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# Correcting Errors in the Electronic Medical Record

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Despite all of the benefits that electronic health records (EHR) offer, there remain opportunities for incorrect data entry due to problems with system design and or user error. Errors caused by system problems (e.g., a confusing screen design, etc.) can be prevented by working with your vendor to reset user preferences as needed. In order to preserve data quality and protect patient safety, it is essential to set an office policy to funnel all errors to necessary staff and physicians in a timely manner. The case study below illustrates why establishing a sound system is very important.

*Suppose that a physician orders a pregnancy test on a patient before administering a variety of drugs known to cause birth defects in the fetus. An incorrect result is recorded in the patient's record, but subsequently discovered. The patient might well have begun treatment prior to the correction of the lab report. In such a situation, it would be important to the physician to be able to prove that the initial (incorrect) report on which he relied, existed. It is also important that a corrected report be brought to the immediate attention of the physician.*

In the case of electronic records, the problem is that the correction of the lab report may potentially eliminate information that the physician relied on for a period of time. Also, the correction might be made without the physician ever being aware that a reporting error was made. State laws vary on how medical records can be amended. Generally the law frowns on erasing relevant information so that it cannot be recovered. That's why opaque correction fluid should not be used in correcting paper records, and why incorrect entries in the written medical record be lined out and rewritten rather than obscured.

The possibility exists that over-writing the initial EHR, even though the information is incorrect, could be construed as improper alteration of the historical medical record. In general, states merely require that electronic records be maintained "to the same standards" as paper copies. Also, the amended EHR should be flagged to indicate that it has been corrected, and some mechanism be put in place to retain and easily access copies of the original, if incorrect, data. A comment field in the amended report may suffice. In general, a narrative entry in the medical record statement indicating that an error has been made, and is being corrected, is the best procedure. When a lab or diagnostic report is involved, the facility director or pathologist should

assume the responsibility for insuring that such an entry is made. Both the original error and the correction should be well documented for future reference.

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Personal contact between the laboratory/diagnostic facility and the involved physician is always desirable, and should occur whenever an erroneous report must be corrected. Keep in mind that the report may be critical and time may be of the essence. Most importantly, whenever an error in lab/diagnostic test reporting is made, it is essential for the laboratory/facility to retrace the handling of the specimens, films etc., and determine how erroneous results were released.

The facility should then institute appropriate policy and procedure changes to prevent recurrence of such errors.

In summary, correcting errors in EHR systems should follow the same basic principles as correcting paper copies. These specific considerations apply:

- Work with your vendor to confirm that your EHR system allows error correction and determine whether or not the vendor has established a process.
- The system must have the ability to track corrections or changes once the original entry has been entered or authenticated.
- When correcting or making a change to an entry, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted.
- In situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected.
- The process should permit the author of the error to identify, and time/date stamp, whether it is an error.
- The process should offer the ability to suppress viewing of the actual error but ensure that a flag exists to notify other users of the newly corrected error.
- The location of the error should also point to a correction. The correction may be in a different location from the error if there is narrative data entered, but there must be a mechanism to reflect the correction.



- Develop a practice policy to ensure that your facility corrects and reports errors in a consistent and timely manner.

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