College of
Speech and Hearing
Health Professionals of BC

Regulator of Audiologists, Hearing Instrument Practitioners and Speech-Language Pathologists

DOCUMENTATION AND RECORDS MANAGEMENT

Clinical Practice Guideline

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Contents

1.0 PURPOSE

This guideline addresses the responsibilities of all College of Speech and Hearing Health Professionals of BC (CSHHPBC) registrants and communication health assistants in the preparation, maintenance, communication, retention and disposal of clinical and related records.

CSHHPBC recognizes that variations in practice settings (e.g., public versus private practice), types of services provided (e.g., assessment, diagnosis, treatment/intervention, dispensing of hearing instruments, etc.) will impact the type of documentation required. The application of these guidelines will depend on the clinical context in which registrants find themselves. Clear, concise, timely and accurate records are an essential component in the delivery of speech- language pathology, hearing instrument dispensing and audiology services.

2.0 BACKGROUND

The registrant or the agency where the client's health record is held is the legal owner of the record as a piece of physical or electronic property. The information in the record, however, belongs to the client. Clients have a right of access to their records and to protection of their privacy with respect to the access, storage, retrieval and transmittal of the records. The rights of clients and obligations of public agencies are outlined in BC's *Freedom of Information and Protection of Privacy Act* (FOIPPA) and are often summarized in agency policies.

FOIPPA provides the legislative framework for information and privacy rights. This act applies to all public bodies including health authorities, hospitals, schools, agencies, CSHHPBC and other similar organizations. The legislation gives the public a right of access to records held by one of these public bodies. Individuals have a right of access to personal information about themselves (including their health records) and a right to request correction of such information. FOIPPA also prevents the unauthorized collection, use or disclosure of personal information by a public body.

Registrants in non-publicly-funded agencies need to be aware of the requirements of BC's *Personal Information Protection Act* (PIPA) and other laws dealing with privacy. The purpose of PIPA is to govern the collection, use and disclosure of personal information by organizations including private offices. It is important that in a private business, there is a "privacy officer" assigned who is required to ensure information is handled appropriately. Employees must be made aware of their responsibilities for handling personal information and how it will be used and disclosed; take reasonable steps to ensure protection of information against theft, loss, unauthorized use, disclosure, copying, modification and disposal, and ensure that client requests for information or access to their information under PIPA are answered promptly and appropriately.

3.0 DEFINITIONS

"Client" means any person to whom services are provided including but not limited to hospital patients, outpatient and private clients, residents in long-term care facilities, preschoolers in agencies, and school-age students in educational institutions.

"Client waiver" means a written waiver signed by the client declining physician referral or consultation based on informed consent.

"Late Entry" means a late entry is an entry occurring outside acceptable time limits set by agency or employer policy or one that is out of chronological order.

"Minor" means a person under the age of 19 years.

"Person with a disability" means a person with a disability is who is incapable of or substantially impeded in managing their affairs.

"Primary documents" means assessment and diagnostic reports, consultations, progress letters or reports, discharge summaries and any formal letters and correspondence.

"Record" means information in any form or medium, including notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers, papers and any other information that is written, photographed, recorded or stored in any manner. In addition to individual clinical records, there may also be a need for administrative or business records, equipment service records, financial records or transitory records.

"Screening" means a test or preliminary investigation (prior to an assessment) to determine the presence or absence of a problem, usually with pass or fail results

"Secondary documents" means documentation that includes, but is not limited to, diagnostic information, test protocols working documents, progress notes, appointment notices.

"Transitory documents" means documents intended for short-term use that are not part of an official record-keeping system. They may include documents used for a temporary purpose (e.g., phone messages, post-it notes, invitations, etc.), copies of main records (e.g., working files or ghost files), unsolicited materials and draft reports that were used in the preparation of formal documents. Transitory records do not include any documents that fall into another record category.

4.0 TYPES OF RECORDS

4.1 Administrative or Business Records

Administrative or business records are typically maintained by the employing agency regarding the day-to-day operations of the business.

