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Module 6:

Medical Records Management

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Key Learning Points

- *Why physicians must maintain good medical records*
- *How long must doctors keep their records?*
- *What are the regulatory standards for medical records?*
- *31 self-assessment questions that demonstrate the medical records standards of regulatory colleges*
- *Privacy legislation and medical record-keeping*
- *Practical advice for using paper records*
- *EMR: The electronic medical record and the future of medical record-keeping*

INTRODUCTION

The medical record is the most important practice tool used by physicians, regardless of specialty, because it supports and enhances the care that our patients receive. It is also a legal document that details the care you provide to your patients, and acts as a record of your billing practices. In the event of a random or specifically indicated review of a physician's medical or billing practice, the medical record will come under scrutiny. The medical review committees of the regulatory Colleges of Physicians and Surgeons and the health ministries base their decisions primarily on the medical record without interpretation by the physician.

As a resident, you deal with patient records every day. What percentage of your written or electronic medical records would meet regulatory standards as legible, comprehensive and stand-alone documents? When we informally poll residents attending Practice Management seminars, they typically indicate that only about 50% of the charts they work with would, to the best of their knowledge, pass a medical review committee audit. This is not acceptable from a learning perspective, a care perspective, and especially not from a medical liability perspective. All physicians have a vested interest in ensuring that their medical records meet provincial licensing standards. Unfortunately, many medical training programs still do not offer formal instruction on the best-practice standards needed to maintain the structure, content and legal requirements of medical records.

In developing this module, the author has drawn from personal knowledge and experience as an expert witness for the prosecution for the College of Physicians and Surgeons of Ontario (CPSO), from his own experience of having his office and medical records reviewed by the CPSO Peer Assessment Program in a random review, and now as a Peer Assessor for the CPSO.

Note that this module will address, in detail, the principles, policies and practice of excellent medical record-keeping that applies to either paper or electronic record management systems. *Module 7: Electronic Medical Records* will address EMR issues in much greater detail.

The author acknowledges that the key resource for the development of this module is the excellent and comprehensive CPSO administrative policy statement #4–12 *Medical Records*, last revised and approved June 2012 and published by the CPSO. This latest policy update addresses in detail the many issues that are unique to electronic medical records (also see Resources, below).

WHY PHYSICIANS MUST MAINTAIN GOOD MEDICAL RECORDS

There are five reasons to keep comprehensive medical records for every patient.

First and foremost, a comprehensive medical record enhances and supports the patient-centred care the patient receives.

More specifically, we must maintain good medical records:

- to provide an accurate and complete account of the history, examination, investigations, treatment plan and ongoing progress of the patient;

Key Message

- *Physicians are required to keep accurate, comprehensive medical records that will stand alone without their interpretation. In addition to meeting medico-legal requirements, good medical records will assist you and your colleagues in offering comprehensive, effective and efficient care for your patients.*

- to assist colleagues when they are consulted or are assuming care for your patients;
- to facilitate the preparation of chart summary, insurance and medico-legal reports; and
- to defend and protect the best interests of the physician and patient in the event of a review by the provincial licensing body or Ministry of Health billing review agency, and especially in the event of a malpractice action.

As an account of the patient's medical history. Considering the number of patients you will deal with over an extended period of time, it is essential that you take the time to ensure that your medical records are comprehensive, accurate, legible and complete. This applies to all physicians, whether you provide ongoing care for the patient or are brought in only for periodic assessments and consultations. Relying on your memory is a formula for disaster.

As a reference for colleagues. A comprehensive record with a clear, well-organized history and workup assists colleagues who cover for your occasional absences, or who see your patients in consultation. They will save valuable time and healthcare resources if they can avoid redundant investigations and medication trials. If you have clearly documented the next medical management steps in the chart, you can also reduce the chance that another physician will drastically change the treatment plan. Not only will you save your colleagues time, your comprehensive record will make their interaction with your patient more clinically effective and financially rewarding.

As a reference for official reports. A comprehensive, well-organized medical record will also help you to prepare reports efficiently and effectively. This will save you time (and thus generate income), especially when the preparation of a medical report is non-insured. For example, a request from an insurance company for an attending physician report can easily be prepared and dictated in five minutes if your chart has an up-to-date cumulative patient profile and medication flow sheet. In most provinces, the payment for this non-insured service was about $110 in 2010. A family physician would be hard-pressed to generate $110 for any other 15-minute service. For consultants, a copy of the comprehensive consultation report with some additional comments is often sufficient, saving the need to create a completely new report.

As evidence in a medical record audit. When physicians accept their independent licence to practise from a provincial College of Physicians and Surgeons and their billing number from the provincial Ministry of Health, they agree to comply with and be accountable to all of the rules, regulations and standards of both regulatory bodies. The college or ministry can request copies of your records from any clinical encounter, at any time, for a random review. If the college review reveals that either your record-keeping or the care documented in these records is substandard, then a more formal review will be initiated and disciplinary action can be mandated. If a Ministry of Health review of your record does not justify the fees you submitted for that clinical encounter, then a more formal review may follow and you can be required to reimburse the ministry for all alleged overbilling. This can be catastrophic, and all costs for defending and appealing a Ministry of Health decision will be your responsibility.

