Health Record Policy

1. Introduction

The health record is a record of care and treatment created by healthcare professionals while providing patient/client/resident care services which is used for the purposes of care and for administrative, business and payment purposes. Documents that comprise the health record may physically exist in separate and multiple paper or electronic records.

The health record serves as a legal business record for the organization. It is the record that will be released to third parties in response to authorized requests.

The health record is:

- Created and kept in the usual and ordinary course of business and is a business record of the organization as defined by the *B.C. Evidence Act*.[1]
- Made at or within a reasonable time of the provision of service.
- Created by the person with knowledge of the events and facts recorded in it.

Health Record documents include:[2]

1. Primary documents are documents that contain:
    a. Pertinent health care data of a person's health record including case histories, discharge summaries, consultation reports, day care records and other documents prepared or signed by an attending physician or, as the case may be, practitioners.
    b. Reports regarding significant findings, items or comments, initially recorded in a secondary or transitory document that have been transferred to and recorded on a primary document
2. Secondary documents are documents that contain:
    a. Information about a person that may be of vital medical importance at a particular time and may have lasting legal significance but are not considered necessary for care and treatment of the person beyond that particular time and includes any diagnostic report, authorization, out-patient record and nursing report or note.
3. Transitory documents are documents:
    a. That appear to have no medical importance or lasting legal significance once a person has been discharged from a hospital or program and includes such things as a diet report, graphic chart or departmental checklist

[1] B.C. Evidence Act – Section 42

[2] Hospital Act Regulations, B.C. Reg. 121/97

2. Policy Purpose

The *Health Record Policy* is intended to:

- Provide direction to health care providers on the most current and accurate source of patient information for the paper-based, hybrid and electronic health record (EHR) through the Health Record Document Inventory list
- Define and clarify the paper and/or electronic health record to ensure the integrity of the information contained within the health record is maintained.
- Outline the process that qualifies electronic systems as a "source of truth" or a component of the official health record.
- Protect the confidentiality, security and integrity of health records through compliance with organizational policy and appropriate legislation.
- Provide guidance to ensure a consistent decision-making approach between the organizations in the adoption of an electronic health record.

3. Policy Scope

This policy applies to all employees, physicians, students, residents, researchers, contractors, affiliate agencies, and others that contribute to the creation of the health record under the control and/or ownership of the organizations. It applies to all care levels and settings in hospitals, residential and community.

4. Policy Statements

4.1 General

4.1.1 Organizations will meet legislative requirements around health records such as, but not limited to, the Hospital Act, Hospital Act Regulations, BC Freedom of Information and Protection of Privacy Act, BC Evidence Act and the Electronic Transactions Act. Organizations must also meet the Canadian Council on Health Services Accreditation standards and comply with internal policies and Medical Staff Bylaws, Rules & Regulations.

4.1.2 Records will be created, stored and disclosed in accordance with the *BC Freedom of Information and Protection of Privacy Act.*

4.1.3 The primary source of patient/client/resident clinical information is the media on which the information originated.

4.1.4 The health record is generated at or for a healthcare organization as a business record and is the record that will be disclosed upon request to appropriately authorized requestors.[3] [4]

4.1.5 The health record is the property of the organizations.

4.1.6 The organizations must determine what information constitutes the official health record to be used as a legal business record for the organizations. Organizations are obligated to keep legally sound records to satisfy business requirements and information requests from many parties. The definition of the legal health record must include whether the official record is in paper form or electronic form. An inventory of records, reports and/or documentation and their status is required.

4.2 Documentation

4.2.1 Any document contained in the health record will be created at the time of the encounter or within a reasonable time of the encounter. [5]

4.2.2 Late entries, corrections, or annotations will be clearly identified as such without obliterating the original entry.

4.2.3 Organizations must establish the guidelines that determine if and when it is acceptable to maintain information electronically only and destroy any printed copies in the patient's paper record. In order to protect patient/client/resident safety, it is advisable for all information to be in one location for access by the care providers. Electronic documentation may be printed for inclusion in the paper record, or paper information may be scanned for viewing in the electronic record.

4.3 Retention

4.3.1 The integrity of the health record will be maintained by ensuring the security and protection of both the paper and electronic record.

4.3.2 Records will be retained as per organizational policy, the *Hospital Act Regulation* requirements (hospital), or the Community Care and Assisted Living Act Regulations (community), and any directives from the BC Ministry of Health to retain records indefinitely. Scanned images will meet the legal requirements of the Electronic Transactions Act for record retention.

[3] AHIMA, Practice Brief – Update: Guidelines for Defining the Legal Health Record for Disclosure Purposes

[4] BC Evidence Act, R.S.M. 1996, s. 42(2)(a).

[5] BC Evidence Act, R.S.M. 1996, s. 42(2)(b)

4.4 Access / Release of Clinical Information

4.4.1 The Health Information Management department is delegated stewardship around paper or electronic records for the purposes of access and/or release of clinical information, to the degree determined by the organizations and based on official delegated responsibilities for each Health Authority.

