By-Law 6: Medical Records

Standards governing the keeping of medical records as part of the practice of medicine, made pursuant to paragraph 15(1)(i) of the *Medical Act, 2011*.

Application of this By-Law

1. This amended By-Law replaces the following Guidelines of the College:

    - Guideline – The Patient Medical Record
    - Guideline – Retention and Storage of Medical Records

2. This By-Law applies to any records containing patient information in the possession or control of a medical practitioner.

3. For records which are considered to be under the control of a regional health authority (RHA), this By-Law applies provided that this By-Law is not contrary to the policies of the RHA. In the event that a subsection of this By-Law is contrary to a policy of the RHA, the policy of the RHA shall prevail for that subsection only.

Personal Health Information Act ("PHIA")

4. The records referred to in this By-Law contain "personal health information" as defined by the Personal Health Information Act (Newfoundland and Labrador) ("PHIA").

5. Under PHIA, medical practitioners are "custodians" of personal health information. Medical practitioners must be aware of their responsibilities as custodians under PHIA.

6. Where records referred to in this By-Law are records to which PHIA also applies, a medical practitioner must meet the requirements of this By-Law to the extent that it is possible to comply with both this By-Law and PHIA.

7. Medical practitioners are responsible to make themselves, and their staff, familiar with the information regarding compliance with PHIA available at the Provincial Government website including the

    - PHIA Risk Management Tool Kit
    - PHIA Policy Development Manual

8. It is recommended that medical practitioners refer to the *Guidelines for Protection of Health Information*, produced by Canada's Health Informatics Association (COACH).

Continuing responsibility for medical records

9. As more specifically set out in sections 21-28 of this By-Law, a medical practitioner continues to be responsible to keep, or cause to be kept, medical records in accordance with this By-Law even if

   (a) the medical practitioner has retired,

   (b) the medical practitioner has left the Province,

   (c) the medical practitioner has discontinued or changed his or her practice, or

   (d) the doctor-patient relationship is terminated.

Medical Records: the patient information to be recorded

10. A medical practitioner must ensure that there is recorded and retained an individual record for each patient which includes:

   (a) The full name, address, date of birth and gender of the patient;

   (b) The patient's medicare health number, if he or she has one;

   (c) The name and contact information of the patient's legal representative(s) or substitute decision maker(s), if applicable;

   (d) In a consultant's record, the name and address of the patient's primary care physician and of any health care professional who referred the patient;

   (e) The date of each professional encounter of the medical practitioner with the patient, including each occasion on which the patient is seen or spoken to by telephone by the medical practitioner; and

   (f) A contemporaneous record of the assessment and disposition of the patient by the medical practitioner for each visit, including:

      i. evidence of use of SOAP (Subjective, Objective, Assessment, Plan) or other similar plan appropriate to area of practice;

      ii. the family medical history and personal medical history of the patient, as obtained and updated by the medical practitioner from visit to visit, including pertinent negatives;

iii. a history of the patient’s allergies;

iv. the findings of the physical examination and other medical examinations performed by the medical practitioner, including pertinent negatives;

v. the diagnosis, or a differential diagnosis;

vi. investigations ordered by the medical practitioner;

vii. a description of each drug or other treatment prescribed or administered by the medical practitioner, including prescribed drug dosage and duration;

viii. evidence that the medical practitioner periodically reviews the list of medications being taken by a patient with multiple or chronic conditions;

ix. a record of professional advice given by the medical practitioner;

x. particulars of any referral made by the medical practitioner; and

xi. results of investigations ordered by the medical practitioner, and the date and manner (ie. in person, by telephone, or in writing) the results were communicated to the patient by the medical practitioner or by an appropriately-trained staff person.

11. In addition to the requirements of section 10 of this By-Law, it is recommended that the medical record of a patient also include:

(a) A cumulative patient profile; and

(b) Chronic disease flow sheets for ischaemic heart disease (IHD), chronic obstructive lung disease (COLD), diabetes, blood pressure (BP), and congestive heart failure (CHF).

