This Guide is intended to explain the procedure for documentation correction regarding the Clinical Charting Interface version 3.2 being released in May, 2012. This new functionality is important for Consolo users utilizing the electronic signature process, as signing any Consolo clinical documentation electronically will result in the prevention of that documentation from being edited, deleted or changed by any user after the fact. Electronically signed documentation, therefore, is a permanent part of the clinical record and must be corrected according to accepted healthcare industry practices.

All clinical documentation will occur in the Clinical Charting area from each patient homepage. Please access the multiple Reference Documents addressing the functionality for the new Clinical Charting Interface posted in Training Tools (renamed Help in the 3.2 Consolo version).

A series of screenshots below will demonstrate correction activity for any electronically-signed Clinical Chart document.

### CLINICAL CHART ENCOUNTER CREATED AND ELECTRONICALLY SIGNED

A Clinical Chart entry is created in a patient chart with Effective Date set, Patient Time and clinical documentation added. Once created, the user is offered a choice to electronically sign and close the document down permanently:
In the above example, the clinician makes the choice to “SIGN” the document. This will apply the clinician’s electronic signature and “locks down” the document as a permanent addition to this patient record. Note the clinician e-signature applied at the bottom of the Clinical Charting entry:

**Signatures**

1. RN Suscanowicz, Scott (User) signed on 05/18/2012. Recorded by scottsm on 05/18/2012.

<table>
<thead>
<tr>
<th>Date</th>
<th>Signed By</th>
<th>Reason</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This Clinical Chart entry can no longer be edited or changed by any user. Note the appearance of the entry in the Clinical Charts summary:

The e-signing clinician realizes after the fact that there was some clinical data omitted in this Clinical Charting entry. In order to add a correction, the following procedure must be followed:
Once on the View page of the Clinical Charting entry, click Related Links tab to open the drop-down and choose Add Addendum (please refer to the Addendum Guide for more information):

**Vital Sign Measurement**

- **Blood Pressure**: 122/68
- **Blood Pressure Arm**: Right
- **Blood Pressure Position**: Sitting

- **O₂**: O₂ Sat (94%), O₂ Sat Orr: na, Respiratory: 16

Addendum box will display – make choices from the appropriate drop-downs:

1. **Addendum Details**
   - **Addendum Reason**: Clinical Chart Section
   - **Note**: This field is required.

2. **Additional Information**:
   - **Note**: This field is required.
   - **Existing completed sections in the entry, please see the section to complete or have items to add related data in the Addendum tab.**
3 – Correction to be made in Vital Signs section:

**General Clinical Chart Details**

| Effective Date | 05/16/2012 | Discipline | 60 |

**Patient Time**

| Date In | 05/16/2012 | Time In | 01:00 |
| Clinical Care Type | | | |
| Regular Visit | | | 10 |

**Vital Sign Measurement**

| Blood Pressure | Blood Pressure Arm Right | 122/65 |
| Respiration | | 16 |
| Pulse | Irregular Apical Pulse | 78 | Yes |
| Temperature And Blood Sugar | Temperature | Method | |

**Create Addendum**

**Addendum Details**

| Addendum Reason | Clinical Chart Section | Vital Sign Measurement |
| Corrected Information | | |

**Note**

Documents corrected clinical data. Will not change the original entry text but adds this corrected info via this addendum.

Create Addendum: No Thanks

Create to Add this correction

4 – Note addition of Addendum to body of the Clinical Chart entry:

**Performance Scales**

| Karnofsky | FAST | 60 |

**Patient Measurements**

| Height | Weight | BMI | Mid Arm Circumference (cm) | Mid Arm Circumference Leg (cm) |
| 150 | 125 | 30 | 21.0 | 31.0 | 31.0 |

**Body Systems Cardiac Circulatory Finding**

**Cardiac / Circulatory**

No Problems

**Pain Observation**

| Pain Type | Frequency | Present Intensity | Comments |
| C | 0 | | 45% follow-up Phone call |

