MEDICAL RECORD KEEPING

PAPER AND EMRs

October 3-4, 2014

Disclosure

We certify that we have no direct or indirect financial interest, arrangement or affiliation with organizations that could be perceived as a direct/indirect conflict of interest.

Purpose

The following presentation contains a compilation of information from a number of Canadian Medical Regulatory Authorities and presents general expectations for medical record keeping.

The standard for paper and electronic medical records are the same.

CPSS Bylaws Require

- The name, address, birth date and provincial health card number of the patient;
- The date that the patient is seen;
- A record of the assessment of the patient, the investigations ordered and, where possible, the diagnosis;
- A record of the disposition including treatment provided or prescriptions written, professional advice given and particulars of any referral made.

Why Records Are Important

They are foremost an essential element of providing quality care and are:

- A critical source of information for medical colleagues and other health care professionals,
- A method of protecting yourself in the event of a lawsuit against you or the institution or in the event of an investigation by your professional regulatory body,
- A method of protecting yourself from a reassessment by Medical Services Branch

Who Owns the Records?

The record generally belongs to the entity creating the record, but with very limited exceptions, patients have a right of access to all of the information in their chart.

Inquiries regarding exceptions should be directed to the College of Physicians and Surgeons of Saskatchewan (CPSS)

Purpose of the Medical Records

- The main purpose of the medical record is to provide a record of information and medical reasoning. This facilitates the planning of future investigations and treatments.

- Patients benefit from the expertise of professionals working either alone or in “shared care” in both the office and ward. The medical record is an important tool to ensure better communication and coordinated care

(Canadian Medical Protective Association)

Purpose of the Medical Records continued

The medical record must "tell the story" of the patient as determined by the physician in the circumstances in which he or she saw the patient. The record is not just a personal memory aid for the individual physician who creates it. It must allow other health care providers to read quickly and understand the patient's past and current health concerns.

College of Physicians and Surgeons of Ontario – "Medical Records"

Purpose of the Medical Records continued

Within a physician's office, the medical record performs multiple functions in that it:

- Maintains the history of patient care
- Supports workflow (clinical and administrative) within the office
- Supports the communication with external sources of medical information such as hospitals, laboratory and radiology clinics as well as consultations and referrals with colleagues.

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The medical record is a comprehensive compilation of all patient-physician encounters together with all documentation related to those encounters.

- For patients who attend the physician on an ongoing basis, the record is a single file containing all material related to the patient.

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For isolated single encounters, such as for episodic care, or single visits to "no-appointment" clinics, the record may be limited to that visit and filed chronologically.

Repeat visits by a patient to such clinics may be considered as continuous care requiring the creation of a comprehensive patient record.

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Essential Elements of the Records

The record should include:

- The patient's demographic information such as name, date of birth, address, telephone numbers, personal health number, family contacts and other information pertinent to the patient.
- A cumulative patient profile.

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Essential Elements of the Records continued

The summary sheet (cumulative patient profile), usually detailed on a face sheet, lists significant:

- Medical problems (current and relevant past),
- Therapeutic interventions (including surgeries and current medications with dosage schedules),
- Known allergies and drug sensitivities/interactions.

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Essential Elements of the Records continued

For every patient contact:

- Relevant complaints, review of systems, and physical findings (present or absent).
- A provisional diagnosis or working diagnoses.
- A management plan, including investigations, consultations, and therapeutic interventions, implemented or under consideration, and the specifics of plans for follow-up or patient return.

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Essential Elements of the Records continued

- Past medical and surgical history, family history, social history, personal habits (cigarette smoking, alcohol use, athletic activity, etc.).

Many physicians find that the SOAP format [Subjective, Objective, Assessment and Plan] facilitates systematic documentation.

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In Summary

The structure of the medical history should include:

- Basic information about the patient;
- Description and history of the presenting problem;
- Review of body systems;
- Past medical and surgical history;
- Family history; and
- Social history.

Organization of the Medical Records

- In office based practices where there is a single patient chart, it is expected that all materials in each patient chart will ordered in a chronological and systematic manner.

- In settings such as walk in clinics, single patient files must be created for that patient and all documentation must be kept in the patient's file in a chronological and systematic manner.

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Clinical Notes

- Clinical notes are notes that are made contemporaneously with a physician-patient encounter. They must capture all relevant information from a patient encounter.

- One of the most widely recommended methods for documenting a patient encounter is the Subjective Objective Assessment Plan (SOAP) format.

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Subjective Data

The subjective elements of the patient encounter (that which is expressed by the patient) should be documented in this section (e.g., patient reports of nausea, pain, tingling).

