Making Changes to Medical Records

Inevitably, incorrect information can find its way into a patient chart or pertinent information may be inadvertently omitted. It is advisable to review the patient record on a routine basis and if errors are discovered, to correct them in a timely manner during the course of the patient's care and treatment. Changes to a patient's medical record should be made as timely as possible, leaving no room for any suggestion that an entry was made for any reason other than to properly document patient care.

If the charting is in paper form and incorrect information has been entered in the patient's chart, then it is advisable to draw a single line through the incorrect information, making sure that what has been drawn over can still be read. Then, the physician making the correction should sign, date, and include an explanation as to why the change was made. It is not appropriate to use white-out or other correction fluid to correct errors in medical records.

Other methods are available for electronic health records (EHR); and the software used may dictate how the record can be modified. The EHR should capture the date, time, and change made to the record as well as the identity of the recorder making the change. Remember that changes to EHR are many times reflected in the printed version of the chart and are almost always reflected in metadata; thus, it is virtually impossible to "simply delete" information from the record.

If additional information should have been included but was inadvertently omitted from the patient record, then it is appropriate to add a note captioned "Addendum" or "Late Entry." In an EHR, there may be an opportunity to include this type of note as a narrative entry. This type of entry makes the record whole. The practitioner making the addendum should sign, date, or electronically authenticate the entry and indicate why the information being supplied was added.

Diligence in documentation serves to preserve both the integrity of the physician making the record and the medical record itself. Altering a medical record for any reason other than to safeguard a patient can have serious consequences.