Medical Records: the documents to be retained

12. A medical practitioner must ensure that there is retained for each patient:

(a) copies of correspondence and reports concerning the patient, prepared by or under the direction of the medical practitioner;

(b) the originals or copies of correspondence and reports concerning the patient received by the medical practitioner;

(c) all consultants’ reports, imaging reports, pathology reports, hospital discharge summaries and operative notes received by the medical practitioner, which should have stamped or otherwise recorded on them the date received by the medical practitioner’s office, and which should be dated and initialled or otherwise

distinctively marked by the medical practitioner at the time of his or her review, or a summary of such reports, summaries and notes containing all pertinent information including the respective dates of his or her review of that information;

(d) blood testing and other laboratory reports, which should have stamped or otherwise recorded on them the date received by the medical practitioner's office, and which should be dated and initialled or otherwise distinctively marked by the medical practitioner at the time of his or her review, or a summary of blood testing and other laboratory reports containing all pertinent information including the respective dates of his or her review of that information; and

(e) in circumstances where a medical practitioner views any of the reports or other documents referred to in paragraph (c) and (d) on Meditech or some other electronic health record network, and does not print off or receive a paper copy of that report or document, then the medical practitioner shall contemporaneously with that viewing note in the medical record for that patient all pertinent information in relation to the report or other document viewed, including the date it was viewed.

Medical Records: multiple physician entries

13. If more than one medical practitioner is making entries into the medical record of a patient, a system should be used to ensure that the physician making each individual entry is identifiable.

Medical Records: details of disclosure

14. A medical practitioner must record details of the disclosure of personal health information of a patient, specifically

(a) the name of the person or body to whom the personal health information was disclosed,

(b) a description of the information disclosed, the date of the disclosure, and

(c) the purpose of the disclosure, including with reference to the requirements of PHIA whether the disclosure was for the purpose of

i. further treatment of the patient;

ii. health and safety of the patient or the public, including mandatory reporting requirements;

iii. responding to a request from the College made under the Medical Act;

iv. legal proceedings or enforcement purposes;

v. meeting another legal requirement;

vi. research; or

vii. payment for medical services.

Non-insured fees

15. A medical practitioner must record all fees charged which were not in respect of insured services under the *Medical Care Insurance Act, 1999,* which record of non-insured fees may be kept separately from the clinical record.

Other records

16. In addition to the above records, a medical practitioner must also keep those other records relating to a patient as may be required by federal and provincial laws or regulations, or by other by-laws, policies or guidelines of the College.

Daily diary of patients seen

17. In addition to the medical record for each individual patient, the medical practitioner shall also keep, for each work day, a day book, daily diary, appointment sheets or an equivalent record containing the names of all patients seen, treated or in respect of whom professional services are rendered on that day.

The manner of making and retention of records

18. The records required to be made and retained by a medical practitioner by this By-Law must be

(a) Legibly written, typewritten, or electronically recorded in accordance with section 19, and kept in accordance sections 21-28 of this By-Law;

(b) Kept in a systematic manner;

(c) Where it is necessary to revise an existing medical record entry, the revision shall be made in such manner as to not remove, delete, erase, or render illegible each previously existing unrevised record or entry, and the date of the revision shall be clearly noted in the vicinity of each such revision; and

(d) Kept in a secure manner, and accessible only to

i. the medical practitioner;

ii. to such persons employed or associated with the medical practitioner's practice who are specifically authorized by the medical practitioner to access a patient record and who are made aware by the medical practitioner of the need to maintain the confidentiality of patient records;

iii. patients and other authorized persons in accordance with the Medical Act, PHIA and any other applicable law or regulation, or by-law, policy or guideline of the College, as may be amended from time to time, including without limiting the foregoing those policies and guidelines listed in Schedule "A" to this By-Law.

19. Medical records may be made, or converted to, and retained by a medical practitioner by using an electronic information system, including a practice management system, an electronic medical record system, an electronic database or an authorized regional or provincial information system, only if it has the following characteristics:

(a) All requirements of this By-Law continue to be met;

(b) The system provides a visual display of the recorded information;

(c) The system provides a means of access to the record of each patient by the patient's name and, if the patient has a medicare health number, by the health number;

(d) The system is capable of printing the recorded information promptly;

(e) The system is capable of visually displaying and printing the recorded information for each patient in chronological order;

(f) 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. is capable of being printed separately from the recorded information for each patient; and

vi. retains a description of the information that is accessed or that could have been accessed;

(g) 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, damage to, and inaccessibility of, information;

ii. the system has data protection functionality, which it is recommended include appropriate virus protection and encryption; and

iii. all transfer of information from the system is done through secure communications.

Medical records on mobile technology

20. Notwithstanding paragraph 19(g) ii. of this By-Law, where patient records are kept in or copied into mobile technology, such as a laptop computer or USB key, the record shall be, at minimum, protected with a password and encryption, and consideration shall be given to implementation of other safeguards which may be available to protect against unauthorized access.

