AT0100 – Health Records

Interior Health would like to recognize and acknowledge the traditional, ancestral, and unceded territories of the Dãkelh Dené, Ktunaxa, Nlaka'pamux, Secwépemc, St'át'imc, Syilx, and Tŝilhqot'in Nations, where we live, learn, collaborate and work together.

Interior Health recognizes that diversity in the workplace shapes values, attitudes, expectations, perception of self and others and in turn impacts behaviors in the workplace. The dimensions of a diverse workplace includes the protected characteristics under the human rights code of: race, color, ancestry, place of origin, political belief, religion, marital status, family status, physical disability, mental disability, sex, sexual orientation, gender identity or expression, age, criminal or summary conviction unrelated to employment.

1.0 PURPOSE

- Define the Health Record and clarify procedures for paper and/or Electronic storage of information to maintain the integrity of that record.
- Direct Health-Care Providers on how to obtain the most current and accurate patient information from the Health Record.
- Establish practices for a consistent decision-making approach to maintain the Health Record.

2.0 DEFINITIONS

TERM	DEFINITION
Client	*Any person receiving care in an Interior Health owned and/or operated facility.*
Control	*(of a Health Record) - The power or authority to manage the Health Record throughout its life cycle, including restricting, regulating, and administering its use or disclosure.*
Document Imaging	*Scanning paper documentation into an Electronic format.*
Electronic	*Created, recorded, transmitted or stored in digital or other intangible form by Electronic, magnetic or optical means or by any other similar means.* *Reference: Electronic Transactions Act BC – Part 1*

Electronic Document	*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 output of data. Reference: Canada Evidence Act section 31.8 Definitions*
Electronic Health Record (EHR)	*An Electronic clinical record that captures and shares real-time patient information across the care continuum and provides current and lifetime patient information which is available for simultaneous viewing by authorized health-care providers.*
Health-Care Providers (HCP)	*Refers to both regulated Health-Care Professionals and non-regulated Health-Care Professionals.* *a. Regulated Health-Care Professionals: Professionals regulated by regulatory colleges under the Health Professions Act BC. For complete list see BC Ministry of Health Professional Regulation.* *b. Non-regulated Health-Care Professionals: Additional non-regulated professionals (including students) designated through the health organizations approval process (e.g., Medical Imaging Technologists, Cardiology Technologists).* *c. Students in designated health-care professions*
Health Record	*Records created by all Health-Care Providers (HCP) delivering care to a Client containing a compilation of pertinent facts of a Client's health history, including all past and present medical conditions, illnesses and treatments, with emphasis on the specific events affecting the Client during the current episode of care including:* *1. Primary documents which contain:* • *Pertinent health-care data of a Client's Health Record including case histories, discharge summaries, consultation reports, day care records, and other documents prepared or signed by an attending physician or practitioners.* • *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 which contain:* *Information about a Client 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 Client beyond that particular time and includes any diagnostic report, authorization, out-patient record and nursing report or note.* 3. *Transitory documents are documents:* • *That appear to have no medical importance or lasting legal significance once a Client has been discharged from a hospital or program and includes such things as a diet report, graphic chart or departmental checklist.* • *Also includes working documents that are shredded following use.* *Reference: Hospital Act Regulations, Sections 13 and 14*
Hybrid Record	*Client information that is a combination of information stored in an Electronic and paper format and uses both manual and Electronic processes.*
Revision	*An addition, correction or deletion.*

3.0 POLICY

3.1 Interior Health (IH) will maintain Health Records in a manner that meets legislative requirements relating to 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*, *Electronic Transactions Act*, *Community Care and Assisted Living Act*, *Personal Health Information Access & Protection Act*, *Mental Health Act*, *Mental Health Regulations*, and *Residential Care Regulations*. IH must also meet the Canadian Council on Health Services Accreditation standards, comply with internal policies, and Medical Staff Bylaws, Rules & Regulations.

3.2 The Health Record is an IH legal business record and is the record that will be disclosed upon request to appropriately authorized requestors.
Reference: Canada Evidence Act section 31(1)
Reference: Freedom of Information and Protection of Privacy Act [RSBC 1996] Chapter 165

3.3 The Health Record is in the custody and Control of IH in IH owned and/or operated settings. This policy does not apply to private sector providers who receive funding from IH.
Reference: CMPA-ACPM Good Practice Guide – Who owns the medical record.

