AMERIMED SOP
3.1.2 Amended PCRs
Rev 10/2020

OVERVIEW

Addendums or corrections to patient care reports such as narratives, vitals, and/or scales are sometimes necessary but should be minimal. Altered records must be valid, traceable, dated and signed by the person making the addition or change. Electronic records amendments must begin with "//" and end with the name of crew member amending and date of amendment followed by "//". A reason for the amendment must be included and should come at the very bottom of the narrative, identified as such: **Reason for amendment: ** There should be an audit trail accessible in the software for all electronic record access.

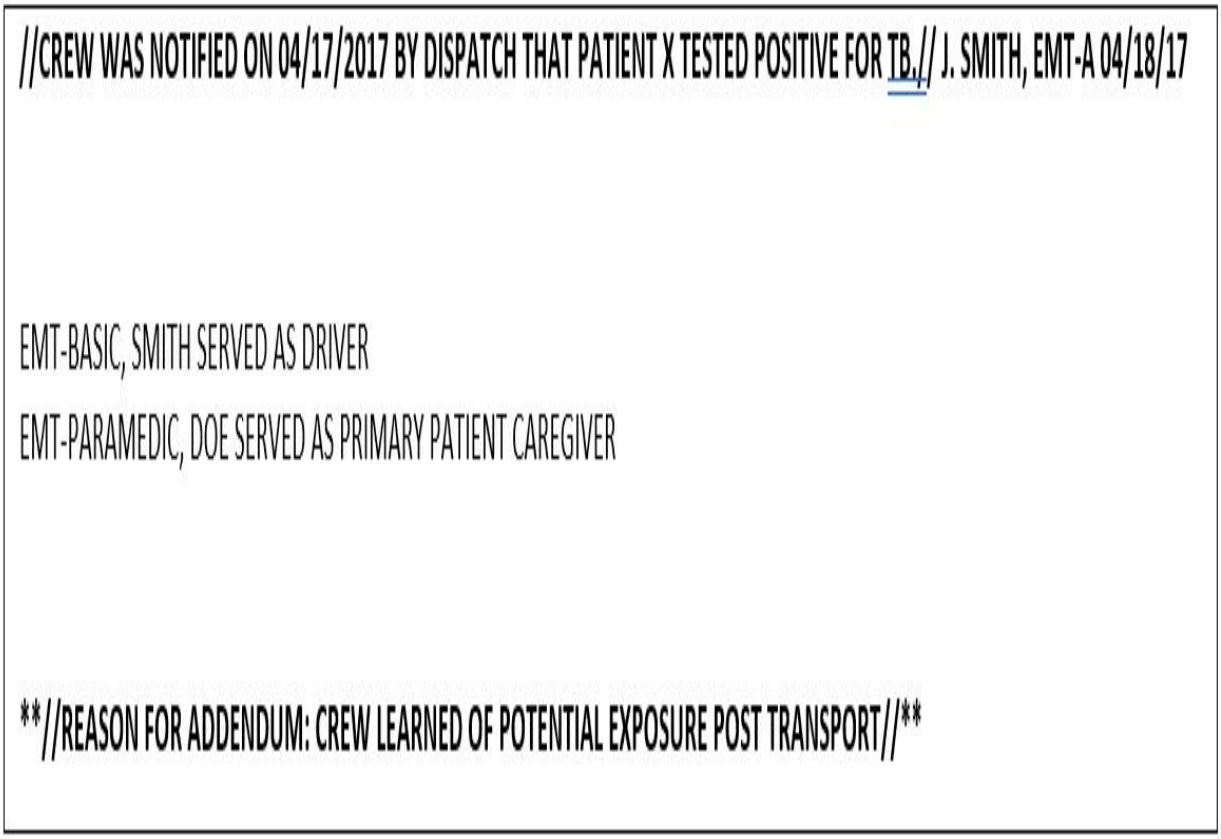
Paper record amendments must be clearly documented either on the original document or by a supplemental amendment document. Changes to written documents should be scored out with a single line with the original writing visible and initialed. The original writing must be visible and the new information should be signed with date and time.

With the exception of demographic changes, all addenda or corrections should be made by a member of the treating crew. Transcription of changes may be provided by supervisory or compliance personnel only in approved circumstances.

SECTION A

Addendum

Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.



SECTION B

Corrections

Correction: Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

When making a correction to a paper generated medical record, never write over, white out or otherwise obliterate the passage when an entry is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the crossed out section, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

If necessary for legibility, an amendment to a paper report may need to be done on an “Amendment” document and attached to the original.

SECTION C

Additional Requirements

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents containing amendments, corrections or addenda must:

- Clearly and distinctly identify any amendment, correction, or delayed entry as such
- Only the original author may amend any health records
- Clearly indicate the date and author of any amendment, correction, or delayed entry
- Clearly identify all original content, without deletion
- Only the original author may amend any health records

Paper Medical Record

- Use a single line strike through so the original content is still readable, and
- The author of the alteration must sign and date the revision.

Patient accounting, Shift Commanders, Division Managers and/or Operations Managers may alter only certain parts of a medical record as related to:

- Correcting transport/run/response numbers
- Date of service
- Spelling of name
- Address and/or responsible party
- Other items such as DOB's, SSN's and insurance information
- Service locations

Any record altered on the server must be documented in the "memo" function stating the nature of the amendment, the name of the person making the amendment and the date amended.