Newfoundland & Labrador
Centre for
Health Information

PROVINCIAL REGISTRATION STANDARD

February 2019

Approved by the
Provincial Health Information Management Leadership Committee
June 8, 2011
Revised: June 13, 2013; March 8, 2016; February 23, 2017; December 4, 2018

The Provincial Health Information Management Leadership Committee plays a key role in setting provincial health information standards, particularly those related to clinical and administrative data standards, and facilitating implementation within the public health system. The Committee also fulfills the role of the Client Registry Advisory Committee, by providing advice and making recommendations to the Newfoundland and Labrador Centre for Health Information, on matters related to the provincial Client Registry (a component of the Newfoundland and Labrador Electronic Health Record known as HealtheNL).

PROVINCIAL REGISTRATION STANDARD

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BACKGROUND

Accurate demographic information is essential for positive patient identification and the foundation for effective and efficient health information management regionally and provincially. This information is generally collected through the registration/admitting functions related to the provision of health services and is recorded in multiple information systems which support those services. Accurate demographic information is also key to exchanging health information between systems and using health data for secondary purposes such as health system planning, management, evaluation, policy development and research.

The Client Registry is the cornerstone of the provincial electronic health record (EHR) known as HEALTHe NL. Demographic and administrative data is collected at many points of registration within the Newfoundland and Labrador health system. Similar information is collected by community-based pharmacies that exchange demographic and drug information with the provincial Pharmacy Network, physician offices using the provincial electronic medical record (EMR), and the Department of Health and Community Services as residents of the province register for provincial health insurance coverage known as the Medical Care Plan (MCP).

The information captured within the registration module of MEDITECH, the Client and Referral Management System (CRMS), MCP, Vital Statistics, the Pharmacy Network, and Med Access (the provincial EMR) flow into the provincial Client Registry for use by these and other stakeholders. Information received from one source is available to the other approved sources to update the records of individuals as they present for services. Therefore, it is vital that only the most accurate, complete and up-to-date information be collected and exchanged.

To support the collection and exchange of high quality demographic and administrative data, the following registration protocol must be followed by all staff who enter this information into their local information system(s). Lack of adherence to these standards will cause incomplete and inaccurate information to be exchanged within the Client Registry and among stakeholder source and receiving systems, increasing the potential for health record mix-ups and overlays, privacy breaches, and decision-making based upon erroneous information.

PURPOSE

The purpose of this standard is to ensure accurate and complete demographic and administrative information is collected through standardized registration processes at all points within the health system. This includes situations where the patient is not available or not able to confirm demographic and/or administrative information.

REQUIREMENTS

When registering the patient/client/resident, staff must adhere to the following procedures. DO NOT register unidentified persons, stillbirths or individuals dead on arrival (DOAs) in this manner. See Appendices A and B for specific guidance related to registration for these groups. Specific guidance related to registration for Telehealth services is included in Appendix C.

SEARCH METHOD

To find the correct patient/client/resident in the most accurate and efficient manner, the search criteria order should be:

1. MCP number, e.g., #123456789001 (This typically results in a direct match.)
2. Hospital Card, CRMS ID, Unit numbers, e.g. U12345678
3. Patient/client/resident demographic information, e.g. Brown, Mary Date of Birth: 1980-01-01

Staff must validate and update information as appropriate by asking specific questions such as: What is your first/middle/last name? What is your mother's first name?

FULL LEGAL NAME FIELDS

Record the full legal name of the patient/client/resident in the last name, first name, and middle name fields of the registration system where available. In the MEDITECH system, a single name field is provided in which the name is entered as Last Name, First Names (separated by a comma and a 'space' between each first and middle names). The information should align with the name on the MCP card with few exceptions. In the case of long names and hyphenated names, MCP truncates the name to 28 characters and removes punctuation, including hyphens (due to MCP card physical limitations). Otherwise, registration staff are strongly discouraged from making changes to name fields unless the changes align with the information on the MCP card.

Use approved punctuation only, e.g. hyphen (-), apostrophe ('), period (.) and number sign (#) when the legal name includes such characters e.g., MARY-ANN, O'REILLY, ST. CLARE, BROWN-SMITH. All other punctuation, including quotation marks (""), parentheses (), asterisk (*), back slash (\),colon (:) and forward slash (/) is prohibited.

