ALBERTA COLLEGE of OCCUPATIONAL THERAPISTS

Practice Guideline

Standards for Documentation

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Background

Documentation of the various stages of occupational therapy (OT) involvement in a client record is a vital component of both clinical and non-clinical OT practice.

A client record tracks the events, decisions, interventions, and plans made throughout the course of the OT-client[1] relationship. It is a legal document that serves many purposes including, but not limited to:

Communication - In clinical settings, the client record serves as a communication tool to report and monitor a client's health status and aid in continuity of care for a client with other health care or service providers (e.g. reporting of screening and assessment results, response to interventions, changes to treatment plans/services provided, outcomes attained, etc.). In both clinical and non-clinical settings, documentation is used to communicate findings and recommendations to clients and key participants. It can also be used to promote collaborative practice and knowledge sharing.

Accountability - Client records serve as evidence of services provided. They may be used by your employer/contracting organization or ACOT to investigate complaints. Formal reporting of assessment results, services provided or program evaluation, may also be a contractual requirement of a referral or funding source.

Quality Assurance/Quality Improvement - Documentation may be used by your employer/contracting organization for performance reviews (e.g. chart audits), accreditation processes, critical incident reviews, and/or quality improvement programs.

Legislative Requirements – OTs in Alberta are required to document the various stages of OT involvement according to ACOT's Standards of Practice (SoP) and Code of Ethics (CoE). Failure to adhere to the documentation requirements or falsifying documentation meets the definition of unprofessional conduct according to the *Health Professions Act* (HPA).

Research – Clinical records can offer a valuable source of data for researchers. Researchers can review historical client records for information related to the effectiveness of clinical interventions.

Applicability of this Guideline

ACOT fields frequent inquiries about the "what, when, how, where and why" of documentation requirements. The **why** OTs need to document has been described above. Expectations for **what** OTs need to document are addressed throughout the SoP and CoE indicators which will be reviewed and discussed

[1] A client can be an individual, group, organization, system or combination of these.

in this practice guideline.

Given the diversity of clinical and non-clinical OT practice across the province, the determination of **how** (e.g. paper or electronic records), **when** (e.g. same day, within two weeks, by service completion) and **where** (e.g. formal assessment/treatment/consent forms, narrative notes) documentation occurs, is up to OTs in private practice or the employers/contracting organizations of OTs to determine.

The how, when and where of documentation should be established in documentation policies and procedures based on what is best suited for your practice area and setting, the requirements of your referral source/funder, or what is required by your employer/contracting organization.

Seeking, Receiving and Documenting Consent

NOTE: As the documentation of consent is integral to a meaningful informed consent process, it is included in this guideline. An expanded practice guideline on seeking/receiving informed consent for OT services in complex situations (e.g. mature minors, consent from guardians in cases of divorce, consent from persons with cognitive impairment) is under development.

SoP/CoE Indictors Related to Documentation of Consent:

SoP 2.5 *Discuss and document the terms of agreement for the services to be provided.*

SoP 2.8 *Document the screening results and recommendations along with the client's consent to and agreement with the services offered or lack of consent or agreement.*

CoE 1.3 *Collaborate with the client(s) in setting goals and priorities of services as much as reasonably possible.*

CoE 1.4 *Provide client with the information they need to make decisions about the options available to them.*

CoE 1.5 *Accept clients' choices.*

How this looks in clinical settings: OTs are required to confirm and document consent at the various stages throughout client involvement:

- Informed consent from a client/parent/guardian (and assent if a client/student is a minor) should always be sought but it can be received verbally and then documented.
    - Documentation of verbal consent can be recorded in a client record or a formal consent form may be also used - both are legally acceptable.
- The initial documentation of the consent process should include the nature and purpose of the proposed treatment, the probable risks and benefits, the reasonable alternatives, and the fact that the criteria for valid consent were met (e.g., the parent that is consenting also has guardianship of the child/student).
- Consent should also be received regarding the collection, use and disclosure of information and for use of electronic communications (email, text, videoconferencing) for service delivery. See ACOT's practice guidelines on Information Privacy and Disclosure Legislation, Electronic Communications with Clients and Delivery of OT Services Through Virtual/Remote Means for more information on consent in those situations.

