Practice Standard- Record Keeping

Approved: June 2012 **Revised: September 2022**

Intent

This Standard deals with expectations for members for creating, using, maintaining, storing and destroying records. A member shall, when working independently or with others, take all reasonable steps to ensure that records are made, used, maintained, retained and disclosed in accordance with this Standard.

Standard statement

Record keeping is an essential part of a kinesiologists' practice regardless of the practice setting. Records provide the ability to track a patient's/client's progression, determine future care needs and ensure accountability of the practitioner for the care provided. Records are also an important communication tool to allow others to understand the patient's/client's past and current status in order to facilitate safe and quality care in the best interests of the patient/client. Further, records act as a memory recall for members about their patients/clients. The objectives of proper record keeping are as follows:

- To facilitate the safe and quality care and treatment of patients/clients.
- To ensure patients/clients have access to up-to-date, accurate information about their health.
- To ensure continuity of care for patients/clients from successive members or other treating health professionals.
- To ensure accountability to patients/clients, payors, the College, the profession and other healthcare providers.
- To demonstrate judgment, reasoning and adherence to the practice standards of the profession.
- To meet any other requirements mandated by the organizations they are associated with or where required by law.

Records are also a story about the patient's/client's health history, health goals and outcomes and prognosis; they do so by providing details of each encounter, including what was done, by whom, when, where and why. It is crucial that members consider the principles of record keeping when making decisions regarding any element of record keeping.

Records must be:

- Identifiable;
- Legible and understandable;

- Comprehensive;
- Accurate and timely;
- Accessible and retrievable; and
- Secure and confidential.

Performance expectations

A kinesiologist demonstrates this Standard by:

- Ensuring that every part of a patient/client health record has a reference which uniquely identifies the patient/client. Date of birth and/or names are not considered unique. A patient's/client's health card number would be considered unique.
- Ensuring that records have a sequential system in place.
- Ensuring that every entry in a patient/client health record is dated and includes the identity (i.e., signature, College-approved title and/or registration number, if applicable) of the person who made or dictated the entry.
- Ensuring that every amendment or correction to a patient/client health record will indicate what change was made without destroying the original record, at what date, by whom and the reason for the correction.
- Ensuring that information is entered within a reasonable time period to ensure accuracy and that any late entries are clearly indicated and the reason for the late entry.
- Ensuring that records are legible and are in either English or French.
- Ensuring appropriate and respectful language is used.
- Ensuring (or, if the member is employed in a facility or larger setting, advocate for) an audit trail be part of the record keeping program.

Members will maintain the following records: equipment service record, financial record and patient/client health record.

1. Equipment service record

The equipment service record contains servicing information for any instrument or equipment that requires regular servicing and is used by the member for the purpose of assessing, treating or providing a service to a patient/client.

2. Financial record

The financial record contains information on bills for services and clinical products to the patient/client either billed directly or indirectly through a third party. This includes:

- Patient's/client's name;
- Each treatment, service or clinical product provided to the patient/client and the date provided;
- The fee charged or received relating to each treatment, service or clinical product provided to the patient/client; and
- Balance of account.

3. Patient/client health file/record

The patient/client health record for each patient/client that the member assesses or treats contains:

