



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) In addition, the patient record shall:**

- 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.