Standard:	CMNL Record Keeping Standard
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COLLEGE OF MIDWIVES OF NEWFOUNDLAND AND LABRADOR

Record Keeping Standard
College of Midwives of Newfoundland and Labrador

The purpose of this CMNL Standard is to assist the Registered Midwife (RM) in understanding their professional, legal, and ethical obligations to comply with regulatory and legislative requirements regarding medical records pertaining to:

1. Creation, content, and consent
2. Stewardship, custody, confidentiality, and ongoing accessibility

Regulatory and Legislative Requirements

Federally, the Personal Information Protection and Electronic Documents Act (PIPEDA, 2018) https://www.priv.gc.ca/en/privacy-topics/privacy-laws-in-canada/the-personal-information-protection-and-electronic-documents-act-pipeda/ governs privacy in the private sector whereas provincial legislation guiding public sector privacy is established by the Access to Information and Protection of Privacy Act, 2015 (ATIPPA, 2015). https://www.gov.nl.ca/atipp/

RMs providing care in the province of Newfoundland and Labrador (NL) are bound to the provisions of the Personal Health Information Act (PHIA). https://www.health.gov.nl.ca/health/PHIA/ PHIA is a provincial law that governs the collection, use of and disclosure of personal health information by individuals and organizations, otherwise known as custodians, involved in the delivery of health care services. PHIA is intended to ensure that personal health information is kept confidential and secure while allowing for effective delivery of health care services in the province. In addition, record keeping must comply with the requirements of the Regional Health Authority Policies and CMNL Code of Ethics. http://www.cmnl.ca/pdf/65CMNL-Code-of-Ethics-Final-July-182018.pdf

Compliance issues will be investigated by The Newfoundland and Labrador Council of Health Professionals (NLCHP) who are mandated to uphold public protection by Healthcare Professionals. Additionally, the Office of Information and Privacy Commissioner (OIPC) https://www.oipc.nl.ca/ will investigate any personal information privacy breaches or access complaints. RMs and former registrants are obligated to comply with relevant legislation as related to medical records at all times.

Creation and Content of Medical Records

RMs are expected to maintain comprehensive medical records that document all aspects of care provided during the antepartum, intrapartum, and postpartum periods for each individual client. Medical records must be legible, in English, and all verbal and written communication related to clinical care must be clearly documented and maintained as part of the medical record. This communication includes, but is not limited to: in-person, telephone, video chat, text, email, letter and fax. The record must also include the name of every midwife involved in the client's care, the business or practice address, and a signature sheet.

The RM is expected to clearly document the following:

1. Relevant medical history, all clinical assessments and observations, informed choice discussions and recommendations, plans for management, and any consultations and/or transfers of care.
2. Laboratory results, operative procedures, prescriptions issued, consultation reports and discharge summaries.

Checklists are an effective tool for use in a client record; they support communication in a shared care model of midwifery care. To ensure continuity of information provided by RMs, it is important to have practice protocols that reflect the items addressed by a checklist. The checklist will document the discussion of a topic, the clients informed decision, the date, and identity of midwife/student involved in the discussion.

A separate client health record will be kept for each client (i.e., one for client and one for the newborn). Each should have a client code identifier assigned by the midwifery practice.

Medical records may be maintained in paper or electronic format. Additional narrative notes should be maintained in a consistent, timely and organized format. All entries should be legible, logical and include the date, time, and RM identification (initials, signature and/or NLCHP Registrant Number). If a student is involved in the documentation process, the RM must co-sign entries made by the student in the medical record. A record may be amended or altered but the RM must clearly identify themselves, and the date, time, and reason for the amendment. Medical records may not be altered after a complaint or legal action has been initiated, unless a clinical fact is missing, and a clear late entry is made to the record. In compliance with PHIA, medical records shall be secured with appropriate administrative, technical and physical safeguards.

Consent

Per paragraph 24 and 25 of PHIA, it is imperative the RM gain informed consent from a client, free from coercion, prior to the collection and/or disclosure of the client's personal health information. They should be aware of their right to give or withhold consent and that the information may only be collected, used, or disclosed without their consent in accordance with this Act.

RMs may, for the purpose of providing or assisting in the provision of health care to a client, permit a health care provider within the client's circle of care to examine the client's medical record and may share information contained in the record with them. In this circumstance, sharing information within the client's circle of care, client consent is implied.

Data Stewardship

When the RM is creating or contributing to medical records in a group or shared medical record environment, a corresponding practice protocol must be in place. The protocol must address physical security, data sharing with other health care providers, the backup of electronic data, and user-based levels of access. It should also state how ownership, custody, confidentiality and enduring access by individual RMs and clients are managed, including following the relocation, retirement, or death of a RM. Much of this will rely on the standards set by the RHA. In NL, the length of time for record retention and the process for safe disposal is determined by the RHA.

Original records are considered the best evidence if there is a complaint or a lawsuit. RMs should consider retaining original client records for any case where an incident report has been filed or a complaint has been made. If the image quality compromises the legibility, an original paper copy of the record should be kept.

Custody and Access

In compliance with the RHA, RMs must make copies of medical records available to:

- another midwife or health care provider upon request by the client
- perinatal data collection agencies following an out of hospital birth
- an inspector or a quality assurance assessor from NLCHP
- the Office of Information and Privacy Commissioner during an investigation

- a client's legal representative when provided with a written, dated authorization from the client or client's legal representative specifying the records that are requested
- the Coroner upon request. Coroners have the responsibility and authority under the Coroners Act to obtain copies of the complete medical record. RMs are advised to consider seeking legal advice when involved in a coroner's investigation.

RMs must also provide a copy of medical records to the client within thirty (30) days of the client's request per section 52 of PHIA. However, the RM may withhold parts of the client record that may:

- result in a risk of serious harm to the mental or physical health or safety of the individual who is the subject of the information or another individual,
- lead to the identification of a person who was required by law to provide information in the record to the custodian, or
- lead to the identification of a person who provided information in the record to the custodian in confidence under circumstances in which confidentiality was reasonably expected.

Ongoing Access

Clients must have access to their medical records for the length of the legal retention period as set by the RHA.

Ceasing Practice

When a midwife ceases to practice, all medical records for any previous or current clients in their care that remain within the legal retention period, must be transferred to another RM, health care provider, person within the RHA to take custody of the records. The RM transferring the records must ensure the transfer of records is secure and retain documentation of this transfer. The receiving person in the organization must confirm acceptance of custody of those records in writing. They become responsible for the secure storage, retention and enduring access to both the RM and client. When medical records are transferred to another location, the RM must also take reasonable steps to notify clients of the location of their medical records.

Practice Protocols

It is important for midwifery practices to develop protocols that are PHIA compliant. This should include what to do if there is a privacy breach. In compliance with PHIA and RHA protocols, if medical records or a client's private information are stolen or lost, the RM must notify the individual at the first reasonable opportunity and report the type of information compromised and what steps are being taken to recover it. Exceptions may be made if the custodian reasonably believes that the loss will not have an adverse impact on the

a) provision of healthcare to the individual
b) the mental, physical, economic, or social well-being of the client

Practices protocols should also ensure a consistent management approach for all client records. This may include pertinent privacy and protection laws, an orientation to record keeping for all new RMs or students, environmental issues (e.g. use of a dehumidifier, fire-proof space and/or cabinets to protect records) a process to offer all clients a copy of their records at final discharge and a signing of an oath of confidentiality. For more comprehensive examples of PHIA best practices and policies, please refer to https://www.health.gov.nl.ca/health/phia/.