



Professional Standard Regarding Medical Records

This document is a **standard** approved by the Council of the College of Physicians and Surgeons of Nova Scotia.

A **standard** reflects the minimum professional and ethical behaviour, conduct or practice expected by the College of Physicians and Surgeons of Nova Scotia. Physicians licensed with the College are required to be familiar with and comply with the College **standards**.

Preamble

The primary purpose of the medical record is to enable all health care providers to provide quality health care to their patients. The medical record contributes to the quality, continuity and assessment of patient care.

Complete and accurate medical records are those that meet all legal, regulatory and auditing requirements. Medical records are legal documents providing evidence of the health care provided to a patient. Medical records can be reviewed as part of a regulatory, civil, criminal or administrative proceeding.

The requirements in this standard apply equally to both paper-based records and records in electronic format.

Professional Standard

The medical record must reflect all care provided.

1) Content of Medical Records

The College requires physicians to maintain or contribute to a paper record, electronic medical record (EMR) or electronic health record (EHR) for each patient they have consulted and/or treated. The College recommends that entries be recorded as soon as possible after the encounter.

Records must contain the following information:

- a) patient identification (i.e. name, address, contact numbers, personal health number, date of birth, emergency contact);
- b) for a consultation, the name and address of the primary care physician and of any health professional who referred the patient;
- c) the date of each professional encounter with the patient;
- d) the patient's medical history, including family history;
- e) risk factors;
- f) allergies and drug reactions;
- g) health maintenance (annual exams, immunizations, disease surveillance ie. mammogram, colonoscopy);
- h) long-term management (current medication, dosage, frequency);
- i) copies of reports from all other physicians or healthcare professionals, including diagnostic reports, operative procedures, consultation reports, discharge summaries and other information which is relevant to the patient's medical care;
- j) the particulars of each medical examination or consultation (dated);
- k) investigations ordered and their results (dated);
- l) all diagnoses or provisional diagnoses (dated);
- m) every treatment prescribed or administered (dated);
- n) professional advice given to the patient (dated);
- o) referrals (dated); and
- p) copies of emails or other communications with the patient, related to clinical care and follow-up, including documentation of telephone consultations or prescriptions.

The College requires that records are legible and capable of being read by any health care professional. The College further requires that the records can be interpreted and understood by any health care professional with similar medical training.

Records must be capable of being reproduced in a way that allows for a complete and accurate review of their contents, timelines, and third-party contributions.

2) Altering Medical Records

Medical records may only be altered as a result of the following circumstances:

- the correction or amendment is routine in nature, such as a change in name or contact information;
- to ensure the accuracy of the information documented; or
- at the request of a patient identifying incomplete or inaccurate information.

Notwithstanding the above, a physician may refuse to make a requested correction or amendment to a patient record in accordance with the [Personal Health Information Act](#).

Alterations to a medical record are to be made as follows:

- a) indicate the date of the correction and the identity of the individual making the correction;
- b) corrections should be made in a way that ensures the correct information is recorded and striking out the incorrect information;
- c) if incorrect information is removed from the record, there must be a note in the record that allows for this information to be traced;
- d) corrected information should be maintained in the record but clearly labeled as having been corrected; and
- e) incorrect information must be readily accessible whether or not it is removed from the record.

All medical record-keeping systems must allow for a full review or audit of any changes made to the patient record.

Custody

Physicians who have custody of medical records, whether paper or electronic are responsible for ensuring that they are maintained and stored in accordance with:

- ethical expectations as set out in the [Canadian Medical Association Code of Ethics](#) (section 31); and

- legal requirements as set out in the [Nova Scotia Personal Health Information Act \(PHIA\)](#).

Enduring Access

Patients own the information in their medical records, as affirmed by the Supreme Court of Canada in its decision in *McInerney v. MacDonald* in 1992.

Patients are entitled to examine and receive a complete copy of their medical record, which includes any records created by other physicians, and this access should be provided to the patient upon request (usually within 30 business days).

Securely retaining medical records and making copies available as appropriate is a professional obligation that continues after a physician ceases to practice.

Physicians are expected to make appropriate arrangements for either the retention or transfer of patient records (in paper or electronic form) if they permanently or temporarily close their practice. A number of companies will securely store confidential records and assist in releasing specific information to designated parties as directed.

The College of Physicians and Surgeons of Nova Scotia endorses the [Canadian Medical Protective Association's recommendations](#), which advise physicians to retain their medical records for at least ten years from the date of last entry or, in the case of minors, ten years from the time the patient would have reached the age of majority, which is 19 years in Nova Scotia.

Except under limited circumstances described in the [Nova Scotia Personal Health Information Act \(PHIA\)](#), patients and former patients are entitled to have access to the information contained in their medical records. However, as noted above, physicians are strongly encouraged to securely retain the original records. Specifics about record retention and acceptable charges for providing copies of information to patients or other authorized parties are available from the [Privacy and Access Office at the Nova Scotia Department of Health and Wellness](#).

Beyond their obvious obligations to current and former patients, physicians and/or their estates may be called upon to produce records in the event of a later legal action or regulatory complaint. Failure to provide records in these situations can have significant consequences.

Statutory Obligations

Physicians must be in compliance with the [Nova Scotia Personal Health Information Act \(PHIA\)](#). PHIA addresses the following *duties of a custodian* of medical records:

- access to and correction of personal health information (including fee to access and fee for viewing the record);
- collection;
- use;

- disclosure and release;
- retention; and
- disposal and destruction.

Resources

Canadian Medical Protective Association:
[A matter of records: Retention and transfer of medical records \(2013\)](#)

Canadian Medical Protective Association:
[Electronic Records Handbook](#)

Government of Nova Scotia:
[Personal Health Information Act](#)

Government of Canada:
[The Personal Information Protection and Electronic Documents Act \(PIPEDA\)](#)

College of Physicians and Surgeons of Nova Scotia
[Guidelines on the Responsibilities when Permanently or Temporarily Closing a Medical Practice](#)

Acknowledgements

In developing this standard, the College adapted existing policies from the College of Physicians and Surgeons of Ontario, British Columbia and Alberta.

Document History

Amended and approved by the Council of the College of Physicians and Surgeons of Nova Scotia: **April 1, 2016**

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This document was formerly entitled *Policy on the Content and Maintenance of Medical Records* (2013).

This document was formerly entitled *Guidelines for Medical Record-Keeping* (2008).

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