

Clinical Record Documentation

Clinical Records

Personal information provided to the Medical Services Plan /Health Insurance BC is collected under the authority of the Medicare Protection Act and is used to determine eligibility for Ministry programs available to residents of BC. This information is protected and accessible under the Freedom of Information and Protection of Privacy Act. It is treated with the utmost confidentiality.

Information submitted by nurse practitioners related the clinical care of an MSP beneficiary is likewise collected under the authority of the Medicare Protection Act and is protected with the same degree of confidentiality and respect.

Documentation of Clinical Records

The College of Registered Nurses of BC's Professional Standards require nurse practitioners to document timely and appropriate reports of assessments, decisions about client status, plans, interventions and client outcomes. Documentation is any written or electronically generated information about a client that describes the care or service provided to that client – and it is an integral part of nurse practitioner practice. Information on documentation and professional and practice standards is available at:

<https://crnbc.ca/STANDARDS/Pages/Default.aspx>

Documentation serves three purposes:

- It facilitates communication
- It promotes safe and appropriate nurse practitioner care
- It meets professional and legal standards.

Additionally, clinical records must support the information submitted to Medical Services Plan /Health Insurance BC for all encounter records, physician referrals, and requests for diagnostic tests.

Information to include in clinical records:

- a. Date and location of the service.
- b. Identification of the patient and the attending practitioner.
- c. Presenting complaint(s) and presenting symptoms and signs, including his/her health history.
- d. All pertinent previous history including pertinent family history.
- e. The relevant results, both negative and positive, of a systematic enquiry pertinent to the patient's problem(s).
- f. Identification of the extent of the physical examination including pertinent positive and negative findings.
- g. Results of any investigations carried out during the encounter.
- h. Summation of the problem and plan of management.

Release of Medical Services Plan /Health Insurance BC Data

The MSP maintains personal data and encounter records for a period of seven years plus current year. Individuals (beneficiaries/patients) may request a copy of their personal data and encounter records from MSP under the Freedom of Information and Protection of Privacy Act. MSP will release personal data and encounter record data to a third party only if the following conditions are met:

- The third party submits a written request for the records,
- MSP is satisfied that the request is appropriate, and
- The release is authorized and accompanied by an authorization or consent form signed by the beneficiary whose records have been requested.

Patient Access to Clinical Records

In June 1992, the Supreme Court of Canada made a judgment regarding office medical records. While recognizing the practitioner's ownership of the clinical records, the case judgment states that the information in those records belongs to the patient and that the patient has a right to access that information upon request.

The ruling means that patients have the right to read and copy the information contained in their medical files, including material in the files from other practitioners but excluding medical legal correspondence and independent medical examinations. In practical terms, it is advisable to provide the requesting patient with photocopies of the contents of the medical record to ensure that the original office medical record remains intact.

The practitioner may refuse the patient access to the office clinical record if it is the practitioner's judgement that the information may cause harm to the patient or to an innocent third party. Nurse practitioners are advised to become familiar with the freedom of information and protection of privacy policies of the health authorities or other agencies in which they are employed. Requirements for patient record keeping is found in CRNBC's Bylaws Section 7: <https://crnbc.ca/crnbc/Documents/CRNBC%20Bylaws.pdf>

Records Retention

Under the Health Professions Act, nurse practitioners must retain medical/clinical records for a period specified by the appropriate regulatory body and their employer.