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

Record Keeping – *more than just a note*.

What to expect

This module is developed ***by*** occupational therapists ***for*** occupational therapists.

We want to thank the members of the COTO Quality Assurance Subcommittee for their wisdom and experiences that form the basis of this module.

The module highlights key record keeping concepts and challenges that occupational therapists face in day-to-day practice.

Each section includes:

- **Questions:** Questions and answers about record keeping.
- **Expectations and considerations:** Requirements and considerations to help make decisions.
- **In my practice:** Short scenarios provide an opportunity to see how other OTs apply the competencies and standards to actual practice. See how these can help you connect the learning to your practice.
- **In your practice:** Reflection questions allow a few moments to pause and reflect on your record keeping practices. Please note, the College does not record individual responses.

Why is record keeping important?

Record keeping is a foundational skill in occupational therapy practice. Our skills are often refined with training and experience. Whether you are in a clinical or non-clinical role, this training module is an opportunity for you to integrate insights and resources into your practice.

This topic is significant because records are legal documents that officially capture the entire cycle of the occupational therapy services provided- from initiation to discontinuation, and sometimes beyond.

Records are a mechanism to communicate health information to clients and other professionals, partners, and interested parties. They enable interprofessional collaboration and continuity of care. Client records demonstrate the provision of safe, ethical, and effective occupational therapy (*Standard for Record Keeping*, COTO, 2023).

Record keeping – it's more than just a note.

Research

Research indicates three relevant steps to incorporate into a health record to promote quality and continuity of care within evolving environments. They are:

1. Initiate new training and policies demonstrating a commitment to promoting diversity, equity, and inclusion in record keeping practices.
2. Implement additional and ongoing precautions to protect privacy and security with the use of emerging technologies used for record keeping; and
3. Incorporate regulatory and legislative requirements to direct record keeping practices.

Regarding artificial intelligence (AI), current health care trends in record keeping confirm a shift to electronic record keeping and the use of artificial intelligence (AI). As we move towards this change, using competencies and standards as a reference, having a consistent record keeping format improves transparency and accuracy.

Studies have also shown that privacy and security issues with record keeping continue to be a focus as technology changes and improves. Being up to date on legislative and policy requirements improves record keeping practices.

Research shows that providing continuous education to health professionals on record keeping improves the care provided to clients. Please see the list of references and resources below.

Trends from COTO

The College gathers data on challenges with record keeping from various programs. Here is the story the data tells:

Practice consultation

Record keeping is the topic most often asked about when occupational therapists reach out to the College's practice team for advice or information.

Resources

The Standard for Record Keeping is consistently one of the top three most viewed documents on the College website.

Concerns and complaints

When the College receives concerns and complaints about occupational therapy practice, record keeping is one of the key trends.

For instance, complaints about client records being incomplete or missing key information and not being completed in a timely way are common.

Competency assessment

Quality assurance data indicates that occupational therapists identify their main record keeping learning needs are:

- the timeliness of record keeping;
- what to do with draft notes and standardized assessments; and
- documenting discontinuation.

Module Sections

We asked a broad group of occupational therapists to tell us about their questions and challenges with record keeping. Each is presented as a theme in this module:

- **Section A.** Approach to record keeping;
- **Section B.** Content of the clinical record; and
- **Section C.** Security, confidentiality and access.

Resources

Each topic includes a reference to key College resource(s). There is a comprehensive resource list at the end of this module.

You can answer the reflective questions as you move through the module, or you may use the Scenario Reflection Worksheet. This worksheet also contains a list of the resources used in the creation of this module – it's your choice!

Before You Begin

A couple of things to keep in mind before you begin:

A snapshot: Much has been included in each section, but it is not exhaustive. The module serves as a general overview related to required Competencies and Standards. The module is intended to stimulate learning and continued quality improvement for documenting safe, effective, and ethical service.

Professional judgement: Some topics have established College expectations and others require critical considerations. In these cases, we have included key factors to help formulate professional reasoning and a rationale for decisions.

Information in this module does not take the place of legal advice.

Terminology: In this module, we use the terms "record keeping," "documentation," "notes," and "chart" synonymously. Similarly, other terms with similar meanings (such as the terms "client" and "patient") are used synonymously, which extends to substitute decision-makers where relevant.

Broad application: Examples address a variety of practice settings (clinical and non-clinical roles) representing the diverse nature of occupational therapy practice across the province.

Section A: Approach to record keeping

It is worth starting this module with some fundamentals that establish your overall approach to documentation in your practice.

Please take this time to be open and intentional about changes that might benefit your practice and the clients within it.

After all, your documentation is your opportunity to demonstrate that you have provided safe, ethical, and effective occupational therapy service.

1. Level of Detail

Occupational therapists ask: How detailed do my notes need to be?

Expectations and Considerations

The level of detail in an occupational therapist's notes varies and may be influenced by factors such as a client's risk, what is expected in the sector, what is required by organizational policy, and of course, your professional reasoning.

The expectation is that there should be enough detail included in the client record to capture the continuum of occupational therapy services provided—from beginning to end. The details of the record include aspects such as:

- the processes of consent and assessment;
- the analysis, intervention plan, monitoring, and outcome, including risk;
- client input or preference;
- discontinued or transferred service; and
- any other relevant information.

See section 3 (Know what details to record) of the **Standard for Record Keeping** document for the minimum expectations.

Test of time: The health record can be accessed by clients and others far into the future. Therefore, documentation should be concise, well thought out, and provide enough detail to present an accurate account of the client's journey through the continuum of occupational therapy service.

Risk: When detailing risk, provide enough information to clearly articulate the nature of the risk, efforts to manage the issue, outcome of interventions, and any input that the client has provided. Risk can be described qualitatively, for example, recording an observation or statement made by the client, or quantitatively, for example, recording the score of an assessment, or both.

Some ways to check for expectations about the level of detail in your documentation:

- Ask if your workplace may have a guideline or policy related to record keeping.
- Talk with a supervisor or manager—show them a sample entry and confirm the level of detail you have captured is appropriate.
- Add the topic to a team meeting so there is talk about an agreed upon and consistent approach to the level of detail needed.

Consider learning from a chart review—either self-directed or with a trusted colleague. You can use the Record Keeping Review Tool for this purpose.

We have much to share and learn from each other about documentation and aim to continually improve our practice.

In my practice

I am an OT working in schools. One of the factors that helps me to determine the level of detail needed in a report relates to risk. For example, if during a visit, I make recommendations regarding positioning a student for functional school activities, such as the use of a stander or height-adjustable desk and tilt wheelchair, my notes are more detailed than those following a visit to provide a "lunch and learn" session.

To mitigate risk, notes involving the use of equipment describe aspects such as: the training provided to educate staff who attended the training, questions addressed regarding the utility of my recommendations, plans for follow up, written notes left with the education team outlining positioning, and indicators that warrant contacting me for an earlier follow up visit. For example, a change in the personnel that is working with the student.

In your practice

What aspect(s) of your practice requires the most detailed documentation?

2. Organization

Occupational therapists ask: How should information in the client chart be organized?

Expectations and Considerations

Organization is a must. The information should be organized so it is understandable, concise, consecutive, and complete—from initiation to discontinuation. Clients and system partners (for example, parents, providers, funders) may request access to the clinical record.

