



College of Occupational  
Therapists of Ontario

# STANDARDS FOR RECORD KEEPING







# STANDARDS FOR RECORD KEEPING

*Store at Tab #2 of your Registrant Resource Binder*

## Introduction

The *Regulated Health Professions Act, 1991* as amended (RHPA 1991), acknowledges occupational therapists as autonomous practitioners. Regulation of the profession also requires that occupational therapists practice according to established standards and principles of practice, and apply these consistently in a responsible and intentional manner within the health care environment. Although each area of practice has its own unique characteristics and challenges, the principles that guide practice are constant and apply across all environments.

Keeping records is an integral part of every occupational therapist's practice and a demonstration of their professional accountability. The client record is a legal document and source of evidence whose primary purpose is to officially record events, decisions, interventions, and plans. Records also act as a communication tool to aid in ensuring continuity of care that helps health care professionals provide care, manage and track a client's health care, services and outcomes. Records are used to communicate information to clients and stakeholders, and can be used to promote interprofessional collaboration. Records facilitate appropriate client care as well as enhance client safety.

Appropriate records demonstrate professional accountability by documenting service through the continuum of care, from receipt of the referral, through the discussions related to consent for assessment and treatment decisions, as well as goals, plans, and outcomes of care. Records reflect the occupational therapist's professional analysis and/or opinion, interventions, and recommendations. Records should also reflect information provided by the client, as well as communication between the occupational therapist and the client using any means. Records can demonstrate compliance with the standards of the profession as well as other standards, laws, and ethical considerations.

The Standards for Record Keeping have included much of the information contained within the *Personal Health Information Protection Act 2004* (PHIPA). However, where legislation exists that supercedes these standards, the legislation is the higher authority. Occupational therapists should consider their role related to record keeping within the context of PHIPA. 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 Privacy Commissioner, [www.ipc.on.ca](http://www.ipc.on.ca).

## STANDARDS FOR RECORD KEEPING

The purpose of this document is to ensure occupational therapists in Ontario are aware of the minimum expectations for record keeping within an occupational therapy practice.

College publications contain practice parameters and standards which should be considered by all Ontario occupational therapists in the care of their clients, and in the practice of the profession. College publications are developed in consultation with occupational therapists and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

### APPLICATION OF THE STANDARDS FOR RECORD KEEPING

- The following **standards** describe the minimum expectation for each aspect of record keeping within an occupational therapy practice.
- The **performance indicators** listed below each standard describe more specific behaviours that demonstrate the standard has been met.
- There may be some situations where the occupational therapist determines that a particular performance indicator is not relevant due to client factors and/or environmental factors.
- It is not expected that all performance indicators will be evident all the time, but could be demonstrated if requested.
- It is expected that occupational therapists will always use their clinical judgement to determine how to best maintain records based on the scope of the referral and stakeholder and client needs.
- It is expected that occupational therapists will be able to provide the rationale for any variations from the standard.

### OVERVIEW OF THE STANDARDS FOR RECORD KEEPING

1. Clinical Record Information
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4. Application of Signature
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## (1) Clinical Record Information

### Standard

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 occupational therapy service provided.

### Performance Indicators (Record Keeping)

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

- 1.1 Full name and contact information of the source of referral of the client, including self referral;
- 1.2 Reason for the referral;
- 1.3 Client's full name and address, date of birth, and unique identifier (if applicable);
- 1.4 Date, time (if relevant), and duration of each professional encounter with the client is recorded and accessible for retrieval;  
*Note: Duration of the encounter can be recorded in the progress notes, a workload measurement system, daytimer, or through a billing system.*
- 1.5 Charts, notes, forms and other material, regardless of the medium or format (i.e. email, fax, telephone, etc.) in which relevant information has been received from, or provided to, the client or his or her authorized representatives or other health care professionals/other professionals involved in the client's care;
- 1.6 Record of any occupational therapy assessment including assessment procedures used, the results obtained, the conclusions, problem formulation or other professional opinion regarding client status;
- 1.7 Confirmation of accuracy/currency of information provided about the client on the referral;
- 1.8 Record of the occupational therapy intervention plan, formulated in collaboration with the client, including the goals of the prescribed intervention;
- 1.9 Clear reference to any specific care map, clinical pathway, or similar assessment/intervention plan used; a copy of the plan and any updates to it will be reasonably available;
- 1.10 Progress note(s), indicating the outcome of an intervention, each change in client condition, problem formulation or intervention plan/goals. Charting by exception is acceptable, when there are no changes to a previously documented care map, clinical pathway or similar intervention plan;
- 1.11 Every report sent or received respecting the client;  
*Note: A list of reports that have been reviewed and returned to the sender is also sufficient when not relied upon to deliver care, as long as the most relevant/current report and background information is retained by the occupational therapist in the client record.*

