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& SURGEONS OF ALBERTA

STANDARDS OF PRACTICE

Patient Record Content

Under Review: Yes
Issued By: Council: January 1, 2010 (*Patient Records*)
Reissued by Council: July 1, 2011; January 1, 2016 (*Patient Record Content* and *Patient Record Retention*)

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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.

Please refer to both this and the *Patient Record Management* (formerly *Patient Record Retention*) standard of practice for the full expectations related to patient records.

PREAMBLE

Documentation of the care provided to patients is an essential component of safe and competent medical care.[1] The goal of the patient record is to "tell the story" of the patient's health care journey[2]: the patient record should be understandable for another healthcare provider to take over care of the patient if needed.[1] This includes avoiding the use of abbreviations that are known to have more than one meaning in a clinical setting or that are not commonly used or understood.[3]

This standard applies to all individuals registered with CPSA, all clinical encounters, whether patients are seen in-person or virtually; and to both paper and electronic medical records (EMRs).[4] Where this standard is more stringent than institutional requirements, the more stringent requirements of this standard must be followed; however, where this standard is less stringent, the institutional requirements must be followed.[5]

It is a professional obligation that regulated members are aware of, keep current with, and comply with the requirements of the *Health Information Act* (HIA) for the collection, use and disclosure of personal health information.[6]

Related standards and companion resources can be found at the end of this document.

[1] From CPSM's *Documentation in Patient Records* Standard of Practice (Feb. 2022), accessed Dec. 2025.
[2] From CPSO's *Medical Records Documentation* Policy (Mar. 2020), accessed Dec. 2025.
[3] From HQA's "Hazards of Abbreviations, Symbols and Dose Designations" (n.d.), accessed Dec. 2025.
[4] From CPSNS's *Charting* Professional Standards and Guidelines (Mar. 2023), accessed Dec. 2025.
[5] From CPSNB's *Patient Medical Records* Professional Standards (Apr. 2025), accessed Dec. 2025.
[6] From CPSM's *Documentation in Patient Records* Standard of Practice (Feb. 2022), accessed Dec. 2025.

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DEFINITIONS

Cumulative patient profile (CPP): 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 healthcare providers using the patient record, to quickly get a picture of the patient's overall health.[7]

Electronic medical record (EMR): a computer-based patient record that is created digitally or stored digitally (e.g., a paper record that has been scanned).[8] [9]

Financial record: means a record documenting the charging and payment of fees for a non-Plan service.

Commented [CD1]: From *Dual Practice* draft.

Medical scribe: a person who provides administrative support by documenting patient encounters in real time and may include gathering medical history, vital signs, prescription dosages, etc. This service can be done in person, virtually or off-site.

Patient record: means a record, information or document that a physician is required to create and maintain, in accordance with CPSA's *Patient Record Content* and *Patient Record Management* standards of practice.

Commented [CD2]: From Bill 11.

STANDARD

Documenting the encounter

1. A regulated member **must** create or contribute to a patient record for each patient they have assessed, treated or provided formal consultative service by:[10]

Commented [CD3]: From CPSNL: added to clarify documentation is required of all regulated members, regardless of format.

   a. documenting the encounter in a patient record;

Commented [CD4]: Removed to modernize and clarify.

   b. ensuring the patient record is:

      i. completed as close in time as practicable to the patient interaction to promote accuracy;[10]

Commented [CD5]: From CPSNL: added to provide requested clarity (vs. current "as soon as reasonable").

[7] From CPSO's *Medical Records Documentation* Policy (Mar. 2020), accessed Dec. 2025.
[8] From CPSM's *Documentation in Patient Records* Standard of Practice (Feb. 2022), accessed Dec. 2025.
[9] From CPSNS's *Charting* Professional Standards and Guidelines (Mar. 2023), accessed Dec. 2025.
[10] From CPSNL's *Medical Records Documentation & Management* Standard of Practice (Dec. 2023), accessed Dec. 2025.

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ii. an accurate, complete and comprehensive reflection of the encounter to facilitate continuity of care;

iii. legible and in English;

iv. compliant with relevant legislation and institutional expectations; and

v. professional and non-discriminatory, in accordance with the *Alberta Human Rights Act*;[11] and

c. where a non-Plan service is provided, complying with the additional documentation and record requirements in the *Dual Practice* standard of practice.

