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

Standard

Standards for Record Keeping

Revised February 2016

Originally Issued July 2008

Introduction

Keeping records is an integral part of occupational therapy practice and demonstrates the occupational therapist's accountability as a regulated health professional. Clinical, mixed-practice and non-clinical occupational therapists (OTs) have record keeping responsibilities related to the appropriate management of information and effective communication as outlined in Essential Competency 5 (Essential Competencies of Practice, 2011). The Standards for Record Keeping focus on the record keeping responsibilities related to clinical records, financial records and equipment maintenance.

The client record is a legal document and source of evidence intended to officially record events, decisions, interventions, and plans made in the course of the OT-client relationship. Records serve as a tool to aid in continuity of care, assisting health care professionals to monitor a client's health status, services provided and outcomes. Records are used to communicate information to clients and stakeholders and can be used to promote interprofessional collaboration. Records that comply with the Standards for Record Keeping facilitate safe, effective, ethical client care.

Appropriate records demonstrate professional accountability by documenting service through the continuum of care from receipt of the referral through to discharge. They reflect processes such as informed consent, collaborative goal setting, clinical reasoning and care planning as well as evaluation of client outcomes. Records should reflect the OT's professional analysis and/or opinion, interventions, recommendations and ethical considerations. Records should incorporate information provided by the client as well as communication between the OT and the client. Records can demonstrate compliance with laws and professional standards as well as organization-specific policies and procedures.

The Standards for Record Keeping address many of the same requirements that are covered by the *Personal Health Information Protection Act, 2004* (PHIPA). OTs must know and understand the record keeping requirements of their specific practice as responsibilities will vary depending on the role each OT assumes under PHIPA. Prior to delivering occupational therapy service, an OT must establish whether they are the **Health Information Custodian** or **Agent of the Health Information Custodian** to ensure appropriate management of personal health information. For more information about this topic, refer to PHIPA or the Office of the Information and Privacy Commissioner of Ontario.

The Standards for Record Keeping reference the documentation obligations set out in other College publications (for example, standards, guidelines, guides and position papers) to provide a comprehensive reference for record keeping expectations.

The purpose of these Standards is to ensure OTs in Ontario are aware of the minimum expectations for record keeping. Record keeping is a requirement for all aspects of occupational therapy clinical practice including individual and group interventions. OTs are expected to adhere to the Standards for Record Keeping and be aware of all legislation, standards, and policies applicable to the area of practice and practice setting. Where practice setting policies exceed the requirements of these Standards, OTs are also expected to adhere to the practice setting policies.

Application of the Standards for Record Keeping

- The following **standards** describe the minimum expectations for OTs.
- The **performance indicators** listed below each standard describe more specific behaviours that demonstrate the Standard has been met.
- It is not expected that all performance indicators will be evident all the time. It is expected performance indicators could be demonstrated if requested.
- There may be some situations where the OT determines that a particular performance indicator has less relevance due to client factors or environmental factors. Such situations may call for the OT to seek further clarification.
- It is expected that OTs will always use their clinical judgement to determine how to best maintain records based on the scope of the practice, practice setting, client and stakeholder needs.
- It is expected that therapists will be able to provide reasonable rationale for any variations from the Standard.

College publications contain practice parameters and standards which should be considered by all Ontario OTs in the care of their clients and in the practice of the profession. College publications are developed in consultation with OTs 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.

Pursuant to the *Regulated Health Professions Act, 1991* (RHPA), the College is authorized to make regulations in relation to professional practice. The College's Professional Misconduct Regulation establishes that "contravening, by act or omission, a standard of practice of the profession or failing to maintain a standard of the profession" constitutes grounds for professional misconduct.

