Standard of Practice: Records Keeping

Standard of Practice

Naturopathic doctors must create, maintain and keep all records in an ethical, accurate, secure and comprehensive manner and in compliance to the *Personal Information Privacy Act* SA 2003, C. P-6. Members must report any loss, unauthorized access to or unauthorized disclosure of information in accordance with any applicable privacy legislation.

Introduction

The intent of this standard is to advise naturopathic doctors with respect to the expectations for record keeping in their practice. This standard applies to written and electronic records and includes appointment records, billing records, patient medical records, dispensary records and clinical equipment records.

Definitions

Appointment: an arrangement to meet a patient for naturopathic service at a particular time and place; this includes meeting on the phone.
Appointment record: an account or evidence of scheduled and serviced appointments.
Billing record: an account or evidence of payments for services rendered to patients and products sold to patients and the public.
Dispensary: a place where products are combined, prepared and/or sold.
Dispensary record: an account or evidence of products sold to patients and the public.
Disposition: for the purposes of this standard, disposition refers to the disposal of, or the ending of use of equipment.
Equipment record: an account or evidence of the purchases, maintenance and disposition of clinical equipment.
Mature minor: In Alberta, a mature minor who is not a ward of a director under the *Child, Youth and Family Enhancement Act* is entitled to give or refuse consent for a proposed treatment, and a guardian has no authority to override or veto the mature minor's decision (mature minor doctrine). Alberta has established no set age for a mature minor.
Naturopathic services: services within the naturopathic doctor's scope of practice delivered by the naturopathic doctor as part of a patient's treatment.
Patient medical record: an account or evidence of documented patient findings, assessments, diagnoses and treatments.
Product: any device and substance that does not qualify as a drug.
Prescription: the recommendation of a product by a regulated health professional.
Public: individuals who do not have a prescription from a regulated health care professional for the product they wish to purchase.
Purchaser: patient, patient of another regulated health professional or member of the public who makes purchases from a dispensary.
Service: any work performed by a person or professional.

Standard of Practice: an authoritative statement that describes a minimum required behaviour of every naturopathic doctor and is used to evaluate individual conduct. Naturopathic doctors should always strive to practice above the minimum standards. Performance below the minimum standard may result in disciplinary action.
Substance: anything that is publicly available and which may include botanical tinctures, botanical powders or loose herbs, fluid/solid extracts, base creams, salves and ointments, homeopathic remedies, vitamins, minerals and amino acids.

A. Appointment Records

Naturopathic doctors must maintain appointment records that are accurate, legible and comprehensive.

Naturopathic doctors demonstrate this standard of practice by:

1. maintaining an appointment record that clearly and legibly identifies:
   a) naturopathic doctor's name and clinic name,
   b) date and time of each appointment,
   c) name of patient, including at least their first and last name, and
   d) type of appointment;
2. ensuring all appointment records are kept securely;
3. ensuring appointment records are made available at patient's request and in accordance with any applicable privacy legislation; and
4. keeping appointment records for at least seven (7) years.

B. Billing Records

Naturopathic doctors must maintain billing records that are accurate, legible and comprehensive.

Naturopathic doctors demonstrate this standard of practice by:

1. ensuring that billing records clearly and legibly record:
   a) name of treating naturopathic doctor, clinic name, address, telephone number,
   b) patient's name, address and telephone number,
   c) date of service rendered,
   d) services billed,
   e) products dispensed,
   f) payment amount and method of payment, and
   g) balance of account;
2. issuing receipts for all payments;
3. ensuring that receipts provided to patients are clearly itemized by:
   a) name and registration number of treating naturopathic doctor, clinic name, address, telephone number,
   b) patient's name, address and telephone number,
   c) date(s) of service(s) rendered,

d) rendered naturopathic service(s) billed, separating fees for naturopathic service(s) from all other fees,
e) laboratory services, when applicable,
f) products sold, when applicable and
g) payment amount and method(s) of payment;

4. maintaining copies of receipts for all payments;
5. ensuring all billing records are kept securely;
6. ensuring billing records are made available at patient's request and in accordance with any applicable privacy legislation; and
7. keeping billing records for at least seven (7) years.

C. Dispensary Records

Naturopathic doctors must maintain dispensary records that are accurate, legible and comprehensive.

Naturopathic doctors demonstrate this standard of practice by:

1. ensuring that dispensary records legibly and accurately document:
   a) purchaser's name,
   b) purchaser's phone number,
   c) product(s) purchased,
   d) date of purchase, and
   e) name of prescribing health care professional, when applicable;
2. documenting and maintaining an inventory of products purchased or received, including date of receipt;
3. maintaining a log containing a record of distribution of each product sold to enable the naturopathic doctor to notify the purchaser of any recalls of any sold product;
4. maintaining a record of any product recalls or alerts provided by the manufacturer or Health Canada;
5. ensuring all dispensary records are kept securely; and
6. keeping these records for at least seven (7) years.

D. Patient Medical Records

Naturopathic doctors must maintain patient medical records that are accurate, legible and comprehensive and kept in a safe manner.

