The College of Naturopaths of Ontario

Standard of Practice:

Record Keeping

Introduction

The intent of this standard is to advise Members with respect to the expectations for record keeping in their practice. This standard applies to both written and electronic records as appropriate.

Definitions

Patient Record: Consists of the patient chart, appointment record and financial records.

1. Appointment Records

The Member maintains an appointment record that is accurate, legible and comprehensive.

Performance Indicators

The Member maintains an appointment record that clearly and legibly identifies:

- Member's name, clinic name, address and telephone number;
- date and time of appointment;
- name of patient (minimum of last name and first initial); and
- duration of appointment.

The Member maintains and retains appointment records 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, regardless of the date of the last entry.

2. Patient Financial Records

The Member maintains a financial record that is accurate, legible and comprehensive.

Performance Indicators

The Member ensures that financial records clearly and legibly record:

- name of treating Member, clinic name, address, telephone number;
- patient's name, address and telephone number;
- date of service;
- services billed;
- substances, drugs or devices dispensed;
- payment amount and method of payment; and

- balance of account.

The Member ensures that:

- patient financial records are clearly itemized;
- fees for naturopathic consultation are separated from all other fees;
- fees for supplements, injectable substances, devices, special testing, etc., are individually listed;
- receipts are issued for all payments and copies are maintained in the patient financial record.

The Member maintains and retains financial records 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, regardless of the date of the last entry.

3. Patient Charts

The Member maintains a patient chart that is accurate, legible and comprehensive.

Performance Indicators

In all patient charts, the Member ensures:

- all written entries are made in indelible ink;
- the patient's name or patient number is recorded on each page;
- all entries are made in either English or French. Other languages may be used provided that English or French are also used;
- there is no highlighter used over writing;
- all written records are clearly legible;
- there are no blank spaces between entries;
- all pages are in chronological order, consecutively numbered and dated;
- a consistent format is used for recording the date;
- all chart entries are recorded as soon as possible after the patient interaction; and
- when other than generally accepted medical abbreviations are used, a legend of abbreviations or codes is available.

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;
- 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
- indication of who made each entry and when the entry was made.

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

- name and strength of all drugs and/or substances administered;
- dosage and frequency;
- date of administration;
- method of administration; and
- how treatment was tolerated.

The attending Member includes his/her registration number and signs the written record so that the treating ND is clearly identified.

The Member maintains and retains patient records 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, regardless of the date of the last entry.

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 each 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 comments.

5. Storage of Charts

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.

Performance Indicators

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 Patient Charts

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

Performance Indicators

The Member ensures that:

- any amendment to a written chart is initialed, dated and indicates what change was made;
- all previous written entries remain legible;
- amendments are only to be in the form of additions and not erasure or overwriting;
- the original entry is available and legible;
- a patient chart is never re-written.

7. Privacy

The Member adheres to the Personal Health Information Protection Act, 2004 (PHIPA).

Performance Indicators

The Member obtains the patient's consent when collecting, using or disclosing personal health information unless provided otherwise by law.

The Member maintains patient confidentiality in the course of collecting, storing, using, transmitting and disposing of personal health information.

The Member identifies the Health Information Custodian (HIC) who establishes written policies and procedures relating to the collection, use, and disclosure of all personal health information. The patient is informed of who has custody and control of their personal health information and how their information will be managed.

All patients are made aware that other practitioners may have access to their charts and patients may choose to decline that access.

8. Retention and Transfer of Patient 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.

Performance Indicators

The Member:

- maintains the original chart unless it is requested by the College 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 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 a reason for the Member to withhold the information;
- retains and transfers records in a manner that ensures continued access by patients and the College.

The Member maintains and retains records 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, regardless of the date of the last entry.

In the event of the death of a Member, 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 are maintained as above.

If a Member relocates a practice he/she takes the patient records to the new location. 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 patient records. The College is also notified and provided with a forwarding address for a minimum of ten (10) years.

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. The College is also informed in writing of the sale and in whose care and control the original records will be maintained.

In all cases, the College 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

9. Dispensing and Selling of Drugs and Substances

The Member creates and maintains appropriate records of the dispensing and selling of drugs and substances for a minimum of ten years.

Performance Indicators

The Member:

- records and maintains an inventory of drugs and substances purchased or received, including date of receipt;
- records the date drugs and substances are dispensed and/or sold;
- records the name of the person to whom the drugs and substances were dispensed and/or sold;

- maintains copies of prescriptions/recommendations from other Members or health care providers;
- maintains a log containing a record of distribution of each drug or substance dispensed to enable the Member to issue a recall of any dispensed drug or substance;
- maintains a record of any product recalls or alerts provided by the manufacturer or Health Canada; and
- maintains these records for a minimum of ten (10) years.

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.

Performance Indicators

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

Consent
Dispensing
Fees and Billing
Prescribing
Recommending Non-Scheduled Substances
Selling

Legislative Framework

Personal Health Information Protection Act, 2004
Professional Misconduct Regulation

Approval

Original Approval Date: October 15, 2012
Latest Amendment Date: March 6, 2019.

Disclaimer

In the event of any inconsistency between this standard and any legislation that governs the practice of Naturopathic Doctors, the legislation shall govern.