College of Occupational Therapists of Manitoba

Quality Occupational Therapy – Accountable to Manitobans

Managing Client Information - Meeting Legislative Obligations 2017

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College of Occupational Therapists of Manitoba (COTM)

7 - 120 Maryland Street

Winnipeg, MB R3G 1L1

T 204.957.1214

F 204.775.2340

www.cotm.ca

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Preamble

The Occupational Therapists Act acknowledges occupational therapists as autonomous practitioners. The College of Occupational Therapists of Manitoba (COTM) regulates the practice of Manitoba occupational therapists. COTM has the mandate "to serve and protect the public interest."

Regulation of the profession also requires that occupational therapists practise according to established guidelines and principles of practice, and apply these consistently in a responsible and intentional manner within the practice environment. Although each area of practice has its own unique characteristics and issues, the principles that guide practice are constant and apply across all environments in which occupational therapists provide client-focused service.

The purpose of this document is to ensure occupational therapists in Manitoba are aware of the expectations for managing client information.

COTM publications contain practice parameters and guidelines which should be considered by all Manitoba occupational therapists in the provision of service to their clients and in the practice of the profession. College publications are developed in consultation with occupational therapists and describe current professional expectations. It is important to note that these COTM publications may be used by COTM and other agencies / individuals in determining whether appropriate guidelines of practice and professional responsibilities have been maintained.

Occupational therapy (OT) is regulated as a health profession, yet practice extends beyond the healthcare environment. The principles of managing client information apply even when providing health services in a variety of environments such as workplaces, schools, corrections, in the community and in other environments in which occupational therapists provide client-focused services.

COTM wishes to acknowledge the generosity of the College of Occupational Therapists of British Columbia (COTBC). This COTM document is based upon the COTBC document Practice Standards: Managing Client Information (2014). We also value the opportunity to utilize the College of Occupational Therapists of Ontario (COTO) Standards for Record Keeping 2016 document.

Background

COTM's *Managing Client Information – Meeting Legislative Obligations 2017* replaces a prior document COTM Practice Guideline: *Client Records in Occupational Therapy Practice, June 2003* which had modest updates in 2012.

This 2017 practice guideline was developed by occupational therapists in Manitoba who work in a variety of practice settings and serve on the COTM Practice Issues Committee. The committee reviewed the previous guideline as well as parallel documents from Canadian occupational therapy and health regulatory organizations, and considered practice questions, issues, and concerns presented by members and others.
This practice guideline includes information contained in federal and provincial legislation. Cross-referencing to other COTM documents and to provincial and federal legislation appears throughout.

Note to Readers

Throughout this guideline, reference is made to the following support documents. Please check that you have the most recent versions, download these from the College of Occupational Therapists of Manitoba website, or contact COTM to receive updates.
Association of Canadian Occupational Therapy Regulatory Organizations. (2011). *Essential Competencies of practice for occupational therapists in Canada (3rd ed.)*. Retrieved from http://cotm.ca/upload/COTM_Essential_Comptencies_3rd_Ed_Web.pdf

College of Occupational Therapists of Manitoba. (2010). *COTM Code of Ethics.* Retrieved from http://www.cotm.ca/upload/COE_2010.pdf

The Personal Health Information Act (of Manitoba)
Retrieved from http://web2.gov.mb.ca/laws/statutes/1997/c05197e.php

The Personal Health Information Act is provincial legislation outlining your obligations regarding the collection, recording, protection, access, disclosure, retention and destruction of client related documentation.

Purpose of Guidelines

College of Occupational Therapists of Manitoba practice guidelines are published by COTM to assist the occupational therapist in meeting their legislated obligations under the Personal Health Information Act (PHIA) and their professional obligations as outlined in the *Essential Competencies of Practice for Occupational Therapists in Canada (3rd Ed*.) by:

- outlining member responsibilities;
- describing expectations for occupational therapy practice; and
- defining safe, ethical, and competent occupational therapy practice.

The COTM Guideline is consistent with the legislated requirements and provides occupational therapists with added detail to assist in achieving compliance with the Personal Health Information Act. The document does not include the descriptive quality of an employer or agency policy or procedure. COTM does not prescribe how its members need to meet legislative or regulatory requirements.

