<table>
<thead>
<tr>
<th>Definitions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>addendum</td>
<td>New documentation used to add information to an original documentation entry of patient health information.</td>
</tr>
<tr>
<td>amendment</td>
<td>Additional documentation completed to clarify a pre-existing entry in the patient medical record.</td>
</tr>
<tr>
<td>care plan/clinical pathway</td>
<td>A plan that outlines patient care from admission to discharge including expected outcomes/goals, typical course of recovery and interventions (e.g. knee arthroscopy care plan).</td>
</tr>
<tr>
<td>charting by exception</td>
<td>Recording of all assessment findings, interventions and patient outcomes that vary from established assessment norms or standards of care (e.g. care plan, clinical pathway).</td>
</tr>
<tr>
<td>charting by inclusion</td>
<td>Recording of all assessment findings (normal and abnormal), interventions and patient outcomes.</td>
</tr>
<tr>
<td>correction</td>
<td>A change made to the documented patient medical information meant to clarify the entry after the document has been authenticated.</td>
</tr>
<tr>
<td>electronic medical record (EMR)</td>
<td>An electronic version of the paper medical record traditionally maintained to document the clinical care provided to the patient.</td>
</tr>
<tr>
<td>electronic signature</td>
<td>A generic term referring to a wide variety of non-manual signature options. An electronic signature is attached to or associated with an electronic document and may consist of letter, characters, numbers or symbols.</td>
</tr>
</tbody>
</table>
## Facility processes ensure that medical records meet provincial and federal statutory requirements and professional/regulatory standards

### INDICATORS:

- Facility has written policies and procedures in place that meet medical record requirements and include but are not limited to:
  - medical record format, e.g. written (paper), electronic (scanned written records, electronic data entry records) or combination of both
  - method of documentation (e.g. focus charting, SOAP charting, narrative charting)
  - if charting by exception is used, normal assessment findings are defined and written care plans/clinical pathways are in place
  - expectations for the frequency of documentation
  - email communication with patients related to clinical care, telephone consultation and follow-up
  - process for corrections, addendums, amendments and “late entry” recording
  - listing of acceptable abbreviations
  - do’s and don’ts (e.g. document only the care you provide, blacking out an error)
  - acceptance and recording of verbal and telephone orders
  - storage, transmittal, retention and destruction of medical records
  - patient request for access to their medical record

- Facility has written policies and procedures in place that ensure medical records converted from one format to another (e.g. paper to electronic, or legacy EMR system to new EMR system) meet requirements and include but are not limited to:
  - conversion process (e.g. scanning) to demonstrate how archived records are created
  - retention of paper records, which are scanned into an electronic record system, for a minimum of six months
  - retention of paper records which are not scanned into the electronic system (e.g. when a combination (paper and electronic) medical record format is used and the patient’s medical record is not entirely scanned into the electronic record system)
  - quality assurance process to ensure the original paper record has been accurately converted (e.g. complete, legible, unalterable)
  - destruction of the original paper record

- Each entry made in the electronic record system is identified by who made the entry and when

- The electronic record system is configured to identify who has accessed the record

- The electronic record system is configured to identify what, if any, alterations have been made, when and by whom

- The electronic record system can print and view a copy of the unedited original version of the record and amendments, if any, are separately visible (e.g. original entry is preserved when amendments are made)
Conversion to an electronic record (e.g. scanning process) creates an unalterable “read-only” digital image of the original

Electronic records can be promptly printed in a format that is easy to understand

Records are retained for a minimum period of sixteen years from the date of last entry; where the patient is a minor, records are kept for at least sixteen years from the age of majority

Where details of certain procedures (e.g. ophthalmic surgical procedures) may be critical to future surgical interventions, consideration is given to retaining those medical records at least to the time of the patient’s death

Medical records are destroyed in accordance with the College’s professional standard Medical Records (e.g. supervised cross-shredding, incineration or by electronic erasure including any backup copies of the records)

Facility processes ensure that patient information is appropriately collected, kept secure, held confidential and protected from unauthorized disclosure

INDICATORS:

Facility has written privacy policies and procedures in place that meet the provincial Personal Information Protection Act (PIPA) requirements and include but are not limited to:

- assigning a staff member responsible for ensuring facility compliance with PIPA
- identifying the purpose(s) for which personal information is needed and how it will be used
- informing patients, either verbally or in writing, of the purposes for collecting the personal information before or at the time that it collects personal information
- medical record and personal information safeguards (e.g. physical, technological and organizational security)
- use and handling of email to transmit patient information
- identifying protocols and restrictions for the appropriate use of mobile devices, e.g. cell phone, tablet, video imaging
- staff training about privacy policy and procedures
- use of confidentiality agreements to ensure that third parties providing services that involve the collection, use or processing of personal information provide the appropriate privacy protection (e.g. electronic records backup provider)
- a process for handling a privacy breach
- a process for handling privacy complaints

Access to patient information and medical records is limited to authorized individuals and is based on their role, responsibility and function

A confidentiality or non-disclosure agreement is on file for each staff member
Discussion about the inherent risks in email communication and the patient’s express consent to email communication is documented in the patient’s medical record; a consent form should be used in addition to the medical record documentation (see Appendix A).

