 Department of Health Government of Nunavut		<b>NURSING POLICY, PROCEDURE AND PROTOCOLS</b>	
		<b>Community Health Nursing</b>	
<b>TITLE:</b>		<b>SECTION:</b>	<b>POLICY NUMBER:</b>
Health Records Management		Communications	06-006-00
<b>EFFECTIVE DATE:</b>	<b>REVIEW DUE:</b>	<b>REPLACES NUMBER:</b>	<b>NUMBER OF PAGES:</b>
February 10, 2018	February 2021		2
<b>APPLIES TO:</b>			
Community Health Nurses			

#### **POLICY:**

The Department of Health and Social Services shall ensure that policies exist for the management of active and inactive health records and shall be in accordance with Canadian Council on Health Services Accreditation (CCHSA) standards. The health record policies shall address:

- Completion of health records
- Security of health records
- Confidentiality of health records
- Release of health record information
- Removal of health records from agency
- Retrieving and filing health records
- Retention/disposal of health records
- Access to health records
  - by resident health care professionals
  - by visiting health care professionals
  - by clients
  - by others

Where a health records department does not exist, nurses shall abide by existing Department of Health and Social Services policies to guide management of health records. Health records shall not be destroyed or otherwise disposed of without prior approval from the designated authority within the Health Records department.

#### **DEFINITIONS:**

**Health Record:** a compilation of pertinent facts on a client's health history, including all past and present medical conditions/illnesses/treatments, with emphasis on the specific events affecting the client during any episode of care. All healthcare professionals providing care create the pertinent facts documented in a client's health record. Health records may be paper or electronic documents such as electronic health records, faxes, e-mails, audio or videotapes, or images. (College of Registered Nurses of Nova Scotia, 2005)

**Completion of Health Records:** the method of required completion of the health record to ensure continuity of client care. (Canadian Health Information Management Association [CHIMA], 2006)

## PRINCIPLES:

Health records are confidential and legal.

Timely record completion is required for the mandatory coding of clinical information to the Canadian Institute for Health Care Information (CIHI).

The purposes of the health record are to:

- Communicate health information
- Provide continuity of care
- Demonstrate accountability
- Provide information supporting the quality assurance process
- Facilitate education and research
- Facilitate the legal process
- Facilitate financial reimbursement (CHIMA, 2006)

Where facilities do not have a health records department it is essential that policies exist to ensure the proper keeping and handling of health records in accordance with Nunavut's *Access to Information and Protection of Privacy Act* (ATIPP). (S.N.W.T. 1994, c. 20, enacted for Nunavut).

## RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-001-00 Confidentiality

Guideline 06-001-01 Confidentiality

Policy 06-008-00 Documentation

Nunavut *Access to Information and Protection of Privacy Act* (1994). S.N.W.T. 1994, C. 20, enacted for Nunavut pursuant to the Nunavut Act, S.C. 1993, c.28.

## REFERENCES:

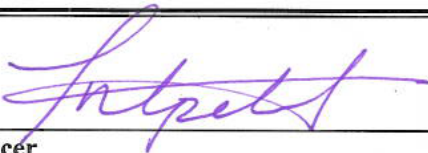
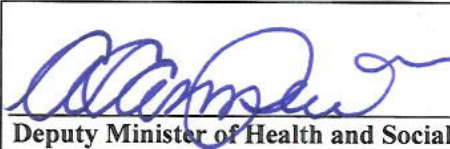
Nunavut *Access to Information and Protection of Privacy Act* S.N.W.T.

1994, c.20, enacted for Nunavut pursuant to the Nunavut Act, S.C. 1993, c.28.

Canadian Council on Health Services Accreditation (2007). *Patient/Client Safety Goals and Required Organizational Practices. (Patient Safety Area 2: Communication)*. Ottawa, ON.

Canadian Institute for Health Care Information (2007). *Canadian Coding Standards for ICD-10*. Ottawa, ON.

College of Registered Nurses of Nova Scotia (2005). *Documentation Guidelines for Registered Nurses*. Halifax, NS.

Approved by:		Effective Date:
	11 FEB 2011	
Chief Nursing Officer	Date	
	February 11, 2011	April 1, 2011
Deputy Minister of Health and Social Services	Date	

