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CHARTING

This policy has been developed to ensure high standard of patient care, accountability and legal protection.

Preamble:
Effective charting is a fundamental aspect of quality medical care. It ensures continuity by providing future healthcare providers—who may be unfamiliar with the patient—a reliable foundation for informed decision-making.

Comprehensive documentation should capture all relevant information and all care provided. Once a chart encounter is signed by a registrant, it is assumed to be complete. In line with this, the College follows the principle: *"If it's not documented, it's considered not done."*

This Policy outlines the College's expectations regarding proper charting practices. These expectations apply equally to both paper and electronic medical records, and to all clinical encounters—whether conducted in person or virtually.

Policy:
Registrants are expected to:

- Use only universally recognized abbreviations, recognizing that ambiguous abbreviations can lead to misinterpretation.
- Maintain each patient's chart in a clear, chronological, and organized manner, ensuring that identifying information (such as name, date of birth, health card number, and gender information) and contact details (including phone number and address) are consistently recorded in the medical record.
- Document clinical entries as soon as possible following the patient encounter.
- Ensure all handwritten notes are legible to others.
- Confirm that any content generated from templates accurately reflects the specific details of the individual patient encounter, including relevant information about the patient's health status.
- Recognize that while electronic templates can support good documentation, overreliance on them may compromise accuracy. Registrants must carefully review and update any prepopulated fields to reflect the specifics of each visit.

Charting must be comprehensive and include:

- A clear summary of the patient's health concerns and status;
- Relevant information that may assist the registrant or any future healthcare provider involved in the patient's care;
- The clinical reasoning behind any treatment decisions or procedures performed.

All documentation should be factual, objective, and professional in tone.

Telephone and Electronic Communication with Patients

Registrants are required to document all patient communications related to clinical care that occur by telephone or through digital platforms (e.g., email, patient portals, or other electronic tools). This documentation must include both the content of the communication and the method used. For further guidance, refer to the College's Policy on ***Virtual Care***.

Editing Medical Records

When it is necessary to correct or complete a medical record, physicians must:

- Document the date and time of any additions or changes;
- Initial all additions or changes; and
- For any corrections made, whether on paper charts or electronic medical records (EMRs), either:
    - Retain the original incorrect information in the record, clearly mark it as incorrect, and ensure it remains readable (e.g., by striking through the incorrect text with a single line); or
    - Remove the incorrect information, store it separately, and include a note in the record referencing the removed information.

In situations involving legal or regulatory matters, physicians are advised to consult the Canadian Medical Protective Association (CMPA) or legal counsel before making edits to medical records.

Registrants should inform any other healthcare providers involved in the patient's care if the record changes could affect their treatment decisions.

Once a complaint or legal action has been initiated, medical records must not be altered unless a missing clinical fact is added as a clear late entry, in accordance with this Policy.

Registrants must address patient requests to amend their medical records. The decision to make an edit is at the registrant's professional discretion. When responding to such requests, the registrant must either:

- Comply with the procedures outlined above; or
- If the registrant decides not to amend the record, document the patient's request and the reasons for refusal in the medical record.

Guidelines

1. Utilizing the SOAP method (subjective, objective, assessment and plan) as a minimum standard, registrants should document the following for all patient encounters:
    a. presenting complaint;
    b. a focused relevant history;
    c. an assessment and an appropriate focused examination;
    d. a diagnosis and/or differential diagnosis;
    e. any treatment or therapy provided and the patient's response and outcomes;
    f. a management and follow-up plan, including advice given to patients and/or care givers;
    g. any prescriptions issued in accordance with the College's *Policy on Prescribing*;
    h. consent in accordance with the College's *Policy on Informed Patient Consent to Treatment* and any consent to treatment obtained in writing;
    i. all tests requisitioned and referrals made, including a copy of the referral note, and any associated reports and results (e.g., laboratory, diagnostic, pathology);
    j. any treatments, investigations, or referrals that have been declined or deferred, the reason, if any, given by the patient, and discussion of the risks;
    k. any operative and procedural records; and
    l. any discharge summaries.

Documentation for In-Patient Encounters

Preamble

In-patient medical records provide a structured and comprehensive account of a patient's hospital stay and are securely stored within the healthcare facility. These records are accessible to all authorized healthcare professionals involved in the patient's care, with various health professionals contributing documentation.

The most responsible physician is accountable for maintaining accurate, current, and easily accessible documentation within the in-patient record. Physicians who are involved intermittently or on a limited basis should use their professional judgment to document their role appropriately, reflecting the care provided, their clinical decisions, and any other relevant information pertaining to the patient's treatment.

Cumulative Patient profile

It is the responsibility of physicians to decide whether to include a Cumulative Patient Profile (CPP) or a similar patient health summary in the medical record. This decision should take into account factors such as the nature and duration of the physician-patient relationship, the type of care delivered, and whether including such a summary would enhance the quality of care. It would be expected that all patients in a longitudinal family practice would have a CPP on file.

Document History:

October 9, 2025