LEARNING SERIES: PUTTING STANDARDS INTO PRACTICE

Workbook

Record-Keeping

Module 1

College of
COMPLEMENTARY HEALTH
PROFESSIONALS OF BC

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Introduction

As a licensee of the College of Complementary Health Care Professionals of BC (CCHPBC), you are responsible for maintaining complete and accurate health care records in accordance with the Professional Standard: Record-Keeping.

This workbook is designed to help you understand and apply the Professional Standard: Record-Keeping in your day-to-day practice.

HOW TO USE THIS WORKBOOK

The workbook has been designed to review one Principle at a time. Make sure you have a copy of the professional standard open as you go through the workbook and reflect on how you meet the professional standard within your day-to-day practice. Be sure to use the fillable text boxes throughout the workbook to record your answers and reflections. Answers to the "Apply to Practice" questions can be found in the Answer Key at the end of the workbook.

Resources are available to support you. See the orientation video and the resources at the end of the workbook for more information.

Professional Standard
Record-Keeping

Learning Outcomes

After reviewing the Professional Standard: Record-Keeping and engaging with the workbook, licensees will demonstrate practical understanding of the legal and ethical requirements for creating and maintaining health care records and obtaining personal information.

Specifically, licensees will be able to:

- Describe the requirements for creating and maintaining accurate, complete, and up-to-date health care records.
- Evaluate health care record storage and management methods to ensure they are secure and align with legal requirements.
- Identify the requirements related to health care record access requests from patients, the College, and third parties.
- Describe how to obtain and handle personal health information responsibly.

Principle 1 and Outcome Statement

Principle 1	Outcome Statement
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.	People receiving health care services from a CCHPBC licensee expect that their health care practitioner will ensure that the health care records they keep are accurate, complete, and up-to-date.

Why is accurate, complete, and up-to-date record keeping important?

Health care records are legal documents—clear, factual entries help ensure a licensee meets professional and legal obligations. Accurate and complete health care records support safe and effective care by documenting the patient's health history and reason for care, the care provided, and the clinical rationale for the licensee's decisions. Complete documentation also supports continuity of care between health care practitioners.

As you review Principle 1, think through and respond to the following questions. Answers to the questions with a (key icon) can be found in the Answer Key, while questions with a (light bulb icon) are for your own reflection.

1 A typical work day means that you provide care to between 5 and 10 patients.

CHECK YOUR UNDERSTANDING

(a) Does each patient require a separate health care record?

- ◯ Yes
- ◯ No

(b) What other records must be maintained separately?

IN YOUR PRACTICE...

...can a patient who sees multiple health care practitioners in a multi-disciplinary clinic have one health care record? If so, how must the patient's confidentiality be preserved? Consider if the answer differs for paper versus electronic medical records.

2 You are creating a new health care record, and so far, it contains the patient's name and treatment provided.

CHECK YOUR UNDERSTANDING

Based on Principle 1, what information are you missing?

IN YOUR PRACTICE...

... do you have a procedure for ensuring that all relevant communication is added into the patient's health care record? This includes reports, emails, texts, and other forms of correspondence pertinent to patient care.

3

You regularly have unsigned or draft health care records for patients that date back a few weeks.

CHECK YOUR UNDERSTANDING

Which of the following is required when completing health care records? Select all that apply:

- ◯ **(a)** Updating health care records only at the end of each week for efficiency.
- ◯ **(b)** Editing original entries by deleting information that is no longer relevant.
- ◯ **(c)** Completing health care records at the time of the visit or as soon as practical afterward, ensuring they are dated, signed, and legible.
- ◯ **(d)** Using different formats and systems for each patient as long as all information is stored somewhere.

IN YOUR PRACTICE...

... do you ensure that the health care records you create are complete and signed (including digitally) as soon as possible? If not, can you identify what changes need to be made to your existing processes?

