ACCREDITATION STANDARDS

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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 Electronic Documents Act* (*PIPEDA*), *Privacy Act*, *Access to Information Act,* BC's *Limitation Act*, and BC's *Freedom of Information and Protection of Privacy Act* (*FIOPPA*).

No.	Description	Reference	Risk	Change
DOC1.2.2				

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 the patient's medical record and a written consent form has been completed and is on file. A "Consent to use electronic communications" form 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 patient's 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	
DOC1.3.4	M	The electronic medical record system indicates any changes in the recorded entry and the identity of the user making the change. *Guidance: Each authorized user has a unique log-in and password, and the system is configured to identify who has accessed the record.*		M	
DOC1.3.5	M	The electronic medical record system preserves the original entry when changed or updated.		M	

No.		Description	Reference	Risk	Change
DOC1.3.6	M	The electronic medical record system automatically backs up files or otherwise provides			

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 necessary to retain the original paper record. If only part of the paper record is transitioned to the electronic system, then the remainder of the paper record must be retained as part of the original medical record. Medical records may be destroyed/deleted when the legal retention period has expired. Medical records must be destroyed using supervised cross-shredding, incineration, or by electronic- erasure of data, including any backup copies of the records. It is recommended that an accredited service provider be hired to destroy patient information maintained in electronic medical records. A wipe utility may not completely erase electronic information.*		M	
DOC1.5		Medical record reviews ensure the integrity of the data and promote quality improvement.			

No.		Description	Reference	Risk	Change
DOC1.6.1	M	Pre-admission documentation includes a current physical exam. *Guidance: The physical exam must include a systems review and full functional inquiry. It may be completed by a family physician, the surgeon or a nurse practitioner, and as appropriate, by an oral surgeon, podiatrist or osteopath. Patients with a BMI greater than or equal to 40 must have had the physical exam completed within 60 days of the surgery. For all other patients, the physical exam has been completed within 90 days of the surgery.*		M	
DOC1.6.2	M	Pre-admission documentation includes a current medical history. *Guidance: The medical history must include indication(s) for surgery, comorbidities, previous surgery, medications, allergies and sensitivities.*			

No.	Description	Reference	Risk	Change
DOC1.6.9				

No.		Description	Reference	Risk	Change
DOC1.6.14	M	Pre-admission documentation includes consultations as appropriate. *Guidance: These include but are not limited to surgeon, anesthesia, cardiology and internal medicine. An in*			

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No.	Description	Reference	Risk	Change

No.	Description		Reference	Risk	Change
DOC1.10.2	M	Sedation record documentation includes height, weight and BMI.		M	
DOC1.10.3	M	Sedation record documentation includes the name and role of each person involved in the IV procedural sedation care.		L	
DOC1.10.4	M	Sedation record documentation includes the name of the surgeon/procedure physician.		L	
DOC1.10.5		Sedation record documentation includes confirmation of the IV procedural sedation safety checks. *Guidance: Safety checks include but are not limited to monitoring equipment, suction equipment, oxygen equipment, emergency cart medication and equipment, and availability of medication reversal agents.*		L	
DOC1.10.6	M	Sedation record documentation includes procedure performed. *Guidance: The procedure performed matches the procedure noted on other procedural records.*		L	
	M	Sedation record documentation includes procedure start and stop times.		L	

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 increase the patient's risk for positioning injury. Patient factors include 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	
DOC1.11.7					

No.	Description		Reference	Risk	Change
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 of elapsed time, and condition of the skin under the cuff before and after tourniquet use.*		M	
DOC1.11.9	M	Intraoperative (nursing) record documentation includes preoperative skin preparation. *Guidance: Skin preparation documentation includes but is not limited to method of hair removal (if performed), name and concentration of antiseptic agent(s) used, any skin reaction (if occurred), and the name of the person performing skin preparation.*		M	
DOC1.11.10	M	Intraoperative (nursing) record documentation includes electrosurgery devices, as indicated. *Guidance: Electrosurgery device documentation includes but is not limited to type of device and serial number, location of dispersive electrode pad placement, cutting and coagulation settings, condition of the patient's skin before placement and removal of dispersive electrode pad, use of safety holster on the sterile field, and (as indicated) patient education if unable and/or refuses to remove jewelry, piercings.*		M	
DOC1.11.11	M	Intraoperative (nursing) record documentation includes laser devices, as indicated. *Guidance: Laser documentation includes but is not limited to type of laser including the fiber and hand piece used, laser parameters/settings, treatment performed, on/off laser activation and deactivation time for head, neck and chest procedures, persons*			