Disciplinary reviews. You can best defend yourself and your actions in a malpractice suit or formal review of billing practices if you have medical records that stand alone without your interpretation. Comprehensive documentation and legible record-keeping are essential.

HOW LONG MUST PHYSICIANS KEEP MEDICAL RECORDS?

For certainty, reference your own province's regulations, but, in many jurisdictions, the following rules apply:

- 10 years after the last entry, or
- 10 years after the patient would have reached 18 years of age, or
- until the physician ceases to practise (subject to, in the Ontario example, subsection 2 of the Regulated Health Profession Act, which states that a family physician who ceases practice must transfer the records to a colleague with the same address and phone number, or
- notify each patient that records will be destroyed in two years unless the patient requests transfer of their records to another doctor).

Note that legal claims against physicians can be made up to 15 years after the alleged incident occurred, so the CMPA advises doctors to keep their records for 15 years after the last encounter.

Many family doctors who cease practice either are not aware of these requirements, or fail to follow the rules. As one can imagine, it would be very costly to contact every patient by phone or mail if the retiring doctor cannot find a physician to assume the practice. Ignorance is not a defence, however. There are now several companies that offer medical record storage and retrieval for physicians who close their practices or retire. Ensure that you verify that such a company meets your college requirements, especially if the company is located out of province. Some provincial medical associations administer a medical record storage and retrieval service for retiring family physicians, making records available to patients who request their medical information.

Because the rules for specialists are not specifically clarified, all consultants are advised to meet the requirements for GPs when applicable and clarify the bestpractice standards with their specialty-specific advisors from the provincial regulatory colleges.

WHAT ARE THE REGULATORY STANDARDS FOR MEDICAL RECORDS?

The rules, regulations and standards for medical records are similar across the country. In this learning module, we will use the College of Physicians and Surgeons of Ontario guidelines to exemplify the rules and regulations. Readers are encouraged to visit the website of their own regulatory college to learn about variations that may exist in their home province.

What Must Be Included In A Medical Record?

There are clear guidelines for medical record-keeping in general and family practice across Canada. Specialty-specific guidelines are now being addressed, so consultants should contact the provincial college for advice on the standards that reviewers would expect to find in an audit of records and consult reports.

The basics are the same for all physicians, however. Although the guidelines apply to both traditional paper and electronic medical records, this discussion will focus on traditional hard-copy charting systems. Specific resources for EMR are included in the Resources section below, and in our dedicated *Module 7* on EMR.

In Ontario, for example, should the College of Physicians and Surgeons audit your medical records, the peer reviewer will use several assessment tools as the basis for evaluation. These are outlined in detail on cpso.on.ca/members/peerassessment. Similar protocols are used throughout the country. The quality of your medical records, as well as the quality of the medical care chronicled in the records, will be assessed and rated.

Each of the criteria will be rated on a scale, such as: present all of the time, most of the time, some of the time, infrequently. The assessor will then summarize the key components of the review of your medical records in one of four levels:

- Appropriate
- Appropriate with suggestions
- Concerns
- not applicable

After the results are summarized and reviewed with you, the assessor will make recommendations. Mandatory remedial work and medical record-keeping upgrade courses may be required if your records do not meet the criteria most of the time. If your quality of care is questioned, then a formal review will be initiated. The same process is followed when the college investigates a complaint lodged by a patient.

Self-Evaluation

Auditing your own medical records is an excellent self-directed learning experience, as well as a tool to help you prepare for a peer assessment. The College of Physicians and Surgeons of Ontario has prepared an excellent selfassessment tool that includes 31 questions. These self-assessment questions are useful to physicians in any province.

Self-evaluation: Assess Your Own Medical Records: CPSO policy statement # 4–12 Medical Records; Appendix C:

When applying the following questions—do your records meet each criteria all of the time, most of the time, or need improvement?

1. Is each individual patient file readily retrievable?
2. Is the record readable to any and all reviewers?
3. Is the patient's name on all components of the chart?
4. Are the patient's name, age, sex and address clearly shown on the chart?
5. Is the date of each visit recorded?
6. Are the family history, past history and functional inquiry (including significant negative observations) clearly recorded and maintained?
7. Are allergies clearly documented?
8. Are immunization records clearly visible?
9. Is a cumulative patient profile (CPP) summary sheet present and maintained?
10. Is the chief complaint clearly stated?