- Confidential and sensitive patient information sent by email is encrypted or, at a minimum, password protected.
- Written records are located in a secure area where there is no public access and where only authorized personnel are allowed.

**Electronic medical records are kept secure, held confidential and protected from unauthorized disclosure**

**INDICATORS:**

- Facility has written policies and procedures in place and include but are not limited to:
  - maintaining physical security of the system
  - maintaining the technological security of the system (e.g. antivirus and spyware software, automatic logout)
  - defining user-based access levels
  - monitoring and auditing unauthorized access
  - preventing deletion of information
  - identifying changes and updates to the record
  - data sharing with other health-care professionals
  - secure transmission of records
  - backup of records
  - data recovery and testing
  - alternate documentation method in the event of a system failure

- Each authorized user has a documented access level based upon the individual’s role.
- Each authorized user has a unique ID with appropriate password controls.
- Audit logging is enabled to record actions taken by each authorized user and privacy audits are conducted.
- Records are physically secured (e.g. paper records located restricted access areas, server located in locked area).
- Technological security (e.g. firewall, anti-virus software) is in place and regularly updated.
- Backup procedures are in place and files are encrypted.
- Restore process of backed-up files is tested regularly.
- Local wireless networks are encrypted and password protected.
Facility processes ensure that the medical record provides an accurate and comprehensive account of the care provided to each patient

INDICATORS:

○ An operative log book which contains the name of the patient, the date, the procedure performed and the name of the surgeon and anesthesiologist is maintained

○ There is a medical record for each patient admitted for surgery

○ The medical record is a single comprehensive file containing all information and documentation related to the patient’s surgical encounter

○ The contents of the medical record follow a standardized structure and layout

○ General information contained in the medical record includes but is not limited to:
  • patient name
  • gender
  • date of birth
  • contact information (e.g. address and telephone number)
  • unique identifying number (e.g. personal health number (PHN))
  • medical or claim record number, as appropriate (e.g. health authority, WCB, ICBC)
  • next of kin contact information

○ Clinical information contained in the medical record includes but is not limited to:
  • preoperative care (pre-admission, admission)
  • anesthetic care
  • intraoperative care
  • post-anesthesia care
  • overnight stay care, if indicated

Documentation practices comply with professional and regulatory standards

INDICATORS:

○ Designated facility forms are used for documentation

○ Each form clearly identifies the patient with two patient identifiers

○ Entries made in the medical record adhere to facility written policy and procedures for documentation

○ All relevant information about the patient is documented in the patient’s medical record

○ Health-care providers indicate their accountability and responsibility by adding their signature and appropriate title to each entry they make in the patient’s medical record

○ Documentation is performed at the time care is provided or as soon as possible afterward
Pre-admission documentation provides an accurate account of the patient’s preoperative status and supports appropriate patient selection

INDICATORS:
- Pre-admission documentation contained in the medical record includes:
  - booking card
  - patient self-reported questionnaire
  - medical history including indication(s) for surgery, comorbidities, previous surgery
  - physical assessment including systems review and full functional inquiry
  - height (measured), weight (measured) and body mass index (BMI)
  - medications
  - allergies including a description of the reaction
  - ASA classification
  - consultations, as appropriate (e.g. anesthesia, cardiology, internal medicine)
  - laboratory, ECG, radiology and all other diagnostics test results and reports as indicated
  - consent form, signed and witnessed

Admission documentation provides an accurate account of the patient’s status, preparation for surgery and appropriateness for admission to a non-hospital facility

INDICATORS:
- Admission documentation contained in the medical record includes:
  - date and time of admission
  - vital sign measurements including blood pressure, heart rate, respiratory rate, oxygen saturation and temperature
  - height, weight and body mass index (BMI) is remeasured if pre-admission measurements were performed greater than 14 days prior to admission
  - time of last intake of food and fluids
  - medications including time last dose taken
  - allergies including a description of the reaction
  - blood glucose level, as indicated
  - name and contact information of the responsible adult accompanying the patient upon discharge
  - in circumstances where patient is unable or unwilling to arrange for someone to accompany them upon discharge, documentation that the anesthesiologist and surgeon are aware
  - preoperative teaching and discharge planning
  - preoperative checklist
Anesthesia documentation provides an accurate account of the patient’s status and outcome

These indicators provide a general overview of the anesthesiologist record documentation requirements. The Canadian Anesthesiologist Society (CAS) Guidelines to the Practice of Anesthesia shall be referenced in addition to this document.