Overview of the Standards for Record Keeping

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2. Documenting Receipt of Delegation of Controlled Acts
3. Organizational Administrative Matters
4. Application of Signature
5. Privacy and Access
6. Confidentiality and Security
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9. Financial Records
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1. Clinical Record Information

The clinical record assists OTs to provide safe, effective, ethical client care. The clinical record is a living document that should tell the story of the client and facilitate continuity of care among health professionals and service providers. OTs must document sufficient information to support the legal, communication, care planning and client outcome monitoring functions of record keeping in the context of their practice setting. Documentation, whether in paper or electronic format, must meet the minimum expectations for record keeping. Occupational therapy interventions occur with individual clients and with groups. To ensure the clinical record contains the necessary information to support the primary functions of record keeping, OTs must consider their scope of practice, the nature of the client-therapist relationship, the objectives and risks of the intervention as well as the expectations of the client. Proactively defining the scope and format of service delivery will support decision-making related to the content of the clinical record and may facilitate the development of protocols for efficient documentation.

For group interventions, there may be considerable variability in the nature of the therapeutic relationship and the objectives of the intervention that may influence the record keeping. For example, an OT offering a drop-in education session on arthritis to members of a community centre may choose to document differently than an OT offering intensive cognitive behavioural therapy to a group of six clients over the course of a year-long program. OTs are expected to use their professional judgement and consider the context of their practice in the application of record keeping standards.

Standard 1

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

Performance Indicators

An occupational therapist will document or ensure that the clinical record includes:

1.1	Client's full name and address, date of birth, and unique identifier (if applicable);
1.2	Full name and contact information of the client referral source, including self-referral and the purpose for the referral;
1.3	Confirmation of accuracy/currency of information provided about the client on the referral;
1.4	Date of each professional encounter with the client (dates must be accessible for retrieval). Time and duration, while not required, may be appropriate for the practice setting; **Note**: If required by practice setting, time and duration of the encounter may be recorded in the progress notes, workload measurement system, or through a billing process.
1.5	Charts, notes, forms and other material regardless of the medium or format (for example, email, fax, telephone) in which relevant information has been received from or provided to the client or his or her authorized representatives, other health care professionals or service providers 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. **Note:** Please refer to the Standards for Occupational Therapy Assessments.
1.7	Record of the occupational therapy intervention plan formulated in collaboration with the client, including the goals of the prescribed intervention;

1.8	Reference to any specific care map, clinical pathway, or similar assessment/intervention plan used. A copy of the plan (and any revisions) will be reasonably available;
1.9	Progress note(s), indicating the outcome of an intervention, each change in client condition, problem formulation or intervention plans and goals. Charting by exception is acceptable when there are no changes to a previously documented care map, clinical pathway or intervention plan;
1.10	Every report sent or received by the OT with respect to 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 OT in the client record;
1.11	Every consent obtained; **Note**: Please refer to the Standards for Consent, Standards for Supervision of Support Personnel; Standards for Supervision of Students.
1.12	Clear accountability for any occupational therapy service components assigned to other care providers (for example covering therapists, support personnel or students) that may include the name and designation of the individual or reference to process for providing coverage for occupational therapy service (for example, a roster system where different OTs are assigned accountability for service delivery in the absence of the treating OT). **Note**: Please refer to the Standards for the Supervision of Support Personnel and the Standards for the Supervision of Students
1.13	Specific information related to any referral made by the OT;
1.14	Record of any cancelled or missed appointments; **Note**: Recording cancelled or missed appointments may not be practical or applicable in all practice settings.
1.15	Discharge information (for example, 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. Receipt of Delegated Controlled Acts

The RHPA defines controlled acts that can only be performed by health professionals authorized to perform the acts. OTs may receive delegation to perform a controlled act from a professional authorized to perform and delegate the act. The following Standard reflects the documentation expectations for OTs receiving delegation of controlled acts and carrying out the controlled acts.

Standard 2

The occupational therapist will ensure that information is documented on all delegated controlled acts that he or she performs for a client.

Performance Indicators

An occupational therapist will:

2.1	Ensure that the client's health record contains reference to the controlled act which 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 (for example, referencing a medical directive or order may be appropriate). **Note**: Please refer to the Guide to the Controlled Acts and Delegation.
2.2	Document information about the performance of the act and the outcome of the intervention including the impact on the client.

