Management of Incorrect Entries in Electronic Patient Records

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| Version number : | 0.3 |
| Consultation Groups | Information Governance, Chief Clinical Information Officers, Digital, Chief Medical Officer |
| Approved by (Sponsor Group) | Information Governance Steering Group |
| Ratified by: | Quality Committee |
| Date ratified: | 24th April 2024 |
| Name of originator/author: | Clinical Systems Development Lead |
| Executive Director lead : | Chief Medical Officer |
| Implementation Date : | April 2024 |
| Last Review Date | April 2024 |
| Next Review date: | April 2027 |

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| Services | All patient-facing services using EPR |
| Trust wide | Awareness |
| Mental Health and LD | Awareness and Compliance |
| Community Health Services | Awareness and Compliance |

Version Control Summary

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| **Version** | **Date** | **Author** | **Status** | **Comment** |
| 0.1 | 01/11/2023 | Anne Crozier | Draft | For Circulation |
| 0.2 | 17/04/2024 | David Pearson | Draft | Minor change to “RiO Procedure – Removal by the original author” section to amend process if note has been validated |
| 0.3 | 18/04/2024 | David Pearson | Draft | Minor change to “RiO Procedure – Strike-through by the original author” section to make it clear that it refers to bullet point 3 |

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**Executive Summary**

This policy describes the controls in place to safely, effectively and consistently manage incorrect entries into clinical and care records on East London NHS Foundation Trust (hereafter referred to as ELFT) Electronic Patient Record systems.

As a provider of National Health Services, ELFT and its employees have a legal duty and professional responsibility to ensure that all personal-identifiable information is processed fairly, lawfully, and as transparently as possible. Part of that fair and lawful processing is ensuring that health and care records are accurate and kept up to date, and part of that transparency is ensuring that inaccuracies are identified and corrected, with full visibility of the correction where appropriate. This policy sets out to define this appropriateness, providing a tool for decision-making regarding the correction of health and care records, and details the steps that should be subsequently followed.

1. **Introduction**

This policy is intended as an extension to, and should be read in conjunction with ELFT Clinical Record Keeping Policy. It covers specifically the adequate correction of inaccuracies in records contained within ELFT’s main Electronic Patient Record keeping systems, namely RiO, EMIS, and SystmOne only, although the principles it is based on are system agnostic. This policy should be referred & adhered to when an inaccuracy in an electronic patient record has been identified.

1. **Duties and Responsibilities**

Appropriate records management is the responsibility of all staff within ELFT, and all staff should ensure that they understand their duties regarding this. This policy relates only to electronic health records of service-users and therefore the following staff/bodies have specific additional duties.

* **Information Governance Steering Group**

This body holds overall responsibility for this policy and all records management related policy and procedures. They will ratify this policy and ensure that it is reviewed and updated every 3 years, or as soon after published changes to relevant legislation or guidance as possible.

* **Health and Care Professionals**

Health & Care Professionals are responsible for adherence to the steps contained within this policy and the Clinical Record Keeping Policy. Where a mistake has been made the person who made the inaccurate entry is responsible for its rectification and for making a judgement on which course of action to follow as per this policy.

* **All users of Clinical Systems**

Any user of any of our clinical systems can identify an inaccuracy within an electronic patient record. They have a responsibility to raise this to the professional who made the entry into the record as an initial step. If that person is no longer in the role, then they should raise it with the relevant service manager.

* **Clinical Systems Services**

Clinical Systems Services are responsible for advising Health & Care Professionals on the technical aspects of clinical system usage in adhering to the steps laid out in this policy. They are also responsible for running any system related audits as necessary. They will be able to support services with removal where the original author is no longer in post.

* **Caldicott Guardian**

The Caldicott Guardian is ultimately responsible for making the decision on the appropriate course of action to take regarding the removal of inaccurate information from electronic patient records on a case by case basis.

In 2022, NHS England published guidance approved by the Health and Care Information Governance Panel, the Information Commissioners Office, and the National Data Guardian, on amending patient and service-user records. The guidance covers how staff should amend records, as well as how patients and service-users can request changes to their records.

1. **Principles and Procedures**

* **Principles**

Where a request for removal has been received (either from another user or from the subject themselves) for an entry that is factually accurate, it should not be removed.

Where a request for removal has been received (either from another user or from the subject themselves) for an entry which was factually accurate at the time it was entered but has since changed, it should not be removed.

