ALTERING MEDICAL RECORDS: BEST PRACTICES

Notice to College Members

July 12, 2023

A patient's medical record contains valuable information about their clinical history and interactions with healthcare providers. It is important that the record is accurate and complete.

Circumstances may arise where you need to alter a record which you previously created. As a medical record is a legal document, you must ensure all additions and deletions are appropriately documented. The College's By-Law 6: Medical Records explains how to do this:

1. **Do not remove or render illegible the previously existing record**
   - For paper records – cross out the incorrect information with a single line.
   - For electronic records* – use an addendum, note, and/or a digital strikeout.
2. **Include the date of the alteration**

Electronic medical records have an audit function that tracks who made any changes to entries and when. While this information may be available through auditing, you must still alter the record as required by the College's By-Law 6: Medical Records.

*For physicians using the Med Access EMR, attached please find guidance from eDOCSNL on how to appropriately alter your records.

This and all other Notices can be viewed on our website at www.cpsnl.ca > News

All College communication to its members will be by email. It is a professional obligation for College members to read all College communications.

The College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) issues guidance on the composition, editing and amendment of medical records in the form of By-Law 6: Medical Records on their website which can be found here. Realizing that all edits or additions to medical records in the Telus Med Access EMR will be captured by the audit functionality, simply modifying the record and capturing the changes in the audit log does not conform to the CPSNL standard.

eDOCSNL would like to support physician users with aligning with the practice standard and suggests the following options. These options have been discussed with the CPSNL and determined to meet the requirements as specified in By-Law 6: Medical Records

1. In any text box or other editable fields where text can be entered, the user should make a note within the field indicating that an edit or addendum has occurred and note the date, without altering the original note:


2. In discrete data fields, such as recording patient height, the user should make the change and indicate in the associated note/comment field (revealed by hovering in the area to the right of the field) that a modification has occurred and what the original value was:

3. As an alternative to options 1 and 2, or for cases where no text or notes field exists, the user should click in the empty space on the applicable template, select "Add Observation" and select "Addendum" from the displayed options. This will add an Addendum field to the template (usually at the bottom), where all changes or addendums can be summarized, if preferred.
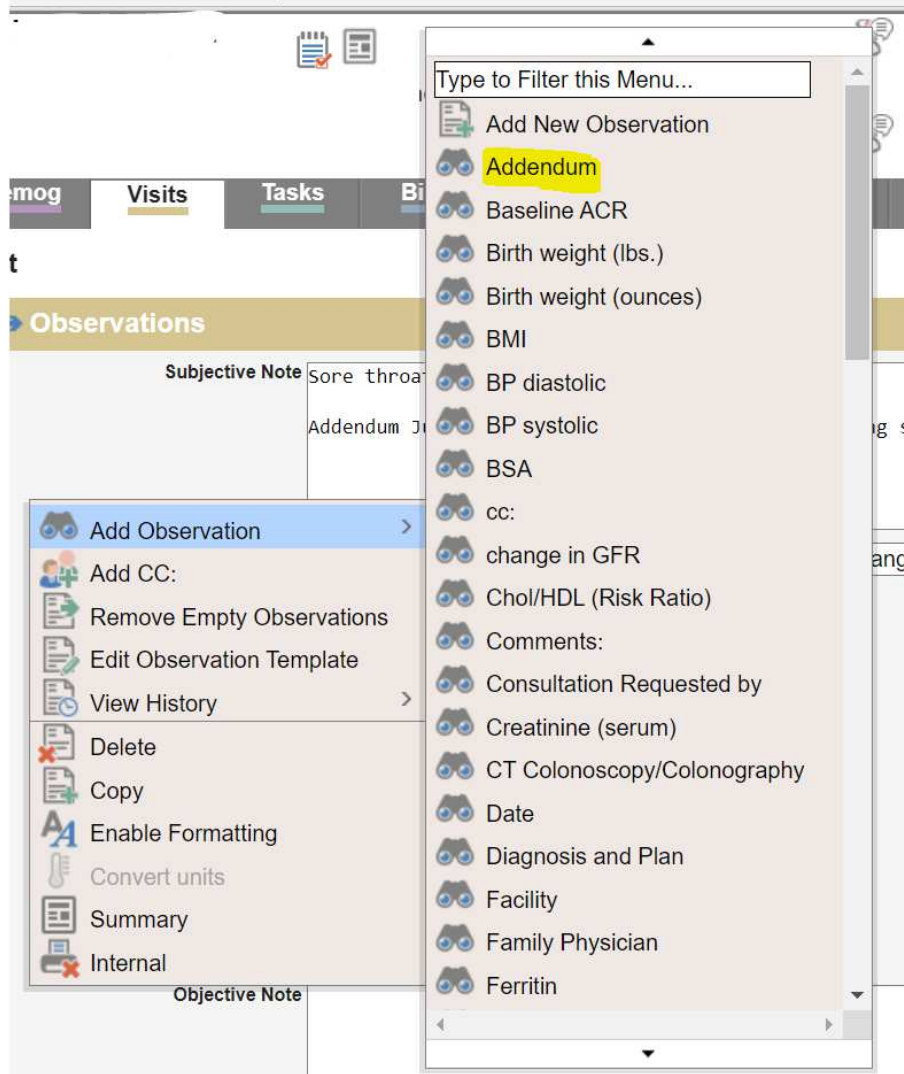
Which will result in this:
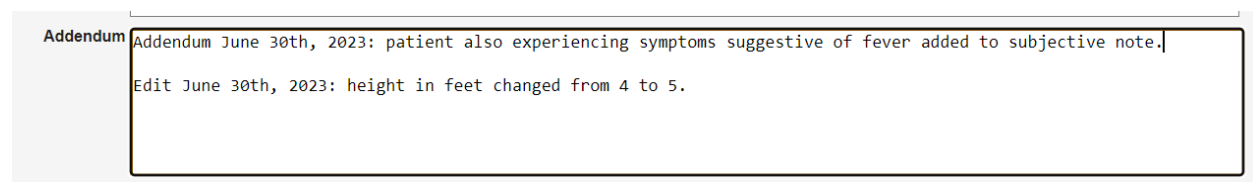
If there are any questions about the above workflow, please contact the eDOCSNL Program at info@edocsnl.ca. For information about this and other physician practice standards, please contact the CPSNL.