College of Occupational Therapists of Ontario
Regulator of occupational therapists in Ontario

Record Keeping Review Tool

Occupational therapist:

Records reviewed by (optional):

Date of review:

Record Scoring Key

Y – Item present

N – Item not present

N/A – Item not applicable

Section A: 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 to review.
3. Review each record in combination with the Standards for Record Keeping.*
4. Rate each indicator to identify potential areas for learning in practice.

* Not all requirements are included in the Review Tool. This Review Tool should be used in conjunction with the Standards for Record Keeping to ensure performance expectations are met. References to the standard are indicated in RED.

		Client Record			Comments and Recommendations
		1	2	3	
Clinical Record Information – Each record includes:					
Client identifying information (client's name and unique identifier) 3.1, 5.1a					
Referral or service initiation information 3.1					
Service details 3.3	Assessments and reports used				
	Findings				
	Analysis/goals				
	Outcomes/interventions/recommendations/plans				
	Reference to any specific care map, clinical pathway or protocol used				
	Other clinically significant events				
Data that was used to inform clinical decisions (Paper-based standardized assessments which cannot be summarized in the record, should have their location noted or converted to electronic format) 2.8					

Clinical Record Information (Continued) **Each record includes:**	Client Record			Comments and Recommendations
	1	2	3	
Input and collaboration with clients/others 3.3				
Information that is accurate and complete 3.1, 2.4				
Information about group Interventions 3.4				
Information when services are transferred or ending 3.7				
Consent – Each record includes:				
Informed consent for all occupational therapy assessment 3.2				
Informed consent for ongoing occupational therapy service (intervention or consultation) 3.2				
Knowledgeable consent for the collection, use and disclosure of personal health information 3.2				
Informed consent for the assigning of occupational therapy components or transfer of care to other providers (e.g. OTA, student, covering therapist) 3.5				
Controlled Acts – N/A **Each record includes:**				
Details of the controlled act delegated (reference to any medical directives or orders) 3.6				
Acceptance of the delegation 3.6				
Information about the performance of the act and outcomes 3.6				
Supervision of Students and OTAs – N/A **Each record includes:**				
Names and titles of the persons assigned (if known) 3.5				
Tasks that have been assigned or any workplace protocol followed for task assignment 3.5				
Review records completed by students or OTAs and co-sign if required 4.4, 4.5				
Organization and Administration – Each record is:				
Legible and understandable 2.4				
Systematically organized 2.4				
Dated with every entry 2.2				
Signed with every entry or page 2.2				

Organization and Administration (Continued) **Each record includes:**	Client Record			Comments and Recommendations
	1	2	3	
Signed using appropriate title or designation 4.1				
Noted with the duration or timing of services provided 2.3				
Clear on the portion of the report for which the OT is responsible for in interprofessional reports 4.3				
Supported by an explanation or reference for abbreviations 2.5				
Modified or changed with: • An audit trail of changes while maintaining the original content • Clear identification by the OT or the person responsible for the record, with date and signature/initials 6.2				
Modified only by addendum after a document is distributed 6.2				
Documented in a timely manner in accordance with clinical need and organizational requirements 2.6				
Written using respectful, professional and culturally sensitive language 1.3				
Financial Records – N/A				
Full name and designation of the providers of the services or products 9.1 a				
Full name of the client to whom the services or products were provided 9.1 b				
Full name and address of any third party to whom fees were charged 9.1c				
Description of the items sold, or services delivered (Including dates and associated fees) 9.1 d e f				
Method of payment 9.1 g				
Invoice or receipt of payment 9.1 h				
Description of any differential fees charged (For example, reduced fees) 9.1 i				
Equipment Records – N/A				
Record of equipment maintenance activities or maintenance protocols 10.1				
Retention of equipment records for 5 years (even if the equipment is discarded) 10.3				

Section B: Use the following sections to assess your compliance with privacy laws, organizational policies and procedures.

	Client Record			Comments and Recommendations
	1	2	3	
Record Management – the OT is:				
Health information custodian (HIC)				
Agent of the HIC				
Privacy and Access – the OT:				
Is aware of the process to facilitate client access to their record 2.7				
Is aware of the process to respond to requests for changes to the record 6.1				
If under PHIPA, is aware of the policies for the management of lock box information 2.9a				
If acting as a HIC, has a contingency plan for unexpected events for client to access their record 2.9b				
Confidentiality and Security – the OT:				
Uses acceptable systems for maintaining records 5.1				
Has physical and technical safeguards to protect the privacy of health information for storage and during transport or transmission 7.2, 7.5				
Follows processes to ensure the security of signatures, including electronic signatures 4.2				
Follows processes to ensure the record is securely stored and managed to prevent unauthorized access 7.1, 7.4				
Retention and Destruction – Records (including audiovisual, multimedia and financial records) are:				
Retained for the necessary time period in accordance with the legislation and organizational policies applicable to the practice setting 11.1				
Retained beyond the necessary time period if there is a valid reason to believe the health information is needed (e.g., legal proceeding) 11.1				
Securely destroyed following legal and organizational requirements after retention requirement is met. A list of destroyed files is maintained. 11.1				