- Ongoing documentation of consent is required more "by exception" when an intervention plan is altered or when there is refusal of consent, withdrawal of consent, or a decision by the OT that a particular client/parent/guardian is not capable of giving consent (including the basis of that judgement).

How this looks in non-clinical settings: Meeting consent requirements will look different for OTs in non-clinical roles depending on how they see/define their client(s). Initial and ongoing consent to proceed with a project, staff supervision or post-secondary student education, for example, is likely implied and does not need to be explicitly received. Documentation of consent will also occur in whatever form a "client record" takes in a non-clinical role/setting (e.g. in employment records, correspondence with staff/team members/ management, etc.).

In summary, an OT must always keep their clients informed of what the occupational therapy services might entail and receive their consent/assent prior to proceeding.

NOTE: How you go about documenting consent will be influenced by your role in an organization and/or your/your employer's consent and documentation requirements. Employers, or organizations such as school boards or early childhood service (ECS) providers which you hold a contract with, may have more stringent consent requirements from a legal/liability perspective that are above and beyond an OT's need to adhere to professional standards and ethics.

You may also be interested in a resource prepared by the Office of the Information and Privacy Commissioner on Guidelines for Obtaining Meaningful Consent for more information.

Documentation of OT Services

SoP/CoE Indictors Related to Documentation of OT Services:

SoP 2.1 *Document the request for occupational therapy services.*

SoP 2.6 *Document the occupational performance issues arising from the process of identifying, validating, and prioritizing these issues with the client.*

SoP 4.4 *Document the assessment results within a predetermined time frame. These results should include the assessment methods used and indicate the performance components and environmental elements to be targeted.*

SoP 4.5 *Communicate the assessment results and recommendations to appropriate parties with consideration of confidentiality and within a predetermined timeframe.*

SoP 5.4 *Document the action plan and describe desired outcomes; indicators of attainment of desired outcomes; type, nature, and methods of intervention; time frame; and evaluation process. The documentation shall be completed within a predetermined time frame, known to the client or appropriate parties.*

SoP 6.3 *Document changes in and factors limiting: the client's response to the intervention, the client's goals, the client's satisfaction with the process and outcomes, occupational performance, performance components, evaluation elements.*

SoP 6.4 *Document the services provided, and the frequency of these services, within a predetermined time frame.*

SoP 7.4 *Document the outcomes of the occupational therapy process and when appropriate,*

communicate with key participants (e.g., past, present and future service providers, referral source).

SoP 8.5 *Communicate in a manner that is timely, complete, respectful, reflective of the services provided and understandable to the receiver.*

How this looks in clinical settings: Depending on your practice area or setting, documentation of the various stages of OT involvement may be written in paper charts or typed into electronic health/student records. You/your employer/contracting organization may choose to record required information in formal assessment or treatment records/forms/templates, or a less structured, narrative format.

How this looks in non-clinical settings: Depending on your role/work setting, documentation can take the form of email correspondence, decision-tracking logs, briefing notes, policy documents, practice support guidelines, program evaluation reports, scoring/assessment rubrics, or any other written form that documents the events, decisions, interventions, and plans made throughout the course of your work with your client.

Documentation Timeframes

The "predetermined time frame" mentioned throughout the standards is left intentionally unspecified due to the variation in operational requirements of the various practice areas/settings in which OTs work. Depending on where you provide OT services, documentation timelines may be determined at a program or site level. Check the documentation guidelines for your employer/contracting organization for the expected/required timelines.

If you or your employer do not have documentation policies and procedures in place, think about the timeframes required to ensure the accuracy of information recorded, the timeliness of information for continuity of care, and/or to meet any contractual/funding source requirements.

Storage, Retention and Disclosure of Client Records

Record storage and retention requirements may also vary depending on where an OT works and the information privacy legislation a workplace needs to adhere to. Most employers/contracting organizations should have record storage and retention policies in place.

