POLICY: Creation of a Hospital Unit Chart

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

	NEW	Previous
BC Cancer		HIM 060-14-10 Creation of a Hospital Unit Chart. Last Revised :May 16, 2013

1. Introduction

1.1. Purpose

To provide a policy for creation of a Hospital Unit Chart.

1.2. Scope

This policy applies to any patients who are admitted to the In Patient Ward of Vancouver Centre or who have Day Care surgery

2. Policy

2.1. All patients attending BC Cancer will have a soft cover health record paper chart.

2.2 A patient must attend BC Cancer in person or be seen in Consultation by a BC Cancer oncologist before a soft cover health record paper chart will be created.

2.3 Dictated documentation generated from discussions where the patient was not seen (eg. telephone conversation, conference, etc.) will be retained in CAIS until such time as the patient is seen.

2.4 A hard cover record (binder) will be created for all patients admitted to a Hospital Unit or seen in a Day Care Unit.

2.5 The hard cover record (binder) will be created for the duration of each hospital admission or Day Care Unit Chart.

2.6 A list of documents will be specified for the Hospital Unit Chart.

3.0 Responsibilities and Compliance

The Unit clerk is responsible for managing the hard cover record (binder).

4. Related Documents

Procedure – Creation of a Hospital Unit Chart

5. Definitions

5.1 Health Record Paper Chart/Soft Cover Chart (synonymous)

The term "soft cover chart" is used to differentiate the chart from the hard cover chart (the binder on the in-patient unit).

The Health Record paper chart is 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.

5.2 Hard cover Chart (binder)

The record created at the Nursing Unit for the duration of an inpatient or day care stay which contains all documents received or created during that stay.

5.3 Hospital Unit Chart

The record created at the time of patient discharge once the hard cover chart is disassembled separating documents for filing in the soft cover chart (per order of assembly). The remaining documents mainly consist of handwritten physician notes, nurses' notes, and other nursing charting forms.

6. References

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

****Last page of document****

First Issued:	03-04-1991, revised 16-05-2013		
Approving Body:	Medical Advisory Committee		
Final Sign Off:	**Name**	**Title**	**Date Signed**
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	Clinical Records Committee		
Owner(s):	Clinical Records Committee and Medical Advisory Committee		
Posted Date:	29-10-2018		
Version:	3.0		
Revision:	**Name of Reviser**	**Description**	**Date**
	Clinical Records Committee		24-07-2018