- Relevant and appropriate demographic information about the patient/client;
- Name(s) of primary care physician(s) and any relevant referring health professionals, if appropriate;
- Reason for referral, if appropriate;
- The date and purpose of each professional contact with the patient/client, and whether the contact was made in person, telephone or electronically;
- Patient's/client's chief complaint(s)/concern(s) and supporting data;
- Relevant past health history;
- Appropriate family and social history when indicated by the presenting complaint(s)/concerns(s);
- Reasonable information about each initial examination, assessment and reassessment, all relevant diagnostic tests, and all relevant impressions made by the member;
- Reasonable information about each treatment performed, and the identity of the person applying the treatment if the person applying the treatment was not the member;
- Every written report and imaging record and report received by the member with respect to examinations, tests, consultations or intervention performed by other health professionals;
- Reasonable information about any consultation and correspondence with other treating practitioners;
- Reasonable information about any informed consent (including consent to the collection, use or disclosure of personal health information), including any records of written consent;
- Reasonable information about any recommendations given by the member including any pre-treatment or post-treatment recommendations given to the patient/client by the member and the identity of the person giving the advice if it was not the member;
- Reasonable information about every referral of the patient/client by the member to another health professional;
- Reasonable information about any controlled act performed by the member, including the authority (e.g., emergency, delegation) by which it was performed;
- Reasonable information about a procedure that was commenced but not completed, or refused, including reasons for non-completion or refusal;
- Every cancellation of an appointment by the patient/client together with the reason for the cancellation, if available;
- Reasonable information regarding real, perceived or potential conflicts of interest, including situations where the patient/client is a close personal relation (including the spouse) of the member, and the circumstances leading to the decision to provide treatment or other services in such a situation;
- Information regarding any abbreviations that may be used by the member and/or others making entries in the personal health record (this may take the form of a list of abbreviations);
- Reasonable information regarding discharge of the patient/client, including any discharge plan of care.

Retention

Members will ensure that every patient/client health record and every financial record will be retained for the following periods of time:

(a) For patients/clients who are 18 years of age or older at the time of the last contact: a period of at least 10 years.

(b) For patients/clients who are less than 18 years of age at the time of the last contact: a period of at least 10 years following the date at which the patient/client would have become 18 years of age.

Equipment service records must be retained for a minimum of 5 years.

Destruction of patient/client health records will be done in a secure fashion appropriate to the medium in which the records are stored to ensure that the records cannot be recovered, reconstructed or identified in any form.

4. Closing or transferring a practice

As part of the process of closing or transferring a practice, the member will take reasonable steps to ensure records are stored or transferred securely. The member must ensure that:

- The patient/client is notified that the member intends to close or transfer his or her practice and information about the future location of records is provided; and
- The record is transferred to another health information custodian and the patient/client is notified, or to another member, if the patient/client so requests.

5. Confidentiality of and access to records

(1) Members will ensure that the confidentiality of a patient's/client's personal health information is maintained through the collection, storage, use, transmission and disposal of personal health information through the appropriate use of administrative, physical and technical safeguards.
(2) Members will ensure that records meet the obligations outlined under privacy legislation, including the *Personal Health Information Protection Act* (PHIPA) when acting as either the health information custodian (HIC) or as an agent of the HIC[1].
(3) Members will ensure that any disclosure of personal health information is in accordance with PHIPA.
(4) Members will ensure that a patient's/client's record is retrievable and reproducible throughout the retention period.
(5) Members will ensure that any breach or potential breach of a patient's/client's confidentiality is dealt with appropriately, including notifying the patient/client, and/or the Office of the Privacy Commissioner.
(6) Members will ensure that, on request, copies of or access to a patient/client health record to any of the following persons, or any person authorized by the following persons:
    a. the patient/client;
    b. a personal representative authorized by the patient/client to obtain copies from or access to the record; or
    c. the patient's/client's other substitute decision maker under PHIPA.
(7) Members will ensure that any refusal to a request for access is done in accordance with PHIPA.
(8) Members will ensure that any correction requests made by the patient/client are done in accordance with PHIPA.

[1] Members should consult the resource "***What You Need to Know About Privacy Law: An Overview of the Personal Health Information Protection Act, 2004"*** for more information on the duties and responsibilities under PHIPA

(9) Members shall maintain records in a manner that ensures that an investigator, assessor or representative of the College who is authorized under the *Regulated Health Professions Act, 1991* has access to the records.

