



## MANAGING INCORRECT INFORMATION

### Introduction

No matter how many times we remind our healthcare professional colleagues to be vigilant when they are filing patient information into the paper record or uploading information in the electronic patient record, there are always going to be occasions when you find something that is not correct.

This may manifest itself in several ways:



1. Wrong document filed in another patient's record – paper or electronic
2. Wrong information within a document that belongs to another patient
3. Wrong information recorded incorrectly but for the right patient



**WHAT SHOULD YOU DO  
&  
WHAT SHOULDN'T YOU DO?**

### Background

The Data Protection Act 2018 requires organisations to ensure the personal information that it holds is accurate and not misleading and if any information is identified as such, that reasonable steps will be taken to correct or erase it as soon as possible. Organisations must also consider any challenges made as to the accuracy of the personal data that it stores and processes. The Information Commissioner's Office (ICO) provides a checklist to manage this situation, indicating that we should comply with the individual's right to rectification and that a record is kept of any challenges made and decisions taken.

The quality of the data being recorded is open to more challenge since individuals now have free right of access to their records. This is generally perceived as a good thing although requires robust and transparent information and data management processes to be in place.

### Management of incorrect data

When information has been identified as being in the wrong record, or incorrect information has been recorded against the right patient, the first thing that should be done is to raise an incident on the organisation's Incident Reporting system. This is done for several reasons:

1. It recognises that the incident has happened
2. It allows for an investigation as to why and where the incident happened
3. It provides information to be able to monitor the situation and to see if there are any trends
4. It allows the Records Management Team (or equivalent) to rectify the incorrect information

Management of clinical records (whether on paper or digital) can be managed in a number of different organisational departments but the rectification of incorrect information should sit with the appropriate team with the necessary skills and knowledge.

### **Rectifying the error (s)**

**NOTE: DO NOT REMOVE THE INFORMATION – THIS IS VERY IMPORTANT**



The reason you should not remove the information is that you will not know if any treatment, procedure or care had been given based on this incorrect information.

Once you have recorded the incident on the Trust's Incident Reporting system you should send the physical record to the Records Management / Data Quality department (or equivalent in your organisation) to manage with the author/s or their representative, and appropriate actions taken in line with Duty of Candour.

Once information has been identified as recorded in error there should be a mechanism in place for the Records Management or Data Quality teams to manage this.



### **CASE STUDY #1: A DOCUMENT INCORRECTLY FILED IN A PATIENT'S PAPER RECORD**

1. If the incorrect information is a single document and the information recorded on both sides belongs to another patient, then remove the document – identifying where you have removed it from (see 4/5 for how this is done)
2. Photocopy the document
3. On the original document place a label similar to below:

This information was  
previously filed in  
another record  
Date rectified:

4. On the photocopied document you must redact the patient's details (so as not to breach confidentiality within the patient record that it was found). On this copy of the document place a label similar to below:

Do not remove  
Copy of misfiled  
Information  
Date rectified:

5. File the photocopied document (now redacted) back into the record where it was originally filed.
6. File the original document in the correct patient's record and inform the lead clinician that this event has occurred.
7. You must keep a record of both patients' details to enable Duty of Candour.
8. It is recommended that you record information about this data incident separately, for example:
  - a. Date identified
  - b. Date of recorded information
  - c. Type of document and information
  - d. Setting of information recorded i.e. outpatient clinic, inpatient ward, day case, theatres etc

This will provide evidence of the episode which will stimulate discussion at Health Records Group or Information Governance Group meetings on how this error occurred and how it can be avoided in future.

## **CASE STUDY #2: PART OF A DOCUMENT CONTAINS INFORMATION ABOUT ANOTHER PATIENT**

1. If the information that has been identified belongs to patient A but it is within a document belonging to patient B, example:
  - halfway through a document the information changes from male to female or vice versa
  - the name changes completely
  - medically, information changes that is gender specific, for example 'this pregnant lady' or 'this cervical examination' is recorded within a record belonging to a male patient

you must identify the healthcare professional who wrote the entry and arrange to meet with them or their responsible clinician to understand what information belongs to which patient.

2. Identifying patient A, who has been written about within the document may be challenging, but it is important to note that this must be a clinical decision and not an administrative one.
3. Once the information has been unpicked, the document is photocopied and patient A's name on the original document redacted and the content is crossed through, ensuring that it can still be read. You **must** record that the information was documented in error and belonged to another patient alongside the entry.
4. On the photocopied document you need to redact patient B's name and the information belonging to them, recording that the information belonged to another patient.

If you have been able to identify patient A who has been written about within the document, request their paper record so that you can file the information in the right place. You must have redacted all the information belonging to patient B so that a breach of confidentiality does not occur in any future disclosures of the record. You should also inform the lead clinician of both patients that this error has occurred, and the steps taken to remedy the errors.

5. You must keep a record of both patients' details to enable Duty of Candour.
6. It is recommended that you record information about this data incident separately, (i.e. for each patient)
  - a. Date identified
  - b. Date of recorded information
  - c. Type of document and information
  - d. Setting of information recorded i.e. outpatient clinic, inpatient ward, day case, theatres etc

This will provide good evidence to stimulate discussion at Health Records Group or Information Governance Group meetings on how this can be improved.

## MANAGING INCORRECT INFORMATION IN ELECTRONIC RECORDS



**The management of incorrect data/information within a digital electronic record (aka EPR) will vary depending on the EPR supplier's software.**

**In principle there are TWO elements where data errors can occur:**

**Within a digitised (scanned) paper document.  
Incorrect data within the EPR or feeder systems.**

### CASE STUDY #3: ON A DIGITISED (SCANNED) PAPER DOCUMENT

In the same way that an incorrect paper document SHOULD NOT BE REMOVED from a paper record (in case a clinical interaction was based on that incorrect data), so too in a digital record (EPR) **the incorrect information shouldn't be removed.**

If a digitised document has incorrect information within it, this needs to be clearly marked as incorrect. Find the incorrect document in the EPR system and annotate the document by adding an appropriate statement.

- COPY OF INACCURATE INFORMATION BELONGING TO THIS PATIENT. DO NOT REMOVE.
- COPY OF MISFILED INFORMATION WHICH BELONGS TO THIS PATIENT AND ANOTHER PATIENT. DO NOT REMOVE AS THERE IS CORRECT INFORMATION WITHIN THIS DOCUMENT.
- COPY OF MISFILED INFORMATION RELATING TO ANOTHER PATIENT. DO NOT REMOVE.

#### **NOTE:**

- Any personal information on documentation relating to the incorrect patient i.e. hospital number/NHS number etc should be **redacted.**
- A DATE must be added to any of these statements identifying when the information was rectified.
- The statements above should also be added as a WATERMARK to the document (s) in question.

### CASE STUDY #4: CORRECTING INCORRECT INFORMATION WITHIN THE ELECTRONIC PATIENT RECORD.

The process you use will depend on the EPR system involved but the principles applied to correcting errors in paper or digitised paper documents apply equally to patients' electronic information.

Any incorrect information MUST BE LEFT IN SITU with a note saying that it is INCORRECT and a date that this was noted. Any demographic information from the INCORRECT entry MUST be redacted and a note inserted to explain the nature of the error.



**YOU CANNOT SIMPLY REMOVE INCORRECT INFORMATION AS CLINICAL INTERVENTIONS MAY WELL HAVE BEEN INFLUENCED BY THIS.**

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