk Management Committee. A copy of the erroneous EMR entry will be printed and attached to the “Incident Report”, as well as reference to the correct patient SID #. If the error is caught prior to any resultant harm, an “Opportunity for Improvement” form will be completed (rather than an “Incident Report” form) with an attached copy of the erroneous note and the SID # of the correct patient. It is the responsibility of the staff member who made the documentation error to forward either the “Incident Report” or the “Opportunity for Improvement” form to the Assistant to the Director for reporting to the QM committee.

3. **Notify the Health Information Management (HIM) Staff.** The HIM Staff (Medical Records/System Administrator or Business and Information Systems Coordinator) will be notified the same day the erroneous entry is recognized. After review with the Medical Director, the HIM staff will print a copy of the erroneous entry for a Medical Records log and delete the erroneous entry from the EMR. The MRSA will facilitate the deletion of any resulting erroneous diagnoses, orders, billing, referrals in the EMR that may have resulted from the erroneous signed entry.

4. **Correct Documentation of the Encounter.** It is the responsibility of the clinician to transfer the contents of the erroneous entry into the correct patient’s medical record, using the appropriate template with a diagnosis, encounter code and electronic signature on the same day the error is recognized. Use of copy and paste functions may lessen the time to transfer some of the information but some items such as vital signs may need to be entered manually. This staff member must also remove any erroneous Problem List entries that resulted.