



<b>SP-P001</b>
<b>Patient Record Management</b>
<b>Approved Date: Effective May 27, 2026</b>
<b>Amended: n/a</b>
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**Note to Readers: This document continues from the former regulatory body and also replaces previous versions titled NSCC “Record Keeping” Standard of Practice. In the event of any inconsistency between this document and the legislation that governs chiropractic and naturopathic practice in Nova Scotia, the legislation prevails.**

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## **1. INTRODUCTION**

The Nova Scotia College Chiropractic and Naturopathic Regulator (“**NSCNR**”) is the regulatory authority for the practice of chiropractic and naturopathy in the Province of Nova Scotia. The NSCNR serves and protects the public interest to advance ethical, safe, and competent chiropractic care in the province.

## **2. APPLICATION AND ADMINISTRATION**

This Standard of Practice shall apply to all chiropractors and naturopathic doctors registered with the NSCC (the “**Registrant**” or collectively the “**Registrants**”).

The administration and application of this Standard of Practice shall be the responsibility of the Registrar, or any designated committee in accordance with the NSCNR’s by-laws or policies, at its sole direction. Should the NSCNR (or designated committee) become aware of any alleged breach or non-compliance with this Standard of Practice, it may take any action it considers appropriate, including but not limited to:

- a. contacting a Registrant to request the immediate remedy of any suspected breach or non-compliance; and
- b. filing a formal complaint under the *Regulated Health Professions Act* regarding the suspected breach or non-compliance.

In addition to the provisions of this Standard of Practice, Registrants are expected to adhere to all ethical, legal and regulatory requirements related to medical record-keeping, including the *Personal Health Information Act*.

## **3. OBJECTIVES**

The objectives of this Standard of Practice are to:

- a. uphold the public’s interest and safety by:

- i. ensuring the diligent, secure, and proper management storage, retention, custodianship or destruction of patients' information, including their Patient Record, in accordance with applicable privacy legislation; and
  - ii. ensuring that patients have access to their Patient Record in a timely and cost-effective manner.
- b. provide Registrants with clear criteria outlining their obligations with respect to:
  - i. maintaining appropriate best practices in their storage, maintenance, custodianship, retention, and/or destruction of Patient Records; and
  - ii. ensuring continued competency in the maintenance, storage, custodianship, retention and/or destruction of Patient Records.

#### 4. DEFINITIONS

The following terms have the following meanings when used in this Standard of Practice:

**“AI scribes”** are digital tools powered by artificial intelligence and natural language processing that assist clinicians by transcribing and summarizing patient interactions in real-time.

**“Custodian”** means the individual or organization who has custody or control of personal health information as a result of or in connection with performing the person's powers or duties, as set out in the *Personal Health Information Act*.

**“EMR”** means an electronic medical record storage system.

**“Patient Record”** or **“Patient Records”** means a digital or physical record of all interactions between a Registrant and a patient.

**“PHIA”** means the Nova Scotia [Personal Health Information Act](#).

**“Securely Destroyed”** means destroyed in such a manner that reconstruction of such data or information is not reasonably foreseeable. This could include shredding paper records in a manner that prevents the reassembling of the record (cross-shredding or pulverizing) and/or wiping the hard drive of any electronic devices.

#### 5. STANDARDS OF PRACTICE

##### a. **RECORDKEEPING OBLIGATIONS**

Registrants must take all reasonable steps to ensure the secure, ethical, and responsible ownership, storage, security, and destruction of Patient Records for which they are the custodian, including any Patient Records generated by an Artificial Intelligence (**AI**) scribe.

A Registrant's recordkeeping obligations under this Standard of Practice apply regardless of whether they are a sole practitioner or in a group practice setting.

The provisions outlined in the Standard of Practice are applicable to all Patient Records, regardless of whether they are stored in physical format or an EMR or generated by an AI scribe.