If in a private practice (or if your employer does not have record storage and retention policies in place), you should establish record retention and disposal processes in order to adhere to CoE indicator 1.6 – *safeguard client information from unwarranted disclosure*. At a minimum these processes should:

- ensure record storage and disposal protects against threat or hazard to the security, integrity or loss of the health or personal information collected as a result of service provision. This applies to both client and business records and paper or electronic records.
    - See the Office of the Information and Privacy Commissioner (OIPC) Cause of Breaches and Breach Prevention Recommendations document for actions you can take to prevent information breaches.
    - For maintenance of integrity of records stored electronically, documentation in a client/student record should be stored in a way that incorporates an audit trail which can track and capture any edits or alterations made to those records including who made the change/addition and the date when the change/addition was made.
- ensure compliance with a retention period of at least *11 years and three (3) months after the last date*

of service provided to the client. If the last date of service was provided when the client was a minor, records should be retained for *11 years and three (3) months after the date on which a client turns 18*.[2]

According to Alberta's *Limitations Act*, there is a 10-year limitation period in which a civil action can be filed unless it is a claim of sexual assault or battery, in which case there is no limitation.

- The no limitation period extends to claims of sexual misconduct (other than sexual assault) if the claimant was a minor or under guardianship at the time of the alleged misconduct.

As well, beyond the limitation period (if applicable) for filing a claim in Court, the Alberta Rules of Court provide that a claimant must serve the claim within one year of being filed in Court, with the possibility of extending time for service by up to three months.

Although there is always a risk that client records may be required for litigation purposes, the indefinite retention of records may not be practical for OTs in private practice, as such, ACOT's guidance is to retain records for at least 11 years and three months after the last date of service delivery or after your client turns 18.

If your employer has record retention requirements beyond what is described in this guideline, or if your legal counsel has recommended a longer period based on your practice area/client population, adhere to those retention requirements.

- Adhere to the requirements in any applicable information disclosure legislation relating to when release of client information is required and appropriate. See ACOT's practice guideline on Information Privacy and Disclosure Legislation; Appendix A of this document outlines the general processes to follow when a release of information request is received.

Electronic Signatures on Client Records

The current pandemic has triggered a shift in practices requiring guidance for use of electronic signatures not just during the pandemic but into the future.

For those employers/organizations that have already shifted to electronic medical records, electronic or digital "signatures" (may not always be an actual signature, could be an approved digital timestamp) on client records are already part of acceptable/approved practice (approved by the organization's health and personal information security officers and legal counsel prior to implementing).

For those OTs (and the support personnel they supervise) working in practice areas/settings that do not have electronic record keeping systems or policies and procedures in place for when and how electronic signatures are acceptable, the following direction is offered:

- An electronic signature on a document or chart note that is part of a client record is acceptable if/when steps have been taken to ensure that it is only affixed by you, that no one else has access to use of your electronic signature and the document you are signing/have signed is converted to a non-editable format (e.g. pdf).
    - Most secure option: use of a digital signature application with secure login, unique identification

[2] ACOT has updated the guidance on record retention based on recent legal advice. It reflects the requirements of the *Limitations Act* which was amended in 2017.

for each user and a date/timestamp for when the digital signature was applied (examples of such applications include but are not limited to Adobe Pro, PandaDoc, etc.).

    - These types of applications embed information regarding the signature and document into the software, creating an audit record and security associated with both the signature and the document signed. This audit record is also encrypted for security.

- If cutting and pasting of an electronic signature into a document, the signature line should also include the date and time the signature was added to the document along with a note indicating "electronically signed by" prior to converting to a non-editable format (e.g. pdf).

    - While this option is acceptable, it is not as secure as a digital signature and should only be used if a digital signature application is not available.

- Each OT is ultimately responsible for safeguarding digital/electronic signatures from unauthorized use.

Although use of an e-signature, according to what has been described above, is in adherence to ACOT's Standards of Practice, your employer or contracting organization may have specific requirements over and above what ACOT permits. You should confirm with your employer/contracting organization whether electronic/digital signatures are permitted or if your actual signature (known as "wet" signature) is required on client notes/documents for business or legal purposes.

Additional resources

College of Occupational Therapists of British Columbia (COTBC)– Practice Standards for Managing Client Information

College of Occupational Therapists of Ontario (COTO)– Standards for Record Keeping

Contact ACOT if you have any concerns with the content in this practice guideline or if you would like to discuss requirements for your specific workplace.