Are Corrections/Supplements to Clinical Records Illegal or Unethical?

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Many providers are appropriately conducting a variety of retrospective reviews of patients' clinical records. These audits may reveal incomplete or inaccurate records. The records must be, therefore, corrected or supplemented, if possible, in order to help ensure quality of care, meet applicable regulatory requirements, and avoid allegations of fraud and abuse.

When managers ask clinicians to assist them with this process, however, some staff members still conclude that they are being asked to engage in illegal and/or unethical conduct. On the contrary: it is absolutely essential to correct and/or supplement records whenever it is appropriate to do so.

Specifically, clinicians may supplement and/or correct patients' clinical records under the following circumstances:

- Clinicians have a clear recollection of the information; and/or

- There is a writing that serves as the basis for clinicians' supplements and/or corrections.

Supplements to patients' clinical records must include:

- The date the entry is actually made;

- The information that was originally omitted and the date on which the information was available; and

- The signature and title of the employee who supplements the record.

Corrections to patients' clinical records must be made by drawing a solid line through mistakes. Providers' internal policies and procedures may also require staff to write the word "error" in relation to the information through which a line has been drawn.

If correct information is also added to the record, clinicians must write the correct information in a location specified by internal policy and procedure. The date on which the correction was made and the initials of clinicians who make corrections will also be written with each correction. Clinicians may not use correction fluids or erasures when making corrections. Providers should develop and implement polices and procedures that make it clear that staff members are obligated to correct or supplement records of care provided under the circumstances and in the manner described above. Internal policies and procedures may also provide for discipline of staff members who fail to do so.

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Changes to clinical records are consistent with applicable national standards of care and are essential for all of the reasons stated above. Field staff who fail to make appropriate changes are not acting in their own best interests or the best interests of patients and providers.

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