PEI College of Occupational Therapists

PRACTICE STANDARD:
Record Keeping

Practice Standard:
Record Keeping

The Prince Edward Island (PEI) College of Occupational Therapists (PEICOT) regulates the practice of occupational therapists in PEI. The College's main mandate is to "serve and protect the public interest".

Occupational Therapists are required to follow established guidelines and principles of practice in a consistent, responsible and intentional manner. These guidelines and principles apply to all occupational therapists providing client-focused service, regardless of their area of practice.

This College publication is based upon similar standards in Ontario, Manitoba, Nova Scotia and British Columbia and has been reviewed by occupational therapists practicing in PEI. The standard describes current professional expectations and may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been followed

Purpose

The purpose of this document is to ensure occupational therapists practicing in PEI are aware of the minimum practice parameters and standards for record keeping.

Background Information

The client record officially documents information related to the client and fulfills many purposes:

- serves as a legal document and source of evidence;
- acts as communication tool to manage and track client care;
- records events, decisions, interventions and plans;
- provides a means to communicate information to clients and stakeholders;
- assists inter-professional collaboration;
- facilitates appropriate client care and enhances client safety.

Proper record keeping demonstrates professional accountability by documenting service such as:

- receipt of the referral;
- discussions related to consent for assessment and treatment decisions;
- information from the client;
- communication between the occupational therapist and the client;
- client goals and progress; and
- intervention plans, and outcomes.

The client record reflects the occupational therapist's professional analysis/opinion and recommendations as well as their compliance with professional standards, other standards,

laws and ethical considerations.

The Standards for Record Keeping have included much of the information contained within the ***Health Information Act*** **(HIA, 2017).** Where legislation exists that supersedes this standard, the legislation is the higher authority. Occupational therapists should consider their role related to record keeping within the context of the Health Information Act. It is important to determine whether the practitioner is the Health Information Custodian or an Agent of the Custodian.

For more information about this topic, refer to the website for the Health Information Act at https://www.princeedwardisland.ca/sites/default/files/legislation/h-01-41-health_information_act.pdf

Practice Standard Organization

The Record Keeping Standard is divided into the following headings:

1. Key Responsibilities
2. Definitions
3. Criteria:
    a. Collecting and Recording Client Information
    b. Organizational & Administrative Matters
    c. Privacy and Access
    d. Confidentiality and Security
    e. Retention and Destruction
    f. Discontinuation or Transfer of Practice
    g. Financial Records
4. References
5. Frequently Asked Questions
6. Risk Assessment and Management Framework

1. Key Responsibilities

- The criteria describe the minimum expectation for each aspect of record keeping.
- The performance indicators listed below each criterion describe more specific behaviours that demonstrate the expectation has been met.
- There may be some situations where a particular criterion/performance indicator is not relevant due to client factors and/or environmental factors, but it's expected that the occupational therapist will provide a rationale for any variations.
- It is expected that occupational therapists will always use their clinical judgment to determine how to best maintain records based on the scope of the referral as well as stakeholder and client needs.

2. Definitions

A working understanding of the following definitions is essential for the appropriate interpretation of this document.

Agent

An Agent is an individual who is authorized to perform services or activities on behalf of a health information custodian*. Examples: employee or volunteer of a custodian.*

Attest/Attestation

The process of assigning responsibility and authorship for an activity, usually by applying a signature.

Care Pathway

An outline of anticipated care, placed in an appropriate time frame, to help a client with a specific condition or set of symptoms move progressively through a clinical experience to anticipated positive outcomes. It can also be referred to as a clinical pathway, protocol or care map.

Charting by Exception

A method of client care documentation that uses a pre-determined plan whereby only unusual occurrences, changes to that plan, or significant findings are recorded.

Circle of Care

Individuals and activities related to the care and treatment of a patient. Thus it covers the health care providers who deliver care and services for the primary therapeutic benefit of the patient and it covers related activities such as laboratory work and professional or care consultations with other health care providers.

