HEALTH LAW

Medical Records
The Legal Requirements

TTL HEALTH LAW

Legal Requirements

By Law physicians are required to record certain information in their patients' records and physicians are required to follow particular procedures in the maintenance, transfer and eventual disposal of their records.

These requirements are found in the *Medicine Act*, the *Health Insurance Act*, the *Public Hospitals Act*, and also, in various College policy bulletins.

The Legal Framework

- Statutes:
  - Medicine Act
  - Public Hospitals Act
  - Health Insurance Act
- College Guidelines
- College Decisions
- Common Law

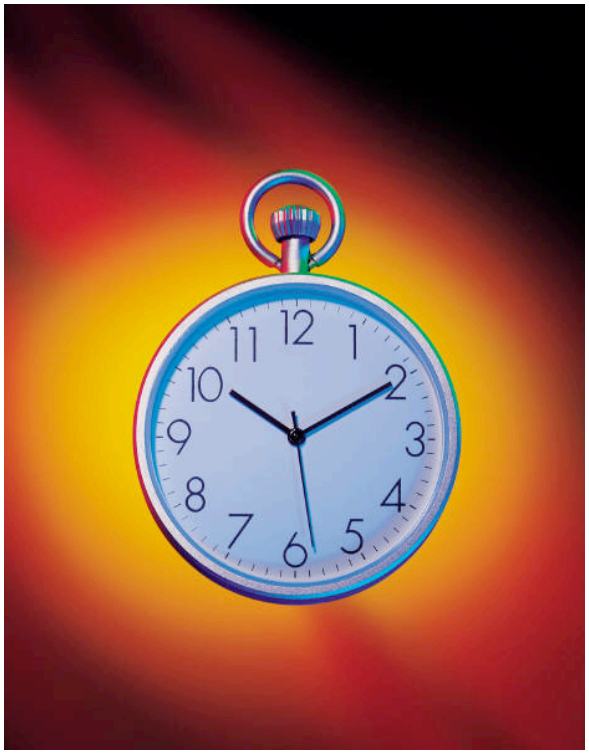
Medicine Regulations

It is an act of professional misconduct to:

- Fail to keep records as required
- Falsify a record relating to your practice
- Sign or issue a document in your professional capacity which you know, or ought to have known, contains a false or misleading statement

Timing

- Entries should be made on a chronological basis
- Include date and time of care or event
- Entries should be made contemporaneously with events
- Late entries should be marked as such
- Should only correct entries by crossing out original and dating correction
  - No white out!



Law of Confidentiality

Patient records must be kept confidential, but they do not belong to you!

***McInerney v. McDonald*, [1992] 2 SCR 138**

- Medical records are the property of the patient – not the physician
- Only in certain circumstances can a patient be denied access to their own medical records
  - i.e. if it will cause the patient harm to learn such information

Mandatory Reporting

There are instances where you are required by law to disclose a patient's medical information to a third party:

- Fitness to drive or fly a plane
- Suspected child or elderly abuse
- Certain communicable diseases
- Sexual abuse by a health professional

Duty to Warn

Smith v. Jones, there must be:

- The threat of serious harm
- An identifiable group of potential victims
- An imminent and conceived plan

Legal Uses

Medical records will be used:

- As evidence in Professional Misconduct Prosecutions
- As evidence in lawsuits, hearings or inquests
- Components of external reviews
  - Audits, peer assessments, etc.
- To investigate billings

Medicine Act Regulation for "All" Records

Records must contain the following:

- Personal information and health care number
- Consultation – referring physician information
- All written reports received
- For assessment (date, Hx, exam details, investigations ordered)
- Details of each Tx prescribed or administered
- Details of all advice and referrals made
- Record of all fees (uninsured)
- Daily appointment book
- Records must be legible and kept in systematic manner
- Records must be retained for 10 years

*Also, Medical Records must conform to all other legislation applicable to physician practice (Health Insurance Act, PHIPA, etc.)

General Record Keeping Standards

- Legibility
- Corrections
- Storage, security, confidentiality and record retention
- Contents of records
  - Cumulative patient profile
  - Progress notes (“SOAP”)
  - Required elements as per encounter
    - General, intermediate and minor assessment
    - Psychotherapy and counseling (i.e. time in and time out)
  - Consultations and procedures

“All of the principles discussed in the policy apply equally to electronic records. The records must contain the story of the patient.”

Core Standards for Record Keeping

- Documentation must be clear, concise and comprehensive
- Entries should be accurate, true and honest
- Records should contain relevant notes that are reflective of observations – not conclusions
  - i.e. Do not write “patient uncooperative”
  - i.e. Do write “patient refuses breast examination”
- Records should reflect a complete picture of the care provided

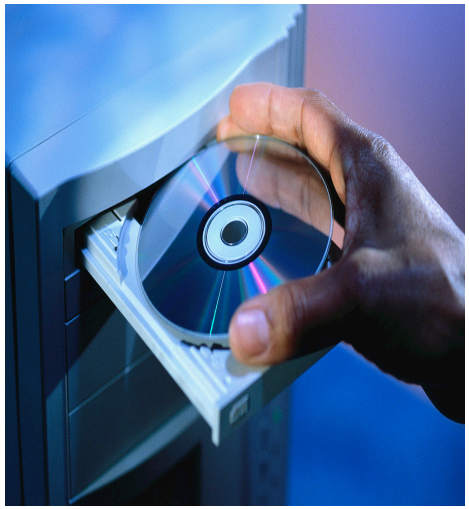
Document Everything

- Patient Non-Compliance:
  - Make sure you document all instances of a patient refusing an examination
- Document all telephone conversations and home visits.