## STANDARDS FOR RECORD KEEPING

- 1.12 Each consent should be obtained, recorded, dated and maintained as part of the client record; (please refer to the *Standards for Consent*, COTO, 2008)
- 1.13 Name and designation of an individual to whom the occupational therapist has assigned a significant component of the intervention plan; e.g. Support Personnel and which tasks were assigned;
- 1.14 Specific information related to any referral made by the occupational therapist;
- 1.15 A record of any cancelled or missed appointment;  
**Note:** *Recording cancelled or missed appointments may not be practical or applicable in all practice settings.*
- 1.16 A record of discharge information (for example, this may include: client status at discharge, reason for discharge, explanatory note when intervention was initiated but not completed, summary of outcomes attained, recommendations for post-discharge home program, record of referrals).

### (2) Controlled Acts

In Ontario, there are certain acts outlined in the RHPA that are controlled or authorized to only designated professionals. Occupational therapists, may receive delegation from someone authorized to perform some of these acts in their stead.

#### Standard

The occupational therapist will document information on all delegated controlled acts that he or she performed for a client.

#### Performance Indicators (Controlled Acts)

An occupational therapist will:

- 2.1 Document in the client's health record which act has been delegated, any specific instructions related to the delegation, acceptance of the delegation, and the name, date, and designation of the person delegating the controlled act;
- 2.2 If performing a delegated controlled act through the use of a medical directive or other authority, reference the specific medical directive document or authority when documenting the details of performing the controlled act.

### (3) Organizational/Administrative Matters

There are several principles to keep in mind when using either the electronic record or a paper-based system. The ability to correct/modify/augment entries (notes, assessments/documents, etc.), while maintaining and preserving the original entry, must be made available and allow the author to indicate the type of change, i.e. a correction to erroneous information and the reason. The electronic system should record the date, time and user/author. In addition, the electronic system should leave an audit trail to prevent tampering with the record. The electronic system also needs the capacity to identify pending (incomplete documents) entries similar to notifications of incompleteness of records that occur in the paper world.

#### Standard

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 (Organizational/Administrative Matters)

An occupational therapist will ensure that:

- 3.1 Records are organized in a logical and systematic fashion to facilitate retrieval and use of the information;
- 3.2 Documentation is completed in a timely manner appropriate to the clinical situation;
- 3.3 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.);
- 3.4 Every entry in the record is dated, attested and the identity of the person who made the entry is identifiable;
- 3.5 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;
- 3.6 A record originating from more than one health care professional, where one of the contributors is an occupational therapist, contains the signature of the occupational therapist. If a combined disciplinary note/report is created, the occupational therapist should identify the portion of the note/report for which he or she is responsible and accountable. When two occupational therapists contribute to the same record, the signature/attestation of each is required. The record should clearly indicate the author of each entry and who rendered the services;
- 3.7 Copies of a record distributed without an original signature by the occupational therapist should clearly indicate where the original signed/attested record is located;
- 3.8 Draft documents kept on file are considered part of the record and will be released, upon client request;

**Note:** *Occupational therapists are not required to maintain draft documents or rough notes, however, these may be beneficial in certain practice situations.*

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- 3.9 Raw data gathered from standardized evaluation, which are not placed on the record, are retained separately in accordance with the *Standards for Record Keeping*, COTO 2008. A notation should be placed in the record indicating the existence of this raw data and its location;
- 3.10 The records may be created and maintained in a computer system if it has the following characteristics:
- 3.10.1 The system provides a visual display of the recorded information;
  - 3.10.2 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;
  - 3.10.3 The system is capable of printing the recorded information promptly for each client;
  - 3.10.4 The system is capable of allowing more than one author or contributor to sign/attest;
  - 3.10.5 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;
  - 3.10.6 The system maintains an audit trail which:
    - a) Records the date and time of each entry of information for each client;
    - b) Indicates the identity of the person who authored the entry;
    - c) Indicates any changes in the recorded information;
    - d) Preserves the original content of the recorded information when changed or updated;
  - 3.10.7 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.);
  - 3.10.8 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;
- 3.11 Modifications/Errors/Revisions/Additions:
- 3.11.1 Modifications (errors/revisions/additions) in the completed record for which the occupational therapist is responsible shall be identified, dated, signed/initialled by only the Registrant that entered it originally, without changing/obliterating/deleting the original entry whether in paper or electronic form;