- Presenting complaint and associated functional inquiry, including the severity and duration of symptoms;

Subjective Data continued

- Identify if this is a new concern or an ongoing/recurring problem;
- Changes in the patient's progress or health status since the last visit;
- Review of medications, if appropriate;
- Review of allergies, if applicable;

Subjective Data continued

- Past medical history of the patient and his or her family, where relevant to the presenting problem;
- Patient risk factors, if appropriate;
- Salient negative responses

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Objective Data

The measurable elements of the patient encounter and any relevant physical findings from the patient exam or tests previously conducted are documented in this section.

- Physical examination appropriate to the presenting complaint;

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Objective Data continued

- Positive physical findings;
- Significant negative physical findings (as they relate to the problem);
- Relevant vital signs;
- Review of consultation reports, if available;
- Review of laboratory and procedure results if available

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Assessment

This section will contain the physician's impression of the patient's health issue:

- Diagnosis or differential diagnosis

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Plan

- The physician's plan for managing the patient's condition is described in this section.
- Discussion of management options;
- Tests or procedures ordered and explanation of significant complications, if relevant;
- Consultation requests including the reason for the referral, if relevant;
- New medications ordered and/or prescription repeats including dosage, frequency, duration and an explanation of potentially serious adverse effects;

Plan continued

- Any other patient advice or patient education (e.g., diet or exercise instructions, contraceptive advice);
- Follow-up and future considerations;
- Specific concerns regarding the patient, <u>including any decision by the patient not to follow the physician's recommendations.</u>

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Consultation Requests

Consultation requests should include:

- Reasons for referral;
- Urgency of the consultation;
- Relevant medical history;
- Current medications and all relevant test and procedure results.

The physician should retain a copy of the referral note as part of the ongoing record of the patient's care.

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Operative Notes

The typical operative note should include:

- patient name and the identifiers such as birth date, health care number, address, and hospital identification number if applicable;
- the name of the family physician (and referring health professional if different from the family physician);

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Operative Notes continued

- the operative procedure performed;
- the date on which the procedure rook place;
- the name of the primary surgeon and assistants;
- the name of the anaesthetist (if applicable) and type of anaesthetic used (general, local, sedation);
- pre-operative and post-operative diagnoses(if applicable);

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Operative Notes continued

- a detailed outline of the procedure performed, including
  - administration of any medications or antibiotics,
  - patient positioning,
  - intra-operative findings,
  - prostheses or drains left in at the close of the case,
  - complications including blood loss or need for blood transfusion,

Operative Notes continued

- review of sponge and instrument count (i.e., a statement of its correctness at the conclusion of the case), and

- patient status at the conclusion of the case (stable and sent to recovery room vs. remained intubated and transferred to ICU).

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Consultation Reports

- The consulting physician must report to the referring family physician or health professional (if he or she is not the family physician) after completion of the initial assessment (which may take more than one visit). In general, the following content should be included (as applicable) in the initial consultation report:

- An opening statement outlining the reasons for the consultation;

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Consultation Reports continued

- An appropriate history related to the problem with documentation of the relevant positive and negative findings to assist in making a differential diagnosis, including any risk factors related to the disease under consideration;
- A review of systems;
- Family and social histories;
- A review of medications and allergies;

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Consultation Reports continued

- A complete physical examination of the system of interest;
- A review of available laboratory results, reports of relevant investigations, and any other pertinent patient data;
- A summary of conclusions and recommendations including the following:

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Consultation Reports continued

- the investigations to be done,
- the potential risks and benefits of each investigation (if applicable),
- the treatment prescribed or administered, including any changes to existing medications or new medications prescribed, and a list of side effects that were discussed with the patient,

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Consultation Reports continued

- the professional advice provided to the patient, and particulars of any referral made by the physician; and

- the follow up plan indicating if the consultant or the referring physician will follow up and when the patient is to return to the consulting physician/referring health professional.

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Subsequent Consultation Reports continued

Subsequent reports should be sent to the referring physician when there are new findings or a change to the treatment plan.

Follow up reports should include:

- A detailed review of the problem originally consulted on and any response to therapy;
- A detailed physical examination related to the system or problem;

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Subsequent Consultation Reports continued

- A review of any laboratory reports, consultation reports;
- reports of investigations performed, and any other pertinent patient data received since the previous visit related to the system/problem; and
- a summary of conclusions, recommendations, and follow-up plan as noted above.