2. A regulated member using a medical scribe **must** ensure:

a. a written agreement is in place that complies with the requirements of the HIA;

b. the medical scribe is appropriately trained and qualified to perform their duties;

c. the medical scribe services comply with all relevant laws, legislation and professional standards related to confidentiality, privacy and data collection;

d. the work performed by the scribe is appropriately supervised and the regulated member remains responsible for the accuracy, completeness and timeliness of the documentation; and

e. that a medical scribe does not perform tasks beyond their level of competence or engage in activities that constitute the unauthorized practice of medicine.[12]

3. A regulated member using dictation tools or artificial intelligence (AI) for the collection, transcription or analysis of patient data or to assist in clinical decision-making **must** ensure compliance with all relevant laws, legislation and professional standards related to confidentiality, privacy and data collection.[12]

4. A regulated member **must** ensure the patient record contains:

Commented [CD6]: Added to align with dual practice framework.

Link to be added.

Commented [CD7]: Reworded for clarity.

Commented [CD8]: From CPSS: added for clarity.

Commented [CD9]: Added based on consultation feedback.

Commented [CD10]: From CPSS: added for alignment with legislation, etc.

[11] From CPSO's *Medical Records Documentation* Policy (Mar. 2020), accessed Dec. 2025.
[12] From CPSS's Regulatory Bylaws: Part 6 – Practice Standards (23.1 Electronic Medical Records (EMRs)) (Jan. 2025), accessed Dec. 2025.

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a. an accurate and up-to-date CPP, relevant to the physician-patient relationship (i.e., the longer and more complex the relationship, the more extensive should be the record), detailing:

   i. patient identification (e.g., name, date of birth, gender information), contact information (e.g., address, phone number, email address), personal health number, contact person in case of emergencies;

   ii. the full name of the patient's substitute decision-maker or legal representative, if applicable;[13]

   iii. personal and family data (e.g., occupation, life events, habits, family medical history);

   iv. past and ongoing medical history (e.g., serious illnesses, operations, accidents, genetic factors, ongoing conditions, identified risk factors);

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

   vi. allergies and drug reactions;

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

   viii. date the CPP was last updated;

b. clinical notes for each patient encounter, including:

   i. the date;
      1. where the date of the encounter differs from the date of documentation, both dates must be recorded;[14] [15]

   ii. presenting concern, relevant history, assessment and appropriate focused examination, diagnosis and/or differential diagnosis, any treatment or

Commented [CD11]: Reworded based on consultation feedback.

Commented [CD12]: From CPSNL: consistent with other standards.

Commented [CD13]: From CPSM and CPSO: ensures a record of time differential if encounter not recorded on the same day.

[13] From CPSNL's *Medical Records Documentation & Management* Standard of Practice (Dec. 2023), accessed Dec. 2025.
[14] From CPSM's *Documentation in Patient Records* Standard of Practice (Feb. 2022), accessed Dec. 2025.
[15] From CPSO's *Medical Records Documentation* Policy (Mar. 2020), accessed Dec. 2025.

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therapy provided and management plan, including follow-up when indicated;[15][16]

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

iv. tests, referrals and consultations requisitioned, including a copy of the referral request and any associated reports or results;[17]

v. any treatments, investigations or referrals declined or deferred by the patient, including the reason given by the patient, if any, as well as the discussion of the risks;[17]

vi. interactions with other databases, such as the Alberta Electronic Health Record (EHR) (e.g., Netcare, Connect Care);

c. where applicable, products recommended or supplied to the patient;

d. any related financial disclosures, written acknowledgements, signed agreements and invoices, where applicable;

e. information pertaining to the consent process;

f. laboratory, imaging, pathology and consultation reports;

g. operative records, procedural records and discharge summaries;

h. any communication with the patient concerning the patient's medical care, including unplanned face-to-face contacts (e.g., virtual care, telephone, email, text messages, patient portals, etc.);[17][18][19][20]

i. a history of patient encounter billing data, as required by the *Alberta Health Care Insurance Regulation* (identifying type of service, date of service and fee(s) charged); and

Commented [CD14]: From CPSO, CPSNS: added for clarity.

Commented [CD15]: From CPSO: expanded from current version (see (iv)) to ensure additional information is captured in record.

Commented [CD16]: From CPSBC, CPSM, CPSO, and CPSPEI: ensures non-traditional encounters are captured in the record.

Commented [CD17]: Timeframe removed, as addressed in *Patient Record Retention.*

Modified to identify regulation.