Application of this Guideline

This guideline clarifies the occupational therapist's accountability and COTM's expectations respecting the occupational therapist's management of client information. It is also designed to assist occupational therapists to identify and reduce the risks inherent in managing client information, thereby protecting clients from harm. Managing client information requires compliance with legislation and the legal requirements as set out in the *Personal Health Information Act*. COTM's focus is on the quality and content of the information contained in the occupational therapy record, as well as on how the occupational therapist collects, records, protects, and ensures access to client information. COTM acknowledges that individual occupational therapists perform these tasks in different ways within varied practice contexts and settings. Managing client information is important because of the many ways in which the occupational therapy record is used. It is a legal document and source of evidence that can demonstrate compliance with the standards of the profession as well as with other standards, laws, and ethical considerations.

The client record…

- *enables client access to information*

  Clients can, with due process, expect access to current, legible, accurate and complete records of the occupational therapy services and process. They can also have an expectation of involvement in the collection, recording and protection of their information.

- *describes the occupational therapy process*

  Since occupational therapists collect and record client information to plan, implement, and carry out a systematic client-centred care plan, the occupational therapy process is reflected in the client record. Collecting, recording and protecting client information can allow an occupational therapist to demonstrate that safe,

ethical and competent care was delivered to the client. The record can also make explicit the therapist's critical thinking, reasoning and decision-making.

- *advances quality occupational therapy services*

The management of client information also aids occupational therapists to communicate effectively with the client, his/her primary caregivers, family, other health professionals and others involved in the care of the client. Client information may be used to advance the profession's evidence and knowledge base through education and research activities. It can also be used by administrators, planners and the college to guide decision-making, for quality improvement activities, and reflection on practice.

- *facilitates effective communication*

The record allows for clear communication between the occupational therapist and others within the client's care team. With client consent the record will also facilitate communication with other stakeholders.

Important considerations:
It is not expected that all performance indicators will be evident all the time. It is expected that the performance indicators could be demonstrated if requested.
It is expected that OT's will always use their clinical judgement to determine how to best maintain records based on the scope of the practice, practice setting, client and stakeholder needs.
It is expected that occupational therapists will be able to provide reasonable rationale for any variations from the Practice Guideline.

Definitions

Agent – An individual who is authorized to perform services or activities on behalf of a health information manager or trustee.

Attendance record – A document that lists a client visit by a health professional for a specific date. (COTO, 2016)

Attest/Attestation - The process of assigning responsibility and authorship for an activity, usually by applying a signature. (COTO, 2008)

Care pathway/Clinical pathway/Care protocol - An outline of anticipated care with time frames to address how a client's conditions or symptoms will be addressed from initial contact to anticipated outcome.

Charting – The process of recording client care data into a health record.

Charting by exception – A method of client care documentation that uses a pre-determined plan whereby only unusual occurrences or changes to that plan or significant findings are recorded.

Client - An individual, family, group, community, organization, or population who participates in occupational therapy services by direct referral or contract, or by other service and funding arrangements with a team, group, or agency whose work includes occupational therapy. Client is synonymous with patient or consumer and means a recipient of occupational therapy services. (Townsend & Polatajko, 2007)

Client representative - For the purposes of this document, the reader should reference Section 60 of the Personal Health Information Act - https://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php

Confidentiality - The ethical, professional or legal obligation not to disclose personal information without consent or the client's authorization.

Digital signature – An electronic signature that uses encryption technology to provide a unique signature that verifies its authenticity, integrity (cannot be altered) and non-repudiation (signer cannot easily deny affixing the signature). (COTO, 2016)

Electronic health record (EHR) / electronic medical record (EMR) - A computer-based electronic file that resides in a system specifically designed to support users by providing access to complete and accurate health data, alerts, reminders, clinical decision support systems, links to medical knowledge, and other aids. (Canadian Health Information Management Association, n.d.a)

Electronic signature - A signature or attestation applied by electronic means. (COTO, 2008)

Encryption - The process of transforming information (referred to as plain text) using an algorithm (called cipher) to make it unreadable to anyone except those possessing special knowledge, usually referred to as a password or key.

Firewall – A firewall is a dedicated appliance, or software running on another computer, which inspects network traffic passing through it and denies or permits passage based on a set of rules.

