Standard of Practice

Documentation in Patient Records

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Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, and Bylaws. All members must comply with Standards of Practice of Medicine, per section 86 of *The Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of *The Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

PREAMBLE

This Standard sets out the requirements of members for documentation of medical care. It is separated into four parts:

1. Definitions
2. General requirements for all practice settings
3. Requirements specific to non-emergency department outpatient care
4. Requirements specific to inpatient care and emergency department care

The requirements in this Standard are in addition to those required in sections 5, 10 and 11 of the College of Physicians and Surgeons of Manitoba Standards of Practice Regulation **("Standards Regulation")**, *The Personal Health Information Act*, CCSM c. P33.5 **("PHIA"),** and regulations made under PHIA. Unless otherwise stated, the requirements of this Standard are to be read in conjunction with other documentation requirements for certain clinical situations that are set out in other CPSM Standards of Practice of Medicine.

Note: Maintenance requirements for patient records and the record of appointments are dealt with in CPSM's **Standard for Maintenance of Patient Records**.

STANDARD OF PRACTICE

1. DEFINITIONS

For the purposes of this Standard:

1.1. **"Patient record"** means a record containing the information described at section 11 of the **Standards Regulation**. Section 11 of the **Standards Regulation** provides:

11(1) A member must appropriately document the provision of patient care in a record specific to each patient.

11(2) A member must document on the patient record the medical care given to the patient containing enough information for another member to be sufficiently informed of the care provided.

1.2. **"EMR"** means an electronic medical record or electronic patient record and includes any computer-based patient record that is created digitally or stored digitally (e.g., a patient record that has been scanned).[1]

1.3. **"Inpatient"** means a patient to whom a member provides care while the patient is admitted in an institutional setting (e.g., hospital).

1.4. **"Institutional setting"** has the same meaning as it does elsewhere in the CPSM's Standards of Practice of Medicine, which is:

(a) a facility that is designated as a hospital under The Health Services Insurance Act; or

(b) a hospital or health care facility operated by the government, the government of Canada, a municipal government, a regional health authority or CancerCare Manitoba.

1.5. **"Outpatient"** means a patient who is not admitted as an inpatient at an institutional setting. This includes patients attending an emergency department who are not admitted and patients who have been discharged from an institutional setting.

1.6. **"Non-Emergency Department Outpatient"** means the same as paragraph 1.5, above, but excludes patients being cared for in an emergency department or institutional urgent care department who are not admitted as an in-patient.

2. GENERAL REQUIREMENTS FOR ALL SETTINGS

Part 2 of this Standard sets out requirements for documentation in patient records that apply to all members who provide care during one or more encounters to either inpatients or outpatients regardless of the practice setting in which the care was provided, whether care is provided in person or virtually or whether the documentation is paper based or digitally stored.

[1] **Note:** For the purposes of this Standard, this definition will capture what are commonly referred to as EMRs, EPRs, EHRs, or digital records.

Overarching principles for documentation

2.1. Documentation is an essential component of safe and competent medical care. Sections 5 and 11 of the **Standards Regulation** establish that members:

> *Must appropriately document the provision of patient care in a record specific to each patient*.

And:

> *When a member and one or more other health care providers are involved in the health care of a patient, the member must … document, on the patient record, the member's contribution to the patient's care.*

2.2. To meet this Standard and satisfy the requirements of the **Standards Regulation**, care must be documented in the patient record in a manner that facilitates:
- 2.2.1. maintenance of the expected standard of care over time,
- 2.2.2. other members or health care professionals acting on significant information in the patient record as and when required, and
- 2.2.3. a meaningful review or audit of the care provided by others, including by CPSM and other authorized health authorities when required.

2.3. For each encounter, documentation should be adequate for another member to take over care of the patient if needed.

Institutional rules and bylaws

2.4. Members who provide either outpatient or inpatient care in an institutional setting must comply with all legislation, by-laws and rules established by the institution. For members who provide care in an institutional setting:
- 2.4.1. where this Standard imposes requirements more onerous than those of the institution, then the more onerous requirements in this Standard must be followed, and
- 2.4.2. where this Standard imposes requirements less onerous than those of the institution, then the more onerous institutional requirements must be followed.