Time period medical records must be retained

21. Subject to section 22, a medical practitioner must keep, or cause to be kept, a patient's medical records

(a) for a minimum of ten (10) years following the date of last provision of service to a patient by that medical practitioner, or

(b) in the case of a patient who at the date of last provision of service was under the age of nineteen (19) years, until that patient attains the age of twenty-one (21) years or for ten (10) years following the date of last provision of service to that patient, whichever is the longer period.

22. A medical practitioner must keep a patient's medical records for a time period longer than that set out in section 21 in the following circumstances:

(a) If the medical record contains personal health information that is the subject of a request for access or request for correction under PHIA, in which case the medical practitioner must retain the medical record for as long as necessary to allow the individual to exhaust any recourse under PHIA; or

(b) If the medical practitioner has received written notice, prior to destruction of the patient's medical record, that the record may be evidence in or relevant to any investigation, inquiry, action or other proceeding.

Obligation to retain records continues regardless of status of practice or of doctor-patient relationship

23. Regardless of whether the doctor-patient relationship is terminated or the medical practitioner has retired, left the Province, or otherwise discontinued or changed his or her practice, the medical practitioner must ensure that the patient's medical record is retained for the time period required under section 21 or section 22, whichever is applicable.

24. The patient's medical record must be retained in such a manner that they are available to be disclosed, in accordance with the PHIA, the College's Guideline – "Patient Access to Medical Records and the Personal Health Information Act", and this By-Law, to

(a) The patient; and

(b) Another person authorized by the patient or by law to disclosure.

25. A medical practitioner must retain patients' medical records, in such a manner as to ensure that they are secure from unauthorized access, in one of the following places:

(a) In his or her medical office or in a private clinic in which he or she practices;

(b) In bonded commercial storage, provided an appropriate information manager agreement is entered into as contemplated by the PHIA Policy Development Manual (see section 7 of this By-Law); or

(c) In another secure location with the prior written approval of the College.

26. Excepting in a circumstance described in section 22, a medical practitioner may terminate his or her personal responsibility as custodian of a patient's medical records by transferring complete custody and control of the records to the patient or to the patient's authorized representative, to another medical practitioner, or to a regional health authority, provided

(a) In the case of an intended transfer to the patient or to the patient's authorized representative, the patient or patient's authorized representative has confirmed in writing, signed by him or her, that he or she voluntarily accepts the transfer;

(b) In the case of an intended transfer to another medical practitioner or to a regional health authority, that

i. paragraph 39(1)(j) of PHIA applies,

ii. subsections 39(2) and 39(3) of PHIA have been complied with, and

iii. the other medical practitioner or regional health authority has confirmed in writing that he, she or it accepts the transfer as the new custodian of the medical record; and

(c) In the case of either paragraph (a) or (b), notification of the transfer is given to the College, and if the transfer is to another medical practitioner or regional health authority then notification of the transfer to the patient as well, in the same manner as contemplated by the College's Policy - "A Physician's Responsibilities When Permanently Closing a Medical Practice".

27. A medical practitioner planning to cease practice in the Province must give prior written notification to the College of where their medical records will be retained, or of the authorized person under section 26 of this By-Law to whom their medical records have been transferred, as contemplated by the College's Policy - "A Physician's Responsibilities When Permanently Closing a Medical Practice".

28. A medical practitioner must make adequate provision to have his or her personal representative discharge the medical practitioner's responsibilities under PHIA and this By-Law as a custodian of patient medical records in the case of the medical practitioner's mental incompetence or death.

Destruction of medical records

29. Following the applicable period of retention under section 21 or section 22, medical records which are not required to be retained in accordance with this By-Law must be destroyed in such a way that reconstruction of the record is not reasonably foreseeable in the circumstances.

Other legal requirements

30. A medical practitioner shall make his or her equipment, books, accounts, reports and records relating to his or her medical practice available for inspection by the College, or other body or person, as may be required by law.

31. Notwithstanding any other provision of this By-Law, a medical practitioner shall also remain responsible for ensuring that medical records are kept and dealt with in accordance with

(a) applicable College policies and guidelines listed in Schedule "A" to this By-Law and as may be added to and amended from time to time; and

(b) any applicable health insurance, health information, personal information and privacy laws, and any other laws applicable to patient records or to specific categories of patient records or of other health records.

SCHEDULE A

Policies and Guidelines of the College on Patient Records

- Policy – A Physician's Responsibilities When Permanently Closing a Medical Practice
- Guideline – Patient Access to Office Medical Records and the Personal Health Information Act
- Guideline – A Physician's Responsibilities When Closing his or her Medical Practice for an Extended Period

Document History

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