**Location**

| Body Site | Left Y-A-X-1 | External |

**Signatures**

1. RN: Susan Schiavone, Scott (c/n) signed on 05/18/2012. Recorded by scott on 05/18/2012.

**Addendums**

| Date | Signed By | Reason | Section | Note |
| 05/18/2012 08:30 PM | Susan Schiavone, Scott (c/n) | Corrected Information | Vital Sign Measurement | Correction to O2 Sat - note states 68%. Correct reading was 90% on Room Air |
Time Entry Errors to an E-signed Note

In the event a time error entry is made to a Clinical Chart entry that is already e-signed and locked down, time corrections can still be accomplished. Note the Patient Time entry below:

To correct, go to Main Menu tab / Timesheet and locate Patient Time entry for this visit:

Click the Edit icon in the Timesheet visit box to open and correct:
2 –

Patient Time

Leave times blank to ignore time entry.

Date In 06/16/2012

Time In 07:00

Date Out 06/16/2012

Time Out 06:30

Make sure that the entered times are in 24 hour format, i.e. 0700 and 1500.

Corrected Time Out

Comments

Clinical Care Type Regular Visit

Mileage 10

Travel Start Time 06:15

Out Of Pocket Expense 0

Update

3 –

<table>
<thead>
<tr>
<th>05/13/2012</th>
<th>05/14/2012</th>
<th>05/15/2012</th>
<th>05/16/2012</th>
<th>05/17/2012</th>
<th>05/18/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Unrecorded</td>
<td>2 Recorded Times</td>
<td>5 Unrecorded</td>
<td>2 Unrecorded</td>
<td>1 Unrecorded</td>
<td>1 Recorded Time</td>
</tr>
</tbody>
</table>

05/19/2012 Time: 01:45

Legend

Patient Time

4 – When returning to the Clinical Chart entry, note the Patient Time correction:

General Clinical Chart Details

Effective Date 05/18/2012

Discipline RN

Chart Owner Suscanovitz, Scott (sco19013)

Created By Suscanovitz, Scott (sco19013)

Patient Time

Date In 05/18/2012

Clinical Care Type Regular Visit

Time In 07:00

Mileage 10

Date Out 05/18/2012

Travel Start 645

Time Out 06:30

Corrected Time Out displays

Vital Sign Measurement
Visit Type Corrections in Visit Note section

Visit Type corrections require a different correction process. To review, Visit Types can be applied to a Visit Note entry and can be made billable by selecting a choice with an asterisk (*). This type of Visit Note becomes billable and flows to the Claims area. In the event a clinician erroneously assigns a billable selection to a non-billable Note or vice versa, the following must be done to correct this scenario.

The following screenshots depict the creation of a Visit Note and an incorrect Visit Type applied.

1 – Error Visit Note with Patient Time attached and incorrect Visit Type selected:

![Screenshot 1](image1)

2 – Error entry e-signed and consequently locked-down:

![Screenshot 2](image2)
Since the Visit Type is chosen as Phone Call SW* and the entry has Patient Time associated to it, this Visit Note is queued for Claims processing. A correction must be made once this error has been found:

1 – The first correction takes place in the employee Timesheet:

![Timesheet Image]

2 –
Deleting this Patient Time entry will remove the incorrect visit entry from the Claims processing queue. Entry must now be corrected in Clinical Charting.

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### General Clinical Chart Details

