Standard of Practice

Medical Records Documentation & Management (2023)

A **Standard of Practice** is the minimum standard of professional behavior and ethical conduct expected by the College on a specific issue.

Preamble

Medical records contain valuable information about a patient's clinical history and interactions with healthcare providers. Ensuring that a patient's medical record is complete, accurate, accessible, and securely stored contributes to the quality and continuity of medical care for the patient.

Standard of Practice

Physicians have an ethical, professional, and legal obligation to create medical records that are accurate and complete. Physicians who act as custodians of medical records must also ensure the confidentiality, appropriate access, and retention of records within their custody and control.

Content of the Medical Record

Physicians must maintain or contribute to a medical record for each patient they have assessed, treated, or provided formal consultative services. To ensure the accuracy of records and access to records by other treating healthcare providers, physicians must create records as close in time as practicable with their interaction with the patient.

Physicians must ensure that a comprehensive record, detailing each professional encounter, is recorded in their patient's medical record. This record must include:

(i) the full name and date of birth of the patient;
(ii) the full name of the patient's legal representative or substitute decision maker, if applicable;
(iii) the patient's medical care plan (MCP) number or extra-provincial healthcare plan number (if applicable);
(iv) the name of the referring healthcare provider, if applicable;
(v) the date of the professional encounter and, where relevant, the time of the encounter;
(vi) the patient's presenting concerns and relevant history;
(vii) the findings of any examinations performed or requestioned, including pertinent negatives;

(viii) any diagnosis/provisional diagnosis made;
(ix) any investigations ordered;
(x) a description of each drug or other treatment prescribed or administered, including prescribed dosage and duration;
(xi) particulars of any referral(s) made by the physician;
(xii) any medical advice given;
(xiii) any written consent forms; and
(xiv) any additional details that may be useful to future healthcare professionals who may review the medical record.

Physicians must also ensure that the following information is contained within the patient's medical record:

1. the patient's mailing address and preferred contact information;
2. the results/reports of investigations or diagnostic imaging ordered by the physician, including the date received by the physician's office, the date reviewed by the physician, and the date and manner the information was communicated to the patient; and
3. copies of electronic and paper communication with the patient, related to clinical care.

In addition to the above requirements, physicians who provide primary care to patients must also ensure the following information is included in the patient's medical records:

1. copies of consultant reports, operative reports, discharge summaries and other information created by other physicians or healthcare professionals which is relevant to the patient's medical care.

2. a cumulative patient profile, contextual to the physician-patient relationship, detailing:

    (i) current medications and treatments;
    (ii) allergies and drug reactions;
    (iii) medical history and ongoing health conditions;
    (iv) risk factors;
    (v) family medical history;
    (vi) health maintenance plans (e.g., immunizations, screening tests);
    (vii) contact person in case of emergencies; and
    (viii) date the cumulative patient profile was last updated.

3. chronic disease flow sheets, where applicable.

Altering a Medical Record

Physicians may alter a medical record to ensure its accuracy and completeness. Where it is necessary to alter a medical record, physicians must clearly identify the alteration and the date the alteration was made.

When removing incorrect information from a record:

1. the original record must be clearly labeled as incorrect; and
2. the date the record was altered must be clearly indicated.

When adding new information to a record:

1. the new information must be clearly identified as an addition to the original record; and
2. the date the record was altered must be clearly indicated.

In circumstances where a patient requests a correction to their medical record, physicians are expected to comply with the requirements set out in the *Personal Health Information Act*.

Responsibilities of Custodians of Medical Records

While the information contained within a medical record belongs to the patient, the person or organization responsible for the creation and overall management of the record is considered the *custodian.*

Physicians who act as custodians of paper or electronic medical records are responsible for ensuring that they are maintained, stored, transferred, retained, and destroyed in accordance with this Standard of Practice and the requirements set out in the *Personal Health Information Act.*

The following expectations apply to **physicians who act as custodians of medical records:**

Establishing Custodianship and Accountabilities

Physicians who create medical records in a private practice where there are multiple contributors to the record (e.g. a shared practice or interdisciplinary practice) must have a written data-sharing agreement in place to address the issues of defining the custodian of the record and determining how access to the records and transfer of custodianship can occur.

Data-sharing agreements must address the following issues:

1. custody and control of medical records, including upon termination of employment or the practice arrangement;

2. privacy, security, storage, retention, and destruction of records; and
3. enduring access for themselves and their patients.

