



Book of

Style & Standards *for* **CLINICAL DOCUMENTATION**

4th Edition

Author & Chairperson of the Book of Style and Standards Development Team
Laura Bryan, MS, MT(ASCP), CHDS, AHDI-F

Managing Editor
Kristin Wall, CHDS, AHDI-F

Foreword By
Claudia Tessier



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Introduction

The underlying principles for editing clinical documentation should always be accuracy and clarity. Generally, pre-authenticated documentation should be edited:

- when the spoken form does not match the written form.
- to correct an error.
- to reduce ambiguity.
- to avoid misinterpretation.

This chapter covers general guidelines for editing, including when to edit, when not to edit, and recommendations on how to edit.

2.1 Notification and Flagging

Notification and flagging refer to marking a transcript for review by quality assurance, risk management, or the clinician. The exact methods of notification and flagging are dependent on the technology and workflow being used. All facilities and service providers should have policies and procedures in place for flagging reports that need special attention by quality assurance staff, risk management, or the clinician prior to authentication. Post-authentication procedures for assessing and monitoring quality are also recommended. See AHDI's *Health-care Documentation Quality Assessment and Management Best Practices* white paper and toolkit at www.ahdionline.org/QA.¹

2.1.1 Comments

Flagging procedures should include notations explaining the reason for the review. Avoid derogatory or inflammatory language in comments.

EXAMPLE(S)

Left below-knee amputation mentioned in the HPI is referred to as a right BKA in Assessment. Please resolve discrepancy.

2.1.2 Blanks

A blank represents a portion of the audio that could not be transcribed and is indicated with a blank space to indicate missing information. Insert a series of underscore characters (_____) or other system-compatible symbols in place of the missing word(s). Blanks may be used in conjunction with flagging, depending upon policies and procedures for managing blanks and flags.

EXAMPLE(S)

The patient came in today complaining of _____ for the last 3 days.
The patient came in today complaining of [_____] for the last 3 days.
The patient came in today complaining of ### for the last 3 days.

When a portion of dictation is missing, cut off, obscured, inaudible, or indiscernible, leave a blank and flag the report.

EXAMPLE(S)

D: The patient was sent home on <inaudible dictation> and will follow up in the office.
T/E: The patient was sent home on _____ and will follow up in the office.

2.1.3 Audio Indexing

Audio indexing links a specific time in the audio to a given point in the corresponding text. Indexing enables quality assurance personnel or the clinician to quickly jump to that portion of the dictation to resolve blanks or flagged issues. This procedure can be as simple as manually noting the time (in minutes and seconds) or programmatically linking the indexed position within the audio file to a blank or marker in the corresponding text.

2.2 When to Edit

The following describes instances where edits should be made.

2.2.1 Verbatim Transcription

True verbatim transcription includes all speech disfluencies, interruptives, and instructions—as in a court reporter’s transcript. In the context of clinical documentation, verbatim refers to the transcription of the dictation exactly as dictated, including dictation errors and syntax errors, but without superfluous artifacts and fillers such as uh and um. AHDI does not endorse verbatim transcription. See AHDI’s position statement on verbatim transcription at www.ahdionline.org/verbatim.²

2.2.2 SRT Translation Errors

Speech recognition translation errors include (but are not limited to) incorrect words and numbers, soundalike words, nonsensical phrases, incorrect division of words and numbers, incorrect division of sentences, and incorrect punctuation. All translation errors should be corrected.

EXAMPLE(S)

D: Lipitor twenty two pills a day.
SR: Lipitor 22 pills a day.
T/E: Lipitor 20 mg 2 pills a day.

D: Levemir insulin eight units has been ordered for the patient.
SR: Levemir insulin 80 units has been ordered for the patient.
T/E: Levemir insulin 8 units has been ordered for the patient.

D: He had a syncopal episode yesterday.
SR: He had a single bowl episode yesterday.
E: He had a syncopal episode yesterday.

- D: Cough has been present for approximately three days.
 SR: Cough has been present for prostate 3 days.
 T/E: Cough has been present for approximately 3 days.
- D: After the induction of adequate general endotracheal anesthesia and placement of appropriate monitoring devices in sterile fashion we opened the left deltopectoral groove.
 SR: After the induction of adequate general endotracheal anesthesia and placement of appropriate monitoring devices in sterile fashion. We opened the left deltopectoral groove.
 T/E: After the induction of adequate general endotracheal anesthesia and placement of appropriate monitoring devices in sterile fashion, we opened the left deltopectoral groove.