4.2 Clinical Records

Clinical records contain details related to services provided to the client. They are kept in the client's individual file or chart, which may be paper or electronically based. Clinical records serve multiple purposes, including:

- justifying the need for the service or intervention;
- delineating the care plan;

- documenting effectiveness of service(s);
- communicating the delivery of the professional services;
- promoting continuity of care;
- providing a legal record of events.

4.3 Equipment and Equipment Service Records

It is the registrant's responsibility to maintain up-to-date supply and equipment lists (including test materials and the edition being used). These lists may, in some instances, be maintained by the employer. Equipment service records are necessary when the proper functioning of equipment may impact client health and safety or the accuracy of assessments or testing results. This includes calibration reports (see section 8.5.3).

4.4 Financial Records

Financial records ensure effective financial management, controls, reporting and compliance with applicable laws. They are necessary for tax-related purposes as required by the Canada Revenue Agency. As with all businesses, registrants who work in private practice or non-publicly- funded settings should maintain an effective and efficient accounting system. This system should include cash records, customer records, supplier records, employee records, capital equipment records and office records. Sales agreements form part of the financial records and registrants who sell supplies or equipment including hearing instruments should be familiar with Policy QA-09 Sale of Supplies and Equipment.

5.0 CONTENT PRINCIPLES FOR CLINICAL RECORDS

Clinical records must be based on the following principles:

- All entries should include the date, name and professional designation(s) of the person documenting the information;
- Documentation should contain accurate, legible, precise and objective information supported by facts;
- Documentation must include all services and interactions with clients;
- Judgment and derogatory remarks should be avoided;
- Records should be clear and proofread to minimize the chances of any ambiguity;
- Records should be concise -- point form is acceptable;
- Correct spelling and common terminology should be used;
- Abbreviations should be refined by writing the term in full first, e.g., therapy (Tx), and subsequently the abbreviation can be used;
- Potentially confusing abbreviations should be avoided, e.g., drug names and administration;
- Counter-signatures are not required for communication health assistants;
- Late entries should be noted as late and include the date and time of the actual event described in the late entry;
- Formal reports should be signed by the registrant who is responsible for the client. Communication health assistants do not write or sign formal reports;
- Only one final version of a formal report or document should exist—modified versions should be considered transitory records and be destroyed appropriately. The same report content in more

than one medium (e.g. electronic and hard copy) is considered one version of a report if the content is identical.

- Reports or documents written by a student must be co-signed by the supervising registrant and noted as "reviewed by" plus a signature and professional designation (e.g., this report has been read and reviewed by J. Doe, RSLP/RAUD/RHIP).

  EXCEPTION: Registration policy *HIP Intern Practicum Requirements* (POL-R-02) 02 states that HIP Interns who meet the education requirements as substantially equivalent and have at least five years dispensing experience from another jurisdiction, may be employed in off-site/remote locations during the fulfillment of practicum requirements under a supervision plan approved by the Registrar. These HIP Interns do not need a co-signature for their reports, audiograms, or verifications.

- If two or more registrants are involved in the provision of care, individual registrants may document and sign for care that they have provided. Alternatively, one registrant can complete the documentation and identify what care was provided by which registrant.

6.0 CORE COMPONENTS OF RECORDS

6.1 Administrative or Business Records

Depending on the nature and size of a private practice, a registrant may be required to maintain some or all these types of business records, including but not limited to:

- personnel and human resource files (including resumes, applications, criminal record checks);
- reference checks;
- performance evaluations;
- disciplinary records;
- registration information;
- benefits, leaves, termination and layoff information;
- student information (including practicum and evaluation information);
- occupational health and safety documents;
- legal documents (e.g., liability insurance, corporate documents, business licenses);
- log books (e.g., mileage and telephone logs);
- fixed assets and capital equipment;
- supply lists
- operational manuals (e.g., emergency procedures).

6.2 Clinical Records

4.2.1 Client Identification

Client identification should include:

- complete name of client or unique identifier on each page of record;
- identification of parents, legal guardian(s) or decision maker(s);
- date of birth;
- client identification number or other identifying process;
- third-party numbers (e.g., Veterans Affairs Canada);
- contact information.

