October 6, 1994

Proposed Regulation
for the College of Midwives of Ontario
Records

RECORDS RELATING TO A MEMBER'S PRACTICE

1. In this regulation, "client" means the woman and newborn.

2. (1) A member shall, in relation to his or her practice, take all reasonable steps necessary to ensure that records are kept in accordance with this regulation.

   (2) Reasonable steps under subsection (1) shall include the verification by the member, at reasonable intervals, that the records are kept in accordance with this regulation.

3. An equipment service record shall be kept that sets out the servicing of equipment controlled by the midwife used to examine, treat or render any service to clients.

4. (1) A client health record shall be kept for each client.

   (2) The client health record must include the following:

   1. The client's name and address.

   2. The date of each of the client's visits with the member.

   3. The name and business or practice address of every primary care midwife involved in the client's care.

   4. A health history of the client.

5. Reasonable information about every examination performed by the member and reasonable information about every clinical finding and assessment made by the member.

6. Reasonable information about every order made by the member for examinations, tests, consultations or treatments to be performed by any other person.

7. Every written report received by the member with respect to examinations, tests, consultations or treatments performed by other health professionals.

8. Reasonable information about all discussions with the client relevant to client care and decision-making and all suggestions made by the member.

9. Reasonable information about every controlled act, within the meaning of subsection 27(2) of the *Regulated Health Professions Act, 1991*, performed by the member.

10. Reasonable information about every referral of the client by the member to another health professional.

11. Reasonable information about all procedures performed and those commenced but not completed including reasons for non-completion.

12. A copy of every written consent and refusal.

(3) Every part of a client health record must have a reference identifying the client or the client health record.

(4) Every entry in a client health record must be dated and the person who made the entry must be identifiable.

(5) Every client health record shall be retained for at least 10 years following,

(a) the client's last visit; or

(b) if the client was less than eighteen years old at the time of his or her last visit, the day the client became or would have become eighteen years old.

5. (1) Where in this regulation a notation, report, record, order, entry, signature or transcription is required to be entered, prepared, made, written, kept or copied, the entering, preparing, making, writing, keeping or copying may be done by electronic or optical means or combination thereof.

(2) The member shall ensure that the electronic or optical means referred to in subsection (1) are so designed and operated that the notation, report, record, order, entry, signature or transcription is secure from loss, tampering, interference or unauthorized use or access.

6. (1) A member shall provide reasonable access to a client health record and copies from a client health record for which the member has primary responsibility to any of the following persons on request:

1. The client.

2. A personal representative who is authorized by the client to obtain copies from the record.

3. If the client is dead, the client's legal representative.

4. If the client lacks capacity to give an authorization described in paragraph 2,

(i) a committee of the client appointed under the *Mental Incompetency Act*,

(ii) a person to whom the client is married,

(iii) a person of the opposite or same sex, with whom the client is living in a conjugal relationship outside marriage if the client and the person,

A. have cohabited for at least one year,

B. are together the parents of a child, or

C. have together entered into a cohabitation agreement under section 53 of the *Family Law Act*,

(iv) the client's son or daughter,

(v) the client's parent.

(2) A member may provide copies from a client health record for which the member has primary responsibility to any person authorized by a person to whom the member is required to provide copies under subsection (1).

(3) Despite subsection (1), a member is not required to provide access to or copies from a client health record if the member is of the opinion that disclosure of the health record would be likely to result in,

(a) serious harm to the care of the client; or

(b) serious physical or serious emotional harm to the client or another person.

(4) A member may, for the purpose of providing health care or assisting in the provision of health care to a client in an emergency, permit a health professional to examine the client health record or give a health professional any information or thing contained in the record.

(5) A member may provide information or copies from a client health record to a person if,

(a) the information or copies are to be used for health administration or planning or health research or epidemiological studies; or

(b) the use of the information or copies is in the public interest as determined by the Minister; and

(c) anything that could identify the client is removed from the information or copies.

(6) Where the member has primary responsibility for a client health record, the member shall, at the request of the client, cause a correction to be made to the client's health record or attach a statement of disagreement reflecting the correction requested by the client.

(7) The member shall give notice of every correction made and statement of disagreement attached to a client health record to every person and every organisation to whom the record was disclosed within the year before the correction was requested.

7. (1) Before resigning as a member or ceasing to practice midwifery in Ontario, a member shall ensure that, for every client health record for which the member has primary responsibility,

(a) the record is transferred to another member; or

(b) the record is transferred to the custody of the College of Midwives of Ontario.

(2) The member to whom the record is transferred and the College of Midwives of Ontario shall retain the record for the balance of the period of time referred to in subsection 4(5).

(3) Where a member transfers a record to another member or to the College of Midwives of Ontario, the member shall make reasonable efforts to notify the client, but where notice cannot be given; the member shall notify the College of Midwives of Ontario of the name of the member to whom the record is being transferred.

8. The following are acts of professional misconduct for the purposes of clause 51(1)(c) of the Health Professions Procedural Code:

(1) Allowing any person to examine a client health record or giving any information, copy or thing from a client health record to any person except as required by law or as required or allowed by this regulation.

(2) Failing to provide access to a client health record or to provide copies from a client health record for which the member has primary responsibility, as required by this regulation.