4 When reviewing a previous health care record entry for an upcoming patient, you notice that you made an error.

CHECK YOUR UNDERSTANDING

How do you correct the error?

IN YOUR PRACTICE...

... what procedures do you have in place to properly correct errors in a health care record? Why is it important to correct errors properly?

5 You regularly document and maintain health care records in your first language, which is not English.

IN YOUR PRACTICE...

... if required, do you have a policy or procedure for producing certified translated copies of health care records?

Principle 2 and Outcome Statement

Principle 2	Outcome Statement
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.	People receiving health care services from a CCHPBC licensee expect that their health care practitioner will ensure that the health care records they keep are securely stored and disposed of in accordance with legal and regulatory requirements.

Why is storage and disposal of health care records important?

Securely storing, transferring, retaining, and properly disposing of health care records is essential to protecting patient privacy and maintaining public trust. Secure management of health care records helps prevent unauthorized access, identity theft, and misuse of information while ensuring patient access and continuity of care.

As you review Principle 2, think through and respond to the following questions. Answers to the questions with a (key icon) can be found in the Answer Key, while questions with a (light bulb icon) are for your own reflection.

1

You are planning on retiring and need to determine which health care records will require ongoing retention and which can be destroyed.

CHECK YOUR UNDERSTANDING

How many years must a patient's health care record be stored?

- ○ **(a)** 10 years
- ○ **(b)** 11 years
- ○ **(c)** 9 years
- ○ **(d)** 16 years

IN YOUR PRACTICE...

... how do you ensure adequate retention of health care records in your possession both currently and upon retirement?

2 A number of health care records in your possession have met the retention requirements and can be properly destroyed.

CHECK YOUR UNDERSTANDING

What disposal requirements must you meet?

IN YOUR PRACTICE...

... how will you ensure that health care records in your possession will be securely destroyed when they have met the retention period? Be mindful of differences between securely destroying paper or electronic health care records.

3 You receive a request for a patient's health care record by a third party.

CHECK YOUR UNDERSTANDING

Protection of patient privacy and confidentiality is set by which legislative act?

- ○ **(a)** *Personal Information Protection Act* (PIPA).
- ○ **(b)** *Infant Act.*
- ○ **(c)** *The Limitations Act.*
- ○ **(d)** *The Health Care (Consent) and Care Facility (Admission)* Act.

IN YOUR PRACTICE...

... what processes do you have in place that limit access to health care records to authorized people only?

4 Another licensee requests a former patient's health care records.

CHECK YOUR UNDERSTANDING

What are you required to do?

IN YOUR PRACTICE...

... what documentation is required when transferring a health care record?

5 You want to switch providers for the management of your digital health care records.

CHECK YOUR UNDERSTANDING

What is required to ensure health care records are stored safely and in a legally compliant manner?

IN YOUR PRACTICE...

... do you meet the Professional Standard: Record-Keeping requirements for health care record storage? If not, identify which areas require attention and develop a plan for implementation.

Principle 3 and Outcome Statement

Principle 3	Outcome Statement
CCHPBC licensees must respond promptly and professionally to requests for access to health care records from patients and patients' authorized representatives.	People receiving health care services from a CCHPBC licensee expect that their health care practitioner will respond promptly to inquiries for access to a patient health care records in compliance with all applicable legal requirements.

Why is responding promptly and professionally for access to health care records important?

By adhering to applicable laws when providing access to health care records, licensees maintain a professional, supportive, and respectful relationships with patients or their representatives.

As you review Principle 3, think through and respond to the following questions. Answers to the questions with a 🔑 (key icon) can be found in the Answer Key, while questions with a 💡 (light bulb icon) are for your own reflection.

1 A parent of a 10-year-old patient calls your clinic to ask for a copy of their child's health care record as soon as possible.

🔑 CHECK YOUR UNDERSTANDING

How long do you have to prepare the health care record copy?

💡 IN YOUR PRACTICE...