6.2.1 Case History Information

Pertinent case history information must be documented for each client. Case history information must include all related medical and educational information that influences the care and services provided by the registrant (e.g. medications, allergies). This should also include developmental information that is pertinent to the care provided. Information contained elsewhere in a medical chart does not need to be repeated extensively if the registrant information will be part of the same record. The information can be referenced to avoid duplication and repetition of information. Anecdotal information received from a third party (e.g., parent) should be recorded as such in the case history information. Medical diagnoses pertinent to the care and services to be provided should be documented. For long-term clients, medical and related information may need to be updated periodically, particularly if the client's health status has changed in any significant way. Significant relates to any health changes that would positively or negatively affect the client's achievement of their objectives.

6.2.3 Referrals

Referrals to other health care team members should be documented as well as any work outsourced to a clinic, lab or agency. Client refusals of a referral should also be noted.

Referrals received by the registrant should be noted including the reason for referral.

6.2.4 Screening

The outcome of any screening must be documented including the "go forward plan" for any client who does not pass the screening that was administered. The requirements for mass screening events should follow agency policy for that specific event. The plan may vary depending on the clinical context and may include referral(s) for further investigation, an additional screening, a formal assessment etc. Outcomes of mass screening programs should be documented in accordance with agency policy.

6.2.5 Assessment and Diagnosis

The core components of any assessments and diagnostic testing should be recorded, including the outcomes of such testing, any consultation with client/caregivers that occurred and the specific diagnoses, where applicable. Formal results form part of the assessment and diagnoses. Transitory records should be appropriately destroyed (see Disposal of Records) once the formal assessment /diagnosis report is complete. Assessment/diagnostic reports should be recorded as soon as possible following the completion of the session(s). Clients should be notified when they can expect the results, and an explanation of any significant delay should be provided.

6.2.6 Care Plans (Plan of Care), Treatment and Interventions

Depending on the clinical context, the care plan may be a stand-alone plan or may form part of a larger, comprehensive inter-professional care plan for the client. The registrant's portion of the care plan should include but not be limited to the:

- urgency and priority of treatment;
- treatment options and alternatives;
- risks to various treatment options, including those pertaining to no treatment;
- recommendations, instructions and advice provided, together with pertinent client comments;
- discussion of financial implications and payment options;

- information provided about services that are to be provided or augmented by another registrant or by communication health assistants;
- client's decisions in respect of choice of treatment;
- client's informed consent where applicable including consent for services provided by communication health assistants;
- planned schedule of follow-up, reassessment or outcome assessment, depending on the treatment plan;
- objectives of treatment and intervention and expected outcomes;
- changes to the care plan and any associated rationale for the change(s);
- any agreement to assign or delegate services to communication health assistants must be documented by the registrant in the location that is according to agency policy and where a policy does not exist the registrant must document the agreement in the client record.

6.2.7 Progress Notes

Progress updates must be documented for all service provision. Updates should be well- organized, legible, and provide a comprehensive description of the care provided. Participation and progress should be noted for individual service as well as for services involving a group of clients.

Communication health assistants, who are delegated to by a registrant, must chart their notes in the clinical record and must sign the entries with their name and title. Counter signature by the registrant is not required.

Progress notes should include, but are not limited to the:

- date(s) of intervention;
- registrant's name and designation;
- objective that the treatment /intervention relates to;
- outcome of any testing conducted;
- type and quantity of local anesthetic administered (where applicable);
- materials used or provided;
- recommendations, instructions, explanations or advice given to the client;
- changes in client status (positive or negative);
- complications and adverse events, including who was advised of the incident and what options were available to address it;
- proposed follow-up or next intervention planned.
- If office staff are relied upon to document the registrant's chart entries, the registrant is expected to sign or initial each entry after reviewing it for accuracy and completeness. Entries made by dictation must be initialed by both the registrant and the writer.

6.2.8 Equipment Service Records

Calibration and inspection of equipment as per the manufacturer's standards (i.e., daily, weekly, monthly, annually or as required) must be documented in a record that includes the date, service provider and where the service was completed in case future follow-up is required.

6.2.9 Financial Records

The financial records for clients must include:

- a copy of any agreement with the client or representative;
- the date and amount of all fees charged;
- the date and amount of all payments made and method of payment;
- an itemized list of services and supplies provided;
- copies of all claim forms for the client;
- any agreement for payment from a third party;
- statement of the timeline for which an agreement is in effect.

