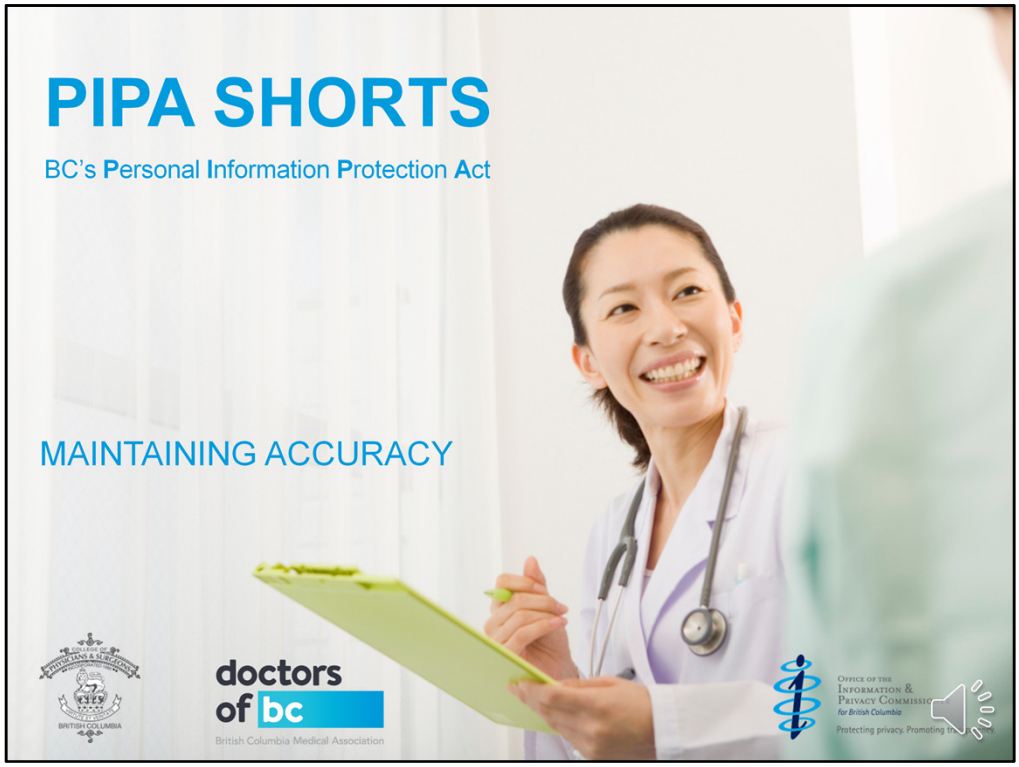
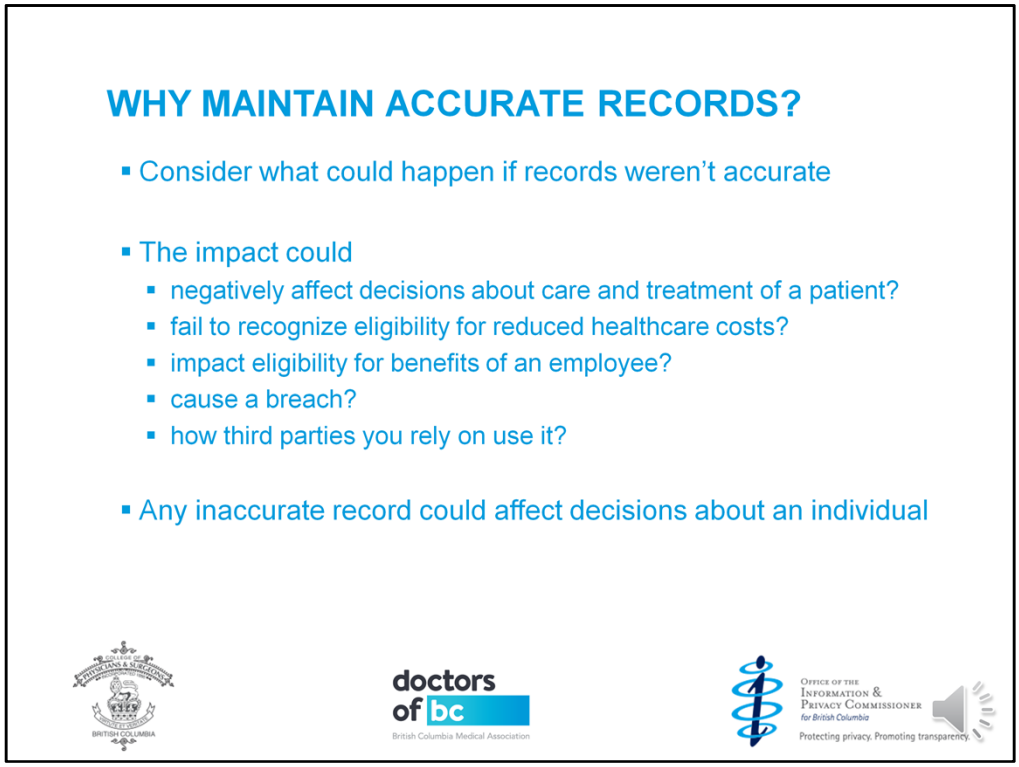
