Professional Standard

Record-Keeping

Principle	Outcome Statement
As a licensee, you must meet the following Principles within the Professional Standard: Record-Keeping.	**People receiving health care services from a CCHPBC licensee expect that their health care practitioner will:**
Principle 1: CCHPBC licensees must create and maintain patient health care records that are accurate, complete, up to date, and clearly reflect the care provided and the patient's current health status.	Ensure that the health care records they keep are accurate, complete, and up to date.
Principle 2: CCHPBC licensees are responsible for ensuring that all patient health care records are retained, stored, transferred, and disposed of in a secure, confidential, and legally compliant manner.	Ensure that the health care records they keep are securely stored and disposed of in accordance with legal and regulatory requirements.
Principle 3: CCHPBC licensees must respond promptly and professionally to requests for access to health care records from patients and patients' authorized representatives.	Respond promptly to inquiries for access to a patient's health care records in compliance with all applicable legal requirements.
Principle 4: CCHPBC licensees are responsible for handling personal health information carefully and lawfully, ensuring it is only collected, used, and disclosed with proper consent and/or legal authority..	Collect, use and disclose only the personal information necessary to deliver safe, quality care and ensures that this information remains confidential.

Principle 1: CCHPBC licensees must create and maintain patient health care records that are accurate, complete, up to date, and clearly reflect the care provided and the patient's current health status.

To meet this standard, CCHPBC licensees must:

1.1 Create and maintain separate physical or digital health care records for each individual patient.

1.2 Ensure that their patient health care records are clear and comprehensive. At minimum, licensees must document:

- **1.2.1** Patient identifying information as provided by the patient, including the patient's full name, sex or gender, date of birth, current contact information and emergency contact;
- **1.2.2** The name of any referring licensee or health care practitioner;
- **1.2.3** All relevant communications with patients, other health care practitioners and insurance providers, including reports, emails, texts, and other forms of correspondence that are pertinent to patient care;
- **1.2.4** All relevant medical history, allergies, medications, risk factors, and current health conditions, as provided by the patient, as of the date of their last appointment;
- **1.2.5** Dates of appointments;
- **1.2.6** Any clinical assessments, working diagnoses, treatment plans, treatment provided, response to treatment, follow-up recommendations, and treatment changes; and
- **1.2.7** Patient informed consent, refusal, and any signed forms related to assessment, treatment and information sharing.

1.3 Ensure that patient health care records are completed in a timely, consistent, and professional manner to ensure clarity, accuracy, and accessibility, including by:

1.3.1 Completing health care records at the time of the patient visit or as soon as practical afterward, ensuring they are finalized, dated, and signed (including digital signature, where applicable).

1.3.2 Dating each entry and identifying the treating licensee making it.

1.3.3 Ensuring that entries are legible, permanent, and easily understood.

1.3.4 Indicating any changes by clearly dating and initialing them, ensuring that original entries remain intact and are not deleted or erased.

1.3.5 Maintaining health care records in a consistent format (e.g., books, files, binders) or storing them electronically in accordance with any applicable College policies and guidelines on electronic health records.

1.4 Ensure that entries are produced in English upon request by a patient or third-party, by:

1.4.1 Creating the record entries in English, or in relation to entries for the practice of traditional Chinese medicine and acupuncture only, having certified translated copies prepared and produced.

1.5 Maintain separately both of the following:

1.5.1 A daily appointment log that records the date and time of each appointment, the name of each patient, and the treatment and service provided.

1.5.2 Billing records and receipts that clearly identify the patient's name, date of service, nature of the service provided, products supplied and their descriptions, location of the service, fees charged, and licensee name and license number.

Principle 2: CCHPBC licensees are responsible for ensuring that all patient health care records are retained, stored, transferred, and disposed of in a secure, confidential, and legally compliant manner.

To meet this standard, CCHPBC licensees must:

2.1 Retain patient health care records, appointment logs, billing records, and receipts for a minimum of 16 years from either the date of the last entry, or from the age of majority, whichever is later, except as otherwise required under the *Limitation Act* or any other applicable legislation.

2.2 Protect the privacy and confidentiality of patients' personal health information as set out in the *Personal Information Protection Act*, and any other applicable legislative and regulatory requirements.

2.3 Ensure that the method of record creation and retention, including digital systems, complies with requirements set out in the *Personal Information Protection Act* and any other applicable legislation.

2.4 Securely store patient health care records using appropriate physical, electronic, and administrative safeguards, limit access to authorized individuals only, and maintain documentation of the storage locations and security measures in place.

2.5 Ensure that the transfer of health care records is conducted, with patient consent, in a secure and appropriate manner that protects patient privacy.

2.6 Dispose of health care records in compliance with all legal and regulatory requirements, only once the applicable retention period has been met. Health care records must be permanently and securely destroyed so that the information cannot be retrieved or reconstructed.

2.7 Ensure the proper retention, transfer or disposal of patient health care records when ceasing to practice by:

2.7.1 Ensuring that health care records subject to retention requirements are either securely transferred or retained until the expiry of the retention period.

2.7.2 Planning in advance for the secure transfer of health care records in the event of death or incapacity by designating a practicing licensee in the same or another regulated health profession as custodian.

2.7.3 Notifying patients in writing if their health care records are transferred under these provisions as soon as reasonably possible.

2.8 Provide the College, upon request, with information about where and how health care records are stored.

2.9 Take reasonable steps to protect all records from theft, loss, and unauthorized use or disclosure and, in the event of a privacy breach, comply with applicable breach notification and response requirements under the *Personal Information Protection Act* and any other applicable privacy legislation, and any applicable College policies or protocols.

Principle 3: CCHPBC licensees must respond promptly and professionally to requests for access to health care records from patients and patients' authorized representatives.

To meet this standard, CCHPBC licensees must:

3.1 Provide patients or their representatives with access to their personal health care records within 30 business days, unless an exception for disclosure is made under applicable privacy legislation.

3.2 Provide patients with copies of their personal health care records within 30 business days, subject to applicable legal exceptions (e.g., under the *Personal Information Protection Act*).

3.3 Ensure that any fees charged for health care record transfers or production of copies of patient health care records are reasonable.

Principle 4: CCHPBC licensees are responsible for handling personal health information carefully and lawfully, ensuring it is only collected, used, and disclosed with proper consent and/or legal authority.

To meet this standard, CCHPBC licensees must:

4.1 Collect only the personal information reasonably required to provide health care or fulfill legal obligations, and do so in a manner that respects patient consent and complies with requirements set out in applicable privacy legislation.

4.2 Be transparent with patients about what information is collected, why it is collected, and how it will be used.

4.3 Limit the use of personal information to the purposes for which it was collected, and limit obtaining consent for any additional use unless otherwise permitted by law.

4.4 Protect the privacy, confidentiality, and security of personal information at all times, and disclose it only when necessary for patient care, administration, legal purposes, or as otherwise authorized by law and/or patient consent.

4.5 Document all disclosures of patient information in the patient health care record.