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STANDARDS AND GUIDELINES

TITLE:	RECORD KEEPING AND PRIVACY OF INFORMATION[1]
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Note to Readers: In the event of any inconsistency between this document and the legislation that affects homeopathic practice, the legislation governs.

College publications contain practice parameters and standards which should be considered by all Ontario homeopaths in the care of their patients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

This practice guideline has been developed to assist Registrants understand the requirement for Record Keeping, as laid out in the Draft Record Keeping Regulation for the College of Homeopaths of Ontario (the "CHO" or the "College"). The proposed regulation, at the end of this document, is before the Ministry of Health and Long-Term Care.

POLICY

Records – hard copy or electronic – are maintained and retained 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. An important component of record keeping is ensuring that the patient's health information is kept confidential. This policy will assist Registrants in ensuring that staturory obligations are fulfilled.

INTENT

To assist Registrants in developing, achieving and maintaining best practices in record keeping and patient privacy of information.

PREAMBLE

Record keeping is an essential component of patient care. Good records help registrants to provide effective, progressive and organized care. They also assist in providing continuity of services if the care of the patient is transferred to another practitioner for any reason. Concise, accurate, legible records should provide a full account of the patient's past and current health status and concerns, the treatment provided and the patient's response to treatment.

[1] College of Dietitians of Ontario, Record Keeping Guidelines for Registered Dietitans

Patient records provide patients with evidence of the care that was provided to them and when it was provided. Patients have the right to access and control the information contained in their health records. Registrants, or the facilities they work for, act as the custodians of that information[2].

Good record keeping helps to facilitate the care of treatment of patients, ensures patients have access to up-to-date, accurate information about their health, provides Registrants with a framework for organizing clinical notes and other records, and maintains confidentiality and prevent unauthorized disclosure of patient records.

Record keeping is also a requirement for professional practice. The record can assist Registrantsin demonstrating their competence, and that they have met their professional and regulatory obligations by providing homeopathic care that is in the best interests of the patient. A record that is complete and documented in a timely fashion can assist Registrants to reliably recall events and decisions made during a course of treatment.

The patient record consists of the patient chart, appointment book and financial records. The patient chart is an essential chronicle of the history of medical care and a guide for the direction of future care. It is often the Registrant's most important evidence in a complaint or a lawsuit.

Legibility of records is vital. Even if all the requirements of the Guideline on Record Keeping and Privacy of Information are met, if a record is not legible it is impossible to comprehend the care that was provided. This renders the record useless to the patient or any individual with authorized access.

Respect for each patient's privacy is critically important. Privacy legislation exists at both the Federal and Provincial level to guide patients and health care professionals in the handling of a patients' personal and confidential information. At the Federal level, the Office of the Privacy Commissioner (OPC) of Canada oversees compliance with the *Personal Information Protection and Electronic Documents Act (PIPEDA).* At the Provincial level the Information and Privacy Commissioner of Ontario oversees the *Personal Health Information Protection Act, 2004* (*PHIPA*), which governs the collection, use and disclosure of personal health information within the health-care system. PHIPA establishes rules about how government organizations and health information custodians may collect, use, and disclose personal data. PHIPA also establishes a right of access that enables individuals to request their own personal information and have it corrected if necessary.

In addition to this guideline excellent resources on privacy of information and the applicable legislation is available on the OPC (www.priv.gc.ca), IPC (www.ipc.on.ca) and CHO (www.collegeofhomeopaths.on.ca) websites.

[2] *Personal Health Information Protection Act, 2004* (PHIPA)

A. DISCRETIONARY ISSUES

Registrants can use their discretion and make their own decisions regarding:

- The format, organization or style of the record (e.g. use of SOAP, DAR, FOCUS or other method); however the CHO does recommend that a consistent method be used to ensure that all relevant information is included.

- The colour of ink to be used when documenting. Keep in mind that the content of the record should be retrievable and reproducible for the entire retention period.

- The method of recording or storing information and the media used (e.g., paper vs. electronic), provided that the complete record can be retrieved and reproduced throughout the retention period; an audit trail of persons who have made entries or changes (and the changes made) can be identified and authenticated; and a method of protecting both confidentiality and data integrity exists.

