

**Peel House Medical Practice**

**Errors In Medical
Records – Policy**

 **Original Auth­­­­or:** Craig Lee

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*The business is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.*

*To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full impact assessment conducted where necessary prior to consultation. The business will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.*

*The Practice will provide guidance and support to help those to whom it applies understand their rights and responsibilities under this policy. Additional support will be provided to managers and supervisors to enable them to deal more effectively with matters arising from this policy.*

*This policy and procedure can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages on request.*

*The business will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.*

**Overview**

The surgery takes patient confidentiality very seriously, however from time to time there may be a genuine mistake on a patient’s medical record, whether that has occurred during the patient’s time with the surgery or before they registered with the surgery. Patients can request a rectification at any point, to any member of staff, whether verbally or in writing. There are no fees charged.

All mistakes relating to medical notes could be very serious and should be treated as such. Any incident must be reported to the Information Governance (IG) lead, who may need to report such incidents to the Information Commissioners Office (ICO), Care Quality Commission (CQC) and other relevant bodies. All errors should be rectified and corrected as soon as they come to light or within a reasonable timeframe thereafter.

**Protocol**

When the surgery is made aware of an error within medical records, firstly apologise for the incident and explain we take all incidents very seriously. Errors can be split broadly in to 3 categories;

* **Factually Inaccurate Entry** – Sometimes, despite policies in place to prevent it, an entry will be made on the incorrect patient. This could be a clinical letter, a consultation or a simple coded entry. These incidents should be immediately reported to management who will remove the incorrect entry and add it to the correct patient, if known. Administration staff should not remove or delete entries to resolve the issue, rather, contact a manager who can do so on their behalf. All of these incidents must be reported to the IG lead as they are potential data breaches.
* **Incorrect-diagnosis** – Sometimes patients will disagree with a diagnosis on their record or may have a problem recorded inaccurately. If this occurs the patient will need to make an appointment to discuss this problem with the clinician who added the incorrect code or miss-diagnosis. If it is not possible to see the clinician who added the entry, then the patient should see the clinician who has seen them the most often or recent.
* **Disputed information** – Patients may seek correction of information they believe is inaccurate. The clinician is not obliged to accept the patient’s opinion, but must ensure that the notes indicate the patient’s view. Information which is clinically relevant must not be deleted from medical records. If this occurs the patient will need to make an appointment to discuss this problem with the clinician who added the disputed information. If it is not possible to see the clinician who added the entry, then the patient should see the clinician who has seen them the most often or recent.

Any such amendments must be made in a way that makes it clear what has been altered, who made the alteration and when it took place. Please refer to the separate protocol for further information.

This policy is in no-way meant to supersede or replace guidance issued by the relevant regulatory bodies including GMC, BMA and NMC guidance.