### **Ethical, Honest, and Detailed Recordkeeping**

- 5.1** Registrants shall include the following information and/or documentation in all Patient Records:
- a. date of assessment;
  - b. patient's name, address, phone number, date of birth, gender identity, and their healthcare number;
  - c. accurately documented facts about the patient's personal health history;
  - d. signed patient consent form (or forms) consistent with the NSCC's Informed Consent Standard of Practice Form;
  - e. documented consent of the patient if an AI scribe is being utilized by the Registrant;
  - f. all physical examination results and findings in support of a diagnosis;
  - g. any additional required tests or investigations;
  - h. a written diagnosis and any working or differential diagnoses;
  - i. if Vertebral Subluxation Complex (VSC) is used, it must identify the segmental level(s) and components of the "complex";
  - j. if International Statistical Classification of Diseases (ICD) codes are used, they must have a two-digit, post-decimal point descriptor code that identifies segmental level(s) and tissue(s) involved;
  - k. a written treatment plan including all recommended treatment methods; and
  - l. any additional progress notes, as required.
- 5.2** All services provided by Registrants must be legibly documented in the Patient Record.
- 5.3** Services provided by members of Registrants' clinical support staff or any other authorized individuals must be documented in the Patient Record. Entries made to the Patient Record by a person under the direction or supervision of the Registrant remain the responsibility of the Registrant.
- 5.4** If an AI Scribe is being utilized to assist with documentation, Registrants must inform patients that an AI Scribe is being used, obtain the patient's consent, and record the patient's consent in the chart.

- 5.5** Registrants must also ensure the accuracy of Patient Records generated by the AI scribe, including a review of all information summarized by the AI scribe for accuracy and completeness.
- 5.6** Registrants may not retain recorded patient interactions with an AI scribe.
- 5.7** Patient Records may only be later amended as follows:
- a. to update patient demographic information, such as a change in name or contact information; or
  - b. to make corrections to information contained in the Patient Record, in which case the amendment must be dated and signed by the Registrant.
- 5.8** Registrants shall not amend a Patient Record in response to a potential or actual regulatory or legal claim made against them.
- 5.9** Registrants may refuse to make a requested correction or amendment to a Patient Record in accordance with the *PHIA*.

#### **Secure Storage of Patient Records**

- 5.10** Registrants, either as a sole practitioner or practicing in a group setting, must take all necessary steps to ensure the secure storage of Patient Records in their custody or control, including any Patient Records generated by an AI scribe. This includes:
- a. ensuring that Patient Records are physically stored in Nova Scotia in a safe and secure environment;
  - b. ensuring the storage of Patient Records includes protective measures to maintain their integrity and confidentiality including:
    - i. taking reasonable steps to protect records from theft, loss, unauthorized access, use, disclosure, copying, modifying or disposal; and
    - ii. keeping all Patient Records in restricted access areas, including a locked filed cabinet.
- 5.11** Registrants, either as a sole practitioner or practicing in a group setting, when using EMR systems and/or engaging EMR service providers, must ensure they:
- a. follow all applicable privacy legislation and regulations in the respect the collection, storage, and protection of Patient Records;
  - b. confirm that all data and backups and related infrastructure related to the storage of Patient Records are located in Canada;
  - c. have a written data backup and recovery procedure that is tested at least once annually;

- d. require a password or other reasonable forms of protection against unauthorized system access;
- e. maintain clear and up-to-date logs of person(s) who access electronic Patient Records, including:
  - i. the date and time of each entry of information for each patient, any changes in the recorded information, preserves the original content of the recorded information when changed or updated.

### **Patient Privacy and Confidentiality**

**5.12** Registrants, regardless of practice setting, are expected to comply with the *PHIA*, its regulations, and any other applicable legislation to ensure the continued protection of patient privacy and confidentiality. In the event of an actual or suspected privacy breach involving Patient Records, Registrants must immediately notify the affected patient(s) and the NSCC in writing, in addition to the requirements set out in the *PHIA*.

**5.13** In addition to the above requirements regarding the secure storage of Patient Records, Registrants are required to make available to the public a written statement that:

- a. provides a general description of their privacy information practices;
- b. describes how to reach a contact person or custodian of the Patient Record;
- c. describes how an individual may obtain access to or request a correction of a record of their personal health information in the custodian's custody or control; and
- d. describes how to make a complaint under the *PHIA* to the custodian and to the review officer.