In cases where the middle name on the MCP card or registration system is blank or an initial, registration staff should ask the client for the middle name and update. Do not delete an initial unless more information can be added.

MCP inserts a '.' on the card when the person has no first or last name. Regardless of the system used, when a person has no first name and one or more surnames, enter the phrase "NO FIRST NAME" in the first name field and the person's single or multiple surname(s) in the LAST NAME field. In the case of a person with a first name but no surname, enter the person's name in the FIRST NAME field and the phrase "NO SURNAME" in the LAST NAME field.

If there is a typo on the MCP card (e.g. Mayr instead of Mary), it is recommended registration staff telephone MCP and advise of the discrepancy; or advise the patient to do so. If MCP can verify the correct data against its records, it will issue another card immediately. If MCP has no record of the typo, it requires legal documentation to make the change.

If there are other name changes or discrepancies, advise the patient/client/resident to submit the *Information Update* form to MCP with accompanying legal documentation (e.g. birth certificate). Alternatively the regional health authority (RHA) has the option to submit (fax) the completed documentation to MCP on behalf of the patient/client/resident.

When registering newborn babies or neonates, the mother's surname is used in combination with the first name expressed as BB OF_____ or BG OF _____, e.g. Brown, BB of Mary. The number sign (#) is added to indicate the birth order of multiple births as described below:

- BROWN,BB#1 OF MARY and BROWN,BB#2 OF MARY for same sex twins
- BROWN,BG#1 OF MARY and BROWN,BB#2 OF MARY for twins of both sexes
- BROWN,BG#1 OF MARY, BROWN,BB#2 OF MARY and BROWN,BG#3 OF MARY for triplets involving both sexes.

This naming convention is used for the duration of the newborn's admission unless an MCP# is issued under the child's full legal name during the admission. In this case, the name can be updated in the registration system in accordance with the name on the MCP card.

MEDITECH, MedAccess (EMR) and CRMS users should register with the name as provided by the parent if a child returns for service after discharge but before an MCP card has been issued. CRMS users should apply the above newborn guidelines if the proper name is not recorded on the Live Birth Notification form. Any subsequent change to the name after first entering the child's name into the system requires the legal name change process.

Babies born of a surrogate mother should be registered in the same manner as other babies, using the birth mother's name and baby's name, if known. If a legal name change is ordered, the

baby's name should be revised but not the mother's name. Once the adoption goes through, then the mother's name should be changed as well.

In the case of an unidentifiable person, register as JOHN or JANE DOE #1, #2 OR #3 as specified in Appendix A.

MOTHER'S NAME FIELD

Mother's Name Field is used to record the birth (or adoptive) mother's first name only; the names of step-mothers, other relatives, non-relatives or guardians are not permitted. This information is used for patient identity management purposes only and in the interest of patient safety to distinguish patients from those with the same or similar names. It is not used for notification purposes. Information recorded in the Mother's Name Field is exchanged with the Client Registry.

In the case of two same-sex parents, record both first names, separated by a space, in the Mother's Name Field.

This field is mandatory in some, but not all, systems. If the mother's first name is not known or available in the Client Registry, where mandatory, enter 'unknown'; where not required, leave blank.

While changes to the Mother's Name Field are uncommon, changes may be made upon request if the mother has made a legal name change which may or may not be associated with a gender change as well.

MAIDEN NAME FIELD

This field records patient/client/resident surname prior to first marriage.

OTHER NAMES FIELD

This field records additional names, derivatives or nicknames of a patient/client/ resident if required. It can record multiple surnames.

SEX FIELD

This field is used to record the sex at birth of the patient/client/resident and must align with the data in the Client Registry. Gender information cannot yet be recorded in RHA registration systems; however, currently individuals are given the opportunity to choose to change the sex previously recorded as Male or Female to Unknown or in the case of errors or gender

transformation from/to Male or Female. This may change in the future as new standards are developed for recording sex and gender information.

ADDRESS FIELDS

Address Fields are used to record a single, primary mailing address for the purpose of mail notifications or appointments and other correspondence. The primary address recorded for a person should be the mailing address of the permanent home; temporary addresses are considered secondary.

CRMS has the capability of recording the mailing address and the street address in separate fields. Some facilities have MEDITECH customer defined screens to collect this information.

