THE COLLEGE OF AUDIOLOGISTS AND SPEECH – LANGUAGE PATHOLOGISTS OF MANITOBA

PRACTICE DIRECTION: RECORD KEEPING

Regulated Health Professions Act, Section 85

BACKGROUND:

The College may issue Practice Directions in respect of the practice of a regulated health profession, (RHPA: Section 85).

These Practice Directions may be stand-alone documents or may enhance, explain, add to or guide registrants of the College with respect to subject matters described in the regulations, code of ethics, or other college documents.

A registrant of the College must comply with practice directions for the registrant's health profession, (RHPA: Section 86).

Official College documents such as Practice Directions contain practice parameters and standards which must be considered by all Manitoba audiologists and speech – language pathologists in the provision of health care service to their clients in the practice of the professions. College documents are developed in consultation with the professions and describe current professional expectations. It is important to note that these College documents may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

Hence, registrants shall comply with all applicable sections of the RHPA, General Regulation, and this Practice Direction relating to record keeping. In the event of any inconsistencies between this Practice Direction and any legislation that governs the practice of audiology and speech – language pathology, the legislation governs.

RECORD KEEPING

I. RATIONALE

Record keeping is an essential part of a health care service providers' practice regardless of the profession or the practice setting.

Records provide the ability to track the client's course, determine future care needs, and give evidence of and rationale for the treatment provided. Records also serve as an important communication tool to allow others to understand the client's past and current status. All this is done to facilitate safe, quality health care provision and to improve efficiency, consistency, and coordination.

Records are not just a memory aid for the documenting health care professional. Records tell the client's story by providing a record of each encounter including: what was done, by whom, when, where, why, the outcome and any recommendations for additional treatment or follow up.

Appropriate records demonstrate professional accountability by documenting assessments and analyses, discussions related to proposed interventions and consent, decisions and plans to implement treatment, and compliance with the standards of practice of the profession, other laws, and ethical obligations.

While the media (e.g., paper, computer hard drives or networks) and the tools (e.g., pen, keyboard or voice recorder) used to maintain records may vary from practice to practice, the essential principles of record keeping remain constant. This Practice Direction describes the essential elements and desired outcomes to be achieved by maintaining appropriate records. The details of how the elements can be achieved will vary according to practice setting, provider choice and client need.

II. STANDARDS OF PRACTICE

In Accordance with the CASLPM General Regulation, Part 5: Standards of Practice:

Client records

5.9(1) A registrant must appropriately document the provision of client care in a record specific to each client.

5.9(2) A client's record must be retained by the regulated registrant having last custody of it for at least 10 years after the date of the last entry on the record, and client records of minors must be retained for at least 10 years after the date the minor becomes 18 years old.

5.9(3) If a client or his or her authorized representative requests that a copy of the client's records be transferred to another regulated registrant or to a health care professional, the registrant must ensure that the request is complied with as promptly as required in the circumstances but no later than 30 days after the registrant receives the request.

5.9(4) A reasonable transfer fee may be approved by the council. A registrant may charge that fee in respect of approved transfers.

5.9(5) The obligations under this section are in addition to any other requirements relating to client records under the Act, The Personal Health Information Act, and any other enactment, by – law, standard of practice, code of ethics, and practice direction with which a registrant must comply.

Notice when closing or leaving practice

5.10(1) A registrant must give to his or her clients and the college at least 30 days written notice of the registrant's intention to close or change the location of his or her practice, cease to engage in or take a leave of absence from his or her professional practice.

5.10(2) The notice must include information about where client records are to be located and how copies of the records can be obtained from or transferred to another regulated registrant, health care professional or trustee under The Personal Health Information Act in Manitoba.

5.10(3) The registrar may waive or vary the requirements under this section in exceptional or extenuating circumstances.

5.10(4) This section does not apply if the client records are maintained by a trustee who employed or engaged the regulated registrant in his or her professional practice.

5.10(5) This section does not apply if the registrant engages in professional practice as an employee or independent contractor and the client records are transferred to a regulated registrant, or another health care professional, who is either an employee of the same

employer, or engaged by the same person, at the same practice location and with the same telephone number as that registrant.