Health record - A compilation of pertinent facts of an individual's health history, including all past and present medical conditions, illnesses, and treatments, with emphasis on the specific events affecting the client during the current episode of care. The information documented in the health record is created by all health care professionals providing the care. (Canadian Health Information Management Association, n.d.a)

Information Manager - means a person or body that
(a) processes, stores or destroys personal health information for a trustee, or
(b) provides information management or information technology services to a trustee. (PHIA)

Locked document - A document may be “locked for editing” or “read only,” which means that the author or system administrator has disabled the means to edit the document in electronic form.

Managing client information - The process by which the occupational therapist collects, records, uses, stores, and discloses the personal information of the client.

Occupational therapy record - A compilation or any written or computerized text information and audiovisual media generated by the occupational therapist or individuals supervised by him or her, and that relate to the occupational therapy services provided to the client. It may also include appointment recording, equipment administration, and financial records pertinent to the individual client. An occupational therapy record may be part of an overall health record.

Occupational therapy practice – Includes services to clients as well as research, education, consultation, or administration.

Occupational therapy service – Client-focused services.

Personal information: would include name, address, birthdate and other demographics and family information.

Personal health information or client information - means recorded information about an identifiable individual that relates to:
(a) the individual's health, or health care history, including genetic information about the individual,
(b) the provision of health care to the individual, or
(c) payment for health care provided to the individual, and includes
(d) the PHIN and any other identifying number, symbol or particular assigned to an individual, and
(e) any identifying information about the individual that is collected in the course of, and is incidental to, the provision of health care or payment for health care. (PHIA, 1997)

Practice/Service - The overall organizational and specific goal-directed tasks for the provision of activities to the client, including direct client care, research, consultation, education, or administration.

Privacy – This is the right individuals have to control how their personal information is handled, that is, their right to determine what personal information is collected, used and disclosed, when, how and with whom.

Progress notes – A formal record of client contact including the outcome of an intervention, changes in the client's condition, problem formulation, or the intervention plan and goals.

Record or "recorded information" - means a record of information in any form, and includes information that is written, photographed, recorded or stored in any manner, on any storage medium or by any means, including by graphic, electronic or mechanical means, but does not include electronic software or any mechanism that produces records. (PHIA)

Rough notes – Also referred to as scratch notes or side bar notes or raw data that may or may not become part of the client's health record. (They may be destroyed if not needed, but if they exist at the time that access to the record is sought, they are considered a legal part of the client's record). (COTO, 2016)

Security - The administrative, physical, and technological safeguards in place to prevent accidental or intentional disclosure by inappropriate access or by unauthorized individuals. It also includes the mechanisms in place to protect the information from alteration, destruction, or loss. (COTO, 2008)

Sign/Signature - The occupational therapist's signature or attestation, including an electronic signature as long as the occupational therapist takes reasonable steps to ensure that only the occupational therapist can affix it. (COTO, 2016)

Stakeholder - Someone who has a valid interest in the outcome of a decision involving the client. Examples of stakeholders include family members, other health care team members, physicians, employers, insurance companies, legal representatives, and third-party payers. (COTO, 2008)

Time stamping – is a process used primarily in the electronic health record. Time stamping provides proof that a document existed at a specific date/time.

Trustee - a health professional, health care facility, public body, or health services agency that collects or maintains personal health information. (PHIA)

Unique identifier - A number / alphanumeric assigned to a case file to identify a unique individual and to distinguish him or her from others. (COTO, 2008)

Overview of the Guideline for Managing Client Information

1. Collecting and Recording Client Information
2. Protecting Client Information (Privacy and Security)
3. Client Access to the Occupational Therapy Record
4. Disclosing the Occupational Therapy Record
5. Records Respecting Financial Matters
6. Equipment Records
7. Retention and Destruction of the Occupational Therapy Record
8. Discontinuation or Transfer
9. Retention and Destruction of Research Records
10. A Risk Assessment / Analysis and Risk Management Tool – An approach to clinical and professional reasoning regarding managing client records.

Guideline #1: Collecting and Recording Client Information

Guideline #1.A. The occupational therapist will ensure that an accurate record of occupational therapy services is created and includes documentation of receipt of referral, informed client consent, assessment, intervention, discharge, and follow-up.

