HEALTH RECORD POLICY

Summary of Changes

	New	Previous
All Sites	Health Record Policy defining what constitutes the health record in paper, electronic and hybrid (combination of paper and electronic format), how the health record is created and used, and rules for retention, stewardship , imaging, and printing Scanned documents will be subject to an auditing process and are to be retained for three months prior to destruction, as per Health Organization Record Retention policy, and HIM processes around auditing and receipt of scanned documentation	Scanned documents will be subject to an auditing process and are to be retained for six months prior to destruction, as per Health Organization Record Retention policy, and HIM processes around auditing and receipt of scanned documentation
VCH		
PHC		Health Record Policy
PHSA		

HEALTH RECORD POLICY

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. It is the record that will be released to authorized requestors, including **third parties.**

The health record can include:[1]

a. Primary documents consisting of :
   i. Pertinent health care data of a person's health record including case histories, discharge summaries, consultation reports, day care records and other documents prepared or signed by an attending physician or other DHCPs.
   ii. 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.

b. Secondary documents consisting of:
   i. Documentation about a person that may be of vital medical importance at a particular time and may have lasting legal significance, but is not considered necessary for care and treatment of the person beyond that particular time and includes any diagnostic report, authorization, out-patient record and nursing report or note.

c. Transitory documents consisting of:
   i. Documentation that has no medical importance or lasting legal significance once a person has been discharged from a hospital or program (e.g. diet report, graphic chart, departmental checklist).

d. Working documents, that are to be shredded following use, such as
   i. Hand written notes on scrap paper.
   ii. Any material printed from the EHR that is not included in the paper chart.
   iii. Drafts of reports.

[1] BC Hospital Act Regulations, B.C. Reg. 206/2013 Section 13 http://www.bclaws.ca/civix/document/id/complete/statreg/121_97

1.1. Purpose

The Health Record Policy is intended to:

a. Define what constitutes the health record, how the health record is created and rules for maintaining it.

b. Provide direction to health care providers on the most current and accurate source of patient information for the paper-based, hybrid, and **electronic health record (EHR)** through the Health Record Document Inventory list.

c. Outline the process that qualifies **electronic** systems as a "**source of truth**" or a component of the official health record. (See Appendix B.).

d. Protect the confidentiality, security, and integrity of health records through compliance with organizational policy and appropriate legislation.

e. Provide guidance to ensure a consistent decision-making approach between the organizations in the adoption of an electronic health record.

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 the organizations. It applies to all care levels and settings in hospitals, residential facilities and in the community.

2. Policy

2.1. Documentation

2.1.1. For the general principles and requirements for documenting a patient's care in their health record see the Documentation Policy.

2.1.2. Emails received from other health professionals, family members or patients that have clinical relevance/significance (i.e. would normally have been documented in the patient's health record) should be added to the patient record.

2.1.3. Organizations must establish guidelines that determine if and when it is acceptable to maintain information electronically only and destroy any printed copies in the patient's paper record. In order to protect patient safety, it is advisable for all information to be in one location for access by the care providers. **Electronic documentation** may be printed for inclusion in the paper record (e.g. non-Cerner site prints off Cerner information from CareConnect), or paper information may be scanned for viewing in the electronic record.

2.2. Retention

2.2.1. The integrity of the health record will be maintained by ensuring the security and protection of both the paper and electronic record.

2.2.2. Records will be retained as per organizational policy (see Records Retention and Disposal – Health Records Policy), the Hospital Act Regulation requirements (hospital), or the Community Care and Assisted Living Act Regulations (community), including, but not limited to, any directives from the BC Ministry of Health to retain records indefinitely. Scanned images will meet the legal requirements of the Electronic Transactions Act for record retention.

2.2.3. Any information from working documents deemed important to the patient's ongoing care should be added to the official health record. Working documents should be shredded when no longer needed.

2.3. Stewardship of Clinical Information

2.3.1. 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, to the degree determined by the organizations and based on official delegated responsibilities for each Health Organization.

2.4. Electronic Records

2.4.1. The electronic record is the legal business record when the following criteria have been met:[2]

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.

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

c. The record is accessible in a manner usable for subsequent reference by any person who is entitled to have access to the record or who is authorized to request its production.

d. The record in electronic form 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.

2.4.2. Organizations seeking to certify new systems as part of the electronic health record will:

a. Assess the system for compliance with the Electronic Transactions Act and other applicable legislation and standards (see Appendix A).

