COPOM College of Podiatrists of Manitoba

Standard of Practice #1 – Patient Health Records

Originally approved September 17, 2008; Revision approved December 2 ,2017

Introduction

Clause 1.1 (a) of Schedule B to the Podiatrists Regulation (M.R. 99/2006) requires a member to *"maintain a patient health record, an appointment schedule and a financial record, in accordance with policies established by the council;"*

The intent of this standard is to set out for members, the policies established by the council respecting the expectations for record keeping in their practice.
This standard applies to both written and electronic records as appropriate.

Definitions

Patient Health Record: Consists of the patient chart, appointment record and financial records.

1. APPOINTMENT RECORDS
   Standard: The member maintains an appointment record that is accurate, legible and comprehensive.

   Performance Indicators:

   The Member maintains an appointment record that clearly and legibly identifies:
   - Member's name, clinic name, address and telephone number;
   - name of patient (minimum of last name and first initial);
   - date and time of appointment and whether the patient attended; and
   - duration of appointment.

   The Member maintains and retains appointment records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

2. PATIENT FINANCIAL RECORDS

   Standard: The member maintains a patient financial record that is accurate, legible and comprehensive.

   Performance Indicators:

The Member ensures that financial records clearly and legibly record:

- name of treating member, clinic name, address, telephone number;
- patient's name, address and telephone number;
- date of service;
- services billed;
- devices dispensed;
- payment amount and method of payment; and
- balance of account.

The Member ensures that:

- patient financial records are clearly itemized;
- fees for podiatric consultation are separated from all other fees;
- fees for injectable substances, devices, special testing, etc, are individually listed;
- receipts are issued for all payments and copies are maintained in the patient financial record.

The Member maintains and retains financial records pertaining to patients for a period of at least 10 years after the date of the last entry for the patient. in the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

3. PATIENT CHARTS

Standard: The member maintains a patient chart that is accurate, legible and comprehensive.

Performance Indicators:

In all patient charts, the Member ensures:

- all written entries are made in indelible ink;
- the patient name or patient number is recorded on each page;
- all entries are made in either English or French;
- there is no highlighter used over writing;
- all written records are clearly legible;
- there are no blank spaces between entries;
- all pages are in chronological order, consecutively numbered and dated;
- a consistent format is used for recording the date;
- all chart entries are recorded as soon as possible after the patient interaction; and
- when other than generally accepted medical abbreviations are used, a legend of abbreviations or codes is available.

The Member ensures that all records contain:

- subjective information provided by the patient or their authorized representative including:
    - the patient's name, address, telephone number and date of birth;
    - The name and address of the primary care physician and any referring health professional;
    - The patient's relevant medical history;
- relevant objective findings;
- results of any examinations including:
    - examinations, tests, consultations or treatments performed, or to be performed, by any other person or health professional'
    - every written report received by the member regarding examinations, tests, consultations or treatments performed by other health professionals;
- an assessment of the information and any diagnosis;
- proposed treatment plan, including recommendations and referrals;
- relevant communications with or about the patient;
- a copy of any prescription for shoes, orthotics etc.;
- a copy of any photographs taken of the affected area;
- relevant information obtained from re-assessment; and
- indication of who made each entry and when the entry was made.

The Member records the following information related to the delivery of treatment:

- the treatment provided;
- relevant information about every procedure that was commenced but not completed, including reasons for why the procedure was not completed;
- name and strength of all injectable substances administered;
- dosage and frequency;
- date of administration;
- method of administration; and
- how treatment was tolerated.

The member signs or initials the written record so that the treating podiatrist is clearly identified.

The member maintains and retains patient charts for a period of at least 10 years after the date of the last entry. In the case of a minor, the chart is retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

4. ELECTRONIC RECORDS

Standard: The Member ensures that electronic records are maintained and retained in a secure manner.

Performance Indicators:

The Member ensures that, when patient records are maintained in an electronic system, the following criteria are met:

- the system provides a visual display of the recorded information;
- the system provides a means of accessing the record of each patient by the patient's name;
- the system is capable of printing promptly the recorded information in chronological order for each patient;
- the system maintains an audit trail that:
    - records the date and time of each entry for each patient;
    - preserves the original content of the record if changed or updated;
    - identifies the person making each entry or amendment;
    - identifies a person accessing the recorded information; and
    - is capable of printing each patient record separately.
- the system provides reasonable protection against unauthorized or inappropriate access;
- the system backup:
    - is done once a day
    - is tested for recovery on a regular basis
    - is retrievable if the system malfunctions or is destroyed; and
- files are encrypted if they are transferred or transported outside of the facility.

