

# Record Keeping Standard of Practice For Naturopathic Doctors

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Initial Policy: January, 1999

Board publications contain practice considerations and standards that, in the absence of extenuating circumstances, must be adopted by all Registrants in the care of their clients and in the practice of the profession. Board standards and guidelines are developed in consultation with professional practice leaders and describe current professional expectations. It is important to note that these publications may be used by the Board or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

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***Definition of Standard of Practice:*** An approach to a professional issue that is generally accepted as appropriate by informed and competent Registrants.

***Definition of Performance Expectation:*** The manner in which a Registrant typically achieves the corresponding standard of practice.

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**PURPOSE:** The BDDT-N has established the following standard of practice and performance expectations regarding the proper recording, maintenance and retention of all records in a naturopathic practice. This document will delineate Registrants' obligations and patients' rights regarding naturopathic records.

**INTENT:** To assist Registrants in developing, achieving and maintaining best practices in record keeping in naturopathic practice.

The patient record consists of the patient chart, appointment book and financial records. The patient chart is an essential chronicle of the history of medical care and a guide for the direction of future care. It is often the Registrant's most important evidence in a complaint or a lawsuit.

Registrants will take all reasonable steps to ensure written and electronic records are kept in accordance with this standard. Unless otherwise indicated, these standards pertain to written records. For electronic records specifically refer to section 5.

Good records help Registrants to provide effective, progressive and organized care. They also assist in providing continuity of services if the care of the patient is transferred to another practitioner for any reason. Concise, accurate, legible records should provide a full account of the patient's past and current health status and concerns, the treatment provided and the patient's response to treatment.

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**Standard of Practice**

**Practice Expectations**

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**1.0 APPOINTMENT RECORDS**

Appointment records – hard copy or electronic – are maintained and retained for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient’s 18<sup>th</sup> birthday.

Each Registrant is able to produce a hard copy of the original appointment record if legally required.

**2.0 FINANCIAL RECORDS**

Financial records - written or electronic - are maintained and retained for a period of at least 10 years after the date of the last entry for the patient. In the case of a minor, records are retained for at least 10 years following the patient’s 18<sup>th</sup> birthday, regardless of the date of the last entry in the file.

**2.1 Receipts**

A receipt is issued for each payment if requested.

**1.0 APPOINTMENT RECORDS**

The Registrant maintains an appointment record that clearly and legibly identifies the following:

- ND name, clinic name, address and telephone number,
- date and time of appointment,
- name of patient (minimum of last name and first initial),
- duration and type of appointment

Abbreviations/codes may be used for appointments, cancellations, missed appointments, re-booked appointments, new patients, special techniques, tests etc. A legend of abbreviations/codes is in the appointment record and/or accessible elsewhere in the office.

Each Registrant in a clinic maintains his/her own appointment record or has his/her appointments recorded on separate pages, or at a minimum in separate columns.

**2.0 FINANCIAL RECORDS**

Financial records clearly and legibly record the following:

- name of treating ND, clinic name, address, telephone number,
- patient’s name, address, telephone number,
- date of service,
- services billed,
- payment and method of payment,
- balance of account.

**2.1 Receipts**

Receipts clearly and legibly record the following information:

- name of treating ND, clinic name, address, telephone number,
- ND’s registration number,
- patient’s name and address,
- date of service,

**Standard of Practice**

**Practice Expectations**

**3.0 PATIENT CHARTS**

Patient charts - written or electronic - are maintained and retained for a period of at least 10 years following the last entry in the chart. In the case of a minor, the chart is retained for a period of at least 10 years following the patient's 18<sup>th</sup> birthday, regardless of the date of the last entry in the file.

- services billed,
- payment received,
- GST registration number (if GST charged).

If a replacement receipt is issued it is clearly marked 'COPY'.

Fees are properly itemized. For example, fees for naturopathic consultation are separated from all other fees. Fees for supplements, PT injectibles, devices, special testing etc., are listed separately, either on the same or another receipt. Charges for supplements are billed as such.

The purchase and redemption of vouchers or gift certificates are clearly documented as such.