3. Organizational and Administrative Matters

As occupational therapy practice evolves and technology advances, OTs are expected to understand record keeping principles and meet the Standards regardless of the format used for documentation. To ensure records are accurate and accessible, OTs must appropriately manage information in the context of their practice.

Interprofessional Documentation

Many OTs practice as part of an interprofessional team. Ensuring processes are in place to clearly document and demonstrate the accountability of each care provider for implementation of components of the care plan is essential to safe, effective care. OTs should ensure that any interprofessional or joint documentation with colleagues complies with the Standards for Record Keeping.

Centralized or Decentralized Records Management

Depending on the practice setting, teams may document in one centralized chart or maintain their own profession-specific records separately. Centralized records require OTs to confirm or determine up front who will assume the responsibility of health information custodian and accountability for the administration of the health record. Understanding or establishing organizational policies and procedures for record maintenance and future access by the OT should he or she leave the practice setting is essential to clarify expectations for all elements of record keeping.

Access to Client Records

OTs retaining separate independent client records must ensure clients are aware of the process to access their records. When appropriate, OTs should also ensure procedures are in place to notify interprofessional team members about the existence and location of independent records to support communication and continuity of care.

Standard 3

The occupational therapist will ensure records are legible; understandable; recorded in either official language of Canada (English or French); and, prepared and maintained in a timely and systematic manner that clearly delineates professional accountability for client care.

Performance Indicators

An OT will ensure that:

3.1	Records are organized in a 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 (for example, full name) and the client's unique identifier (for example, date of birth, record number, claim number);
3.4	Every entry in the record is dated, signed and the identity of the person who made the entry is identifiable;

3.5	Abbreviations, acronyms, and diagrams used in a client record have a supporting reference available for those who access the records to ensure consistency of interpretation;
3.6	If a combined inter/intraprofessional note/report is created, the portion of the note/report for which the OT is responsible and accountable (in the absence of this clear delineation, the OT is taking accountability for the entire report) is identified;
3.7	Any draft documents or rough notes kept on file are considered part of the record and will be released upon client request;
3.8	Data gathered by the OT and used to inform clinical decisions, which cannot be included or summarized in the record, will be retained with a notation in the record indicating the existence and location of this data (for example, paper-based standardized assessment forms with client drawings); **Note:** Converting data to an electronic format, for retention purposes, is appropriate as long as the integrity of the data is upheld.
3.9	A computer system used for the purpose of creating and maintaining records has the following characteristics:
3.9.1	The system provides a visual display of the recorded information;
3.9.2	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;
3.9.3	The system is capable of producing a copy of the recorded information for each client in a timely manner;
3.9.4	The system is capable of allowing more than one author or contributor to sign;
3.9.5	The system maintains an audit trail which:
(a)	Records the date 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.
3.9.6	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 (for example, locking of documents, read-only access, firewalls, encryption, etc.);
3.9.7	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 back-up process should be in place in the event the electronic record is not available due to unforeseen or scheduled downtime of the system;
3.10	Modifications/errors/revisions/additions are addressed in the following manner:
3.10.1	Modifications/errors/revisions/additions in the completed record for which the OT is responsible shall be identified, dated, signed/initialed only by the registrant who created the original entry, without changing/obliterating/deleting the original entry whether in paper or electronic form;
3.10.2	Modifications to a document after the document has been distributed will only be accomplished through the use of addenda. Copies of the addendum will be sent to all recipients of the original document;
3.10.3	When errors in the record are noted, the system will time stamp the original entry, modifications to the entry and/or exchange of data and identify the individual taking the action;
3.10.4	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.
3.11	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

The purpose of signing the clinical record is to assign responsibility and authorship for an activity. Every entry on the client record should be signed by the author and should not be made or signed by anyone but the author. Noting the protected title occupational therapist or designation OT Reg. (Ont.) transparently communicates that the author is a regulated health professional and more specifically an OT with accountabilities and responsibilities.