11. Are the durations of symptoms noted?
12. Is there an adequate description of symptoms present?
13. Are positive physical findings recorded?
14. Are the significant negative physical findings recorded?
15. Is there clear documentation of the requested lab and X-ray investigations?
16. Are consult requests noted, and is there documentation that the consult has been arranged?
17. Is the diagnostic impression or differential documented?
18. Are the treatment plan and follow-up instructions clearly noted?
19. Are medication doses and duration of use noted? Are medication amounts and number of repeats noted?
20. Are dated progress notes clearly evident?
21. Are pathology reports retained?
22. Are hospital discharge summaries retained?
23. Are operative notes maintained?
24. Is there documented evidence that periodic health assessments are being performed?
25. Is there evidence that health maintenance issues are periodically discussed; e.g., smoking, alcohol and drug use, obesity?
26. Is there clear evidence that the physician does a review of ongoing medication use; e.g., for chronic medical problems?
27. Is there a system in place to clearly show that all lab tests come to the attention of the physician (i.e., does the physician initial all lab reports)?
28. Is there evidence that an appropriate follow-up appointment has occurred after the receipt of an abnormal lab report?
29. Do all physicians clearly indicate their entries in the chart by signing or initialling their names?
30. Are pediatric growth charts evident?
31. Are provincial antenatal forms used?

DISCUSSION AND SUGGESTIONS

Disclaimer: The author offers the following comments and suggestions for consideration. All attempts to meet best practice standards have been made. Readers need to refer, however, to their specific college policy and guideline statements, and contact their college 'physician advisory service' whenever in doubt.

Before specifically discussing the CPSO's "Self Evaluation Tool", it is important to address a significant hurdle that all physicians must overcome, and that is the timeliness of clinical documentation, It is essential to document all clinical information as soon after the encounter as possible to ensure accuracy and completeness. Regardless of the method—dictating, typing or writing—develop good habits and procedures to promptly complete your notes.

The following comments apply to traditional paper charts. For electronic medical records (EMR), the principles are the same. More specific information is available in the CPSO Policy statement # 5–05 Medical Records, and PMC Module 7, which is dedicated to EMR.

1. Is each individual patient file readily retrievable?
Your medical records must be accessible and organized for ready retrieval. In addition to protecting the privacy of the records, you are required to have office policies that ensure patient confidentiality, and which are clearly available to all patients. These regulations are set out by federal and provincial *Health Information Protection Acts*. The federal *Personal Information Protection and Electronic Documents Act (PIPEDA)* has been widely publicized since coming into effect on January 1, 2000, but, because health care is regulated provincially, your practice must meet the standards of your province's customized health information protection legislation. Most provinces are currently using the *Personal Health Information Protection Act (PHIPA)* 2004 for their standards.

Chart retrieval should be possible in one of three ways: by looking up the patient's name, chart number or health insurance number. Lateral filing with colour-coding for each chart is the most efficient storage format. Files should be stored in cabinets that can be closed, or at least are located in secure areas where there is no public or patient traffic. Reception staff and file clerks should be able to access them in a timely and ergonomically efficient manner.

You can use either alphabetical or numerical coding. Small group practices that offer ongoing care typically find the one-step alpha system to be the most effective. Staff locate charts by looking on the label flap for the first three letters of the last name, which are tabbed with stickers. Obviously, some alphabetical filing is still required for patients with the same name, and yes, filing errors do occur. This system is also more expensive (stickers and initial chart preparation), but the staff time it saves is worth it.

The numerical system that employs pre-numbered charts is simpler and cheaper to set up. Charts generally have five coloured digits, starting at 00001, and are purchased in units of consecutive numbers up to 50000 or more. Filing errors are minimized with this two-step system, but chart retrieval and filing requires much more staff time. The only place that the patient's name and chart number appear together is in a computer database, so someone has to use the computer to cross-reference the name and chart number so that the file can be pulled. Lab and consult reports also have to be cross-referenced, unless the labs and diagnostic departments agree to include your patient's chart number when they send you the results. If a file clerk handles 120 charts per physician daily, and it takes 10 seconds more to cross-reference the chart number, then 20 more minutes of filing time is required. Pulling charts for other purposes, such as dealing with pharmacy requests, will also take time.

The numerical filing system is generally recommended for consultants who do not see the same patients on a regular or ongoing basis. In larger family practice or specialist clinics, with clerical staff dedicated to medical record management, the numerical system will also make more sense.

Year labels, which indicate the last time the patient was seen, are essential. This makes it easy to purge the patient charts that are not current, and cues you when to dispose of a chart. A quick glance at an orderly filing area can indicate how current and dynamic the practice is. Family doctors may want to use the primary filing area for charts of patients seen within the past three years, moving the more dated charts to a secondary filing area until they meet the criteria for shredding. This will ensure that the primary filing area is efficient.

2. Is the record readable to any and all reviewers?
There is no defence for having illegible records. Yet, how often have you received a copy of an emergency encounter, or reviewed an admission or consult record, and not been able to understand all that was written? How often have you had to go to the order sheet to figure out what was done? Do not copy substandard recordkeeping habits!