Practice expectations The occupational therapist will, in carrying out the above requirement, ensure that the following information is collected and is part of the occupational therapy record:
1.A.1. - Contact information for the source of the referral, including self-referral.
1.A.2. - Reason for the referral.
1.A.3. - Confirmation that client consent was obtained related to the collecting, recording and disclosing client information and for the occupational therapy assessment and potential impacts and services.
1.A.4. - Confirmation of the accuracy and currency of the information provided about the client on the referral.
1.A.5. - Client's full name, address, date of birth, and if applicable a unique identifier.
1.A.6. - Client information that is necessary and pertinent to the purpose of the occupational therapy assessment and intervention.

Guideline #1: Collecting and Recording Client Information (continued)

Guideline #1.B. The occupational therapist is responsible for the content of the client record related to occupational therapy services and will ensure that the content accurately reflects the occupational therapy services provided.

Practice expectations The occupational therapist will, in carrying out the above requirement, include the following information on the client record:
1.B.1. – Consent as obtained and maintained. This entry should be dated and specific.
1.B.2. – Occupational therapy assessments including the assessment procedures, results obtained, and conclusion or professional opinion regarding the client's status.
1.B.3. – Documentation of the occupational therapy intervention plan, formulated in collaboration with the client.
1.B.4. – Clear reference to any specific care pathway or similar assessment and intervention plan.
1.B.5. – Progress notes indicating the outcome of an intervention, changes in the client's condition, problem formulation, or the intervention plan and goals.
1.B.6. – Name, designation, and supervision plan when the occupational therapist assigns a component of the intervention plan (e.g., to students or support personnel).
1.B.7. – Cancelled or missed appointments.
1.B.8 – Discharge information, which may include the client's status at discharge, reason for discharge, summary of outcome attained, recommendations such as home program, referral, and an explanatory note when interventions initiated were not completed.

Guideline #1: Collecting and Recording Client Information (continued)

Guideline #1.C. The occupational therapist will ensure that records are legible, understandable, complete, and prepared and maintained in a timely and systematic manner.

Practice expectations The occupational therapist will, in carrying out the above requirement, ensure the following:
1.C.1. – Records are organized in a logical and systematic fashion to facilitate retrieval and information use.
1.C.2. – Documentation is completed in a timely manner appropriate to the client and clinical situation.
1.C.3. – All documents identify the client and the client's unique identifier, such as date of birth, record number, or claim number. It must be possible to identify the client in any part of the record.
1.C.4. – The date of each professional encounter of any kind with the client, regardless of the medium (email, fax, telephone, or in person), is recorded.
1.C.5. – If an email has been used to contribute to the decision-making process, sufficient detail is documented and retained as part of the record (electronic or paper). This may include the need to print or scan a document to have it preserved.
1.C.6. – The date of the receipt and disclosure of client information is recorded.
1.C.7. – Abbreviations, acronyms, and diagrams used in the client record have a supporting reference available for those who access the records, to ensure consistency of interpretation.
1.C.8. – Every entry is dated and signed.
1.C.9. – A reader must be able to identify the occupational therapist's full name and designation.
1.C.10. – Electronic signatures are protected and linked to a user ID and password.
1.C.11. – If an electronic system is utilized, each entry is linked to a distinct individual who has logged onto the system using a distinct user ID and a password.
1.C.12. – The occupational therapist who contributes to multidisciplinary notes or reports, identifies the portion of the note or report for which he or she is responsible and accountable.
1.C.13. – When two occupational therapists contribute to the same record, the signature of each is included. The record clearly indicates the author of each entry and who provided the services.

1.C.14. – Copies of a record distributed without an original signature by the occupational therapist clearly indicates where the original signed record is located.
1.C.15. – Drafts of documents if kept are retained as part of the record and released upon request. Draft notes may be destroyed if not needed, but if they exist at the time that access is sought to the record, they are considered a legal part of the client's record.
1.C.16. – The record may be created and maintained in a computer system if it has the following features: ✓ provides a visual display of the recorded information. ✓ provides a means of access to the record of each client by the client's full name and a unique identifier, and the record can be validated by confirming additional reliable key indicators such as date of birth. ✓ provides a means to view and print recorded information promptly and in chronological order for each client. ✓ allows more than one author or contributor to sign or attest. ✓ Maintains an audit trail which ✓ records the date and time of each entry of information for each client; ✓ indicates the identity of the person who made the entry ✓ indicates any changes in the recorded information; and ✓ preserves the original content of the recorded information when changed or updated. ✓ provides reasonable protection against unauthorized access. All systems will have user ID and password protection with mechanisms to prevent unauthorized changes to documents (e.g., document locking, read- only access, firewalls, encryption, password). ✓ automatically backs up files at reasonable intervals and allows the recovery of backed-up files or provides reasonable protection against loss of, damage to, and inaccessibility of information. A process is in place to reliably provide recorded information if due to unforeseen or scheduled downtimes of the system, the electronic record is not available.