Note: Please refer to the Guide to Use of Title.

Standard 4

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

	Performance Indicators
An occupational therapist will:	
4.1	Sign 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 OT 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, and where the full name and designation is clearly referenced and easily accessed for identification.

5. Privacy and Access

Privacy relates to the right of individuals to determine when, how and to what extent they share their personal information. OTs must understand and correctly apply all applicable legislation and must

determine their personal roles and responsibilities within the context of his or her practice. The *Personal Health Information Protect Act, 2014* (PHIPA) defines the requirements for the collection, use and disclosure of personal health information and the responsibilities of Health Information Custodians (HIC) and Agents. Each of these roles has specific accountabilities for the client record. Depending on the practice setting, OTs may assume the role of HIC or Agent. For example, an OT with an independent practice may be considered the HIC, while an OT working as an employee in a hospital may be considered an Agent. OTs are expected to consult the relevant legislation to determine their role. It is essential that OTs understand their responsibilities to ensure client privacy and appropriate management of personal health information. In general, informed consent must be obtained from the client for the collection, use, and disclosure of personal health information and the client has the right to access his or her personal health information. Any exceptions are defined in the legislation.

Standard 5

The occupational therapist will ensure that the privacy of client information is maintained in accordance with all applicable legislation.

Performance Indicators

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 clinical record for which the OT is the health information custodian, to any of the following persons on request: **Note**: Refer to PHIPA 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	A 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	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. **Note:** Lock Box - Where the client directs that part of the information be withheld, that request will be respected. If the information withheld is deemed reasonably necessary for the provision of health care for the client, the recipient of the record must be notified that information has been withheld. The content of the withheld information must not be disclosed. An OT can only disclose personal health information about an individual without consent if the OT believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to the client or others.
5.9	Respect a client's request for a change to his/her record. This request can be in writing or be made orally. The OT 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 and the rationale for the decision.
5.10	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 OT has been employed, and is the Health Information Custodian, ceases to operate.

An occupational therapist may:

5.11.1	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;
5.11.2	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;

	Refuse to grant an individual access to a client record if another reason for refusal in the *Personal Health Information Protection Act, 2004*, applies.
5.11.3	**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.

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. Regardless of the record keeping format, content should be protected by procedures, information technology systems and/or functions that ensure maintenance of data integrity, security, reliability, trustworthiness and interoperability.

The *Personal Health Information Protection Act, 2004* (PHIPA) describes the requirements for confidentiality and security as follows:

> A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information in the custodian's custody or control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal. PHIPA, 2004, c. 3, Sched. A, s. 12 (1).
>
> A health information custodian shall ensure that the records of personal health information that it has in its custody or under its control are retained, transferred and disposed of in a secure manner and in accordance with the prescribed requirements, if any. PHIPA, 2004, c. 3, Sched. A, s. 13 (1).

OTs are expected to apply practices that ensure the confidentiality and security of personal health information is maintained in accordance with all applicable legislation.

Standard 6

The occupational therapist will ensure client confidentiality and security of client information to prevent unauthorized access and to maintain the integrity of the record.

	Performance Indicators
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 travel with client personal health information and/or limit the amount of personal health information transported in paper or electronic format to that which is essential for service delivery. If using electronic devices, OTs must take reasonable measures to ensure that personal health information stored on these devices is protected from unauthorized access which may include use of security methods such as encryption and/or 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 OT 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. The OT should incorporate a

	confidentiality statement to affix to any outgoing communications including email, fax and paper; **Note**: Safeguards may include confirming the email address, fax number or other contact information, periodic auditing of pre-programmed numbers, and transmission receipts.
6.9	Ensure that client information to be delivered by electronic communication is performed in a confidential and secure manner, for example, encrypted, password protected, secure network, and limit use of personal health information (data minimization principle, authenticated sources and destinations).