Storing, accessing and disposing of client records

5.11(1) A registrant who closes or changes the location of his or her practice or ceases to engage in or takes leave of absence from professional practice must:

a. ensure the secure storage of any client records for the remainder of the retention period required by subsection 5.9(2) and, as required, ensure the destruction of the information in accordance with The Personal Health Information Act;

b. either

   i) ensure that clients will have a reasonable opportunity to obtain copies of their records as required under The Personal Health Information Act, or

   ii) transfer the records to another regulated registrant, health care professional or a trustee; and

c. give the college

   i) a copy of the notice provided to clients, according to The Personal Health Information Act requirements;

   ii) information about how the notice was provided to clients, and

   iii) a description of the arrangements that have been made for protecting, securely storing or disposing, or accessing client records.

5.11(2) The obligations under this section are in addition to any other requirements relating to client records under the Act, The Personal Health Information Act, and any other enactment, by – law, standard of practice, code of ethics, and practice direction with which a registrant must comply.

III. PERFORMANCE EXPECTATIONS

A registrant of the College demonstrates appropriate record – keeping relating to a registrant's practice by:

1. A registrant shall, in relation to his or her practice, take all reasonable steps necessary to ensure that records are kept in accordance with this practice direction and the Personal Health Information Act (PHIA) and Regulations.

2. Each registrant shall maintain a system that records the date of each contact with a client whom the registrant assesses or treats.

3. Each registrant shall keep an equipment service record which sets out a record of the servicing of those pieces of equipment which the registrant uses to examine, treat or render service to clients and which, if not properly serviced, create a risk of harm to clients or a risk of affecting the accuracy of assessment or treatment results.

4.0 Financial Records

4.1 Each registrant shall keep a financial record for each client in situations where the registrant, either directly or indirectly through a third party, bills for the services provided to that client.

4.2 The financial record must contain the following information concerning the services performed and the amount billed:

a. the recipient of the services;

b. the provider of the services;

c. the date the services were performed;

d. the nature of the services performed;

e. the unit fee for the services;

f. the total charge for the services;

g. whether payment has been received for the services;

h. the date and source of the payment.

5. 0 Contents of Records

5.1 Subject to Sections 6 and 7 (below), a registrant shall keep a client record for each client whom the registrant treats or assesses.

5.2 The client record must include the following:

a. the client's name and contact information;

b. the client's date of birth, if client is under 18 years of age;

c. the date of each of the client's visits with the registrant, unless this information is available from some other readily accessible source;

d. the name of the referring source;

e. pertinent history of the client or reference where this information may be found;

f. reasonable information about screenings, assessments and treatments performed by the registrant and reasonable information about significant clinical findings, diagnosis and recommendations made by the registrant;

g. reasonable information about significant recommendations made by the registrant for screenings, assessments, examinations, tests, consultations or treatments to be performed by any other person;

h. every written report received by the registrant with respect to examinations, tests, consultations, or treatments performed by other professionals or a reference to where the reports are available;

i. reasonable information about advice given by the registrant and every pre-treatment or post-treatment instruction given by the registrant;

j. reasonable information about every reserved act within the meaning of Section 4 of the Regulated Health Professions Act, performed by the registrant;

k. reasonable information about every delegation of a controlled act within the meaning of Section 4 of the Regulated Health Professions Act, by the registrant including the name of the person to whom the act was delegated;

l. reasonable information about every referral of the client by the registrant to another professional;

m. any reasons a client may give for cancelling an appointment;

n. reasonable information about every relevant and material service activity that was commenced but not completed, including reasons for the non-completion;

o. a copy of every written consent related to the registrant's service to the client.

5.3 Every part of a client record must have a reference identifying the client or the client record.

5.4 Every entry in a client record must be dated and the identity of the person who made the entry must be apparent.

5.5 If the registrant keeping the record is self-employed, every client record shall be retained for at least ten years following:

a. the client's last visit; or

b. if the client was less than eighteen years old at the time of his or her last visit, the day the client became or would have become eighteen years old.

5.6 If the registrant keeping the record is employed by, or is providing professional services to or on behalf of, a company, institution, agency or other organization, the registrant shall take all reasonable steps to ensure that the records maintained by the company, institution, agency or organization for the clients whom the registrant treats or assesses are retained as specified in 5(5) or, where other legislation is in effect governing the retention of records by the company, institution, agency or organization, as specified in that legislation.