7.0 LOGISTICS FOR CLINICAL RECORDS CONSENT

Informed consent is based on the right of each person to determine what will be done to his or her own body. It is a process that ensures that each client understands the risks and benefits of each treatment or service option presented as well as the costs involved. The client has the right to refuse any service or treatment, to consent to service or treatment and to withdraw consent at any time. The standard for client-centered consent is based on what information does the client reasonably need to know, in the client's position. The information provided is client specific and to be "informed," the information should include the diagnosis or problem noted, the treatment/intervention alternatives available, the risk and benefits of intervention and the estimated cost of each option (if applicable), the nature and purpose of the treatment and the likely consequences of not having the treatment.
Registrants must adhere to the practice standard entitled *Client Consent* (SOP-PRAC-06) and the adopted clinical practice guideline entitled: *Health Care Providers' Guide to Consent to Health Care* (ACPG-12).

7.1 Supervisory Responsibilities

Registrants may have clinical, supervisory responsibilities related to other registrants (e.g., conditional active registrants and advanced certificate applicants), communication health assistants, and students. The clinical supervisor is responsible for overseeing the work others have completed and for ensuring that supervisees have documented appropriately. The clinical supervisor may not necessarily be the supervisee's administrative or reporting supervisor. In some instances, supervisees may have more than one clinical supervisor, for specific clients, during their training period or in the provision of their services. In situations where the clinical supervisor is responsible for signing documents, the supervisor has a responsibility to be familiar not only with the client's case (including their individual needs) but also with their wishes, risks and goals related to the care.

If the registrant who is the author of a report or letter is unavailable to sign the document, a supervisor may sign off and be clear who the report was written by. For example, this report was written by J. Doe, RSLP/RAUD/RHIP and reviewed by J. Smith, RSLP/ RAUD/RHIP.

7.2 Referral Documentation

Referrals to other health care providers or service providers should be documented. Client consent is required to send or provide client information to any third party. Client refusal for referrals should also be noted.

7.3 Timeliness

Any employer or agency policies regarding timing of documentation should be adhered to.

In the absence of such directives, it is imperative that registrants document all required information as soon as possible after the service is rendered. Formal letters or reports should also be completed as soon as possible after the assessment and diagnosis. Clients should be informed of an estimated timeline for the letter or report to be available.

When it comes to preparing clinical documentation, there is no "one-size-fits-all" rule as to what time frame is required in every situation. Ideally, charting should be contemporaneous with the events described. In general, clinical observations and data and records of a treatment should be recorded concurrently with or as soon after the assessment/treatment as possible. As a matter of common sense, the longer the delay in making such records, the less reliable they will be. Some delay in writing up a clinical opinion interpreting those observations and data would not necessarily affect the reliability of the interpretation, provided that the underlying observations and data were recorded contemporaneously and accurately. Even so, delays should not be excessive. It is difficult to imagine a situation in which a delay of months would be acceptable. The degree of urgency for completion of the records could vary depending on the circumstances and is a matter of professional judgment. The factors to be considered would include the client's circumstances, the nature of the assessment/treatment provided, the role that SLP/Audiology/HIP services play in the overall context of the client's care, and the turnaround time requested or expected by the referring source.

7.4 Amendment of Records

Clients have a legal right to request access to personal records that are in the custody or control of a health-care setting, private-sector organization or public body. If clients believe that their personal information contains any errors or omissions, they may request the holder of the information to correct or amend the record. Requests should be made in writing. Registrants must make every reasonable effort to respond within legislated time frames and assist clients with their requests. If the registrant agrees with the change, they should inform the client in writing when the change or amendment has been made. It may be necessary to also inform any third party, who was previously sent the erroneous information, of the corrected information.

Registrants should not make a correction or amendment to a professional opinion or observation made by another health care provider or to a record that was not originally created by the registrant. To complete a correction or amendment, the original information must be maintained in the original form. The corrected entry or amendment should be inserted into the record, indicating the date, name and designation of the registrant making the correction or amendment.