- List of abbreviations The CHO requires that reasonable means be provided for those who access the record to understand the meaning of acronyms and abbreviations used in charting. The CHO does not specify which abbreviations are acceptable for use or how this information is maintained. For example, a term may be written out in full the first time it is used with the acronyms/abbreviations and their meanings could be referenced and maintained for the duration of the retention period. A legend of abbreviations/codes is in the appointment record and/or accessible elsewhere in the office.

B. DESCRIPTION OF GUIDELINE

1. Reports

Patient records are commonly needed to prepare reports. Patients may request them for use by others, such as insurers, employers and lawyers. Patients may need the information for legal proceedings, such as a disability claim, motor vehicle accident, or a discrimination suit on the basis of disability. Failure to provide an adequate report because of poor records may lead not only to embarrassment for the homeopath who kept those records.

2. Accountability

Records are critical in a Registrant's accountability for services. Patients, employers, payers and the CHO will rely heavily on a Registrant's record in assessing the adequacy of a Registrant's conduct or competency if the occasion arises. The axiom "if it wasn't recorded, it wasn't done" is not that far from the truth.

Accountability is not restricted to disputes with patients. A Registrant's record is often the focus of risk management. In its Quality Assurance Program, the CHO may review charts.

3. Tips for Good Record Keeping

Records must be an accurate and honest account of what occurred and when it occurred with attention to clarity and legibility. The following tips will help ensure accuracy, clarity and legibility.

Although the focus here is on the individual patient record, the inherent principles apply to all types of documenting and record keeping in any setting.

a. Clear, concise and complete - includes the essential information.
b. Accurate and honest - an objective report of findings.
c. Relevant - reflects important issues requiring communication.
d. Objective - based on observations and supported by facts.
e. Factual and professional - use factual terms e.g. patient shouting, shaking fists vs. difficult, non-cooperative, rude.
f. Retrievable - easy to locate within the patient health record.
g. Confidential - respects the privacy of the patient and others.
h. Patient-focused - incorporates patient goals. Always assume the patient will read their chart.
i. Consistent - a consistent format is used throughout the chart for recording the date e.g. DD/MM/YYYY OR MM/DD/YYYY.
j. Using forms, methods or systems that are consistent with the CHO's Professional Misconduct Regulation and #1 Guideline on Record Keeping and Privacy of Information.
k. Timely - information is recorded in charts and consult reports are sent out in time frames appropriate for use. All chart entries are recorded as soon as possible after the patient encounter while the details are fresh in the Registrant's mind.
l. Chronological - events are recorded in the order that they occurred, with documents consecutively numbered and dated.
m. Permanent and cannot be altered – written in ink or electronic medium that is permanent, no blank lines between written entries; or using electronic medium from which the original content can not be deleted or permanently altered.
n. Audio and video records must be authicated or the original source must be stated.
o. Signed (name and credential) by the individual who saw the patient. Never chart or sign an entry on behalf of another Registrant or support personnel.
p. Secure - All notes and papers must be secured in the file.
q. Accountable - Assume the patient will read the record. Avoid non-factual language.

4. Correcting Records

Necessary corrections to the patient chart are acceptable as long as the change is clearly indicated as such and is dated and initialed. Corrections are only to be in the form of additions and not erasure or overwriting. At all times the original entry is available and legible. A patient's chart is never to be re-written.

Registrants can only make corrections to their own documentation. Electronic records require special programming in order to make sure that the original entry can be retrieved for corrections if necessary.

a. Corrections must be made openly and honestly using a strikethrough or single line through the error ensuring that the correction and the original note are both legible.

b. Handwritten corrected notes should still be legible. Do not erase, white out or use correction tapes as they obscure the original documentation. Simply draw a neat line through the entry or use strike through for electronic entries.
c. Corrected by date, initial and an explanation of the corrections, if deemed appropriate – A signature and date are always necessary when a correction is made. In some cases, the time of the day may also be required.
d. Depending on the urgency of the correction, a homeopath may need to communicate the correction to others by means other than the correction noted in the chart. This action should be noted.
e. Attach the original notes if required. Date record and note date of subsequent changes to the record.
f. Changes to dictated records must be initialed.