Write your notes with the assumption that they can and will be reviewed by clients. Ask yourself: does your note make it easy for you and others to follow the clinical journey?

As per the **Standard for Record Keeping**, occupational therapists are required to "*keep records that are accurate and complete, clearly organized, legible, and in English or French*" (*Standard for Record Keeping*, 2.4).

To be sure that all the basics are included, see section 2 of the Standard for Record Keeping for the administrative requirements.

Being systematic helps you get organized and stay organized. You can use a variety of strategies to ensure completeness, such as:

- Using **templates** with all the required fields of information to record, for example, discharge summary template.
- Using a **structured documentation format**, for example, SOAP notes: Subjective, Objective, Assessment, and Plan.
- Including an **abbreviation list** or reference to a list noting its physical or electronic location.

We often use short forms, which can be efficient, but the meaning may not be obvious to others. Please be sure to "*explain abbreviations in a note or refer readers to a list of terms or abbreviations with explanations*" (*Standard for Record Keeping*, 2.5).

In my practice

I am an OT who owns a private clinic with a primarily pediatric population, and I oversee a team of Ots and other clinicians. I have seen how important good record keeping is, and I want to make it easy for my team to keep timely and complete records.

The patient information and record keeping software I have chosen to implement at my clinic offers a combination of checklist and fillable portions, such as the date, time, location, and client information, to list a few. There are also writing prompts for open-ended sections, such as SOAP or other narrative formats, to add additional context so that the rationale for decisions is clear. We also have sections for including short-term and long-term goals, and the option for having these goals automatically populate in the open-ended fields.

Feedback from my team is that having a consistent template for completing notes in an organized way allows them to ensure notes are completed quickly without missing any important information. For more detailed reporting, such as assessment reports or discharge summaries, we are creating templates with a similar approach to organizing information consistently and concisely.

In your practice

What strategies do you use to keep information in the chart accurate, complete, organized, and legible?

- Templates
- Structed documentation format
- Abbreviation list
- Use of Record Keeping Review Tool
- Other strategy

3. Sensitive Information

Occupational therapists ask: How do I document a difference of opinion from other team members?

How do I document if services are being discontinued due to limited resources or pressure?

Expectations and considerations

Each word matters. It is expected that occupational therapists "*keep all parts of records respectful, using professional and culturally sensitive language*" (*Standard for Record Keeping*, 1.3).

Difference of opinion: Opinions may vary, but the professional approach to documenting any difference of opinions does not. OTs should be reflective about the ways opinions are expressed and include a sound rationale for their professional judgement.

The content of records pertains to the client, should be factual, and is free from bias and extraneous information. The notes pertain to the client and should not be a place to air out debates. When the opinions differ from others, language should remain objective and professional.

Occupational therapists are guided by two fundamental values: **respect** and **trust (Code of Ethics)**. These can be applied to the words written as well as any attitudes and actions that are reflected in the record.

Managed resources: It's a balancing act. There are many involved in the health environment — clients, providers, organizations, and funders, just to name a few. Occupational therapists balance the needs of clients and the resources available. Accountability is to the clients and is extended to the organizations that facilitate service. Document respectfully about available resources and other potentially sensitive topics, for example, note alternatives considered and include a sound rationale for your professional opinion.

In my practice

I'm an OT in the auto sector. I work with clients in the community who often have a non-treating OT conducting a one-time assessment or independent examination. There have been occasions where the assessing OT's opinion differs from my own. Keeping the ***Code of Ethics*** *in mind, I need to be able to document my differing views respectfully and professionally.*

One approach may be to acknowledge the assessing OT's findings, then objectively state my findings, and add information that may provide more context for the potential differences in opinion. For example, the assessing OT's report may state that the client demonstrated independence with a select self-care task during the assessment.

Based on my work with the client, I could provide additional context by noting that while the client can perform a select self-care activity, they experience increased difficulty and need for assistance when more than one self-care activity is performed, such as in the context of a complete morning routine.

In my practice

I am an OT who works in homecare, and I collaborate with an OT colleague working in a local outpatient mental health program. Each of our clinical settings offers our clients a limited number of OT sessions. We have both struggled with coming to the end of the available sessions when the client still has OT needs.

To help address this challenge, we are careful to ensure the client is aware of the approved number of sessions as a part of the initial consent process and let them know what options exist if they want to pursue additional services, if any. This practice is documented in our clinical notes, such as "The client was made aware of the number of sessions available and the process for obtaining additional sessions was explained."

We also reiterate the number of remaining appointments with the client during subsequent OT sessions and document our collaborative goals based on the number of sessions available. At the end of the allotted sessions, we note the client's status and the reason for discharge, including a statement, such as "OT services are discontinued at this time, having completed the number of approved sessions. Options for additional services were reviewed with the client."

In your practice

What documentation strategies do you use when there are differing opinions?

4. Timing

Occupational therapists ask: What does timeliness mean for record keeping?

Expectations and considerations

Complete and timely documentation is of particular importance to prevent negative impacts on the client and other health practitioners involved in their care. The client's needs, changes in their condition, and the expectations and policies of the organizational setting determine the timeframe for the completion of clinical documentation. While occupational therapists need to complete records "*in a timely manner in accordance with the clinical need and organizational requirements*" (*Standard for Record Keeping*, 2.6), there is no single timeline for documentation that applies to the variability across all practice settings.

Occupational therapists will determine the timeline based on a combination of factors:

- reasonable timelines to meet the needs of the client;
- rationale about potential risks to the client;
- organizational expectations and industry norms;
- nature of the practice setting; and
- personal factors.

About personal factors: As many of us experience, memory wanes as time passes. Events become blurred and delaying documentation could impact the quality of the content. Other personal factors may include:

- time management routines;
- workload management and priorities; or
- access to technology and tools to support record keeping.

Research by Khumalo & Kane (2022) indicates that real-time data collection facilitates accurate recall and can improve care quality, coordination, and client-centeredness.

Consider that your record is a source of information for the family and care team about safe, ethical, and equitable service for a client.

Did you know? Early data from the quality assurance competency assessment shows that OTs do identify “timeliness” as an area for improvement in their record keeping.

About time

Consider the following guidance in the timeliness of documentation. See how these apply to the clients you work with:

- clinical factors and risk;
- organization guidance;
- industry norms; and
- access to service and resources.

Clinical factors and risk

Details about risks identified through formal or informal assessment and intervention are recorded in timely ways that minimize potential harm and increase client safety.

Ask yourself: Can my client’s safety be impacted by the timing of the information I document? Yes or no?

Organization guidance

Some organizations are explicit about documentation expectations, for example, how to gather and record consent. If you aren’t sure, check your organization’s policies or ask for support.

If you are in private practice, you may consider developing a policy document to describe specific record keeping practices. This encourages consistency and accountability. It also may prevent future problems before they arise. For example, when and how do you document financial transactions, changes to the client record, or the process to follow in the event of a privacy breach?

Ask yourself: Does my work have (or should I develop) additional guidance to follow about record keeping? Yes or no?

Industry norms

Timing may differ between industries and workplaces. There may be an expectation for "real-time" or immediate documentation in settings where there are quick changes in the client's status (For example, acute care in a hospital, or an increased likelihood of transfer between programs or services). Some industries account for the time needed to administer in-depth, comprehensive assessments, interventions, and follow-up reports.