8.0 MAINTAINING THE INTEGRITY OF CLIENT RECORDS AND INFORMATION

8.1 Confidentiality

Information in the health record is considered confidential. Disclosure of information to agency staff for the purposes related to care and treatment is implied upon admission, unless there is a specific exception established by law or agency policy. Client consent is required if the contents of the health record are to be used for research or education and the client can be identified or if any client information is to be transmitted outside the agency. Documentation must be produced according to agency policy when clients request access to their personal records, when CSHHPBC needs to inspect or

investigate records, when a subpoena is provided or if a statutory mandate (e.g., child abuse) requires the release of the information.

8.2 Transmission of Records

Records being transmitted via email must be done so using a secure and confidential system. All identifying information should be removed from the email message. Password protection of electronically transmitted files containing personal information may be considered in situations where one has control over both the sending and receiving end of the electronic exchange. Verify email addresses of intended recipients prior to transmission and request an acknowledgement of receipt of the email and attachments (e.g. reports). Include a confidentiality statement on the email stating that the information is confidential, to be read only by the intended recipient and that emails received in error must be deleted without being read or printed.

Records being transmitted via facsimile must be sent via a secure and confidential system. Registrants should ensure that the recipient is available to retrieve the fax immediately or have made arrangements for secure storage at the receiving end. Verify fax numbers and distribution lists prior to transmission. Include a confidentiality statement on the cover sheet stating that the information is confidential and is to be read only by the intended recipient and requiring that facsimiles received in error must be destroyed without being read.

8.3 Privacy and Sharing of Personal Health Care Information

In general, health care providers assume that a client consents to the disclosure of their personal health information to other care providers, if necessary, for the client's care and treatment (these providers are referred to as being in the client's "circle of care"). Health care providers generally require the client's express consent to disclose personal information to others outside the "circle of care." Registrants can refer to the government bulletin entitled: "Your Privacy and your Personal Health Information".

8.4 Protection of Information on Personal Computers, Laptops, and Mobile Devices

Registrants who store personal information regarding clients on personal computers, laptops, or other mobile devices must ensure that the information is protected if the device is lost or stolen. Privacy statutes impose an obligation to take reasonable measures to guard against unauthorized access to information. Reasonable measure would include password protection using complex passwords, encryption and anti-virus and anti-malware software. In the case of an employing organization, the obligation to implement and enforce appropriate policies rests with the employer who would be considered the designated custodian of the information as designated in privacy legislation.

8.5 Retention of Records

8.5.1 Administrative or Business Records

Agency policy and local policy applies to the retention of business-related records that are not directly related to client care and services.

8.5.2 Clinical Records

For public employees (e.g., hospitals, agencies, schools), primary documents (e.g. reports) and secondary documents (e.g. test protocols) should be kept in accordance with agency policies. In some settings such as community care, public health and mental health settings, the length of time for adults is generally 10 years and for minors for 25 years from the date of last service. Registrants should ensure

that they are aware of their agency's policies regarding retention as some settings (e.g., forensic mental health) may have longer retention periods.

Where record retention policies do not exist, and for registrants involved in private practice, primary client records for adults should be retained for a minimum of 16 years from the last date of service, which is within the new BC *Limitation Act* requirements. Clients have 15 years following service to file a claim or lawsuit. Registrant records may also be requested through a freedom of information request and may also be pertinent in a case involving another health care provider. Secondary records should be kept for a minimum of 6 years following the last date of service.

In the case of minors, where record retention policies do not exist, including private practices, primary records should be maintained for 16 years after the person turns 19. If a person has a disability, records must be kept for 16 years after receiving formal notice that the person's disability has ended. If formal notice is not provided or the disability has not ended, primary records must be kept indefinitely. Records must be retained, even in the event of a client death as the estate may require information related to care and services. Electronic retention of records is acceptable.

> NOTE: It is recommended that records for services prior to June 1, 2013 should be retained for 30 years under the former BC *Limitation Act* provisions.

8.5.3 Equipment Service Records

Records should be retained for 10 years from the date of the last entry.

8.5.4 Financial Records

Records should be retained in accordance with applicable laws such as the Canada Revenue Agency. In general, this is six years from the date of the tax year to which the records apply.