**3.0 PATIENT CHARTS**

All patient charts meet the following criteria:

- All written entries are made in indelible ink.
- Highlighting over writing is not used as it accelerates ink fading and may not be legible when photocopied; underscoring is permitted.
- All written records are clearly legible.
- There are no blank spaces between entries.
- All pages are in chronological order, consecutively numbered and dated.
- A consistent format is used throughout the chart for recording the date e.g. dd/mm/yy, OR mm/dd/yy.
- All chart entries are recorded as soon as possible after the patient encounter while the details are fresh in the Registrant's mind.
- Generally accepted medical abbreviations may be used. A legend of abbreviations/codes is in the appointment record and/or accessible elsewhere in the office.

Recording derogatory, judgmental or otherwise inappropriate comments about patients is inadvisable. Use factual terms e.g. patient shouting, shaking fists vs. difficult, non-cooperative, rude. Always assume the patient will read their chart.

**Standard of Practice**

**Practice Expectations**

**3.1 Storage of Charts**

All patient charts are stored in an area accessible only to authorized staff as per the (Ontario) *Personal Health Information Protection Act 2004* (PHIPA).

All patient charts are securely stored and organized in a way that the chart can be extracted for each individual patient when required.

**3.2 Corrections to Patient Records**

Necessary corrections to the patient chart are acceptable as long as the change is clearly indicated as such and is dated and initialed. Corrections are only to be in the form of additions and not erasure or overwriting. At all times the original entry is available and legible. A patient’s chart must never be re-written.

**4.0 PRIVACY ASPECTS OF RECORD KEEPING**

Registrants adhere to the (Ontario) *Personal Health Information Protection Act, 2004* (PHIPA). The Registrant identifies

The attending Registrant signs his/her chart notes and includes his/her registration number so that the treating ND (e.g. primary, locum or other) is clearly identified.

\*For detailed record keeping practices and S.O.A.P. format please see Appendix I and II

**3.1 Storage of Charts**

When storing patient charts, the Registrant will:

- Ensure all patient charts are secured when the office is closed, e.g. in a locked filing cabinet.
- Ensure sensitive information is never left unattended in an unsecure location.
- Store all patient charts alphabetically or numerically, such that a specific file can be easily identified and retrieved.

Registrants maintain a separate chart for each patient. In multi-disciplinary clinics, naturopathic patient charts may be filed with other charts in the clinic as long as they can be readily identified e.g. different colored file folders. Registrants maintain a chart for each patient so that the information can be extracted individually when required. If other practitioners also see the same patient, their notes are kept in a separate file. Charts for patients receiving Parenteral Therapy are easily identifiable for retrieval for inspection purposes.

**4.0 PRIVACY ASPECTS OF RECORD KEEPING**

In a single-practitioner private naturopathic practice, the owner of the practice is generally the HIC and often serves as its privacy information officer.

In a shared practice/partnership/associateship, the terms

**Standard of Practice**

**Practice Expectations**

a Health Information Custodian (HIC) who establishes written policies and procedures relating to the collection, use, and disclosure of all personal health information. See Appendix III for more information.

**5.0 ELECTRONIC RECORD KEEPING**

Patient charts – written or electronic – are maintained and retained for a period of at least 10 years following the last entry in the chart. In the case of a minor, the chart is retained for a period of at least 10 years following the patient’s 18<sup>th</sup> birthday, regardless of the date of the last entry in the file.

Electronic records are backed up each practice day and separate copies of the back-up are kept in a safe place, off-site.

of the written agreement made between or among the Registrants specifies that the patient charts are the responsibility of the HIC of the practice. Regardless of the agreement, all treating Registrants are given access to the chart where necessary to fulfill their professional obligations, including their obligations to the BDDT-N. All patients are made aware that other practitioners may have access to their charts and patients may choose to decline that access in accordance with PHIPA. See [www.ipc.on.ca](http://www.ipc.on.ca).

**5.0 ELECTRONIC RECORD KEEPING**

Patient records may be maintained in an electronic system as long as the following criteria are met:

- The system provides a visual display of the recorded information.
- The system provides a means of accessing the record of each patient by the patient’s name.
- The system is capable of printing promptly the recorded information in chronological order for each patient.
- 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,
  - iv. is capable of printing each patient record separately.
- The system provides reasonable protection against unauthorized access, such as requiring person specific passwords to access the system and a separate password for the patient management software.
- 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.
- Files are encrypted if they are transferred or transported outside of the facility.