7. Retention and Destruction

Standard 7

If the occupational therapist is the Health Information Custodian, he or she 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, he or she 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:	
7.1	A record is retained for at least 10 years from the latter of the date of the last entry in the record or the date 10 years after the day on which the client reached or would have become 18 years old;
7.1.1	Records are maintained after the 10 year period if it is reasonably known that health information will be required for a valid reason, for example, notification of pending legal proceeding;
7.2	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, for example, cross-shredding, incineration etc.;

7.3	For health information custodians, 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;
7.4	Records, regardless of the medium used, should be stored and maintained to safeguard the privacy and security of this health information;
7.5	Retention of audio/visual multimedia (for example photos, video, audio recordings, 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 multimedia should clearly identify the client's name, unique identifier and date;
7.6	Audio/visual multimedia 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. Discontinuation or Transfer of Practice

OTs, 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 licence, death, disability, leave of absence.

Standard 8

If the occupational therapist is the Health Information Custodian, he or she will take reasonable steps to ensure that clients retain right of access to their records prior to discontinuation of practice.

Performance Indicators

An occupational therapist who is the Health Information Custodian will:

8.1	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 PHIPA;
8.2	Make reasonable efforts to notify the client to inform them about how they can access their record.

9. Financial Records

In every circumstance in which an OT 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 transparently document the financial transaction.

Note: Please refer to Business Practices in the Misconduct Regulations

Standard 9

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 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, for example, client's full name and address and unique identifier if applicable;
9.1.3	The particulars of item sold and/or service delivered;
9.1.4	The fee for 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 OT 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.

10. Equipment Records

The equipment and assessment tools used by OTs require periodic maintenance and inspection for safety, efficacy and accuracy. OTs have a responsibility to ensure that records of these activities are maintained, even if this activity and the associated record keeping 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 should generally be kept in the individual client record.

Standard 10

The occupational therapist will ensure that service maintenance records are kept for equipment used in the provision of care that may pose a risk of harm or impact the accuracy of assessment results.

Performance Indicators

An occupational therapist will:

10.1	Ensure that equipment maintenance activities such as inspection and servicing are documented. **Note:** OTs who own and operate their own equipment are responsible to develop equipment service protocols and maintenance records. OTs who are not directly accountable for equipment maintenance processes are responsible to ensure appropriate records are being maintained. For example, an OT working in a hospital is responsible to know and adhere to the equipment maintenance procedures of the organization and to ensure that maintenance records are kept.

10.2	Ensure equipment records are retained for a minimum of five years from the date of last entry even if the equipment is discarded;
10.3	Incorporate appropriate equipment documentation regarding cleaning, disinfection, and sterilization protocols into practice. **Note**: Please refer to Standards for Infection Prevention and Control

11. Records Available to the College

Standard 11

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

Performance Indicators

An occupational therapist will:	
11.1	Not charge a fee for any copies of a record requested by the College;
11.2	Not be required to obtain consent nor inform the client if records are submitted to the College. **Note**: Under the RHPA client consent is not required in order for an OT to submit records to the College in the course of a College proceeding or inquiry.

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.
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 service delivery.
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 *Personal Health Information Protection Act, 2004,* 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.
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 health care 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	Controlled acts, defined in the Regulated Health Professions Act, 1991, are acts restricted to authorized 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 assignment 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 email or similar technology.
Electronic health record	The longitudinal integration of a service recipient's health information collected over a period of time that resides within computer architecture.
Electronic signature	A signature applied by electronic means.
Encryption	Encryption is the process of transforming information (referred to as plain text) 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
Lock box	A term of reference in the Personal Health Information Protection Act, 2004, 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 *Personal Health Information Protection Act, 2004*.
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.
Record	A record means information, however recorded (for example written, electronically recorded/entered, audio, video, photographs, diskette), generated (in the case of an occupational therapy record) by the OT or an individual supervised by the OT, pertaining to occupational therapy services provided by the OT. This includes but is not limited to referrals, 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 to the record is sought, they are considered a legal part of the client’s record.)
Security	This is the administrative, physical and technological safeguards a health care 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, 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 OT) 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.

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