Ask yourself: What is the expectation for the time to complete record keeping in my industry?

Access to services and resources

Timing of record keeping can also have implications for access to other services and funding. Promptness may facilitate a smooth transition and access to funding. A delay may have implications for continuity, a client's progress, and even safety.

Ask yourself: What implications does the timing of my documentation have for clients accessing services or other resources?

In my practice

I am an OT who works in the auto sector, where rehabilitation services are often linked to the timeliness of reports. I have many clients and I'm very busy with new referrals and ongoing clients. The timeliness of my reports can directly impact my clients' ability to access their auto benefits, including needed resources and rehabilitation. For example, completion of an Assessment of Attendant Care Needs (Form 1) at the time of a client's hospital discharge helps identify the need for assistance and includes recommendations for needed devices or equipment required to facilitate safety and occupational participation.

Without prompt completion of this documentation, the client is at risk of not receiving the needed resources by the time they are discharged home. Timely completion of initial assessments and progress reports are also instrumental in increasing the likelihood of a client's ability to access (and continue to access) occupational therapy services. These reports often contribute to their ability to obtain other rehabilitation services. Because time and funding are typically limited, my documentation must be as relevant and concise as possible so the insurer and others can readily identify the client's needs and my related recommendations.

In your practice

Which best describes the expectation for completion of documentation in your industry?

- Immediate;
- Same day;
- Within 24 hours;
- Within a week+;
- By exception; or
- Other.

How might the client be impacted if your documentation is delayed or incomplete?

5. Culturally safer practices

Occupational therapists ask: How can I make my documentation more culturally sensitive?

Expectations and considerations

There are many ways to enhance record keeping to reflect culturally safer language, attitudes, and behaviours. Occupational therapists "*practise self-awareness to minimize personal bias and inequitable behaviour based on social position and power.*" (*Competencies for Occupational Therapists in Canada* C2.2) This extends to our approach to documentation.

The way we phrase information may have an inherent judgment or bias often influenced by our social position. Be aware of what and how information is being conveyed in the record.

The expectation is that occupational therapists "*ensure that all information is truthful and accurate. Consider the subtleties of what is being said and what is not being said and how information is phrased. The occupational therapist should be mindful of their social positions and refrain from comments that contain biases when documenting about clients. For example, there is a difference in tone between writing that a client 'refused' versus 'declined' an element of service*" (*Standard for Record Keeping*, 1.1, 1.2).

Recognize how the sociopolitical context may impact access to care, quality of services, client choices and client interactions. Perhaps a client didn't attend a scheduled appointment; instead of recording the patient isn't being cooperative or non-compliant, consider other possibilities and ask questions.

Use respectful and culturally sensitive language in session and in record to prevent microaggressions, stigmatization, and further oppression. A record should tell descriptive story with humility, empathy, and vulnerability.

Consider how cultural practices and personal preferences can impact the recording of assessment and intervention. For example, when documenting about a kitchen assessment, use words the client would use about the type of food they typically eat or prepare at home without including cultural assumptions.

Research by MacLachlan and Grenier indicated that words used in medical records hold great power in terms of social norms which, when unrecognized, have the potential to cause harm in terms of therapeutic rapport, client outcomes, and systemic barriers. It is crucial to reflect on one's biases and use the power we hold in documentation as an advocacy tool against injustice.

Continually challenge your assumptions. For a more in-depth understanding, please see the Culture, Equity & Justice in Occupational Therapy Practice document. It has reflective questions that explore personal biases and thought-provoking questions on how to create culturally safer and accessible practice.

In my practice

I am an OT who works in an acute care hospital on the medical floor. When I assess activities of daily living, like self-feeding, I take into consideration the patient's beliefs about their need to be independent with this task. I ask the family and patient about their preferences. This consideration of culturally safe care is reflected in my documentation.

For example, rather than writing, "patient is dependent for self-feeding and lacks motivation to try. The patient is reliant on family to feed them," I would write, "it was noted that family members were feeding the patient. The writer discussed this with the patient and family, and it was reported that typically when a family member is sick, family members care for them." Before I submit my notes, I review them to make sure that they reflect my attempts to be unbiased and considerate of the health inequities of patients in my care.

In my practice

I am an OT who works in a busy pediatric clinic. Many online sessions are booked back-to-back. Time is of the essence and punctuality makes the day go a lot smoother. Over the years, I have a better understanding of some of the pressures that families face to get to an appointment. In the past, I may have documented lateness differently. For example, "Dad logged on to today's session 15 minutes late and did not show up to the last OT appointment. Non-compliant with all OT recommendations. Dad was disengaged in the OT session today."

I am increasingly more aware of my own biases and how using certain words can influence the interpretation. While the facts of the situation may not differ—the meaning can. By contrast, my documentation would instead be something like "Parent was able to log on for the last 30 minutes of today's session. They were unable to attend last week's session because of an unexpected appointment for their other child. They had attempted to provide opportunities for self-feeding, but due to competing demands, has not yet been able to follow up on other OT recommendations. We will explore these at the next meeting."

In your practice

What opportunities exist in your practice to document considerations related to culture, equity, and justice: Check all that you might document:

- The effects of systemic and historical factors on the client;
- Biases and social structures that privilege or marginalize this client;
- Factors that promote culturally specific occupational performance for the client;
- Factors that promote culturally safer and inclusive service for the client; or
- Other.

6. Emerging technology

Occupational therapists ask: What about using artificial intelligence (AI) in my work?

Expectations and considerations

Emerging technologies—specifically artificial intelligence—are being used in healthcare. Maybe you use this technology already or perhaps it is new to you. Here are some of the reported ways that AI may be used to make existing electronic health record systems more proficient.

Data extraction

The use of AI to review clinical documentation and identify key terms so related insights can be generated.

Predictive algorithms

The use of AI prediction models from large-scale data to gather information so providers can be alerted to clients that are most at risk for certain conditions or outcomes.

Data entry

The use of AI to create clinical notes using natural language processing.

Decision support

The use of AI to produce recommendations for treatment/services.

Technology may facilitate, but providers are the activators. When used responsibly, new and emerging technology can harness exciting potential in the health sector. We are tasked with using "*electronic and digital technologies responsibly*" (*Competencies for Occupational Therapists in Canada*, B2.3).

Occupational therapists are accountable for confirming that content is accurate and free from any bias that may disadvantage a client or client group. This means that you will be able to stand behind your professional rationale for any content that has been assisted with AI.

When you apply your signature to an entry, you are stating that the information is accurate and complete (*Standard for Record Keeping*, 4.1). You should also be aware of the safeguards in place to maintain the privacy and security of personal health information. With much being new, institutions are quickly developing policies and guidelines for the use of AI. If you are unsure, ask.

Considerations

1. Ethical implications: COTO should emphasize the importance of ethical considerations when using AI in occupational therapy practice. This includes ensuring patient privacy, data security, and transparency in decision-making processes.
2. Bias and fairness: COTO should guide occupational therapists to be aware of potential biases in AI algorithms and promote the use of fair and unbiased AI systems. It is crucial to ensure that AI does not perpetuate discrimination or inequities.