Additional Resources related to Collecting Client Information

COTM Resources
COTM Code of Ethics http://www.cotm.ca/upload/COE_2010.pdf Value G: Confidentiality and Privacy

ACOTRO Essential Competencies of Practice for Occupational Therapists in Canada http://cotm.ca/upload/COTM_Essential_Comptencies_3rd_Ed_Web.pdf Unit 5: Communicates and Collaborates Effectively Unit 7: Manages Own Practice
COTM Registration Information Sheet on Use of Title (2014) http://cotm.ca/upload/FACTS-Use_of_Title2014.pdf
Links
MB Health – Personal Health Information Act http://www.gov.mb.ca/health/phia/resources.html
MB Laws – Personal Health Information Act, 1997 http://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php
MB Ombudsman https://www.ombudsman.mb.ca/info/access-and-privacy-division.html

Guideline #2: Protecting Client Information (Privacy and Security)

Guideline #2. The occupational therapist will take measures to ensure client confidentiality and the security of client information in order to prevent unauthorized access.

The occupational therapist has a responsibility to understand and apply the legislation that applies to his or her practice and determine personal roles and responsibilities within the context of the practice.
The occupational therapist should make reasonable efforts to notify the individual involved if his or her information has been lost or stolen, or accessed without his or her authorization
The occupational therapist is expected to consult the relevant legislation, provincial and federal, to determine his or her role in this context. This includes the Personal Health Information Act, the Freedom of Information and Privacy Protection Act (FIPPA), and in some cases the federal Personal Information Protection and Electronics Documents Act (PIPEDA) and other potential relevant legislation such as the Mental Health Act.

Privacy relates to the right of individuals to determine when, how, and to what extent they share their personal information

Security refers to those mechanisms that restrict unauthorized access and preserve the integrity of information

Practice expectations The occupational therapist will, in meeting the above requirements, do the following:
2.1. – Develop protocols for storage, access, retention, and destruction of client records in keeping with all applicable legislation.
2.2. – Store all occupational therapy records in locked filing cabinets and ensure password-protected computer access.
2.3. – Establish practices which provide privacy protection for all client-related communication on such devices as USB, smart phones, and other electronics.
2.4. – When travelling, limit the amount and visibility of client information being transported whether on paper or portable electronic devices.
2.5. – Place a notice at the bottom of emails and fax transmissions regarding confidentiality and procedures in the event that the information is inadvertently sent to the wrong address or phone line inadvertently.

2.6. – Obtain client consent regarding what information can be communicated by email and with whom.
2.7. – Ensure that client information to be delivered by mail is sealed, addressed accurately, and marked "confidential."
2.8. – Make reasonable efforts to notify the individual involved if his or her information has been lost or stolen, or accessed without his or her authorization.

Additional Resources related to Protecting Client Information (Privacy & Security)

COTM Resources
ACOTRO Essential Competencies of Practice for Occupational Therapists in Canada http://cotm.ca/upload/COTM_Essential_Comptencies_3rd_Ed_Web.pdf Unit 5: Communicates and Collaborates Effectively
Links
MB Health – Personal Health Information Act http://www.gov.mb.ca/health/phia/resources.html
MB Health - Freedom of Information and Protection of Privacy Act **(FIPPA)** 1996 http://www.gov.mb.ca/chc/fippa/index.html
MB Laws – Personal Health Information Act, 1997 http://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php
MB Ombudsman https://www.ombudsman.mb.ca/info/access-and-privacy-division.html
Personal Information Protection and Electronic Documents Act (PIPEDA) 2000, https://www.priv.gc.ca/leg_c/leg_c_p_e.asp

Guideline #3: Client Access to the Occupational Therapy Record

Guideline #3. The occupational therapist will know and understand legislative obligations and organizational policies and procedures respecting client records so as to be able to help the client access his or her occupational therapy information.