4.0 PROCEDURES

4.1 Documentation

4.1.1 Any document contained in the Health Record is created at the time of the encounter or within a reasonable time of the encounter.
Reference BC Evidence Act, R.S.M. 1996 s 42(2)(b)

4.1.2 Where Revisions to the Health Record are necessary, those Revisions are clearly identifiable, and are made without destroying, obliterating, altering, or removing the original entry.

4.1.3 Client information that is solely available in Electronic format is to be interpreted from the Electronic system which holds that information.

4.1.4 Client information that is solely available in paper format is interpreted from the paper records.

4.1.5 Client information on a paper copy that has been digitized (scanned) is interpreted from the scanned image.

4.1.6 Where an Electronic document is printed and a handwritten clinical notation is added to this document, the document should be scanned into the Electronic health record.

4.2 Retention

4.2.1 Records are retained in accordance with the standards set in AL0700 Records Retention Policy.

4.2.2 Document Imaging/scanned documents meet IH's legal requirements, including the Electronic Transactions Act, for record retention and original documents, once digitized, will be disposed of as per the IH Records Retention Policy to avoid duplicate Health Records.

4.3 Access / Release of Clinical Information

4.3.1 Health Information Management is delegated the responsibility to develop policies and procedures pertaining to the access and release of Health Records.

4.3.2 Departments and services who maintain custody and Control of specific subsets of paper or Electronic Health Records are delegated stewardship of those Health Records for the purposes of access or release. The *Freedom of Information and Protection of Privacy Act* governs the access or release of Client information.

4.3.3 Members of the public will request copies or corrections to personal health records by following the procedures described on the IH Public Website.

4.3.4 The integrity of the Health Record is maintained by regular review and enforcement of procedures related to the security, access, and protection of both the paper and Electronic Health Record.

4.4 Electronic Health Records (EHR)

4.4.1 The legal business record is the Electronic record when the following criteria have been met:
Reference Electronic Transactions Act BC, S.B.C. 2001

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

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

c) The EHR 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 Document Imaging/Scanning

4.5.1 Documents that were originally created in a non-Electronic format may be Imaged/scanned to provide clinicians access to both the Electronically created and Imaged/scanned records in one location.

4.5.2 The Health Information Management Service standard is a grey scale environment for the EHR. Images are stored and reproduced as grey scale images. Color image scanning is provided only when grey scale is not clinically acceptable.

4.6 Paper Records

4.6.1 The paper chart is the legal business record when the criteria in 4.4 and 4.5 are not met.

4.6.2 Custody of paper records is often centralized to the Health Information Management Service. However, some services may be delegated custody and Control of subsets of paper records either temporarily or permanently.

4.6.3 Offsite/secondary storage may be used to store paper records to comply with the B.C. provincial moratorium prohibiting the destruction of any records. Health Records are currently being retained indefinitely at the direction of the Ministry of Health, Risk Management Branch.

4.7 Printing of Electronic Records

4.7.1 Printed copies of the EHR are considered working or transitory documents ONLY and must NOT be retained as part of permanent health record storage.

4.7.2 Additional handwritten documentation should not be added to pages printed from the EHR, as doing so necessitates the retention of that document.

4.7.3 The EHR is reproducible and printable in a timely manner for reference or action by persons authorized to review or action the record using the Request for Access to Health Records process (e.g., Release of Information staff, review by Client, Coroner, court order, etc.).

5.0 REFERENCES

- Hospital Act Regulation, B.C. Reg. 121/97, s. 13 Documents Comprising Health Records
- Hospital Act, R.S.B.C. 1996, c. 200
- BC Evidence Act, R.S.M. 1996, s. 42
- Canada Evidence Act, R.S., 1985, c. C-5, s. 31
- Electronic Transactions Act, S.B.C. 2001, c.10
- BC Freedom of Information and Protection of Privacy Act Policy Definitions.
- Canada Personal Information Protection and Electronic Documents Act. 2000, c.5
- CHIMA https://www.echima.ca/
- IH Policy – AR0200 Information Security
- IH Policy – AR0400 Privacy and Management of Confidential Information
- IH Policy – ROIA0600 Access for Minors and Incapable Adults (MyHealthPortal)
- IH Policy – AL0700 Records Retention, Storage and Destruction of
- Clinical Documentation Standards - http://teamsites.interiorhealth.ca/sites/Clinical/CCGD-DMS/CDSTFinalDocuments/GIP671CPS.pdf
- Clinical Documentation Tools Approval Process (Clinical Records Committee) http://insidenet.interiorhealth.ca/infoResources/him/CRC/Pages/default.aspx
- Allied Health Electronic Documentation
- Mental Health Electronic Documentation
- HIM Release of Information Manual