3. Reliability and accuracy: COTO should encourage occupational therapists to critically evaluate the reliability and accuracy of AI-generated recommendations or predictions. AI should be used as an aid, complementing the professional judgment of occupational therapists.
4. Patient-provider relationship: COTO should emphasize that AI should not replace the human connection between occupational therapists and their clients. Occupational therapists should ensure that the use of AI does not compromise the therapeutic relationship and the personalized care they provide.
5. Continuing education: COTO should promote continuing education and professional development opportunities for occupational therapists to stay updated with the latest advancements and research in AI. This will enable occupational therapists to effectively integrate AI into their practice.

In my practice

I am an OT and professional practice leader, and part of my role involves the development of policy and training materials for the Ots in my organization. For example, I've used AI to assist in developing guidelines on personal protective equipment in the home and community setting. While AI has helped develop my documents, I have had to review each sentence carefully to ensure accuracy and adherence to current guidelines, as some information was either incorrect or didn't apply to our OTs.

In my practice

I have been using AI to assist me in incorporating user friendly language in notes and reports for parents and teachers. When using AI, I am careful to avoid providing the application with any potential identifying information. I do not input any client identifiers like school, educator, or parent names. I review the AI-generated content closely to ensure any analysis is accurate and absent of any bias. While AI assists me with user friendly language, it still requires me to do a thorough clinical review.

In your practice

As technology evolves in your sector, where do you see the risks and benefits for clients?

Section B: Content of the clinical record

1. Emails/text information

Occupational therapists ask: Do I need to transcribe every phone call, email/text communication with a client?

Expectations and considerations

If the interaction has relevance, either clinical or otherwise, it needs to be added to the record. Consider the following when record keeping:

Professional judgement about clinical value: In some situations, it may be helpful to include the full text from electronic communication while in others it may be sufficient to summarize the relevant aspects in the clinical record. It may depend on the purpose of the information.

The **Standard for Record Keeping** notes that occupational therapists are to "*Record all findings, interventions, reports, and service details. Record client input and input from others (obtained with consent) that has clinical value*." (*Standard for Record Keeping*, 3.3)

Here are some questions to ask yourself, when deciding whether to include a summary or the full electronic communication in the record:

- Who is the Health Information Custodian (HIC) responsible for the custody of the electronic medical record? Does the HIC have policies to guide record keeping including the use of text/email communications with clients/others in the record? Refer to the Privacy Legislation and Occupational Therapy Practice document for details about the role of the HIC.
- Does your organization or private practice, have consent, usage, privacy, and exclusion policies to guide record keeping about text/email communications with clients/others?
- Which method respects the dignity of the client, for example, documenting only what is necessary?
- Does having the exact wording in the record address the client's needs?
- Can you adequately summarize the content of the electronic communication? Sometimes the nuances of a message matter. For example, it may be easy to summarize a simple text about a cancelled appointment compared to an email about a cancelled appointment with an explanation that has clinical implications.
- Is there capacity within the documentation system for uploading additional sources of information for example, email quotes from vendors?
- If uploading isn't available, how are additional information sources linked to the client's record?
- Are there potential legal reasons or risks to including complete electronic communication instead of summarizing, for example, threatening language?

In my practice

I am an OT working in the community with children and adolescents with mobility needs and their families. In addition to meetings, consultations and therapy sessions with my clients and their families, I spend a lot of time communicating with clients and vendors about trialing, ordering, and maintaining various mobility devices and equipment, including gait trainers or walkers. We communicate via text, email, and phone, depending on the situation.

For any correspondence where information about pertinent equipment and recommendations is shared by others, I will include the entire message thread as part of my clinical notes, for example, copy and paste the body of the text into my clinical notes. If we are just planning or discussing logistics, I will summarize these in my notes.

For example: "Spoke to Mike at Motion to set up equipment trial for 'pediatric gait trainer' for next Monday, September the 25th. Confirmed date and time with family via phone call and family will attend this appointment." For any additional information, such as a pricing quote or funding information, I will include these as an addendum to my clinical notes by uploading them as a PDF.

In my practice

I work in the hospital, in out-patient geriatric care. I do a lot of work communicating with external partners, organizations, and with the client to organize program participation. As I use electronic documentation, it is easiest to copy my entire email and load it into the e-documentation as this is more accurate and faster. At times, there may be information in the email that is not related to services and may be private. In these cases, I will redact portions of the email and indicate in my clinical notes that the information attached is only part of the email received.

In your practice

What factors help you to decide how to document electronic communication with clients? Check all that apply.

- Value: Does it add clinical value to have the exact wording in the record?
- Summarize: Can I effectively summarize the content of the electronic communication?
- System: Does my system enable or limit uploading of additional sources of information?
- Guidelines: What does the organization expect about charting text/email communications?
- Co-creation: Which method best respects the dignity of the client?
- Other: Are there legal or other reasons to include complete electronic communication?

2. Rough notes and paper assessments

Occupational therapists ask: What do I do with my rough notes and paper assessments?

Expectations and considerations

In short, if data from rough notes or assessments can be summarized adequately in the clinical record you are not required to keep paper copies unless you have other reasons for maintaining original copies, for example, organization policy or legal needs. If you do choose to scan or upload a copy of a rough note or assessment to the clinical record, check that the integrity of the data is kept intact during its transition to the electronic format (*Standard for Record Keeping*, 2.8).

Rough notes, paper assessments, and photographs, for example, a picture of a bathroom, are either kept securely as part of the clinical record or safely and confidentially destroyed.

In my practice

I work in the community primarily with older adults. My work often involves addressing home safety and *accessibility. During visits, I frequently sketch or take a picture of areas in the home that require my focus, problem-solving and recommendations. When I document these visits, I am often challenged with the question of the need to keep these sketches or photos.*

To help me decide if the images need to be stored in the client record, I ask myself if my narrative note will sufficiently capture the needed information. For example, I may have made a sketch or taken a photo to assist me in accurately describing my recommendations, for example, removing loose rugs in front of a sink or moving specific furniture to enable access. In these cases, the images can and should be securely destroyed when the information is captured in the record.

In your practice

What is your process for recording assessments in the record?

- Summarize the findings in a chart;
- Upload or refer to the location of the original assessment;
- Both — it depends on the use; or
- Other.

3. Consent

Occupational therapists ask: Can a signed consent form be enough for documentation? Electronic medical records consent is often a check box—is that enough?

Expectations and considerations

Documenting is a way to provide evidence that the consent process is addressed and may provide details about:

- confirming a client's ability to provide consent;
- the initial consent process at the beginning of service;
- ongoing consent — opportunities for clients to confirm or withdraw consent;
- questions clients have about the service or the information collected; and
- consent to disclose or share information.

Forms and check boxes augment the process and do not replace communication with clients about consent.

Consent forms can be one way to standardize methods of obtaining consent. Along with using a checkbox, there can be reference to a document or resource—such as a decision tree, consent checklist, or process—detailing what steps the occupational therapist followed during the consent process.

A checkbox doesn't necessarily provide evidence of the process used in determining or confirming a client's ability to provide consent. With complex situations, like people who have fluctuating ability to give consent, occupational therapists might need to document additional information. This could include the steps involved in determining capacity, the substitute decision-maker hierarchy, and details about the plan.

