Medical Records Documentation

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.
Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Cumulative Patient Profile (CPP) or equivalent patient health summary: A summary of essential information about a patient that includes critical elements of the patient's medical history and allows the treating physician, and other health care professionals using the medical record, to quickly get a picture of the patient's overall health.

Policy

Documenting the Patient Encounter

1. Physicians **must** comply with all relevant legislation[1] and regulatory requirements related to medical record-keeping.

2. The goal of the medical record is to "tell the story" of the patient's health care journey. As such, physicians' documentation in the medical record **must** be:

    a. legible;[2]
    b. understandable to health care professionals reading the record, including avoiding the use of abbreviations that are known to have more than one meaning in a clinical setting;
    c. accurate;
    d. complete and comprehensive, containing:
        i. all relevant information;
        ii. information that conveys the patient's health status and concerns;

[1] *Personal Health Information Protection Act*, *2004*, S.O. 2004, c.3, Sched. A (hereinafter *PHIPA*); Part V of the General, O. Reg., 114/94, enacted under *the Medicine Act, 1991*, S.O. 1991, c. 30 (hereinafter *Medicine Act*, General Regulation); General, O. Reg., 57/92, enacted under the *Independent Health Facilities Act*, R.S.O.1990, c.1.3 (hereinafter *IHFA,* General Regulation); Hospital Management, Regulation 965 enacted under the *Public Hospitals Act*, R.S.O. 1990, c.P.40 (hereinafter *Public Hospitals Act*, Hospital Management Regulation). *Health Insurance Act*, R.S.O.1990, c. H.6.
[2] *Medicine Act,* General Regulation, s. 18(3).

iii. any pertinent details that may be useful to the physician or future health care professionals who may see the patient or review the medical record; and
iv. documentation that supports the treatment or procedure provided;

e. unique to each patient encounter (e.g., refraining from inappropriate use of cut and paste);
f. professional and non-judgmental, in accordance with the College's *Professional Obligations and Human Rights* policy;
g. identifiable and contain a signature or audit trail that identifies the author;
h. written in either English or French; and
i. organized in a chronological and systematic manner.

3. Physicians **must** date each entry in the medical record. Where the date of the patient encounter differs from the date of documentation, physicians **must** record both dates.[3]

Documentation on the physician's behalf

4. In circumstances where an entry is made on the physician's behalf, physicians **must** ensure that the expectations set out in this policy are met.[4]

Timing of Documentation

5. To support the safe delivery of care, physicians **must** document their patient encounters as soon as possible.

Use of Templates

6. In keeping with the requirements of accuracy and completeness set out in 2(c) and 2(d) above, physicians **must**:

a. avoid the use of templates that are pre-populated, where possible;
b. refrain from using overly general templates;
c. only use templates that allow entry of free-text or that can be customized to allow for greater descriptive detail; and
d. verify that the entries populated using a template accurately reflect the encounter and that all pertinent details about the patient's health status have been captured.

[3] Documenting the date of the professional encounter is a requirement under s. 18 made of the *Medicine Act,* General Regulation; s. 19(2) of the *Public Hospitals Act,* Hospital Management Regulation requires each entry in a medical record to indicate the date on which it was made.

[4] There are circumstances where a physician's records are transcribed on the physician's behalf. In these circumstances the notation "dictated but not read" is often used to signify that that the physician has not yet reviewed the transcription for accuracy. The Canadian Medical Protective Association's article *"Dictated but not read": Unreviewed clinical record entries may pose risks* sets out advice on how to mitigate risks when dictating medical record entries or reports.

What to Document: Medical Records Content

CPP or Equivalent Patient Health Summary

7. Primary care physicians **must** include an easily accessible, up to date CPP, or an equivalent patient health summary, in each patient medical record.

8. All other physicians **must** use their professional judgement to determine whether to include a CPP or an equivalent patient health summary in each patient medical record, considering a variety of factors, such as the nature of the physician-patient relationship (e.g., whether it is a sustained physician-patient relationship[5]), the nature of the care being provided, and whether the CPP or equivalent summary would reasonably contribute to quality care.