Client

Any individual, group, agency, organization, business or other that forms a partnership with an occupational therapist. This includes individuals with occupational performance issues arising from physical, cognitive, psychological, social and/or environmental barriers.

Confidentiality

This is the obligation a healthcare provider/agency has to ensure the client's right to privacy is respected by limiting the access to, or improper use of information without the client's authorization.

Custodian

An individual or organization that collects, maintains, uses or discloses personal health information for the purpose of providing health care. *Examples: solo/group private practice, health authority.*

Designation

Denotes the authorized use of title and/or its abbreviation - for occupational therapists the abbreviation is OT Reg. (PEI).

Electronic Communication

Communication by means of e-mail, internet groups or similar technology.

Electronic Health Record

The electronic health record is the longitudinal integration of a service recipient's health information collected over a period of time, and residing within computer architecture.

Electronic Signature

A signature or attestation applied by electronic means.

Encryption

Encryption is the process of transforming information to make it unreadable to anyone except those possessing a password or key.

Lock Box

A "lock-box" is a term of reference used to describe the right of an individual to instruct a health information custodian not to disclose specified personal health information to another health professional, internal or external to the circle of care, for the purpose of providing health care. An individual can be said to have placed their personal health information into a lock-box by expressly withholding or withdrawing consent for their health information to be collected, used or disclosed.

Personal Health Information

Identifying information about an individual, in both recorded and unrecorded forms, if the information pertains to providing health-care services; includes personal information that is not health information but is contained in a health-care record.

Practice/Service

These two terms are used interchangeably and refer to the overall organizational and specific goal directed tasks for the provision of activities to the client; including direct client care, research, consultation, education or administration.

Privacy

An individual's right to control how their personal information is handled, that is, their right to determine what personal information is collected, used and disclosed, when, how and with whom.

Raw Data

Data recorded for standardized or non-standardized assessments which have not been converted into scale scores or modified by statistical means. Raw data includes any sources that are used to form your clinical opinion. Raw data can be in a variety of formats including: video tape, audio recordings, print, or electronic. It can include such things as emails, completed assessments and forms, invoices, faxes, etc.

Reasonable Measures

The steps that a reasonably prudent person would observe under a given set of circumstances to avoid liability or negligence.

Record

Information, however recorded (e.g. written, electronically recorded/entered, audio, video, photographs) by the occupational therapist or an individual supervised by the occupational therapist, pertaining to occupational therapy services. This includes but is not limited to referral, assessment, therapy goals, progress toward goals, attendance, remuneration, etc.

Rough Notes

Also referred to as scratch notes, or side bar notes that may or may not become part of the client's health record. They may be destroyed if not needed, but if they exist at the time that access is sought to the record, they are considered a legal part of the client's record.

Security

This is the administrative, physical, and technological safeguards a healthcare agency has in place to prevent accidental or intentional disclosure by inappropriate access or by unauthorized individuals. It also includes the mechanisms in place to protect the information from alteration, destruction or loss.

Signature

The Registrant's signature or attestation, including an electronic signature as long as the Occupational therapist takes reasonable steps to ensure that only the Occupational therapist can affix it.

Stakeholder

This is someone who has a valid interest in the outcome of a decision involving the client. Examples of stakeholders include family members, other health care team members, physicians, insurance company, legal representative, etc.

Substitute Decision Maker

An individual identified in a personal directive or provincial legislation who may make decisions on behalf of the client when the client is deemed incapable of making a decision in the specific domain.

Third Party Payer

This is someone, other than the client and the occupational therapist, who is involved in a transaction.

Unique Identifier

A series of numbers and/ or letters assigned to a case file to identify a unique individual and to distinguish them from others.

3. Criteria

a. Collecting and Recording Client Information

The occupational therapist will be responsible for the content of the clinical record related to occupational therapy services and will ensure that the content accurately reflects the service provided.

Performance Indicators

An occupational therapist will make a clinical record for each client containing the following:

1. Full name and contact information of the source of referral of the client, the reason for referral, and, where applicable, the accuracy of the content in the referral.