6.0 Agency Records

6.1 Where a registrant is employed by, or is providing professional services to or on behalf of, a company, institution, agency or other organization which maintains its own client records, the registrant shall not be required to keep a separate client record for a client whom the registrant treats or assesses.

6.2 In such a case, the registrant shall take reasonable steps to ensure that the records maintained by the company, institution, agency or other organization for the clients whom the registrant treats or

assesses, meet the requirements of this practice direction or, where other legislation is in effect governing the keeping of records by the company, institution, agency or other organization, the requirements of that legislation.

7. 0 Integrated Records

7.1 A registrant shall not be required to keep a separate client record for a client where:

a. the client is seen as part of a multi-disciplinary team where several professionals work collaboratively on an assessment or provide ongoing therapy and for which a multi-disciplinary report is written;

b. the registrant is providing only consultative or peripheral services to the client; or

c. the client is receiving primary prevention, public education, group training or group screening services.

7.2 For the purposes of this section “consultative or peripheral services” means services where a registrant is not the primary provider of services to a particular client and is brought into the case for a short period of time due to his or her expertise in a particular area to provide an opinion or recommendations.

7.3 Where a registrant contributes to a multi-disciplinary report about a client, the registrant shall ensure that the section of the report pertaining to the service provided by the registrant is accurate, and is attributed to the registrant.

8.0 Electronic Records

8.1 Where, in this practice direction, a notation, report, record, order, entry, signature or transcription is required to be entered, prepared, made, written, kept or copied, the entering, preparing, making, writing, keeping or copying may be done by such electronic or optical means or combination thereof.

8.2 A registrant shall ensure that the electronic or optical means referred to in subsection (1) is so designed and operated that the notations, report, record, order, entry, signature or transcription is secure from loss, tampering, interference or unauthorized use or access.

8.3 Where a registrant makes or keeps records required by this regulation in an electronic computer system, the system shall have the following characteristics:

a. the system provides a visual display of the recorded information;

b. relative to the client record(s) and financial record(s), the system provides a means of access to the record of each client by the client’s name;

c. the system is capable of printing the recorded information without unreasonable delay;

d. relative to the client record(s) and financial records(s), the system is capable of visually displaying and printing the recorded information for each client in chronological order;

e. the system maintains an audit trail that:

i) indicates any changes in the recorded information;

ii) preserves the original content of the recorded information when changed;

iii) in respect to the client record and financial record of each client;

f. records the date of each entry of information for each client; and

g. is capable of being printed separately from the recorded information for each client.

h. the system includes a password or otherwise provides reasonable protection against unauthorized access; and

i. the system 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.

8.4 A registrant shall ensure that the method of keeping the records provides:

a. the means by which the registrant can readily comply with the laws governing access by a client or his or her legal representative to his or her client record;

b. ready access to an authorized investigator, inspector, assessor or representative of the College, for the inspection of records; and

c. that equipment must be readily available for the making of hard copies of the record at no expense to an authorized investigator, inspector or assessor or representative of the College.

9.0 Security and Disposal of Records

9.1 Records must be stored in such a way that only those who need to obtain the information contained within the records will have access to it.

9.2 A registrant must establish administrative, technical, and physical safeguards to ensure the security, confidentiality and accuracy of records.

9.3 Safeguards must include procedures to limit access to authorized people

9.4 Safeguards must ensure that the electronic transmission of records is not intercepted.

9.5 Records must be disposed of in a manner that preserves the confidentiality of the information contained.

IV. REFERENCES

Regulated Health Professions Act, Sections 85

CASLPM General Regulation, PART 5: Standards of Practice, Sections 5.9, 5.10, 5.11

"The Personal Health Information Act (PHIA), A Brief Summary for Health Professionals." Manitoba Health. Retrieved 11th December 2012, from http://www.gov.mb.ca/health/phia/hp.html?print

"Guide for Record Keeping, Standards for Practice for Physiotherapists." College of Physiotherapists of Ontario. Retrieved 7th April 2013, from http://www.collegept.org/Standards/English