4.5 Electronic Records

4.5.1 The legal business record is the electronic record when the following criteria have been met:[6]

4.5.1.1 There is reliable assurance as to the integrity of the record in an electronic form as supported by business practices that ensure the record has remained complete and unaltered, apart from the introduction of changes that arise in the normal course of communication, storage and display.

4.5.1.2 The record is retained in the format in which it was created, provided or received or in a format that does not materially change the record.

4.5.1.3 The record is accessible in a manner usable for subsequent reference by any person who is entitled to have access to the record or who is authorized to require its production.

4.5.1.4 The record in electronic form is accessible by the person to whom it is provided and is capable of being retained by that person in a manner usable for subsequent reference.

4.5.2 Organizations seeking to certify new systems as part of the electronic health record will assess the information system for compliance with the *Electronic Transactions Act* and other applicable legislation and standards.

4.5.3 Organizations seeking to certify new systems as an official electronic health record will complete the *Checklist for Certifying Systems as part of the Electronic Health Record* document (see appendix).

4.5.4 Organizations must have the *Checklist for Certifying Systems as part of the Electronic Health Record* document approved by the designated parties (HIM Executive, IMIT / IMITS, Risk Management). Certification is dependent upon meeting all criteria in the Checklist (see appendix).

4.5.5 Organizations must maintain an official record inventory in real time which will identify the official status of documents and whether they are maintained in paper form or electronic form (see appendix).

[6] Electronic Transactions Act, S.B.C. 2001, c.10

4.5.6 In addition to all terms related to electronic records, imaged (scanned) records will be treated as copies of originals and will be counted as a substitute for the original if the following are applied:

4.5.6.1 The source record is no longer available[7]

4.5.6.2 The copy was made with the intention of standing in the place of the source record[8]

4.5.6.3 The absence of the source record is adequately explained, and

4.5.6.4 The circumstances of disposal of the source record and the creation of the copy are adequately explained.[9] [10]

4.5.7 Organizations will assign a custodianship role for each system certified as part of the official health record.

4.5.8 Access to personal and confidential information contained in the health record will be controlled and granted only to those individuals who have provided proof of their authority to receive such information.

4.6 Document Imaging

4.6.1 Document imaging is used as a bridge between paper and electronically created records. To minimize risk to patient care, documents that are not electronically created will be imaged to provide clinicians access to both the electronically created and imaged records from one location. *See 4.2.3 above.*

4.6.2 The Health Information Management department supports a grey scale environment for the EHR; images will be stored and reproduced as grey scale images. Colour image scanning will be provided only when grey scale is not clinically acceptable.

4.7 Paper Records

4.7.1 The paper chart is the official health record when the criteria in 4.5 and 4.6 above are not met.

4.7.2 Custody of paper records is often centralized to the Health Information Management department. Organizations will identify the department(s) maintaining custody of all paper records.

[7] Canada Evidence Act, R.S., 1985, c. C-5, s. 31.2(e)

[8] Canada Evidence Act, R.S., 1985, c. C-5, s. 31.2(d)

[9] CAN/CGSB-72.11-93, Microfilm and Electronic Images as Documentary Evidence, Part III, s. 4.1.3

[10] CAN/CGSB-72.11-93-AMEND, Microfilm and Electronic Images as Documentary Evidence

4.8 Hybrid Health Record

4.8.1 Over the course of a patient's stay, it is recognized that a hybrid state will exist, with both electronic and paper documentation being utilized. Following discharge or ambulatory care visit, a hybrid record scenario where some clinical information exists only in electronic form and other information exists only in paper form is not recommended, nor supported where document imaging has been implemented.

4.9 Printing Requirements for Electronic Records

4.9.1 Once a decision has been made to consider electronic records as the official health record, any printed documents from the clinical information system or permanent electronic records will be considered as working, or transitory, documents only. No additional documentation is to be added to these pages, as doing so would necessitate the retention of that document.

4.9.2 Electronically created records will be stored within the clinical information system and will not be printed for permanent health record storage if they have been qualified as an official health record and signed off by the designated parties (HIM Executive, IMIT / IMITS, Risk Management).

4.9.3 Organization employees who have been granted printing privileges may print transitory patient information from the electronic health record for the purposes of providing care to patients. Transitory documents will not be written upon and are to be securely destroyed following use.

4.9.4 The electronic record must be reproducible and printable in a timely and efficient manner for subsequent reference or action by persons authorized to review or action the record (eg. release of information staff, review by patient, court order, etc.).

4.10 Authorship / Authentication

4.10.1 Organizations must designate which individuals are authorized to make entries in the patient/client records. Documents and authors that require co-signatures across all media, such as students, residents, etc. must be identified.

4.10.2 Organizations must identify who is authorized to make changes when errors are discovered in a patient/client record. Organizational documentation standards referencing how changes are made must be followed.

5. Exceptions (situations where the policy may not be applicable)

No exceptions.