2. Client's full name and address, date of birth and unique identifier (for example, health card number).

3. Date, time (if relevant) and duration (if relevant) of each professional encounter with the client is recorded, along with consent.

4. Client's case history, including relevant medical and social history.

5. Client information that is pertinent to the occupational therapy assessment and intervention (including assessment procedures used, results obtained and conclusions).

6. Sufficient objective/subjective data to support the writer's conclusions.

7. Record of the occupational therapy intervention plan and goals (including clear reference to any individual or group protocols or care pathways), formulated in collaboration with the client.

8. Progress note(s), indicating the outcome of an individual or group intervention, each change in client condition, occupational performance issue or intervention plan/goals. Charting by exception is acceptable, unless changes occur to the care plan or pathway; frequency of charting by exception should be determined by the professional judgment of the occupational therapist unless it is dictated by the facility/agency.

9. Record of any equipment provided for loan or trial, as well as documentation that equipment is in safe working order.

10. Every report sent respecting the client.

11. Name and designation of an individual to whom the occupational therapist has assigned a significant component of the intervention plan and which tasks were assigned (refer to *Practice Guideline).*

12. Specific information related to any referral made by the occupational therapist.

13. Where practical and applicable, a record of any cancelled or missed appointments.

14. A record of relevant discharge information.

b. Organizational & Administrative Matters

The occupational therapist will ensure records are legible, understandable, recorded or entered in either official language of Canada (English or French) and are prepared and maintained in a timely and systematic manner.

Performance Indicators

An occupational therapist will ensure that:

1. Records are organized in a logical and systematic fashion to facilitate retrieval and use of the information.

2. Documentation is completed in a timely manner appropriate to the clinical situation.

3. Every part of the record has a reference identifying the client (e.g. full name) and the client's unique identifier, (e.g., date of birth, record number/claim number).

4. Every entry in the record is dated, attested and the identity of the person who made the entry is identifiable.

5. Abbreviations, acronyms, and diagrams used in a client record should have a supporting reference available for those who access the records to ensure consistency of interpretation.

6. If more than one health professional contributes to a report, it is clearly identified which person is accountable for each part of the assessment or intervention. This applies to both interdisciplinary reports, as well as more than one occupational therapist involved with the same report. Occupational therapists should be aware if they sign at the bottom of a document, they can be held liable for the full document, even if they did not write it.

7. If draft documents are kept, they are considered part of the record and will be released, upon client request in accordance with privacy legislation and/or organizational policy. Occupational therapists are not required to maintain draft documents or rough notes.

8. A summary of any standardized evaluation results should be included in the clinical record regardless of whether raw data is kept. Raw data can be kept on the client record, kept separately from the client record or properly destroyed. If stored separately, a notation should be placed in the record indicating the existence of this raw data and its location.

9. The records may be created and maintained in a computer system if it has the following characteristics:
    a. The system provides a visual display of the recorded information;

b. The system provides a means of access to the record of each client, by the client's full name and a unique identifier, and can be validated by confirming additional reliable key indicators such as date of birth;
c. The system is capable of printing the recorded information promptly for each client;
d. The system is capable of allowing more than one author or contributor to sign/ attest;
e. When capturing and maintaining client records electronically or on paper, the record keeping system should provide the ability to view or print client data in a manner that supports chronology;
f. The system has the ability to correct/modify/augment entries (notes, assessments, documents, etc.), while maintaining and preserving the original entry and allow the author to indicate the type of change, i.e. a correction to erroneous information and the reason;
g. The electronic system also needs the capacity to identify pending (incomplete documents) entries;
h. The system maintains an audit trail which:
    i. Records the date and time of each entry of information for each client;
    ii. Indicates the identity of the person who authored the entry;
    iii. Indicates any changes in the recorded information;
    iv. Preserves the original content of the recorded information when changed or updated;
    v. Keep a record of user activity.
i. The system provides reasonable protection against unauthorized access. At a minimum, all systems will have user ID and password protection with mechanisms to prevent unauthorized alterations to documents (e.g. locking of documents, read-only access, firewalls, encryption, password, etc.);
j. The system automatically backs up files at reasonable intervals and allows the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to, and inaccessibility of information. A process should be in place to provide capability, reliability and availability of the system and record information in the event the electronic record is not available due to unforeseen or scheduled downtimes of the system;

