Standard

Record Keeping

Purpose:

This document contains guidelines that pertain to Members of the Manitoba Naturopathic Association, with regards to their patient records. The records can be written or electronic medical records. Record keeping includes patient chart, appointments records, equipment records and financial records.

Personal Health Information:

The Personal Health Information Act (PHIA) came into force on December 11, 1997 and governs the collection, use, disclosure, retention, disposal and destruction of personal health information. The act recognizes both the right of individuals to protect their personal health information and the need of health information trustees to collect, use and disclose personal health information to provide, support and manage health care.

All members are required to set up policies and procedures for themselves and their staff regarding the collection, use, retention and disclosure of personal information such that they are in compliance with the Personal Information Protection and Electronic Documents Act (PIPEDA) and the Personal Health Information Act (PHIA).

Record Retention:

The Member maintains and retains patient files, financial records and appointment books 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.

1. Appointment Record:

The member must maintain an appointment record that is legible, comprehensive, and accurate. The record must include: patient's name, the date of appointment, time and length of appointment, clinic name, and member's name.

2. Patient Financial Records:

The member must maintain a financial record that is legible, comprehensive, and accurate. The record must include the member's name, clinic, patient's name, date of service, services billed, substances, drugs or devices dispensed, payment amount and method of payment.

3. Patient Charts:

The member must maintain a patient chart that is legible, comprehensive, and accurate. In the patient charts, the member ensures:

-all entries are in indelible ink, highlighters and or correction tape are never used;
- patient's name or patient's number is on every page;
-there are no blank spaces;
- indication of who made each entry and when the entry was made.
-entries are in English;
-all pages are in chronological order, numbered, and correct date;
-the date must have a consistent format;
-medical abbreviations are allowed if a legend is provided

The Member ensures that all records contain:

• the patient's chief complaint(s);
• relevant health, family and social history;
• subjective information provided by the patient or their authorized representative;
• relevant objective findings;
• signed informed consent;
• results of any naturopathic examinations;
• an assessment of the information and any diagnosis;
• proposed treatment plan, including prescriptions and recommendations;
• relevant communications with or about the patient;
• the patient's reactions/feedback to treatment;
• relevant information obtained from re-assessment;
• relevant referral and consultation information, where applicable; and

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

• name and strength of all substances administered;
• dosage and frequency;
• date of administration;
• method of administration; and
• how treatment was tolerated.

4. Electronic Records:

The Member ensures that electronic records are maintained and retained in a safe and effective manner.

Performance Indicators:

Electronic records are subject to the same security requirements as paper/written information. 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 or other unique identifier;

- the system is capable of printing 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; and
- is capable of printing each patient record separately.
- the system provides reasonable protection against unauthorized or inappropriate access;
- the system is backed up at least every practice day and allows for the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to and inaccessibility of records;
- backed-up files are stored in a physically separate and secure area; and
- files are encrypted if they are transferred or transported outside of the facility.

When making the transition from paper to electronic records, the Member must:

- ensure the integrity of the data that has been converted into electronic form;
- verify that documents have been properly scanned;
- ensure that the entire patient record is intact upon conversion, including all attached notes and hand-written

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.

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:

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

The Member ensures that:

- any amendment to a written chart is initialled, 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:

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 Records:

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.

The Member:

- maintains the original chart unless it is requested by the Association 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 Association.

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 Association 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:

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

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.

10. Disposing of Patient Records:

The Member does not dispose of a record of personal health information unless their obligation to retain the record has come to an end.

When the obligation to retain records comes to an end, the records may be destroyed:

- paper or hard copy records must be disposed of in a secure manner such that the reconstruction of the record is not reasonably possible;
- Electronic records must be permanently deleted from all hard drives, as well as other storage mechanisms.
- Hard drives must either be crushed or wiped clean with a commercial disk wiping utility.
- Similarly, any back-up copies of the records must be destroyed. The Members maintains a record of disposal dates, and names of patient whose records were disposed.

Related Standards and Resources:

MNA Manipulation Guidelines
MNA Informed Consent Standard
Personal Health Information Act (PHIA)
Personal Information Protection and Electronic Documents Act (PIPEDA)