**Standard of Practice**

**Practice Expectations**

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**6.0 RETENTION AND TRANSFER OF PATIENT RECORDS**

All records are retained for **at least ten (10) years** following the date of the last entry in the chart. In the case of a minor, records are retained for at least 10 years following the patient's 18<sup>th</sup> birthday, regardless of the date of the last entry in the file. Records are transferred in a manner ensuring continuing access by patients and the Board.

**6.0 RETENTION AND TRANSFER OF PATIENT RECORDS**

- Under PHIPA, patients or their legal representatives are generally entitled to copies of their “medical record.” The Registrant always maintains the original file unless it is requested by the BDDT-N for a regulatory purpose or is required for legal purposes. Except as authorized by PHIPA, the Registrant may not provide any information concerning the patient to a person other than the patient or his/her authorized representative(s) without the express consent of the patient, an authorized representative, or as otherwise authorized by law.
- The Registrant may charge a reasonable fee to reflect the actual cost of reproduction, the time required to prepare the material and the direct cost of sending the material to the authorized party. The Registrant may not require prepayment of this fee. Non-payment of the fee is not reason for the Registrant to withhold the information.
- In the event of death of the Registrant, the responsibility for the maintenance of the records lies with the estate, which is obliged to maintain those records as defined above. If the estate sells the practice to another Registrant, all records are transferred to the purchasing Registrant and are maintained as above. It is each Registrant's responsibility to ensure there is an orderly preservation of patient records in the event of his/her death and to ensure that the Registrant's authorized representative notifies the BDDT-N of the Registrant's death within a reasonable period. PHIPA has additional requirements in respect of the transfer of health records (e.g., notice to patients).
- If a Registrant relocates a practice s/he may take the patient records to the new location. If the practice ceases operation, the Registrant either appropriately transfers or maintains the original of all patient records as described above. Patients are notified, in writing, as to how they can obtain access to their patient records. The BDDT-N is also notified and provided with a forwarding

**Standard of Practice**

**Practice Expectations**

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**7.0 OFF-SITE STORAGE OF HEALTH RECORDS**

Section 14 of PHIPA permits practitioners to store records at a patient’s home (e.g. for homecare, a long term care home or retirement home) or a third party storage site if the patient consents, reasonable safeguards are taken and all applicable Board regulations or guidelines are complied with. Refer to Appendix IV.

address for a minimum of ten (10) years.

- In the event of a sale of the practice, all of the original records are transferred to the purchasing Registrant who maintains those records as described above. Where feasible, (in some cases by newspaper notice) patients are notified, in writing, of the practice sale so that any patient who requires a copy of his/her record may obtain it. The BDDT-N is also informed of the sale in writing and in whose care and control the original records will be maintained.
- In all cases, the BDDT-N is notified, in writing, of the forwarding address where the records are kept for a minimum of ten (10) years from the date of the last day of practice of the Registrant.
- Any records that are destroyed after the minimum period of retention are destroyed by shredding, burning, overwriting software or some other method to render them illegible and irretrievable. A record is kept of disposal dates and the names of patients whose records were disposed of.

**7.0 OFF-SITE STORAGE OF HEALTH RECORDS**

Please follow the guidelines outlined in Appendix IV.

**Related Policies:**

- Standards of Practice**
- Consent to Treatment**
- Definition of Professional Misconduct and/or Incompetence**
- Guide to Ethical Conduct of Naturopathic Doctors**
- Parenteral Therapy Policy**
- Research Devices, Appliances, Instruments or Techniques**
- Ontario’s Health Information and Protection Act (2004)*

## APPENDIX I DETAILS OF RECORD KEEPING

All patient charts are expected to contain the following:

- a. patient's name, address, telephone number, date of birth and gender,
- b. treating ND's name, clinic name and patient's name and date on each page,
- c. contact information for any parent or substitute decision maker and copy of authority for substitute decision maker where applicable,
- d. the identity of anyone in attendance during the patient visit, including an interpreter
- e. a copy of the office privacy policy signed by the patient or his or her substitute decision maker,
- f. documentation of any disability or special needs the patient has,
- g. a complete case history including modalities and concomitants of the chief concerns, secondary concerns, medical history, relevant family history, prior diagnoses, results of diagnostic testing, prior treatment and medication history,
- h. positive and negative results of a complete and/or relevant physical exam,
- i. copies of results of any testing performed by the Registrant,
- j. copies of all relevant written reports received from tests, examinations, consultations or treatments performed by other health care providers,
- k. diagnosis (naturopathic/medical/differential),
- l. a record of consent for an assessment or treatment including any signed consent forms e.g. history taking, physical exam, parenteral therapy, manipulation, research devices, acupuncture, (refer to the Consent Policy),
- m. treatment plan, future plan and prognosis
- n. all prescriptions or refills, including dosage, frequency and duration
- o. discussion of potential risks and side effects of any treatment
- p. identity of all other health care providers involved in the patient's assessment or treatment,
- q. patient's or Registrant's refusal of any or all aspects of physical exam, lab tests, or treatment plan and reasons given,
- r. re-assessments, re-examinations, changes to treatment plan and rationale for changes,
- s. documentation of requests for information and the response provided
- t. documentation regarding all professional communications including office consultations and new information provided by email or telephone
- u. record of all professional recommendations
- v. a copy of all reports issued by the Registrant in respect of the patient,
- w. a copy or identification of all handouts (which should be dated and contain the Registrant's name/clinic name and telephone number). Standard handouts can be named in the file provided copies are easily obtainable in the event of an inquiry.
- x. a note of all referrals to other health care practitioners with an explanation of the reasons for the referral,
- y. record of discharge of patient with reasons and recommendations,
- z. record of early termination of treatment by Registrant or patient with reasons for and recommendations.

## APPENDIX II S.O.A.P. FORMAT RECORD KEEPING

**S.O.A.P.** is the acronym for Subjective, Objective, Assessment and Plan. Use of this system simplifies record keeping, clarifies what occurs at each appointment and makes it easier for the Registrant, an investigator or a subsequent ND to follow the patient's progress.

**Subjective** – This is a report of what the patient reports to the ND, often recorded in the patient's own words. This includes the following:

- complete case history
- changes in patient's health status since the last visit
- response to treatment

**Objective** – This is the report of what the Registrant observes about the patient including the following:

- positive and negative findings of a complete or relative physical examination
- results of laboratory and other diagnostic testing
- reports from other health care providers
- observations of the patient's behavior and apparent mental/emotional state
- timely re-assessments of all relevant findings

**Assessment** – This is the analysis of gathered subjective and objective data which will result in a definitive diagnosis, a differential diagnosis, a working diagnosis, or a need for further investigation. It is important that the reasoning process from the subjective and objective information to the plan for the patient be evident.

Also included are the following:

- patient risk factors
- review of current supplements and medications
- re-assessment of previous diagnoses

**Plan** – This is the development of a plan of treatment based on the subjective, objective and assessment information recorded. The plan will include the following:

- all patient advice and treatment recommendations
- tests or procedures ordered,
- consultation requests or referrals including rationale
- future considerations for follow-up and treatment
- specific concerns including any refusal of examination or refusal to comply with recommendations,
- informed consent notations

### APPENDIX III PRIVACY ASPECTS OF RECORD KEEPING

Generally, patient consent is required for the collection, use and disclosure of personal health information. Consent can be implied, particularly if the information is only used for the provision of health care. Unless a patient directs otherwise, information can be shared with others on the health care team (i.e., within the circle of care) where obtaining consent is not practical. There are some other exceptions where consent is not required. For example, consent is not needed to use the information to collect an unpaid account. Disclosure can be made without consent for a number of reasons including to protect another person from serious bodily harm or for certain legal proceedings. For example, disclosure of charts to assist the Board in performing its regulatory functions does not need patient consent.

Where a patient is incapable of giving consent, it can be obtained from a substitute decision maker (generally a power of attorney or a relative). Patients, or their substitutes, can prohibit Registrants from disclosing certain information to others (unless *PHIPA* permits disclosure without consent). This is called a "lock box". Where a record is transferred, but the patient refuses to permit another health provider in the circle of care from receiving part of the information that the practitioner will likely need for treatment, the Registrant must notify the other practitioner that some of the information has been withheld.