### **Change in Custodianship (Closure of Practice or Retirement)**

**5.14** All Registrants, regardless of practice setting, must take reasonable steps to ensure that patients have access to their Patient Records. If a Registrant plans to retire from, or close a chiropractic practice, as soon as practicable, and in any event at least two (2) weeks' prior to the anticipated closure, or retirement date, each Registrant must:

- a. notify the NSCC in writing of the anticipated closure, or retirement date;
- b. identify in writing the individual appointed the custodian of the Patient Records and provide the NSCC with such information, including the new custodian's contact information;
- c. ensure the name of the new custodian and their contact information is filed with the NSCC and is up to date; and
- d. inform the new custodian in writing of their obligations in acting as custodian at the time of their appointment.

- 5.15** Registrants in group or multidisciplinary practices must have written agreements in place to ensure the enduring right of patients to access Patient Records in the event the practice closes, or if the Registrant retires.

### **Retention and Destruction of Patient Records**

- 5.16** For patients receiving treatment that are under the age of majority, Registrants must retain their Patient Records for a period of not less than ten (10) years from the later of:
- a. the date the patient reaches the age of majority in Nova Scotia; or
  - b. the date of completion of any legal or regulatory proceedings in which the Patient Records may be relevant.
- 5.17** For patients of the age of majority, Registrants must retain their Patient Records for a period of not less than ten (10) years from the later of:
- a. the Registrant's last date of entry in the Patient Record; or
  - b. the date of completion of any legal or regulatory proceedings in which the Patient Records may be relevant.
- 5.18** At the end of the required retention period, the Registrant may take reasonable steps to ensure the Patient Record is Securely Destroyed, as defined by this Standard of Practice.
- 5.19** Notwithstanding the Registrant's obligations regarding the retention and destruction of Patient Records under this Standard of Practice, any copies of Patient Records provided to the NSCC by a Registrant or their appointed custodian, for the purpose of quality assurance, disciplinary or continued competency processes, will be the responsibility of the NSCC.
- 5.20** Following the completion of any quality assurance, disciplinary or continued competency processes by the NSCC requiring a copy of a requested Patient Record from a Registrant, the NSCC will Securely Destroy the copy of the Patient Record, and notify the Registrant in writing of the same.

### **b. PATIENT RECORD ACCESS AND FEES**

- 5.21** A patient has a right to access their Patient Record. A Registrant who is also custodian of the Patient Record must take all reasonable steps to ensure a consistent, timely, and available process for a patient to access their Patient Record.
- 5.22** Upon receiving a written request from a patient for their Patient Record, including payment of applicable fees as further described below, the custodian must provide to the patient a copy of their Patient Record within thirty (30) calendar days.
- 5.23** Where a custodian makes a record of personal health information, or a part of it, available to an individual or provides a copy of it to an individual, the custodian may charge the individual a fee for that purpose if the custodian first gives the individual an estimate of the fee. The fee

charged to the individual must be no more than the fee prescribed and set out in the *PHIA* Regulations.

**5.24** This applies equivalently to others empowered by law to access patient records.

**c. PROFESSIONAL COMPETENCY OBLIGATIONS**

**5.25** Registrants must remain informed of and compliant with all applicable recordkeeping requirements and best practices. This includes keeping up to date and understanding their obligations under applicable legislation, clinical standards, ethical obligations, and relevant policies regarding recordkeeping.

**5.26** Registrants must complete the NSCC approved Record Keeping Workshop, as required, or when requested by NSCC but no less than once per every 5 years.

**6. EXEMPTIONS**

There are no applicable exemptions to this Standard of Practice.

**7. RESTRICTIONS**

There are no applicable restrictions to this Standard of Practice.

**8. LEGISLATIVE CONTEXT**

*Regulated Health Professions Act*  
*General Regulations to the RHPA*  
*Regulations Respecting Chiropractic and Naturopathy*  
*NSCNR Bylaws*