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Introduction

Whether in paper or electronic format, the medical record must contain comprehensive documentation of the clinical care provided to the patient and personal information that must be protected.

British Columbia's *Personal Information Protection Act* (*PIPA*) applies to private organizations such as physician offices and non-hospital facilities and governs how personal information about patients and employees may be collected, used and disclosed. Other relevant legislation includes but is not limited to the *Personal Information Protection and*

Medical records and documentation

No.	Description	Reference	Risk	Change
DOC1.0	MEDICAL RECORDS AND DOCUMENTATION			
DOC1.1	The patient's medical record provides an accurate and			

No.		Description	Reference	Risk	Change
DOC1.1.3	M	The medical record is organized in a standardized and chronological order. *Guidance: The medical record is organized in sections, and the information in each section is organized in chronological order. Sections include but are not limited to patient identification and demographic information, consent, history, physical, progress notes, forms/records (e.g. intraoperative (nursing), anesthesia record, post-anesthesia recovery), consultations, orders, diagnostic testing, radiologist examination results. Each section of the medical record (paper or electronic) should be tabbed for ease of review. The order of the medical record is at the discretion of the facility, as per facility policy.*		M	

No.		Description	Reference	Risk	Change
DOC1.2.2	M	A confidentiality or non-disclosure agreement is on file for each staff member and any contractors. *Guidance: Contractors include but are not limited to any person who may come into contact with patients and/or patient information (e.g. information management/information technology personnel/companies, external environmental cleaning personnel/companies). A sample confidentiality/non-disclosure agreement is available from the Canadian Medical Protective Association.*		L	
DOC1.2.3	M	Paper medical records are located in a secure area where there is no public access and are accessible to authorized personnel only. *Guidance: Paper medical records are stored in a location that prevents members of the public from viewing the records (i.e. avoid leaving medical records at the reception desk where other patients can see them) and are returned to the filing location as soon as possible after use. Paper records should also be retrieved promptly from fax machines and photocopiers. Facility policies and procedures* *information and medical records is based on the role, responsibility and function of the individual.*		M	
DOC1.2.4	M	The electronic medical record server is located in a secure area where there is no public access and is accessible to authorized personnel only. *Guidance: Cloud computing is acceptable provided the facility has addressed privacy and security considerations before storing data with a cloud service provider such as preventing secondary use of personal health information, audit trails, restricted access, strong password protection, encryption, notification in the event of a privacy breach, backup procedures to prevent data loss, system outages, and ensuring access to medical records at all times.* *Note: Standard cloud service terms of use agreements may not be sufficient for regulated health professionals to fulfill all of their privacy and confidentiality obligations.*		M	

No.		Description	Reference	Risk	Change
DOC1.2.7	M	Express consent is obtained before using email to communicate with patients and/or transmit their health information. *Guidance: Email communication is acceptable provided there has been a discussion with the patient about the inherent risks of email communication (i.e. privacy, security, timeliness of response, clarity of communication). This discussion is documented in medical record and a written consent form has been completed and is available through the Canadian Medical Protective Association. Confidential and sensitive patient information sent by email is encrypted or, at a minimum, password-protected.*		M	
DOC1.3		Electronic medical record systems comply with professional and regulatory documentation and medical records practices.			
DOC1.3.1	M	Electronic medical records can be visually displayed and printed for each patient promptly and in chronological order. *Guidance: An individual electronic medical record can be accessed by entering their name.*		L	
DOC1.3.2	M	The electronic medical record system records the date, time and identity of the user when records are accessed. *Guidance: Each authorized user has a unique log-in and password, and the system is configured to identify who has accessed the record.*		M	
DOC1.3.3	M	The electronic medical record system records the date and time of each entry made for each patient and the identity of the user making the entry. *Guidance: Each authorized user has a unique log-in and password, and the system is configured to identify who has accessed the record.*		M	