5. Storage of Records

5.1 Retention Period

Records – written or electronic –are retained 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 file. Records are transferred in a manner ensuring continuing access by patients and the CHO. Security and confidentiality are criteria to protecting patient's privacy and identity.

Even though records must be kept for ten years, there is no limitation on a patient complaint or civil litigation. For example, although the statuory limitation period is usually limited to 2 years from the date of discovery, that timeline can be found to never trigger in certain situations.

5.2 PHIPA and Record Keeping

The federal legislation, *Personal Information Protection and Electronic Documents Act* (PIPEDA), became law on January 1, 2004 and applies to personal information, including health information, collected and used for commercial activities in Canada. The Ontario Government passed its own *Personal Health Information Protection Act* (PHIPA) May 13, 2004, in effect November 2004. Both acts build on the same set of privacy and access principles and both require information policies and practices to be transparent.

PIPEDA and PHIPA are based on a number of principles that organizations individual, associations, partnerships and trade unions must follow when collecting, using and disclosing personal information in the course of a commercial activity. This involves the making and provision of a product or service that is commercial in nature.

a. Let patients know about the collection, use or disclosure of their personal information;
b. Obtain consent to disclose information to third parties when appropriate;
c. Provide an individual with access to his or her own personal records;
d. Provide secure storage of information and implement measures to limit access to patient records;

e. Ensure the proper destruction of records that are no longer necessary;
f. Inform patients of the organizations information-handling practices through various means (i.e. the posting of notices, brochures and pamphlets, and/or through normal discussions between a patient and a health care provider.

5.3 Practice Expectation – Storage of Records

All patient charts are stored in an area accessible only to authorized staff as per the *PHIPA*.

All patient charts are securely stored and organized in a way that the chart can be extracted for each individual patient when required.

When storing patient charts, the Registrant will:

- Ensure all patient charts are secured when the office is closed, e.g. in a locked filing cabinet.
- Ensure sensitive information is never left unattended in an unsecure location.
- Store all patient charts alphabetically or numerically, such that a specific file can be easily identified and retrieved.

Registrants maintain a separate chart for each patient. In multi-disciplinary clinics, patient charts may be filed with other charts in the clinic as long as they can be readily identified e.g. different colored file folders. Registrants maintain a chart for each patient so that the information can be extracted individually when required. If other practitioners also see the same patient, their notes are kept in a separate file.

Every patient health case record, including accompanying reports and every financial record, shall be retained for at least ten years following the patient's last visit, or, if the patient was less than 18 years old at the time of his/her last visit, the day the patient became or would have become 18 years old.

6. Confidentiality of and Access to Records

Registrants adhere to the *PHIPA*. The Registrant identifies a Health Information Custodian (HIC) who establishes written policies and procedures relating to the collection, use, and disclosure of all personal health information.

In a single-practitioner private practice, the owner of the practice is generally the HIC and often serves as its privacy information officer.

In a shared practice/partnership, the terms of the written agreement made between or among the Registrants specifies that the patient charts are the responsibility of the HIC of the practice. Regardless of the agreement, all treating Registrants are given access to the chart where necessary to fulfill their professional obligations, including their obligations to the CHO. All patients are made aware that other practitioners may have access to their charts and patients may choose to decline that access in accordance with PHIPA.

Generally, patient consent is required for the collection, use and disclosure of personal health information. Consent can be implied, particularly if the information is only used for the provision of health care. Unless a patient directs otherwise, information can be shared with others on the health care team (i.e., within the circle of care) where obtaining consent is not practical. There are some other exceptions where consent is not required. For example, consent is not needed to use the information to collect an unpaid account. Disclosure can be made without consent for a number of reasons including to protect another person from serious bodily harm or for certain legal proceedings. For example, disclosure of charts to assist the CHO in performing its regulatory functions does not need patient consent.

Where a patient is incapable of giving consent, it can be obtained from a substitute decision maker (generally a power of attorney or a relative). Patients, or their substitutes, can prohibit Registrants from disclosing certain information to others (unless *PHIPA* permits disclosure without consent). This is called a "lock box". Where a record is transferred, but the patient refuses to permit another health provider in the circle of care from receiving part of the information that the practitioner will likely need for treatment, the Registrant must notify the other practitioner that some of the information has been withheld.

