Following the move to the primary use of electronic documentation, several questions have been asked regarding the process for correcting or deleting documentation that may contain errors. Documentation (either electronic or paper) should not be routinely deleted as a practice. Refer to Policy 3.11 – ‘Legally Correcting Documentation Errors’ for specific policy related to this. Here are a few tips that should be followed to limit the need for documentation corrections.

**Be proactive** to minimize the need to retain incomplete documents that cannot be deleted:
1. Utilize the Documentation Schedule Report and Incomplete Documentation Report to ensure documents are completed timely. **Complete documentation on the day that it is due.**
2. Utilize the Documentation Schedule Report to identify when multiple documents may be due in the week. By scheduling the therapist to complete a Progress Note or UPOC on the earliest date in the week documentation is due you can avoid having multiple therapists complete weekly documents on the same patient and reduce the risk of draft documents in the system.

Example: Med B patient, Mrs. Smart, has an Assistant Progress Note scheduled on Tuesday, and a 10th Visit Progress Note scheduled on Wednesday, and a UPOC scheduled for Thursday. If the therapist completes the UPOC on Tuesday, (and submits G codes), this one document will cover all of the scheduled document requirements for the week for this patient, and the additional scheduled documents will be removed with the overnight process. **Remember that it is always ok to do documentation early.** **Please note: if the UPOC is completed on Thursday, but the activity date is moved to Tuesday, the system will not forgive the two previously scheduled progress notes.**

3. Review and manage the Missing Documentation alerts
4. When completing a document, therapists need to ensure that there are no previous documents that are incomplete. On the mobile device, tap on the documentation bar in the upper right of the screen to see document status in the drop down:

Additional guidance for the proper retention/deletion of eDoc:

1. The only document that can be deleted (under specific circumstances) is a current document with no additional documentation after it.
   a. A document (other than the POC) that has been initiated on the mobile device in error an be deleted from the device as long as it is deleted prior to synchronization.
   b. Examples:
      i. The therapist taps on the weekly progress note for Mrs. Smith and begins to document, but realizes that she intended to document on Mrs. Jones.
      ii. An assistant taps on a weekly note for Mr. Doe but realizes that the UPOC is due the next day; the assistant asks the therapist to complete the UPOC that day instead of the next day.
c. If a document has been selected in error and synchronized, (and there is no documentation following this document and there is no pertinent information in the document) the document can be deleted from the desktop in this manner:

1. Click on Documents tab to see a list of the documents in the system for the patient.
2. A document that is available to delete will have a red dot with a line on it.
3. Click on the red icon.
4. The device will display the message "Are you sure you want to remove....."
5. Once the document is removed the icon will no longer show next to the document.

**Please note: you do not need to "complete to delete" a document**

Once the therapist has synchronized and logged out, access the patient on the desktop; select the document that was entered in error, highlight it, and select the Delete button at the bottom of the discipline column.
Scheduled Documents:
2. Scheduled documents that are not replaced by a completed document on the same day or before cannot be deleted. Example: if an assistant weekly note is scheduled for Monday, but a therapist completed a weekly note dated the same day (and there is additional documentation after this date), free text in the “Other Notations” blue box “see Therapist Progress Note dated this date” and leave the assistant note in draft. The alert for the incomplete documentation will fall off 45 days after discharge. Please follow the same guidelines for documents that have been entered in error but that have documentation completed after it.

Interface Discharge Scenario:
3. For facilities with interfaces: If a patient leaves the facility overnight but are not truly discharged, the facility interface may have entered a facility discharge in Smart; upon return of the patient from the LOA, the new admission can be merged with the previous admission (must be completed by Support) which prevents the need for a DC summary and new POC. In order to delete the DC summary that is no longer needed in this scenario, the EOC reason must be manually changed on the desktop from ‘Facility Discharge’ to any other reason on the drop down. At this point the ‘delete’ button will be present to allow the interface-generated discharge summary to be removed.