“EMR” Records – *Medicine Act* Regulations

Records may be maintained in electronic format ONLY IF:

- System provides a visual display of recorded information
- Access by name and/or health card number
- System can print records promptly
- System can display and print in chronological order
- System maintains an Audit Trail
  - Records date and time of each entry
  - Indicates any changes in recorded information
  - Preserves original content when info changed
  - Can be printed separately from recorded information
- System has password or other protection
- System automatically backs up files and allows recovery



EMR Standards - College

An Electronic Medical Record must do the following:

- Capture all pertinent personal health information
- Display patient's "story" on several screens
- Print copies upon request
- Privacy & Security – onsite or offsite
- Ability to expunge all records from system
- If email records (with patient's consent) – use encryption
- Do not send records using Rogers, Sympatico, Hotmail, etc. email accounts
- Backup and update frequently – Offsite backup is highly recommended
- Document office protocols re "who" has access to records (login and password required to access)
- Can scan records into EMR and then destroy paper (as per CPSO Policy)

Simple Not Scary

- Adoption of EMR is inevitable
- EMR vendors provide all levels of support – for experienced computer users to first timers
- EMR software “appropriateness” for your practice will depend on the “nature” of your practice
- Whatever system you choose, must ensure that you are maintaining **ALL** required elements of records
- *The software must fit around your office and not the other way around*

The Episodic Patient Encounter

Use SOAP

- Subjective Data: i.e. complaints, change in health since last visit, medical history as related to the complaint
- Objective Data: i.e relevant vital signs, positive/negative physical findings
- Assessment: i.e. a review of medications, allergies, risk factors and diagnosis
- Plan discussion of treatment options, medication or tests ordered, education and any follow up.

Record of Disposition

A record of disposition of the patient which includes:

- Each treatment administered/ prescribed by the physician; and,
- A record of professional advice given by the physician

Legal Implications of Poor Record Keeping

- Civil lawsuits
  - Malpractice / negligence
  - Personal injury
  - Insurance
- College Investigations and hearings
  - S. 75 investigations
  - Discipline proceedings
  - Quality management and peer review assessments
- Coroner's investigations and inquests
- Criminal Trials
- Other Boards or Tribunals
  - WSIB, HPARB, IPC

De Jong v. Owen Sound, [1996]

Facts

PJ was a patient at the defendant hospital as he suffered from depression and had suicidal tendencies. PJ was placed in a room on the main floor of the psych wing of the hospital. The window in room had ordinary glass. PJ was observed by a nurse to be throwing his body against the window – did not document this fact. PJ ultimately threw himself through the window and ran towards the road where he was hit by a car. The hospital was sued for negligence for failing to have suitable glass in the windows and for failing to adequately monitor the patient.

Decision

PJ's claim for negligence was successful as against the hospital, doctors and nurses. The nurse was held to be negligent. Her failure to chart according to standards was determinative for the judge in finding that she breached her duty of care owed to her patient.

De Jong v. Owen Sound, [1996]

“Nurse Oberle's charting for that final shift on August 23, 1984 was not done until the weekend immediately following the plaintiff's escape and injury, following a request of Nurse Oberle by the hospital for a recounting of the events of that shift. By all accounts, there were significant items of information contained in Nurse Oberle's charting that bore upon the presentation of the plaintiff; information that was necessary to inform the clinical judgments of those team members who followed her.”

Penalty

Suspension and educational courses.

RR *and the College of Nurses of Ontario* [2003]

Facts

RR, a full time RN was treating a client (chronic alcoholic suffering from alcohol withdrawal) who suffered multiple injuries due to a fall. RR began to notice that client began to experience symptoms of alcohol withdrawal. RR reported condition to anesthetist who verbally ordered her to administer 10 mg Valium (IM) initially and additional Valium prn (IV) as required. Both RR and anesthetist failed to document orders with regard to amount, frequency and maximum amount to be administered. In total, RR administered 65 mg Valium between 0800h and 1230h (with no documented written orders to do so). Later the same day, client began to experience respiratory distress and became comatose and required emergency intervention.

RR *and the College of Nurses of Ontario* [2003]

Decision

RR was found guilty of professional misconduct in that she:

- Failed to document orders with regard to amount, frequency and maximum amount of Valium to be administered;
- Failed to make contemporaneous chart entries of drugs administered / vital signs during administration of Valium in period of 0900h to 1300h;
- During period of administration of 55 mg Valium (0900h to 1300h), RR only recorded heart rate every hour and failed to record any assessment of the client's level of consciousness

Penalty

Suspension, educational courses and supervision order

Insured Service Requirements

- To establish that an insured services has in fact been provided
- That the procedure was medically or therapeutically necessary
- Potential criminal and civil charges if records do not adequately meet legal requirements

Audits

If being assessed, the assessor will note whether:

- The chief complaint is clearly stated
- The duration of symptoms is noted
- An adequate description of symptom is present
- Positive physical findings are recorded
- Significant negative findings are recorded
- Requests for consultations or tests are documented
- The diagnosis is recorded
- The treatment plan is recorded
- Doses and duration of medications are noted and the ***end justifies the means***

Issues for Another Day

Issues for Another Day

- Confidentiality and privacy of client records
- Client's right to access their own records
- How to respond to a summons for your records

Questions?