Naturopathic doctors demonstrate this standard of practice by:

1. documenting all entries related to patient care either in a paper or electronic patient medical record;
2. ensuring that all patient medical records contain:
   a) entries written in English,
   b) chart entries that are recorded as soon as possible after the patient interaction,
   c) clearly indicate the health care service provider,

d) a legend of abbreviations or codes when other than generally accepted medical abbreviations are used,
e) subjective information provided by the patient or their authorized representative,
f) relevant objective findings including any lab or test results,
g) results of any examinations,
h) an assessment of the information and any diagnosis,
i) proposed treatment plan, including prescriptions, diet and lifestyle recommendations, and any referral(s) to another health care professional,
j) relevant consent forms, including documentation of informed consent as required by the CNDA Standard of Practice: General and the CNDA Standard of Practice: Consent,
k) documenting any assessment made to determine mature minor status,
l) relevant communications with or about the patient,
m) relevant information obtained from re-assessment,
n) signature and registration number of the naturopathic doctor and date of each entry;

3. documenting the following information related to the delivery of treatment, as applicable:
   a) name and strength of all products administered,
   b) dosage and frequency,
   c) date of administration,
   d) method of administration,
   e) health care service provider administering treatment, and
   f) how treatment was tolerated;
4. ensuring that no changes are made to previous entries in a patient medical record except where a patient requests a correction or amendment to their information in accordance with any applicable privacy legislation;
5. ensuring any addendums to a patient medical record is initialed and dated;
6. ensuring that when patient medical records are created and maintained on paper, the following criteria are met:
   a) all written entries are made in indelible ink,
   b) the patient's name or patient number is recorded on each page,
   c) all written entries are clearly legible,
   d) there are no blank spaces on the page or blank pages between entries,
   e) all pages are in chronological order and dated,
   f) a consistent format is used for recording the date,
7. ensuring that, when patient medical records are created and maintained electronically, the following criteria are met:
   a) the system provides a visual display of the recorded information,
   b) the system provides a means of accessing the record of each patient by the patient's name,
   c) the system maintains an audit trail that:
      i) records the date and time of each entry for each patient,
      ii) preserves the original content of the record if changed or updated,
      iii) identifies the person making each entry or amendment, and
      iv) is capable of printing each patient record separately;

d) the system provides reasonable protection against unauthorized or inappropriate access;
e) the system is backed up at least each practice day and allows for the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to and inaccessibility of records; and
f) files are encrypted if they are transferred or transported off-site;
g) ensuring, if other practitioners also see the same patient, that the member's electronic records can be individually retrieved;

8. ensuring all patient records are never left unattended in an unsecured location;
9. storing all patient medical records in such a manner that a specific file can be easily identified and retrieved;
10. maintaining a separate patient medical record for each patient;
11. ensuring all patients are made aware that other health care professionals and/or administrative staff may have access to their patient medical records and patients may choose to decline that access,
12. ensuring that any disclosure of personal health information is shared in accordance with CNDA Standard of Practice: Consent and any applicable privacy legislation;
13. ensuring that a log is kept of all disclosures of a patient's medical record to external parties in accordance with any applicable privacy legislation;
14. appropriately transferring patient medical records to another naturopathic doctor in Alberta in the event of sale of practice, transfer of practice, retirement from practice or similar circumstance in accordance with CNDA Standard of Practice: Transfer and Termination of Care;
15. notifying patients in writing as to how they can obtain access to their patient charts:
    a. when their charts are to be transferred;
    b. when the naturopathic doctor is changing practice location(s); and
    c. regardless of the naturopathic doctor's practice status.
16. ensuring all patient medical records are kept securely by having in place administrative, technical and physical safeguards to protect the confidentiality of information and the privacy of patients and that such safeguards be regularly assessed and documented in policies and procedures;
17. ensuring patient medical records are made available at patient's request and in accordance with any applicable privacy legislation; and
18. ensuring patient medical records are maintained and accessible, regardless of the naturopathic doctor's practice status, for a minimum of:
    a. ten (10) years from the date of last record entry for an adult patient; and
    b. ten (10) years after the date of last record entry for a minor patient, or two years after the patient reaches or would have reached the age of eighteen (18), whichever is longer.

E. Clinic Equipment Records

Naturopathic doctors must create and maintain appropriate records of the purchase, maintenance, and disposition of clinical equipment requiring servicing.

Naturopathic doctors demonstrate this standard of practice by:

1. documenting and maintaining an inventory of equipment purchased or received, including date of receipt;
2. documenting the date and nature of service or maintenance on equipment;
3. documenting the date of disposition of equipment;
4. ensuring all clinical equipment records are kept securely; and
5. maintaining these records for a minimum of five (5) years after disposition of the equipment.

Expected Outcomes

Patients are satisfied that:

- all records pertaining to their care with naturopathic doctors are created ethically, accurately and comprehensively, and
- all records pertaining to their care with naturopathic doctors are maintained and kept securely.

Related Documents

Health Professions Act
Naturopaths Profession Regulation
Personal Information Privacy Act
CNDA Code of Ethics
CNDA Standard of Practice: Collaboration in Patient Care
CNDA Standard of Practice: General
CNDA Standard of Practice: Selling
CNDA Standard of Practice: Transfer and Termination of Care
CNDA Guideline: Collaboration in Patient Care in a Shared Healthcare Setting
CNDA Guideline: Obtaining Consent for a Minor/Mature Minor