HRSC 206 - Patient Record Fundamentals

Course Description:
This course introduces learners to the organization, structure and chart management functions of a patient health record. The policies for record completion, security, numbering, filing, storage, retention and disclosure of information will also be covered.

1.5 Credits

Time Guidelines:
The standard instructional time for this course is 22 hours.

Course Assessment:

Assignments	25%
Exams	75%
Total:	100%

Other Course Information:
The School of Health and Public Safety (HPS) expects that students familiarize themselves with policies, procedures, and guidelines that are applicable to SAIT, HPS, and their program of study. All students should explore institutional, school, and program-specific information on sait.ca in order to ensure they are informed with regards to relevant policies, procedures, and guidelines.

School of Health and Public Safety Attendance Guideline:

The School of Health and Public Safety (HPS) has expectations, consequences, and processes for excused and unexcused absences. The entire Attendance Guideline may be found on the HPS program orientation requirements resources website. This document is located under the General Resources section found on your Program page. **Students are expected to review the entire Attendance Guideline.** Students should also take note of the attendance expectations shown below.

Attendance Expectations:

Students in the School of Health and Public Safety are expected to achieve 100% attendance for scheduled classes, and to participate in all learning activities. There is a positive correlation between attendance, participation, and grades. Attendance is required to achieve the necessary knowledge, skills, and abilities while attending both SAIT and workplace-integrated learning experiences, in order to become a successful, well-rounded, and job-ready Allied Health graduate. Failure to keep up with course work and/or repetitive and cumulative absences will result in a formal review of a student's progress.

SAIT Policies and Procedures:
For information on the SAIT Grading Scale, please visit policy AC 3.1.1 Grading Progression Procedure, found on the SAIT Academic Policies and Procedures page: https://www.sait.ca/about-sait/administration/policies-and-procedures

For information on SAIT Academic Policies, please visit: www.sait.ca/about-sait/administration/policies-and-procedures /academic-student

Optional Reference Publication(s):
Thompson, V. (2021). *Administrative and Clinical Procedures for the Canadian Health Professional* (5th ed.). Toronto, ON: Pearson Canada.

Course Learning Outcome(s):
1. Describe the purpose, contents and management of health information in both the medical office and hospital settings.

    Objectives:

        1.1 Describe the purpose of a medical record.

        1.2 Identify the components of a medical record.

        1.3 Create a medical form designed to collect client information.

        1.4 Explain the administrative responsibilities related to registering a client in a hospital setting.

        1.5 Describe the components of the health record used in the hospital setting.

        1.6 Describe panel identification and management within the Alberta context.

        1.7 List screening maneuvers related to panel management.

        1.8 Create a screening outreach script related to panel management.

        1.9 Describe the life cycle of a client record.

2. Select the most appropriate filing method for a particular clinical environment.

    Objectives:

        2.1 Explain the need for an identification system for both paper and electronic client records.

        2.2 Explain the alphabetical filing system for chart organization.

        2.3 Explain the consecutive numeric and terminal digit filing systems for chart organization.

        2.4 Explain the purpose of color coding on file folders.

        2.5 File charts according to the alphabetical and terminal digit filing principles.

3. Explain how paper charts are filed in a clinical environment.

    Objectives:

        3.1 Describe the function of file folders.

        3.2 Describe the management of paper charts in an electronic environment.

        3.3 Describe the use and location of temporary filing space.

        3.4 Demonstrate proper filing procedures.

4. Describe client record storage solutions for various clinical environments.

    Objectives:

4.1 Outline the structure of computerized record keeping.

4.2 Explain the purpose of archiving client information.

4.3 List options for archiving client records.

4.4 Explain the procedures for archiving.

4.5 Differentiate between centralized and decentralized systems of storage.

5. Differentiate between the authorized and unauthorized access to, and disclosure of, client information.

Objectives:

5.1 Differentiate between privacy, security and confidentiality in relation to client care.

5.2 Summarize the legislation applicable to safeguarding client information.

5.3 Identify the legislation that governs retention periods.

5.4 Explain the practice of permitting access to client records in a multiple physician group practice.

5.5 Explain the rules for exchange of medical information between medical practitioners.

5.6 Outline the mandatory provincial reporting requirements.

5.7 Identify the guidelines for client access to his/her chart.

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