Dictate, dictate, dictate: All physicians should consider dictating, or at least typing, their medical records. Dictation is cost effective—in fact, a family physician who currently writes legible, comprehensive records on 30 patients a day could reduce the amount of time spent on record-keeping by at least one hour by dictating instead. That hour could be used to see four or five more patients—the income from which would greatly exceed the cost of a medical dictatypist, or have more time for lunch, or go home earlier.

Voice-to-print technology has also come a long way, and many specialists use it for consults and office records. Although typing the medical record yourself is better than handwriting it, generally, this is not good use of a physician's time. For every minute that you type, are you saving the same amount of money that you would generate if you saw another patient? Studies have shown that dictation is still more cost effective than even voice-to-print. For most physicians, a combination of writing/typing and dictation would be most practical.

3. Is the patient's name on all components of the chart?
This labelling is often forgotten when the physician or staff member adds a new progress sheet to the paper chart. Unfortunately, paper charts can fall on the floor and get mixed up.

4. Are the patient's name, age, gender, MOH number, contact numbers and address clearly shown on the chart?
Medical billing systems will have patient registration and label-maker functions that can make this task more efficient and effective. It is essential that, at every visit, staff ensure that this information is up to date.

5. Is the date of each visit recorded?
This is essential so that billing records can be cross-referenced with clinical records. Date stamps are cost effective, easy to use and available at any business supply store.

6. Are the family history, past history and functional inquiry (including significant negative observations) clearly recorded and maintained?
The past history and family history should be included in the up-to-date cumulative patient profile (CPP) that is typically taped on the inside front coverof the chart folder.

The functional inquiry is a standard part of the daily progress notes, and should be comprehensive enough to address red flags and significant positives/negatives. You may use short forms, as well as your own standardized use of common abbreviations, such as HEENT NAD, URI and UTI. These are

acceptable as long as you can provide a glossary of customized short forms to the reviewer.

7. Are allergies clearly documented?
These should be noted in the CPP. If the patient has allergies to medications, it is a good idea to also document these in the cumulative medication profile (CMP) and on the front of the chart, with orange caution labels to cue the medical office staff.

8. Are immunization records clearly visible?
It is easy to customize ink stamps to document immunizations. This is especially important if you care for children and are responsible for the delivery of primary immunization. Stamp and date the routine immunizations on the front or back of the chart for quick reference when parents ask you to complete school forms. Document immunizations in the progress notes or pediatric growth and assessment records, noting the date given, the lot number, expiry date of the immunization, the injection site, and whether the immunization was given intramuscularly (IM) or subcutaneously (SC).

9. Is a cumulative patient profile (CPP) summary sheet present and maintained?
Maintenance of an up-to-date CPP summary sheet is critical and can save you lots of time when reviewing the ongoing care of a patient. Your CPP can make the preparation of reports very time efficient and income effective. There are several formats available, such as those provided by the College of Family Physicians of Canada, which you may customize. The CPSO, for example, also provides a list of what should be included.

Having an up-to-date CPP will also facilitate the transition to an electronic medical records program, if and when you choose to do so.

10. Is the chief complaint clearly stated?

11. Are the durations of symptoms noted?

12. Is there an adequate description of symptoms present?

13. Are positive physical findings recorded?

14. Are the significant negative physical findings recorded?

15. Is there clear documentation of the requested lab and X-ray investigations?

16. Are consult requests noted, and is there documentation that the consult has been arranged?

17. Is the diagnostic impression or differential documented?

18. Are the treatment plan and follow-up instructions clearly noted?

Questions 10–18, as well as Question 20 and the functional inquiry portion of Question 6, address all of the essential components that you must include in the progress notes to document each patient encounter.

Regulatory colleges encourage the use of the “SOAP” format (Subjective/Symptoms, Objective/Observations, Assessment and Plan) in the medical record, as long as it is legible and addresses all of the essential questions. Short

forms can be used, and reference to the CPP can reduce redundant documentation (e.g., CPP reviewed and UTD [up to date]).

You can either use ink stamps that summarize physical examinations or the complete examination form. One advantage of the physical exam stamp is that it enables you to chronologically document the annual or periodic health exam in the progress notes without having to file, reference and organize a separate, complete examination sheet every time. If you use a stamp, include the areas that were examined, and whether the findings were normal or abnormal. It is good practice to complement the use of a stamp with specific comments on significant positive and negative findings. See Appendix 1 at the end of this module for an example of a physical examination stamp.

16. Are consult requests noted, and is there documentation that the consult has been arranged?
Consult letters should be copied and filed in the chart, along with a notation that the consult has been made and the patient notified. It is increasingly difficult to do this when consultants ask to review your request and then contact the patient directly, but the family physician is still responsible for closing the loop. If the consultant follows this practice, clearly indicate in your request that the consultant's office must advise your office when the patient will be seen. The components of a good consult letter are discussed later in this module (see *Hospital Charting And Operative Reports*).