6. Electronic equipment

In general, the expectations described above apply equally to electronic records. A few special considerations include the following:

- A member may maintain an electronic record keeping system in accordance with this Standard.
- A member will take reasonable steps to ensure that the electronic record keeping system is designed and operated so that patient/client health records:
    - are secure from loss, tampering, interference or unauthorized use or access; and
    - will be retrievable and reproducible through the entire retention period.
- A member will ensure that the personal health information of patients/clients that is stored on any devices have the appropriate safeguards.
- An electronic audit log shall be maintained that shall include, for every instance in which personal health information is viewed, handled, modified or otherwise dealt with, the following:
    - the type of information that was viewed, handled, modified or otherwise dealt with;
    - the date and time on which the information was viewed, handled, modified or otherwise dealt with;
    - the identity of all persons who viewed, handled, modified or otherwise dealt with the personal health information;
    - the identity of the individual to whom the personal health information relates; and
    - any other information that may be prescribed (in legislation or elsewhere)

Legislative context

Regulated Health Professions Act, 1991

Personal Health Information Protection Act, 2004

Notation

In the event of any inconsistency between this standard and any legislation that governs the practice of members, the legislation governs.

APPENDIX I
OFF-SITE STORAGE OF HEALTH RECORDS GUIDELINES

Section 14 of the Personal Health Information Protection Act, 2004 permits practitioners to store records at a patient's home (e.g., for homecare, a long term care facility) or a third party storage site if the patient consents, reasonable safeguards are taken and any College regulations or guidelines are complied with. The following guideline balances the interests of the member and the patient while maintaining appropriate accountability.

1(1) A member may store personal health information (the "chart") at a patient's residence, including an institutional residence so long as the following criteria are met:

(a) the patient, or the patient's substitute, consents;
(b) the patient, or patient's substitute, understands and appreciates the reasonably foreseeable consequences of maintaining the chart at the patient's residence and has identified a reasonable plan for safeguarding the chart;
(c) the patient, or the patient's substitute, agrees that the member has access to the chart or, in the alternative, the member shall keep an up-to-date copy of the complete chart with the member's other records;
(d) the patient, or the patient's substitute, agrees to retain the chart for the period required under this policy or, in the alternative, the member keeps an up-to-date copy of the complete chart with the member's other records;
(e) a reasonable clinical purpose is served by keeping the chart there;
(f) either the chart kept at the patient's residence or the record kept with the member's other records, or both, is a complete and up-to-date copy of the record and both records indicate which is the complete, up-to-date copy of the record; and
(g) unless the member keeps an up-to-date copy of the complete chart with the member's other records, the member shall keep a copy of the following information with the member's other records:
    a. the name and contact information for the patient;
    b. the location of the chart;
    c. the essential, up-to-date, clinical information about the patient, including assessment results, a summary of the treatment plan and the major milestones in the implementation of the treatment plan; and
    d. documentation of compliance with clauses (a) to (f).

(2) A member may store personal health information at a storage facility other than one under the control of the member or the member's employing custodian or the patient's residence so long as the following criteria are met:

(a) the patient, or the patient's substitute, consents;
(b) the storage facility has a privacy policy consistent with the *Personal Health Information Protection Act, 2004* and the College's record keeping standards;
(c) the storage facility provides the member with a written privacy assurance that it will safeguard the chart and will only use or disclose it at the express direction of the member;
(d) the member describes the fact that he or she uses a storage facility in his or her privacy policy;
(e) the storage facility is not a private residence;
(f) the member contracts with the storage facility to retain the chart for the period of time specified in the College's record keeping standard before it will destroy the chart in a secure manner;

(g) the member keeps the account with the storage facility current at all times so that the charts are not discarded or destroyed prematurely; and
(h) the member keeps, with his or her other records, a list identifying the patient, the nature of the record kept at the storage facility, the location of the file in the storage facility (e.g., file box number), documentation of compliance with clauses (a) to (g) and the contact information for the storage facility.

(3) If the member is an agent of a health information custodian as defined in the *Personal Health Information Protection Act, 2004*, the member may comply with the custodian's privacy policies on storing records at a patient's residence or a storage facility rather than this policy so long as the policies are substantially similar to this policy.