Under *PHIPA* the patient has a right to review or obtain a copy of his/her patient chart. That right of access includes any portions of the chart provided by others, such as consultation reports. Generally the Registrant may only decline access to information for legally permitted reasons like the following:

- the information is raw data from standardized psychological tests or assessments,
- there is a risk of serious harm to the treatment or recovery of the patient or of serious bodily harm to another person, or
- providing access to the patient would reveal the identity of a confidential source of information (assuming that the case was a suitable one for the Registrant to collect information in this way, e.g., for a medico-legal report).

An individual also has the right to request the correction of erroneous personal information held by the Registrant. If the Registrant agrees that an error has been made, s/he must correct the error. Where the individual and the Registrant cannot agree, then the Registrant must note the disagreement in the file. Some grounds for refusing to correct information include the following:

- where the request is frivolous, vexatious or made in bad faith,
- the custodian did not create the record and the custodian does not have sufficient knowledge, expertise or authority to make the correction, or
- the information consists of a professional opinion or observation made in good faith.

For more detailed information about the implications of *PHIPA* on record keeping, see the website of the Information and Privacy Commissioner of Ontario at www.ipc.on.ca.

RELEVANT COMPETENCIES & PERFORMANCE INDICATORS

Competencies are the specific knowledge, skills, attributes and abilities required of an entry-to-practice homeopath in order to practise safety and ethically. These competencies, from the Competency Profile for Entry-to-Practice Homeopaths Practising in Ontario, where adopted by the transitional Council of the College of Homeopaths of Ontario in 2012.

1.5 Maintain patient confidentiality and privacy. (K, S) (20)
PERFORMANCE INDICATORS
1. Apply the confidentiality and privacy requirements as per the *Personal Health Information Protection Act (*2004).
2. Apply the confidentiality and privacy requirements as per the *Personal Information Protection and Electronic Documents Act (*2000).
3. Describe how confidentiality can be inadvertently breached.
4. Provide an environment that fosters patient privacy.

2.26 Review patient intake form (e.g., family health history, patient health history, chief complaint, etiology, supplements and pharmaceuticals, lifestyle assessment). (20)
PERFORMANCE INDICATORS
1. Confirm intake form information during initial meeting with the patient.
2. Evaluate and clarify any information pertaining to the form.

2.39 Provide written instruction to patient on use of medicine including:
(20)a. Administration; (K, S)
PERFORMANCE INDICATORS
1. Provide, in writing, how medicine is to be taken.
b. Storage; (K, S)
PERFORMANCE INDICATORS
1. Provide, in writing, how medicine is to be stored.
c. Cautions and warnings; (S)
PERFORMANCE INDICATORS
1. Provide, in writing, the cautions and warnings associated with taking the medicine.
d. Interactions; (K,S) and
PERFORMANCE INDICATORS
1. Provide, in writing, the possible interactions with other treatments.

2.41 Document treatment plan in patient's file including name, potency and posology, and rationale of medicine. (K, S) (20)
PERFORMANCE INDICATORS
1. Record all applicable data related to patient treatment plan.

3.2 Maintain confidential patient records as per standards, regulations and guidelines. (K) (20)
PERFORMANCE INDICATORS
1. Demonstrate knowledge of relevant standards, regulations and guidelines.
2. Demonstrate how to protect confidentiality and security of information throughout collection, use, storage, disclosure and destruction processes.

DEFINITIONS

For the purpose of this guideline, the following defintions apply:

Clinical Record

Clinical Record is anything that contains information (in any media) that has been created or gathered as a result of any professional encounter, aspect of care, or treatment by a Registrant or a person working under the supervision of a homeopath. It may also include information created or gathered by other health care providers.

Health Information Custodian (HIC or Custodian)

A HIC is a person or organization that has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties. It includes health care practitioners or people who operate a group practice of health care practitioners, community care access corporations, and other organizations including hospitals, independent health facilities and nursing homes. (See the *Personal Health Information Protection Act* for a complete definition.)