<table>
<thead>
<tr>
<th>Patient</th>
<th>Effective Date</th>
<th>Discipline</th>
<th>Chart Owner</th>
<th>Created By</th>
<th>Completed Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 0</td>
<td>05/18/2012</td>
<td>RN</td>
<td>Susanowicz, Scott</td>
<td>Susanowicz, Scott</td>
<td>visit note</td>
</tr>
<tr>
<td>Patient 1</td>
<td>05/19/2012</td>
<td>RN</td>
<td>South Carolina Hosp Care of</td>
<td>South Carolina Hosp Care of</td>
<td>body systems cardiac circulatory finding, pain observation, vital signs measurement, No, 4</td>
</tr>
<tr>
<td>Patient 2</td>
<td>05/19/2012</td>
<td>RN</td>
<td>South Carolina Hosp Care of</td>
<td>South Carolina Hosp Care of</td>
<td>body systems multiorgan system finding, body systems cardiac circulatory finding, body systems elimination finding, coordination of care, nursing summary, supervisory visit, visit note, vital signs measurement, No</td>
</tr>
<tr>
<td>Patient 3</td>
<td>05/19/2012</td>
<td>RN</td>
<td>Susanowicz, Scott</td>
<td>Susanowicz, Scott</td>
<td>wound assessment</td>
</tr>
</tbody>
</table>

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### General Clinical Chart Details

**Visit Note**

- **Time Of Event:** 1200
- **Note:** Phone call made to the home to follow-up on AM visit issue regarding...

**Signatures**

1. RN Susanowicz, Scott (UH) signed on 05/19/2012. Recorded by scotcm on 05/20/2012.

**Date** | **Signed By** | **Reason** | **Section** | **Note**
|---------|--------------|------------|-------------|-------|

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### General Clinical Chart Details

**Visit Note**

- **Time Of Event:** 1200
- **Note:** Phone call made to the home to follow-up on AM visit issue regarding...

**Signatures**

1. RN Susanowicz, Scott (UH) signed on 05/19/2012. Recorded by scotcm on 05/20/2012.

**Date** | **Signed By** | **Reason** | **Section** | **Note**
|---------|--------------|------------|-------------|-------|

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### Create Addendum

**Addendum Details**

- **Addendum Reason:** Clinical Chart Section

**Note**

- **Incorrect Visit Type:** Phone Call SW1. Entry was Phone Call.
At this point the clinician should create a new corrected Clinical Charting entry as demonstrated below:

**Incorrect Effective Date**

Repair of an e-signed document that has an incorrect Effective Date is similar to correction instructions above:

1. An e-signed note will not allow editing to correct the Effective Date. It is necessary to delete any associated Patient Time and change the note to an Unrecorded Note in Timesheet.
2. An addendum should be created and associated to the entry with an incorrect Effective Date denoting the charting error.
3. A new Clinical Charting entry with the correct Effective Date and Patient Time should be created to replace the error note (the error entry remains in Clinical Charts Summary permanently but is not billable and employee time is removed).
4. The new note should have a comment added denoting Late Entry or Correction in Comments or some other location within the note.
ADDENDUM SPECIFIC INSTRUCTIONS

CREATING ADDENDUMS

Once e-Signed, clinical charting is permanently locked from editing. Users should take time to properly review their charting before signing, to ensure it is complete and accurate. In the event of errors or omissions, Addendums may be added to clinical charts.

1. From the clinical charts summary screen, click to “View” the chart:

2. Click Related Links, then “Create Addendum”
Complete the Addendum:

- Addendum Reason is required – Why is the Addendum being added?
  - Wrong Patient – Addendum added because chart was completed for wrong patient
  - Corrected Information – Addendum added because chart contains erroneous information
  - Additional Information – Addendum added because chart is missing information

- Clinical Chart Section – Which section of the chart is being amended?
  - Leave blank if the Addendum is global; it applies to the entire chart
  - Specify a chart section if the Addendum relates to just that section

- Note – What is the Information to include in the Addendum?
  - Text field captures the information entered by User

- Create / No Thanks – Do you want to create this Addendum?
  - Once created, Addendums cannot be edited or removed
  - “No Thanks” will destroy the draft Addendum; nothing is Saved

Addendums will display prominently at the bottom of the associated clinical chart:

Addendums include:
- Date and Time created
- User who created Addendum
- Reason for Addendum
- Section (if any) being Addended
- Note
NOTE: It is not possible to edit or remove Addendums.

Amended charts are identified on the clinical charts summary screen by a “tag” icon:

Addendums also display prominently on printed or faxed versions of the chart: