Ensuring Accuracy of Patient Records

This section will:
• Identify the requirements on keeping paper and electronic records accurate. • Explain patients' rights to verify accuracy of their records and ask for corrections.

Regardless of the method used to record patient health information, physicians must ensure that the information is up-to-date and accurate. Patient information must be documented in the record as soon as possible after an event has occurred, providing current information on the care and condition of the patient. The clinical consequences of inaccurate personal health information range from personal embarrassment to physical harm or even death.

Under the Personal Information Protection Act (PIPA), patients have the right to request their personal health information be corrected if they believe it is not accurate or complete. Of course, professional or expert opinions cannot be corrected or changed.

The practice's privacy policy must be openly available, must describe how patient information is kept accurate, and must describe how patients may request correction to their information. Patients (or their legally authorized representative) may make a request for correction in writing (see the Patient Request Form for Correction of Personal Information) and physicians' offices must respond **within 30 working days** of receiving a request. If appropriate, an amendment is made and a copy of the amendment is sent to each organization to which the inaccurate or incomplete information was disclosed within the past year. If no correction is necessary, the designated Privacy Officer or delegate must explain the reasons to the patient.

The designated Privacy Officer must educate staff on how to appropriately respond to such requests. If a patient is not satisfied with the outcome, he or she may request a review by the College of Physicians and Surgeons of BC or take the matter to the Office of the Information and Privacy Commissioner for BC (OIPC) .

Patient information in physician records should:

1. Be written clearly, legibly, and in such a manner that it cannot be erased.

2. Have any alterations or additions dated, timed, and signed in such a way that the original entry can still be read clearly.
3. Be accurately dated, timed, and signed, with the name of the author printed alongside the first entry.
4. Be readable on any photocopies or faxes.
5. Be written, wherever possible and appropriate, with the involvement of the patient.
6. Be clear, unambiguous, and written in terms that the patient can understand. Abbreviations, if used, should follow common conventions.
7. Note clearly, if applicable, reasons for not making a correction indicating a correction was requested but not made.
8. Be consecutive.

Other medical observations must also be included, such as examinations, tests, diagnoses, prognoses, prescriptions, and other treatments.

In addition to the above requirements, Electronic Medical Records (EMRs) should:

1. Have the ability to correct information through an amendment. The original data must not be modified or deleted; it should be maintained as history.
2. Accurately date and time-stamp a correction, recording who made the amendment.
3. Allow for notation, if applicable, that a correction was requested but not made.
4. Be able to generate a copy of a patient record with the amended data and correction history.