

Practice Standard

Medical Records Documentation

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Related topic(s):	Medical Certificates and Other Third Party Reports ; Medical Records Management ; Photographic, Video and Audio Recording of Patients ; Leaving Practice ; Primary Care Provision in Walk-in, Urgent Care and Multi-registrant Clinics ; Referral-Consultation Process

A **practice standard** reflects the minimum standard of professional behaviour and ethical conduct on a specific topic or issue expected by the College of its registrants (all physicians and surgeons who practise medicine in British Columbia). Standards also reflect relevant legal requirements and are enforceable under the [Health Professions Act](#), RSBC 1996, c.183 (*HPA*) and College [Bylaws](#) under the *HPA*.

Registrants may seek advice on these issues by contacting the College and asking to speak with a member of the registrar staff, or by seeking medical legal advice from the CMPA or other entity.

PREAMBLE

This document is a practice standard of the Board of the College of Physicians and Surgeons of British Columbia.

The purpose of this standard is to outline a registrant's professional and legal obligations regarding medical records documentation. Information regarding the management of medical records can be found in the College's [Medical Records Management](#) practice standard.

BACKGROUND

Registrants must practice in accordance with applicable legislation. Sections 3-5 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183, outline the following requirements related to medical record documentation:

Requirements for medical practice records

- 3-5 (1) A registrant must
- (a) keep records in English,
 - (b) keep a clinical record on each patient containing
 - (i) the patient's name, gender, personal health number, date of birth, address and dates of attendance,
 - (ii) sufficient information to clearly explain why the patient came to see the registrant and what the registrant learned from both the medical history and the physical examination,
 - (iii) a clear record of what investigations the registrant ordered,
 - (iv) a clear record of either the provisional diagnosis or diagnosis made, and
 - (v) a clear record of the specifics of any treatment, recommendation, medication and follow-up plan,
 - (c) keep a paper or electronic record with respect to each patient containing the date of the service rendered, type of service and charge made,
 - (d) for each day, keep a day book, daily diary, appointment sheets or equivalent containing the names of patients seen or treated, or in respect of whom professional services are rendered,
 - (e) keep a record, separate from the patient's medical record, of all narcotics and controlled drugs purchased or obtained for the registrant's practice and a record of all such narcotics and controlled drugs administered or furnished to a patient in or out of the registrant's office, containing
 - (i) the name, strength, dose and quantity of the drug purchased or obtained,
 - (ii) the name, strength, dose and quantity of the drug administered or furnished,

- (iii) the name and address of the person to whom the drug was administered or furnished, and, if applicable, the name and address of the person who took delivery of the drug, and
 - (iv) the date on which the drug was obtained and the date on which the drug was administered, furnished or otherwise disposed of, and
- (f) keep all records either,
 - (i) typed or legibly written in ink and filed in suitable systematic permanent form such as books, binders, files, cards or folders, or
 - (ii) in electronic form, compliant with the policies and guidelines of the board with respect to the creation, maintenance, security, disposition and recovery of electronic medical records.
- (2) The information kept in the records must be capable of being reproduced promptly in written form and the material so reproduced, either by itself or in conjunction with other records, must constitute an orderly and legible permanent record that would provide, without delay, the information required under sections 3-5(1)(b), (c) and (d), and the record keeping system must audit or record any subsequent changes made.
- (3) A registrant attending a patient in hospital must promptly complete the medical records for which the registrant or other health care facility is responsible.

COLLEGE'S POSITION

Registrants must ensure that the content of a patient's medical record meets the requirements as set out in section 3-5 of the Bylaws. The medical record must contain comprehensive documentation of the clinical care provided to the patient, including:

- documentation of patient history, complaints and symptoms, examinations, and laboratory and imaging reports
- copies of emails, text messages, or other communication with the patient, related to clinical care and follow-up, including documentation of virtual consultations or prescriptions
- copies of operative procedures, consultation reports, discharge summaries and other information created by other registrants or health-care professionals which is relevant to the patient's medical care

A cumulative patient profile (CPP) or equivalent patient health summary (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 health-care professionals using the medical record, to quickly get a picture of the patient's overall health) must be documented by family practitioners. All other registrants must use their professional judgement to determine whether to include a CPP or an equivalent patient health summary in each patient medical record, considering a variety of factors, such as the nature of the physician-patient relationship (e.g. whether it is a sustained physician-patient relationship), the nature of the care being provided, and whether the CPP or equivalent summary would reasonably contribute to quality care.

The Medical Services Commission (MSC) of British Columbia defines what it considers an adequate medical record for payment in section C.10 of the [MSC Payment Schedule](#), such as the location of service, and the identification of the patient and attending medical practitioner.

Altering a medical record

Registrants may alter a medical record, but they must clearly identify what alterations were made and when. This is best accomplished by dating and signing or initialing the changes. If a registrant deletes part of the record, a simple line through that information with a date and signature is appropriate. The content of the entry being deleted must be visible. It may be helpful to indicate why the alteration is being made. Amendments to EMRs must be made in a similar fashion using addendums, digital strikethrough of text and/or using the “track changes” function found in most word processing programs.

Registrants must never alter a medical record after a complaint or legal action has been initiated, unless a clinical fact is missing, and a clear late entry is made to the record as outlined above.

If a patient requests a correction of their personal information in the medical record, and the registrant agrees, it must be made as soon as reasonably possible. If applicable, the corrected information must also be provided to any organization to which the personal information was disclosed during the year before the date the correction was made.

If a patient requests a correction of their personal information, and the registrant is not in agreement, the requested correction must be documented along with the reason for declining to make the correction, in accordance with section 24 of the *Personal Information Protection Act (PIPA)*.