DOCUMENTATION AND ERROR CORRECTION

☒ St. Joseph Medical Center, Tacoma, WA
☒ St. Francis Hospital, Federal Way, WA
☒ St. Clare Hospital Lakewood, WA
☒ St. Anthony Hospital Gig Harbor, WA
☒ St. Elizabeth Hospital Enumclaw, WA
☒ Highline Medical Center Burien, WA
☒ Harrison Medical Center, Bremerton, WA
☒ Harrison Medical Center, Silverdale, WA
☒ PSC

PURPOSE

To describe appropriate documentation standards for error corrections on forms and other records used at CHI-Franciscan Health Laboratories including communications and clarifications about laboratory specimens and/or orders, corrections to manual records for quality control data, temperature logs, and intermediate test results or worksheets. This document does not pertain to changes made in patient results.

BACKGROUND

Appropriate, accurate documentation is vital to laboratory quality. Copies of lab records must be complete, legible, and contain the original content. This item applies to both electronic and paper records. Documentation must be legible, indelible, and errors must be corrected so as to enable the reader to see what error was made and how it was corrected. This is mandated by CLIA, CAP, AABB, TJC, and the Department of Health. Communications and clarifications with providers regarding laboratory samples must be documented on manual records or in electronic systems and be available to all staff to view. In all cases an audit trail must be maintained.

GENERAL PRINCIPLES FOR DOCUMENTATION

- Standard documentation for comments regarding patient testing must be documented in the LIS (or other manual record if applicable) and include the name of who was contacted, the lab tech ID or initials, and the date and time the information was obtained.
- If clarification of a laboratory order is required before testing the Laboratory Compliance Addenda requires documentation of a full name of the person clarifying the order.
- Corrected data, including the identity of the person changing the record and when the record was changed, must be maintained in an audit trail.

CHARTABLE COMMENTS

Chartable comments are displayed in the chart or on a printed lab report and should be important for the provider to know to aid in deciding how to interpret the test result(s). Information in the chartable section should be restricted to test results and pertinent result related comments.

NON-CHARTABLE COMMENTS

These comments are important for the laboratory to know. This documentation is for internal communication and aids in better customer service by providing handoff information.

STANDARDS FOR PLACEMENT OF DOCUMENTATION COMMENTS

- Chartable comments about tests are made on the test in the LIS in a white box. Important documentation about

- Non-chartable comments are placed in a yellow box in areas of the LIS.

COMMENT TYPE	Chartable or Non-Chartable	STANDARD
Miscellaneous Referral	Chartable- White box	At the time of order, answer all prompts (AOEs) to document the test, referral lab, test code, and storage requirements
Critical Result Documentation		Comm Log for standard communication
Testing Information i.e., verified by repeat analysis	Chartable-White Box	Individual test result (Result Entry)
Laboratory result called or Faxed	Chartable-White Box	Specimen Update
Sample Issues that can affect test results; i.e. hemolysis, lipemia, etc.	Chartable-White Box	Result Entry at the Individual test result line or overall sample comment for panel tests. May need to take into Result Correction to add a comment after results have been verified.
Internal comments for lab use regarding an issue with the order or sample	Non-Chartable-Yellow Box	Specimen Update
Internal comments regarding an issue with the results	Non-Chartable-Yellow Box	Specimen Update if results have already been verified. Result entry if results are not verified

STANDARDS FOR CORRECTION OF DOCUMENTATION ON MANUAL RECORDS

- All official documentation must be done with blue or black ink. Red ink is allowable only for error correction or review. Pencil or other colored inks are not allowed except while processing outpatient requisitions to document the types of samples received in the transport bag. Green ink serves to differentiate lab markings from client markings on the requisition).
- Do not use ink that will bleed through to the other side of the page.
- Documentation must be legible and indelible. Write neatly so that others can see what has been done.
- If blank spaces are not applicable, “n/a” must be clearly written – do not leave the space blank.
- White out or other obliteration (i.e. scribbling over the error or blacking out the error) are not allowed.
- Do not place arrows, quotation marks, or other marks in blank spaces. The appropriate information must be written in its entirety.

Example of Improper Documentation of a correction

Incorrect					Correct				
Date	**Lot #**	**QC in (Y/N)**	**Corrective Action**	**Tech ID**	**Date**	**Lot #**	**QC in (Y/N)**	**Corrective Action**	**Tech ID**
1/1/13	141785	Y		C58	1/1/13	141785	Y	n/a	C58
1/2/13	”	”		C58	1/2/13	141785	Y	n/a	C58
1/3/13		Y	yes	C58	1/3/13	141785	N	See Lookback Form	C58
1/4/13		Y		C58	1/4/13	141785	Y	n/a	C58

- Errors must be corrected in the following fashion: A single line through the error, with the date and tech ID noted alongside the error. If something needs to be inserted, a caret "^" should be placed, the information added and the date and tech ID should be noted next to the added information.

Examples of Proper Documentation of a correction

Reviewed ~~1/4/12~~ 1/4/13, C58 QC not in^, lookback done.