North Huron
Family Health Team

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| Subject: | Patient Records Management | Date Approved: | May 22, 2010 |
| Approved by: | Executive Director | Date Revised: | June 15, 2017<br>April 25, 2013 |
| Specific to: | Clinical Personnel | Next Review Date: | September 2020 |

**PRINCIPLE**:
The creation and maintenance of records is an essential component of professional practice. The process of preparation and organization of material for the record provides a means to understanding the patient/ client and planning the intervention. The purpose of the record is to document services in a recognizable form in order to ensure the continuity and quality of service, to establish accountability for and evidence of the services rendered and to enable the evaluation of service quality. The records must comply with the privacy legislation (PHIPA) and the documentation standards of practice established by the specific clinical disciplines' regulatory bodies. In addition, the records management encompasses all forms or records- electronic and paper.

**POLICY**:
All clinical staff members ensure that documentation is recorded for each patient visit and ensure that the records are current, accurate, contain relevant information about patients and are managed in a manner that protects client privacy in accordance with any applicable privacy and other legislation.

**DEFINITIONS**:
**Patient:** A patient refers to a person who is mentally capable to provide consent with respect to the collection, use and disclosure of his/her personal health information and may be referred to as a client in a clinician's practice. In the event that the patient is not mentally capable, the Power of Attorney for Care designate would be considered as the capable party on behalf of the patient.

**Record:** The record means an information record in any form or media, including written, printed, photographic or electronic form, but excluding computer programs and other mechanisms that produce a record.

**Member:** A member is a North Huron Family Heath Team (NHFHT) staff member that is a clinician, sees patients for clinical intervention, and is a current member in good standing of their professional college / regulatory body. A member may also be a NHFHT administrative staff member that handles confidential patient records.

**PROCEDURES:**
**1.0 Record Content and Format:**

**1.1** All recorded information in the record is relevant to the services provided, and conforms to accepted service or intervention standards and protocols within the clinician's professional standards of practice.

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**1.2** All recorded information in the record is in a format that facilitates the monitoring and evaluation of the result of the service/intervention.

**1.3** Members do not make statements in the record or reports in the record that are known to be false, misleading, inaccurate or otherwise improper.

**1.4** All records are kept systematically as part of the Electronic Medical Record (EMR), are dated and understandable for each patient/client served, for each patient/client visit.

**1.5** The record reflects the service provided and the identity of the service provider. Members will use their designation in documentation, in connection with their professional practice, as the case may be.

**1.6** Information in the record is recorded when the event occurs or as soon as possible thereafter.

**1.7** Members document their own actions. Members do not sign records, including reports within the record, authored by any other person. Exceptions to this include but are not limited to a note that is created within an interdisciplinary team setting and also, within the context of a supervisory role. It is the responsibility of the member to know and understand other exceptions as noted in the members' professional association standards of practice. See links to the different professional associations at the end of this section.

**1.8** Members must comply with the recording standards of practice within their professional association. Where there is a conflict between this policy and the member's professional standards of practice, the member shall follow their professional standards of practice. **See links to the different professional associations at the end of this section**. In addition, the member must notify the Executive Director of the conflict and then note the conflict in the record.

**1.9** The member shall create records within the patient chart that include:

- Identifying information regarding the recipient of services
- The date, initiator, purpose of the visit, place of contact
- The history obtained by the member
- Assessment, diagnosis, formulation and plan
  **(Note: assessments are based upon facts that should be clearly documented. Only facts that are clearly relevant to the assessment and planned intervention should be recorded)**
- Treatment and other interventions (i.e. facilitation, advocacy, transfer of skills, development of action plans)
- Outcome or results, mutual review and evaluation
- Referrals made by the member
- Recommendations
- Other services (ie: verbal and/or written reports, briefs, analysis from outside consultations)
- For mental health clients of the Social Worker, the Mental Health Services form signed by the client at the initial visit **(See 4.2 below)**
- Consents, releases or authorizations pertaining to the intervention or the communication of information about the client.

**1.9.1 Ethical Dilemmas** – At times when the clinician needs to choose between two competing values, (i.e.: confidentiality and duty to protect), it is important that she/he clearly documents in the record, the ethical decision-making process that is followed when resolving the ethical dilemma.

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**1.9.2 Legal Correspondence –** All legal correspondence pertaining to the patient/client shall be scanned into the electronic record. NHFHT staff who receives legal correspondence directly shall ensure that the correspondence is date stamped and shall alert the Executive Director immediately to discuss action to be taken, if any.