Post office box, Box number or Rural Route should be recorded as:

When there is a mailing address in addition to a street address:

Line 1: PO Box 555	Line 1: Box 555	Line 1: RR 6 Station Main
Line 2: 70 O'Leary Avenue	Line 2: 70 O'Leary Avenue	Line 2: 70 O'Leary Avenue

When there is a mailing address only (no street address provided):

Line 1: PO Box 555	Line 1: Box 555	Line 1: RR 6 Station Main
Line 2:	Line 2:	Line 2:

Street address only should be recorded as:

Line 1: 70 O'Leary Avenue	Line 2:	Line1: 70 O'Leary Avenue
Line 2:		Line 2: Apt 22

General Delivery should be recorded as such, not abbreviated as G/D, GD, GenDel or any other variation.

Line 1: General Delivery
Line 2:

It is at the discretion of the patient/resident/client to provide a mailing address when s/he is living in a temporary shelter. If desired by the patient/resident/client, staff shall collect the mailing address of a friend or relative or the mailing address of the shelter (do not include shelter names, e.g. Iris Kirby House) to receive correspondence.

- MEDITECH users record "No Known Address" if no address is available
- CRMS users record a blank Mailing Address Field if no address is available. The shelter address (but not name) may be recorded as the Preferred Address (Temporary).

When a child in protective custody presents to an RHA for service, the onus is on the person accompanying the child (e.g. social worker, foster parent) to register according to the appropriate Department of Children, Seniors, and Social Development (CSSD) guideline/s. When recording the mailing address for CSSD clients, do not include the phrase or acronym 'Department of Children, Seniors and Social Development (CSSD)' in any of the address fields.

The local address of transient workers, incarcerated persons or vacationers (e.g. cottagers, travelers) is considered a temporary residence and the family home should be recorded as the permanent address.

The phrase "No Known Address" should be used to record the address of homeless people and unidentifiable people (e.g. John and/or Jane Doe).

In the case of people who refuse to, or cannot, provide their address to registration/clinical staff upon presentation for services, staff who are Meditech users should query the Client Registry and accept Client Registry information if available. Users without Client Registry query capability should use local information (if it exists) otherwise a new record should be added to the local system using "No Known Address," which can be updated if/when the patient/resident/client can be identified.

POSTAL CODE FIELD

Format must be alphanumeric (e.g. A1B 2C7). Visit www.canadapost.ca *'Find a Postal Code'* to use Canada Post's free Postal Code look-up tool.

Do not skip, bypass or add incomplete/invalid data such as a mini postal code (NL), XIX IXI or other variations as these actions cause data quality issues and impact use of the data. There are two exceptions to this rule:

- In the case of unidentifiable people (i.e. John and/or Jane Doe), use the postal code of the registering facility as specified in Appendix A.
- In the case of postal codes that are unknown, unavailable or not yet assigned by Canada Post, use A9A 9A9.

EMAIL ADDRESSES

Email addresses are not collected as part of the core registration information but may be recorded in customer-defined screens within the MEDITECH ADM module if a person has identified email as the preferred mode for receiving appointment notifications.

PHONE NUMBER FIELDS

Must include the area code (e.g. 709-752-6006). If the phone number is unknown, enter 000-000-0000. Do not add text based qualifiers or any other punctuation, e.g. 709-752-6006 (father).

DATE OF BIRTH FIELD

This field is used to record the patient's date of birth (DOB).

MEDITECH users enter January 1, 1850 if date of birth is unknown (e.g. in the case of unidentifiable people such as John and/or Jane Doe). CRMS users leave this field 'blank' if the date of birth is unknown.

If a date of birth discrepancy is discovered during the registration process, no change to a DOB should be made unless it is supported by appropriate legal documentation (e.g. birth certificate). If there is an error in the DOB recorded on the MCP card, advise the client to request correction by submitting the *Information Update* form to MCP with accompanying legal documentation (e.g. birth certificate).

REGISTRATION OF LABORATORY SPECIMENS

In addition to the above: LABORATORY Staff require additional registration procedures when processing 'Requisition Only' rather than in-person registration.