8.5.5 Storage of Records

Reasonable measure to guard against unauthorized access to information is required. Hard-copy client records should be stored in a secure location such as a locked filing cabinet or file room.

Registrants employed by an agency should follow the file-management policies of their employer.

8.5.6 Disposition and Transfer of Records

8.5.6.1 Managing Clinical Files When Closing or Transferring Ownership of a Practice or Clinic

If a practice closes or is transferred to new ownership, the registrant is required to ensure that records are dealt with in an appropriate manner. Records should be transferred, as necessary and with client consent to another registrant. Clients should be given a choice of where they want their records transferred (i.e. another clinic or their home).

If a client requests a transfer to another clinic, for any reason, then records should be sent within two weeks of the request. The originating clinic maintains all original client records.
If the registrant is unable to provide ongoing management or storage of the client records on their own premises, those records should be put into commercial storage for custody. In accordance with the CSHHPBC bylaws, the registrant must notify the Registrar of the practice closure and what steps were taken with the client records.

Disagreements (e.g. payment) are not grounds to withhold the access to or transfer of records. In no instance should a service fee be charged to the client or the receiving clinic, when there is a request to transfer a client record. Any sundry costs related to the transfer (e.g. photocopies) should be documented on a sales agreement (*Sale of Supplies and Equipment* (POL-QA-09)).

8.5.6.2 Disposal of Records

After the appropriate time has elapsed, records should be destroyed. The security and confidentiality of records must be maintained during the disposal process. Generally accepted methods would include shredding, incineration or de-identifying personal and health information on the documents being discarded. A record should be maintained that includes the name of the clients, file number (if applicable), last date of service and date that the record or file was destroyed. The destruction of electronic records must render them unreadable and eliminate the possible reconstruction of the records in whole or in part.

9.0 REFERENCES

Alberta College of Speech-Language Pathologists and Audiologists. *Clinical Practice Guideline: Documentation*. Retrieved from www.caslpa.ab.ca.

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College of Dental Surgeons of BC. Dental Record Keeping Guidelines. Retrieved from www.cdsbc.org.

College of Registered Nurses of BC. Standards of Practice (Documentation). Retrieved from www.crnbc.ca.

College of Occupational Therapists of BC. Documentation. Retrieved from www.cotbc.org

10.0 RELATED CSHHPBC DOCUMENTS

Client Consent (SOP-PRAC-06)
Health Care Providers' Guide to Consent (ACPG-12)
Documentation and Record Management (SOP-PRAC-01)
Use of Communication Health Assistants (SOP-PRAC-04)
HIP Intern Practicum Requirements (POL-R-02)
Sale of Supplies and Equipment (POL-QA-09)

11.0 APPENDIX A

Your Privacy and Your Personal Health Information

Questions and Answers about the Privacy of Personal Health Information and E-health in British Columbia from www.healthinfoprivacybc.ca

What is Personal Health Information?
Personal Health Information is information about an identifiable individual's health and includes information about the individual's health care providers, health numbers (such as care card number) and insurance.

My Personal Health Information is Confidential, isn't it?
Doctors, nurses and other independent health care providers have a duty of confidentiality to their patients. They are under legal and ethical duties to keep their computerized and paper records containing their patients' personal health information secure and protected from unauthorized access, use and disclosure. With a few legal exceptions (discussed below), health care providers need the patient's consent to collect, use or disclose their personal health information. They are allowed to use patient personal health information only for very limited purposes, mainly for providing care and treatment, billing and related administrative purposes.

If health care providers want to use the personal health information of patient for other purposes, such as research, they have to get the patient's consent unless a number of special conditions are met.
Generally, your health care providers will assume you consent to the disclosure of your personal health information to other care providers if necessary for your care and treatment (these providers are referred to as being in your "circle of care").

Health care providers generally have to get your express consent to disclose your information to others outside the "circle of care."
Different laws apply to the government and therefore to the Ministry of Health and to Health Authorities, and the hospitals and clinics they operate.

