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Professional Standards and Guidelines Regarding Charting

Preamble

Good charting is an essential component of medical care. Good charting provides a foundation for good care by future providers unfamiliar to the patient.

Good charting is comprehensive, reflecting all relevant information and all care provided. Charts signed off on by physicians are presumed to be complete. In making this presumption, the College applies the axiom: "not documented, not done."

The purpose of this document is to set out the College's expectations with respect to charting. This document applies equally to paper-based and electronic medical records. The document applies to all clinical encounters, whether patients are seen in-person or virtually.

Professional Standards

General

Physicians must:

1. Be mindful of the ambiguity of abbreviations and use universally accepted abbreviations;

2. Maintain each specific patient's chart in a chronological and systematic manner, ensuring that patient identification (i.e., name, date of birth, health card number, gender information) and contact information (i.e., telephone number and address) are captured in all medical records;

3. Document entries as soon as possible after the patient encounter;

4. Ensure handwritten records are legible to others;

5. Verify that the entries populated using a template accurately reflect each patient encounter with all pertinent details about the patient's health status captured;

Electronic record templates are useful for good patient care but may pose a risk if overly relied upon. Physicians should review and update prepopulated fields for each patient encounter. Physicians are expected to review prepopulated templates.

6. Ensure charting is comprehensive, containing:

    a. information that conveys the patient's health status and concerns;

    b. any pertinent details that may be useful to the physician or future health care professionals who may see the patient or review the medical record; and

    c. the rationale for the treatment or procedure provided;

7. Ensure charting is factual and professional in tone.

Telephone and Electronic Communications with Patients

Physicians must capture details of all communication with patients related to clinical care that occur via telephone, or other digital means (e.g., e-mail, patient portals or other digital platforms), including the mode of communication in the medical record. Refer to the College's *Professional Standards Regarding Virtual Care* and *Professional Standards and Guidelines Regarding Physician Use of Social Media.*

Editing Medical Records

8. Where it is necessary to edit an inaccurate or incomplete medical record, physicians must:

    a. record the time of the additions or changes;

    b. initial the additions or changes; and

    c. where changes are being made, whether on paper charts or an EMR, either:

        i. maintain the incorrect information in the record, clearly label it as incorrect, and ensure the information remains legible (e.g., by striking through incorrect information with a single line); or

        ii. remove and store the incorrect information separately and ensure there is a notation in the record that allows for the incorrect information to be traced.

In the context of legal or regulatory proceedings, physicians are encouraged to seek the advice of the Canadian Medical Protective Association (CMPA) or other legal counsel before editing medical records.

9. Notify any health care providers involved in the patient's care if the change in charting would have an impact on that health care providers treatment decisions.

10. Not 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 per this Standard.

11. Physicians must respond to a patient's request to edit a medical record. The decision to edit a medical record is a function of the physician's professional judgement. When responding to a patient's request to edit a medical record, a physician must either:

    a. follow the provisions provided in Standard 8; or

    b. when choosing not to edit a medical record in response to a patient's request, the physician must document the request in the chart, as well as the reasons for declining the request.

Guidelines

1. Physicians should document the following for all patient encounters:

    a. presenting complaint;

    b. a focused relevant history;

    c. an assessment and an appropriate focused examination;

    d. a diagnosis and/or differential diagnosis;

    e. any treatment or therapy provided and the patient's response and outcomes;

    f. a management and follow-up plan, including advice given to patients and/or care givers;

    g. any prescriptions issued in accordance with the College's *Professional Standards and Guidelines Regarding Prescribing*;

    h. consent in accordance with the College's *Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment* and any consent to treatment obtained in writing;

    i. all tests requisitioned and referrals made, including a copy of the referral note, and any associated reports and results (e.g., laboratory, diagnostic, pathology);

    j. any treatments, investigations, or referrals that have been declined or deferred, the reason, if any, given by the patient, and discussion of the risks;

    k. any operative and procedural records; and

    l. any discharge summaries.

Documentation for In-Patient Encounters

Preamble

In-patient medical records are a systematic documentation of a patient's hospital stay which are stored within the facility. In-patient medical records are designed to be accessible by all health care professionals authorized to provide health care to the patient. Various health professionals will be documenting care on an in-patient record.

2. The most responsible physician must maintain accessible, accurate, and up-to-date documentation in the in-patient record.

3. Physicians involved on an occasional or episodic basis must use their professional judgement when documenting the nature of their involvement so as to reflect the care received by the patient, their professional judgement, and such other details as they think relevant to the patient's treatment.

   It will be for these physicians to determine whether to include a cumulative patient profile (CPP) or an equivalent patient health summary in each patient's 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 summery would reasonably contribute to quality care.

Definitions

Electronic medical records (EMR) means a computer-based patient record that is created digitally or stored digitally (e.g., a patient record that has been scanned). EMR's are real time records that make patient health information available instantly. Also known as an electronic health record.

Resources

College of Physicians and Surgeons of Nova Scotia

- Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment
- Professional Standards Regarding Initiation of Opioid Therapy for Acute Pain
- Professional Standards and Guidelines Regarding Prescribing
- Professional Standards Regarding Virtual Care
- Professional Standards and Guidelines Regarding Physician Use of Social Media

Canadian Medical Protective Association

- Writing With Care
- Good Practices Guide: Documentation
- Physician-patient Documentation and Record Keeping

Acknowledgements

The development of this College standard was informed by the College of Physicians and Surgeons of Ontario's document *Medical Records Documentation* and the Colleges of Physicians and Surgeons of Manitoba's *Standard of Practice Documentation in Patient Records*.

Document History

Approved by the Council of the College of Physicians and Surgeons of Nova Scotia on: **March 3, 2023**

This standard replaces the Standard entitled *Professional Standard Regarding Medical Records.*

Date of next review: **2026**

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