COLLEGE OF OCCUPATIONAL THERAPISTS OF NOVA SCOTIA

PRACTICE GUIDELINES:

CLIENT RECORDS

Practice Guidelines

Members of the College of Occupational Therapists of Nova Scotia are accountable for the practice they provide to the public. Guidelines are issued by the College for the assistance of the professional. They represent guidance from the College on how members should practice. Guidelines are intended to support, not replace, the exercise of professional judgement by therapists in particular situations.

COTNS Practice Guidelines: Clients Records

Background

Each year the College receives numerous phone calls from occupational therapists and members of the public regarding the issue of client records. Often, the individual is requesting additional information to that outlined in the *Occupational Therapists Act. 1998, c. 21, s. 1.* or the College regulations. Therefore, the College felt that the development of a practice guideline would assist occupational therapists in their practice. This practice guideline represents guidance from the College on how members should practice. Guidelines are intended to support, not replace, the exercise of professional judgement by therapists in particular situations.

This guideline was adapted from the College of Occupational Therapists of Ontario (COTO) Client Records Guideline. The guideline developed by COTO has become the standard for regulatory bodies in Canada and has been used by several provinces in the development of similar guidelines. The College's practice committee reviewed and revised this document to suit the needs of occupational therapists practicing in Nova Scotia, including ensuring all requirements of the *Occupational Therapists Act. 1998, c. 21, s. 1.* and the College Registration Regulations, specifically Section 57 were adequately reflected in the document.

Upon completion of this review and revisal, the draft document was sent to 15 occupational therapists from across the province for feedback. The College ensured that a wide variety of settings were included in this feedback including: a general hospital, a mental health facility and outpatient program, several private practice settings, an employer based setting, a community based practice setting, occupational therapy educational setting and a rehabilitation facility. The feedback was then incorporated into the final document and was sent to two provincial regulatory bodies for additional feedback.

A. Definitions

Member:

As defined by the *Occupational Therapists Act. 1998, c. 21, s. 1.*: member means " a person who is registered in the Register and holds a license."

Record:

A record means information, however recorded (e.g. audio, video, diskette), generated by the occupational therapist or an individual supervised by the occupational therapist, pertaining to occupational therapy services provided by the occupational therapist

Client:

The client is defined by the College as the individual(s) whose occupational performance issues have resulted in a referral for occupational therapy service. Most often the client is the direct recipient of occupational therapy service. The referral source or payer of the service is not defined as the client and while these individuals play an important role within service delivery, their interests are secondary to those of the client. Occupational therapists must establish and fulfill contractual agreements with stakeholders in a manner that respects the rights of the client.

Care Protocol:

This term is intended to capture any care map, clinical pathway or protocol that has been developed and approved for client use.

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.

Sign/Signature:

The member's signature, including an electronic signature as long as the member takes reasonable steps to ensure that only the member can affix it.

B. General Principles

1.0 A member is responsible for the content of the record related to the occupational therapy services. The record must reflect the member's professional analysis and/or opinion, intervention and recommendations.

2.0 A member shall take all reasonable steps to ensure that records of his or her practice are kept in accordance with this guideline. Reasonable steps include the verification by the registrant, at reasonable intervals, that the records are kept in accordance with this guideline.

3.0 Records will be kept respecting both reasonable measures of security, and the confidential nature of the material.

The records required shall be:

(i) Legible and understandable;
(ii) In English or French; and
(iii) Kept in a systematic, timely manner.

4.0 This guideline applies to members in <u>all</u> practice settings, but additional documentation requirements may be required depending on the policies of your work setting.

C. Record Information

1.0 In accordance with Registration Regulation 57(1)(c), a member shall maintain a legible record for each client that shall include:

(i) the name, address, age and sex of the client,
(ii) the name of the client's physician and/or referring agency,
(iii) the client's case history, including relevant medical and social data and an occupational profile which summarizes the client's prioritized occupational performance issues, occupational [performance components and environmental conditions, and the] client's strengths and resources,
(iv) the evaluation and assessment procedures utilized, the findings obtained, and the occupational performance issues identified,

(v) progress notes containing a record of the action plan implemented to achieve targeted outcomes, with progress, changes to the plans, reasons for the changes and referrals to other sources documented, and the status of the client on discharge,

(vi) copies of reports respecting the client received from other sources or issued to other sources,

(vii) documentation to substantiate the frequency the client was seen by the member, or rendered a professional service by the member in accordance with workplace requirements, where applicable,

(viii) where applicable, a record of the member's fees and charges, and

(ix) all applicable information from the referring source including diagnosis and prescription from a physician where required by the member's workplace.

2.0 The member shall document evidence of informed consent throughout the therapeutic process.

D. Administrative Matters

1.0 Every part of the record must have a reference identifying the client or the client's health record.

2.0 Every entry in the record must be dated, and the identity of the person who made the entry must be identifiable. Modifications to a document after the document has been distributed can only be accomplished through the use of addenda. Copies of the addendum must be sent to all recipients of the original document.

