



## **PRACTICE STANDARDS**

(updated Feb 23, 2004)

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### **1. Patient Health Records**

a) The patient health record must include the following:

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

b) In addition, the patient record shall:

- i. Include complete and up to date information.
- ii. Be legible.
- iii. Be written in permanent black or blue ink.
- iv. Have all corrections initialled.
- v. Use a clear and logical format.
- vi. Have a glossary available if abbreviations are used.
- vii. Be secured and kept together.
- viii. Be recorded at the time or within 24 hours.
- ix. Identify the author
- x. Conform to the institutional policies where applicable.
- xi. Each part of the health record must have a reference identifying the patient

### **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 and retained for at least ten years following:
  - i. the patient's last visit or,
  - ii. if the patient was less than 18 years old at the time of the last visit, the day the patient becomes, or would have become, 18 years old.
- e. Records must be stored securely.
- f. Records must be destroyed in a manner that ensures confidentiality and in accordance with current Federal and Provincial legislation.

### **7. Resignation of a membership**

Before resigning, a member must ensure that for each patient for which the member has primary responsibility,

- a. The record is transferred to another member, and/or
- b. The patient is notified of the resignation and informed that the patient can obtain copies from the patient health record.
- c. Where the record is not transferred to another member it must be stored in compliance with section 6.

Before resigning, a member must ensure that within 30 days of resigning from practice he/she attends the COPOM office (by appointment) to give the following information to the Registrar :

- a) Resignation letter addressed to the Registrar of the College to include :
  - i) date of termination of practice,
  - ii) forwarding/contact address,
  - iii) transfer of 'Registration Status' to either : Non Practising or No Longer Registered.
  - iv) Resignation information given to the member's patients.
  - v) The storage location of all patient records.
  - vi) Confirm intent to maintain liability insurance after resignation as per the liability insurance company's recommendations.
  
- b) Confirm understanding of obligations relating to resignation, and
- c) Return COPOM License and COPOM ID name tag.

## **8. Computerized Records**

***Computerised 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 charting meets legal and professional standards.
- c. There will be locked and controlled access to computer facilities.
- d. Health facilities' policies and procedures for access to written information must serve as minimum standards for computerised information.
- e. Controls and audits shall be in place to assure integrity of the data.
- f. Backup copies of files are to be stored in a physically separate and secure area.
- g. Legislation regarding computerised health information shall be routinely monitored.
- h. Policies shall be developed for the control of retention and destruction of computerised information.
- i. Health information recorded or stored by electronic methods or tapes, disks or cassettes, shall be destroyed by erasing.

## **9. Standard for Continuing Professional Development**

The aim of the standard is to encourage all practising members to keep up to date and to be aware of changes in practice, the latest developments and best practice based on the current available evidence.

### *The Requirement*

- 1) 20 hours of CPD activity each two-year cycle.
- 2) One CPD Point equals one hour of activity.
- 3) The two-year cycle runs from January 1<sup>st</sup> 2004 to December 31<sup>st</sup> 2005 and so on.
- 4) Council will review any extenuating circumstances in meeting the CPD requirements.

Ten areas of clinical practice, which are considered essential for CPD, the 'core topics' are:

*Core Topics*

- |                            |                       |
|----------------------------|-----------------------|
| a. Vascular assessment     | f. Local analgesia    |
| b. Neurological assessment | g. Pharmacology       |
| c. Wound healing           | h. Podiatric surgery  |
| d. The diabetic foot       | i. Biomechanics       |
| e. The rheumatoid foot     | j. Infection control. |

It is recommended that a course on three of the core topics be completed every year. Over a three-year cycle, each course should therefore have been attended at least once.

In addition, it should be noted that an update in :

- i) Basic Life Support (CPR) every year, and
- ii) First Aid once every 3 years (ie: once each two year cycle)

is mandatory, and evidence of successful completion of a course of instruction must be provided to the CPD Officer before annual renewal of membership.

In addition to the core topics, members will be expected to engage in general professional development each year.

*Achieving CPD Points*

CPD Points can be achieved by either :

- i) Attending Activities, or
- ii) Independent Learning.

i) Attending Activities – at least 50% of the required CPD Points for each cycle must be credited

- a. Scientific sessions of international, national and provincial podiatric conventions.
- b. University courses, lectures, seminars and scientific meetings relevant to podiatric practice or research.
- c. Short-term residencies.
- d. Formal ward rounds, grand rounds, etc.

ii) Independent Learning up to 50% of the required CPD Points for each cycle may be credited

Under this section credit may be claimed for learning carried out privately, including:

- a. Video tapes.
- b. Online CPD, completing self-assessment questions where available.
- c. Teaching and preceptorship, e.g. includes that to health professions.
- d. Attending a journal club (this may be online)
- e. Publication of case studies; research and/or audit;
- f. Time spent in preparation for examination for speciality or other formal higher education activities  
Programs which have met Continuing Medical Education (CME) requirements, or recertification by a certifying body, association, college, etc., which is accepted by this College for that purpose.
- g. Clinical supervision, mentoring or reflective practice and health education lecturing;
- h. Representation on health or work related committee(s).

Other than Podiatry Conferences, all CPD credits, either Attending Activities or Independent Learning, must be pre-approved by the CPD Officer for eligibility. Proof of attendance must accompany the portfolio; proof of payment of fee is not sufficient.

All members must be able to demonstrate they are engaged in CPD. It is therefore the responsibility of each member to maintain a current portfolio detailing all CPD activities undertaken.

It is the responsibility of each member to ensure the CPD Officer receives proof of his or her CPD activity within the required time frame.

#### **10. Infection control**

Members must adopt Infection Control Guidelines from the College of Physicians and Surgeons of Manitoba.