INDICATORS:
○ Anesthetic record documentation contained in the medical record includes:
  • anesthetic consult, as indicated
  • patient assessment in the immediate preoperative period
  • previous anesthetic history
  • family history of adverse reactions to anesthesia
  • ASA classification
  • BMI
  • anesthesia agents, types and technique(s)
  • medications administered including time, dose and route
  • fluids administered including time, solution and volume
  • fluid/blood loss
  • blood pressure, heart rate at least every five minutes
  • oxygen saturation recorded at frequent intervals
  • end-tidal carbon dioxide, as indicated, recorded at frequent intervals
  • complication occurrences during the course of anesthesia
  • patient’s level of consciousness, blood pressure, heart rate, oxygen saturation and respiratory rate as first determined in the PACU

Intraoperative documentation provides an accurate account of the patient’s status, the actions of the perioperative team and the patient’s outcome

These indicators provide a general overview of the intraoperative (nursing) record documentation requirements. Operating Room Nurses Association of Canada (ORNAC) shall be referenced in addition to this document.

INDICATORS:
○ Intraoperative (nursing) record documentation contained in the medical record includes:
  • perioperative event times
  • name and professional designation of all personnel involved in patient care and any visitors (e.g. equipment reps)
  • surgical safety checklist (SSCL), clearly specifying the times that the briefing, time-out and debriefing were completed
  • positioning
  • warming or cooling units, as indicated
• pneumatic tourniquet, as indicated
• laser(s), as indicated
• electrosurgical unit (ESU), as indicated
• insufflators, as indicated
• mechanical irrigation devices, as indicated
• surgical equipment
• application of monitoring devices if not already documented by the anesthesiologist (e.g. local or IV sedation cases)
• skin preparation
• surgical wound classification
• prostheses/implants/allografts, as indicated
• packing, as indicated
• drains and/or catheters, as indicated
• specimens and/or bloodwork, as indicated
• intraoperative X-rays, fluoroscopy and type of patient protection, as indicated
• surgical counts
• medication, hemostatic agents, dyes and irrigation administered by surgeon and/or nursing staff
• urinary output and iv infusions if not already documented by the anesthesiologist
• estimated blood loss
• exact surgical procedure(s) performed
• initiation of special precautions (e.g. latex allergy) as indicated
• flash sterilization incidents including reason and description of device
• unusual occurrences

○ Surgeon’s operative report is contained in the medical record

Post-anesthetic care unit (PACU) documentation provides an accurate account of the patient’s status, the actions of the perianesthesia team and the patient’s outcome

These indicators provide a general overview of the pre-admission documentation requirements. The National Association of PeriAnesthesia Nurses of Canada Standards of Practice (NAPAN) shall be referenced in addition to this document.

INDICATORS:

○ PACU documentation contained in the medical record includes:
  • date and time of transfer to PACU
  • initial and continuous monitoring of cardiac rhythm, blood pressure, pulse, respirations, oxygen saturation, temperature, level of consciousness, pain, procedure site and general status
  • neurological, neurovascular and/or neuromuscular assessments, as indicated
• discharge scoring system
• medications administered including time, dose, route, reason and effect
• treatments given and their effect
• fluids administered and/or discontinued including time, solution and volume
• status of drains, dressings and catheters including amount and description of drainage
• voiding, if monitoring indicated (e.g. spinal/epidural anesthesia, gynecological, rectal, urological or neurosurgical procedures)
• fluid balance (input and output) summary
• information reported to the anesthesiologist and/or surgeon
• discharge teaching including instructions given to the patient and planned follow-up
• discharge status (e.g. date and time of discharge, vital signs, general status, written instructions, accompanying escort)

Overnight stay documentation provides an accurate account of the patient’s status, the actions of the health-care providers and the patient’s outcome

INDICATORS:

○ Overnight stay documentation contained in the medical record includes:
  • date and time of transfer to overnight stay
  • initial and regular monitoring of blood pressure, pulse, respirations, oxygen saturation, temperature, level of consciousness, pain, procedure site and general status
  • care plan
  • discharge scoring system
  • medications administered including time, dose, route, reason and effect
  • treatments given and their effect
  • fluids administered and/or discontinued including time, solution and volume
  • status of drains, dressings and catheters including amount and description of drainage
  • voiding, if monitoring indicated (e.g. spinal/epidural anesthesia, gynecological, rectal, urological or neurosurgical procedures)
  • fluid balance (input and output) summary
  • information reported to the anesthesiologist and/or surgeon and when appropriate that provider’s response
  • discharge teaching including instructions given to the patient and planned follow-up
  • discharge status (e.g. date and time of discharge, vital signs, general status, written instructions, accompanying escort)
Chart auditing processes ensure the integrity of data within the medical record and promote quality improvement

INDICATORS:
○ An auditing process is in place and includes but is not limited to:
  - review 10% of all cases performed annually representing a cross section of procedures and physicians (surgeons and anesthesiologists)
  - use of a medical record audit tool
  - use of an interdisciplinary team (e.g. surgeon, anesthesiologist, nurse)
  - evaluation of compliance with documentation policy and procedures
  - evaluation of compliance with privacy and confidentiality policy and procedures
  - evaluation of compliance with clinical policy and procedures
  - retention of auditing records

Appendix A: Physician-patient email communication template consent form example

Canadian Medical Protective Association
- Physician-patient email communication template consent form

References

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