3.0 A member must not sign or permit to be issued in his/her name any report or similar document without ascertaining or taking reasonable measures to determine the accuracy of its contents. This includes ensuring the report does not contain a statement known or ought to have been known as false, misleading or otherwise improper.

4.0 A record originating from more than one contributor (e.g. a physiotherapist and an occupational therapist), where one of the contributors is a registrant, requires the signature of the registrant. When two occupational therapists contribute to the same record, the signature of each is required.

5.0 Copies of a record may be distributed without an original signature by the member only when the copy clearly indicates where the original may be located.

6.0 A member is not required to maintain draft documents. However, if such documents are kept on file they are considered part of the record upon client request.

7.0 Raw data gathered from standardized evaluation, which is not placed on the record, should be retained separately and consistent with this guideline.

8.0 (i) Errors in the record for which the member is responsible shall be identified and signed or initialed by the member;

(ii) Revisions to a record for which the member is responsible shall be identified and signed or initialed by the member.

9.0 The Records may be made and maintained in a computer system if it has the following characteristics:

(i) The system provides a visual display of the recorded information;

(ii) The system provides a means of access to the record of each client by the client's name.

(iii) The system is capable of printing the recorded information promptly;

(iv) The system is capable of visually displaying and printing the recorded information chronologically for each client;

(v) 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 made the entry and who rendered services;
- (c) Indicates any changes in the recorded information;
- (d) Preserves the original content of the recorded information when changed or updated; and
- (e) Is capable of printing separately the recorded information for each client.

(vi) The system provides reasonable protection against unauthorized access;

(vii) The system automatically backs up files and allows the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to, and inaccessibility of information.

10.0 A member transmitting records by either facsimile (fax) or electronic mail (e-mail) is accountable for assuring that confidentiality and security are maintained in all aspects of the transaction. E-mail communication of records must be completed through encryption.

E. Confidentiality and Access

1.0 A member shall provide copies from a client clinical record for which the member has primary responsibility to any of the following persons on request:

(i) The client;

(ii) A person who has a signed consent from the client to obtain copies from the record;

(iii) If the client is deceased, the client's legal representative;

(iv) If the client lacks capacity to give an authorization:

- (a) An official guardian appointed by the court.
- (b) An attorney for personal care.
- (c) Board appointed representative.
- (d) Spouse, partner or relative in the following order:
  - (i) Spouse or partner;
  - (ii) Child, if 16 or over; custodial parent;
  - (iii) Parent who has only a right of access;
  - (iv) Brother or Sister;
  - (v) Any other relative.

2.0 A member can refuse to provide copies from a record until the member is paid a reasonable fee.

3.0 A member can refuse to release a client record or a portion of the client record if the member reasonably believes the health or safety of the client or another individual is at risk. Reasons for the refusal must be provided to the requester in writing.

4.0 A member may, with consent of the client, allow another health professional, external to the employment organization/agency of the registrant, to examine the client clinical record or give a health professional any information from the record.

5.0 A client request for a change to his/her record must be in writing and must be respected by a member. The member must use his/her professional judgement as to whether to accommodate the request. The request must be responded to in writing. A notation of the request and the response must be made on the record. If a modification is made the member must consider section D. Part 2.0.

6.0 If the agency/organization in which the member is an employee is ceasing to operate, the member must take reasonable measures to ensure the preservation, security and ongoing access to his/her client record.

F. Retention and Destruction

1.0 Subject to subsection (4), a member shall keep the records required under clause (1)(c) in a systematic manner and shall retain each record for a period of not less than 6 years after the date of the last entry in the record and, upon cessation of practice, shall ensure the safe custody of the member's records. (In the case of minor children, records shall be maintained until the age of majority)

2.0 Destruction of a record must be done in a secure manner that prevents anyone from accessing, discovering or otherwise obtaining the information.

G. Custodial Requirements

Where

(a) a member

(i) dies, disappears, is imprisoned, leaves the Province or surrenders the members licence or specialist's licence,

(ii) is struck off a register or is the subject of suspension of licence or specialist's licence,

(iii) has been found to be an incapacitated or unfit member, or

(iv) neglects the practice of occupational therapy; and

(b) adequate provision has not been made for the protection of the member's clients interests, the College may, with or without notice as the court directs, request the court to appoint a custodian who is an occupational therapist to take possession of the client records of the member.

H. Financial Records

1.0 (i) A financial record shall be kept for every client to whom a fee is charged by the member;

(ii) The financial record must include the item/service sold, the cost of the item/service; the date the item/service was sold/provided; the individual or agency responsible for paying the fee and the date monies were received.

2.0 A financial record must be retained separately from the client record.

I. Equipment Record

1.0 An equipment service record shall be kept that sets out the servicing of the equipment used to examine, treat, or render any service to clients.

3.0 Equipment records must be retained for 5 years.

J. Records Available to College

1.0 A member shall make records kept pursuant to clause (1)(c) and books, records, documents, equipment and things relevant thereto available at reasonable hours for inspection by a member or members of a committee of the College.

2.0 A member shall not charge a fee for any copies of a record requested by the College.

NOTE: Adapted from College of Occupational Therapists of Ontario Practice Guidelines: Client Records