The Ministry, all health authorities and the hospitals, clinics and agencies they operate also have to keep your personal information secure and make sure that it is not collected, used or disclosed by unauthorized people or for unauthorized purposes. However, the law allows them to authorize the

collection, use and disclosure of your personal information for more purposes than simply giving you care and treatment or related administrative purposes, and in these cases, your consent is not required. These other purposes are sometimes called “stewardship purposes”.

What are “Stewardship Purposes”?
“Stewardship purposes” is a broad term and includes all types of health-system management activities, such as health systems planning, maintenance or improvement; developing, operating, monitoring or evaluating a program authorized under a health law; monitoring or evaluating a hospital or health authority; doing research into health issues; and other similar activities.
Sometimes personal health information will be seen and used in a form that identifies the person (that is, a name or Personal Health Number or other identifier is attached to the information) and sometimes all the identifying information is removed before the health information is used or disclosed for a stewardship purpose, so the information isanonymous.

How is my information collected into the system?
Your health care providers may get information directly from you, and from the other health care providers, hospitals, labs and pharmacies that participate in your care. Sometimes your family members or other people close to you may give some information to your health care providers, if necessary.

What is my information used and disclosed for?
Personal health information is used and disclosed to other health care providers within the patient’s circle of care for the purpose of providing or supporting the provision of care and treatment to the patient.

Depending on the situation, personal health information that is collected by a hospital, clinic, hospital laboratory, diagnostic centre, or specialized government health agency may also be used and disclosed within the health care system for authorized administrative and billing purposes, and for the Stewardship Purposes listed above.

What are E-Health and the Electronic Health Record?
In B.C. today, the government is working on province-wide project called “E-Health”. This is a plan to move from paper files to a wide range of computerized databases and communication tools, so health care can be delivered over distances, and so that patient health information can be accessed more readily by authorized people, for legally authorized purposes.

The major aim of this project is to build a number of special databases to hold certain specific types of health information. Each of these special databases will be a “health information bank” or “HIB”. There will be a HIB to store diagnostic test results, another to store laboratory test results, and still another for prescription information.

In addition, doctors in BC are also being encouraged to move to electronic systems, so that in the future, they will be more able to transmit and access patient personal health information through the system. It is intended that doctors will in the future be connected to the larger e-health system, which will, in turn, also be connected to labs, pharmacies, hospitals, health authorities and the Ministry.

The purpose is to ensure that personal health information about an individual – their ‘electronic health record’ - will be available, as required, to people in the health care system who are legally authorized to see the information.

This system is currently under construction, and the first health information bank has been developed and launched. It is called the Provincial Laboratory Information System or "PLIS". It is intended to hold all diagnostic laboratory test results done in BC, and to provide simple and quick access for authorized health care providers to an individual's lab test results. It is also meant to enable the collection of laboratory information for the purpose of analyzing and managing chronic disease in BC.

Patients are allowed by law to put some limits on who sees their health information in a health information bank by putting a “disclosure directive” on their electronic health record. A “disclosure directive” is an instruction by you about whether or not your information can be disclosed, or to whom, or for what purposes, which you may attach to your electronic record in a particular health information bank.

There are a few steps involved in putting a disclosure directive on the information in a health information bank. You must download the form from the Ministry of Health website or call Health Insurance BC at 604683-7151 in the Lower Mainland or elsewhere in BC: 1-800-663-7100. If you call, a representative on the helpline can answer any questions you may have.

What is PharmaNet?

PharmaNet is a province-wide computerized system for recording all your prescriptions. It holds the record of all prescriptions dispensed from community pharmacies in BC as well as prescriptions dispensed from hospital outpatient pharmacies for patient use at home. Each time a prescription is filled, a drug interaction check is done, and a claim is sent to PharmaCare to determine how much the patient must pay and how much is covered by PharmaCare.

Hospital emergency departments, mental health facilities, the nurses at HealthLink BC, and even some doctor’s medical practices can use PharmaNet to see what drugs the patient is taking, and to record medications provided to a patient.

If you want to, you can check your PharmaNet record from time to time to make sure that it is correct. For information on how to request a copy of your record and to find out who can see PharmaNet information and how to limit access by others to your PharmaNet information, go to www.healthinfoprivacybc.ca and click on PharmaNet, or contact the College of Pharmacists of BC at www.bcpharmacists.org or call 604-733-2440 or 1-800-663-1940.

