ACCESSIBILITY OF PAPER HEALTH RECORDS FOR PATIENT CARE PURPOSES POLICY

Summary of Changes

	NEW	Previous
BC Cancer	16-MAR-2023 Combining Policies – "Accessibility of Paper Health Records for Patient Care Purposes" and "Health Record Movement/Transportation within BC Cancer" New policy statement and alignment with overarching legislation Added headings to better organize policy statements More detail added to convey policy statements Responsibility and Compliance piece added	HIM 060-IV-B-100 Accessibility of Paper Health Records for Patient Care Purposes HIM 060-IV-B50 – Health Record Movement/Transportation within BCCA 01-MAR–2013 18-APR-2013

1. Introduction

The Health Record is a record of care and treatment of an individual created by Designated Health Care Professionals (DHCPs) while providing Patient care services. The health record is used for the purposes of promoting safe care, facilitating communication, administrative, research, or payment purposes, and meeting professional and legal standards. Information that comprises the health record may exist in separate or multiple paper or Electronic Records. The health record serves as a legal business record for the organization.

Stewardship around paper or electronic records for the purposes of access and/or release of clinical information has been delegated to the Health Information Management department by BC Cancer.

1.1. Purpose

The purpose of this policy is intended to:

- Provide direction to health care providers regarding accessibility to the patients' paper health records.
- Protect the confidentiality, security, and integrity of health records through compliance with organizational policy and appropriate legislation
- Provide direction to health care providers regarding movement/transportation of paper health records within BC Cancer.

1.2. 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 custody of BC Cancer.

2. Policy

The "Accessibility of Paper Health Records for Patient Care Purposes Policy" aligns with the VPP Health Record Policy, the VPP Records Retention and Disposal Health Records Policy, and the BC Freedom of Information and Protection of Privacy Act.

BC Cancer 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, and BC Evidence Act. Organizations must also meet the Canadian Council on Health Services Accreditation Standards and comply with internal policies and Medical Staff Bylaws, Rules & Regulations.

Information will be collected, used and disclosed in accordance with the BC Freedom of Information and Protection of Privacy Act.

2.1. Movement and Review of Patient Charts by Risk/Quality and for: Direct Patient Care Delivery, Research or Studies

- Paper Health records may be removed from Health Information Management department only for the purpose of direct patient care delivery. They must be stored in a secure, safe manner.
- Paper Chart Reviews must be done within HIM department where Record Completion Room exists.
- Paper Health records required for research or studies are to be reviewed within Health Information Management.
- Risk/Quality Management Department may remove a paper health record from the HIM department with prior notice for review and return on the same day.

2.2. Movement of Patient Charts for Treatment Purposes

- Paper Health records delivered for active treatment such as Radiation Therapy and Systemic Therapy must be retained in a secure manner in the Active Treatment Areas during active treatment of the patient. All other health records are to be returned to HIM department by HIM closing time the same day they are loaned, unless the patient is admitted. Failure to return health records may result in a delay in providing the health record to another requester.
- In order to ensure accessibility and security, all BC Cancer patient paper records will be located and transported within BC Cancer as follows:
  - Inactive charts will be filed in the Health Record Management Department
  - Where several requests are made for a specific record, the record will be made available according to the following areas of priority:
    a) Clinic location of the patient;
    b) Doctor's office (most responsible physician; treating physician; alternate);
    c) Health Information Management, Transcription Services;
    d) Pathology/Diagnostic Imaging;
    e) Ancillary patient care staff (social work, physics, etc.);
    f) Health Information Management (Technical Services/equivalent);
    g) Approved research requests.
- All patient record movements will be documented in Chart Tracking.
- Patient records will not be removed from doctor's offices except where necessary for direct patient care, and where removed, the doctor's office will be notified and the chart returned as soon as possible.

- All patient records will be transported by BC Cancer staff or volunteer members, not by patients.

2.3. Review of Patient Charts after Hours

Where Clinics operate beyond HIM hours, paper health records must be secured and returned to HIM the following day.