2.2.3 Syntax

Syntax refers to the appropriate arrangement of words in a sentence and is important to ensuring clarity of communication. Spoken language tends to have a looser syntax, and absolute verbatim transcription of spoken language may create confusion or ambiguity. Syntax is especially important to written communication because it lacks the rhythm, pauses, and inflection that naturally contribute to comprehension of spoken language. Gross syntax errors should be edited as minimally as possible to improve clarity yet still maintain the dictator's style.

EXAMPLE(S)

- D: The patient developed a puffy right eye that was felt to be secondary to an insect bite by the ophthalmologist.
 T/E: The patient developed a puffy right eye that was felt by the ophthalmologist to be secondary to an insect bite.
- D: CT scan showed there was nothing in the brain but sinusitis.
 T/E: CT scan of the brain showed there was nothing but sinusitis.
- D: Inside his ear the mother said is pain and a lot of wax.
 T/E: The mother said inside his ear is pain and a lot of wax.
or:
 T/E: Inside his ear, the mother said, is pain and a lot of wax.
- D: The sensation has completely returned in her fingers.
 T/E: The sensation has completely returned in her fingers. (*acceptable*)
 T/E: The sensation in her fingers has completely returned. (*better*)
- D: Discussed with the patient the importance of walking around drinking binges fruits and vegetables and nuts.
 T/E: Discussed with the patient the importance of walking around, fruits and vegetables and nuts, and no drinking binges.

(continued next page)

- D: Patient is a 30-year-old white female with a very significant family history of breast cancer with a mother who was diagnosed at age 35 and died of breast cancer and now has a history of fibrocystic changes in her breasts.
- T/E: Patient is a 30-year-old white female with a very significant family history of breast cancer, with a mother who was diagnosed at age 35 and died of breast cancer. Patient now has a history of fibrocystic changes in her breasts.
- D: It was suggested to him that he should drink a glass or two of water at nighttime when he is asleep.
- T/E: It was suggested to him that he should drink a glass or 2 of water at nighttime.

2.2.4 Subject-Verb Agreement

Edit verbs for subject-verb agreement. See the discussion of irregular singular and plural forms as well as foreign terms in *Chapter 5—Plurals, Possessives, and Foreign Terms*.

EXAMPLE(S)

- D: The patient and her husband is headed to the OB/GYN floor for delivery of their baby.
- T/E: The patient and her husband are headed to the OB/GYN floor for delivery of their baby.

2.2.5 Gender Pronouns

Edit pronouns to align with the patient's gender.

EXAMPLE(S)

- D: This is an elderly male whose arthritis pain has been bothering her.
- T/E: This is an elderly male whose arthritis pain has been bothering him.
- D: This patient returns for his yearly Pap smear.
- T/E: This patient returns for her yearly Pap smear. (*Demographic information indicates patient is female, but the male pronoun is used.*)

Transgender patients: Edit gender pronouns to reflect the patient's preferred gender. Determining the preferred gender may be difficult depending on transition status. During transitions, government IDs, passports, and birth certificates may or may not correspond to the patient's gender preference. Not all transgender individuals make a complete anatomical transition. For example, a patient may choose a male gender identity without undergoing a hysterectomy. If the patient's preference is unknown and the documentation is inconsistent, transcribe or edit as dictated and flag the report for risk management assessment.

NOTE: The gender-neutral, plural pronouns *they/their* are now acceptable to use in the singular.

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Staging indicators: Used along with TNM criteria to define cancers and assess stages. These are expressed with capital letters and arabic numerals.

Staging Indicator	Symbols
histopathologic grade	GX, G1, G2, G3, G4
host performance	H0, H1, H2, H3, H4
lymphatic vessel invasion	LX, L0, L1, L2
residual tumor	RX, R0, R1, R2
scleral invasion	SX, S0, S1, S2
venous invasion	VX, V0, V1, V2
certainty factor (C-factor)	C1, C2, C3, C4, C5 (NOTE: C-factor removed from the 8th edition of the TNM standard, 2016)

Prefixes: In the TNM system, prefixes indicate the criteria used to stage the tumor and are written in lowercase.

Letter	Determining Criteria
a	autopsy staging
c	clinical classification
p	pathological classification
r	recurrence/retreatment classification
yc, yp	classification post neoadjuvant (radiation or systemic) therapy, clinical/pathological

EXAMPLE(S)

pT1 pN1 pM0
 pT2 cN1 cM0
 pT1 cN0 cM0 stage 1

Suffixes: T, N, M, and other symbols used for staging may be followed by lowercase suffixes. These further delineate qualities such as size, invasiveness, and extent of metastasis.