- 3.11.2 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;
- 3.11.3 Error in e-records – the system should time stamp the initial (original entry), modification, or exchange of data and identify the individual taking the action;
- 3.11.4 Copies of the modifications, indicating the date and type of change and the reason for the change or updated report, will be sent to all recipients of the original document;
- 3.12 When completing a note for a client intervention that occurred on a date other than the current day, the Registrant will apply the current date to the note and clearly state the date that the intervention occurred.

#### **(4) 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. Every entry on the client record should be signed/attested by the author and should not be made or signed by anyone but the author. Electronic signatures, if used, should be protected and linked to a user ID and password.

##### **Standard**

The occupational therapist will ensure that documentation is accurate and complete prior to applying his/her signature.

##### **Performance Indicators (Application of Signature-attestation)**

An occupational therapist will:

- 4.1 Sign/attest each of his/her entries on the client record;
- 4.2 Only sign or permit to be issued in his/her name any report or similar document once he or she has ascertained or has taken reasonable measures to determine the accuracy of its contents. This includes ensuring the report does not contain statements that the occupational therapist knows or ought to know are false, misleading or otherwise improper;
- 4.3 Use a digital or electronic signature where the signature is protected and applied through a password and user ID;
- 4.4 Use acceptable signatures which include: The author's full name and designation; the author's first initial and full last name and designation; the author's initials, where the full name and designation is clearly referenced and easily accessed for identification.

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### (5) 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. This includes determining if they are acting as the Health Information Custodian or an Agent. A Health Information Custodian is described as a health care practitioner who provides health care for payment whether or not the services are publicly funded. An Agent is someone who is authorized to act on behalf of a custodian as would be the case of an occupational therapist employed by a hospital to provide health care. Agents may include employees and volunteers. Occupational therapists are expected to consult the relevant legislation to determine their role in this context.

#### Standard

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 (Privacy and Access)

An occupational therapist will:

- 5.1 Collect only personal health information that is necessary and pertinent to the purpose of the collection;
- 5.2 Collect, use, and disclose personal health information only with consent unless otherwise permitted to do so by law;
- 5.3 Ensure that the individual's health information is accurate, complete and current for the purpose for which the information is being used;
- 5.4 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;
- 5.5 Inform individuals of the existence, use, and disclosure of his or her personal health information.
- 5.6 Provide copies from a client's clinical record for which the member is the health information custodian, to any of the following persons on request:  
**Note:** Refer to the Personal Health Information Protection Act, 2004 for more detailed information.
  - 5.6.1 The client;
  - 5.6.2 A person who has a signed consent from the client to obtain copies from the record;
  - 5.6.3 If the client is deceased, the client's legal representative;
  - 5.6.4 If the client lacks capacity to give an authorization:
    - 5.6.4.1 An official guardian appointed by the court;
    - 5.6.4.2 A person holding an appropriate power of attorney;
    - 5.6.4.3 A representative of the Consent and Capacity Board;

5.6.4.4 Spouse, partner or relative in the following order:

- a) Spouse or partner;
- b) Child, if 16 or over; custodial parent;
- c) Parent who has only a right of access;
- d) Brother or Sister;
- e) Any other relative.

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

5.8 An occupational therapist may:

- 5.8.1 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;
- 5.8.2 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;
- 5.8.3 Refuse to grant an individual access to a client record if another reason for refusal in the *Personal Health Information Protection Act, 2004*, applies.  
**Note:** *Health Information Custodians may only refuse access in limited situations including: the information is subject to legal privilege, information was collected as part of an investigation, or another law prohibits the disclosure of that information.*

An occupational therapist will:

5.9 With consent of the client, allow another health professional, external to the employment organization/agency of the member, to examine the client clinical record or give a health professional any information from the record they are legally entitled to receive;

(Lock Box) Where the client directs that part of the information be withheld, that request will be respected. The recipient must be notified that part of the information has been withheld if the information withheld is deemed reasonably necessary to disclose it for the provision of health care or assisting in the provision of health care to the client;

5.10 Respect a client's request for a change to his/her 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;

5.11 Take reasonable measures to ensure the preservation, security and ongoing access to his/her 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.