The member must take appropriate measures to remedy a security breach as soon as reasonably possible after discovering any unauthorized access, use, disclosure or destruction of recorded information. Appropriate measures would include:

- recovering the information if possible;
- ensuring the security of remaining information;
- notification of affected persons and the College if the information has been lost or stolen;
- notification of law enforcement if the loss results from criminal activity (e.g. a break-in);
- modifying security measures to prevent a re-occurrence.

5. STORAGE

Standard: When storing patient charts, the Member takes reasonable measures to ensure patient confidentiality and security of patient information to prevent unauthorized access and maintain its integrity.

Performance Indicators:

The Member:

- ensures all patient charts are secured;

- ensures sensitive information is never left unattended in an unsecured location;
- stores all patient charts alphabetically or numerically, such that a specific file can be easily identified and retrieved;
- maintains a separate chart for each patient; and
- ensures, if other practitioners also see the same patient, that the Member's electronic records can be individually retrieved.

6. AMENDMENTS TO RECORDS

Standard: The Member ensures that any amendments made to a patient chart are properly documented.

Performance Indicators:

The Member ensures that:

- any amendment to a written chart is initialed, dated and indicates what change was made;
- all previous written entries remain legible;
- amendments are only to be in the form of additions or corrections and not erasure or overwriting;
- Corrections should be crossed out using one line;
- the original entry is available and legible;
- a patient chart is never re-written.

7. PRIVACY

Standard: The Member complies with *The Personal Health Information Act* (PHIA) and regulations.

Performance Indicators:

- The member is aware of and complies with the requirements under PHIA for the collection, use, disclosure and retention of personal health information;
- The member is aware of and complies with the written policies and procedures required under PHIA;
- The member acknowledges the right of a patient to have access to, and receive a copy of, his or her chart upon request.

8. RETENTION AND TRANSFER OF A RECORD

Standard: When retaining and transferring records, the Member takes reasonable measures to ensure confidentiality and security of information to prevent unauthorized access and maintain the record's integrity.

Performance Indicators:

The Member:

- maintains the original chart unless it is requested by the College for a regulatory purpose or is required for legal purposes in which case a copy is retained by the Member.
- never provides any information concerning a patient to a person other than the patient or their authorized representative(s) without the express consent of the patient, an authorized representative, or as otherwise required or authorized by law;
- may charge a reasonable fee to reflect the actual cost of reproduction, the time required to prepare the material and the direct cost of sending the material to the authorized party. The Member shall not require prepayment of this fee. Non-payment of the fee is not reason for the Member to withhold the information;
- retains and transfers records in a manner that ensures continued access by patients and the College.

The member retains patient records for at least ten (10) years following the date of the last entry in the chart. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry in the chart;

In the event of the **member's death**, the responsibility for the maintenance of the records lies with the estate, which is obliged to maintain those records as defined above. If the estate sells the practice to another member, all records are transferred to the purchasing member and who is then responsible for their maintenance.

If the **practice ceases operation**, the member either appropriately transfers or maintains the original of all patient records as described above. Patients are notified in writing as to how they can obtain access to their records.

In the event of a **sale of the practice**, all of the original records are transferred to the purchasing member who maintains those records as described above. Where feasible (in some cases by newspaper notice) patients are notified, in writing, of the practice sale so that any patient who requires it may obtain a copy of their record.

In all cases, the College is notified, in writing, of the forwarding address where the records are kept for a minimum of ten (10) years from the date of the last day of practice of the Member.

Any records that are to be **destroyed** after the minimum period of retention are destroyed by shredding, burning, overwriting software or some other method to render them illegible and irretrievable. The Member maintains a record of disposal dates and the names of patients whose records were destroyed.

9. EQUIPMENT RECORDS

Standard: The Member creates and maintains appropriate records of the purchase, maintenance and disposition of clinical equipment.

Performance Indicators:

The Member:

- records and maintains an inventory of equipment purchased or received, including date on which it was received;
- records the date and nature of service or maintenance on equipment;
- records the date of disposition of equipment;
- maintains these records for a minimum of five years or until the end of the useful life of the equipment whichever is longer.
- Removes and permanently destroys the hard drive in any equipment being sold or discarded so that the personal information or personal health information stored on the hard drive cannot be reconstructed. This applies to printers and fax machines particularly.