19. Are medication doses and durations of use noted? Are medication amounts and number of repeats noted? Medications must be noted in the progress notes, and we recommend that you establish a dedicated flow sheet to track all medications prescribed. Ideally, the medication flow sheet or cumulative medication profile (CMP) will be filed just after your last progress note. Note the medications vertically in the left-hand column, indicating dosage and frequency of use. On the right are several vertical columns, where you document renewals, amounts and number of repeats. The medication flow sheet allows for easy periodic review of the patient's medications, as well as for cross-reference when the patient or pharmacy calls to request renewals. This record is very helpful for accountable billing when you renew prescriptions by telephone.

20. Are dated progress notes clearly evident?
See discussion of Question 6.

21. Are pathology reports retained?

22. Are hospital discharge summaries retained?

23. Are operative notes maintained?

Physicians are obliged to review, initial and keep any medical record that involves their patient, even if it was not requested. When you request past medical files, we recommend that you do not request a copy of the entire chart. Specify the information you really want and need.

24. Is there documented evidence that periodic health assessments are being performed?
It is impossible to offer all patients an annual check-up, and doing so is not evidence-based for most patients. It is important, however, for the comprehensive family physician to encourage and document periodic health exams. Make the documentation effective and efficient by using forms or ink stamps, an updated CPP and CMP.

The CPSO Policy Statement #4–12 offers more detailed advice as to whatdocumentation is expected for a periodic health exam. Ministries of health may use this reference when auditing for appropriate billing.

25. Is there evidence that health maintenance issues are periodically discussed; e.g., smoking, alcohol and drug use, obesity?
It is both effective and efficient to provide patients with standardized information sheets for specific health maintenance issues; plus, it saves you from having to rewrite the same information in each chart. Instead, a medical record entry might read "Osteoporosis info sheet reviewed and given to patient". Information sheets for lipid counselling and low-cholesterol diets, diabetic diets, smoking cessation, contraception counselling, vasectomy, diarrhea treatment, fever management, hormone replacement therapy, etc., are very valuable to patients and can be an extension of your medical record. You should document or photocopy any customization of advice for the chart.

26. Is there clear evidence that the physician does a review of ongoing medication use; e.g., for chronic medical problems? Maintaining an up-to-date medication flow sheet makes this monitoring easy, effective and efficient. Document your review of the CMP in your progress notes; e.g., "*Cumulative Medication Profile (CMP) reviewed and updated*".

27. Is there a system in place to clearly show that all lab tests come to the attention of the physician?
As a physician, you are obliged to review and initial all information that you receive that applies to patients. This includes the reports of all tests and consults you have ordered, as well as any medical information that you receive but which you did not personally order. Accordingly, no medical information should be filed in the patient's chart until you have reviewed and initialled it. College reviewers will pay particular attention to this detail.

Are you responsible if you order a test and do not receive the results?
Yes. Physicians who order a test or make a consultation are responsible for closing the loop, so it is important to have a system in place to verify that you have received, reviewed and acted appropriately upon all tests ordered. The importance of this medico-legal responsibility was highlighted by the Canadian Medical Protective Association in its June 2004 CMPA Information Letter (Vol. 19, No. 2, IL0420E). The article is titled Follow-up from lab reports and tests: *A key to patient safety.*

How can I establish policies and procedures to audit and capture overdue tests and consult reports?
The traditional paper medical record system does not provide an easy solution, so you will require a strict protocol to monitor the receipt of tests and reports.

Charts awaiting results can be set aside in a dedicated "results pending" area of your medical records. It can sometimes take several days or weeks, however, to receive the results, and you may need the chart in the interim, so we recommend that you flag charts to indicate that tests are pending. Use colour-coded tabs or inserts that stick out beyond the edge of the chart so that, when they are re-filed, it is easy to see which charts have reports outstanding. Use dedicated colours to indicate the first to fourth week of the month. When a chart flag indicates that it is two or three weeks since the test was ordered, staff can try to track down overdue results. When the report is received, the flag is removed.

Staff can maintain a daily log of all tests ordered, cross-referenced with the appointment schedule, but this is very time-consuming to do manually. It will

be easier if you are completely computerized and linked electronically with all of your labs, diagnostic centres, hospitals and consultants. Closing the loop on results pending/overdue is one of the many advantages of electronic medical record systems. If all users and providers are linked, it is easy to implement programs that track overdue results.

28. Is there evidence that an appropriate follow-up appointment has occurred after the receipt of an abnormal lab report?
Physicians are responsible for contacting and advising their patients of all abnormal tests. To do so, it is essential to establish strict office policies. First and foremost, no report is to be filed unless the physician has initialled it and signed off for filing. In the case of abnormal test results, the physician is obligated to write clear instructions for staff on the report. When the follow-up is completed, staff initial and date that the order was carried out.