If you use a check box or standard consent form, there may be situations where additional information needs to be added to an open textbox on the fillable form or as a separate note in the record.

Legislation outlines the aspects that are to be included in the consent process. Refer to the Health Care Consent Act, 1996 and ensure the health record indicates that your clients have all the information a reasonable person would need to decide about the occupational therapy services. This information includes:

- scope and reason for the referral or services;
- purpose and nature of the services;
- expected benefits and risks of proceeding, including any cultural, ecological, or economic considerations;
- likely consequences of not proceeding;
- expected outcomes;
- alternative courses of action;
- the right of clients to withdraw consent at any time;
- how services will be paid for; and
- any legal authority given through a legal process for occupational therapy services.

Occupational therapists will want to include enough context about the consent, so it is evident that clients are provided with information to make informed decisions and to confirm compliance with legal expectations.

The detail of the documentation should provide a clear picture of how consent was obtained and be sufficient to stand the test of time should a question about the consent process or need for information arise in the future.

In my practice

I am an OT who has a private practice in psychotherapy. The clinic I work in provides a list of all the key areas that must be reviewed with clients when gathering consent. I wanted to be consistent with each client, so I created a form to fit my service. It helps to guide the conversation that I have with clients and their parents who often wonder about confidentiality.

I also provide and go through a "what to expect" one-pager that helps to describe the services and has some crisis resources. I include the signed and dated form so I know all the topics were discussed. I document any questions and if I had to make any determination about a client's ability to consent to services—especially with younger clients.

In my practice

I am an OT who works doing independent medical evaluations with the auto sector. When developing my written consent form, I made sure to include statements outlining both informed consent, like services that I am going to be providing, and knowledgeable consent, such as disclosure of personal health information.

Regarding knowledgeable consent, I clearly communicate who I will be sharing my report with. I also communicate that the client has the right to withdraw this consent at any time, but that it is not retroactive to information already shared. My knowledgeable consent section includes the following sections: client awareness of how personal health information will be used, consent to share report with third parties, client awareness of ability to withdraw consent of shared material.

In your practice

What are some of the ways you document consent to make sure that all the key aspects are covered? Check all that apply.

- I include a standard form so there is consistency in the consent communication;
- I make sure consent is a discussion — not just a form or check box;
- I document additional context about consent in open text areas;
- I document conversations with clients about ongoing consent throughout the service;
- I approach consent in a way that is agreed upon and consistent across the team; or
- Other.

4. Group intervention

Occupational therapists ask: What is the best way to document a group education session? What details are required?

If I co-lead a group, who has responsibility for documenting—me, them, or both of us?

Expectations and considerations

What to document: What and how group participation is documented can depend on the group purpose, level of risk, and what information is available. For example, it may be sufficient to document the collective, not individual, experience in drop-in groups, such as home safety education sessions.

Information to document about the **collective group experience** can include the date, participant names, if available, group content/description, copy of information provided to participants, overall feedback, and any unexpected events. This information should be maintained securely for possible future reference.

For groups where participants may receive **individual** assessment or intervention, and/or an increased level of risk, separate individual documentation is likely required for each person participating in the group, for example, cardiac rehabilitation or mental health groups.

The **Standard for Record Keeping** expects that occupational therapists will "*document relevant clinical information about group therapy in which clients participate, for example, stated goals, client insights, and*

adverse events. Notes may be made in individual client records or in a group record, such as a file containing a group's purpose, duration, attendance, and resources provided." (*Standard for Record Keeping*, 3.4).

Who documents for co-facilitated groups:

Before the group begins, decide who will document. Your organization may have a policy or develop the approach with the co-leaders before you start.

Perhaps you alternate or one provider may be the lead facilitator and take responsibility for the documentation in each client record while the other will refer to the more fulsome note in their record.

The role and responsibility of each facilitator should be clear, as well as who is taking accountability for various aspects of the group service. The record should present an accurate and sequential "client path" from the start to end of the continuum of occupational therapy service—even in situations where, because of the nature of the service, documentation is shared.

In my practice

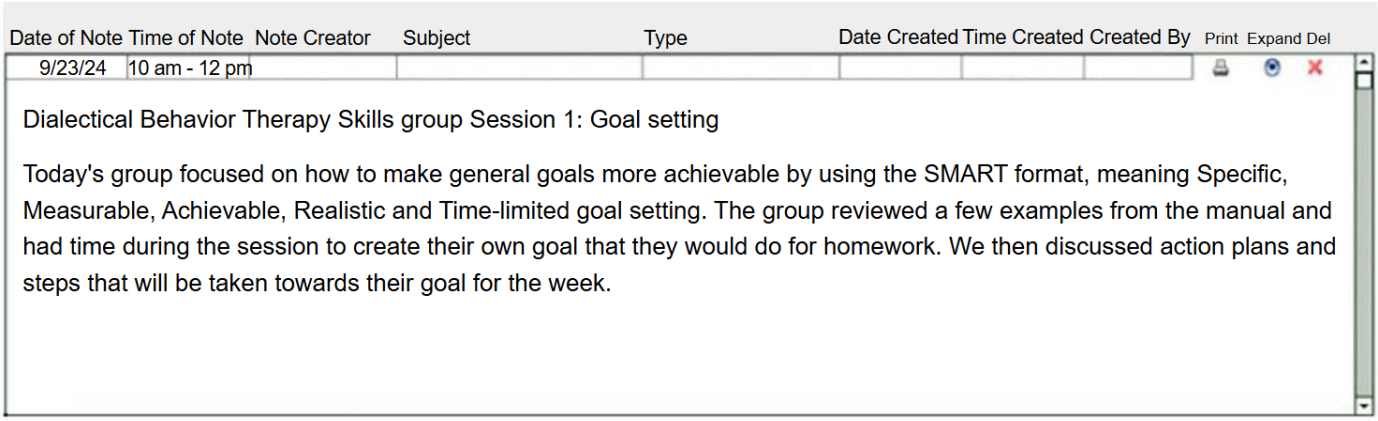
I am an OT working with youth in the community. I frequently offer programs for small groups of youth with physical disabilities to support developing community independence. To be efficient while ensuring my documentation was sufficiently detailed, I prepare program descriptions that outline the goals and activities for the series of sessions in the community independence program.

When a client joins the group, the program outline or protocol is uploaded into the client's record. With that level of detail available in the client record, each note can be brief, capturing the client's attendance, contributions, and any intervention that deviates from the outlined protocol for the group session. For example, a client's power mobility device failing, or a client being overwhelmed at a busy intersection.

While preparing the program outline requires preparation before the group sessions begin, the time required is much less than that required to provide detailed notes following each group session. With that, notes in the record are made in a timely way.