2.4. Notifying HIM When Moving Patient Charts

- When forwarding paper health records to another BCCA Clinic or Unit, HIM department must be notified immediately by telephone or by electronic chart tracking.
- Except for emergencies, 72 hours notice is required for review of paper records when paper record location is off-site and for Clinic requests, 24 hours notice by telephone is preferred.

3. Responsibilities and Compliance

3.1. Responsibilities

BC Cancer Leaders/Medical Staff Leaders will be notified if any providers remove the patient's paper record from any sites authorized by BC Cancer.

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.

The health record is the property of the originating organization, while the patient owns the information within.

3.2. Compliance

Information in the health record is crucial to patient care delivery and must be available at all times. Compliance with this policy is subject to audit.

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.

4. Related Documents

1) VPP Health Record Policy
2) VPP Records Retention and Disposal - Health Records Policy
3) BC Freedom of Information and Protection of Privacy Act
4) Hospital Act,
5) Hospital Act Regulations,
6) BC Evidence Act
7) Canadian Council on Health Services Accreditation Standards
8) Medical Staff Bylaws
9) Rules & Regulations

5. Definitions

Control (of a record): 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. The public body with the greater interest processes the request for information. Providence Health Care (PHC) staff provides Records Management services, including release of clinical information, across the Lower Mainland. 2

Designated Health Care Professionals (DHCPs): Refers to both Regulated Health Care Professionals and Approved Non-regulated Health Care Professionals.

Regulated Health Care Professionals: Professionals regulated by regulatory colleges under the Health Professions Act (e.g. Physicians, Midwives, Pharmacists, Nurses, and Dietitians). For complete list see BC Ministry of Health Professional Regulation.

Approved 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).

Electronic: Created, recorded, transmitted, or stored in digital or other intangible form by electronic, magnetic, or optical means or by any other similar means.

Electronic Documentation: 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, print-out or other input of data.

Electronic Health Record (EHR): An electronic health record (EHR) refers to the systems that make up the secure and private lifetime record of a person's health and health care history. These systems store and share such information as lab results, medication profiles, key clinical reports (e.g.,

hospital discharge summaries), diagnostic images (e.g., X-rays), and immunization history. The information is available electronically to authorized health care providers.3

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.

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.
- As per HO policy (i.e. Documentation Policy, Downtime Policy) made at or within a reasonable time of the provision of service.
- Created by the care providers with knowledge of the events and facts recorded in it.

The Legal Health Record is:

- 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

Patient: For the purposes of this document, patient refers to patient/client/resident.

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.

Third Parties: In relation to a request for access to a record or for correction of personal information, means any person, group of persons or organization other than the person who made the request or a public body.

6. References

1) American Health Information Management Association (AHIMA). 2011. Practice Brief – Fundamentals of the Legal health Record and Designated Record Set. Retrieved from http://library.ahima.org/doc?oid=104008

2) B.C. Evidence Act, Section 42. RSBC 1996, online: BC Laws: Laws of British Columbia

3) BC Freedom of Information and Protection of Privacy Act, RSBC 1996, online: BC Laws: Laws of British Columbia http://www.bclaws.ca/civix/document/id/complete/statreg/96165_00

4) BC Hospital Act Regulations, B.C. Reg. 206/2013 Section 13 and 14, online: BC Laws: Laws of British Columbia http://www.bclaws.ca/civix/document/id/complete/statreg/121_97

5) BC Freedom of Information and Protection of Privacy Act Policy Definitions. http://www2.gov.bc.ca/gov/content/governments/services-for-government/policies-procedures/foippa-manual/policy-definitions

6) Canada Health Infoway; https://www.infoway-inforoute.ca/en/what-we-do/digital-health-and-you/understanding-ehrs-emrs-and-phrs

7) B.C. Evidence Act – Section 42 http://www.bclaws.ca/civix/document/id/complete/statreg/96124_01)

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Approving Body:	Medical Advisory Committee Clinical Records Committee		
Final Sign Off:	**Name**	**Title**	**Date Signed**
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