PHIA

2.5. It is a professional obligation that members be aware of, keep current with, and comply with PHIA's requirements for the collection, use and disclosure of personal health information.[2]

[2] Manitoba Health, Seniors and Active Living provides useful and comprehensive information and resources, including educational and training materials and templates, on its website: https://www.gov.mb.ca/health/phia/

Record of Appointments for Non-Emergency Department Outpatient care

2.6. While not part of an individual patient's patient record, members must create and maintain a record of appointments for their practice in accordance with section 10 of the **Standards Regulation**, which states:[3]

> *A member must keep a record of [their] appointments with patients and those persons seeking medical care indicating, for each day, the names of persons seen and patients for whom medical care was provided.*

Patient identification and contact information

2.7. Members must ensure that both patient identification and reliable contact information are captured in the patient record:
- 2.7.1. Standard identifiers, including the patient's full name, date of birth, MH#[4], PHIN number, and administrative sex designation or gender (i.e., the one that matches MH#) must be collected and documented.
  - 2.7.1.i. If not available, the reason must be documented.
- 2.7.2. Standard contact information, including the patient's name, telephone number, address, must be collected and documented.
  - 2.7.2.i. If not available, the reason must be documented.
  - 2.7.2.ii. Secondary options for contact information may include an email address or contact information of an agreed upon intermediary.
- 2.7.3. An emergency contact person should be documented and kept current.

Accuracy and completeness

2.8. Members must maintain accurate, up-to-date, and complete patient records. This requires that they:
- 2.8.1. create entries contemporaneous with any care provided to a patient or as soon as reasonably possible thereafter, and
- 2.8.2. clearly indicate sources of information when it is not provided directly by the patient to the member or is not otherwise obvious by virtue of the nature of the information.

2.9. In creating an entry, the use of templates or macros carries substantial risk that information not relevant to the specific patient's actual clinical circumstance or the specific encounter may inadvertently be included in the patient record, rendering the entry unreliable or inaccurate. For this reason:
- 2.9.1. Templates or macros prepopulated with clinical information should be avoided.

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[3] **Note:** For clarity, this includes keeping a record of virtual visits.
[4] **Note:** It is acknowledged that not every patient will have an MH# (i.e., Manitoba Health No.).

2.9.2. Members who use templates or macros must review them and ensure that the content accurately and comprehensively reflects the care given.

2.10. Members must not copy and paste an entry related to a prior visit with a patient unless the copied entry is modified to remove outdated information and include current information which reflects the actual circumstances the visit entry is meant to reflect.

2.11. Members must avoid the use of abbreviations that are:

2.11.1. peculiar to only the person creating the entry such as to be confusing or unknown to other readers,

2.11.2. known to have more than one meaning in a clinical setting, or

2.11.3. that are otherwise not commonly used or understood in the member's area of practice.

2.12. Members must take care to ensure that any documentation made in the patient record used for the purpose of remuneration faithfully represents the care provided. Diagnoses entered for the purpose of remuneration are used for public health surveillance, policy decisions and research, thus this Standard mandates that care should be taken to ensure all patient record entries accurately reflect the care provided during an encounter.

Communication with patient

2.13. Members must include in the patient record (e.g., through document scanning, file upload, or other means such as a written description) details of all communication with patients related to care provided by the member that occur outside a typical member-patient encounter[5] via telephone, or other digital means (e.g., e-mail, patient portals or other digital platforms), including the mode of communication. Members are exempt from this requirement when all the following factors are met:

2.13.1. the communication is brief, unscheduled and outside a typical member-patient encounter,

2.13.2. the patient record is not readily accessible, and

2.13.3. the member, using good clinical judgment, determines documentation of the communication is not necessary respecting ongoing care.[6]

[5] See CPSM's Virtual Medicine Standard for virtual visits.