Situations occur where the patient does not present for services but services are provided on behalf of the patient, e.g., specimen analysis. When the registration is performed based on a requisition:

- Users with CR query capability (such as MEDITECH users) should query the Client Registry and accept Client Registry information if available, matching at minimum two of three key identifiers (1. MCP number, 2. Name, 3. Date of Birth)
- Users without CR query capability should use local information (if it exists), matching at minimum two of three key identifiers (1. MCP number, 2. Name, 3. Date of Birth)
- When no match occurs, a new record should be added to the local system

When Med Access (EMR) generated requisitions are received, staff must accurately enter the EMR Clinic mnemonic into the MEDITECH system in the Other Provider field. This is required to ensure correct routing of lab results to the requesting provider within the EMR.

Changing administrative or demographic information based on the information provided on the requisition and/or specimen is strongly discouraged. In limited situations, test results are de-identified to some degree to protect the patient/resident/client's privacy. To avoid potential re-identification and linkage to the patient/resident/client's record in the Client Registry, staff should seek direction from their manager.

AUTHORIZATION TO CHANGE REGISTRATION DATA

The following table identifies the demographic and administrative data elements commonly collected through registration processes and the appropriate person(s) authorized to make changes to this information.

DATA ELEMENT	Can be updated at a self-registration kiosk by the patient; identity is verified by MCP# for NL residents. Can also be updated by a registration clerk during a fact-to-face registration.	Can be updated by phone; identity is verified by name, date of birth and HCN (MCP# for NL residents). Can also be updated by a registration clerk during a fact-to-face registration.	Can be updated by letter or email; identity is verified by name, date of birth and HCN (MCP# for NL residents). Can also be updated by a registration clerk during a fact-to-face registration.	**Must be updated by a Registration Clerk/Clinical Service registration lead.** Identity is verified through the usual registration process, supported by official documentation for name/sex change requests.
Name				✓
Address	✓	✓	✓	
Telephone Numbers	✓	✓	✓	
Date of Birth				✓
Sex				✓
Health Care Number (HCN) (both in province and out of province/country HCNs)				✓
Next of Kin	✓	✓	✓	
Marital Status	✓	✓	✓	
Person to Notify	✓	✓	✓	
Mother's First Name				✓

Preferred contact method for automated notifications	✓	✓	✓	
Family Physician	✓	✓	✓	
Attending Physician				✓
MCP Expiry Date				✓
Other Insurance Details				✓

Changes to demographic and administrative data collected during registration processes can only be requested by the individual, a parent, guardian, or substitute decision-maker as designated in an Advanced Health Care Directive. In the case of a child in care, the social worker assigned to that child may make the request.

While infrequent, there are situations in which patients cannot provide their health care card for registration. Registration may be conducted if supported by presentation of a picture/photocopy of a health care card, or a representation of a card on a mobile app; however, any requests for information changes are limited to those allowed at a self-registration kiosk.

When a request for change is made that is not attached to a specific appointment or visit, the requester may be asked to sign a release to ensure a record of the request for change is available for audit purposes.

Questions regarding this standard can be directed to:
Clinical Standards and Information
Data Quality and Standards Division
Newfoundland and Labrador Centre for Health Information (NLCHI)
Telephone: (709) 752-6000
Email: csi@nlchi.nl.ca

Master Index Reference No: 2008-07
Issued: 2008-12-09, Re-issued 2011-06-08, 2013-06-13, 2016-04-14, 2017-02-27, 2019-02-28
Distribution: Provincial HIM Leadership Committee, Provincial Registration Committee, NLCHI, CRMS Standards Sub-Committee, and DHCS (MCP)

APPENDIX A

REGISTRATION OF UNIDENTIFIABLE PERSONS

Purpose

This standard has been developed to standardize the data collected during the registration of unidentifiable persons. This will improve the consistency and accuracy of the information within the local MEDITECH system and the data shared with the provincial Client Registry. This will minimize the risk of duplicate records and erroneous patient/record identification once the identification of the person is established.

Registration Requirements

Prior to initiating a new registration in the MEDITECH system for an unidentifiable person, staff should do a look up in the system for any existing John/Jane Doe's.
Each John/Jane Doe registered should receive a new unit number.

The following data fields are required as a minimum data set to save a registration record for an unidentified person in the MEDITECH systems of the regional health authorities. Where necessary, the applicable valid value is prescribed and noted below. Where a selection from a dictionary is required and will be dependent on the situation, the phrase 'dictionary selection' is noted for the field.

