Standards of Practice

Records

STANDARD:

The member shall ensure that documentation is clear and accurate, satisfying optimum patient care and legal requirements.

CRITERIA:

Patient Health Record

The patient health record must include the following:*

1) The patient's name and address.
2) The date of each of the patient's visits to the member.
3) The name and address of the primary care physician and any referring health professional.
4) A history of the patient.
5) Reasonable information about every examination performed by the member and reasonable information about every clinical finding, diagnosis and assessment made by the member.
6) Reasonable information about every order made by the member for examinations, tests, consultations or treatments to be performed by any other person.
7) Every written report received by the member with respect to examinations, tests, consultations or treatments performed by other health professionals..
8) Reasonable information about all significant advice given by the member and every pre and post-operative instruction given by the member.
9) Reasonable information about every post-operative visit..
10) Reasonable information about every controlled act, within the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991 performed by the member.
11) Reasonable information about every delegation of a controlled act witin the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991, delegated by the member.
12) Reasonable information about every referral of the patient by the member to another health professional, service or agency.
13) Any pertinent reasons a patient may give for cancelling an appointment.
14) Reasonable information about every procedure that was commenced but not completed, including reasons for the non-completion.
15) A copy of every written consent.
    (*see Records regulation)
16) The patient health record card number must be obtained, recorded and verified where applicable.
17) Any radiographs taken by or on behalf of the member.

In addition, the patient record shall:

a) Include complete and up to date information.
b) Be legible.
c) Be written in permanent ink.
d) Have all corrections initialled.
e) Use a clear and logical format.
f) Have a glossary available if abbreviations are used.
g) Be secured and kept together.
h) Be recorded at the time or within 24 hours.
i) Identify the author.
j) Conform to the institutional policies where applicable.
k) Conform to the requirements set out in the Records regulation under the Chiropody Act 1991.

Each part of the health record must have a reference identifying the patient or the patient health record.

Daily appointment record
The daily appointment record must include the following:

1) The name of each patient
2) The date and time the patient attended the appointment

Institutional records
The records of the institution must:

1) Include particulars of every order, medication prescribed, treatments, consultations and referrals
2) Include a financial record if applicable
3) Comply with the legislation and standards of practice outlined regardless of where the treatment was rendered

Financial record
The financial record must contain:

1) Name and address of the patient
2) Health record card number of the patient
3) Date the service was rendered
4) Fees charged to and received from or on behalf of the patient
5) Daily appointment record or day sheet giving name and financial details for each day

Equipment record

(Please see Safety and the Practice Environment 3 and Records regulation 15)

Confidentiality

1) Information contained in the health record is confidential
2) Records may only be released to persons authorized under section 18 of the Records regulation.

Storage and destruction

Records must be stored and destroyed in accordance with current legislation and:

1) Be retained for at least ten years in the following circumstances:
   a. after the patient's last visit or,
   b. if the patient was less than 18 years old at the time of the last visit, the day the patient became, or would have become, 18 years old.
2) Be retained for at least 7 years after a patient is deceased
3) Stored securely.
4) Destroyed in a manner that ensures confidentiality.

Resignation of a member

Before resigning or ceasing to reside in Ontario, a member must ensure that for each patient health record for which the member has primary responsibility,

1) The record is transferred to another member, or
2) The patient is notified of the resignation and that the patient can obtain copies from the patient health record.

COMPUTERIZED RECORDS

STANDARD:

Computerized health information is subject to the same security and requirements as written information.

CRITERIA:

The following must be observed with respect to computerized records:

1) Data shall be protected so that it cannot be altered or purged without proper authority.
2) Principles of documentation of health information shall be adhered to in order that the computer charting meets legal and professional standards.
3) There will be locked and controlled access to computer facilities.
4) Health facilities' policies and procedures for access to written information must serve as minimum standards for computerized information.
5) Controls and audits shall be in place to assure integrity of the data.
6) Backup copies of files are to be stored in a physically separate and secure area.

7) Legislation regarding computerized health information shall be routinely monitored.
8) Policies shall be developed for the control of retention and destruction of computerized information.
9) Health information recorded or stored by electronic methods or tapes, disks or cassettes, shall be destroyed by erasing.

Note.

It is recognized that a computerized system can be as secure as a paper system and should allow relative ease of use for authorized personnel, while eliminating unauthorized access.

The issue of confidentiality should not be used as a barrier to the implementation of computerized information systems.

FAXING OF HEALTH INFORMATION

STANDARD:

The member shall ensure that when faxing health information confidentiality is maintained.

CRITERIA:

1) The individual's right to privacy must be recognized.
2) The transmitter of the information shall be responsible for ensuring the security of the health information transmitted.
3) Authorization to transmit health information by fax is subject to the same conditions and consent requirements as information transmitted by other means.
4) Health care facilities shall establish policies and procedures specific to the transmission of health information by fax.

References:

Canadian College of Health Record Administrators

Canadian Health Record Association, Position Statement and Recommendations concerning Computerized and Faxed Health Information.

Ontario Regulation 746/94 made under the *Chiropody Act*, 1991, Part III Records.

Approved by Council February 5, 2010