In my practice

As an OT working in mental health, I run an open Dialectical Behavioral Therapy group focused on skill development. I co-facilitated the group with a psychologist and agreed to alternate documentation weekly. Please see the sample text for group documentation for all client charts and individual notes for a client:



Date of Note	Time of Note	Note Creator	Subject	Type	Date Created	Time Created	Created By	Print	Expand	Del
9/23/24	10 am - 12 pm									

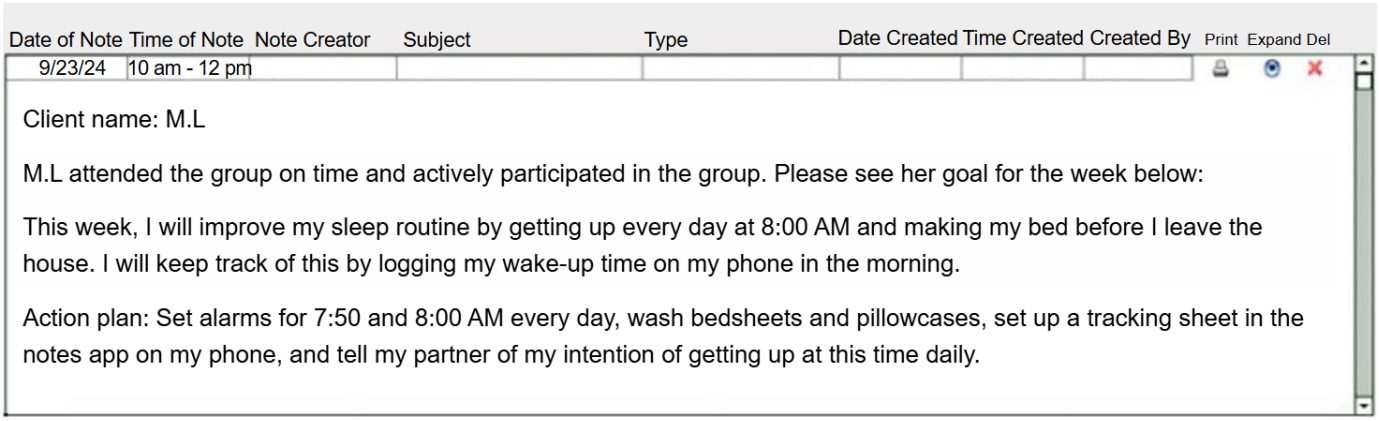
Dialectical Behavior Therapy Skills group Session 1: Goal setting

Today's group focused on how to make general goals more achievable by using the SMART format, meaning Specific, Measurable, Achievable, Realistic and Time-limited goal setting. The group reviewed a few examples from the manual and had time during the session to create their own goal that they would do for homework. We then discussed action plans and steps that will be taken towards their goal for the week.

Date: September 23rd, 2024, from 10 AM to 12 PM (virtual)

Name of group and session number: Dialectical Behavior Therapy Skills group Session 1: Goal setting

Outline of content: Today's group focused on how to make general goals more achievable by using the SMART format, meaning Specific, Measurable, Achievable, Realistic and Time-limited goal setting. The group reviewed a few examples from the manual and had time during the session to create their own goal that they would do for homework. We then discussed action plans and steps that will be taken towards their goal for the week.



Date of Note	Time of Note	Note Creator	Subject	Type	Date Created	Time Created	Created By	Print	Expand	Del
9/23/24	10 am - 12 pm									

Client name: M.L

M.L attended the group on time and actively participated in the group. Please see her goal for the week below:

This week, I will improve my sleep routine by getting up every day at 8:00 AM and making my bed before I leave the house. I will keep track of this by logging my wake-up time on my phone in the morning.

Action plan: Set alarms for 7:50 and 8:00 AM every day, wash bedsheets and pillowcases, set up a tracking sheet in the notes app on my phone, and tell my partner of my intention of getting up at this time daily.

Client name: M.L

Client-specific information: M.L attended the group on time and actively participated in the group. Please see her goal for the week below:

This week, I will improve my sleep routine by getting up every day at 8:00 AM and making my bed before I leave the house. I will keep track of this by logging my wake-up time on my phone in the morning.

Action plan: Set alarms for 7:50 and 8:00 AM every day, wash bedsheets and pillowcases, set up a tracking sheet in the notes app on my phone, and tell my partner of my intention of getting up at this time daily.

In your practice

Imagine that tomorrow you are asked to (co) facilitate a group. Which statement best describes your understanding of the expectations for documenting the group? For example, who takes responsibility for documenting co-facilitated groups, what details are included, etc.

- I am very confident about how to document group intervention;
- I have some confidence about how to document group intervention; or
- I have little confidence about how to document group intervention.

5. Assistants and students

Occupational therapists ask: What needs to be documented when assigning tasks to assistants and students?

Expectations and considerations

Communication is key. Occupational therapists who supervise students or occupational therapy assistants remain professionally accountable for clients receiving safe, appropriate, and ethical care. Keeping clear and accurate documentation is an official way to detail the roles of multiple providers.

When assigning a portion of the intervention to others in the **Standard for Record Keeping**, it is expected, at a minimum, that occupational therapists "*identify tasks that have been assigned to others (for example, occupational therapy assistants or students), and confirm that client consent was obtained. Include names and titles of the persons assigned if known or indicate any workplace protocol followed for assignment.*" (*Standard for Record Keeping*, 3.5)

In my practice

I work in the community where I also supervise OTAs. Before the OTA begins work with the client, I confirm the OTA's competence to carry out assigned tasks and I include the following in the client's record: client consent, the OT goals to be implemented by the OTA, and a supervision and communication plan.

After the OTA has begun work with the client, I document ongoing supervision of the OTA, including a review of their documentation and client progress. I also document the client's response to the services provided by the OTA, including my reassessment of the client and the progression of their goals, which are both communicated to the OTA. I note any questions or concerns the OTA may have and the direction I provide in response so that I know to follow up accordingly, for example, to contact the client or re-assess the assigned task.

In your practice

At a minimum, what do you document about the use of assistants and students?

- Client consent for involvement;
- Tasks that have been assigned;
- Name and title of the support person(s);
- Additional workplace guidelines; or
- Other.

6. Interprofessional teams

Occupational therapists ask: Interprofessional collaborative notes can be challenging. Who signs for interdisciplinary records?

Expectations and considerations

An occupational therapist signs for their portion of the service, indicating accountability. Interprofessional teams allow clients coordinated access to a variety of professionals with the common goal of improving health outcomes. The delineation of specific parts of the service can sometimes be hard to reflect in the clinical record, especially with overlapping roles. If someone unfamiliar with the team were to review the shared documentation would your accountability for the occupational therapy services be clear?

Risk-based approach: Consider your interprofessional practice and what client risks are co-managed by the members of the interprofessional team. Refer to organizational policy or develop an agreed upon approach with the team about accountability and timelines for documenting about any safety or other risk.

The **Standard for Record Keeping** notes that "*Where there are shared and overlapping roles and responsibilities with other professionals and combined reports are created, identify the portion of the report for which the occupational therapist is responsible. If there is no clear delineation, the occupational therapist is accountable for the entire report.*" (*Standard for Record Keeping*, 4.3)

Occupational therapists "*apply a signature to each entry after verifying that the information is accurate and complete. The signature must include the author's designation and either their full name or, if the full name is referenced or easily available, their first initial and last name or their initials.*" (*Standard for Record Keeping*, 4.1)

In my practice

In our acute care medicine stroke unit, I typically work closely with the physiotherapist to see clients for balance and mobility reassessments. We typically will split up charting, with only one of us entering the detailed information. When the physiotherapist does the detailed note, I will co-sign the note in the electronic documentation. I carefully review all the content to ensure it is accurate for me, within my scope of practice, and it is clear which provider is responsible for specific aspects of the service.

