

Records

The public can expect that licensed healthcare professionals will secure and maintain complete, accurate, and timely records in a way that supports safe, ethical, and effective care and service, protects privacy, and meets legal and professional obligations. The public are entitled to access their records.

This Practice Standard applies to all records created, collected, maintained, accessed, used, and disclosed in the provision of health services or the completion of other professional activities. It applies to written, electronic, audio, visual, and other forms of records related to patients or individuals being assessed, services, communications, and professional decisions. It applies in all practice contexts, including clinical care, assessments, consultations, supervision, and administration.

A licensee must:

1. *Create complete and accurate records, which means to:*

- 1.1. Create and maintain a record for each patient or individual being assessed containing and documenting:
 - 1.1.1. The licensee's identity and professional designation.
 - 1.1.2. Only the personal and demographic information required to provide the health services.
 - 1.1.3. Sufficient information to clearly explain why the patient or individual is being assessed and what the licensee learned from the patient's relevant interview, history, and/or physical examination.
 - 1.1.4. Patient consent to proceed with the collection of information and the provision of health services.
 - 1.1.5. Investigations, evaluations, interventions, assessments, and re-assessments the licensee conducted or ordered, and their findings, results, data, or reports.
 - 1.1.6. The assessment and, where applicable, the diagnosis or provisional diagnosis.
 - 1.1.7. The specifics of any treatment, education, recommendations, medication, goals, monitoring, or follow-up plan.
 - 1.1.8. Patient outcomes and responses to treatment.
 - 1.1.9. Changes to the care plan and the discharge plan, where known.
 - 1.1.10. The assignment or transfer of care.
 - 1.1.11. Communications with other healthcare providers.
 - 1.1.12. Critical thinking and decision making where deviating from expected standards.



- 1.1.13. The date on which service was provided, the type of service, the amount charged, and the method and date of payment, if appropriate to the setting.
 - 1.2 Identify themselves in each entry they make in the patient record, if more than one healthcare provider is contributing to the patient record.
 - 1.3 Make any necessary amendment to the patient record in a transparent manner, without obscuring the original entry, by adding a notation of the amendment and the date the amendment was made or by having an audit trail that records who made the change, what was changed, and when the change was made.
- 2. *Ensure the timeliness and accuracy of record keeping, which means to:***
- 2.1. Ensure that each record has a unique identifier.
 - 2.2. Complete records contemporaneously or promptly after service delivery.
 - 2.3. Record the date and, where appropriate, the time of each entry in the record.
- 3. *Ensure clarity and legibility, which means to:***
- 3.1. Ensure records are legible, clear, and accessible, regardless of format.
 - 3.1.1. Define abbreviations or use standardized abbreviations where applicable to the practice setting and profession.
- 4. *Use accessible language, which means to:***
- 4.1. Use clear, respectful language that balances patient understanding with appropriate professional and clinical terminology.
 - 4.2. Make a certified translation available to the patient, others involved in the patient's care, the third party that contracted the licensee to provide the service, or CHCPBC, upon request and at no cost to the patient, if the patient records are completed in a language other than English or French.
- 5. *Enable patients to access and/or identify corrections to their records, which means to:***
- 5.1. Upon request, provide the patient or other authorized person with access to and/or a copy of the patient record within 30 business days, unless:
 - 5.1.1. Access poses a significant likelihood of physical, mental, or emotional harm to the patient or a third party.
 - 5.1.2. The patient is a minor and the state of their physical, mental, and/or emotional development would not enable them to understand the record contents.
 - 5.1.3. The disclosure could reasonably be expected to disclose personal information about another person.



- 5.1.4. The disclosure would jeopardize the security and integrity of test materials, test data, or scoring keys used by psychologists.
 - 5.2. Charge clear and reasonable fees for copies of records and reports.
 - 5.3. Clearly document and date any change requested by a patient or authorized person, noting the particulars of the correction sought if the licensee disagrees with the need for correction.
- 6. *Appropriately retain and dispose of records, which means to:***
- 6.1. Maintain a complete patient record or ensure that a system is in place to maintain a complete patient record for at least 16 years from the date of the last encounter with the patient, or 16 years from the date the patient reaches the age of majority—whichever date is later.
 - 6.2. Ensure that patient records are disposed of securely, in a manner that maintains confidentiality, after the retention period in s. 6.1 expires.
- 7. *Protect records in the event of discontinuing practice, which means to:***
- 7.1. Ensure that there is a system in place to meet the requirements of this Standard where the licensee works in a practice environment in which the records are in the custody and control of an employer, institution, public body, or other organization.
 - 7.2. Make a succession plan for record retention that will ensure ongoing compliance with the Ethics and Practice Standards and legislation in the event the licensee discontinues practice, moves to a different jurisdiction, or becomes incapable of practice.
 - 7.3. Transfer custody and control of records to another regulated healthcare professional or to a health organization or records management service if the licensee or former licensee is no longer able to retain the records and respond to access requests after discontinuing practice or moving to a different jurisdiction.
 - 7.4. Provide current patients with advance written notice, to the extent possible, prior to discontinuing practice or moving to a different jurisdiction, including explanation of how patients can continue to access their records.
 - 7.5. Make reasonable efforts to ensure information is available to all current and former patients about how they can obtain or continue to access their records.
 - 7.6. If records are relocated, notify CHCPBC of their new location within 30 business days.
- 8. *Ensure the accuracy of shared and collaborative records, which means to:***
- 8.1. Take reasonable steps to address any error or omission identified in a record, including contacting the individual responsible for the entry and seeking correction or clarification where feasible.



9. *Protect records when using third-party storage services, which means to:*

- 9.1. Ensure any storage service used complies with all privacy, security, access, and retention requirements under privacy legislation and the Ethics and Practice Standards.

Related Standards and Legislation

Consent

Privacy and Confidentiality