10. Modifications/Errors/Revisions/Additions should be noted as follows:
    a. Modifications (errors/revisions/additions) in the completed record for which the occupational therapist is responsible shall be identified, dated, signed/initialed by only the Occupational therapist that entered it originally, without changing/obliterating/deleting the original entry whether in paper or electronic form;
    b. Modifications to a document after the document has been distributed can only be accomplished through the use of addenda. Copies of the addendum will be sent to all recipients of the original document;

11. When completing a note for a client intervention that occurred on a date other than the current day, the Occupational therapist will clearly indicate the date of the intervention and the date the note was created.

12. Application of Signature (attestation): The purpose of signing or attestation in both the electronic and/or paper record is to assign responsibility and authorship for an activity.
    a. The occupational therapist must take steps to ensure the security of their electronic signature.
    b. Someone else cannot put your signature on a document without your expressed permission.
    c. The occupational therapist will ensure that documentation is accurate and complete prior to applying their signature.
    d. Sign/attest each of their entries on the client record.
    e. Only sign or permit to be issued in their name any report or similar document once they have ascertained or have taken reasonable measures to determine the accuracy of its contents.
    f. Use a digital or electronic signature where the signature is protected.
    g. Use acceptable signatures which include: The author's full name and designation; Initials within a report and a full name and designation at the end of the report.

c. Privacy and Access

Privacy relates to the right of individuals to determine when, how and to what extent they share their personal information. Occupational therapists have a responsibility to understand and apply the legislation that applies to their practice and determine their personal roles and responsibilities within the context of their practice.

Occupational therapists should consider their role related to record keeping within the context of HIA. It is important to determine whether the practitioner is the Health Information Custodian or an Agent of the Custodian. Agents may include employees and volunteers. Occupational therapists are expected to consult the relevant legislation to determine their role in this context.

For more information about this topic, refer to the website for HIA at:
https://www.princeedwardisland.ca/sites/default/files/legislation/h-01-41-health_information_act.pdf

The occupational therapist will maintain the client's record ensuring that the privacy of client information is in accordance with all applicable legislation.

Performance Indicators

An occupational therapist will:

1. Collect only personal health information that is necessary and pertinent to the purpose of the collection.

2. Collect, use, and disclose personal health information only with consent unless otherwise permitted to do so by law.

3. Ensure that the client's health information is accurate, complete and current for the purpose for which the information is being used.

4. Ensure that transferring, sharing or disclosing personal health information to other persons outside of the circle of care only occurs with express consent of the client or substitute decision maker unless consent is not required by law.

5. Inform clients of the existence, use, and disclosure of their personal health information.

6. Provide copies from a client's clinical record, for which the therapist is the health information custodian, to any of the following persons on request:
    a. The client;
    b. With the consent of the client, to a custodian or person outside of the province for the provision of health care;
    c. Substitute decision maker or legal guardian;
    d. Regulated health profession organization;
    e. Official of correction facility for the provision of health care;
    f. Another custodian for the purpose of determining or verifying eligibility for insured services;
    g. Litigation or legal representative.

7. If working for a third-party payer, facilitate the release of client records from the third party to the client.

8. With consent of the client, allow another health professional, external to the employment organization/agency of the occupational therapist, to examine the client clinical record or give a health professional any information from the record they are legally entitled to receive. Where the client directs that part of the information be withheld (i.e. Lock Box), that request will be respected. The recipient must be notified that part of the information has been withheld if that information is deemed necessary for the provision of health care to the client.

9. Respect a client's request for a change to their record. This request can be in writing or be made verbally. The occupational therapist must make the change if there is a factual error, but, need not change a professional opinion. **The request must be responded to**

in writing within 30 days of receiving the request. A notation of the request and the response should be made on the record as well as the rationale for the decision.

