Team Name: Health Information Services Team Lead: Regional Manager Health Information Services Approved by: Vice President Corporate Services	Reference Number: ORG.1410.PL.007 Program Area: Health Information Services Policy Section: Health Information
Issue Date: January 9, 2017 Review Date: Revision Date:	Subject: Management of Electronic Health Information System Printouts

POLICY SUBJECT:
Management of Electronic Health Information System (EHIS) Printouts.

PURPOSE:
To promote the use of Electronic Health Information Systems as reference tools for client information.

To eliminate filing, scanning and retention of redundant information printed from Electronic Health Information Systems in paper-based and/or electronic health records.

To promote use of hybrid health records by health care providers.

BOARD POLICY REFERENCE:
Executive Limitation (EL-2) Treatment of Clients
Executive Limitation (EL-7) – Corporate Risk

POLICY:
1. When using Electronic Health Information Systems (EHIS), including eChart, providers are discouraged from printing and making entries on printouts as these printouts will **not** be considered part of the site or program health Record. An audit report of the person who accessed and the report content at the time of access is available upon request.

2. When clinically relevant documentation is required based on the EHIS information accessed, the documentation is recorded in the client's paper-based health Record or electronic Record (i.e. Integrated Progress Note, Med Reconciliation form, etc.) and **not** on the EHIS printouts.

DEFINITIONS:
eChart - also known as eChart Manitoba shared service, is a key component of the electronic health record available across Manitoba. eChart is a secure, Electronic Health Information System that connects authorized health care providers with a summary of a client's Personal Health Information from several disparate provincial systems, such as drug prescriptions that have previously been filled, immunization histories, and diagnostic and lab reports from participating organizations. This Access is provided to support direct client care.

Electronic Health Information Systems (EHIS): Refers to regional (i.e. Salumatics) and provincial (i.e. Clin Doc, SIMS, Procura, eChart Manitoba, DPIN, EDIS, Panorama, etc.) systems where health care providers obtain client Personal Health Information electronically.

Health Record - personal health information compiled by individuals authorized to make entries on approved health record forms and maintained by facilities, sites or programs of Southern Health-Santé Sud as the official record of health care provided. Health records, including electronic and paper-based health records, are the physical property of a facility, site or program of Southern Health-Santé Sud. For the purposes of this policy, Health Records include clinical records as defined in The Mental Health Act.

Hybrid Health Record - an accumulation of client information for an Individual that is stored in a combined paper-based and electronic format within a site or program. The hybrid health record exists during the transition from a paper-based health record to an electronic patient record (EPR) or electronic medical record (EMR).

Transitory/Working Record: Documents of short-term use and significance containing Personal Health Information and not considered part of the Record post discharge i.e. Kardex, DPIN and eChart printouts. Personal Health Information in this category may include raw data that is used to create primary documents. Transitory records are destroyed at the end of each episode of care.

PROCEDURE:

1. Health Care Provider responsibilities:
   - Whenever possible, view information directly in the Electronic Health Information System viewer and refrain from printing.
   - Document clinically relevant entries pertinent to the decision making process during the provision of care in the client's paper-based Health Record or electronic record (i.e. Integrated Progress Note, Med Reconciliation form, etc.).
   - Do **not** make entries on the printouts with the expectation that they will be filed on paper-based Health Records or scanned into electronic systems.
   - It may be necessary to print from an Electronic Health Information System; for example, when
     - The access to the Electronic Health Information System is not in the location where the client is being seen,
     - A unit has limited computer access. In these cases, information may be printed by someone other than the person actually reviewing the document.
     - The Physician Clinic requires the documents to be scanned into their EMR to allow trending i.e. of lab results.
     - A printout of the information is required to attach to other forms i.e. Personal Care Home (PCH) application forms.
   - When it is necessary to print from an Electronic Health Information System; the printouts are considered Transitory/Working Records and are destroyed at the end of each episode of care.

2. Health Information Services Department responsibilities:
   - Place all Electronic Health Information System printouts received post discharge into confidential waste for shredding.

REFERENCES:

WRHA HIS-RG-8 Management of eChart Printouts 2013
Prairie Mountain Health Management of Printouts from Electronic Health Information Systems 2015