University Health Network Policy & Procedure Manual
Administrative: UHN Medical Record of Personal Health Information

Policy

University Health Network (UHN) ensures that a system is established for the keeping of a record of personal health information for each patient. At UHN, records of personal health information are comprised of both electronic information and paper documents. Paper components of the UHN record of personal health information may be scanned and the original paper documents destroyed in accordance with section 20 of the Public Hospitals Act (Regulation 965). The electronic chart, including scanned documents, is deemed source documentation for research and legal purposes.

UHN endeavours to maintain an accurate and secure medical record, in compliance with both the Public Hospitals Act and the Personal Health Information Protection Act. Patient access to the medical record is governed under Patient Access to the Medical Record policy 1.40.003.

Records originating and stored in private offices within UHN are not considered a part of the UHN record of personal health information. This standard is applicable in situations where the physician is not acting for, or on behalf of, UHN, regardless of whether or not the clinician is employed or remunerated by UHN, and is distinguished by the patient having no MRN to indicate they are registered at UHN. These records and associated information management practices are the responsibility of the clinician and independently subject to provisions of the Personal Health Information Protection Act.

Systems without inbound and outbound interfaces to e-gate are not part of the UHN medical record, although they contain personal health information that must be kept confidential and secure, in accordance with the Personal Health Information Protection Act and UHN policies on privacy and confidentiality.

Data Quality, Accuracy & Integrity

UHN takes all reasonable steps to ensure the quality, accuracy, and integrity of the UHN medical record. This includes verifying demographic and clinical information with patients, running quality assurance audits, and allowing access to the medical record by independent third parties, as outlined in contract or systems’ reviews.

UHN is also responsible for the quality, accuracy, and integrity of user information related to the UHN medical record, including the construction of user profiles and access privileges.
Custodians of record holdings located in a clinician’s private office that are not part of the UHN medical record are responsible for the quality, accuracy, and integrity of personal health information under their custody or control.

**Data Privacy, Confidentiality & Security**

All system owners, administrators, and users are subject to UHN policies on privacy, confidentiality, and security of personal health information, whether or not such information is part of the UHN medical record. (Also refer to Privacy policy 1.40.007.)

Patients’ paper charts must be destroyed in accordance with Storage, Transport & Destruction of Confidential Information policy 1.40.006, the requirements laid out in the Public Hospitals Act (Regulation 965, Sec. 20), and in the Health Canada Regulations amending the food and drug regulations (1024 – Clinical Trials, C.05.012, Sec. 4).

**Data Copying & Linkages with the UHN Medical Record**

Since UHN assumes responsibility for the quality, accuracy, and integrity of personal health information in the UHN medical record only, data from other systems or databases cannot be copied and uploaded into the UHN record of personal health information without approval from the vice-president & chief information officer (VP & CIO).

Similarly, data from the UHN medical record cannot be copied into any system or database that is not part of the UHN record of personal health information without approval from the VP & CIO (or a delegated committee).

In cases where there is a discrepancy about the quality, accuracy, or integrity of data in the UHN medical record and copies of other personal health information, the UHN medical record will stand as the official record.

**Retention of the UHN Medical Record**

Records are retained for as long as necessary to serve the purpose for which the information was collected, and for the minimum duration described below:

- In the case of a patient who is eighteen years of age or older, for at least 15 years after the date of discharge, last visit, or death.

- In the case of a patient who is under eighteen years of age, for at least 15 years after the 18th anniversary of the birth of the patient.

If, before the end of a period described above, UHN receives notice of a court action or of an investigation, assessment, inspection, inquest, or other inquiry referred to below...
relating to the treatment of a patient at UHN, UHN shall retain the applicable records until:

- in the case of a court action, the action is finally disposed of
- in the case of an investigation, assessment, inspection, inquest, or other inquiry referred to below, it has been completed and any subsequent hearing is finally disposed of; or
- in the case of an access request under section 53 of the Personal Health Information Protection Act, 2004, for as long as necessary to allow the individual to exhaust any recourse under that Act that they may have with regard to the request

The above applies if UHN receives notice of the following:

- An investigation, assessment, inspection, or other inquiry by a committee of a College of a health profession set out in Schedule 1 to the Regulated Health Professions Act, 1991.
- An inspection by the Medical Review Committee or by a practitioner review committee under the Health Insurance Act.
- An investigation or inquest by a coroner under the Coroners Act.
- An access request under section 53 of the Personal Health Information Protection Act, 2004.

In the case where the medical record is a source document relating to a clinical trial, the medical record is retained for 25 years in accordance with section C.05.012 of the Health Canada Food & Drug Regulations (1024 – Division 5 Drugs For Clinical Trials Involving Human Subjects).