10. Take reasonable measures to ensure the preservation, security and ongoing access to their client records in the event that the agency/organization in which the occupational therapist has been employed, and is the Health Information Custodian, ceases to operate.

11. Make their books, records, documents and other items relevant to their practice of occupational therapy available during reasonable hours for inspection, testing or copying by a person appointed for the purpose under the Regulated Health Professions Act (2013). C*lient consent is not required to submit records to the College.*

The Occupational Therapist may also:

a. Refuse to provide copies from a record until they are paid a reasonable fee, unless there is a risk of harm to the client if the information is not released (see HIA regulation for maximum fee schedule).
b. Refuse to release a client record or a portion of the client record if they reasonably believe there is a risk of serious harm to the treatment or recovery of the client or a significant risk of serious bodily harm to another individual. Reasons for the refusal to the extent reasonably possible, should be provided to the requester in writing.
c. Refuse to grant an individual access to a client record if another reason for refusal in the *Health Information Act, 2017*, applies.

d. Confidentiality and Security

Confidentiality is the obligation of a person/organization to keep the information private. Security refers to those mechanisms engaged to restrict access and preserve the integrity of the information. In the case of the electronic health record, content should be supported by information technology systems and functions that ensure and maintain data integrity, security, reliability, trustworthiness and interoperability.

The occupational therapist will take reasonable measures to ensure client confidentiality and security of client information in order to prevent unauthorized access and maintain its integrity.

Performance Indicators

An occupational therapist will:

1. Take reasonable measures to ensure client personal health information is secure from unauthorized access, loss or theft.

2. Limit travelling with client information including paper and/or portable electronic devices that contain personal health information, to essential use only. If using

electronic devices, where possible, these devices should include encryption of client information and password protection. A back-up copy of files should exist in a secure location. Measures should be taken to limit visibility of paper files or records and electronic devices while being transported.

3. Ensure the physical security of on-site records by the use of controls such as locked filing cabinets, restricted office access, logging off computers when out of the office etc.

4. Comply with organizational policies and procedures related to the security of records. If self-employed or the Health Information Custodian, the occupational therapist will establish appropriate policies and procedures, including making a statement available to the public, upon request, describing their information practices.

5. Ensure that client information to be delivered by mail is sealed, addressed accurately and marked "confidential".

6. Ensure there are appropriate administrative, technical, and physical safeguards to protect the privacy of health information that is disclosed using a facsimile (fax). The occupational therapist should incorporate a confidentiality statement and cover sheet with each outgoing fax. **Note:** *Safeguards may include using a fax cover sheet, confirming the fax number, periodic auditing of pre-programmed numbers, placing the fax in a secure location to prevent unauthorized viewing, transmission receipts, and ensuring that the recipient's fax machine is secure.*

7. Ensure electronic communication containing personal information over the internet is performed in a secure manner (i.e. The occupational therapist should incorporate a confidentiality statement to affix to each outgoing e-mail).

8. In the event that personal health information is accidentally disclosed to others, it is the responsibility of the therapist or custodian to notify the client of the breach consistent with their organization policies and HIA. Therapists shall review the cause of the breach and work to rectify any outstanding issues to avoid future potential breaches.

e. Retention and Destruction

The occupational therapist, if they are the Health Information Custodian, will establish a process for retention and destruction of records that ensures that records are maintained for the required period of time and are destroyed in an appropriate manner and in accordance with jurisdictional legislated retention and destruction requirements. If the occupational therapist is not the Health Information Custodian, they will ensure that the record is maintained and that they will have access to it during the minimum retention period and be knowledgeable about the organization's policies and procedures for retention and destruction of the occupational therapy records.

Performance Indicators

An occupational therapist will ensure:

1. Records, regardless of the medium used (paper, electronic, video/audio, pictures, etc.), should be stored and maintained to safeguard the privacy and security of this health information.

