Standard of Practice

Patient Records

Initial Approval: January 1, 2019 **Effective Date: January 1, 2019**

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.

Additional Requirements for Patient Records

This Part sets out requirements for patient records in addition to those described in Sections 10 and 11 of the Regulation which are as follows:

Record of Appointments

10(1) A member must keep a record of his or her appointments with patients and those persons seeking medical care indicating, for each day, the names persons seen and patients for whom medical care was provided.

10(2) The record of appointments must be retained by the member, or another member who has possession of them, for at least 10 years after the date the record was made.

Patient records

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.

11(3) A patient record must be retained by the member having last custody of the record for at least 10 years after the date of the last entry on the record, and patient records of minors must be retained for at least 10 years after the date the minor becomes 18 years old.

11(4) For greater certainty a member who provides medical care by virtual medicine must comply with this section.

11(5) A member must retain control of all his or her patient records unless they are maintained by:

(a) another member; or

(b) by a person or an organization that employed, engaged or granted privileges to a member and is a trustee under The Personal Health Information Act.

11(6) The obligations under this section are in addition to any other requirements relating to patient records under the Act, The Personal Health Information Act, and any other enactment, by-law, standard of practice, code of ethics and practice direction with which a member must comply.

1. Record Content

1.1. A patient record must contain or provide the following information:

1.1.1. patient demographic information including:

1.1.1.i. full name as it appears on the patient's health insurance registration card;

1.1.1.ii. current address;

1.1.1.iii. personal health identification number or other unique identifier;

1.1.1.iv. date of birth;

1.1.1.v. telephone number and any alternative telephone contact numbers; and

1.1.1.vi. next of kin.

1.1.2. all dates the patient was seen or was in communication with the member and the identity of the member attending the patient on those dates.

1.1.3. patient clinical information including:

1.1.3.i. documentation of presenting complaints and relevant functional inquiry;

1.1.3.ii. significant prior history/active problem list;

1.1.3.iii. current medications, allergies and drug sensitivity, where relevant;

1.1.3.iv. relevant social history including alcohol or drug use or abuse;

1.1.3.v. relevant family history;

1.1.3.vi. findings on physical examination, including relevant abnormalities or their absence;

1.1.3.vii. diagnoses (tentative, differential or established);

1.1.3.viii. treatment advised and provided, including medication prescribed;

1.1.3.ix. if a prescription is issued:

1.1.3.ix.1. the name of the medication;

1.1.3.ix.2. the dose of medication to be taken at each administration;

1.1.3.ix.3. the frequency that medication is to be taken or administered;

1.1.3.ix.4. the duration of the period for which the patient is to take the medication;

1.1.3.ix.5. whether or not refills have been issued or approved;

1.1.3.ix.6. significant prior history/active problem list;

1.1.3.x. investigations ordered and results obtained;

1.1.3.xi. instructions, precautions and advice to the patient, including instructions for follow-up;

1.1.3.xii. responses of the patient to the advice given, if refused;

1.1.3.xiii. reports received or sent in regard to the patient's medical care;

1.1.3.xiv. particulars of any sample medication provided to the patient.

1.1.4. the following reports and information:

1.1.4.i. laboratory and imaging reports;

1.1.4.ii. pathology reports;

1.1.4.iii. letters of referral and consultation reports;

1.1.4.iv. hospital summaries;

1.1.4.v. surgical notes.

1.1.5. on the referring member's record a summary of any telephone consultation between two members with respect to a specific patient, and on the consultant's record, enough information to validate that the consult occurred.

1.2. A member who uses templates in a patient record must modify the content to reflect the actual circumstances of a patient encounter.

1.3. A member must not copy and paste the note of a prior visit by the patient unless the entry is modified to reflect the actual circumstances of the later visit.

1.4. Whether in paper or electronic form, the record must be legible, accessible to ensure continuity of care, and in English.

2. Alteration of Records

2.1. Original patient records must not be altered after an entry is made. If any change, addition or deletion to a patient record is required, the original entry must be identifiable and legible and the identity of the person making the change, addition or deletion to the record and the date of the change, addition or deletion must be clearly set out. All of the entries must be readily accessible to any person reviewing or auditing the record.

3. Record Security

3.1.A member must maintain safeguards to protect confidentiality and to protect against reasonably anticipated threats to the security, integrity, loss, or unauthorized use, disclosure, modification or unauthorized access to personal health information.

4. Ownership of Records

4.1. Members in group medical practice must determine the ownership of patient records within that practice so that:

4.1.1. if a member or members leave the practice, ownership of the patient records will be clear to all members in the practice and to the patients;

4.1.2. departing members and their patients have reasonable access to patient records.

4.2. If a member works as a physician for a facility owned by the federal or provincial government or for a company, the member is not required to be the owner of the patient records.

4.3. If a member practices in an office within a provincial health authority facility and the ownership of the patient record is not clear, the member must negotiate an information sharing agreement that includes rules about access to and custody of patient records.

4.4. A member who works in a practice described in subsection 2 or 3 is expected to fulfill all obligations respecting the completion of patient records, the maintenance of security of patient records and the confidentiality of information contained in patient records even if the member does not own the patient record.

5. Access to or Copy of Record

5.1. While a member may be the owner or custodian, or both, of a patient record, the patient whose information is contained in that record owns the information. On the request of a patient, subject to the limitations set out in *The Personal Health Information Act*, the member must:

5.1.1. allow the patient to inspect the patient record;

5.1.2. provide to the patient a copy of the patient record.

5.2. A member may charge a fee as permitted by *The Personal Health Information Act* for a patient's request for access to or a copy of his or her record, unless the member terminated an individual patient from an ongoing practice, in which case no fee may be charged. This exception does not prohibit a member from charging a fee to patients when the member is closing, leaving or moving a medical practice.

6. Discharge Summary

6.1. The member responsible for the care of a patient in a hospital or health care facility must complete a discharge summary in a timely manner consistent with the policies of the institution.

7. Electronic Records

7.1. The same standards apply to electronic records as apply to paper records.

7.2. Electronic medical records must have comprehensive audit capability, including a system which enters all access onto a permanent file log, identifying and recording where the access originated and by whom, and if alterations are made to the record, identifying whom, what was altered, and when the alteration was made.

8. Virtual medicine

8.1. For greater certainty, a member who provides medical care by virtual medicine must comply with the requirements in the regulation and these standards of practice for patient records.

9. Additional Obligations

9.1. The obligations in these standards of practice respecting patient records are in addition to any other requirements relating to patient records under *the Act, The Personal Health Information Act,* and any other enactment, regulation, by-law, standard of practice or code of ethics with which a member must comply.

9.2. A member attending a patient at a hospital shall complete the medical records for which that member is responsible in accordance with the requirements of by-laws of the hospital.

10. Transfer of Patient Records

10.1. If a patient or his or her representative requests a member to transfer patient records to another member, the requested member must ensure that the request is completed promptly as required in the circumstances but no later than 30 days after the member receives the request.

10.2. A member may charge a reasonable fee in respect of a transfer in accordance with any applicable privacy or other legislation.

10.3. A member must not charge another health care provider for the exchange of limited patient information such as a copy of a discharge summary.