No.	Description		Reference	Risk	Change
DOC1.11.23	M	Intraoperative (nursing) record documentation includes unusual occurrences. *Guidance: This includes any complications, unusual or adverse events and near misses.*		M	REVISED
DOC1.12	The operative report provides an accurate account of the surgery/procedure.				
DOC1.12.1	M	The surgeon makes an operative note in the patient's medical record immediately following the procedure. *Guidance: The operative note includes but is not limited to the type of procedure performed, a description of the surgical findings/complications, and patient outcome. This is documented in the progress notes of the patient's medical record. In addition to making an operative note in the progress notes, the surgeon dictates an operative report that is later filed in the patient's medical record.*		M	
DOC1.12.2	M	The surgeon's operative report includes the preoperative and postoperative diagnoses.		L	
DOC1.12.3	M	The surgeon's operative report includes the date of the procedure(s).		L	
DOC1.12.4	M	The surgeon's operative report includes the exact surgical procedure(s) performed.		M	
DOC1.12.5	M	The surgeon's operative report includes the type of anesthesia.		L	
DOC1.12.6	M	The surgeon's operative report includes the name of 328.55 24.2407 Tr			

No.		Description	Reference	Risk	Change
DOC1.12.11	M	The surgeon's operative report includes any complications.		M	
DOC1.12.12	M	The surgeon's operative report includes the physician's signature. *Guidance: The operative report may be electronically signed.*		L	
DOC1.13		Progress note documentation by physicians provides an accurate account of the patient's status, the actions of health professionals, and the patient's outcomes.			
DOC1.13.1	M	Physicians document their encounters with patients including any assessments, treatments, complications, unusual or adverse events and near misses.			

No.		Description	Reference	Risk	Change
DOC1.14.2	M	PACU record documentation includes a systems assessment upon admission to PACU. *Guidance: The patient is assessed and continually monitored in accordance with the National Association of PeriAnesthesia Nurses of Canada (NAPAN) Standards for Practice, which includes but is not limited to: respiratory – airway patency, airway adjuncts, respiratory rate, breath sounds, oxygen therapy, continuous pulse oximetry monitoring; cardiovascular – continuous cardiac monitoring, blood pressure, pulse rate and regularity; neurological/neurovascular/neuromuscular – level of consciousness, neuromuscular function, neurovascular assessment of distal pulse, sensation, colour, temperature, capillary refill and movement (vascular surgery, limb surgery, back surgery, IV regional anesthetic and axillary nerve blocks), dermatome sensory level (spinal/epidural anesthesia); on admission and as clinically indicated – pain, nausea and vomiting (assessment, management and response to treatment); intake and output – intravenous therapy including location of line(s), condition of IV site(s) and the amount, type and rate of solution(s) infusing, output from tube(s), catheter(s), drain(s) and voiding, as indicated; surgical site, dressings and drains – condition of visible incisions and dressings, drainage tube(s), catheter(s) and drain(s) including type, patency, security, drainage and installations. Also see the NHMSFAP Post-anesthesia Care standard.*		M	

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No.		Description	Reference	Risk	Change
DOC1.16.3	M	Entries are made directly into the patient's medical record at the time care is provided or as soon as possible afterward. *Guidance: Entries are made at the time care is provided or as soon as possible afterward. Entries are not made before providing care or completing an activity. Entries are not made on a transitory record (e.g. scrap piece of paper) for entry in the medical record at a later time.*		M	
DOC1.16.4	M	Late entries include the date			

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. British Columbia Ministry of Health. British Columbia health information standards: gender, sex and sexual orientation (GSSO) health information standard and guidance [Internet]. Version 3.0. Victoria (BC): British Columbia Ministry of Health; 2023 Mar 29 [cited 2023 Aug 04]. 94 p.