	POLICY Number: 7311-20-002 Title: Clinical Health Record Form Standards
Authorization [ ] President and CEO [X] Vice President, Finance and Corporate Services	Source: Director, eHealth and Health Information Cross Index: 7311-50-005, 7311-60-004, 7311-75-005 Date Approved: December 2001 Date Revised: December 16, 2016 Date Effective: December 19, 2016 Date Reaffirmed: Scope: SHR

OVERVIEW

The Health Information Protection Act governs collection of personal health information.

DEFINITIONS

All Staff means SHR employees, practitioner staff, professional staff and students.
Clinical Health Record Form means a record or document developed with the primary purpose being collection of personal health information for the purposes of a program, activity or service of SHR that can reasonably be expected to benefit the individual.[1] For more information regarding permanent records and non-permanent records, see SHR Policy: *Retention of Personal Health Information*.

Clinical Health Record Forms Committee (CHRFC) is an oversight Committee for review and approval of all new, revised, and trial clinical forms.

Owner/Sponsor is the department/unit leader such as Manager, Practice Leader, or Director responsible for ensuring the clinical form is compliant with this policy and procedure.

Personal Health Information (PHI) means, with respect to an individual, whether living or deceased[2]:
(i) Information with respect to the physical and mental health of the individual;
(ii) Information with respect to any health service provided to the individual;
(iii) Information with respect to any body part or bodily substance donated by the individual;
(iv) Information with respect to any body part or bodily substance of the individual;
(v) Information collected in the course of providing health services to the individual;
(vi) Information collected incidentally to the provision of health services to the individual;
(vii) Registration information (e.g. demographic information).

[1] HIPA 24(1)
[2] HIPA 2(m)

Record means record of personal health information in any form and includes information that is written, photographed, recorded, digitalized or stored in any manner.

1. PURPOSE

The purpose of this policy is to establish Saskatoon Health Region's (SHR's) standards for development and approval of new and revised permanent Clinical Health Record Forms.

2. PRINCIPLES

2.1 SHR collects PHI and takes reasonable steps to ensure that the information is accurate and complete.[3]

2.2 SHR promotes the standardization and consolidation of permanent Clinical Health Record Forms.

2.3 SHR is committed to automating Clinical Health Record Forms and processes in order to advance the Electronic Health Record (EHR).

3. POLICY

3.1 Clinical Health Record Forms developed to collect PHI must be developed in accordance with *HIPA* and this policy and procedure.

3.2 The primary purpose for collecting PHI must be for the benefit of the patient/client/resident and collection shall be limited to only what is needed for a purpose.[4]

3.3 Every effort must be made to consolidate new and revised forms across sites and among providers.

3.4 Staff responsible for Clinical Health Record Form development must ensure compliance with any copyright restrictions that may apply to the use of materials as defined by Canadian Copyright law and as outlined in *SHR Policy: Copyright*.

3.5 All new Clinical Health Record Forms require concept approval from the CHRFC.

3.5.1 All revised forms are approved by the desktop publisher on behalf of the CHRFC.

3.5.2 Order Sets must be approved in accordance with SHR Policy: *Ordering of Medications.*

3.5.2.1 Clinical Health Record Forms that contain information related to medications must be reviewed by Pharmacy.

[3] HIPA s.19

[4] Saskatchewan Ministry of Justice and Attorney General, Information Management Handbook

3.6 Content of all Clinical Health Record Forms must be reviewed for clinical best practices and relevancy by the form owner.

3.6.1 SHR staff must conduct regular maintenance reviews every five years or sooner of Clinical Health Record Forms used by departments/units to ensure content remains current and relevant across the lifecycle of all clinical forms and to ensure best practice in collection of patient/client/resident health information for the provision of safe and quality patient/client/resident care.

4. ROLES AND RESPONSIBILITIES

4.1 Form Owner/Developer or Designate

4.1.1 Develop the content of new or revised forms in consultation with all affected stakeholders using the *Standards for Development of Clinical Health Record Forms* prior to submission to the CHRFC for approval.

4.1.2 If the form contains copyrighted materials, ensure a copy of the written permission accompanies the request for the new form.

4.1.3 Ensure documentation of stakeholder consultation.

4.1.4 Develop work standards for use of the new form and share with all users for comments prior to the approval process.

4.2 Managers or Directors

4.2.1 Sign the Application/*Requisition for Approval of Clinical Health Record Forms* as sponsor and owner in support of the development/revision of the new/revised clinical health record form.

4.2.2 Each department/unit Manager or designate maintains an accessible hardcopy inventory of all applicable Clinical Health Record Forms in the event of system downtimes.

4.3 Clinical Health Record Forms Committee

4.3.1 Develop and maintain clinical health record form standards.

4.3.2 Review and approve all clinical forms that are retained on the permanent health record.

4.3.3 Ensure that all forms are formatted, according to the Standards for Development of Clinical Health Record Forms (see Appendix A), categorized, assigned a form number and date entered into the clinical health record forms inventory database maintained by the Desktop Publisher(s).