### (6) 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.

#### Standard

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 (Confidentiality and Security)

An occupational therapist will:

- 6.1 Take reasonable measures to ensure client personal health information is secure from unauthorized access, loss or theft;
- 6.2 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, 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;
- 6.3 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.;
- 6.4 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;
- 6.5 Make reasonable efforts to notify the individual(s) involved if their information has been lost or stolen, or accessed without their authorization;
- 6.6 Access only records that are applicable to one's practice;
- 6.7 Ensure that client information to be delivered by mail, is sealed, addressed accurately and marked "confidential";
- 6.8 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 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.*
- 6.9 Ensure electronic communication over the internet is performed in a secure manner;

- 6.9.1 E-mail communication will be completed through encryption, locked and password protected;
- 6.9.2 E-mail communication should only occur over a secure network;
- 6.9.3 Express client consent should be obtained to use e-mail as a means of communication;
- 6.9.4 If an e-mail has been used by the occupational therapist to make decisions or to comprise a valid portion of the client's history/assessment, it should be retained as part of the record (electronic or paper). This may include the need to print and/or scan the document to have it preserved;
- 6.9.5 The occupational therapist should incorporate a confidentiality statement to affix to each outgoing e-mail;
- 6.9.6 The amount of personal information in an e-mail should be limited to essential information;
- 6.10 Ensure that personal health information will only be electronically exchanged with known and authenticated sources and destinations, only over secure networks. Information sent electronically should be encrypted, locked, and password protected;
- 6.11 Ensure and uphold authentication principles, such as user identification and passwords before allowing access when using an electronic health record.

## **(7) Retention and Destruction**

### **Standard**

The occupational therapist, if he or she is 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 (Retention and Destruction)**

An occupational therapist will ensure:

- 7.1 A record is retained for at least ten years from the latter of the date of the last entry in the record or the date ten years after the day on which the client reached or would have become 18 years old;
- 7.2 Raw data, whether kept on the record or separately, is retained for at least 10 years from the day on which the client reached or would have become 18 years old;
- 7.3 That destruction of a record, both in electronic form and paper, is done in a secure manner that prevents anyone from accessing, discovering or otherwise obtaining the information (e.g. cross-shredding, incineration etc.);

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- 7.4 A list of names and dates for those files that have been destroyed is maintained in perpetuity or until maintaining the list is no longer reasonably necessary according to facility or practice policy;
- 7.5 Records are maintained after the 10 year period if it is reasonably known that a piece of health information will be required after the 10 year mark for a valid reason (ongoing care, legal proceeding);
- 7.6 Records, regardless of the medium used, should be stored and maintained to safeguard the privacy and security of this health information;
- 7.7 Retention of audio/visual multi-media (photos, videotapes, audio-tapes, images, etc.) created/obtained with client consent, is part of the client's record, and should be maintained in accordance with policies and procedures developed to safeguard the privacy and security of this health information. All multi-media should clearly identify the client's name, unique identifier, and date;
- 7.8 Audio/visual multi-media is subject to the same retention and destruction requirements of paper health information. The deletion/erasure/destruction of electronic health information should be accomplished in a manner that does not permit recovery of data.

### (8) Registrant Resignation

#### Standard

The occupational therapist, if he or she is the Health Information Custodian, will take reasonable steps prior to resigning as a Registrant of the College, or before undergoing a suspension or revocation of his/her certificate of registration, to ensure that clients retain right of access to their records.

#### Performance Indicators (Registrant Resignation)

An occupational therapist who is the Health Information Custodian will:

- 8.1 Maintain these records for, at a minimum, the retention period defined in this standard or any other relevant statute or regulation; and
  - 8.2 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 his/her record;
- OR
- 8.3 Transfer the records to either 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 *Personal Health Information Protection Act, 2004*; and
  - 8.4 When transferring records, make reasonable efforts to notify the individual before transferring the records, or, if that is not reasonably possible, as soon as possible after transferring the records.

## (9) Financial Records

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

### Standard

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 (Financial Records)

An occupational therapist will:

- 9.1 Ensure the financial records include:
  - 9.1.1 A clear identification of the person(s) who provided the product or service and his or her title;
  - 9.1.2 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);
  - 9.1.3 The identification or description of item/service sold;
  - 9.1.4 The cost of the item/service;
  - 9.1.5 The date the item/service was sold/provided;
  - 9.1.6 The date and method of payment received;
  - 9.1.7 Any differential fees charged for services provided by occupational therapist support personnel;
  - 9.1.8 The reason(s) why a fee may have been reduced or waived;
  - 9.1.9 Where the fees were charged to a third party, the full name and address of the third party;
  - 9.1.10 Any balance due or owing; and
  - 9.1.11 Information that documents the retention of an agency for the collection of the outstanding balance.
- 9.2 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.