Under *PHIPA* the patient has a right to review or obtain a copy of his/her patient chart. That right of access includes any portions of the chart provided by others, such as consultation reports and lab results. Generally the Registrant may only decline access to information for legally permitted reasons like the following:

- the information is raw data from standardized psychological tests or assessments,
- there is a risk of serious harm to the treatment or recovery of the patient or of serious bodily harm to another person, or
- providing access to the patient would reveal the identity of a confidential source of information (assuming that the case was a suitable one for the Registrant to collect information in this way, e.g., for a medico-legal report).

An individual also has the right to request the correction of erroneous personal information held by the Registrant. If the Registrant agrees that an error has been made, s/he must correct the error. Where the individual and the Registrant cannot agree, then the Registrant must note the disagreement in the file. Some grounds for refusing to correct information include the following:

- where the request is frivolous, vexatious or made in bad faith,
- the custodian did not create the record and the custodian does not have sufficient knowledge, expertise or authority to make the correction, or
- the information consists of a professional opinion or observation made in good faith.

For more detailed information about the implications of *PHIPA* on record keeping, see the website of the Information and Privacy Commissioner of Ontario at: [www.ipc.on.ca](http://www.ipc.on.ca).

#### APPENDIX IV OFF-SITE STORAGE OF HEALTH RECORDS GUIDELINES

*Section 14 of the Personal Health Information Protection Act, 2004 permits practitioners to store records at a patient's home (e.g., for homecare, a long term care facility) or a third party storage site if the patient consents, reasonable safeguards are taken and any Board regulations or guidelines are complied with. The following guideline balances the interests of the Registrant and the patient while maintaining appropriate accountability.*

1(1) A Registrant may store personal health information (the "chart") at a patient's residence, including an institutional residence so long as the following criteria are met:

- (a) the patient, or the patient's substitute, consents,
- (b) the patient, or patient's substitute, understands and appreciates the reasonably foreseeable consequences of maintaining the chart at the patient's residence and has identified a reasonable plan for safeguarding the chart,
- (c) the patient, or the patient's substitute, agrees that the Registrant has access to the chart or, in the alternative, the Registrant shall keep an up-to-date copy of the complete chart with the Registrant's other records,
- (d) the patient, or the patient's substitute, agrees to retain the chart for the period required under this policy or, in the alternative, the Registrant keeps an up-to-date copy of the complete chart with the Registrant's other records,
- (e) a reasonable clinical purpose is served by keeping the chart there,
- (f) either the chart kept at the patient's residence or the record kept with the Registrant's other records, or both, is a complete and up-to-date copy of the record and both records indicate which is the complete, up-to-date copy of the record, and
- (g) unless the Registrant keeps an up-to-date copy of the complete chart with the Registrant's other records, the Registrant shall keep a copy of the following information with the Registrant's other records:
  - a. the name and contact information for the patient,
  - b. the location of the chart,
  - c. the essential, up-to-date, clinical information about the patient including significant assessment results, a summary of the treatment plan and the major milestones in the implementation of the treatment plan, and
  - d. documentation of compliance with clauses (a) to (f).

(2) A Registrant may store personal health information at a storage facility other than one under the control of the Registrant or the Registrant's employing custodian or the patient's residence so long as the following criteria are met:

- (a) the patient, or the patient's substitute, consents,
- (b) the storage facility has a privacy policy consistent with the *Personal Health Information Protection Act, 2004* and the Board's record keeping policy,
- (c) the storage facility provides the Registrant with a written privacy assurance that it will safeguard the chart and will only use or disclose it at the express direction of the Registrant,
- (d) the Registrant describes the fact that he or she uses a storage facility in his or her privacy policy,
- (e) the storage facility is not a private residence

- (f) the Registrant contracts with the storage facility to retain the chart for the period of time specified in the Board's record keeping policy before it will destroy the chart in a secure manner,
  - (g) the Registrant keeps the account with the storage facility current at all times so that the charts are not discarded or destroyed prematurely, and
  - (h) the Registrant keeps, with his or her other records, a list identifying the patient, the nature of the record kept at the storage facility, the location of the file in the storage facility (e.g., file box number), documentation of compliance with clauses (a) to (g) and the contact information for the storage facility.
- (3) If the Registrant is an agent of a health information custodian as defined in the *Personal Health Information Protection Act, 2004*, the Registrant may comply with the custodian's privacy policies on storing records at a patient's residence or a storage facility rather than this policy so long as the policies are substantially similar to this policy.