In my practice

As an OT on a geriatric outreach team, I meet with the patient separately from the other team members, including the nurse and geriatrician. Our notes are compiled into a comprehensive report and each of us applies our signature to the report and specifies which aspects of the service we are providing. To clearly record my role in creating the report I include the following information:

- *Where and when I met with the client and for how long;*
- *How consent was obtained and if other providers were involved;*
- *What assessments or investigations were completed; and*
- *Any consultations or other information reviewed to make my analysis and plan.*

This way the comprehensive service is captured in the report as well as the occupational therapy components of the service that I am taking accountability for providing.

In your practice

What strategies do you use in interprofessional documentation to clarify the accountability for occupational therapy services?

7. Discontinued & transfer of service

Occupational therapists ask: How do I document that services are not complete if the client is discharged or passes before completion?

What do I need to record if transferring care within the same organization?

Expectations and considerations

Unexpected discontinuation

Health fluctuates and is often unpredictable. When unforeseen events happen, efforts are made to reflect the status of occupational therapy service in both accurate and timely ways. If you no longer have access to a client record, please consult with a manager to determine if or how the final summary is to be captured.

The record should capture the entirety of the continuum of occupational therapy service — from start to finish. It should be accurate and complete. The **Standard for Record Keeping** requires that when services are ending, the record should "*Include relevant details when services are transferred or ending, for example, client status and input, transfer of accountability, resources provided, and recommendations and referrals.*" (*Standard for Record Keeping*, 3.7)

Transferring service

Accurate and timely documentation facilitates a smooth transition of occupational therapy services when transferring patients. It also reduces the risk during the switch in accountability so the receiving team will have timely information to manage any safety or care considerations.

When thinking about information to include in transfer notes, imagine the roles are reversed and consider what the most relevant information is for you to receive about a client coming into your service. Clinical factors, such as the referring source, completed and outstanding goals, risks, barriers, client input, and preference are important for a successful transition.

Also, think about any other details specific to the client that would be valuable to future providers so they can continue to provide safe and effective care.

In my practice

I work at a community hospital in the inpatient cardiology unit. Sometimes a client is discharged unexpectedly before all discharge plans are in place. While ending services unexpectedly sometimes cannot be avoided, the occupational therapist can play a central role in minimizing disruptions and helping to ensure their client's continued wellness.

For example, I will complete an ADL and home equipment assessment and documentation on a Friday with a plan to discuss the recommendation of home and community care on Monday, if the client consents, to initiate the referral. But if the client goes home over the weekend, I will follow up with the client by phone to discuss the home and community referral and equipment recommendations.

If the client consents to the referral, then I would initiate this through my hospital processes. I would then include a discharge note in the patient electronic medical record that includes all this information, such as the reason for discontinuation of OT services, recommendations and rationale for community services and equipment, client consent for referral to community OT services, and a record of the referral to community OT services.

In my practice

As a community occupational therapist, I work with older adults and they sometimes get admitted to hospital in the middle of our treatment. I follow the protocol which is to note the reason for discontinuation, the status of the goals, and indicate that the client has been discharged from my service. This way the status of the service is clearly documented.

In your practice

What details do you include in discharge/transfer notes to ensure a smooth and safe end to your occupational therapy service? Check all that apply.

- Client status (for example, achieved, and outstanding goals);
- Transfer of accountability (for example, service the client is being transferred to);
- Recommendations/referrals and resources provided;
- Barriers to progress or risk to safety;
- Client input/preference; or
- Other.

Section C: Privacy, confidentiality and access

1. Privacy laws

Occupational therapists ask: What privacy law applies to my occupational therapy practice?

Expectations and considerations

The privacy practices of occupational therapists in Ontario are guided by privacy legislation, College Standards, organizational policies, decisions from the Information and Privacy Commissioner of Ontario, and case law from the courts.

Three main privacy laws may apply to occupational therapy practice:

1. *Personal Health Information Protection Act (PHIPA);*
2. *Personal Information Protection and Electronic Documents Act (PIPEDA); and*
3. *Privacy Act.*

Services delivered in Indigenous communities or to Indigenous clients may be subject to additional laws, traditions, or rules of the applicable First Nation, Inuit, or Métis peoples.

The law that applies will depend on:

(1) whether the services provided (such as workplace evaluations or independent assessments) are considered healthcare or non-healthcare; and

(2) the type of organization through which services are funded or delivered (municipal, provincial, or federal government, or services to Indigenous communities).

Each law is outlined in more detail in the Privacy Legislation and Occupational Therapy Practice document. Take a deeper dive to see which applies to your specific practice.

In my practice

I am an occupational therapist and case manager who coordinates health services in the home and community. Our organization is the health information custodian. We contract occupational therapists from other organizations that act as the agent of the health information custodian to provide direct services to our community clients.

Providers, like occupational therapists, have standardized consent forms to go through with clients that include all the different parts of the consent process. This is so we can be sure that the gathered consent is considered valid according to PHIPA. As part of this role, the organization manages the record and I need to return all charts and other personal health information to the organization upon discharge or closure of a client's services. The service providers are not responsible for the long-term storage of this personal health information.

In your practice

Which privacy legislation applies to your practice? Check all that apply.

- Personal Health Information Protection Act;
- Personal Information Protection and Electronic Documents Act;
- Privacy Act;
- Other; or
- Not Sure (please check the Privacy Legislation and Occupational Therapy Practice document).

2. Health Information custodians & agents

Occupational therapists ask: What's the difference between a health information custodian and an agent?

Why does it matter?

Expectations and considerations

Most occupational therapists in Ontario must comply with the *Personal Health Information Protection Act* (PHIPA). This Ontario legislation sets out the rules that health information custodians must follow when collecting, using, and disclosing personal health information for health-related activities.

Health information custodians

This legislation (PHIPA) sets out the responsibilities of health information custodians to:

- protect personal health information,
- obtain consent for the collection, use, and disclosure of such information,
- respond to requests for the release of the information to third parties, and
- facilitate the rights of clients to access their health information and request for their health records to be corrected.

A health information custodian is defined as an individual or organization listed in PHIPA that has "custody or control of personal health information" by virtue of their professional role and/or responsibilities.

Occupational therapists are health information custodians for health records generated in their independent practices. However, when occupational therapists are employed or contracted by an organization, such as a hospital, long-term care home, or family health team, the organization is usually the custodian. If occupational therapists are working in a group practice, the group may be the custodian.

Agents

An "agent" is a person who is authorized to perform services or activities on behalf of a health information custodian. An agent can be a person or organization that contracts with, is employed by, is a student of, or volunteers for a custodian.

An agent is required to follow the custodian's policies for storing, safeguarding, retention, destruction, and responding to access and correction requests regarding the health record.

For example, an agent could be an occupational therapist who is contracted by a long-term care home where the home is the health information custodian. The occupational therapist must comply with PHIPA and follow the information practices of the long-term care home.

Why it matters… an occupational therapist must determine who the custodian is in the context of their work. A health information custodian remains accountable for the personal health information under its control and for the actions of its agents. More information on the responsibilities of each is described in the Privacy Legislation and Occupational Therapy Practice resource.

