512-428 Portage Ave Winnipeg Manitoba R3C 0E2
Tel 204 942 3256
Website: copom.mb.ca
E-mail: registrar@copom.mb.ca

**As Per: Podiatrist Regulation**

*Schedule B:*
*Standards of Practice*

**Standard 1.**
**Patient Health Records**
(approved September 17, 2008)

**1) a) The patient health record must include the following:**

i. Pertinent personal information relating to the patient, collected and maintained in accordance with the Personal health information act and Schedule B of the Podiatrists Regulations(regulation 99/2006) section 1.1
ii. The patient's name, address, telephone number and date of birth.
iii. The date of each patient's visits to the member.
iv. The name and address of the primary care physician and any referring health professional.
v. A medical history of the patient.
vi. Reasonable information about every examination performed by the member and reasonable information about every clinical finding, diagnosis and assessment made by the member.
vii. Reasonable information about every order made by the member for examination, tests, consultations or treatments to be performed by any other person or health professional.
viii. Every written report received by the member with respect to examinations, tests, consultation or treatments performed by other health professionals.
ix. Reasonable information about all significant advice given by the member and every pre and post-operative instruction given by the member.
x. Reasonable information about every post-operative visit.
xi. Reasonable information about every referral of the patient by the member to another health professional, service or agency.
xii. Any pertinent reasons a patient may give for cancelling an appointment.
xiii. Reasonable information about every procedure that was commenced but not completed, including reasons for the non-completion.
xiv. A copy of written consent.

**1) b) <u>In addition, the patient record shall:</u>**

i. Include complete and up to date information.
ii. Be legible.
iii. Identify the author.
iv. Be written in permanent black or blue ink.
v. Have all corrections/alterations initialled. Corrections/alterations should be crossed out using one line. White-out must not be used.
vi. Use a clear and logical format.
vii. Have a glossary available if abbreviations are used.
viii. Be secured and kept together.
ix. Be recorded at the time or within 24 hours.
x. Conform to the institutional policies where applicable.
xi. Each part of the health record must have a reference identifying the patient.
xii. Copies of any prescriptions for shoes, orthotics, etc must be kept with the patient's records.

## 2. Daily appointment record

The daily appointment record must include the following:

a. The name of each patient.
b. The date and time the patient attended the appointment,
c. Cancellation, non-attendance or rescheduling where applicable.

## 3. Institutional records

The records of the institution must:

a. Include particulars of every order, medication prescribed, treatments, consultations and referrals.
b. Include a financial record if applicable.
c. Comply with the legislation and standards of practice outlined regardless of where the treatment was rendered.

## 4. Financial record

The financial record must contain:

a. Name of the patient.
b. Date the service was rendered.
c. Fees charged to and received from or on behalf of the patient.
d. Daily appointment record or day sheet giving name and financial details for each day.

## 5. Confidentiality

a. Information contained in the health record is confidential.
b. Records may only be released to persons authorised by the patient and/or in compliance with all Federal and Provincial legislation.

## 6. Storage and destruction

a. Records must be stored securely in a manner that ensures confidentiality and in accordance with current Federal and Provincial legislation.
b. Records must be destroyed in a manner that ensures confidentiality and in accordance with current Federal and Provincial legislation.

## 7. Computerised/Electronic Records

***Computerised/Electronic health information is subject to the same security and requirements as written information***.

The following must be observed with respect to computerised records:

a. Data shall be protected so that it cannot be altered or purged without proper authority.
b. Principles of documentation of health information shall be adhered to in order that the computer/electronic charting meets legal and professional standards.
c. There will be locked and controlled access to computer facilities.
d. Computer/electronic records must be protected by password.
e. Alterations/corrections to computer/electronic records must be identifiable by a tracking program.
f. Health facilities' policies and procedures for access to written information must serve as minimum standards for computerised information.
g. Controls and audits shall be in place to assure integrity of the data.
h. Computer/electronic records should be backed up on a daily basis.
i. Backup copies of files are to be stored in a physically separate and secure area.
j. Legislation regarding computerised health information shall be routinely monitored.
k. Policies shall be developed for the control of retention and destruction of computerised information, and these shall be in compliance with Federal and Provincial legislation.
l. Health information recorded or stored by electronic methods or tapes, disks or cassettes, shall be destroyed in a manner that ensures total destruction.
m. When transferring personal health information in the form of paper charts to electronic charts, the paper record must either be stored or destroyed in accordance with Federal and Provincial legislation.