6. **Tools, Forms and References** (title of forms, lower level policy and procedure and other manuals, guidebooks and documents relevant to this policy)

   Checklist for Certifying Systems as Part of the Electronic Legal Health Record

   Record Inventory

   Documentation Standards

   Forms Approval Processes

7. **Related Policies** (title of policies that this policy must be consistent with)

   Record Retention Policies (including archiving)

   Access Policies

   Auditing Policies

   Downtime and Backup Policies

   PHC – CPN1000 Health Records Management: Record Printing, Imaging, Use, Access and Destruction

8. **Definitions** (explanation of key words used in the policy statement)

   Control – (of a record) means the power or authority to manage the record throughout its life cycle, including restricting, regulating, and administering its use or disclosure. Where the information in a record directly relates to more than one public body, more than one public body may have control of the record. Usually the pubic body with the greater interest processes the request for information. Providence Health Care (PHC) staff provide Records Management services, including release of clinical information, across the Lower Mainland. [11]

   Document Imaging – The scanning of paper documentation into an electronic format. Document imaging is a bridge between paper records and fully electronic records. Imaged records and electronically created records can generally be viewed together.

   Electronic – means created, recorded, transmitted or stored in digital or other intangible form by electronic, magnetic or optical means or by any other similar means.[12]

[11] BC Freedom of Information and Protection of Privacy Act Policy Definitions. Site accessed 07/09/06; URL; http://www.mser.gov.bc.ca/privacyaccess.manual/other/def.htm

[12] BC Electronic Transacations Act. S.B.C. 2001, c. 10

Electronic Document – means data that is recorded or stored on any medium in or by a computer system or other similar device that can be read or perceived by a person or a computer system or other similar device. It includes a display, printout or other input of data.[13]

Electronic Health Record (EHR) – is a computer-based electronic file that resides in a system specifically designed to support users by providing accessibility to complete and accurate health data, alerts, reminders, clinical decision support systems, links to medical knowledge, and other aids.[14]

Health Record – A health record is a compilation of pertinent facts of an individual's health history, including all past and present medical conditions, illnesses and treatments, with emphasis on the specific events affecting the patient during the current episode of care. The information documented in the health record is created by all healthcare professionals providing the care. [15]

Legal Health Record – The legal health record is the documentation of the health care services provided to an individual in any aspect of health care delivery by a health care provider organization. The legal health record is individually identifiable data, in any medium, collected and directly used in and /or documenting health care or health status. The term includes records of care in any health-related setting used by health care professionals while providing patient care services, for reviewing patient data, or documenting observations, actions, or instructions.

- Created and kept in the usual and ordinary course of business and is the business record of the organization as defined by the *BC Evidence Act.*
- Made at or within a reasonable time of the matter recorded
- Created by the person with knowledge of the events and facts recorded in it
- Retains history of all changes

Source of Truth – A source of truth must be considered part of the legal health record. Systems that comply with the *Electronic Transactions Act* can be considered the source of truth. Systems that are not compliant must interface to a system that is certified, or information must be printed. Where multiple interfaced systems are compliant, the organization will make a decision regarding which is the ultimate source of truth.

[13] Canada Personal Information Protection and Electronic Documents Act. 2000, c. 5

[14] CHIMA. Site accessed 07/09/06. URL: http://www.chima-cchra.ca/pages/01about/04record.html; http://www.echima.ca/pages/01about/04record.html (updated 30/01/07).

[15] CHIMA. *What is a Health Record?* Site accessed July 11, 2006. URL: Http://www.chra.ca/pages/01about/04record.html; http://www.echima.ca/pages/01about/04record.html (updated 30/01/07)

Transitory Document – A document such as a diet report, departmental checklist or any other document, which appears to be of no further value once the patient has been discharged. [16] Also includes working documents that are shredded following use.

9. References (lists any external sources of information or standards. Includes reference documents, e.g., Legislative Acts or other sources used to develop the document. If none, state none. If source is an external web site, include the URL address.)

Record Retention Policies

BC Freedom of Information and Protection of Privacy Act R.S.B.C. 1996, chapter 165

Canada Evidence Act, R.S., 1985, chapter C-5

Hospital Act, R.S.B.C. 1996, c. 200

Hospital Act Regulations. December 3, 2004. Section 13. Documents Comprising Health Records (confirm B.C. Reg. 121/97)

AHIMA Practice Brief – Complete Medical Record in a Hybrid EHR Environment: Part 1: Managing the Change

BC Canada Personal Information Protection and Electronic Documents Act. 2000, chapter 5

BC Electronic Transactions Act. S.B.C. 2001, chapter 10

BC Evidence Act, R.S.M. 1996, chapter 124; section 42

Canada General Standards Board, CAN/CGSB-72.11-93, Microfilm and Electronic Images as Documentary Evidence

Canada General Standards Board, CAN/CGSB-72.11-93-AMEND, Microfilm and Electronic Images as Documentary Evidence – Amendment

Canada General Standards Board, CAN/CGSB-72.34-2005, Electronic Records as Documentary Evidence

Canadian Health Information Management Association. Position Statement on the Access & Disclosure of Personal Health Information 2004.

[16] *Hospital Act and Regulations*, Sections 13 and 14

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