All mistakes and inaccuracies should be corrected immediately, or as close to the time of original entry as possible

In all circumstances, original entries are retained intact with their metadata within the clinical systems and are available to view on the electronic patient record with the correct access rights

Corrections should be made by the original author as far as possible, where this is not possible a call should be logged to the clinical systems support team who will be able to take this action

Where an incorrect entry has been identified by another service (such as the Information Rights team when processing a SAR) they should notify the relevant clinical team who are then responsible for taking appropriate action to correct the data

Corrections should never be made to avoid disclosure as part of a Subject Access Request as this contravenes the Data Protection Act 2018

For the purposes of this policy inaccurate information is categorised in to risk levels as follows:-

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| **Circumstance** | **Risk Category** | **Appropriate mitigation** |
| Incorrect information relating to the same patient | Low | Strike-through |
| Incorrect information relating to another patient but not identifiable | Low | Strike-through |
| Incorrect information relating to another patient which is identifiable | Medium | Removal |
| Incorrect and particularly sensitive information *e.g. incorrect diagnoses, addresses relating to estranged family members* | High | Removal |

If you are in any doubt about what action to take in a specific case please contact the Caldicott Guardian for advice.

* **Procedures**

RiO includes the concept of a ‘validated’ and ‘unvalidated’ entry. Only validated progress notes can be struck-through.

**RiO Procedure – Strike-through by the original author**

* Navigate to the entry on the Progress Notes
* If the note is validated continue with the steps below, if not please follow the guidance under ‘Removal by the original author’ below, from bullet point 3.
* Click on Amend, and tick the Entered in Error Check-Box
* Save your changes

**RiO Procedure – Strike-through by another clinician (as original author unavailable)**

* If the note is validated Log a support request using the IT Service Desk Portal link on your desktop (<https://eastlondon.service-now.com/sp>) requesting that the progress note be made unvalidated
* On receipt of completion of your request or if the note is unvalidated, navigate to the entry on the Progress Notes
* Change the author to yourself and save your changes
* Validate the note and save your changes
* Click on Amend, and tick the Entered in Error Check-Box

**RiO Procedure – Removal by the original author**

* Navigate to the entry on the Progress Notes
* If the note is validated Log a support request using the IT Service Desk Portal link on your desktop (<https://eastlondon.service-now.com/sp>) requesting that the progress note be made unvalidated
* On receipt of completion of your request or if the note is unvalidated, navigate to the entry on the Progress Notes
* Remove the original text, replace the text with ‘this entry has been removed as it was entered in error’
* Save your changes

**RiO Procedure – Removal by another clinician (as original author unavailable)**

* If the note is validated Log a support request using the IT Service Desk Portal link on your desktop (<https://eastlondon.service-now.com/sp>) requesting that the progress note be made unvalidated
* On receipt of completion of your request or if the note is unvalidated, navigate to the entry on the Progress Notes
* Amend the entry and change the author to yourself, remove the original text, replace the text with ‘this entry has been removed as it was entered in error’
* Save your changes

**SystmOne Procedure – Strikethrough**

* Navigate to the entry on the Journal
* Right-click and select ‘Mark in Error’
* Save your changes

**SystmOne Procedure – Removal**

* Navigate to the entry on the Journal
* Right-click and select ‘Mark in Error’
* Save your changes
* Navigate to the entry in the Deleted Items Node on the Administrative Tree\*
* Right-Click and select Remove From Patient Record

*This will send a Task to the Unit’s Caldicott Guardian who will review the case and either Accept or Reject your request. Acceptance will remove the entry, Rejection will leave the item marked in error on the record. You will receive a task detailing the decision and the rationale within SystmOne.*

*\*Not all staff have access to the Deleted Items Node. Please check with your service manager.*

**EMIS Procedure – Removal**

EMIS Does not provide functionality allowing for the distinction of a strike-through and a removal, therefore in this system all cases must be treated as follows:-

* Navigate to the entry in the Consultations Screen within the Care Record
* Right-Click and select ‘Delete Consultation’
* Select a Reason for Deletion from the drop-down list provided, and click on Delete\*

*\*Note that to view a deleted item, you must click on ‘View Deleted’ on the Consultation Screen.*

1. **Monitoring**

Adherence to this policy will be monitored as part of established record audit procedures including Supervision and annual audits.

Issues relating to poor record keeping standards must be managed through established professional conduct processes and procedures.

All cases of inaccurate information being entered into electronic patient records, must be raised as incidents on ELFT’s incident management system (such as Datix, InPhase).

Prevalence of incidents will be reviewed at the Information Governance Steering Group, where additional actions may be taken such as provision of additional training or additional supervision.

1. **References**

NHS England – Transformation Directorate; Amending patient and Service-User Records

<https://transform.england.nhs.uk/information-governance/guidance/amending-patient-and-service-user-records/>

NHS England – Transformation Directorate; Records Management Code of Practice

<https://transform.england.nhs.uk/information-governance/guidance/records-management-code/>

Nursing & Midwifery Council: guidance on the Code for professional standards of practice and behaviour for nurses, midwives and nursing associates

<https://www.nmc.org.uk/standards/code/>

General Medical Council: good medical practice for keeping records

<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-1---knowledge-skills-and-performance?#paragraph-19>

Health & Care Professions Council: guidance on record keeping

<https://www.hcpc-uk.org/standards/meeting-our-standards/record-keeping/>