**Custody of UHN Medical Record**

UHN, the Public Hospitals Act and the Personal Health Information Protection Act require that the original inpatient and ambulatory record of personal health information remain within Hospital control. The department or area where the chart resides is responsible for the care and control of the chart and must be aware of the specific location of each chart. At no time may the original inpatient or outpatient medical record leave Hospital property (except as required by law or as authorized by UHN policies regarding off-site storage).

While some charts may reside in centralized Health Record Services or in clinics, Health Records Services may facilitate locating and releasing information contained in the chart. All releases of information contained in the chart must be documented in the patient chart including what was disclosed, to whom, and for what reason in compliance
with the Personal Health Information Protection Act, Release of Patient Information policy 1.40.002, and Patient Access to the Medical Record policy 1.40.003.

If a record is moved to another location other than that to which it is issued, Health Records Services, the clinic, inpatient unit, or emergency department responsible for the care and control of the chart must be informed immediately. Medical records kept overnight or longer must be stored in a secure location that is not accessible to unauthorized staff or the public but which is accessible to Hospital security for urgent patient care.

**User Access**

Access to the UHN medical record is provided on a need-to-know basis as appropriate to the individual’s role and purpose for access. Access for the purposes of an approved research study is subject to the policies and processes of the UHN Research Ethics Board. As a guideline, the collection, use and disclosure of personal health information for research purposes must be approved by the UHN Research Ethics Board regardless of whether the information being requested is from an individual researcher, organization, government department/agency, or members/employees of UHN.

System owners/administrators of personal health information, whether or not such information is part of the UHN medical record, are responsible for administering access to and disclosure of personal health information in accordance with UHN policies on privacy, confidentiality and security and applicable privacy legislation.

**Patient Access**

Patients wishing to access their own personal health information contained in the UHN record of personal health information may request a copy of their health record in writing or in-person at the appropriate UHN Health Records Department, Medical Imaging Department, or departmental clinic in accordance with Patient Access to the Medical Record policy 1.40.003.

Patients may also contact their physician or care provider directly for access to their personal health information and to ask questions about any information contained in their record.

Patients will be provided with the information contained in the systems (both paper and electronic) outlined in the UHN record of personal health information definition.

Where a patient requests access to personal health information that is not part of the UHN record of personal health information, the Health Records Department will forward the request to the appropriate clinician’s private office, where possible.
Technical Support

UHN provides hardware, software, and database support for information systems that are part of the UHN medical record.

For information systems that are not part of the UHN medical record, UHN provides hardware support only (no software and database support).

Scope of Application

This policy applies to all UHN employees, physicians, students, residents, part-time or temporary staff, researchers, volunteers, and other authorized UHN agents, such as contract workers, office administrative staff, or consultants.

Breach of Policy

A violation of this policy may result in the suspension or permanent removal of a user’s system access privileges. More serious breaches may result in disciplinary action up to and including termination of employment and/or affiliation with UHN and fines in accordance with the provisions of the Personal Health Information Protection Act ($50,000 for individuals, $250,000 for the organization).

For research purposes, the UHN Research Ethics Board may suspend or permanently remove the access of researchers or research groups to the UHN Research Ethics Board and their ability to conduct research at UHN or its affiliates.

Definitions

**Personal Health Information**: Information about an individual whether living or deceased and whether in oral or recorded form. It is information that can identify an individual and that relates to matters such as the individual’s physical or mental health, the providing of health care to the individual, payments or eligibility for health care in respect of the individual, the donation by the individual of a body part or bodily substance and the individual’s health number (Personal Health Information Protection Act, 2004, section 4.1).

Personal health information can be information about a physician or other care provider, a Hospital staff person, a patient, or a patient’s family member. Examples of personal health information include a name, medical record number, health insurance number, address, telephone number, and personal health information related to a patient’s care such as blood type, x-rays, consultation notes, etc.
Record of Personal Health Information: The Personal Health Information Protection Act defines a record as personal health information in any form or in any medium whether in written, printed, photographic or electronic form or otherwise. Furthermore, any information in a health record under the custody or control of the UHN Health Records Department and departmental clinics (as per the Public Hospitals Act, Regulation 965, Sec. 20.3), includes, but is not limited to:

- patient name, medical record number, health insurance number, address, telephone number
- all the names of clinical staff involved in the patients care, films, slides, diagnoses, discharge summaries, progress notes, transcribed reports, orders, consents, electronic images and photographs
- any information that has been scanned, the electronic copy (scanned version) is the official copy or source documentation for patient care and research purposes
- any information and/or medical images in e-film or the Picture Archiving and Communication System (PACS)
- any information in the UHN Clinical Desktop, including information from other systems with an inbound and outbound interface to e-gate
- any information in other UHN clinical systems that are integrated into the UHN clinical desktop, including, but not limited to, Horizon Patient Folder and MUSE (ECG management system)