Summary of Record Keeping Requirements

The length and manner of the retention of patient records and information is controlled by federal and provincial legislation, including *The Health Information Protection Act*. For more information, refer to the links within this document for a brief overview of the requirements.

Record	Description	Retention Requirement	Reference
Prescription	A record of a prescription (paper or electronic) from any authorized prescriber. Authorized Prescriber as listed in *The Drugs Schedules Regulations, 1997*. Includes: • minor ailments prescriptions; • Level 1 Prescriptions; • Level 2 Prescriptions; and • daily witness signature records for methadone & suboxone. The 'prescription' may include a Pharmacist Assessment Record (PAR) and any refill or part fill documentation such as daily witness or take-home dosage documentation for opioid agonist therapy (methadone, suboxone, etc.).[1]	• Keep records in a retrievable location for **2 years** or longer from the last date of recorded pharmacy prescription service provided to the patient.	*Food and Drug Regulations* (C.01.041.1 and G.03.009) *Narcotic Control Regulations* (Sections 30 and 40(1) and (2)) SCPP Regulatory Bylaws (Section 4 and 7 of Part N) Model Standards of Practice for Canadian Pharmacists (General Standard 1.9) Standards of Practice for Saskatchewan Pharmacists (Section on Records)

[1] To distinguish between a PAR as a 'prescription' and a PAR as a 'patient record': PAR is the Pharmacist Assessment Record and may or may not be the 'prescription' depending on the form, whereas the algorithms or decision making trees and corresponding documentation to make clinical decisions as with minor ailments prescribing are the original 'patient record'. Note that any information which is an "assessment of the patient" beyond prescribing, or contains "clinical decisions" is considered a patient record.

Patient Record	A patient record (paper or electronic) includes any and all documentation, information, or services provided pertaining to the care of the patient if the original record was created by the pharmacist/pharmacy technician, which may include but is not limited to: • Emergency Post-Coital Contraception (ECP) – PAR; • Level 1 and 2 Prescribing – PAR; • Saskatchewan Medication Assessment Program – SMAP; • compliance packaging records; • counselling/consultation records; • record of drugs administered by injection or other routes – PAR; • lab requisition records; • Medication Incident Report records; • Health Canada Side Effect Reporting Form or other adverse event records; • speciality supplies records: ostomy, surgical, compression stockings, etc.; and • documents pertaining to the termination of a pharmacist-patient relationship; and • methadone & suboxone – PAR.	• Keep records in a retrievable location for **10 years** or longer from the last date of recorded pharmacy service provided to the patient. OR • Keep records for minors in a retrievable location for **2 years** or longer past the age of majority[2] or **10 years** or longer after the last date of recorded pharmacy service provided to the patient, whichever is later. Refer to the example in FAQ #4.	*Food and Drug Regulations* (C.01.041.1 and G.03.009) *Narcotic Control Regulations* (Sections 30 and 40(1) and (2)) *The Health Information Protection Act (HIPA)* presently has no specific retention requirement legislation CPSS Regulatory Bylaws (Section 23.1(f) of Part 6) Practice Standards: Generally, keep medical patient records retention in line with other healthcare professions and pharmacy regulatory authorities.
CDSA Drug Record	Records (paper or electronic) to comply with *Controlled Drugs and Substances Act*, *Narcotic Control Regulations*, Part G of the *Food and Drug Regulations*, and the *Benzodiazepine and other Targets*	• Keep all records in a retrievable location for **2 years** or longer from the date of last event.	*Food and Drug Regulations* Part G *Narcotic Control Regulations* (Section 30 and 40(1) and (2))

[2] The “age of majority” in Saskatchewan is 18 years old. The “age of majority” may vary depending upon the province/territory.

	Substances Regulations, which may include but is not limited to: • purchase invoice records (including non-narcotics); • prescription sales records (including non-narcotics); • physical inventory counts which are recommended to be done quarterly; a perpetual balance record should always be on-hand; • change of manager - physical inventory count report; • discrepancies reports; • unserviceable stock returns: expired, damaged, and/or unusable drugs; • post-consumer returns: patient returned drugs for disposal; • manufacturer/wholesaler returns; and • loss and theft or Forgery Report Forms.		*Benzodiazepines and Other Targeted Substances Regulations* (Section 9 and 50) SCPP Regulatory Bylaws (Section 4 and 7 of Part N) SCPP Record Keeping Requirements for CDSA Drugs
Patient Privacy & Disclosure Record	A record (paper or electronic) of disclosure of patient health information to other parties without a written signed consent of patient. Includes disclosure, unless otherwise provided under the HIPA (e.g. PRP program) to: • Release of Confidential Records to Law Enforcement Authorities; • Release of Confidential Records to Third Parties; • Release of Confidential Records of Minors to Parents/Guardians; • Release of Confidential Records to another Health Care Provider; and	• Keep these records in a retrievable location for **10 years** or longer after the last date of recorded pharmacy service provided to the patient, whichever is later following the date of disclosure.	*Personal Information Protection and Electronic Documents Acts* (Section 5 of Division 1): presently no specific retention requirement listed. *The Health Information Protection Act (HIPA):* presently has no specific retention requirement legislation Practice Standards: Generally, keep medical patient records retention in line with other healthcare professions

