Creation of Patient Records Policy

Summary of Changes: change in name to BC Cancer and change to new format

	NEW	Previous
BC Cancer		HIM 060-IV-B-10 Creation of Patient Records. Last revised Feb. 18, 2016

1. Introduction

1.1. Purpose

To provide a policy for creation of Patient Records

1.2. Scope

This policy applies to any patients who are seen at BC Cancer.

2. Policy

2.1. Policy Statement #1

In order to ensure that accurate patient records are maintained, a chart will be created for all patients attending BC Cancer for consultation, investigation, treatment or follow up.

2.2. Policy Statement #2

In order to ensure that accurate patient records are maintained, a chart will be created for all patients attending the British Columbia Cancer Agency for consultation, investigation, treatment or follow-up.

2.3. Policy Statement #3

The integrity of the patient record must be maintained at all times. The following guidelines and standards are fundamental to the creation and maintenance of any patient record:

2.3.1 A paper and electronic chart will be created at the time the patient is referred to a British Columbia Cancer Centre or Satellite Clinic. All telephone discussions or recommendations and documents arising out of those discussions will be documented.

2.3.2 An electronic chat is created for Drug Registry patients at the time of registration.

2.3.3 Entries in the patient records must be written in non-water soluble, permanent blue or black ink. Pencil is never to be used. Red ink is only to be used as approved to highlight risk issues. Highlighters must not be used because they obscure documentation during scanning or photocopying.

2.3.4 The use of “white out” and scribbling over errors is strictly prohibited. In the case of errors, the following procedure must be followed:

- Draw a line through the error.
- Enter the correct information above the error.
- Initial the changes.
- Enter date changes are made.

3. Responsibilities and Compliance

This policy pertains to all staff who participate in the creation of patient records

4. Related Documents

Policy – Creation of a Hospital Unit Chart

5. Definitions

Health Record: The continuous patient record containing all dictated notes, results of investigations, doctors' orders, support services documents, outside hospital documents, correspondence, and Health Information Systems generated summaries, retrieved routinely for patient visits, review, and research.

6. References

http://shop.healthcarebc.ca/CST_Documents/CSTHealthRecordPolicy.pdf

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Approving Body:	Medical Advisory Committee		
Final Sign Off:	**Name**	**Title**	**Date Signed**
	Dr. Lorna Weir	Chair. Medical Advisory Committee	17-Jan-2019
Developed By:	**Name**	**Dept.**	**HO**
	Clinical Records Committee		
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