[2] Electronic Transactions Act, S.B.C. 2001, c.10 (http://www.bclaws.ca/civix/document/id/complete/statreg/01010_01)

b. Complete the Checklist for Certifying Systems as part of the Electronic Health Record document (see Appendix A).

c. Have the *Checklist for Certifying Systems as part of the Electronic Health Record* approved by the designated parties (HIM Executive, Information Management / Information Technology Services (IMITS), HCIS (FH), and Risk Management). Certification is dependent upon meeting all criteria in the Checklist (see Appendix A).

2.4.3. Organizations must maintain an official record inventory in real time which will identify the official status of documents and whether they are maintained in paper form or electronic form (see Appendix B).

2.4.4. In addition to all terms related to electronic records, imaged (scanned) records are copies of originals and will be counted as a substitute for the original if the following are applied:[3,4]

a. The source record is no longer available.

b. The copy was made with the intention of standing in the place of the source record.

c. The absence of the source record is adequately explained, and

d. The circumstances of disposal of the source record and the creation of the copy are adequately explained.

2.4.5. Scanned documents will be subject to an auditing process and are to be retained for three months prior to destruction, as per Health Organization Record Retention policy, and HIM processes around auditing and receipt of scanned documentation.

2.4.6. Organizations will assign a custodianship role for each system certified as part of the official health record. Record custodians will have the responsibility to ensure that records are kept in accordance with organizational policies and that all retention periods are upheld.

2.4.7. Access to personal and confidential information contained in the health record will be controlled and granted only to those individuals who are authorized to receive such information, as per HO access policies (see 4.2 Related Policies below).

2.5. Document Imaging

2.5.1. Document imaging is used to bridge between paper and electronically created records. To minimize risk to patient care, documents that are not electronically created will be imaged to provide clinicians access to both the electronically created and imaged records from one location. See 2.1.3.

[3] BC Evidence Act [RSBC 1996] Chapter 124, Section 35 (http://www.bclaws.ca/civix/document/id/complete/statreg/96124_01))

[4] BC Electronic Transactions Act [SBC 2001] Chapter 10 (http://www.bclaws.ca/civix/document/id/complete/statreg/01010_01))

2.5.2. The Health Information Management department supports a **greyscale environment** for the EHR; images will be stored and reproduced as grey scale images. Colour image scanning will be provided only when greyscale is not clinically acceptable.

2.6. Paper Records

2.6.1. The paper record is the official health record when the criteria in 2.4.6 and 2.5 above are not met.

2.6.2. Organizations will identify the department(s) maintaining custody of all paper records. If a department is not identified, custody of paper records is often centralized to the Health Information Management department.

2.6.3. Paper records created before the implementation of the electronic health record system remain the source of truth for those encounters.

2.6.4. Access to personal and confidential information contained in the health record will be controlled and granted only to those individuals who are authorized to receive such information, as per HO access policies (see 4.2 Related Policies below).

2.7. Hybrid Health Record

2.7.1. Over the course of a patient's episode of care, it is recognized that a hybrid state may exist, with both electronic and paper documentation being utilized. Following discharge or ambulatory care visit, a hybrid record scenario may exist. This hybrid record is not recommended, nor supported, where document imaging has been implemented.

2.8. Information Details to Be Recorded in Printed EHRs

2.8.1. Unless otherwise determined in accordance with this Policy, all printed EHRs should contain the following information on each page:

a. The name or other unique identifier of the user who printed the record;

b. The date when the record was printed;

c. The name (or appropriate naming code) of the information system from which the record was printed; and

d. An appropriate confidentiality (and copyright where required) notice.

2.9. Printing Requirements for Electronic Records

2.9.1. Once a decision has been made to move to electronic records as the official health record, any printed documents from the clinical information system or permanent electronic record will be considered as working documents only. No additional documentation is to be added to these pages,

as doing so would necessitate the retention of that document. All information noted on working documents must be entered into the electronic health record.

2.9.2. Any printed copies are to be securely destroyed following use in accordance with the Records Retention and Disposal – Health Records Policy.

2.9.3. Electronically created records will be stored within the clinical information system and will not be printed for permanent health record storage if they have been qualified as an official health record and signed off by the designated parties (HIM Executive, IMITS / HCIS (FH), Risk Management).

2.9.4. The electronic record must be reproducible and printable in a timely and efficient manner for subsequent reference or action by persons authorized to review or action the record (e.g. respond to release of information requests, review by patient, court order, etc.).