**1.9.3 Documentation by exception –** For mental health patients/clients whereby regular ongoing visits are taking place, documentation by exception may be used provided that the total record captures the minimum content as set out in Section 1.9.

**Links to Professional Associations:**

1. **College of Nurses of Ontario:**
   http://www.cno.org/en/learn-about-standards-guidelines/publications-list/standards-and-guidelines/

2. **Ontario College of Social Work and Social Service Work Record:**
   http://www.ocswssw.org/en/downloadcodeofethics.htm

3. **College of Dieticians of Ontario:**
   http://www.cdo.on.ca/en/aboutRD/practice.asp

4. **Ontario College of Pharmacists:**
   http://www.ocpinfo.com/client/ocp/OCPHome.nsf/web/_Practice+Policies+&+Guidelines

5. **Ontario Association of Consultants, Counsellors, Psychometrists, and Psychotherapists**
   http://www.oaccpp.ca/assets/Standards%20of%20Practice%20-%20Final.pdf

**2.0 Record Maintenance:**

**2.1** Where applicable, Members must comply with the requirements in the NHFHT policy - Records Retention with respect to storage, preservation and retention of records.

**2.2** Records may be destroyed following the Records Retention Policy in a manner that ensures that the confidentiality of the information is not compromised.

**2.3** Members must take all steps necessary to protect the confidentiality and security of paper records, faxes, electronic records and other communications. To this end, members must not leave an electronic record open on their computer left unattended. The record must be closed and the computer station locked prior to leaving the computer station.

**3.0 Access and Correction of a Record:**

**3.1** Members shall comply with the requirements regarding access to patient/client information as set out in the NHFHT policy – Release of Personal Health Information and the Personal Health Information Protection Act (PHIPA).

**3.2** Members must preserve the integrity of patient/client records. If a client disagrees with the accuracy or completeness of a record and wishes the record to be amended, the member may

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incorporate into the record, a signed statement by the client specifying the disagreement and the client's correction. The member shall not delete any incorrect information in the record.

**4.0 Disclosure:**

**4.1** All disclosure of records shall be made in accordance with NHFHT policy – Release of Personal Health Information AND PHIPA: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm

**4.2** For clients of the Social Worker only, at the initial visit with clients, the social worker or mental health counselor informs the client of our privacy policy as well as any limits/exceptions of client confidentiality with respect to the client record. The client shall be asked to sign a form called "Mental Health Services" in acknowledgement of being informed about privacy and exceptions. The signed form shall be scanned into the patient chart and in the case of a client refusing to sign the form, the social worker shall note the refusal on the form and it shall be scanned into the patient chart. Link to the form: ..\..\..\FHT Forms\Patient Forms\Form - Mental Health Services - Privacy 04_2013.pdf

**4.3 Lock Box records:**

From time to time, a patient or client may request to the clinician that the information discussed in the visit be kept out of the Electronic Medical Record (eMR) so that the rest of the circle of care cannot view the content for confidentiality reasons. Note that the patient's primary care provider / physician cannot be locked out of any part of the patient chart. For more information, please see the Policy – Lockbox, which is part of the group of privacy policies.

**5.0 Handling and Security**:

**5.1** Health information in paper form is kept in secure areas, double locked, and not left unattended in areas accessible to unauthorized persons.

**5.2** Health information that is carried from location to location by a clinician shall be secured by ensuring that the information is double locked. Health information is never to be left in plain view in a vehicle, but rather shall be locked inside the trunk of a vehicle, out of sight.

**5.3** Health information in electronic format is kept secure. Therefore computers with access to patient/client health information shall be either locked with a password or logged out before leaving the computer station.

**5.4** A member shall not give their own personal computer password to anyone for security reasons.

**5.5** All electronic records are secured by LMH as per their back-up and security policies.

**5.6** All fax transmissions must have a confidentiality warning stamped on it. An activity confirmation report is produced and attached to the transmission.

**6.0 Retention of Records:**

**6.1** All Patients over 18 years of age: 10 Years from the date of the last entry in the record

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**6.2** Underage patients: 10 years after the day on which the patient reaches or would have reached the age of 18 years

**7.0 Destruction of Records:**

**7.1** All records are destroyed by the custodian of the records and the custodian of the records is the physicians. Therefore the staff of the NHFHT does not destroy records. Upon the expiration of the term required to retain records per Section 6 above, all paper records are given to the physicians or designate for destruction.