... how do you respond to requests for health care records?

2 A patient emails asking how much a copy of their health care record will cost.

CHECK YOUR UNDERSTANDING

How much can you charge for producing a copy of a health care record?

- ○ **(a)** A reasonable amount.
- ○ **(b)** The average of what other health care practitioners are charging in your town.
- ○ **(c)** One hundred dollars.
- ○ **(d)** Your hourly rate for treatments.

IN YOUR PRACTICE...

... how do you ensure that the fees you set for producing copies of health care records are reasonable? What is your rationale?

Principle 4 and Outcome Statement

Principle 4	Outcome Statement
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.	People receiving health care services from a CCHPBC licensee expect that their health care practitioner will collect, use and disclose only the personal information necessary to deliver safe, quality care and ensures that this information remains confidential.

Why is it important to carefully collect and lawfully handle personal health information?

Adhering to applicable privacy legislation ensures that licensees meet their professional obligations for professional and ethical practice. Licensees must foster trust with patients by being open and honest about why personal information is collected and how it will be used.

As you review Principle 4, think through and respond to the following questions. Answers to the questions with a 🔑 (key icon) can be found in the Answer Key, while questions with a 💡 (light bulb icon) are for your own reflection.

1 You collect a variety of personal information on your intake form.

🔑 CHECK YOUR UNDERSTANDING

According to Principle 4, what are the two acceptable reasons for collecting personal information?

💡 IN YOUR PRACTICE...

.... how often do you review your intake form? Are there questions that should be removed because they are not required for providing health care or fulfilling legal requirements?

2 You are asking for a new patient's personal information.

CHECK YOUR UNDERSTANDING

What three things are you required to tell a patient about the collection of their personal information?

IN YOUR PRACTICE...

... how do you apply the requirements for the collection of personal information?

3 Another health care practitioner who is not involved in a patient's care, asks you for information about the treatment you have provided.

CHECK YOUR UNDERSTANDING

According to Principle 4, in this situation can you disclose the patient's treatment?

IN YOUR PRACTICE...

... how often are you asked to share treatment information with another health care practitioner? Are you obtaining consent from patients to share their information?

4

A local charity that you volunteer with, unrelated to your practice, is hosting a fundraiser. You decide to send a group email to patients about the fundraiser and use the BCC function to protect patient privacy.

CHECK YOUR UNDERSTANDING

According to Principle 4, is this type of communication acceptable?

IN YOUR PRACTICE...

... do you have consent to send emails to patients? If so, for what purposes has the patient agreed?

5 One of your colleagues regularly leaves their tablet on with health care records open in a busy lunchroom.

CHECK YOUR UNDERSTANDING

Which requirement is not being met in this situation?

IN YOUR PRACTICE...

... how do you ensure that a patient's personal information is secure at all times? Could you improve procedures to guarantee privacy and security of personal information?

Identify Areas for Growth

Referring to your answers from the previous “IN YOUR PRACTICE…” section, use the questions below to identify the areas of your practice where you are consistently meeting the requirements of the standard as well as areas requiring further growth and development.

- What requirements in the Professional Standard: Record Keeping are you consistently meeting?

- What requirements in the Professional Standard: Record Keeping are you **not** consistently meeting?

For the areas of your practice where you are not consistently meeting the requirements:

- What changes can you make within the next 1-3 months to more consistently meet those requirements?

- Are there continuing professional development opportunities that may help improve your understanding and application of the requirements into practice?

Explore More
Reflection Questions

On your own or with a colleague complete the following reflection questions to further explore how the Professional Standard: Record-Keeping applies to practice.

- In your practice, are health care records securely stored with access limited to authorized persons only?

  - If you are in a multi-disciplinary clinic – is patient consent obtained prior to sharing records between health care practitioners?

  - If you are using an Electronic Medical Record (EMR), how are you controlling access and viewing by unauthorized people?