2. Records are retained according to the custodian's retention schedule. If the occupational therapist is the Custodian, the College recommends retaining records for at least **10** years from the last entry in the record. This time period is recommended based on liability exposure and provincial legislation. However, there may be times where the record MUST be kept longer than **10** years (litigation, ongoing care/treatment, organizational policy, etc.).

3. Destruction of a record (paper, electronic, video/audio, pictures, etc.) is done in a secure manner that prevents anyone from accessing, discovering or otherwise obtaining the information contained in the record. ***Note:*** *Although it is not legally required, it may be prudent for custodians to maintain a list showing the name of the client and date of destruction of files to be able to respond to questions of possession.*

f. Discontinuation or Transfer of Practice

Occupational therapists, who are health information custodians, are required to have a plan in place to manage client records upon planned or unexpected discontinuation of their practice, for example resignation, revocation of certificate of registration, death, disability, leave of absence.

Performance Indicators

An occupational therapist who is the Health Information Custodian will:

1. Develop and when appropriate implement a plan for management of client records for planned or unexpected discontinuation of practice to ensure client access to their records. The plan may include secure retention and storage of the documents, or transfer of the client records to another person who is legally authorized to hold the records or to a successor Health Information Custodian in keeping with the provisions defined in the HIA.
2. Make reasonable efforts to notify the client that the occupational therapist intends to resign and provide information on how the client can obtain copies of their record.

g. Financial Records

In every circumstance in which an occupational therapist provides service to a client or sells/provides any product where the client or other person or agency is directly billed for the service, records should be created that document the financial transaction.

The occupational therapist will ensure that a financial record is kept for every client to whom a fee is charged by the occupational therapist.

Performance Indicators

An occupational therapist who is a Health Information Custodian will:

1. Retain financial records in a manner consistent with the preceding standards and indicators for record keeping. These records may be kept separately from clinical records.

2. Ensure the financial records include:

    a. A clear identification of the person(s) who provided the product or service and their title;
    b. A clear identification of the client to whom the service or product was provided - client's full name and address, and unique identifier (if applicable);
    c. The identification or description of item/service sold;
    d. The cost of the item/service;
    e. The date the item/service was sold/provided;
    f. The date and method of payment received;
    g. Any differential fees charged for services provided by occupational therapist support personnel;
    h. The reason(s) why a fee may have been reduced or waived;
    i. Where the fees were charged to a third party, the full name and address of the third party;
    j. Any balance due or owing; and
    k. Information that documents the retention of an agency for the collection of the outstanding balance.

4. References

College of Occupational Therapists of Ontario (2016). Standards for Record Keeping. Toronto, ON.

College of Occupational Therapists of British Columbia (2014). Practice Standards for Managing Client Information. Victoria, BC.

College of Occupational Therapists of Nova Scotia (2017). Practice Standard: Record Keeping. Halifax, NS.

College of Occupational Therapists of Manitoba (2017). Managing Client Information – Meeting Legislative Obligations 2017. Winnipeg, MB.

Guide to the PEI Health Information Act (2017).

Health Information Act (2017).

5. Frequently Asked Questions

Q. I am unclear what information is expected to be retained and what can be destroyed. What is considered raw data and does this include rough notes?

A. The raw data can be kept on the client record, kept separately from the client record or properly destroyed. If stored separately, a notation should be placed in the record indicating the existence of this raw data and its location. A summary of any standardized evaluation results should be included in the clinical record regardless of whether raw data is kept. Rough notes are not considered raw data and include items that are not clinically significant or are already documented in the chart. Rough notes are not expected to be retained. However, if they are retained, they are considered to be part of the legal chart, should the chart be subpoenaed.

Q. I often give clients handouts, but I don't think that I should have to keep a copy of them in each client's file as it takes up too much room. Are we expected to put a copy of every handout that we give to a client in their file?

