



POLICY STATEMENT

Saskatchewan College of Podiatrists

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| <u>Policy Number:</u> | 2008-001 |
| <u>Policy Title:</u> | Record Keeping |
| <u>Approved:</u> | _____ |
| | (PRESIDENT) |
| | _____ |
| | (DATE) |

DESCRIPTION:

Records

All podiatrists will maintain and possess records of patient health, appointment scheduling and financial transactions. These records may be paper, digital or both.

All paper records must be stored in locked cabinets in a secure area with access limited to the podiatrist or designate.

Digital records must be password protected such that they may not be accessed, altered or purged internally or remotely without proper authorization. Controls and audits must be in place to assure the integrity of the data. All backup of the data must be stored in a physically separate and secure area with access controlled by the podiatrist or designate.

All records are confidential. The podiatrist may only release information contained within the patient record with permission from the patient or duly appointed entity in accordance with provincial legislation.

Records must be destroyed in a manner that ensures confidentiality.

All records sent via mail, courier, electronically or any other means must be confidential and the podiatrist is ultimately responsible for ensuring the security of the information.

The patient health record must include the following:

- a) The patient's legal name and address.

- b) The patient's Health Card number or similar identifier.
- c) A pertinent medical history of the patient.
- d) Reasonable information about every examination, clinical finding, diagnosis, assessment, treatment, procedure, medication, prescription, radiograph, modality and advice made by or given by the podiatrist.
- e) Reasonable information about every order for examination, tests, consultations, referral or treatments to be performed by another health care professional or agency.
- f) The date of each patient visit to the podiatry clinic.
- g) Every written report received by the podiatrist with respect to examinations, tests, or consultations performed by another health care professional or agency.
- h) Information pertaining to any communication between podiatrist and patient.
- i) Any pertinent reasons a patient may give for canceling or missing any appointment.

The patient health record should include the following:

- a) The patient's date of birth
- b) The name of the patient's primary care physician and any referring health care professional.
- c) A glossary if abbreviations are used.

The patient health record must also:

Be up to date, legible, if written, in permanent ink, having all corrections initialed, use a clear logical format and be updated no later than 48 hours following the event.

Must be stored in accordance with provincial legislation.

Must be made available for transfer, in accordance with provincial legislation, when the podiatrist resigns from the College or stops practicing in this provincial jurisdiction.

The patient daily appointment record must:

Contain the full name of the patient as well as the date and time of the scheduled appointment.

Be stored for ten (10) years before destruction.

The patient financial record must:

Contain the name of the patient, the date the podiatry service was rendered and the fees charged to and received from or on behalf of the patient.

Be stored for ten (10) years before destruction.