2.10. Authorship / Authentication

2.10.1. Organizations must designate which individuals are authorized to make entries in the patient/client records. Documents and authors that require co-signatures across all media, such as students, residents, etc. must be identified. Refer to the Documentation Policy.

2.10.2. Organizations must identify who is authorized to make changes when errors are discovered in a patient record. Organizational documentation standards referencing how changes are made must be followed. Refer to the Documentation Policy.

3. Responsibilities and Compliance

3.1. Responsibilities

3.1.1. Organizations 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*, *BC Evidence Act* and the *Electronic Transactions Act*. Organizations must also meet the Canadian Council on Health Services Accreditation standards and comply with internal policies and Medical Staff Bylaws, Rules & Regulations.

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

3.1.3. 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.[5]

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

[5] AHIMA, Practice Brief – Fundamentals of the Legal health Record and Designated Record Set http://library.ahima.org/doc?oid=104008#.V6URrNQrLb0

3.2. Compliance

3.2.1. The organizations must determine what information constitutes the official health record to be used as a legal business record for the organizations. 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. An inventory of records, reports and/or documentation and their status is required.

4. Related Documents

4.1. Related Standards / Guidelines / Forms

Checklist for Certifying Systems as Part of the Electronic Legal Health Record – See Appendix A

Health Record Document Inventory – See Appendix B

4.2. Related Policies

Access Policies

- Role-Based Access Control Policy
- Access Management Policy

Auditing Access Policies

- (VCH) Auditing Access to Electronic Health Records
- (PHC) Auditing Access to Electronic Health Records
- (BCCW) Health Records Access and Return Policy

Documentation Policy

Printing Policies

- VCH Printing of Electronic Health Records Policy
- PHC Printing of Electronic Health Records (CPN0507)

Records Retention and Disposal – Health Records Policy

Securing of Health Records and Access to Secured Health Records procedure (in development).

Texting and Email Policies

Texting Policies

- VCH Texting Policy
- PHC Texting Policy
- PHSA Texting Policy
  - BCCDC Email and Text Communications With Clients Guidelines

Email Policies

- PHSA IMITS Internet and Electronic Mail Messaging
- VCH/PHC Email Guidelines
- VCH/PHC Electronic Mail (Email) Usage Policy

5. Definitions

Business Record – refers to information created, received, and maintained as evidence and information by an organization or person, in pursuance of legal obligations or in the transaction of business.[6]

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. [7]

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

a. **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.
b. **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).
c. Students in Designated Health Care Professions.

Document Imaging – The scanning of paper documentation into an electronic format. Document imaging is a bridge between paper records and fully electronic records. Imaged records and electronically created records can generally be viewed together.

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.[8]

Greyscale – In photography and computing, a grayscale or greyscale digital image is an image in which the value of each pixel is a single sample, that is, it carries only intensity information. Images of this sort, also

[6] International Standards Organization. 2016. ISO15489-1:2016(en). Information and Documentation. https://www.iso.org/obp/ui/#iso:std:62542:en

[7] 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

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

known as black-and-white, are composed exclusively of shades of gray, varying from black at the weakest intensity to white at the strongest. Grayscale images are distinct from one-bit bi-tonal black-and-white images, which in the context of computer imaging are images with only two colors, black and white (also called bi-level or binary images). Grayscale images have many shades of gray in between.9

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*.[10]
- 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.

Legal Health Record – The legal health record is the documentation of the health care services provided to an individual in any aspect of health care delivery by a health care provider organization. The legal health record is individually identifiable data, in any medium, collected and directly used in and /or documenting health care or health status. The term includes records of care in any health-related setting used by health care professionals while providing health care services, for reviewing data, or documenting observations, actions, or instructions.

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.

[9] https://en.wikipedia.org/wiki/Grayscale

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

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

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

B.C. Electronic Transactions Act, SBC 2001, c.10, online: BC Laws: Laws of British Columbia http://www.bclaws.ca/civix/document/id/complete/statreg/01010_01

B.C. Evidence Act, Section 42. RSBC 1996, online: BC Laws: Laws of British Columbia http://www.bclaws.ca/civix/document/id/complete/statreg/96124_01

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

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

7. Appendices

Appendix A: Checklist for Certifying Systems as Part of the Electronic Legal Health Record

Appendix B: Health Record Document Inventory

Appendix A

Checklist for Certifying Systems as part of the Official Electronic Health Record

Background:

The Health Record policy establishes that the health records of an organization can be in an electronic format if certain conditions are met. Electronic systems under consideration must demonstrate that they meet the criteria outlined below before being certified as a component of the electronic health record of the organization.