Letter	Meaning	Example
(m)	multiple primary tumors at single site	T2(m)
(#)	where # is the specified number of invasive tumors at a single site	T2(5)
mi	micrometastasis	pN1mi

(continued next page)

Letter	Meaning	Example
(sn)	sentinel node status	pN1(sn)
(i+)	isolated tumor cells detected	pN0(i+)
(i-)	testing performed but no isolated tumor cells detected	pN0(i-)
(mol+)	detected by molecular technique	pN0(mol+)
(mol-)	molecular technique performed, no tumor cells detected	pN0(mol-)
(f)	microscopic exam of regional lymph nodes from fine needle aspiration or biopsy	cN2(f)
(ENE)	extranodal extension	cN1(ENE)

NOTE: *mi* is the only suffix not surrounded by parentheses.

EXAMPLE(S)

Stage IIA, pT1c(sn) pN1 aM0, grade 2, invasive ductal carcinoma of the left upper inner breast.

Site of metastasis: May be indicated by a three-letter abbreviation in parenthesis.

Site	Abbreviation
adrenals	ADR
brain	BRA
hepatic	HEP
lymph nodes	LYM
bone marrow	MAR
osseous	OSS
others	OTH
peritoneum	PER
pleura	PLE
pulmonary	PUL
skin	SKI

EXAMPLE(S)

M1(SKI)
M1(BRA)

13.5.5 Cancer Classification Systems

A classification system that qualifies the location and extent of disease is assigned to virtually every type of cancer. Those provided below represent the most common cancer staging/grading systems, but the table is by no means exhaustive. Consult a reputable resource to verify appropriate expression of classification systems not specified below.

System Name	Description	Details
American Urological Society (AUS)	Cancer Type	adenocarcinoma of the prostate
	Description	capital letters A localized B clinically palpable nodules (localized) C capsular invasion (regionalized) D metastatic disease
	Subclassification	arabic numerals; 1 through 4 correspond to TNM system T1 through T4
	Example(s)	DRE exam revealed clinically palpable nodules, corresponding to stage B.
Ann Arbor system	Cancer Type	lymphoma
	Description	roman numerals, stages I through IV I single lymph node group II two or more lymph node groups on the same side of the diaphragm III lymph node groups on both sides of the diaphragm IV multiple extranodal sites or lymph nodes and extranodal disease
	Subclassification	E extranodal extension or single, isolated site of extranodal disease A absence of B symptoms B B symptoms such as weight loss greater than 10%, fever, drenching night sweats X bulky disease greater than 10 cm

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System Name	Description	Details
	Notations	<p><i>clinical stage</i> (CS) based on clinical evaluation findings <i>pathologic stage</i> (PS) based on invasive procedures</p> <p>N nodes H liver L lung M bone marrow S spleen P pleura O bone D skin</p> <p>Indicate involvement with (+)</p>
	Example(s)	Workup was completed and showed non-Hodgkin lymphoma stage IIE. This patient's precise staging is CS IIB, PS IVB (S+)(H+)(M+).
Astler-Coller	Cancer Type	colon
	Description	stages A through D
	Subclassification	A1, B2
	Example(s)	The patient's Astler-Coller B2 lesion extends through the entire thickness of the colon wall, with no involvement of nearby nodes.
Bethesda system (see CIN, VIN, and VAIN)	Cancer Type	cervical and vaginal cytology (Papanicolaou)
	Description	ASC-US (atypical cells of unknown significance) ASC-H (atypical squamous cells, cannot exclude high-grade squamous intraepithelial lesion) LGSIL (low-grade squamous intraepithelial lesion) HGSIL (high-grade squamous intraepithelial lesion)
	Associated abbreviations	AIS (adenocarcinoma in situ of endocervix) NILM (negative for intraepithelial lesion or malignancy) SCUC (small cell undifferentiated carcinoma)
	Example(s)	Patient is negative for high-risk HPV 16/18 with Pap showing ASC-US.

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Policies for Content Importing Technologies

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Introduction

As with all technological advancements, the evolution of electronic health records (EHRs) brings both time savings and efficiencies but also challenges and inefficiencies. Easily accessible patient histories, exams, diagnoses, labs, diagnostic studies, and treatment plans for use by multiple approved clinicians and in real time has improved patient care and treatment. Along the way, issues based on workflow processes, various user groups, and continuity of care have brought to light the need for appropriate documentation policies and procedures.

Content importing technologies (CIT), such as templates, macros, automated data points, and copy and paste, have been widely implemented. CIT documentation tools make it easier to import clinical material into a Chart Note, H&P, Consultation, or Discharge Summary, or even to export the information for some other use, such as marketing or medical research. With such variations in platforms and functionality, there is no “one size fits all” standard or solution for identification and attribution of text entered using CIT. The hope is for better customization options for copied and pasted notes within an EHR, and programmers will no doubt continue to create and implement such solutions in EHR platforms based on user feedback, but it is impossible to predict what the future will bring.