## STANDARDS FOR RECORD KEEPING

### (10) Equipment Records

The equipment and assessment tools used by occupational therapists require periodic maintenance and inspection for safety and efficiency/accuracy. Occupational therapists have a responsibility to ensure that records of these activities are maintained, even if this activity and the records are completed by a facility maintenance department. These records are different than those related to specific client equipment such as wheelchairs and equipment clients purchase for activities of daily living. Records about specific client equipment are generally kept in the individual client record.

#### Standard

The occupational therapist will ensure the creation and retention of records of servicing, maintenance and inspection of equipment, and assessment tools used in practice that may pose a risk of harm to a client, or a risk of affecting the accuracy or efficacy of the assessment or treatment results.

#### Performance Indicators (Equipment Record)

An occupational therapist will:

- 10.1 Ensure that a record and schedule to track servicing, maintenance and inspection of equipment is developed and maintained;
- 10.2 Ensure equipment records are retained for a minimum of 5 years from the date of last entry, even if the equipment is discarded.

### (11) Monitoring of Records

#### Standard

The occupational therapist will take all reasonable steps to ensure that records are kept in accordance with this standard for record keeping.

#### Performance Indicators (Monitoring of Records)

An occupational therapist will:

- 11.1 Verify at reasonable intervals, that the records are kept in accordance with professional standards including the *Standards of Practice for Record Keeping, COTO 2008*;
- 11.2 Establish and/or adhere to facility policies and procedures for the management of records and as per relevant legislation.

## (12) Records Available to the College

### Standard

The occupational therapist will make his or her books, records, documents and other items relevant to his or her practice of occupational therapy available during reasonable hours for inspection, testing or copying by a person appointed for the purpose under the RHPA.

### Performance Indicators (Records Available to the College)

12.1 An occupational therapist will not charge a fee for any copies of a record requested by the College.

11.2 An occupational therapist will not be required to obtain consent nor inform the client if records are submitted to the College.

**Note:** *Under the Regulated Health Professions Act, 1991 (as, amended) client consent is not required to submit records to the College.*

## GLOSSARY

Agent	An Agent is an individual who is authorized to perform services or activities on behalf of a health information custodian.
Attendance Record	A document that lists a client visit by a health professional for a specific date.
Attest/Attestation	The process of assigning responsibility and authorship for an activity, usually by applying a signature.
Care Pathway/Clinical Pathway	An outline of anticipated care, placed in an appropriate timeframe, to help a client with a specific condition or set of symptoms move progressively through a clinical experience to anticipated positive outcomes.
Care Protocol	This term is intended to capture any care map, clinical pathway, or protocol that has been developed and approved for client use.
Charting	The process of recording client care data into a health record.
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	A non-defined term under the <i>Personal Health Information Protection Act, 2004</i> , (PHIPA) used to describe Health Information Custodians and their authorized agents who are permitted to rely on an individual's implied consent when collecting, using, disclosing, or handling personal health information for the purpose of providing direct health care.
Client	The client (also referred to as "the patient" in the RHPA) is the individual (or group of individuals) or the client's authorized representative, whose occupational performance issue(s) is the focus of care.

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Collaborative Care	Collaborative care, which may require a broad network of collaborative interactions among a variety of health service providers, clients, their families and caregivers, and the community, with clients being both the focal points and full-fledged partners of the overall effort.
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.
Controlled Acts	Are those acts identified in the <i>Regulated Health Professions Act, 1991</i> (as amended). Controlled acts are restricted to designated professionals because the risk of harm to the client is perceived to be significant.
Custodian or Health Information Custodian	This is a listed individual or organization under PHIPA that, as a result of his/her or its power or duties, has custody or control of personal health information.
Delegation	Refers to the transfer of authority from one practitioner to another to perform a controlled act (versus the <b>assignment</b> of tasks to support personnel).
Designation	The term designation is used to denote the authorized use of title and/or its abbreviation — for occupational therapists the abbreviation is OT Reg. (Ont.).
Digital Signature	An electronic signature that uses encryption technology to provide a unique signature that verifies its authenticity, integrity (cannot be altered) and non-repudiation (signer cannot easily deny affixing the signature).
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 (referred to as plaintext) using an algorithm (called cipher) to make it unreadable to anyone except those possessing special knowledge, usually referred to as a key.
Firewall	A firewall is a dedicated appliance, or software running on another computer, which inspects network traffic passing through it, and denies or permits passage based on a set of rules.
Interdisciplinary Care Model	An outline of anticipated care, involving two or more health disciplines, placed in an appropriate timeframe, to help a client with a specific condition or set of symptoms move progressively through a clinical experience, to positive outcomes.