The Health Information Management department supports a grey scale environment for the EHR; images will be stored and reproduced as grey scale images. Business areas that require colour images will need to manage the colour images or coloured documents separately.

All of these criteria must be met to qualify, with no exceptions.

Criteria	Criteria Met	Criteria Met
	YES	**NO**
A requirement under law to retain a record is satisfied by the retention of the record in electronic format if the record is retained in the format in which it was created, provided or received, or in a format that does not materially change the record. [ETA 9 (a)].		
There must be reliable assurance that all documents that comprise the electronic record cannot be altered apart from changes that arise in the normal course of business. Such changes will be clearly identifiable via notations on the electronic document and audit trails. Additions will be in the format of addendums. [ETA 8 (3) (a)].		
The technical infrastructure will ensure that operational functions related to collecting protecting and archiving the health record ensures its completeness, integrity and reproducibility so that it faithfully represents a person's health care [Health Record Policy].		
Additions or deletions to the record must be auditable, must include the user name, date and time, and must be kept for as long as the record is kept per organizational retention policies. [FIPPA and ETA].		
Viewing of the record must be auditable, must include the user name, date and time and must be kept for as long as the record is kept per organizational retention policies. [FIPPA and ETA].		
Audit trails must be kept indefinitely. [FIPPA and ETA].		
Records will be retained as per the Hospital Act Regulation requirements (acute) or the Community Care and Assisted Living Act Regulations (community) and subsequent direction from the B.C. Ministry of Health Services to retain records indefinitely.		
A requirement under law to retain a record is satisfied by the retention of the record in electronic format if the record will be accessible in a manner usable for subsequent reference by any person who is entitled to have access to the record or who is authorized to require its production. Images must be of a high quality for viewing and reproduction. [ETA 9 (b)] i.e.) The system must be defined as mission critical and thus receive 24/7 technical		

support, both internally and externally i.e.) There must be documented system down time procedures.		
The record must be reproducible in a timely and efficient manner for subsequent reference by persons authorized to perform Release of Information duties. Staff will log and release records in accordance with FIPPA, with no exceptions. [FIPPA and ETA 6 (a)].		

Completed by:

Name: _____ Date: _____

Title: _____

Approved by HIM Executive

Name: _____ Date: _____

Title: _____

Approved by IMITS / HCIS (FH)

Name: _____ Date: _____

Title: _____

References:

FH Policy - "Legal Health Record"
FH Policy – "Confidentiality and Security of Personal Information"
Electronic Transaction Act, S.B.C. 2001, c. 10
BC Freedom of Information and Protection of Privacy Act (FIPPA)
Hospital Act Regulations
Community Care and Assisted Living Act Regulation
Ministry of Health Services Correspondence Dated 11 June 2007 and 10 Sept 2015

Appendix B

SAMPLE ONLY

[Name of Organization] HEALTH RECORD DOCUMENT INVENTORY

Report / Document Name	Site(s)	Media Type (P)aper (E)lectronic (S)canned	Source System Application	Electronic Storage Date	Stop Printing Start Date
Admission History	All	P			
Physician Orders	All	P			
Radiology Reports	VA	E	Radiology System	dd/mmm/yyyy	tbd
Operative Reports	VA RH LGH	E	SoftMed	dd/mmm/yyyy	tbd
Emergency Records	All	P			

To consider:

- The record inventory is a tool used to ensure each major document type is addressed during transition
- The record inventory must be maintained in real time
- It must be available to all who have a need to know in an easy to find location (e.g. Intranet)
- The record inventory defines legal status of the documents
- It may need to have columns added to be more specific to the organizational environment
- The responsibility for ownership, maintenance, frequency of updates must be developed

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Approving Body:	Name / Committee:		
Final Sign Off:	Name	Title	Date Signed
		VP Professional Practice, CNIO VP Medicine Chair, HAMAC	09-JUL-2018
		VP, Patient Exp, Acute Care & Chief of Professional Practice Director, Professional Practice Chair, MAC	09-JUL-2018
	PHSA SET		16-APR-2018
Developed By:	Name	Dept.	HO
	Regional Director – Records Management & Registration	Health Information Management	Lower Mainland Consolidation
	Regional Manager – Records Management Process and Standards	Health Information Management	Lower Mainland Consolidation
Owners:	PHC	PHSA	VCH
	Health Information Management	Health Information Management	Health Information Management
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