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Consultation Reports continued

Copies of reports must be kept in the consultants' records except in the case of a consultation which occurs in a hospital, long-term care facility, or other clinic or facility where common medical records are maintained.

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Discharge Summaries

- A discharge summary outlining the particulars of a patient's stay in a health facility must be completed for all inpatients and dated and signed by the attending physician. If the physician anticipates a delay in the completion of the discharge summary, he or she should ensure that an immediate brief summary is available to those who will be responsible for follow-up care.

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Discharge Summaries continued

All discharge summaries must include:

- identifying information
- distribution of copies to the referring physician and/or family physician;
- a brief summary of the management of each of the active medical problems during the admission, including major investigations, treatments, and outcomes;

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Discharge Summaries continued

- details of discharge medications, including reasons for giving or altering medications, frequency, dosage, and proposed length of treatment; and

- follow-up instructions and specific plans after discharge, including a list of follow-up appointments with consultants, further outpatient investigations, and outstanding tests and reports needing follow-up.

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The Codes of Ethics – Privacy

Bylaw 7.1 The Code of Ethics states:

31. Protect the personal health information of your patients.

32. Provide information reasonable in the circumstances to patients about the reasons for the collection, use and disclosure of their personal health information.

The Codes of Ethics – Privacy

33. Be aware of your patient's rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately.

34. Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.

The Code of Ethics – Privacy

35. Disclose your patients' personal health information to third parties only with their consent, or as provided for by law, such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached.

The Code of Ethics – Privacy

36. When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.

37. Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

Health Information Protection Act

The Health Information Protection Act addresses the following:

- Confidentiality
- Security
- Access
- Privacy
- Patient consent

Health Information Protection Act

- The College of Physicians and Surgeons and the Saskatchewan Medical Association have collaborated to develop policies and tools to assist you in maintaining confidentiality and security of your patient records and/or information.
- Visit the websites of both organizations for more information.

Transition from Paper to Electronic

Principles to guide the transition process:

- Patient information must be secure;
- Privacy of patient information must be maintained;
- Integrity of the medical record content must be maintained;
- The integrity of the clinical workflow supported by the medical record must be maintained;
- Continuity and quality of care must be maintained through the transition period.

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Standards for EMR Data Quality

Standards for data quality, accountability, and integrity need to be incorporated into the EMR within each practice and adopted to promote uniformity in the data for group practiced. The features of quality data elements include:

- Accessibility – data items should be easily obtainable and legal to collect
- Accuracy – data are the correct values and are valid

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Standards for EMR Data Quality

- Comprehensiveness – all required data items are included
- Consistency – data is recorded in a consistent manner
- Currency – the data should be up to date
- Definition – the attributes and values of data should be defined at the correct level of detail
- Relevancy – data are meaningful for the purpose for which they were collected.

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EMRs are valuable tools, but must be managed appropriately

- Appropriate security must be in place to prevent unauthorized people from accessing patient information. Security measures may include role-based permissions to access records, password controls and/or data encryption.

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Transition from Paper to Electronic

- Access logging must be enabled so you can monitor who is viewing your EMRs.
- Data must be backed up and recoverable if the system fails.
- Physicians who use an electronic patient record system that they don't control need to have signed agreements describing how the information they enter will be managed and shared with other physicians and health care professionals.

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Transition from Paper to Electronic

- The CPSS Medical Records bylaw requires that a member shall retain medical records for **six years** after the date of the last entry in the record. Records of pediatric patients shall be retained until **two years** past the age of majority or **six years** after the date last seen, whichever may be the later date.
- When disposing of EMRs, disks must be wiped clean or rendered unreadable so the information can never be retrieved.

Cautions for EMR Use

- Be cautious of features embedded within the software application which may set default values that may create data in the medical record that was not an actual observation, or the use of template which may limit the addition of relevant data.
- The standards for medical record keeping for EMRs are the same as for paper records.

Cautions for EMR Use

If you have concerns regarding your EMR contact your **EMR software vendor** or the **SMA EMR Peer Support Program** for assistance and support.

Acknowledgements

Information from the following organizations was used in the preparation of this presentation:

College of Physicians and Surgeons of Ontario:

- Medical Records Policy Statement;

College of Physicians and Surgeons of British Columbia:

- Professional Standards and Guidelines – Medical Records in Private Physician's Offices;
- Professional Standards and Guidelines – Electronic Medical Records;

College of Physicians and Surgeons of Alberta:

- Administration of Practice – Medical Records
- Practice Management – Transition to Electronic Medical Records;
- Information Sheet - EMRs and Physicians

Please contact the College Office if you have questions regarding record keeping.