A. It is expected there is a record of which handouts were given to each client and if any modifications were made to them. This provides a record of what information the client was given and serves as evidence for therapeutic intervention. The handout should be available for reference as it may be required at a later point. Maintaining a copy of handouts, pamphlets or exercise programs can be achieved through a number of different methods. One method is to keep unmodified master copies in a reference binder or electronically with a reference number on each document. Alternatively, a copy can be put in each client's file. If these documents are not kept with a client's record, the record should clearly indicate what document was given to the client (e.g. by reference number) and where it can be retrieved. If any modifications are made to a handout, pamphlet or exercise program, the client's record should indicate that modifications were made and these modifications should be described on the record or a copy of the modified handout should be retained in the client's file.

Q. What should I do if I am receiving information from a client by e-mail?

A. Occupational therapists must take all reasonable means to ensure the confidentiality of client health information. E-mail may be used to schedule appointments and phone meetings. E-mail should only be used to send or receive confidential health information when both the sender and the recipient have adequate security on their e-mail system. Generally, at home systems, such as Gmail and Hotmail, do not provide appropriate security. Some organizations/individuals use secured information sharing systems, such as Titan File, to send or receive health information over e-mail. If clients are

communicating with you via e-mail on a non-secure network it is important to discuss with them the risks of communicating in this way. This, of course, should not be done using e-mail, but through another method such as a telephone conversation or face to face. The client may not be aware that e-mail is not a secure method of communication and that they risk disclosing their personal health information to unintended people when communicating by e-mail. The client may not be aware of these risks of using e-mail and education on this topic may dissuade them from using it any longer for communicating with you. It may be helpful to the client to suggest more secure methods of communication such as using the telephone. If a client continues to communicate with you by e-mail, it is recommended that you document that you've discussed the risks of e-mail communication with your client in the client's record.

Q. I keep a supply of small adaptive equipment such as finger grips and Dycem that I sell for a nominal fee to clients. Do I need to retain financial records on this?

A. Yes, all fees charged to a client should be recorded. These financial records should contain the information outlined in the financial records standard (Section 3 g) and can be kept separate from clinical records to assist with ensuring that client information is not disclosed. Financial records are required to be retained by the Canada Revenue Agency in order to determine your tax obligations.

Q. I want to help my staff of occupational therapists meet acceptable standards of documentation. With the use of so much e-mail, how do we include this communication in the client record? Are we required to print off each e-mail and list it chronologically in the progress note?

A. Assuming that the previous standards are being met, e-mails are expected to be retained if they are used by the occupational therapist to make decisions or to comprise a valid portion of the client's history/assessment. If the e-mails are not used for these purposes they do not have to be retained. E-mails can either be printed off or scanned and saved electronically. If the e-mail is not kept with the client's record, the record should indicate where the copy of the e-mail can be retrieved and these e-mails should be organized in a systematic manner (such as chronologically) for easy retrieval. The standard on record keeping outlines that e-mailing must be done on a secure network (such as an intranet), be limited to essential information, and be encrypted, locked and password protected or anonymized. The e-mail should also contain a confidentiality statement. Communication on e-mail systems such as Hotmail and Yahoo should not be used due to the potential for personal health information to be breached to unauthorized parties. These systems lack the security required and may be used on unsecured networks furthering the risk of disclosing a client's health information. Therefore, occupational therapists should not be communicating with their clients or other healthcare providers using these systems.

Q. I often compose joint reports with other occupational therapists as well as other healthcare professionals. I am sometimes uncomfortable with portions of the document that were done by other healthcare professionals. Am I still required to sign the report?

A. If you are making a contribution to the report, you are required to sign/attest it. When a joint report is created, the occupational therapist should ensure that the report clearly, accurately and completely describes the occupational therapy services provided and the professional opinions and recommendations given. If the report does not clearly indicate the occupational therapy contribution, then the occupational therapist is taking responsibility for the information contained in the entire report when signing it. When more than one occupational therapist makes a contribution to the report, it should also clearly indicate which occupational therapist made each contribution. This ensures that each occupational therapist is only accountable for their contribution when signing the report.

