RECORDS

Standards of Practice for Members of the College of Chiropodists of Ontario

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A. Introduction

The College's Standards of Practice ("Standards") are a set of expectations that assure the quality of the practice of the profession and contribute to public protection. The Standards define the expectations for the profession.

This Standard explains the regulatory expectations for documentation and record keeping. In the event of any inconsistency between this Standard and any legislation that governs the profession, including the Records regulation (Ontario Regulation 203/94 – General, Part III), the legislative requirements prevail. Members shall ensure that documentation is clear and accurate, satisfying optimum patient care and legal requirements. Members should be cognizant of the fact that they have an individual, statutory responsibility for record keeping. That obligation is found in Ontario Regulation 203/94 – a regulation under the *Chiropody Act, 1991*. This regulation requires, among other things, that a Member make appropriate records, take "all reasonable steps necessary" to ensure that records are kept and, at reasonable intervals, verify that the requisite records are being kept and in a manner that meets the regulatory requirements.

In other words, there is a legal onus on every Member to both make and maintain records in their practice and that obligation exists regardless of the Member's particular employment circumstances or arrangement with a clinic. To be clear, these statutory record keeping obligations apply to all Members regardless of the individual clinical circumstances. Consequently, it is incumbent upon every Member to understand their obligations and to explain those obligations to their employers and to clinic owners.

As addressed below, the Records regulation specifically identifies the various types of records that a Member must keep, including: (i) a daily appointment record that sets out the name of each patient whom the Member examines or treats or to whom the Member renders any service; (ii) an equipment service record that sets out the servicing for every potentially hazardous piece of equipment used to examine, treat or render any service to patients; and, (iii) a financial record.

Consequently, among other conduct, failing to keep and retain records as required by the Standard, falsifying a record, signing or issuing a document that contains a false or misleading statement, collecting, using, and disclosing information without patient consent, and failing to make arrangements for the timely transfer of a patient's record when required all constitute professional misconduct under the *Chiropody Act, 1991* and may result in College discipline proceedings.

Members shall maintain records in a manner that ensures that an investigator, assessor, or representative of the College who is authorized under the *Regulated Health Professions Act, 1991* ("Act") has access to the records. It is professional misconduct to fail to keep records or to refuse to allow an authorized representative of the College to enter during business hours any premises in which the Member carries on the practice of chiropody for the purpose of inspecting the Member's practice, records and equipment or for any other purpose authorized by the Act or a regulation under the Act.

B. Patient Health Record

Members shall be personally responsible for all things recorded in relation to a patient, including all treatments, orders, advice and referrals and the Member responsible and the author of the record should both be identified in the record.

The patient health record must include the following:

1) The patient's name, address and date of birth.

2) The date of each of the patient's visits to the Member, including the date and purpose of each contact with the patient and whether the contact was made in person, by telephone, text or electronically.

3) The name and address of the primary care physician and any referring health professional.

4) A health history of the patient, and any other relevant issues concerning the patient, including family and social history when indicated. A notation of the patient's refusal to provide some or all the information.

5) Reasonable information about every examination performed by the Member and reasonable information about every clinical finding, diagnosis, assessment, treatment made/performed 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, and the identity of the person who gave the advice if that person was not 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 within 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) Reasonable information regarding refusal or withdrawal of treatment, including the reason(s) for the refusal or withdrawal of consent to treatment.

16) A copy of every written consent.

17) A report of any adverse outcome relating to the provision of health care services to the patient by the Member, including any injury to the patient, the Member or any person assisting the Member.

18) The patient health record card number must be obtained, recorded and verified where applicable (podiatry class).

19) 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 or typewritten or be in an acceptable electronic format and "locked" on the date to which it is attributed.

d) Be chronological (i.e. events are recorded in the order that they occurred), with documents consecutively numbered and dated.

e) Corrections to the patient chart are acceptable but must clearly be indicated as such, and dated and initialed. Corrections are only to be in the form of additions and not erasure or overwriting. At all times the original entry must be available and legible. A patient's chart is never to be rewritten.

f) Use a clear and logical format. Members can use their discretion and make their own decisions regarding the format, organization or style of the record (e.g. use of SOAP, DAR, FOCUS or other method); however, records must follow a consistent method to ensure that all relevant information is included.

g) Have a glossary available if abbreviations are used.

h) Be secured and kept together.

i) Be recorded at the time or within 24 hours.

j) Identify the author, especially if it is not the Member. All entries should be signed, initialed or otherwise attributable to the treating Member and include the identity of the person who made or dictated the entry.

k) Conform to the institutional policies where applicable.

l) Conform to the requirements set out in the Records regulation under the *Chiropody Act, 1991*.

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

n) Be written in French or English.

C. 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.

D. 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.

E. Financial Record

Members shall maintain a financial record for each patient that contains the following information regardless of whether the Member bills the patient directly for professional products or services provided to the patient or bills a third party.

The financial record must contain:

1) Name and address of the patient, name of the Member, registration number, and the person who provided the professional product or service if it was not the Member.

2) Health record card number of the patient (podiatry class).

3) Date that the service or product was provided.

4) Fees of the product or service charged to and received from or on behalf of the patient, as well as any refund/reimbursement.

5) Daily appointment record or day sheet giving name and financial details for each day.

F. Equipment Record

It shall be the responsibility of each Member to ensure that the practice site be equipped and maintained, and that procedures are in place, to assure health and safety for both patients and staff. The Member must follow the requirements in the Safety and the Practice Environment Standard and section 15 of Ontario Regulation 203/94, including:

1) Every Member shall maintain an equipment service record that contains servicing information, including the date of every service, for any instrument or equipment that requires servicing and that is used by the Member in the practice of the profession.