Lock Box	A “lock-box” is a term of reference in the <i>Personal Health Information Protection Act, 2004</i> , used to describe the right of an individual to instruct a health information custodian not to disclose specified personal health information to another custodian for the purpose of providing health care. An individual can be said to have placed his/her personal health information into a lock-box by expressly withholding or withdrawing consent for his/her health information to be collected, used or disclosed.
Locked Document	A document may be “locked for editing” which means that the author or system administrator has disabled the means to edit a document in an electronic form.
Personal Health Information	Personal information related to an individual health and health care as defined in the <i>Personal Health Information Protection Act, 2004</i> .
Personal Information	Information about an identifiable individual, excluding the name, title or business address or telephone number of an employee of a healthcare agency (PIPEDA).
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	This is the right individuals have 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.
Protocols	(see Care/Clinical Pathways, etc.)
Raw Data	Data recorded for standardized or non-standardized assessments which have not been processed. (converted into scales scores or modified by statistical means).
Record	A record means information, however recorded (e.g. written, electronically recorded/entered, audio, video, photographs, diskette), generated (in the case of an occupational therapy record) by the occupational therapist or an individual supervised by the occupational therapist, pertaining to occupational therapy services provided by the occupational therapist. 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.)

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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.
Sign/Signature	The Registrant's signature or attestation, including an electronic signature as long as the Registrant takes reasonable steps to ensure that only the Registrant can affix it.
Stakeholder	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.
Time Stamping	Time stamping is a process used primarily in the electronic health record. Time stamping provides proof that a document existed at a specific date/time.
Third Party	Someone other than the principals (usually the client and the occupational therapist) who are involved in a transaction.
Unique Identifier	A number assigned to a case file to identify a unique individual and to distinguish them from others.

### References

Access and Disclosure of Personal Health Information, Position Statement, Canadian Health Information Management Association. CHIMA, 2004, reprinted, 2007.

A Guide to the Personal Health Information Protection Act, Information and Privacy Commissioner of Ontario, [www.ipc.on.ca](http://www.ipc.on.ca)

Frequently Asked Questions: Personal Health Information Protection Act, Information and Privacy Commissioner of Ontario, February, 2005.

Practice Guideline: Client Records, College of Occupational Therapists of Ontario, January 1999.

Standards of Practice for Physiotherapists: Record Keeping, College of Physiotherapists of Ontario, 2007.

The Guide to Managing Health Records in Community Care Agencies, Canadian Health Information Management Association. CHIMA, 2003, Revised, 2007.

<http://www.jr2.ox.ac.uk/bandolier/booth/glossary/ICP.html> – Care pathway definition

<http://www.shis.uth.tmc.edu/education/masters-thesis-2/aranzamendez04> – Charting by exception definition

[http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/collabor/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/collabor/index_e.html) – Collaborative care definition

[http://www.wordnet-online.com/third\\_party.shtml](http://www.wordnet-online.com/third_party.shtml) – Third party definition

## Frequently Asked Questions and Answers

**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. All raw data should be retained as it is an integral part of each client's record. It provides evidence for how your professional opinion was established and is required if your findings in the record are disputed. Raw data includes any sources that are used to form your clinical opinion. Raw data can be in a variety of formats (e.g. videotape, audio recording, print, electronic) and can include things such as e-mails, completed assessments and forms, invoices, faxes, etc.

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. 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 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 (<http://www.cra-arc.gc.ca/tax/business/topics/keeprec/menu-e.html>).

**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

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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. These standards for keeping records in electronic format reflect the recommendations and guidelines outlined by the Information and Privacy Commissioner.

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 his/her contribution when signing the report.
- Q. What should I do if I am receiving information from a client by e-mail?**
- A. 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. Discussion with the client should also be had on why you will not be able to respond to their e-mails using this method. It may be helpful to the client to suggest more secure methods of communication such as using the telephone or a secure fax line. 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 you client in the client's record. You can avoid this situation by not providing your clients with your e-mail address.