Homeopath

"Homeopath" means a registrant of the College of Homeopaths of Ontario.

Record

A record is an account that contains information intended to document actions, events or facts. Clinical records are a subcomponent of the broader category of records.

Registrant

A Registrant is a member of the College of Homeopaths of Ontario.

LEGISLATIVE CONTEXT

Health Care Consent Act (HCCA), 1996 www.e-laws.gov.on.ca
Personal Health Information Protection Act (PHIPA), *2004* www.e-laws.gov.on.ca
Personal Information Protection and Electronic Documents Act (PIPEDA), *2000* http://lois.justice.gc.ca
Regulated Health Professions Act (RHPA), 1991 www.e-laws.gov.on.ca

Personal Health Information Protection Act, 2004

Sections 51-54 of the *Personal Health Information Protection Act, 2004*, outline a patient's right of access to his/her records and a health information custodian's obligation to provide information requested. Please consult these sections for further detail, specifically, subsection 54(10-12), which states:

(10) A health information custodian that makes a record of personal health information or a part of it available to an individual under this Part or provides a copy of it to an individual under clause 1(a) may charge the individual a fee for that purpose if the custodian first gives the individual an estimate of the fee.

(11) The amount of the fee shall not exceed the prescribed amount or the amount of reasonable cost recovery, if no amount is prescribed.

(12) A health information custodian mentioned in subsection (10) may waive the payment of all or any part of the fee that an individual is required to pay under that subsection if, in the custodian's opinion, it is fair an equitable to do so.

In addition to the legislative provisions outlined above, Registrants are reminded that the following under *Homeopathy Act, Ontario Regulation 315/12 Professional Misconduct (*Note: This regulation is not yet in force. It comes into force on the day named by proclamation of the Lieutenant Governor.):

23. Failing to keep records in accordance with the standards of the profession.

25. Falsifying a record relating to the member's practice.

35. If the member intends to close his or her practice, failing to take reasonable steps to give appropriate notice of the intended closure to each patient for whom the member has primary responsibility or failing to,

    i. ensure that each patient's records are transferred to the member's successor or to another member, if the patient so requests, or

    ii. ensure that each patient's records are retained or disposed of in a secure manner.

THIS SECTION IS FOR INFORMATION ONLY

The development of this draft regulation received 60-day consultation from August to October 2011. The draft Record Keeping Regulation for the College of Homeopaths of Ontario is before the Ministry of Health and Long-Term Care for consideration and approval.

Part III – Record Keeping

3.(1) The standard of the profession for record keeping relating to the treatment of a patient includes the following:

(a) The record shall be in English or in French.

(b) The record shall contain the name and date of birth of the patient.

(c) The record shall include all relevant subjective information provided by the patient or his or her authorized representative.

(d) The record shall include all relevant objective findings.

(e) The record shall include the results of any testing and any testing from other health professionals obtained by the member to determine the condition of the patient.

(f) The record shall include the member's treatment plan.

(g) The record shall include a notation of all relevant communications with the patient.

(h) The record shall include the relevant information obtained from any re-assessment of the patient and any modification of the treatment plan

(i) The record shall indicate who made each entry and when each entry was made.

(j) Any amendment to the record shall indicate what change was made at what date by whom and shall ensure that the previous entries are legible.

(k) The original record shall be retained by the member or the health information custodian[3] for whom the member works and only copies shall be provided to others

(l) The record shall be retained for ten years from the last interaction with the patient or the patient's eighteenth birthday, whichever is later

(m) The records required by regulation shall be legibly written or typewritten.

[3] The term "health care custodian" is defined in the *Personal Health Information Protection Act, 2004*.

3.(2) The standard of the profession for record keeping includes creating and maintaining appropriate financial records for ten years from the last interaction with the patient or the patient's eighteenth birthday, whichever is later.

3.(3) The standard of the profession for record keeping includes creating and maintaining appropriate equipment records for ten years.

3.(4) The standard of the profession for record keeping includes creating and maintaining appropriate records of the receipt, storage and disposition of homeopathics or other substances for ten years.

3.(5) The standard of the profession for record keeping includes creating and maintaining an appointment and attendance record for ten years.