Team Name: Health Information Services Team Lead: Manager Health Information Services Approved by: Regional Lead – Corporate Services & Chief Financial Officer	Reference Number: ORG.1410.PL.001 Program Area: Health Information Services Policy Section: Health Information
Issue Date: October 19, 2022 Review Date: Revision Date:	Subject: Client Chart (Health Record) Order

Use of pre-printed documents: Users are to refer to the electronic version of this document located on the Southern Health-Santé Sud Health Provider Site to ensure the most current document is consulted.

*Words in **bold** can be found in the definitions.

POLICY SUBJECT:
Client Chart (Health Record) Order

PURPOSE:
Standardization of the **client chart** (health record) order enhances patient safety and mitigates risk, providing optimum communication of client information and creating efficiencies in an environment of shared services.

BOARD POLICY REFERENCE:
Executive Limitation (EL-2) Treatment of Clients

POLICY:
Acute, Home Care and Personal Care Home (PCH) programs follow a standardized approach to the organization of chart forms and documents that comprise **client charts** from the point of admission to post discharge.

DEFINITIONS:
Chart divider – a polyethylene sheet with a pre-labelled tab that has been assigned a specific color. A **chart divider** is used to group and organize similar document types in the **client chart** in the clinical area/program.
Chart divider set – a series of **chart dividers** in a defined order to be used with the **client chart** in a clinical area/program.
Client – a recipient of health services, which may be called a client, patient or resident.

Client chart – refers to the client health record used in the clinical area/program i.e. Acute Care, Home Care, and PCH. Upon discharge, the **client chart** may be referred to as the 'Health Record' for Health Information purposes.
Chart order – An organization of **client chart** documents established by the use of a **chart divider** set.

PROCEDURE:

1. **Client charts** are maintained in accordance with the order outlined in the following supporting documents:
   - Client Chart (Health Record) Order – Acute Care (ORG.1410.PL.001.SD.01)
   - Client Chart (Health Record) Order – Home Care/Nursing (ORG.1410.PL.001.SD.02)
   - Client Chart (Health Record) Order - Home Care/Case Coordinators (ORG.1410.PL.001.SD.03)
   - Client Chart (Health Record) Order – PCH and Transitional Care Centres (ORG.1410.PL.001.SD.04)

2. Place/stamp a correct label in the top right-hand corner of the document only, for one-sided documents. Place/stamp label in the top right-hand corner on both sides of the documents for two-sided documents. Ensure no other information on the document is covered by the label/addressograph stamp. Ensure documentation belongs to the correct **client chart**.

3. Documents filed under each **chart divider** in the **client chart** in the clinical area/program are grouped and maintained as follows:
   - In Acute Care and PCH, documents are maintained in chronological order on the Units except for Prescriber Orders are maintained in reverse chronological order. In Acute Care on discharge, Health Information Services staff places Prescriber Orders in chronological order.
   - A clear plastic sleeve is placed in the front of the **client chart** in Acute Care to accommodate items waiting for response
   - In Home Care, documents are maintained in reverse chronological order.

4. The nursing manager/supervisor or designate:
   - Ensures implementation and maintenance of this policy at their respective sites/units.
   - Where problems are identified, communicate issues to the respective programs for resolution.
   - Conduct audits to monitor compliance with this policy.

5. Programs will audit compliance with the **chart order** annually or if problems are identified, use the corresponding audit tool:

- Client Chart (Health Record) Order Audit Tool – Acute Care (ORG.1410.PL.001.FORM.01)
- Client Chart (Health Record) Order Audit Tool – Home Care/Nursing (ORG.1410.PL.001.FORM.02)
- Client Chart (Health Record) Order Audit Tool – PCH and Transitional Care Centres (ORG.1410.PL.001.FORM.03)

6. Thinning of documents from paper-based **client charts** are outlined in Thinning of Documents from Client Charts in Clinical Areas/Programs (ORG.1410.PL.005) policy.

7. In Acute Care, when the **client chart** is no longer required for providing active care (discharged), remove the documents from each **chart divider** section. Ensure the record sequence is verified, and that all documents belong to the client and are appropriately labeled/embosser stamped. Retrieve any documents not maintained with the **client chart** and place in appropriate sequence order. Deliver to the designated storage area (health record department) promptly.

SUPPORTING DOCUMENTS:

ORG.1410.PL.001.FORM.01	Client Chart (Health Record) Order Audit Tool – Acute Care
ORG.1410.PL.001.FORM.02	Client Chart (Health Record) Order Audit Tool – Home Care/Nursing
ORG.1410.PL.001.FORM.03	Client Chart (Health Record) Order Audit Tool – PCH and Transitional Care Centres
ORG.1410.PL.001.SD.01	Client Chart (Health Record) Order – Acute Care
ORG.1410.PL.001.SD.02	Client Chart (Health Record) Order – Home Care/Nursing
ORG.1410.PL.001.SD.03	Client Chart (Health Record) Order – Home Care/Case Coordinator
ORG.1410.PL.001.SD.04	Client Chart (Health Record) Order – PCH and Transitional Care Centres

REFERENCES:

WRHA policy 75.00.040 Standard Inpatient Chart (Health Record) Order August 2016
Prairie Mountain Policy PPG-00206 Clinical Documentation Standards-Guidelines for the Management of the Open Paper Health Record- Appendix D
ORG.1410.PL.005 - Thinning of Documents from Client Charts in Clinical Areas/Programs