9. Physicians **must** capture in the CPP or equivalent summary, the following, where applicable:[6]

    a. patient identification (i.e., name, address, phone number, date of birth, OHIP number);
    b. personal and family data (e.g., occupation, life events, habits, family medical history);
    c. past medical history (e.g., past serious illnesses, operations, accidents, genetic history);
    d. risk factors;
    e. allergies and drug reactions;
    f. ongoing health conditions (e.g., problems, diagnoses, date of onset);
    g. health maintenance (e.g., periodic health exams, immunizations, disease surveillance);
    h. names of any consultants involved in the patient's care;
    i. long-term management needs (e.g., current medication, dosage, frequency);
    j. major investigations;
    k. date the CPP was last updated; and
    l. contact person in case of emergencies.

Clinical Notes

10. Physicians **must** document evidence of the following for all patient encounters:

[5] A sustained physician-patient relationship is physician-patient relationship where care is actively managed over multiple encounters.

[6] There may be variations in content and format of the CPP or equivalent patient health summary based on the physician's practice area and the nature of the physician-patient relationship (i.e., whether there is a sustained physician-patient relationship).

a. a focused relevant history;
b. an assessment and an appropriate focused physical exam (where indicated);
c. a diagnosis and/or differential diagnosis (where indicated); and
d. a management and follow-up plan.

11. Physicians **must** capture the following in each patient medical record:

a. any prescriptions issued in accordance with the College's *Prescribing Drugs* policy;
b. informed consent in accordance with the College's *Consent to Treatment* policy and any consents to treatment obtained in writing;
c. all tests, referrals, and consultations requisitioned, including a copy of the referral note, and any associated reports and results;[7]
d. any treatments, investigations, or referrals that have been declined or deferred, and the reason, if any, given by the patient;
e. any operative and procedural records;[8] and
f. any discharge summaries.[9]

12. Physicians **must** use their professional judgement in determining whether to document the details of discussions with other health care professionals involved in the patient's care (e.g., by telephone, email, etc.), considering factors such as whether the discussion informed the care and treatment of the patient.

Telephone and Electronic Communications with Patients

13. Physicians **must** capture in the medical record (e.g., document or upload, where relevant) details of all communication with patients where health information about the patient is collected and exchanged (e.g., including via telephone, e-mail,[10] patient portals or other digital platforms) similar to any other patient encounter.

Corrections to Medical Records

Where electronic medical record-keeping systems are used, audit trails achieve the expectations set out in provision 14 below.

[7] For additional guidance regarding information that must be contained in a referral note and consultation report, please refer to the College's *Transitions in Care* policy.
[8] Guidance for documenting operative and procedural notes is set out in the *Advice to the Profession* document.
[9] Sections 19(4) and 19(5) of the *Public Hospitals Act*, Hospital Management Regulation set out a number of additional requirements for documentation in a hospital setting. Physicians who practise in hospitals are advised to refer to the legislation for information about the specific requirements.
[10] For expectations related to e-mail communications with patients please refer to the College's *Protecting Personal Health Information* policy.

14. In accordance with the *Personal Health Information Protection Act, 2004*, in instances where it is necessary to modify a medical record to ensure accuracy and completeness, physicians **must** date and initial the additions or changes and either:

    a. remove and store the incorrect information separately and ensure there is a notation in the record that allows for the incorrect information to be traced; or
    b. maintain the incorrect information in the record but clearly label it as incorrect, and ensure the information remains legible (e.g., by striking through incorrect information with a single line).[11]

15. Where a patient requests a correction to the medical record but the physician feels it is unwarranted, the physician **must** act in accordance with *PHIPA*, including**:**

    a. giving the reasons for the refusal;
    b. informing the patient that they are entitled to prepare a statement of disagreement that sets out the correction; and
    c. attaching the statement of disagreement to the medical record, upon request.[12]

[11] *PHIPA,* s. 55(10).
[12] *PHIPA*, s. 55(11). For additional requirements pertaining to corrections, please refer to s. 55 of *PHIPA*.