	• Release of Confidential Records of to Powers of Attorney, Health Care Directives and Substitute Decision Makers.		and pharmacy regulatory authorities.
Third Party Agreement Record	Records (paper or electronic) of any contractual agreements involving patient records or patient care, which may include but is not limited to: • collaborative practice agreements; • central fill contracts; • shredding, recycling and hazardous waste disposal service contracts; • delivery services contracts; and • long-term care facility contracts.	• Recommend keeping all records in a retrievable location for **2 years** or longer from the date of last event or for the duration of the contract. • Some experts recommend retaining copies of expired contracts/agreements for up to 6 years after expiration in the event of litigation.	*The Limitations Act, SS 2004*
Miscellaneous	Records (paper or electronic) to comply with various regulations and standards of practice, which may include but is not limited to: • fridge temperature logs; • cold chain breaks and drug/vaccine loss records; • PIP audits; and • prescription delivery log.	• Recommend keeping all records in a retrievable location for **2 years** from the date of last event.	SCPP Regulatory Bylaws and standards of practice

Frequently Asked Questions

1. **What is a patient record (paper or electronic)?**
   A patient record is an all-encompassing record of all documentation related to the care of the patient. It includes the prescription record, along with any information, documentation, consultation, counselling or related reference involved in the care of the patient.

2. **Why is the patient record (paper or electronic) retention period so long?**
   The recommended 10 years of patient record retention is consistent with majority of other healthcare professionals and pharmacy regulatory authorities. It is also the recommended retention period by the Canadian Medical Protective Association.

3. **Where can patient records (paper or electronic) be stored?**
   Patient records must be stored in Canada. If they cannot be stored within the pharmacy then they must be stored in a safe and secure, retrievable location within Canada where patient confidentiality is maintained, and the records are protected from unauthorized access, physical damage, loss, theft, and unauthorized use or disclosure.

4. **When can patient records (paper or electronic) be destroyed?**
   Patient records may be destroyed once the appropriate retention period has expired.

   Example 1 (patient is the age of majority): If the first pharmacy prescription or service was provided Jan 1, 2010 to Patient A and the last pharmacy prescription or service provided on Dec 31, 2020 to Patient A, then the entire patient record (from Jan 1, 2010 to Dec 31, 2020) should be retained for 10 years (until Dec 31, 2030) and may be destroyed on Jan 1, 2031 or thereafter.

   Example 2 (patient is the age of majority): If the SMAP or PAR documents contain a detailed assessment and that information was used to prescribe a drug to the patient, then it is a patient record. The SMAP or PAR would be retained for 10 years after the date of service resulting from the assessment (e.g. the last refill).

5. **How should patient records (paper) be destroyed?**
   Paper records must be destroyed in manner that maintains confidentiality and ensures that the records cannot be reconstructed. This can be achieved by cross shredding, pulverizing, or incinerating the expired documents. Before destroying records, it is recommended that a list be made of the names of the patients whose records are to be destroyed, and that this list be kept permanently in a secure location. The purpose is to be able to later determine at a glance that a medical record has been destroyed and has not simply been lost or misplaced.

6. **Who is responsible for patient records?**
   The pharmacy manager is the trustee of the pharmacy records and therefore must ensure compliance with all the federal and provincial legislation and the practice standards. Proper policy and procedures must be established for the retention, storage, and destruction of all pharmacy records.

7. **Who else requires pharmacists/pharmacies to retain patient records?**
   The Canada Revenue Agency and third-party insurers are two examples of stakeholders who may have additional patient/pharmacy record retention requirements. It is the responsibility of the trustee to be aware and adhere to the retention requirements of external stakeholders.

References and Resources

1. Alberta College of Pharmacy, “Keeping prescription and patient records – How long is enough?”
2. Benzodiazepine and Other Targeted Substances Regulations
3. Canadian Medical Protective Association (CMPA), “A matter of records: Retention and transfer of clinical records” October 2016
4. College of Pharmacists of British Columbia, “Practice Review Program Insights: Retaining Prescriptions”, Vol 10 No 4 – June 2015
5. College of Pharmacists of Manitoba, “Frequently Asked Questions: Patient Record Destruction”
6. College of Physicians and Surgeons of Saskatchewan, “Guideline: Confidentiality of Patient Information”, November 2019
7. Controlled Drugs and Substances Act
8. *The Drug Schedules Regulations, 1997*
9. Food and Drugs Regulations
10. *The Health Information Protection Act (HIPA)*
11. Narcotic Control Regulations
12. Nova Scotia College of Pharmacists, “Patient Record Retention”, August 2017
13. Ontario College of Pharmacists, “Record Retention, Disclosure, and Disposal”, September 2014
14. *Personal Information Protection and Electronic Documents Act (PIPEDA)*
15. The Regulatory Bylaws of the Saskatchewan College of Pharmacy Professionals
16. Saskatchewan Medical Association, “Privacy Frequently Asked Questions”