Who has access to my information?

Access by others to your personal health information is generally based on the person’s role. People providing you with care and treatment may have access to some or all of your personal health information. Others with role-based access to the computerized systems operated by a health authority or the Ministry of Health may have limited access to some portion of your personal health information for management purposes, if necessary for them to do their job.

For example, people working in the pharmacy may have access to the PharmaNet system, so they can see patient information as necessary to dispense medication; lab technicians may need to get access to laboratory or diagnostic information; administrators may have access to computerized systems which hold other types of information for billing or administrative purposes. Sometimes personal information may be gathered for the Ministry of Health to determine how effective a program or service is.

In general, electronic and procedural measures are used to make sure individuals do not access your personal information without having first being properly authorized to do so.

How is my privacy protected?
There are laws that apply to health care providers in the private sector (such as your doctor in her office) and to health care providers in the public sector (such as hospitals, public clinics, laboratories and agencies).

These laws require personal health information to be protected from unauthorized collection, access, use, and disclosure. The security applied to the records must be strong and must include electronic protection (such as passwords and encryption) and rules and procedures (such as approval processes before an employee is allowed onto a system or a part of a system).

Only those individuals who are legally authorized to do so, and who have an authorized purpose for seeing or using the personal health information may access the information. The purpose for the access must also be authorized.

For more information about the laws that protect health information privacy, go to www.healthinfoprivacybc.ca.

What are the legal exceptions to my right of confidentiality?
Certain legal requirements limit your right to total confidentiality in your personal health information. For example, billing and administrative purposes required that certain information must be sent to the Medical

Services Plan (MSP). In some other situations, doctors are required by law to file a report. A report must be made to authoritiesif:

- someone is unable to drive;
- there is suspected child abuse;
- someone is wounded by a gun or knife; or
- someone is a danger to others.

If a patient has one of certain identified communicable diseases, it must be reported to the Centre for Disease Control.

Can I limit who can see my personal health information?
Sometimes it is possible to put limits on who can see your personal health information. Your ability to do this will depend on what type of organization holds the information and whether their system has the technical means to block access. Some hospitals have systems that can put a "flag" on a patient's record to indicate that special instructions or limits apply that record during the person's stay in hospital. Some clinics and laboratories can do the same.

To find out what your health care provider can do to limit access to your health record, ask your doctor or health care provider, or contact the privacy officer of the organization.
Information on how to contact the privacy offices of health authorities, and how to limit access to your personal information in the e-Health system, is listed at the bottom of this brochure.

How can I get access to my personal health information?
You can get access to your personal information in your doctor's records by request to your doctor or her office manager.

You can get access to your personal information in a hospital or health authority's records by contacting the privacy officer of the authority. For a list of privacy officers go to www.healthinfoprivacybc.ca and click on Contact Information for Health Authority Privacy Offices, located under the Home tab.

Where can I find out more?
If you want more information about personal health information privacy, your rights and health providers' obligations in British Columbia, go to www.healthinfoprivacybc.ca

For information about privacy laws in BC and to find out about the Office of the Information and Privacy Commissioner for BC, go to www.oipc.bc.ca

For contact information for health authority privacy offices, go to www.healthinfoprivacybc.ca and look for Contact Information for Health Information Privacy Offices in the Home tab.

For more information about British Columbia's e-health projects, go to http://www.health.gov.bc.ca/ehealth/

To find out how to limit access to your records in PLIS, go to the Ministry of health E-Health page at http://www.health.gov.bc.ca/ehealth/ and click on "Disclosure Directives", or call Health Insurance BC Contact Centre (HIBC) in the Lower Mainland: 604-683-7151; or elsewhere in BC: 1-800-663-7100

This brochure and other information about health information privacy is available at www.healthinfoprivacybc.ca, a website created for the BC Freedom of Information and Privacy Association and funded by the Law Foundation of British Columbia to provide free, non-partisan information about personal health information privacy in British Columbia.

This brochure is part of a public education project of BC Freedom of Information and Privacy Association.

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