- When entering a business or employment contract, with respect to health care records, are you able to meet your professional obligations with respect to the storage, maintenance, transfer and disposal of health care records in your possession?

Support

Have questions or need more support?

- **Review Professional Standards and Frequently Asked Questions.**
- Contact a Practice Advisor at **practicesupport@cchpbc.ca**.
- Refer to the ***Limitation Act*** and the ***Personal Information and Privacy Act*** for additional information.

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Feedback Survey

Please take a moment to provide your feedback to improve future learning activities.

Submit feedback

Apply to Practice

Answer Key

1

QUESTION 1 | PRINCIPLE 1

(a) Yes. Licensee's must create and maintain separate physical or digital health care records for each individual patient (Principle 1.1).

(b) A daily appointment log and billing records.

Professional Standard: Record-Keeping, Principle 1.5.1 and 1.5.2 state:

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.*

2

QUESTION 2 | PRINCIPLE 1

Professional Standard: Record-Keeping, Principle 1.2 states:

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.*

3

QUESTION 3 | PRINCIPLE 1

(c) Professional Standard: Record-Keeping Principle 1.3.1 states.

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).*

4

QUESTION 4 | PRINCIPLE 1

Professional Standard: Record Keeping Principle 1.3.4 states:

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

5

QUESTION 5 | PRINCIPLE 1

Professional Standard: Record-Keeping, Principle 1.4 states:

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

QUESTION 1 | PRINCIPLE 2

d) A minimum of 16 years from either the date of the last entry, or from the age of majority, whichever is later.

Professional Standard: Record-Keeping, Principle 2.1 states:

> **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

QUESTION 2 | PRINCIPLE 2

Health care records must be permanently and securely destroyed so that the information cannot be retrieved or reconstructed.

Professional Standard: Record-Keeping, Principle 2.6 states:

> ***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.*

3

QUESTION 3 | PRINCIPLE 2

(a) *Personal Information Protection Act* (PIPA).

4

QUESTION 4 | PRINCIPLE 2

The following transfer requirements must be met:

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

(2) Consider legislation within the Personal Information Protection Act (PIPA) (Principle 2.2).

5

QUESTION 5 | PRINCIPLE 2

Use appropriate physical, electronic, and administrative safeguards 2.4 and take reasonable steps to protect theft, loss, and unauthorized use of the patient health records (Principle 2.9).

Professional Standard: Record-Keeping, Principle 2.4 and 2.9 state:

> ***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.*
> ***2.9*** *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.*

1

QUESTION 1 | PRINCIPLE 3

You should provide a copy of the requested records to authorized people or parties withing 30 business days.

Professional Standard: Record-Keeping, Principle 3.1 states:

> ***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.*

2

QUESTION 2 | PRINCIPLE 3

(a) The fee is at the professional discretion of the licensee. However, licensees must ensure fees are reasonable.

Professional Standard: Record-Keeping, Principle 3.3 states:

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

1

QUESTION 1 | PRINCIPLE 4

Professional Standard: Record-Keeping, Principle 4.1 states:

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.*

2

QUESTION 2 | PRINCIPLE 4

Professional Standard: Record-Keeping, Principle 4.2 states:

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

3

QUESTION 3 | PRINCIPLE 4

No, patient information should only be disclosed with patient consent and when necessary for patient care. Professional Standard: Record-Keeping, Principle 4.4 states:

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

QUESTION 4 | PRINCIPLE 4

No, you should limit the use of personal information to the purposes for which it was collected. Professional Standard: Record-Keeping, Principle 4.3 states:.

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.*

5

QUESTION 5 | PRINCIPLE 4

Licensees need to protect the privacy, confidentiality, and security of patient's personal information at all times.

Professional Standard: Record-Keeping, Principle 4.4 states:

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.*

604.742.6670 | **Toll-free** 1.888.742.6670

900-200 Granville Street , Vancouver BC V6C 1S4