2) Every Member shall retain each equipment service record for 10 years from the date of the last servicing entry relating to the instrument or equipment.

The premises must be in current compliance with any provincial and municipal requirements including the requirements of the *Occupational Health and Safety Act* and any regulations applicable to the practice environment and the *Healing Arts Radiation Protection Act*.

G. Confidentiality

Respect for each patient's privacy is critically important. Privacy legislation exists at both the federal and provincial level to guide patients and health care professionals in the handling of a patient's personal and confidential information. At the federal level, the Office of the Privacy Commissioner (OPC) of Canada oversees compliance with the *Personal Information Protection and Electronic Documents Act* (PIPEDA). At the provincial level, the Information and Privacy Commissioner of Ontario oversees the *Personal Health Information Protection Act, 2004* (PHIPA), which governs the collection, use and disclosure of personal health information within the healthcare system. PHIPA establishes rules about how government organizations and health information custodians may collect, use, and disclose personal data. PHIPA also establishes a right of access that enables individuals to request their own personal information and have it corrected if necessary.

Members should contact the College for directions if they are unsure about their obligations with respect to the confidentiality, privacy, and security of patient information and records. With respect to all aspects of their practice, Members should recognize the following:

1) Information contained in the health record is confidential.

2) Members shall not disclose patient information to anyone or allow any person to examine a record of personal health information or give any information or copy from a record of personal health information to any person except as required by law – see sections 38-50 of PHIPA, or as required or allowed to persons authorized under section 18 of the Ontario Regulation 203/94.

A Member may charge a reasonable fee prior to providing copies of a record of personal health information, including diagnostic images and accompanying reports, to reflect the cost, time and effort required to provide copies of the record of personal health information.

H. Storage and Destruction

Every patient record shall:

1) Be retained for at least 10 years following (a) the patient's last visit; or (b) if the patient was less than 18 years old at the time of his or her last visit, the day the patient became or would have become 18 years old.

2) Be retained for at least seven years after a patient is deceased.

3) Be stored securely.

4) Be destroyed in a manner that ensures confidentiality.

Destruction of the record of personal health information shall be done in a secure fashion to ensure that the records cannot be reproduced or identified in any form. Members must ensure all information is permanently destroyed or erased in an irreversible manner making sure the record cannot be reconstructed in any way. Members must maintain a copy of the destruction date and the names of the individuals whose records were destroyed and seek consultation on the secure destruction of multi-media and computer files from a field expert.

I. Discontinuation of Services by a Member

If a Member intends to discontinue their services (e.g. resign, retire, close their practice, etc.) they shall do both of the following:

1) Take reasonable steps to give appropriate notice of the intended closure to each patient for whom the Member has primary responsibility.

2) Ensure that each patient's health and financial records are:

    i. transferred to the Member's successor or another Member,

    ii. retained in a secure manner, or

    iii. disposed of in a secure manner, subject to the requirements to retain the records as set out in Section H(4) of this Standard (Storage and Destruction).

For more information on the discontinuation of services by a Member, refer to the College's Discontinuation of Services Advisory.

J. Electronic Records

Electronic health information is subject to the same security and requirements as written information. A Member shall take reasonable steps to ensure the electronic record keeping system is so designed and operated that records of personal health information are secure from loss, tampering, interference or unauthorized use or access, and shall be available as hard copies in a printed form when requested.

The following must be observed with respect to electronic 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) Ensure regular off-site back-up and/or automatic back-up to be available for file recovery to protect records from loss or damage.

7) Legislation regarding computerized health information shall be routinely monitored.

8) Policies and procedures 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.

10) The Member shall ensure that personal health information of patients that is stored on a mobile device is encrypted.

11) The electronic medical records system used can confirm the system maintains an audit trail that, at a minimum, records the date and time of each entry of each patient, shows any changes in the record, and preserves the original content when a record is changed, updated or corrected.

12) If documents are scanned and maintained in an electronic form, the original paper copy is to be securely destroyed.

K. Mixed Documentation – Paper & Electronic Records

Where a combination of both paper and electronic records are used by a Member in their practice, the record management system should correspond with one another and be linked. It

should be noted somewhere within both formats that the record is made up of both paper and electronic documentation and that together these two systems constitute the comprehensive record. This ensures that both the paper and electronic formats will be provided upon request.

L. Transitioning from Paper to Electronic Records

In transitioning from paper to electronic records, information can be transferred manually or scanned into the electronic system. It is not necessary to keep duplicates of paper and electronic records, unless organizational policies dictate otherwise. Once the information is stored in an electronic format, the paper records may be destroyed in a way that preserves confidentially (refer to Section H(4) of this Standard (Storage and Destruction)).

M. Individual Logins, Audit Trails & Electronic Signatures

Multi-user electronic documentation systems should contain individual logins that clearly identify each user accessing a record. The system should also generate and maintain an audit trail to demonstrate who viewed or accessed the records, when the records were accessed and/or who completed the document entry. Many systems have electronic signatures built into the user's login for easy signing of the health care provider's name, credentials, date, and time. An electronic signature should correspond to the name under which a Member practices.

N. Electronic Communications of Personal Health Information

Members shall ensure that when using electronic communications (e.g. fax, e-mail, text) with respect to health information, patient confidentiality and privacy are maintained:

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 electronic communication 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 electronic transmission of health information.

References

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