Q. Am I a custodian or an agent?

A. You are a custodian if you have custody or control of the personal health information as a result of your duties. Custodians include regulated health professionals in sole private practice, individuals operating a group practice of regulated health professionals, a health authority, and a continuing-care facility. You are an agent if you are an employee or volunteer of a custodian and have access to personal health information. A regulated health professional may be a custodian in some instances and not a custodian in other instances; for example, a private practice therapist who also sees clients for Veteran's Affairs Canada. *Note: even though it is the custodian's responsibility to keep the records it is the agent's responsibility to abide by the requirements of the custodian.*

6. Risk Assessment and Management Framework

Efficient and safe management of client records requires occupational therapists to make reasoned decision on how they collect, record, maintain, and disclose these records. The College recommends occupational therapists use a risk management framework to minimize risk and prevent harm. A risk management framework is a tool that assists registrants to identify potential risk factors, assess their probability and degree of harm, and take steps to mitigate any associated risk. Risk management is a cyclical process, requiring on-going monitoring and review.

1. Identify Risk Factors (some samples are provided below):

Client ***(Do you have a systematic process in place for gathering appropriate information about the client?)***

- Complexity of client's current condition, including physical, mental, cognitive, social, and environmental
- Stability of condition
- Client's capacity to consent to assessment and treatment and release of information
- Fluctuations in performance across time and environments
- The cultural beliefs and values of the client, family members, and the institution
- Ability to give accurate and complete information due to language barrier, speech deficits, poor comprehension, or visual or sensory deficits

Practice Environment ***(Do you or your employer have appropriate policies/procedures/safeguards in place?)***

- Security of data system
- Software reliability
- Communication formats (i.e. phone, e-mail, in-person, fax, etc.)
- Traveling with documentation
- Access to records by unauthorized persons
- Time limitations
- Access to reliable and appropriate assessment tools

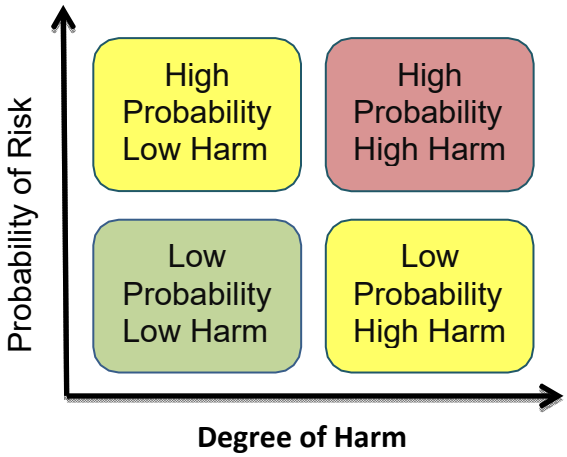
Occupational Therapist ***(Do you have the knowledge & skills to carry out record keeping in this instance?)***

- Knowledge of current legislation and practice standards
- Clinical knowledge required for client care
- Knowledge and experience using technology to store, protect, and transmit information
- Skill and experience in report writing and documentation
- Ability to communicate to client and family at an appropriate level

- Ability to identify potentially impaired decision-making capacity
- Therapeutic relationship with the client and family

2. Assess Probability and Degree of Harm:

Once risk factors are identified, the occupational therapist needs to assess how likely the risk factors are to occur (their probability) and the degree of harm or impact to the client, the occupational therapist, the organization, and the profession.



3. Mitigation Strategies:

Listed below are some potential strategies to mitigate risk. This list is not meant to be exhaustive, but to provide ideas:

- Collecting information that is only relevant and required to provide care
- Collecting information from multiple sources to ensure accuracy of information
- Maintaining accurate and complete documentation; documenting in a timely manner after provision of services
- Only using technology systems with high security systems; minimizing content communicated over e-mail and fax
- Being knowledgeable with current legislation and practice standards
- Obtaining consent prior to any disclosure of information
- Ensuring privacy of conversations that include confidential information
- Seeking assistance where needed

4. Record your Actions:

It is important to record the risk management actions taken to demonstrate that precautions were taken to protect the client from harm and minimize risk.

Approved By	Established	Reviewed/Revised	Reviewed/Revised	Next Review
PEICOT Council	November 4, 2020	March 2024		March 2027