No.		Description	Reference	Risk	Change
DOC1.3.6	M	The electronic medical record system automatically backs up files or otherwise provides reasonable protection against information loss, damage and inaccessibility. *Guidance: System backup is performed daily (i.e. each surgical day). Restore processes should be regularly tested. An off-site backup system is recommended in case computer equipment is stolen, lost or damaged.*		M	
DOC1.3.7	M	Anti-virus, malware and spyware software is installed to protect patient information.		M	
DOC1.3.8	M	Encryption protection is installed on all computer systems containing personal health information. *Guidance: Computer systems include desktop and laptop computers.*		M	
DOC1.3.9	M	Secure networks are used to access and send patient information. *Guidance: Security controls are in place (i.e. local wireless network is encrypted and password-protected) to prevent unauthorized access.*		M	
DOC1.3.10	M	Paper records scanned into the electronic medical record system are in "read-only" format. *Guidance: Scanning procedures include some form of quality assurance (e.g. comparing the electronic copy to the original paper copy to ensure the information has been accurately converted before destruction of the paper record if appropriate).* *Note: Scanning and optical character recognition (OCR) are different. Scanning generates a non-editable electronic representation of an image. OCR converts handwritten or typewritten text into machine-editable text. Once a record has been converted using OCR, the text can be changed, searched or manipulated. OCR may be used in conjunction with scanning. Using OCR alone is contraindicated unless the original paper records are also scanned - format or the original paper record is retained.*		M	
DOC1.4		Medical			

No.		Description	Reference	Risk	Change
DOC1.4.1	M	There are agreements/contracts in place that address medical record ownership, custody, confidentiality and enduring access by individual physicians. *Guidance: In all situations where a physician is creating medical records in a group or shared medical record environment, a data-sharing agreement is in place that addresses medical record ownership, custody and enduring access by individual physicians and patients. In all situations where a physician creating a medical record is not the owner of the facility and/or of the electronic medical record license, a formal contract is in place that addresses medical record custody, confidentiality and enduring access.*		M	
DOC1.4.2	M	The electronic medical record system has robust backup and recovery procedures. *Guidance: Robust security features include but are not limited to encryption, use of passwords, and access controls to protect against unauthorized access.*		M	
DOC1.4.3	M	Medical records are retained for a minimum period of 16 years from the date of last entry. *Guidance: Where the patient is a minor, medical records are kept for at least 16 years from the age of majority. When transitioning to an electronic medical record, once the paper medical record has been fully transitioned to an electronic record, it is not necess4.45 q162.03 12*			

No.		Description	Reference	Risk	Change
DOC1.6.12	M	Sex assigned at birth is an entry field on the patient self -reported questionnaire. *Guidance: Sex assigned at birth is a data element that includes options for assignment of the sex of a person at birth based on biological characteristics. Sex assigned at birth is also frequently used to support clinical care such as interpreting imaging studies or laboratory tests.*		C	V5.0
DOC1.6.13	M	Pre-admission assessment includes infectious diseases and antibiotic -resistant organism (ARO) screening. *Guidance: Screening questions may include: Have you ever been diagnosed (infection or colonization) with an ARO such as MRSA or VRE?; Has anyone in your household ever been diagnosed (infection or colonization) with an ARO such as MRSA or VRE?; Have you received health care in a facility outside of Canada in the last 12 months?; Have you ever been admitted to, or spent more than 12 continuous hours as a patient in, any health-care facility in the last 12 months?*		M	

No.	Description	Reference

No.		Description	Reference	Risk	Change
DOC1.7.1	M	The consent discussion is documented in the patient's medical record. *Guidance: The consent discussion explains the proposed treatment or course of treatment, the condition for which the health care is proposed, the nature of the proposed health care, the risks and benefits of the proposed health care that a reasonable person would expect to be told about, alternative courses of health care (and when indicated, the likely consequences of no treatment). Documentation of the consent discussion includes the nature of the health care proposed, the risks, benefits and alternative(s) discussed with the patient, and any specific additional issues or concerns that arose through the discussion and how they were addressed. The anesthesiologist should include documentation of the anesthesia consent discussion with the patient on the anesthetic record.*		M	

No.		Description	Reference	Risk	Change
DOC1.8.2	M	Admission documentation includes time of last intake of food and fluids. *Guidance: The admission assessment includes verifying fasting*			

No.	Description	Reference	Risk	Change
DOC1.8.				

No.

No.	Description	Reference	Risk	Change
DOC1.9.18	M Anesthetic record documentation includes			

No.		Description	Reference	Risk	Change
DOC1.10.2	M	Sedation record documentation includes			

No.		Description	Reference	Risk	Change
DOC1.10.11	M	Sedation record documentation includes all lines and fluids administered. *Guidance: Intravenous fluid administration including start and end time, solution, volume and rate is documented. The fluid balance (in and out) record is complete.*		M	
DOC1.11		Intraoperative documentation provides an accurate account of the patient's status, the actions of the perioperative team, and the patient's outcome.			
DOC1.11.1	M	Intraoperative (nursing) record documentation includes perioperative event times. *Guidance: Perioperative event times include but are not limited to patient entry into the operating room, surgical safety checklist briefing, time-out and debriefing, and patient exit from the operating room.*		L	
DOC1.11.2	M	Intraoperative (nursing) record documentation includes name and role of each person involved in the patient care provided in the operating room and any visitors. *Guidance: This includes but is not limited to health care professionals, students, residents, fellows, family and vendors (e.g. equipment reps). Documentation includes first and last name and role of each person. Nursing personnel documentation also includes their initials/signature.*		[redacted]	

