

Patient Records Standard 21

Issued: July 1, 2011¹

The **Standards of Practice** of the College of Physicians & Surgeons of Alberta are the minimum standard of professional behaviour and ethical conduct expected of all physicians registered in Alberta. Standards of Practice are enforceable under the *Health Professions Act* and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

- (1) In the course of providing advice or treatment to a patient, where a member has authority and control of the patient record, the member must document and retain that advice and treatment in a patient record.
- (2) In this standard, “patient record” includes paper-based and electronic formats.
- (3) In this standard, “patient record” includes the information described in subsections (4) and (5).
- (4) A patient record must contain enough information for another physician, or other regulated healthcare provider, to be sufficiently informed of the care being provided including:
 - (a) clinical notes,
 - (b) laboratory and imaging reports,
 - (c) pathology reports,
 - (d) referral letters and consultation reports,
 - (e) hospital summaries, and
 - (f) surgical notes.
- (5) In addition to subsection (4), a patient record in a medical practice must contain or provide reference to the following information, at a minimum:
 - (a) the patient's name, address, phone numbers, date of birth, gender, and personal healthcare number,
 - (b) dates seen and the identity of the physician attending the patient on those dates,
 - (c) documentation of presenting complaints and functional inquiry,
 - (d) significant prior history,
 - (e) current medications, allergies and drug sensitivity,
 - (f) relevant social history including alcohol or drug use or abuse,

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- (g) relevant family history,
 - (h) findings on physical examination, including relevant abnormalities or absence thereof,
 - (i) diagnoses (tentative, differential or established),
 - (j) treatment advised and provided, including medication prescribed,
 - (k) when a prescription is issued:
 - (i) the name of the medication,
 - (ii) the dose of medication to be taken at each administration,
 - (iii) the frequency of administration,
 - (iv) the duration of the period for which the patient is to take the medication, and
 - (v) whether or not refills have been issued.
 - (l) investigations ordered and results obtained,
 - (m) instructions, precautions and advice to the patient, including instructions for follow-up care,
 - (n) responses of the patient to the advice given, if refused,
 - (o) letters of referral, and
 - (p) reports received or sent in regard to the patient's medical care.
- (6) A physician must ensure a patient record is legible, and in English.
- (7) A physician must ensure that a patient record is accessible to ensure continuity of care for a patient.
- (8) When information in a patient record is changed, added to or deleted (collectively the "alteration") after the fact, the original entry, the identity of the person making the alteration, and the date of the alteration must be included in the patient record.
- (9) A physician must ensure that a patient record is accessible for a minimum of ten (10) years following the date of last service or, in the case of minors – the record must be accessible for ten (10) years or until two (2) years past the patient's age of majority – whichever is longer.
- (10) In the case of a telephone consultation between two physicians with respect to a specific patient, the referring physician must document a summary of the consultation on the patient record, and the consultant must document enough information as is necessary to validate that the consultation occurred.
- (11) A physician must keep an accounting record showing the date the service was rendered, the type of medical service, and the fee charged as required by the Canada Revenue Agency.
- (12) A physician must keep a record of appointments showing for each day the names of patients who received professional services for a period of at least two (2) years.
- (13) A physician must maintain safeguards to protect confidentiality and to protect against reasonably anticipated threats or hazards to the security, integrity, loss or unauthorized use, disclosure, modification or unauthorized access to health information.

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- (14) A physician who uses an electronic patient record must ensure that the system has safeguards to protect the confidentiality and security of information, including but not limited to, ensuring:
- (a) an unauthorized person cannot access identifiable health information on electronic devices,
 - (b) each authorized user can be uniquely identified,
 - (c) each authorized user has a documented access level based on the individual's role,
 - (d) appropriate password controls or data encryption are used,
 - (e) audit logging is always enabled and meets the requirements of section 6 of the Alberta Electronic Health Record Regulation,
 - (f) where electronic signatures are permitted, the authorized user can be authenticated,
 - (g) identifiable health information is transmitted securely,
 - (h) secure backup of data,
 - (i) data recovery protocols are in place and the regular testing of these protocols,
 - (j) data integrity is protected such that information is accessible as stipulated in subsection (9),
 - (k) practice continuity protocols are in place in the event that information cannot be accessed electronically,
 - (a) when hardware is disposed of that contains identifiable health information, all data is removed and cannot be reconstructed.
- (15) Where a physician places patient information into an electronic record which is not under his or her direct custody and control, there must be in place:
- (a) a written information management agreement which addresses the requirements of subsection (14), and
 - (b) a written information sharing agreement which manages issues related to access, secondary use and disclosure of patient information.
- (16) A physician who works in a medical practice described in subsection (15) is expected to fulfill all obligations respecting the completion of patient records, the maintenance of security of patient records, the confidentiality of the information contained in the patient records, and comply with the requirements of the *Health Information Act*.
- (17) Physicians in a group medical practice must determine custodianship arrangements of patient records within that medical practice so that:
- (a) if a physician leaves the medical practice, custodianship of patient records will be clear to all parties and to the patients of the departing and remaining physicians, and
 - (b) the departing physician and his or her patients have reasonable access to the relevant patient records.
- (18) While a physician may be the custodian of a patient's record, the patient whose information is contained in that record owns the information; on the request of a patient, the physician must, in a timely manner:

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- (a) provide the patient access to the patient record, and
 - (b) provide the patient with a copy of the patient record.
- (19) A physician may charge a fee as permitted by the *Health Information Act* for a patient's request for access to or a copy of his or her record.
- (20) A physician may not charge another healthcare provider for the exchange of limited patient information such as a copy of a discharge summary.
- (21) A physician is required to comply with all relevant privacy legislation regarding patient records.

¹ Replaces *Patient Records, Standard 20*, issued January 1, 2010

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