Data Field	Prescribed Value to Record for an Unidentifiable Person
DEMOGRAPHIC INFORMATION SCREEN	
Name	JOHN OR JANE DOE #1, #2 OR #3, etc #1 should be included even if there is no other John/Jane Doe registered at that time.
Street 1	NO KNOWN ADDRESS
City	NO KNOWN ADDRESS
Province	NL
Postal code	Postal code of the facility
Home phone	000-000-0000
REGISTRATION SUMMARY SCREEN	
Registration category	Dictionary selection
Date of birth	01/01/1850
Sex	Dictionary selection
DOCTOR AND LOCATION INFORMATION SCREEN	
Attending physician	Dictionary selection
MEDITECH location	Dictionary selection
Service date	Dictionary selection
Service time	Dictionary selection
Admitting physician	Dictionary selection
Service	Dictionary selection
Admit priority	Dictionary selection
Requested ward accommodation	Dictionary selection
Smoke/object/neither	Dictionary selection
Room	Dictionary selection
Room rate accommodation	Dictionary selection

APPENDIX B
REGISTRATION STANDARD FOR STILLBIRTHS

PROVINCIAL STANDARD
RELATED TO REGISTRATION AND ABSTRACTING OF STILLBIRTHS

Approved by the
Provincial Health Information Management Leadership Committee
April 20, 2012 Revised December 5, 2014

EFFECTIVE IMMEDIATELY

Background

It has been mandatory to submit stillbirth abstracts to the Discharge Abstract Database (DAD) since April 1, 1995 as per direction from the Department of Health at that time.

In 2011, Canadian Institute for Health Information (CIHI) identified inconsistency between the stillbirth definition applied in the DAD and the classification of a stillbirth in ICD-10-CA. The previous DAD manual allowed for submission of a stillbirth abstract in the circumstances of a missed abortion, i.e. fetal death occurring before 20 weeks gestation, and in the circumstances of a termination of pregnancy before 20 weeks.

For classification purposes in ICD-10-CA, a stillbirth is defined as any intrauterine fetal demise or termination of pregnancy occurring at or after 20 completed weeks of gestation in which the fetus shows no sign of life.

To align with the ICD-10-CA classification definition, the 2012-2013 DAD manual criteria for creating a stillbirth abstract was updated to read “any uterine fetal demise or termination of pregnancy occurring at or after 20 completed weeks of gestation in which the fetus shows no signs of life.”

As of 2012-2013, it became optional to submit stillbirth abstracts to the DAD but Newfoundland and Labrador continued to submit this information as a mandatory requirement upon the request of Perinatal Program NL (PPNL). PPNL does not have a complete provincial database at this time and is using the DAD data (as well as additional fields not submitted to DAD) contained in the stillbirth abstracts on a provincial level for perinatal and maternal reviews.

Since that time, PPNL has requested data be collected and submitted to the DAD based on the definition of a stillbirth in the *Vital Statistics Act, 2009* of the province of Newfoundland and Labrador (NL) which is:

> *"the complete expulsion or extraction of a fetus of at least 500 grams in weight or at least 20 weeks gestation in which, after the expulsion or extraction, there is no breathing, beating of the heart, pulsation of umbilical cord or unmistakable movement of voluntary muscles."*

In addition to abstracting inconsistencies, registration practices for stillbirths vary across the regional health authorities (RHAs). This has implications for local and provincial information systems such as the provincial electronic health record (EHR).

These issues were considered as part of the two year review cycle of this standard and changes approved.

Purpose

In an effort to standardize the collection of data related to stillbirths in NL, this standard has been revised to include direction for abstracting, RHA registration, Vital Statistics registration and PPNL data collection.

Abstracting Requirements

- Stillbirth cases that meet the definition of a stillbirth according to the *Vital Statistics Act, 2009* must be abstracted and submitted to the DAD (mandatory requirement). This will be noted as a provincial variation to Section 3, Stillborn Abstracting in future DAD manuals.
- HIM coders will create an abstract when a Registration of Stillbirth form is attached to the mother's chart.
- HIM coders are referred to the Stillborn Abstracting section of the DAD manual for general information and recording requirements for a stillborn abstract.