Storage and Security

Physicians must ensure that medical records are stored in a safe and secure environment which ensures their confidentiality. This includes taking reasonable steps to protect records from theft or loss and restricting access to authorized persons. Record management protocols must be in place to regulate who can gain access to the medical record and what they can do, according to their role and responsibilities.

For electronic medical record systems, physicians must ensure that each authorized user has a unique ID and password. Physicians must not share their unique credentials and password for electronic medical record keeping systems.

Physicians must ensure that all individuals who have access to the medical record are bound by appropriate confidentiality agreements and are educated on the relevant subsections of the *Personal Health Information Act.*

A physician continues to be responsible to ensure that medical records are kept in accordance with this Standard of Practice, even if the physician has retired, discontinued, or changed their practice, or ended the physician-patient relationship.

Providing Access

Patients own the information contained in their medical records. Physicians are expected to provide patients and authorized parties with access to, or copies of, all the medical records in their custody or control in accordance with the requirements of the *Personal Health Information Act.*

Physicians may charge patients or third parties a fee for professional or administrative services relating to access and transfer of medical records in accordance with the College's Practice Guideline on Uninsured Services.

Electronic Medical Records

Physicians may make, convert to, or retain medical records using an electronic medical records system, provided that the system has the following characteristics:

1. the system can print the recorded information;

2. the system maintains an audit trail that:

    (i) records the user identification of the person who accesses the information;

(ii) records the date and time of each entry of information for each patient;
(iii) indicates any changes in the recorded information;
(iv) preserves the original content of the recorded information when changed or updated;
(v) can be printed separately from the recorded information for each patient; and
(vi) retains a description of the information that is accessed.

3. the system includes, at a minimum, password management and access controls and provides other reasonable protections, including:

(i) the system automatically backs up files and allows the recovery of backed-up files or otherwise provides reasonable protection against loss of information;
(ii) the system has data protection functionality, which includes virus protection and encryption; and
(iii) all transfer of information from the system is done through secure communications.

Retention Period

Physicians must ensure that medical records are retained for a minimum of:

- **For Adult Patients:** 10 years following the date of last entry into the record**.**
- **For Pediatric Patients:** 10 years following the date of last entry into the record or until the patient reaches the age of 21, whichever is longest.

If a physician is aware that a medical record contains personal health information that is the subject to a request for access or has been given notice that the record may be relevant to any investigation, inquiry, or proceeding, the physician must maintain the record until the required access or transfer has been provided.

Transferring Records

A physician may transfer original medical records to another custodian or a bonded record retention facility for the purposes of secure storage, provided that:

1. a written contract is in place with the accepting custodian or record retention facility that ensures the requirements of this Standard of Practice and those outlined in the *Personal Health Information Act* will continue to be met; and

2. the physician notifies the College of the new location of the records.

In the above circumstances, the physician remains the custodian of the records.

A physician continues to act as the custodian of a medical record until such time that custody and control has passed to another person who is legally authorized to hold the record.[1] In circumstances where a physician legally transfers custody and control to a successor custodian, the physician must make reasonable efforts to notify patients of the transfer.[2]

Physicians who are closing their practice or taking an extended leave from practice are expected to comply with the College's Standard of Practice on Closing or Taking Leave from a Medical Practice.

Destruction

Following the applicable period of retention, medical records can be destroyed. When destroying medical records, physicians must ensure that the record cannot be reconstructed or retrieved.

It is only necessary to retain one medical record for the appropriate retention period. As such, if the information contained in a paper record has been fully transitioned to an electronic medical record, the paper record can be destroyed.

Acknowledgements

CPSBC (2020) Medical Record Documentation

CPSBC (2022) Medical Records Management

CPSO (2020) Medical Records Documentation

CPSO (2020) Medical Records Management

Related Documents

Personal Health Information Act, SNL2008 CHAPTER P-7.01

CPSNL (2022) Uninsured Services

CPSNL (2023) Closing or Taking Leave from a Medical Practice

CMPA (2021) Documentation and Record Keeping | CMPA Good Practices

[1] *Personal Health Information Act* SNL2008 CHAPTER P-7.01, s. 4(3)
[2] *Personal Health Information Act* SNL2008 CHAPTER P-7.01, s. 39(2)

Document History

Effective Date:	December 14, 2023
Last Revised:	December 9, 2023
Expected Review Date:	December 9, 2028