Completion of Charts

In order to ensure that B.C. Cancer patient records are accurate and current, all patient care provided by the Agency will be fully documented in an efficient manner.

Policy

B. C. Cancer has a hybrid patient record which means “100% paper record and approximately 60% electronic record”. The paper record is updated with information from the electronic record before each patient visit.

The Electronic Signature Policy – PIM 060-IV-D-70 outlines responsibilities associated with signing patients’ reports/documents electronically.

Created [October 1, 1989]
Revised [March 22, 2011

Revised February 26, 2013

Person Responsible: Brian Schmidt
(19890 CRC and MAC (2013)

Reviewed December 20, 2018

Agency Policy Manual

Procedures

1. The Most Responsible Physician shall be responsible for ensuring that
   - Admission documentation is completed at the time of admission to in-patient wards [1]
   - A discharge summary is completed as soon as possible on all in-patients. [1]
   - An oncological consultation is completed at the time of consultation for all ambulatory patients. [1]

2. A handwritten or transcribed medical summary prepared by the discharging specialist or delegate will accompany all Agency in-patients being transferred to another facility.
3. A handwritten note will be documented by the physician seeing a patient in BCCA out-patient facility from another acute care facility to accompany the patient back to the originating facility. This is in addition to a dictated note for BCCA chart.

4. A Medication Reconciliation Report will be prepared for all patients being discharged/transferred from in-patient wards.

5. Add: The Most Responsible Physician shall identify, with appropriate reference to the Freedom of Information and Protection of Privacy Act, [2] documentation from the patient's clinical record to be sent to the Receiving Agency

6. For best practice management and patient safety Health Information Management will transcribe dictation:

7. All dictations will be transcribed within 48 hours except urgent ones ,when requested, will be transcribed the same day.

Work-types:

Level 1	Within 24 hours	2, 3, 4, 8, 20, 24, 35
Level 2	Within 48 hours	1, 5, 7, 9, 11, 13, 27, 38

Created [October 1, 1989]
Revised [March 22, 2011

Revised February 26, 2013

Person Responsible: Brian Schmidt
(19890 CRC and MAC (2013)

Reviewed December 20, 2018

Agency Policy Manual

Level 3	Within 96 hours	6, 10, 14, 16, 17,, 22, 23, 25, 28, 31, 32, 34, 37, 71, 76
Other	To be linked with corresponding work-types	77, 78, 79

8. Responsibilities for Transcribed Reports:

Reports by Author	Edits/signs all signature documents
Consultations (after author signs) (author must have dictated name of requisitioning physician)	Requisitioning physicians "signs". MRP "reviews" (when not Requisitioning physician)
COP Ready for Discharge Note	MRP signs and initiates discharge order and discharge letter

9. Responsibilities for Transcribed Documents when Physician Away Greater than 2 weeks

- With adequate notice, every effort will be made to complete transcription of signature documents before physician's departure.
- Signature documents are distributed unsigned with disclaimer "Dictated not read. Signed copy to follow".
- Review transcribed documents are routed to Covering Physician.
- Resident's dictation – distributed unsigned with disclaimer "Dictated not read. Signed copy to follow".

Created [October 1, 1989]
Revised [March 22, 2011

Revised February 26, 2013

Person Responsible: Brian Schmidt
(19890 CRC and MAC (2013)

Reviewed December 20, 2018

Agency Policy Manual

10. If the Most Responsible Physician is no longer available, the active patient records should be sent to the appropriate Regional Professional Practice Leader to reassign Responsible physicians in order to maintain continuity of patient care. For medicolegal reasons, dictated notes and verbal orders will not be signed and will be noted as "dictated, not read".. [3]

References:

[1] Medical Staff Rules for the Provincial Health Services Authority – Article 3 – Responsibility for patient care –3.1.3 – Admission Documentation. 3.18.d – Discharge Summary. 3.2 Medical Consultations.

[2] Medical Staff Rules for the Provincial Health Services Authority – Article 3.1.9 – Transfer to another Agency.

[3] Medical Staff Rules for the PHSA – Article 3.3.5 Completion of Health Records.

Created [October 1, 1989]
Revised [March 22, 2011

Revised February 26, 2013

Person Responsible: Brian Schmidt
(19890 CRC and MAC (2013)

Reviewed December 20, 2018

Agency Policy Manual