ASSOCIATION DES ERGOTHÉRAPEUTES DU N.-B.
N.B. ASSOCIATION OF OCCUPATIONAL THERAPISTS

NEW BRUNSWICK ASSOCIATION OF OCCUPATIONAL THERAPISTS

PRACTICE GUIDELINES: RECORDS KEEPING

Practice Guidelines

Members of the New Brunswick Association of Occupational Therapists are accountable for the practice they provide to the public. These guidelines are provided by the Association to assist the professional in practice. They are intended to support, not replace, the exercise of professional judgement by therapists in particular situations.

Background

Each year, the Association receives numerous phone calls from occupational therapists and members of the public regarding the issue of client records. Therefore, the Association felt that the development of a practice guideline would assist occupational therapists in their practice. Guidelines are intended to support, not replace, the exercise of professional judgement by therapists in particular situations.

This guideline was adapted from the following documents: College of Occupational Therapists of Nova Scotia (COTNS) *Practice Guidelines: Client Records* and College of Occupational Therapists of Ontario (COTO) *Client Records Guidelines,* 1999 and *Standards for Record Keeping,* 2008. The guideline developed by COTO has been used by several provinces in the development of similar guidelines. The NBAOT Registration Committee reviewed and revised this document to suit the needs of occupational therapists practicing in New Brunswick and to fulfill the object of the Association 3(2)(e) as found in *An Act Respecting the New Brunswick Association of Occupational Therapists, 1988, Chapter 76*.

Upon completion of this review and revision, the draft document was sent to the NBAOT Clinical Practice Committee for feedback and then was approved by Council.

A. Definitions

Member

As defined by *An Act Respecting the New Brunswick Association of Occupational Therapists. 1988, Chapter 76*: member means "a member of the Association."

Record

A record means information, however recorded (e.g., audio, video, electronic records), 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 Association 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.

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.

Circle of care

"Circle of care" usually includes those health service providers who provide healthcare to a client.

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. (NB).

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.

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).

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.

Registrant

A member of the Association

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 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/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, depending on language of the workplace; and
(iii) Kept in a systematic, timely manner.

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

C. Record Information

1.0 According to employer's policies, a member shall maintain a legible record for each client that shall include:

(i) The name, address, age and gender 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; 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 regarding 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;

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

(x) 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);

(xi) Specific information related to any referral made by the occupational therapist;

(xii) A record of discharge information (e.g., 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).

2.0 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 recognizable. Modifications to a document after the document has been distributed can only be accomplished through the use of an addendum. 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 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.

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

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

8.0 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 for each client;
(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; and
    (d) Preserves the original content of the recorded information when changed or updated;
(vi) The system provides reasonable protection against unauthorized access; and

(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 if email occurs outside of a secured network.

E. 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.

An occupational therapist will:

1.0 Sign/attest each of his/her entries on the client record;

2.0 Only sign or permit to be issued in his/her name any report or similar document once he/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;

3.0 Use a digital or electronic signature where the signature is protected and applied through a password and user ID;

4.0 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.

F. Confidentiality and Access

1.0 Collect only personal health information that is necessary and pertinent to the purpose of the provided service;

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

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

4.0 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) A person holding an appropriate power of attorney.

(c) 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.

* (This guideline should be followed unless employer's policies are different.):

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

6.0 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.

7.0 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.

8.0 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.

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

G. Confidentiality and Security

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

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

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

2.0 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;

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

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

5.0 Make reasonable efforts to notify the individual(s) involved if their information has been lost or stolen, or accessed without their authorization;

6.0 Access only records that are applicable to one's practice;

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

8.0 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.

9.0 Ensure electronic communication over the Internet is performed in a secure manner;

(i) E-mail communication will be completed through encryption, locked, and password protected;

(ii) E-mail communication should only occur over a secure network;

(iii) Express client consent should be obtained to use e-mail as a means of communication;

(iv) 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;

(v) The occupational therapist should incorporate a confidentiality statement to affix to each outgoing e-mail;

(vi) The amount of personal information in an e-mail should be limited to essential information;

10.0 Ensure that personal health information will only be electronically exchanged with known and authenticated sources and destinations, and only over secure networks. Information sent electronically should be encrypted, locked, and password protected;

11.0 Ensure and uphold authentication principles, such as user identification and passwords, before allowing access when using an electronic health record.

H. Retention and Destruction

1.0 A member shall keep the records in a systematic manner and shall retain each record for a period of not less than 10 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 or 10 years after last entry in the record.)

2.0 This guideline should be followed unless employer's policies are different.

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

I. Custodial Requirements

Where

(a) a member

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

(ii) is struck off a register or is the subject of suspension of 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 Association 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.

J. 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.

3.0 Financial records must be kept for a minimum of 7 years

K. Equipment Record

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.

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.

2.0 Equipment records must be retained for 5 years.

L. Records Available to Association

1.0 A member shall make his/her books, records, documents, equipment, and other items relevant to his/her practice available during reasonable hours for inspection, testing or copying by a person appointed by the Association.

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

NOTE: Adapted from College of Occupational Therapists of Ontario and College of Occupational Therapists of Nova Scotia.