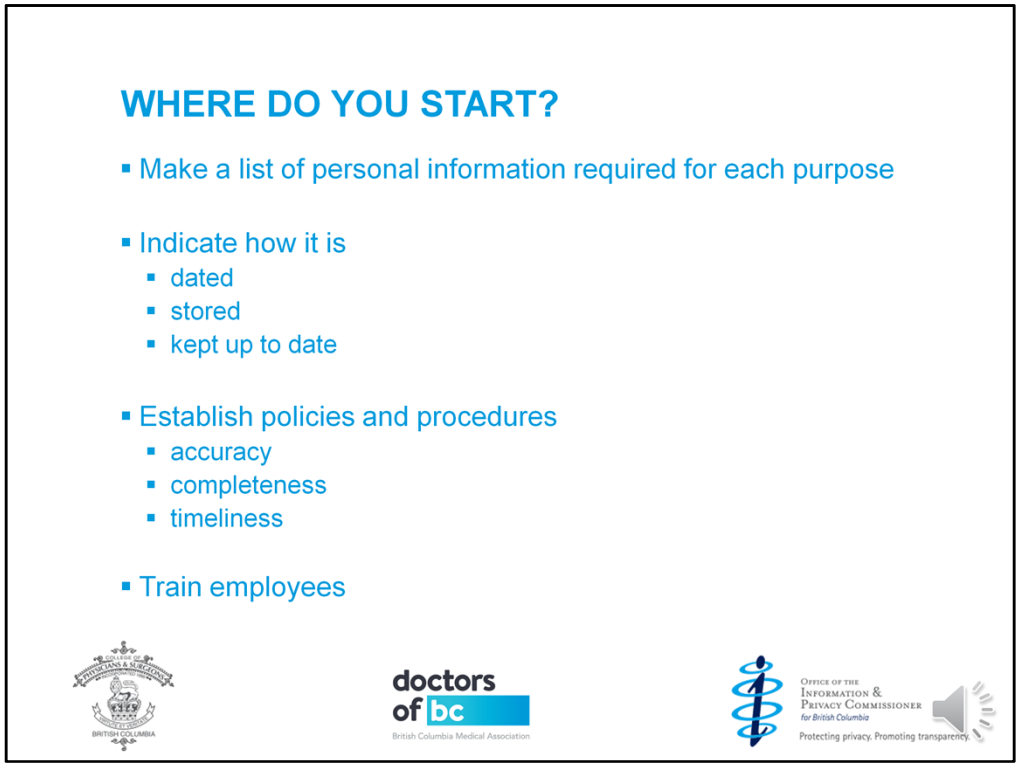