Case example: Abnormal test result. Abnormal PAP test received. Physician writes: "Contact patient to review within 1 week" and places the chart in the staff in-box. Staff contact the patient, then date and document "Patient notified" on the report. Ideally, the date of the appointment is also noted. If the patient does not attend the appointment, further measures must be taken to contact the patient (e.g., registered letter). All efforts to contact the patient must be documented.

29. Do all physicians clearly indicate their entries in the chart by signing or initialling their names? Whether your office uses a paper system or an electronic medical records program, each physician must sign or initial his/her entries. This is essential when more than one doctor is documenting patient care in the medical record. EMR systems provide a mechanism to record signatures electronically.

30. Are pediatric growth charts evident? This is a must for family doctors and pediatricians, but pre-formatted flow sheets, developed by Dr. James Rourke and Dr. Leslie Rourke, make the task easy. The Rourke Baby Record: Evidence Based Infant/Child Health Maintenance Guide is appended to the CPSO Medical Records document (see the Resources section).

31. Are provincial antenatal forms used?
Up-to-date, standardized provincial antenatal forms cue the attending physician to assess all prenatal risks and to offer the best care.

Additional Questions To Ask Yourself

In addition to the questions asked by regulatory colleges, there are additional questions that you should ask and answer when you do a self-audit of your medical record-keeping.

Are all phone-call prescription renewals noted in the chart?
It is important for physicians to document all evaluations and treatments provided indirectly or by telephone. Records should be maintained in both the daily reception phone log and the chart's medication flow sheet.

Do office staff make a note in the medical record of any telephone advice that you have directed them to offer?
An example of this would be documentation that the patient has been contacted by telephone with instructions for their continued use of coumadin. Use of patient-specific INR flow sheets, kept in a dedicated INR treatment binder, makes this easy. This is an extension of the patient's personal medical record, and enables you to discard all of the individual INR lab reports once the results are transcribed to the flow sheet. This record, as well as your appointment scheduler and your staff's daily phone log, must be retained for the same duration as the primary medical record.

Do you record telephone consults with home care workers, specialists, etc.?
Document and retain a record of all care you offer by telephone and fax. When you are on call, you should also retain your on-call log book, or save the record of encounters and instructions that you have documented electronically, such as on a personal digital assistant (PDA).

Are relevant emails and other electronic communications recorded?
Importing or recording of all types of patient encounters and related communications that pertain to patient care must be documented.

Are diagnostic and billing codes noted at each visit?
Because your medical record must stand alone to justify all of the billings you submit to the Ministry of Health, documenting your diagnostic and billing codes is an excellent exercise. This will help you to avoid overbilling for limited services.

HOSPITAL CHARTING AND OPERATIVE REPORTS

Medical record requirements are the same, regardless of where the service is offered, or how many physicians and caregivers are documenting care. Physicians can best protect their own interests, as well as those of their colleagues and patients, by keeping excellent medical records.

Referral Letters

It is extremely important and beneficial for family physicians to provide their consultant colleagues with clear and concise referral letters. When making a consultation request:

- Ensure that the referral letter is legible (ideally, typed).
- Ensure that the consultant receives the letter prior to the patient's assessment.
- State the purpose of the referral clearly, and lay out specific questions to be answered.
- Summarize the patient's history and evaluation to date.
- Include your diagnostic impression, so that your consultant can offer constructive comments.
- Include copies of all appropriate investigations; and
- Clarify whether you are requesting a one-time consultation, shared care or transfer of care.

Consultation Reports

The consultation letter or report should be typed and, like all medical records,stand alone as a record of evaluation, investigation and treatment. Referring physicians appreciate it when consultants assist in the care of the patient by responding with:

- a consultation report within two weeks of the initial assessment;
- a telephone call report when urgent issues must be addressed;
- a follow-up report when all investigations are completed;
- a clear, comprehensive but concise summary of the consultant's assessment and diagnostic impression;
- clear direction regarding the recommendations for investigation, treatment and follow-up plans;
- copies of all investigation reports;

Key Message

- *Develop good recordkeeping habits at the outset of your medical career. Responsible, careful physicians can effectively and efficiently maintain excellent medical records, especially with dictation or voice-to-print, to the benefit of themselves and, most important, their patients.*

- answers to specific questions posed in the referral letter; and
- recommendations for further evaluation by other consultants when indicated.

As a consultant, you can greatly assist your referring physicians when you provide timely reports. This enables the referring doctor to reinforce your recommendations and address questions that patients may not have fully understood when they saw you.

HEALTH INFORMATION PROTECTION GUIDELINES

The rules and regulations about privacy protection in physicians' offices and clinics were significantly upgraded with the enactment of the federal *Personal Information and Electronic Information Documents Act (PIPEDA)* on April 13, 2000. Healthcare regulations that all physicians are obliged to follow fall under provincial jurisdiction, so provinces and territories have customized their own *Health Information Protection Acts*. For example, Ontario uses *PHIPA Personal Health Information Protection Act 2004*, last updated July 2010.