No.		Description	Reference	Risk	Change
DOC1.11.5	M	Intraoperative (nursing) record documentation includes use of mechanical thromboprophylaxis devices, as appropriate. *Guidance: Based upon the American College of Chest Physicians (ACCP), the Canadian Patient Safety Institute VTE Prevention Getting Started Kit provides resources to assist facilities in VTE screening and prophylaxis (http://www.patientsafetyinstitute.ca/en/toolsResources/VTE-Getting-Started-Components/Pages/default.aspx). The appropriate measuring, sizing and application of deterrent stocking applied in the operating room and the use of mechanical thromboprophylaxis devices are documented in the intraoperative (nursing) record.*		M	
DOC1.11.6	M	Intraoperative (nursing) record documentation includes skin assessments. *Guidance: A preoperative skin and positioning needs assessment is performed to identify patient and procedure factors which may* *age (i.e. pediatric, older adults > 65 years), nutritional status, skin condition, comorbidities (e.g. diabetes, peripheral vascular disease), BMI (i.e. underweight, obese), and physical/mobility limitations. Procedural factors include the type of procedure, length of procedure, procedural position and type of anesthesia. Any areas of existing skin breakdown, presence of a rash and/or dermatitis is documented. The patient is assessed postoperatively for signs and symptoms of skin breakdown, positioning injury and/or medical device related injury.*		M	

No.		Description	Reference	Risk	
DOC1.11.8	M	Intraoperative (nursing) record documentation includes pneumatic tourniquets, as indicated. *Guidance: Pneumatic tourniquet documentation includes but is not limited to location and size of the cuff(s), pressure setting(s), perioperative team member(s) applying the cuff(s), unit serial number and model (or facility identification number), time of inflation/deflation/re-inflation, surgeon notification oio*			

No.		Description	Reference	Risk	Change
DOC1.11.17	M	Intraoperative (nursing) record documentation includes drains and/or catheters, as indicated. *Guidance: Drain and/or catheter documentation includes the location of the drain(s)/catheter(s), the type of drain(s)/catheter(s), and the method of securing the drain(s).*		M	
DOC1.11.18					

No.		Description	Reference	Risk	Change
DOC1.11.23	M	Intraoperative (nursing) record documentation includes unusual occurrences.			

No.	Description	Reference	Risk	Change

No.		Description	Reference	Risk	Change
DOC1.14.10	M	PACU record documentation includes medications administered and their effect. *Guidance: All medication(s) administered are documented in the medical record. Medication administration documentation includes the medication name, date, time, dose, route and (if applicable) site, and initials/signature.*		M	
DOC1.14.11	M	PACU record documentation includes lines, drains and/or catheters, as indicated. *Guidance: Intravenous fluid administration including start and end time, solution, volume, and rate is documented. Status of drains and catheters including their location and drainage amount and description is documented. The fluid balance (in and out) record is complete.*		M	
DOC1.14.12	M	PACU record documentation includes dressings. *Guidance: The location and status of dressings is documented.*		M	
DOC1.14.13	M	PACU record documentation includes voiding, if monitoring indicated. *Guidance: Patients who possess one or more at-risk-criteria must void post-operatively prior to discharge. Patients who do not possess any of the at-*			

No.		Description	Reference	Risk	Change
DOC1.14.16	M	PACU record documentation confirms the completion of discharge teaching. *Guidance: Written discharge instructions are reviewed with and provided to the patient. It is recommended that the responsible*			

No.		Description	Reference	Risk	Change
DOC1.15.10	M	ONS documentation confirms the completion of discharge teaching. *Guidance: Written discharge instructions are reviewed with and provided to the patient.*		L	
DOC1.15.11	M	ONS documentation includes date and time of discharge and patient status. *Guidance: Patient status includes but is not limited to vital signs, general status, discharge instructions, prescription, and accompanying responsible adult.*		L	
DOC1.16		Documentation practices comply with professional and regulato	1025 ref*EMC /P <</Q	67.5 402.08 72.025 1025 1025 1025	

No.

No.	Description	Reference	Risk	Change

13. Out-of-hospital premises inspection program [Internet]. Toronto: College of Physicians and Surgeons of Ontario; 2018 [cited 2018 Oct 24]. [about 4 screens].

14.

Revision history

Date	Revisions