- Welcome to a webinar about understanding BC's Personal Information Protection Act or PIPA for short.
- If you're a physician or MOA working in a private practice, this webinar is for you.



WHY MAINTAIN ACCURATE RECORDS?

- Consider what could happen if records weren't accurate
- There can be some serious impacts.
    - an incorrect medical record could result in the wrong decision about patient care like prescribing medication a patient is allergic to or misdiagnosing their condition
    - an incorrect birthdate could result in eligibility issues for patients
    - and employees
    - an incorrect email address could mean sensitive information is sent to the wrong person
    - incorrect data sent to a third party you rely on for processing could result in a number of untold errors
- Any inaccurate record can affect decisions about an individual



WHERE DO YOU START?

- Make a list of personal information required for each purpose
- Indicate how it is
    - dated
    - stored and
    - kept up to date
- Establish policies and procedures so personal information will be
    - accurate
    - complete through use of forms and
    - updated quickly with periodic verification

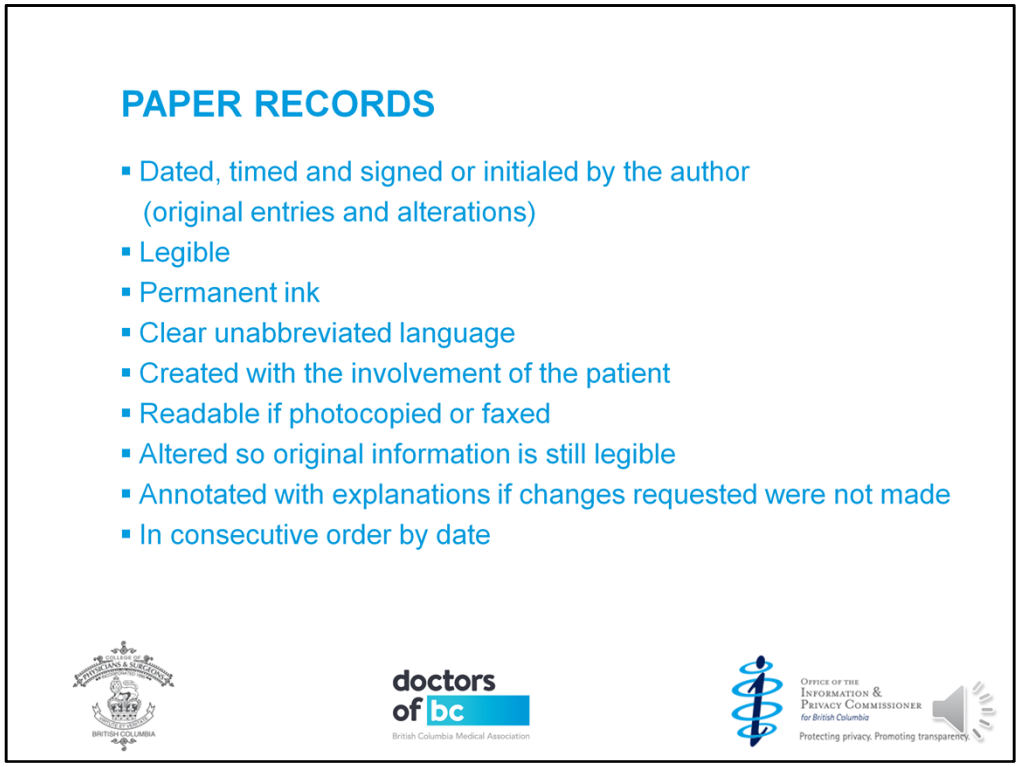
Train employees to follow established procedures

Accurate records can prevent inaccurate diagnoses that could be far worse than this!

PIPA requires that an organization make reasonable efforts to ensure the personal information it collects is accurate and complete.

An individual has the right to ask the organization to correct an error or omission in their personal information.

The organization must either make the correction or make an annotation as to why the correction wasn't made.



Here are some general rules for paper records. They should be

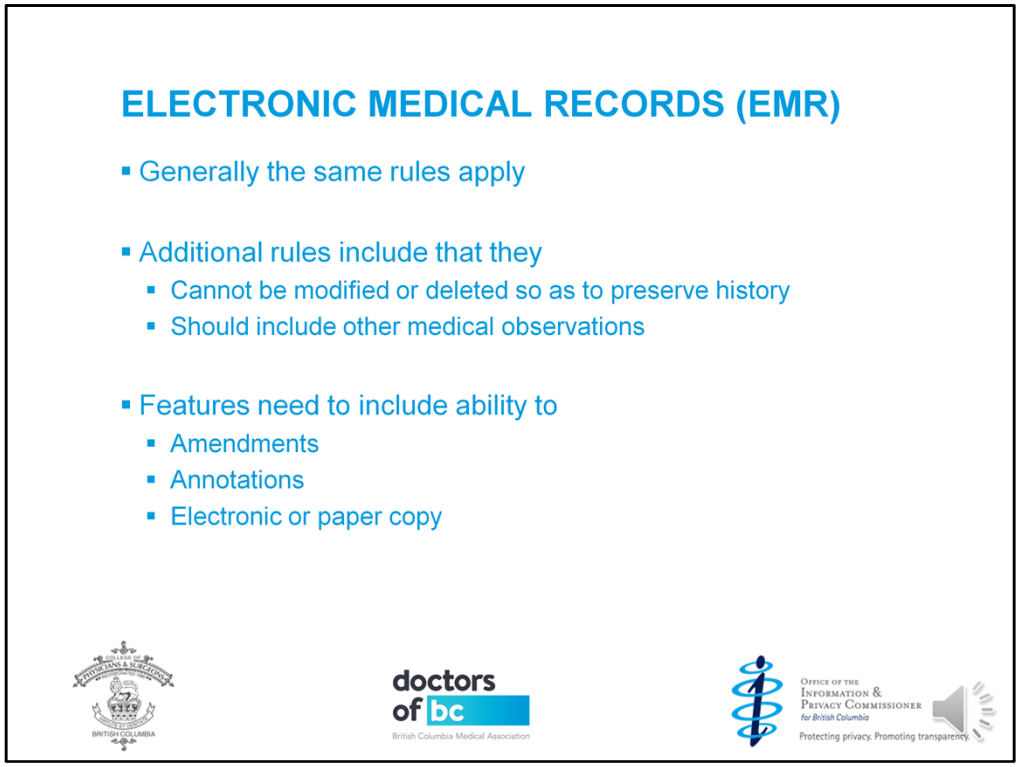
- dated, timed and signed or initialed by the author for both original entries and alterations
- legible,
- written using permanent ink,
- in clear unabbreviated language,
- created with the involvement of the patient whenever possible or practical and
- readable if photocopied or faxed