The Canadian Medical Association has prepared some excellent resources to help physicians meet these new guidelines, including the CMA's *Privacy in Practice: A Handbook for Canadian Physicians* and the online Privacy Wizard to help physicians customize their own office privacy policies.

As physicians, our responsibility to safeguard personal information extends to our use of mobile devices, such as Blackberries, iPhones, removable drives and laptops. The CMPA's excellent resource "Electronic Records Handbook" addresses the importance of encryption and electronic safeguards. See the Resources section below for details on these products.

HIGHLIGHTS FROM PRIVACY IN PRACTICE

Physician Accountability

- The physician has ultimate responsibility for his or her patient records.
- Office employees should be aware of and adhere to privacy policies.
- Records must document a patient visit accurately.
- Clear rules must exist for the retention and disposal of records.

Patient Rights

- Patients own the information in their record but the physician owns the actual record.
- Patients have the right to timely access to their record.
- In extremely limited circumstances, patients may be denied the right of access to their record if this poses a serious risk to themselves or others.
- Patients can get a copy of their record at a reasonable cost.
- Patients can request changes in their own record, and this request should be documented by an annotation in the record.
- A standardized process exists for dealing with patient complaints.

Consent

- Only information needed for the care and treatment of the patient should be collected.
- Patients need to know how their physician will use their health information.

- Consent is implied by the collection, use and disclosure of information needed for care and treatment.
- No consent is needed to disclose patient information when the disclosure is mandated by legislation.
- Consent is required to share information with third parties for reasons other than care and treatment.
- Patient consent can be withdrawn at any time.
- The consequences of denying or withdrawing consent should be made clear to the patient.

Office Safeguards

- Access to patient records is granted on a need-to-know basis.
- Office layout should maximize protection of patient information. The location and access of the records, as well as sound-proofing exam rooms, administration and reception areas, are essentials.
- Physical safeguards should be put in place.
- Electronic safeguards should be put in place.
- Employees should sign confidentiality agreements.
- Office policies need to ensure confidentiality when physicians and staff share medical records.
- Procedures must be in place to meet college and CMPA policies for appropriate destruction of portions of the medical record.

Business Implications

- Contracts signed with third parties should explicitly address the protectionof privacy.
- When physicians close or transfer a practice, they must comply with provincial regulations for the storage or transfer of patient records.

PRACTICAL TIPS FOR PAPER-BASED MEDICAL RECORDS

Avoid family charts. Few physicians still use family charts, but be aware that, if you assume a practice that uses them, they should be replaced with individual charts as soon as possible.

File the latest progress notes at the front and the latest diagnostic reports and consults at the back of the chart. Most physicians will have the latest progress notes at the front of the chart, with the medication summary list as page two. The last consult of lab results is filed at the back of the chart.

After acting on all investigations you receive, consider having your file clerk place the result at the front of the chart. When you next see the patient, this cues you to verify that the patient is aware of the results and/or has received the appropriate instructions. Then you, the doctor, can place the test result at the back of the chart. This is a double-check system to verify that you have closed the loop.

Use helpful stamps.
It is easy to have ink stamps customized for routine, frequent use in your office. Using stamps for such documentation as immunization records, flu shot administration and lot numbers, physical exams, common addresses, signatures and informed consent is efficient and cost effective.

Key Message

- *Privacy legislation obliges all physicians to clearly inform their patients that they have procedures in place to ensure patient confidentiality and appropriate record management in the medical office. Contact the Canadian Medical Association and your provincial Ministry of Health for educational materials and resources to help your practice meet the new guidelines.*

Use flow sheets. Complement the cumulative patient profile, which is most commonly taped to the inside front cover of the chart, with useful flow sheets, such as those for diabetic care, INR treatment and advice, lipid care, prenatal and pediatric care. These will enable you to document care more efficiently and effectively.

Avoid chart divider organization clips. Staff members need to release the clip before they can file lab results and consultations in different sections of the chart. While they are phenomenal for chart organization, these clips are very costly and extremely tedious for the staff to handle in a dynamic practice. In a busy family doctor's office, it is common for staff to handle 120 charts daily. Imagine the time required to break each chart down to clip in reports!

As you consider these file organizing systems, talk with your staff and familiarize yourself with material and staffing costs before implementation.

