College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

Record Keeping Review Tool

Use the Record Keeping Review Tool to assess the content of your clinical records.

1. Use the tool for self or peer assessment.
2. Select a minimum of 3 client records for review.
3. Review each record against requirements of the Standards for Record Keeping.*
4. Rate each indicator to identify potential gaps in practice.
5. Incorporate any gaps into your annual Professional Development Plan.
6. Share strategies with your colleagues to improve the quality of your documentation.

*Not all requirements are included in the Review Tool. Refer to the Standards for Record Keeping to be sure you meet all performance expectations.

Occupational therapist:		**Record scoring key:** Y - Item present N - Item not present N/A - Item not applicable			**Comments and recommendations:**
Records reviewed by:					
Date of review:		**Client Record**			
		1	**2**	**3**	
Organization and administration					
Records are legible and understandable					
Records are organized in a systematic fashion					
Every entry in the record is dated					
Every entry in the record is signed using the appropriate designation					
Client indentifiers are included on each part of the record					
Abbreviations, acronyms, and diagrams have supporting references					
Modifications/errors/revisions/additions are clearly indicated without changing/obliterating/deleting the original entry					
Documentation is completed in a timely manner appropriate to the clinical situation					
Clinical record information					
Client's full name, address, and unique identifier (for example, date of birth, record or claim number)					
Referral source and purpose of the referral					
Client information is accurate and current					
Date of each professional encounter					
Charts, notes, forms and other material regardless of medium or format relevant to the client's care					

Record of any occupational therapy assessment including assessment procedures used, results obtained, conclusions, problem formulation, or other professional opinion				
Evidence of client collaboration				
Rationale for opinions and recommendations				
Record of any occupational therapy intervention plan including goals of the prescribed intervention				
Reference to any specific care map, clinical pathway, or protocol used				
Progress note(s) indicating the outcome of an intervention, change in the client condition, problem formulation, intervention plans and goals				
Discharge information or discontinuation note				
Consent				
Informed consent for all interventions (assessment, treatment or consultation)				
Informed consent for the collection, use, and disclosure of personal health information				
Informed consent for the assigning of occupational therapy components or the transfer of care to other care providers (for example, OTSP, student, covering therapists)				
Controlled acts				
Details of the controlled act delegated (reference to any medical directives or orders)				
Acceptance of the delegation				
Information about the performance of the act and the outcomes of the intervention				
Privacy and access				
Only information relevant to the OT intervention is collected				
Financial records				
Client's full name, address and applicable unique identifiers				
Description of the item/service sold and associated fees				
Date and method of payment for the item/service received				
Where the fees were charged to a third party, the full name and address of the third party				