When changes are made,

- original information still needs to be legible and
- annotations should explain why any requested changes were not made

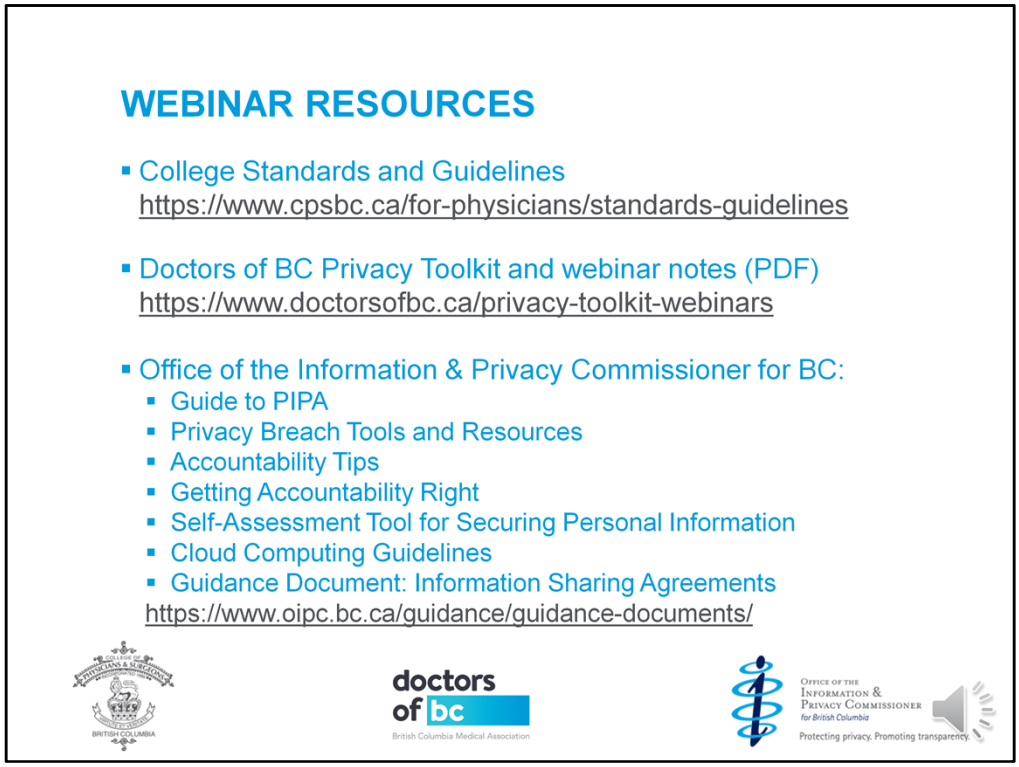
And finally, they should be

- in consecutive order by date



- Generally the same rules apply to paper and electronic medical records
  One obvious difference is that instead of a signature or initial, the person updating the record needs to be indicated
- Additional rules include that they
  - cannot be modified or deleted so as to preserve history
  - should include other medical observations such as examinations, tests, diagnoses, prognoses, prescriptions, and other treatments
- EMR features need to include the ability to:
  - make amendments without changing original information
  - make annotations and
  - generate an electronic or paper copy of the record that includes the full history

Whether on paper or electronic, any changes to information you may have shared with third parties should be communicated to them as well



Links to these Resources are in a PDF document on the Webinars page of the Privacy Toolkit

- College Standards and Guidelines
- Doctors of BC Privacy Toolkit and webinar notes
- and Privacy Commissioner guides, tips and resources

Let us know if you have any questions about complying with PIPA