Registration Practices related to Stillbirths

- Stillbirths should not be registered in the ADM module of MEDITECH. An account under the mother's name in Lab census should be used when available for all lab related work; the paper record should be placed in the mother's chart.
- For radiology follow up, RHAs should use the mother's account (e.g. PACS, X-rays). If paper chart diagnostic imaging records and reports exist, these should be placed in the mother's chart.

- As stillbirths are not registered in the MEDITECH system, an abstract will not be triggered in the 3M Abstracting System and must be created through a manual process.

Registration of Stillbirth for Vital Statistics Purposes

- Stillbirth cases that meet the definition of a stillbirth according to the *Vital Statistics Act, 2009* must be reported to the Vital Statistics Division of Service NL via the Registration of Stillbirth form.
- A copy of the form is retained on the health record of the mother.
- RHA staff are referred to Vital Statistics Division for general information and recording requirements for a registration of a stillbirth.

Perinatal Program Newfoundland and Labrador (PPNL) Data Collection Requirements

- Additional data elements are collected within the 3M System upon the request of PPNL to augment the information collected on the DAD abstract related to stillbirths.
- Coders are referred to PPNL documentation for general information and specific recording requirements related to this additional data collection and reporting process.

Questions regarding this standard can be directed to:

Clinical Standards and Information Data
Quality and Standards Division
Newfoundland and Labrador Centre for Health Information (NLCHI)
Telephone: (709) 752-6000
E-mail: csi@nlchi.nl.ca

Master Index Reference No: 2012-03
Issued: June 5, 2012
Revised: December 5, 2014

Distribution: Provincial HIM Leadership Committee, Provincial Coding Committee, Perinatal Program Newfoundland and Labrador, CIHI and NLCHI.

APPENDIX C
REGISTRATION FOR TELEHEALTH SERVICES

Background

Telehealth is defined as the use of communications and information technology to deliver health care services over large and small distances, including remote and rural areas (Canada Health Infoway).

Telehealth enables the delivery of equitable health services to patients in Newfoundland and Labrador, regardless of location. By reducing the need for patients, family and specialist travel, Telehealth enhances the continuity and capacity of care throughout the health care system.

Registration Guidelines

The method of service delivery should not be the determining factor in registration. All patients/clients/residents presenting for services must be registered to the applicable functional centre providing the service.

Registration is necessary for several reasons:

- Accurate identification of the person to receive services within the information system of the regional health authority (RHA) and access to the health record belonging to that person;
- Continuity of care;
- Accountability from a risk management perspective; and
- Accurate utilization statistics derived from the registration system.

In the case of a Telehealth visit, there are usually two different sites (and their applicable functional centres) involved with that visit; a referral site to which the person presents for service and a host site in which the primary provider is located. The person must be registered at the referral site as well as at the host site providing the consultative service. By doing so, clinicians can access the person's health record in local electronic systems for review and documentation as well as support tracking of services.

During the MEDITECH registration process the functional centre providing the service to the patient is identified in the 'LOCATION' data field within the MEDITECH registration screens. The functional centre should be a valid functional centre, in compliance with the Provincial Chart of Primary Accounts. When a client presents for a Telehealth visit at a community health office, the

person may be registered in MEDITECH or registered in CRMS and the applicable program/service (i.e. functional centre) is associated with that visit.

There is significant variation in how Telehealth services are supported within the RHAs. In some situations, a person may present for a Telehealth service but not receive any services from a health care provider at that site, e.g. a person registers upon arrival at the local Health Centre, proceeds to a videoconference-equipped room and has a half hour session with a specialist located in another facility.) Registration is still required for purposes of continuity of care and risk management in such situations. In this scenario, the applicable referral site functional centre cannot be identified so the 'LOCATION' can be recorded as 'Telehealth'. By doing so, visit statistics will be accurately reported for each valid functional centre and not overstated while still capturing those that did not involve a health care provider on the referral site.

The physician/service provider providing the service remotely can be recorded as the 'Attending Physician' if the visit does not include a physician on the referral site. This information may be found on Telehealth iScheduler reports provided to registration staff or provided directly by the patient/resident/client.

Additional details related to a visit can be recorded in the 'REASON FOR VISIT' field. Such details would be visible in the Visit History of the Meditech Patient Care Inquiry (PCI) but would not be useful for statistical reporting purposes.