[16] From CPSNS's *Charting* Professional Standards and Guidelines (Mar. 2023), accessed Dec. 2025.
[17] From CPSO's *Medical Records Documentation* Policy (Mar. 2020), accessed Dec. 2025.
[18] From CPSBC's *Medical Record Documentation* Practice Standard (May 2022), accessed Dec. 2025.
[19] From CPSM's *Documentation in Patient Records* Standard of Practice (Feb. 2022), accessed Dec. 2025.
[20] From CPSPEI's *Charting* Policy (Oct. 2025), accessed Dec. 2025.

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

5. A regulated member is **not** required to duplicate information required in clause (4) if the patient record clearly identifies where the information can be accessed (e.g., Netcare).

a. A regulated member **must** avoid the use of abbreviations that are: unique to them so that they may be confusing or unknown to others;

b. known to have more than one meaning in a clinical setting; or

c. are otherwise not commonly used or understood in their area of practice.[21]

Use of templates

6. If using templates, particularly those with pre-populated fields, within an EMR, a regulated member **must**:

a. only use templates that allow encounters to be captured accurately and comprehensively (e.g., allow entry of free-text or that can be customized to allow for greater descriptive detail); and

b. verify that entries populated using a template accurately reflect each encounter and that all pertinent details about the patient's health status have been captured.[22] [23] [24] [25]

7. A regulated member using templates **must not** copy and paste information from a prior entry **unless** the copied entry is modified to accurately reflect current and correct information.[22] [23] [24] [25]

Corrections to patient records

8. A regulated member who receives a written request from a patient to correct an error or omission or add additional information **must** consider the request in

Commented [CD18]: Reworded for clarity.

Commented [CD19]: From CPSNB: ensures accessibility and clarity for other healthcare providers/readers (e.g., the patient). Also aligns with Health Quality Alberta's guidance.

Commented [CD20]: From CPSM, CPSO, CPSPEI, and CPSS: added to ensure validity of information.

Commented [CD21]: Moved below.

[21] From CPSNB's *Patient Medical Records* Professional Standards (Apr. 2025), accessed Dec. 2025.
[22] From CPSM's *Documentation in Patient Records* Standard of Practice (Feb. 2022), accessed Dec. 2025.
[23] From CPSO's *Medical Records Documentation* Policy (Mar. 2020), accessed Dec. 2025.
[24] From CPSPEI's *Charting* Policy (Oct. 2025), accessed Dec. 2025.
[25] From CPSS's Regulatory Bylaws: Part 6 – Practice Standards (23.1 Electronic Medical Records (EMRs)) (Jan. 2025), accessed Dec. 2025.

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accordance with the HIA.

9. A regulated member **may** refuse to make a requested correction or amendment to a patient record in accordance with the HIA.

10. A regulated member **must not** alter a patient record after a complaint or legal action has been initiated unless a clinical fact is missing.

    a. In this situation, a late entry that is clearly identified as such, **may** be made in accordance with clause 4.[26] [27]

Commented [CD22]: Combined with clause 7.

Commented [CD23]: Added based on current guidance.

Commented [CD24]: From CPSBC and CPSNS: added for clarity – aligns with hearing tribunal decisions.

ACKNOWLEDGEMENTS

CPSA acknowledges the work of the Colleges of Physicians and Surgeons of British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, Prince Edward Island and Saskatchewan in preparing this document.

RELATED STANDARDS OF PRACTICE

- *Charging Fees*
- *Continuity of Care*
- *Dual Practice*
- *Episodic Care*
- *Establishing the Physician-Patient Relationship*
- *Informed Consent*
- *Non-Treating Medical Examinations*
- *Patient Record Management*
- *Practising Outside of Established Conventional Medicine*
- *Referral Consultation*
- *Virtual Care*

Commented [CD25]: Link to be added.

COMPANION RESOURCES

- Advice to the Profession:

[26] From CPSBC's *Medical Record Documentation* Practice Standard (May 2022), accessed Dec. 2025.
[27] From CPSNS's *Charting* Professional Standards and Guidelines (Mar. 2023), accessed Dec. 2025.

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  - Continuity of Care
  - Episodic Care
  - Electronic Communications & Security of Mobile Devices
  - Establishing a Continuing Physician-Patient Relationship
  - Informed Consent for Adults
  - Informed Consent for Minors
  - Lost or Stolen Medical Records
  - Non-Treating Medical Examinations
  - Physicians as Custodians of Patient Records
  - Referral Consultation
  - Virtual Care
- CMPA:
  - AI Scribes: Answers to frequently asked questions
  - Smartphone recordings by patients
  - eLearning Modules
  - My patients, my records?
- HQA's Hazards of Abbreviations, Symbols, and Dose Designations
- OIPC:
  - Communicating with Patients Electronically
  - Guidelines for Managing Emails