[6] **Note:** Even if an exemption applies, it may be considered prudent for medico-legal reasons for a member to complete their own documentation, concerning which the member would be required to ensure is maintained in accordance with PHIA and the Maintenance of Patient Records Standard.

Organization and intelligibility

2.14. Documentation in the medical record must be understandable, legible, and organized in an appropriate chronological and systematic manner.

2.15. Documentation in patient records must be in English.[7]

Date and time of entries

2.16. Members must ensure that each entry in a patient record is dated and, when appropriate, timed. Members need not personally enter the date or time when that is already done by a digital system. If an entry is not made contemporaneous with the medical care given (i.e., the entry is made significantly later), then the member must clearly indicate as part of the entry:
- 2.16.1. the date and time for both the patient encounter and for the entry, and
- 2.16.2. indication that the entry is a late entry.

Alterations and Corrections

Alteration

2.17. Original entries in patient records must not be altered after the entry is made.
- 2.17.1. Where it is necessary to correct inaccurate, incomplete, or otherwise misleading information in the patient record, the member must date and sign off on the additions or modifications and either:
  - 2.17.1.i. maintain the incorrect information in the patient record, which may be automatically done digitally, clearly label the information as incorrect, and ensure the information remains legible (e.g., by striking through incorrect information with a single line), or
  - 2.17.1.ii. remove and store the incorrect information separately and ensure there is a notation in the patient record that allows for the incorrect information to be traced and readily accessible during the retention period of the patient record.
- 2.17.2. As an exception to 2.16.1., members may correct incorrectly transcribed words while finalizing a dictation without the need to create a new entry.

Corrections at patient's request

2.18. Members are expected to take reasonable measures to notify patients in their professional practice about their access and privacy rights and about their right to request a correction to the personal health information contained in their patient

[7] **Note:** This does not prohibit members from recording comments from the patient made in another language, though a translation must be provided when this occurs.

record.[8] Members must comply with section 12 of PHIA[9, 10] respecting the patient's right to request a correction in a patient record.

<u>Notice of alternation or correction to other health care providers</u>

2.19. In all cases where alterations or corrections are made, members must consider whether to notify any health care providers involved in the patient's care, particularly when the alternation or correction would have an impact on treatment decisions. Respecting corrections, specifically at the patient's request, subsection 12(5) of PHIA requires that:

> *When a trustee makes a correction or adds a statement of disagreement under this section, the trustee shall, when practicable, notify any other trustee or person to whom the personal health information has been disclosed during the year before the correction was requested about the correction or statement of disagreement. A trustee who receives such a notice shall make the correction or add the statement of disagreement to any record of that personal health information that the trustee maintains.*

Documentation of care provided by member via another health care professional

2.20. Medical advice concerning the care of a patient that is communicated to another health care professional (i.e., another member or other health care professional such as a nurse or EMT), in-person or virtually, is considered care in respect to the patient and must be documented in accordance with this Standard (e.g., a consult while on call), even where providing the advice does not involve direct physical contact with the patient at the time it is provided (i.e., close physical proximity). Notwithstanding, members are exempt from this requirement in the following circumstances: [11]

2.20.1. The health care professional receiving the advice is being supervised by the member or acting under their delegation, including respecting documentation of care, and the member is already considered responsible for the documentation of that health care professional.

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[8] **Note:** This can be done by way of a poster or brochure. See section 9.1 of PHIA. Manitoba Health, Seniors and Active Living has created a poster which will adequately meet this requirement when posted on a medical clinic's website and at its physical location. The poster is available at: https://www.gov.mb.ca/health/phia/docs/access_privacy_rights.pdf

[9] See *The Personal Health Information Act*, CCSM c. P33.5, at subsections 12(1) – 12(6)

[10] Helpful information about what is required when a patient requests a correction is contained in the 'PHIA Policy and Procedure Requirements' document published on the Manitoba Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html

[11] **Note:** Even if an exemption applies, it may be considered prudent for billing or medico-legal reasons for a member to complete their own documentation, concerning which the member would be required to ensure is maintained in accordance with PHIA and the Maintenance of Patient Records Standard.

