CNA HealthPro

Correcting and Amending Dental Records

Accurate and complete records are one of the most powerful risk management tools and a foundation for quality patient care. In the event that you do become a defendant in a malpractice action, a comprehensive dental record is your chief defense weapon. It is difficult for a plaintiff to challenge an accurate and organized dental record written at the time of treatment.

Occasionally, erroneous information is entered in the dental record, or important information is left out. These mistakes can happen to anyone that makes chart entries. Correcting record keeping errors and omissions is an important aspect of maintaining proper documentation. Regardless who discovers the error, it is important that the error be corrected in the proper manner.

While it is important to have accurate information in the record, the timing of when a correction or amendment is made, the relative importance of the correction or amendment to patient care and safety, and the manner in which the correction is effected are often key elements in professional liability actions. Ideally, a system of regular chart audits will readily identify any errors or omissions you may have.

Corrections and amendments should be made as soon as discovered, preferably within days to weeks following the treatment date in question. Corrections involving the patient's future safety and well-being should be made regardless of the time that has passed since the original entry. For example, if you notice that you wrote "Patient now taking Proprinal" when you meant to write "Patient now taking propranolol," forgoing a correction due to concerns over its timing could have serious future consequences for the patient.

Corrections and amendments made many months or years afterward are likely to be challenged as to their veracity, considering the number of patient visits in your practice over the intervening time period. This is especially true for corrections and amendments that are not critical to the patient's safety, but merely provide additional information about the patient's visit. Patient conversations or behaviors provide an example of such modification.

Additionally, if an error was corrected or an amendment made only after a claim was initiated by the patient, the correction probably will be argued by the claimant to be a self-serving attempt to avoid responsibility. If you receive a notice of peer review, disciplinary or professional liability action, do not make any changes or additions to the record in question, even if the additions or changes reflect what actually occurred, although not previously recorded. It is also inappropriate to destroy or recreate any pages or components of a record because you believe the information to be incomplete or damaging to your defense.

Current record evaluation methods, such as ink analysis, light reflection tests, transmission analysis, and computerized handwriting analysis, can detect even the most sophisticated attempts to adulterate a paper record. Similarly, computer experts can analyze the hard drives of electronic record systems to determine whether the entry was changed or created on more than one date. An adulterated record makes defense of any patient claim extremely difficult. It also could subject you to allegations of spoliation of evidence or fraud, as well as the possibility of punitive damages or criminal charges, which are not insurable in many jurisdictions.

When making corrections or adding information, it is important for any future reader of the record (even you) to clearly understand both the error and the correction. To that end, never use correction fluid or other means to obliterate an erroneous entry.

If an error is made while making an entry, draw a single line through the error and initial it. Lined-out entries must always remain readable so that incorrect inferences cannot be made about their content. If an error is discovered after an entry is complete, draw a single line through the error and initial and date it. Add the correct information by making an entry in the next available space in the record, keeping the date of the correction clear. You also may wish to clarify the reason for the correction.

When you make an addendum to a prior treatment entry, do so in the next available space in the record rather than in the margin or the body of a previous entry. Always use the date on which the addendum is added, then reference the date of the original note in the note you are adding.

Don't squeeze additions or corrections to an old entry between the lines of text or in the margins. Information scribbled haphazardly into an old note or added in the margins carries the inference of impropriety, even if it was written at the time of service.

Any necessary additions, deletions and changes to the record after notice of a peer review, disciplinary or professional liability action can be made in a separate narrative report or by oral testimony. This supplemental narrative report is ordinarily addressed to the defense attorney to maintain confidentiality under the doctrine of attorney-client privilege. Copies of such a report should be kept in a separate file to prevent the material from being inadvertently copied and released to the plaintiff.

Record errors are an inherent risk in dental practice. Following these suggestions will minimize the risk that an error will adversely affect your patients or your practice.