In my practice

I am a self-employed OT who is contracted by an agency to provide occupational therapy services in the community. The agency acts as the Health Information Custodian. As an agent, I follow PHIPA and comply with the agency's policies.

I am aware that I would need to notify the agency if any of my client's personal health information is stolen, lost, or accessed by unauthorized persons. I take the necessary steps to let the agency know if a request is made to access or correct personal health information. Once I discharge my clients from my services, I, as the agent, comply with the policies of the HIC by returning all personal health information to the agency.

In my practice

I work as an occupational therapist in the hand therapy program of the local hospital. Because my work is done on behalf of the hospital (the "custodian") I am considered the agent. The hospital sets the privacy policies for the organization, and it is my responsibility to know and comply with them. For example, what to do in the event of a privacy breach where a client's personal health information was accidentally shared.

In your practice

Do you work in the capacity of a: (check one)

- Health Information Custodian;
- Agent;
- Both;
- Neither; or
- Not sure (see the Privacy Legislation and Occupational Therapy Practice document).

3. Circle of care and implied consent

Occupational therapists ask: When does the "circle of care" apply?

Expectations and considerations

"Circle of care" is not defined in legislation; however, it is understood to include situations where health information custodians and their agents can assume that they have clients' implied consent to collect, use, or disclose personal health information to another custodian or agent for the purpose of providing healthcare.

This is most common in settings where occupational therapists work with interprofessional teams such as in hospitals, long-term care, primary care, and home and community care.

However, implied consent can also apply to the sharing of a client's personal health information with external healthcare providers. For example, occupational therapists sharing client information with community providers who offer services to the same client, such as a family doctor.

Health information custodians are entitled to assume that they have a client's implied consent to collect, use, or disclose personal health information with other direct healthcare provider custodians for a healthcare purpose unless the client has stated otherwise.

The ability to share information within the circle of care does not apply if consent is withdrawn or withheld. In these cases, express consent would be required for all future collection, use, and disclosure of client information.

Before disclosing information collected from clients, occupational therapists should consider carefully whether another healthcare provider is in the circle of care. Employers, insurance companies, educational institutions, and banks are just some examples of third parties who are not in the circle of care and for whom disclosure requires express consent unless otherwise permitted or required by law.

In my practice

In my occupational therapy work my clients typically have several people who are a part of the circle of care, or who may consider themselves to be a part of the circle of care (WSIB). During the consent process, I document the client's consent for me to share information with others involved such as vendors and PSW providers. Although the family doctor is typically assumed to be a part of the circle of care, it is my practice to document the type of information I may share with the doctor, such as potential fitness to drive or other safety concerns or comments, including no imminent risk.

In your practice

When I provide service to a client, the people considered in the "circle of care" may be:

- Interprofessional team assigned to the client;
- Referral source;
- Family/caregiver;
- Current external providers; or
- Other.

4. Lock box

Occupational therapists ask: What happens if a client tells me not to disclose certain information to another provider?

Expectations and considerations

You can record that information in a separate and secure way. A "consent directive" (also known as a "lock box") is a term used in PHIPA to describe the situation when clients expressly request that specific information not be disclosed to another healthcare provider who is giving them healthcare services.

When a client requests that clinical information not be shared with another healthcare provider within the same health information custodian, this situation is called a "restricted use." When a client wishes to prevent the disclosure of health information to external healthcare providers (other health information custodians), this situation is called a "restricted disclosure."

In situations where locked information cannot be disclosed to another healthcare provider, but the occupational therapist believes that disclosure of the information is reasonably necessary for the provision of client services, the occupational therapist must notify the other provider that information has been withheld. However, the content of the withheld information must not be disclosed.

Information that is subject to a consent directive may be disclosed if the occupational therapist believes, on reasonable grounds, that such disclosure is necessary for the purpose of reducing or eliminating significant risk of serious harm to an individual or a group of persons. Explain to the client why the information is being shared unless that poses a significant risk of serious harm to the health or safety of the client or others.

Why it matters… Occupational therapists working for health information custodians should confirm with the organization the process for implementing consent directives. Those working independently should set up policies and procedures in advance so they can accommodate these requests when they arise. More information on the guidelines for lock box can be found in the Privacy Legislation and Occupational Therapy Practice resource.

In my practice

I am an OT who works in an inpatient mental health unit. I mostly run groups but sometimes meet with people individually to provide supportive counselling and to prepare patients for discharge back home.

During the meeting, a patient disclosed some sensitive information about their past. Towards the end of the conversation, they circled back and wanted to make sure that I would not share what was disclosed with the other team members. In my notes, I documented "The OT indicates that some information has been withheld at the direction of the client as per policy." Our electronic record has an option for this protected entry. Before this, it was done as a separate paper record and stored securely.

In your practice

What steps would you take if a client asked you to withhold information from the rest of the care team?

5. Security of the record

Occupational therapists ask: How can I keep client records safe at work and at home?

Expectations and considerations

If you are allowed remote access to the client records, for example, as an independent contractor or working in your own private practice, you must put in place "*controls to securely store records (such as locked filing cabinets, restricted office access, a protocol for logging off devices after use, and secure passwords.*" (*Standard for Record Keeping*, 7.1)

If you work for an organization, please refer to their policy regarding accessing records outside of the workplace.

Please refer to working from home resources by the Information and Privacy Commission of Ontario.

In my practice

I work in the community, overseeing a team of OTs who work from their home offices when they're not seeing clients. Our company predominantly stores client records using the electronic client records platform. But we still maintain some paper-based documentation, such as original documents that have been scanned to the electronic records, handwritten session notes, documents with handwritten signatures, or paper assignments.

Our laptops also require a secure password to access electronic records through a VPN or virtual private network. All of us are required to lock our computers when we step away from our desks and the computers will automatically lock after a short period of inactivity.

When I provide orientation to new staff, I include instructions on various strategies to maximize the security of client records, including our need to ensure that no one can view or access our computer or phone screens. When we go to see clients in the community, I advise OTs to only take essential documents and avoid taking the entire file into the community or keeping it in their car.

Every OT is required to store paper-based documentation in a locked filing cabinet in their home office, and all unnecessary paper documentation containing client information is to be properly destroyed and not just placed in a recycling bin. Upon client discharge, OTs are required to use a courier service to send physical files to the company's secure storage. This helps limit the number of files that are kept in home offices.

In your practice

Which of the following security measures/processes do you use to keep records safe?

- Locked file cabinet;
- Encryption and password protection;
- Secure Wi-Fi;
- Up to date security software;
- Safe destruction process for electronic and paper materials;
- Secure devices when not in use or left unattended;
- Not work in public places to avoid eavesdropping or equipment loss and theft; or
- Other.

Summary

You have reached the end of this module on record keeping – more than just a note. We hope you have enjoyed the learning and that you can apply the information and examples to your practice.

Thank you.

College and Other Resources

Competencies

Competencies for Occupational Therapists in Canada

COTO Standards and Resources

Code of Ethics

The Standard for Record Keeping

The Record Keeping Review Tool

Privacy Legislation and Occupational Therapy Practice

The Personal Health Information Protection Act, 2004: A Guide for Regulated Health Professionals

Culture, Equity & Justice in Occupational Therapy Practice

Information and Privacy Commission of Ontario

Communicating Personal Health Information by Email

Privacy Factsheet on Working from Home

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