2.20.2. The member is practicing in an institutional setting, including on-call service for a department or emergency medical services, and communicates medical advice, in-person or virtually, to another health care professional (e.g., a consultation) respecting the care of a patient who the member is not in direct physical contact with at the time the advice is being given. In this situation, the member must follow applicable institutional rules and bylaws for documentation of the discussion and the medical advice given.

2.20.3. The member is practicing in a non-institutional setting (e.g., group call for a private clinic) and communicates medical advice concerning the care of a patient to another health care professional (e.g., a consultation), in-person or virtually, and following factors are met in the clinical circumstance:

- 2.20.3.i. the member is not in direct physical contact with the patient,
- 2.20.3.ii. the member providing the advice does not have immediate or reasonable access to the relevant patient record being created by the health care professional providing direct patient care,
- 2.20.3.iii. there is no reasonable expectation by the health care professional seeking the advice that the member providing the advice will document the conversation, and
- 2.20.3.iv. the member can reasonably satisfy themselves that the health care professional seeking the advice is documenting the conversation, including information provided, issues raised, and advice given.

2.20.4. For clarity, whenever documentation of medical advice is required (i.e., no exemption applies under this section):

- 2.20.4.i. the patient record must be maintained in compliance with PHIA and CPSM's Maintenance of Patient Records Standard, and
- 2.20.4.ii. best efforts must be made to ensure a copy of the record created forms part of the main patient record created by the person or persons providing direct patient care.

3. REQUIREMENTS SPECIFIC TO NON-EMERGENCY DEPARTMENT OUTPATIENT CARE

Part 3 of this Standard sets out requirements for patient records for all Non-Emergency Department Outpatient care, which is most often provided in a medical clinic setting. For greater certainty, use of the term outpatient in this part (i.e., Part 3) includes care provided in an outpatient clinic within an institutional setting. Specific requirements for emergency care in an institutional emergency department or urgent care department are dealt with at Part 4 of this Standard along with documentation requirements for inpatient care.

Documentation of expectation of ongoing care

3.1. Appropriately documenting the provision of outpatient care will often depend on the nature of the professional relationship that the member has with the patient and the

care the patient reasonably expects from the member, including expectations for longitudinal care. In this respect, members must:

3.1.1. ascertain the nature of the relationship, including whether there is a reasonable expectation they will continue to see the patient,[12] and

3.1.2. ensure the patient record reflects whether the member or the member's clinic[13] are considered the patient's usual primary care provider, or, if not, if the patient has a primary care provider and the name of that provider.[14]

Components of a complete patient record

3.2. For non-emergency department outpatient medical care, the patient record should contain the following components as applicable:

3.2.1. Cumulative summary of care when required (see below at paragraph 3.4)
3.2.2. Encounter notes, for consultants this may be the consultant's report(s)
3.2.3. Referral letters and consultant reports
3.2.4. Copy of requisitions (e.g., labs, diagnostics)
3.2.5. Lab and imaging reports
3.2.6. Pathology reports
3.2.7. Hospital (e.g., inpatient admission) and discharge summaries, including ER reports
3.2.8. Surgical and procedural reports
3.2.9. Intraoffice communications relevant to patient care
3.2.10. Insurance and third-party related forms (e.g., WCB, MPI, disability, etc.)
3.2.11. Other reports or documents as appropriate

Encounter note principles

3.3. All members must document, or already have in the patient record, the following for all outpatient encounters, including respecting acute or episodic care:

3.3.1. In the encounter is not in-person, the mode of communication (e.g., telephone).

3.3.2. A focused subjective history, including as indicated:

3.3.2.i. a history of the presenting complaint,
3.3.2.ii. appropriate social history and risk factors,
3.3.2.iii. pertinent family medical history,
3.3.2.iv. allergies,
3.3.2.v. active problem list,

[12] **Note:** This may be implied or self-evident depending upon the circumstances.