4.3.4 Confirm forms containing copyright material have written permission enclosed with the form requisition to ensure compliance with Canadian Copyright law and *SHR Policy: Copyright*.

4.3.5 The CHRFC communicates to the organization and educates staff/departments/ units regarding creation and revision of Clinical Health Record Forms.

4.3.6 Establish processes to ensure forms are initiated for review every five (5) years.

5. POLICY MANAGEMENT

The management of this policy including policy education, monitoring, implementation, and amendment is the responsibility of the Clinical Health Record Forms Committee and the Director, eHealth and Health Information.

6. NON-COMPLIANCE/BREACH

Non-compliance with this policy may result in disciplinary action up to and including termination of employment and/or privileges.

7. REFERENCES

Information Management Handbook, Saskatchewan Ministry of Justice and Attorney General
The Health Information Protection Act, Saskatchewan
SHR Policy: Copyright
SHR Policy: Retention of Personal Health Information
SHR Policy: Ordering of Medications

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1. PURPOSE

The purpose of this procedure is to establish the processes for development, revision, approval, and implementation of permanent Clinical Health Record Forms (see SHR Policy: *Retention of Personal Health Information* for definition of permanent record forms).

2. PROCEDURE

2.1 NEW Clinical Health Record Form:

2.1.1 Prior to form development, complete the *Application for Development of a New Clinical Health Record Form* and submit it as per the instructions on the application form).

2.1.2 The Clinical Health Record Forms Committee reviews the request for approval of new clinical forms at the monthly meeting. The Committee considers the request and may request further clarification, or approval will be granted to proceed to form development.

2.1.3 Refer to the Clinical Documentation InfoNet site for information regarding the development of Clinical Health Record Forms: Standards for Development of Clinical Health Record Forms (Appendix A).

2.1.4 Contact the SHR Desktop Publisher at clinicalforms@saskatoonhealthregion.ca to do a search of the clinical forms database to determine if similar forms exist.

2.1.5 Consult with all clinical departments, units, and form users impacted prior to beginning the development process regarding the reason and/or purpose for development and the anticipated implementation date of the new form.

2.1.6 Determine the content of the clinical health record form in consultation with all affected departments, units, disciplines, and clinicians with the goal being to reduce the number of similar forms.

2.1.7 Ensure compliance with any copyright restrictions that may apply to the use of materials as defined by Canadian Copyright law and outlined in *SHR Policy: Copyright*.

2.1.8 Contact Pharmacy for any new forms that include reference to the ordering, preparation and administration of medications.

2.1.9 Trial forms are approved for a maximum of 2-4 months for development and evaluation (see Health Records Work Standard: Trial Clinical Health Record Forms).

2.2 REVISED Clinical Health Record Form:

2.2.1 Refer to the Clinical Documentation InfoNet site for information regarding the revision of clinical health record forms: *Standards for Development of Clinical Health Record Forms* (Appendix A).

2.2.2 Contact the SHR Desktop Publisher at clinicalforms@saskatoonhealthregion.ca to do a search of the clinical forms database to determine if similar forms exist.

2.2.3 Consult with all clinical departments, units, and form users impacted prior to beginning the revision process regarding the reason and/or purpose for re-development and the anticipated implementation date of the revised form.

2.2.4 Determine the content of the clinical health record form in consultation with all affected departments, units, disciplines, and clinicians with the goal being to reduce the number similar forms.

2.2.5 Ensure compliance with any copyright restrictions that may apply to the use of materials as defined by Canadian Copyright law and outlined in *SHR Policy Copyright*.

2.2.6 Contact Pharmacy for any revised forms that include reference to the ordering, preparation and administration of medications.

2.2.7 Trial forms are approved for a maximum of 2-4 months for development and evaluation (see Work Standard – Trail Clinical Health Record Forms)

2.2.8 Complete the requisition to revise a clinical health record form and submit it as per the instructions on the requisition form (see *Requisition for Approval of a Revised Clinical Health Record Form*).

3. PROCEDURE MANAGEMENT

The management of this procedure including procedure education, monitoring, implementation, and amendment is the responsibility of the Clinical Health Record Forms Committee and the Director, eHealth and Health Information.

4. NON-COMPLIANCE/BREACH

Non-compliance with this procedure may result in disciplinary action up to and including termination of employment and/or privileges.

5. REFERENCES

SHR Policy Copyright
SHR Policy Ordering of Medications
SHR Policy Retention of Personal Health Information

6. SUPPORTING DOCUMENTS (also accessible from *Clinical Documentation InfoNet Site*)

Standards for Development of Clinical Health Record Forms (Appendix A)
Application for Development of a New Clinical Health Record Form
Requisition for Approval of a Revised Clinical Health Record Form
Work Standard: Trial Clinical Health Record Form