The following recommendations and best practices are proposed based on extensive research and input from subject matter experts. Organizations should carefully consider the following information when creating policies and procedures based on the technology available that results in a universal, easy-to-use process but also and most importantly, easily identifiable and unambiguous copy-pasted and pulled-forward information. Policies and procedures should facilitate regulatory compliance and ensure that the record is suitable for potential litigation.

23.1 Policy Rationale

Risks and benefits of content importing technologies (CIT) have been widely documented, and patient safety organizations (eg, ECRI Institute, Agency for Healthcare Research and Quality [AHRQ]) and professional associations (eg, American Health Information Management Association [AHIMA], American College of Physicians [ACP]) have strongly recommended facility policies around the use of CIT to promote patient safety.

23.2 Definitions

Attestation: To affirm that something is correct or true; for example, to affirm that the information copied has been verified.

Attribution: The action of ascribing a work or remark to a particular author or person.
Autocomplete: Automatically matches text and suggests one or more options to complete text entry.

Autofill: Automatically draws data from another part of the record and inserts it upon a specific command.

Cloning: Duplication of a note.

Content importing technology (CIT): In the clinical setting specifically, documentation tools that facilitate importing clinical information into the chart, moving it to other sections within a patient's record, or exporting the material for use outside the clinical arena. CIT includes templates, macros, automated data points, and copy and paste functionality.

Copy and paste: Functionality that allows text to be copied from one location and inserted into another location within the record. Synonyms include copy/paste, copy forward, imported documentation, “roll-in,” pull forward, and any other action to duplicate documentation from one part of the record to another part of the health record (or to another patient's record). Action may be performed either by keyboard command (eg, Ctrl+C to copy and Ctrl+V to paste) or with a mouse.

Copy forward/pull forward: Bringing forward a portion of a note or an entire old note (see 23.5.1—*Recommendation 1: Policy for use of Copy and Paste* in this chapter).

Cut and paste: Removing or deleting the original source text or data to place it in another location (eg, Ctrl+X to delete and Ctrl+V to paste). Compare to *copy and paste* above.

Errors/inaccuracies: Incorrect information included in a patient record. Such data integrity failures may result in delayed or missed diagnoses, incorrect treatment, and possible patient harm.

Fraud: Inappropriate billing, inflated claims, or duplicate claims.

Note bloat: Redundant copying of notes that causes lengthy documentation, duplication of patient information, skewed timelines, and obscured information.

Provenance: Place of origin; where the information originated and who first created it.

Redundancy: Patient information, including misinformation, that is repeated.

Skewed timelines: Unclear or misleading timeline of events due to copy-pasted information.
Verify: To check whether or not something is true by examination, investigation, or comparison.

Whole-note cloning: Copying an entire note from one patient encounter to another note with little or no editing.

Workaround: A method for overcoming a problem or limitation in a program or system.

Workflow disruption: A poor user interface that interferes with clinician efficiencies or cognition.

23.3 Risks of CIT

Though content importing technologies bring efficiencies to documentation, they also can bring risks. Copying and pasting notes from other providers' documentation without attribution may be equivalent to plagiarism, the practice of claiming someone else's work as your own, which can lead to fraudulent billing practices. Worse yet, injudicious use of CIT can cause harm to patients when inaccurate or

- **Creation of searchable data for research:** Creates consistent wording which aids in text mining for research.

23.5 Recommendations Framework

The following outlines recommendations for developing policies related to content-importing technologies.

23.5.1 Recommendation 1: Policy for use of Copy and Paste

Develop a policy for sections of documentation in which it would be acceptable to copy and paste.

Rationale: Copy and paste is acceptable in some areas of the health record, and guidelines should be established.

EXAMPLE(S) of acceptable uses of CIT, provided appropriate review and updates have been made:

- Laboratory values
- Medication list
- Allergies
- Problems
- Treatments or therapies
- One's own prior documentation

EXAMPLE(S) of unacceptable uses of CIT:

- Another clinician's medical decision-making (plagiarism)
- An unlicensed provider (eg, medical student)

23.5.2 Recommendation 2: Policy to Avoid Redundancy

Develop a policy for copy and paste that avoids routine duplication and redundancy.

Rationale: Excessive duplication and redundancy leads to note bloat, obscuring pertinent data and making the record difficult to use. Records should be individualized for a particular patient and visit.

EXAMPLE(S) of unacceptable uses:

- Copying sections such as an entire lab panel or imaging report
- Copying an entire report
- Copying a physical exam or review of systems that was not actually performed

23.5.3 Recommendation 3: Policy for Appropriate Attribution and Provenance

Develop a policy for giving attribution of text that has been copied and pasted.