[13] **Note:** When a patient attends repeatedly and consistently at the same medical clinic, then they are presumed to be receiving their primary health care from that clinic. The members at the clinic who have seen the patient become collectively responsible for offering the patient longitudinal medical care, subject to CPSM's **Practice Management Standard**.

[14] See CPSM's **Good Care Standard** respecting required communication with the patient.

3.3.2.vi. active medications,
3.3.2.vii. an appropriate review of systems, and
3.3.2.viii. any other areas as appropriate in the clinical circumstance.

3.3.3. Relevant objective examination, including adequate positive and negative findings from focused physical examination.

3.3.4. An appropriate assessment, including notation of tentative, differential, working or established diagnosis or diagnoses.

3.3.5. Adequate information about the plan, including the following as applicable:

3.3.5.i. all tests or investigations requisitioned, including a copy of the requisition, and any associated reports and results (e.g., laboratory, diagnostic, pathology),

3.3.5.ii. adequate information about referrals to and consultation and collaboration with other health care providers,

3.3.5.iii. adequate information about the management plan for the patient such that it can be understood by another member, including respecting actions taken based on examination(s) or investigation(s) and plans for follow up,

3.3.5.iv. any prescriptions issued, rationale for the prescription and plan for management of same, and

3.3.5.v. adequate information about any treatment or therapy provided, including procedural records, and the patient's response and outcomes.

3.3.6. Any treatments, investigations, or referrals that have been declined or deferred and the reason, if any, given by the patient, and discussion of the risks.

3.3.7. Significant discussions with the patient pertinent to their care, including advice given to the patient respecting any of the above.

3.3.8. Any other areas as appropriate in the clinical circumstance.

Cumulative summary of care

3.4. Members should always maintain an up-to-date cumulative summary of care when doing so reasonably contributes to quality medical care (e.g., summary cover sheet or section in written chart, or EMR summary of care). A cumulative summary of care is required as part of the patient record if one or more of the following apply:

3.4.1. the member is the patient's usual primary care provider,

3.4.2. the patient has attended the member repeatedly and consistently, irrespective of whether one or more of the individual encounters may be considered acute or episodic, or

3.4.3. the patient has repeatedly and consistently attended the practice setting (e.g., medical clinic) where the member practices for outpatient medical care either from the member or another member with whom the member practices in association (e.g., a group medical practice). In this context, all members at the

practice setting who see the patient are collectively responsible for populating the cumulative summary of care over time.

3.5. A cumulative summary of care must include the following when the information is available and relevant (i.e., components required will be what is appropriate to the care needs of the patient and dependent upon the member's professional practice):
  3.5.1. Past medical history
  3.5.2. Problem List (e.g., ongoing health conditions, chronic disease, diagnoses)
  3.5.3. Surgical history
  3.5.4. Medications
  3.5.5. Allergies and significant or worrisome drug reactions
  3.5.6. Social history, including risk factors that impact health status
  3.5.7. Family history

4. REQUIREMENTS SPECIFIC TO INPATIENT AND EMERGENCY CARE

Part 4 of this Standard sets out the requirements for institutional associated inpatient care provided by a member and extends to care provided in an emergency department or urgent care department setting regardless of whether the patient is formally admitted as an inpatient at the institution. It is emphasized the requirements in Part 2, above, apply to these settings.

4.1. Members must recognize that record keeping in an institutional setting is usually multidisciplinary and team-based and must document care accordingly.

4.2. Members must always be aware of their role and responsibilities respecting the continuing care of their patients and document any transfer of responsibility for continuity of care, including in compliance with CPSM's Collaborative Care Standard (i.e., Institutional Settings - Transfer of Care).

4.3. The member responsible for the care of an inpatient must complete an appropriately comprehensive discharge summary in a timely manner consistent with the requirements of the institution.

4.4. Where a patient who has been seen by a member in an emergency department setting or has been admitted as an inpatient departs the institution against medical advice, the member responsible for continuing care must document:
  4.4.1. that the patient left against medical advice,
  4.4.2. the advice given to the patient prior to their leaving, if any, and
  4.4.3. the reasons for departure, if known.