Patient information sheets are time savers. Standardized patient information sheets can save you a lot of time and documentation, plus ensure that the patient has detailed instructions to refer to at home. Design these so that you can customize instructions for individual patients. Commonly used patient information sheets include:

- Contraception options and instructions
- Osteoporosis prevention
- Diabetic information and diets
- Low cholesterol diet guidelines
- Asthma treatment education
- Sinusitis treatment education
- Back-sparing exercise education
- Tips for avoiding repetitive strain injuries; e.G., Carpal tunnel, tennis elbow
- Fever care and medication dosing instruction for pediatric patients
- Wound care education
- Postoperative care instructions
- Gastroenteritis care advice

These are just a few examples of patient information guidelines that you can customize. Because the bulk of the information is repetitive and common to all patients, you can reduce the amount of documentation required in each chart. Noting that you have reviewed and given the patient a standard information sheet, perhaps with specific instructions, will meet the assessor's requirements and save you time.

The physician owns the medical record. Patients have access to the information in the chart and, at their expense, can request a copy of their chart. Always keep the original in your possession.

Share your tips with colleagues. Help others make their daily medical recordkeeping more effective and efficient by sharing your best-practice tips.

ELECTRONIC MEDICAL RECORDS (EMR)

Electronic medical records are, definitely, the present and future of medical record systems. The efficiency and effectiveness that an EMR system can add to the daily

Key Message

- *Develop medical record-keeping practices that are efficient, consistent and effective for you and your staff.*

practice of medicine is amazing, enhancing both the quality and comprehensiveness of care. The number of physicians who are converting to EMR systems is increasing every day.

Regulatory colleges use exactly the same guidelines for EMRs as for paper records. In addition, there are specific requirements that all entries and additions to the record are dated and electronically signed.

Where To Learn More About EMR Systems

While it is beyond the scope of this module to examine the issues related to the partial or complete transition to a chartless office, there are resources available to help. Provincial medical associations as well as provincial colleges offer professional guidance and resources.

While you are still in training as a medical student or resident, you should testdrive as many EMR systems as you can, because, inevitably, you will be working with an EMR in the near future. If you are joining a practice with a system in place, get objective, expert advice and assess it as part of your overall practice evaluation.

Action Plan

- Develop good record-keeping habits at the outset of your medical career.
- Periodically review the best-practice principles, and ensure that you maintain these in your daily medical record-keeping.
- Keep abreast of the privacy legislation in your province.
- Look for efficient, practical and effective ways to save time in your practice.
- Learn as much as you can about electronic medical record systems.

RESOURCES

- *Medical Records* is published by the College of Physicians and Surgeons of Ontario at cpso.on.ca/policies/policies/default.aspx?ID=1686 – policy 4 – 12, updated and approved June 2012. In addition to a very comprehensive review of all policies and obligations for medical records management for paper and EMR records, this publication provides excellent examples of several flow sheets and evidence-based care guides:
  - Cumulative patient profile (CPP)
  - Periodic health exam
  - Generic diabetes flow sheet
  - Patient-requested transfer of medical records
  - Physician request for medical information
  - Antenatal records
  - Appendix C offers 31 self-evaluation questions to help you assess your own medical records.

Key Message

- *As physicians, we are obligated to keep comprehensive, accountable medical records. Our records must stand alone, without our interpretation, to clearly indicate the medical care we have provided our patients, as well as to justify the bills we have submitted. Medical records are no longer "for our eyes only".*

- The Canadian Medical Association's Privacy in Practice: *A Handbook for Canadian Physicians* is available online at cma.ca or in hard copy from:

  CMA Member Service Centre
  1867 Alta Vista Drive, Ottawa ON K1G 3Y6
  Tel: 1 888 855-2555 or 613 731-8610 ext. 2307
  Fax: 613 236-8864
  Email: cmamsc@cma.ca

- The Canadian Medical Association's *CMA Privacy Wizard* is a comprehensive, easy-to-use online tool kit (see cma.ca/privacywizard.htm) that enables physicians to customize their own office privacy policies, based on the latest guidelines. It is available free to CMA members and is eligible for MAINPRO-M2 credits. For more information, contact the CMA Member Service Centre, toll free, at 1 888 855-2555, or email cmamsc@cma.ca.
- Transitioning to EMR: CMPA Perspective, June 2010, Vol. 2 #2.

APPENDIX 1: PHYSICAL EXAMINATION STAMP

The objective is to design an easy-to-use stamp that becomes part of your ongoing progress notes. The text of the stamp denotes anatomical areas and systems examined during a complete patient assessment.

All areas examined should be checked off or circled. Significant positives or negatives on examination would be elaborated in the accompanying progress notes.

On a practical note, create your own stamp (e.g., 12 cm wide, 7 cm high) with legible lettering (e.g., 10-point font or larger). Present it to your local business supply store to have a rubber stamp or self-inking model made. You can modify the following example to suit your personal preferences.

BP		Wt		Ht
HEENT		Fundi	Nodes	Thyroid
Chest		Breasts		Murmurs
Pulses		Bruits		Abdomen
Liver	Spleen		Mass	Hernia Testis
Pap	Vagina		Uterus	Ovaries
Rectal	Prostate		Anoscopy	Skin
Musculoskeletal				Neuro