COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Patient Record Content

Under Review: No
Issued By: Council: January 1, 2010 (*Patient Records*)
Reissued by Council: July 1, 2011; January 1, 2016 (*Patient Record Content* and *Patient Record Retention*)

CPSA
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The ***Standards of Practice*** of the College of Physicians & Surgeons of Alberta ("CPSA") are the **minimum** standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the *Health Professions Act* and will be referenced in the management of complaints and in discipline hearings. CPSA also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

The *Patient Records* standard was split into *Patient Record Content* and *Patient Record Retention* in January 2016. Please refer to both standards for all expectations related to patient records.

1. A regulated member who provides assessment, advice and/or treatment to a patient **must:**
   a. document the encounter in a patient record (paper or electronic);
   b. ensure the patient record is:
      i. an accurate and complete reflection of the patient encounter to facilitate continuity in patient care;
      ii. legible and in English;
      iii. compliant with relevant legislation and institutional expectations; and
      iv. completed as soon as reasonable to promote accuracy.
2. A regulated member **must** ensure the patient record contains:
   a. clinical notes for each patient encounter including:
      i. presenting concern, relevant findings, assessment and plan, including follow-up when indicated;

Terms used in the Standards of Practice:
- "Regulated member" means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- "Must" refers to a mandatory requirement.
- "May" means that the physician may exercise reasonable discretion.
- "Patient" includes, where applicable, the patient's legal guardian or substitute decision maker.

ii. prescriptions issued, including drug name, dose, quantity prescribed, directions for use and refills issued;

iii. tests, referrals and consultations requisitioned, including those accepted and declined by the patient; and

iv. interactions with other databases such as the Alberta Electronic Health Record (Netcare);

b. information pertaining to the consent process;

c. a cumulative patient profile (CPP) contextual to the physician-patient relationship (the longer and more complex the relationship the more extensive should be the record) detailing:

i. patient identification (i.e., name, address, phone number, personal health number, contact person in case of emergencies);

ii. current medications and treatments, including complementary and alternative therapies;

iii. allergies and drug reactions;

iv. ongoing health conditions and identified risk factors;

v. medical history, including family medical history;

vi. social history (e.g., occupation, life events, habits);

vii. health maintenance plans (immunizations, disease surveillance, screening tests); and

viii. date the CPP was last updated;

d. laboratory, imaging, pathology and consultation reports;

e. operative records, procedural records and discharge summaries;

f. any communication with the patient concerning the patient's medical care, including unplanned face-to-face contacts;

   g. a six-year history of patient billing encounter data as required by Alberta Health (identifying type of service, date of service and fee(s) charged); and

   h. a record of missed and/or cancelled appointments.

3. Notwithstanding clause (2) a regulated member **may** indicate that the required documents are available in Netcare or other database that can be reliably accessed for the length of time the record must be maintained.

4. A regulated member **may** amend or correct a patient record in accordance with the *Health Information Act* (*HIA*) through an initialed and dated addendum or tracked change including the following circumstances:

   a. the correction or amendment is routine in nature, such as a change in name or contact information;

   b. to ensure the accuracy of the information documented; or

   c. at the request of a patient identifying incomplete or inaccurate information.

5. Notwithstanding (4c), a regulated member **may** refuse to make a requested correction or amendment to a patient record in accordance with the *HIA.*

6. A regulated member **may** append additional information to a patient record in accordance with the *HIA*.

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RELATED STANDARDS OF PRACTICE

- *Continuity of Care*
- *Episodic Care*
- *Non-Treating Medical Examinations*
- *Patient Record Retention*
- *Referral Consultation*
- *Telemedicine*

COMPANION RESOURCES

- Advice to the Profession:
  - Episodic Care
  - Electronic Communications & Security of Mobile Devices
  - Lost or Stolen Medical Records
  - Telemedicine
  - Transition to Electronic Medical Records
- CMPA's Smartphone recordings by patients
- CMPA's eLearning Modules
- CMPA's Medical records articles
- HQCA's Abbreviations in healthcare
- OIPC's Communicating with patients via email – know the risks
- OIPC's Email communication FAQs