Practice expectations The occupational therapist will, in meeting the above requirements, do the following:
3.1. – Respond within 30 days to requests by the client or a legally authorized representative for access to the client's occupational therapy record.
3.2. – If organizational policies do not exist or are insufficient, develop policies or protocols for client access to occupational therapy records in accordance with legislation, COTM Code of Ethics, and other published COTM documents.
3.3. – Not agree to contractual provisions which are inconsistent with his or her statutory obligations (e.g., requests by organizations to restrict client access to information).
3.4. – Provide an opportunity for the client to review personal information and in response to any concerns that it is not complete or accurate, make necessary corrections to this personal information.
3.5. – The client may request corrections to his or her occupational therapy records, but does not have the right to demand that the correction be made. Any corrections will be recorded. If the occupational therapist does not agree that there is an error or omission, the change need not be entered into the record however the occupational therapist must record the client's request for the correction.
3.6. – Charge only a reasonable fee to cover the costs of copying and, where appropriate, staff time in retrieving and reproducing the requested record.
3.7. – Take reasonable measures to ensure the preservation, security, and ongoing access to client occupational therapy records in the event that the agency or organization in which the occupational therapist is employed ceases to operate.
3.8. – The occupational therapist will record what information has been released to the client and when.

Additional Resources related to Client Access to the Occupational Therapy Record

COTM Resources
COTM Code of Ethics http://www.cotm.ca/upload/COE_2010.pdf Value G: Confidentiality and Privacy
Links
MB Ombudsman Letter to COTM http://www.cotm.ca/upload/Ombudsman_to_COTM_re_PHIA.pdf
MB Laws – Personal Health Information Act, 1997 http://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php

Guideline #4: Disclosing the Occupational Therapy Record

Guideline #4.

The occupational therapist will know and understand legislative obligations and organizational policies and procedures about making and releasing copies of client occupational therapy information.

The occupational therapist will respond to requests by stakeholders in accordance with legislative obligations.

The occupational therapist will transfer, share, or disclose personal information only with the express consent of the client unless otherwise permitted to do so by law

The occupational therapist will make his or her records, documents, and data relevant to his or her practice of occupational therapy available for inspection, testing or copying by a person appointed for the purpose under *The Occupational Therapists Act.*

Practice expectations

The occupational therapist will, in meeting the above requirements, do the following:

4.1. – If organizational policies do not exist or are insufficient, the occupational therapist will develop policies or protocols for disclosure of occupational therapy records to stakeholders in accordance with legislation, the COTM Code of Ethics, and other published COTM documents.

4.2. – With client consent, the occupational therapist will allow another health professional external to the occupational therapist's employment organization or agency to examine the client's clinical record. The occupational therapist will also give a health professional any information from the record which that professional is legally entitled to receive.

4.3. – The occupational therapist may refuse to provide copies from a client record or a portion of the client record under those conditions outlined in the *Personal Health Information Act* where a reason for refusal applies.

4.4. – The occupational therapist may disclose personal information without consent under only those conditions outlined in *PHIA* and other relevant legislation.

4.5. – Where the client directs that part of the information be withheld, the occupational therapist will respect that request. If it is deemed reasonably necessary to disclose the withheld information for the provision of or to assist in the provision of health care to the client, the recipient must be notified that part of the information has been withheld.

4.6. – The occupational therapist will record which information has been released, when it was released, and to whom; and will inform the client of this disclosure.

4.7. – The occupational therapist may charge a reasonable fee to cover costs for photocopying and, where appropriate, staff time in retrieving and reproducing the document for this disclosure.
4.8. – Not charge a fee for any copies of a record requested by COTM.
4.9. – Not be required to obtain consent nor inform the client if records are submitted to COTM. (NOTE: Under PHIA, client consent is not required in order for an OT to submit records to COTM in the course of a COTM investigation).

Additional Resources related to Disclosing the Occupational Therapy Record

COTM Resources
COTM Code of Ethics http://www.cotm.ca/upload/COE_2010.pdf Value G: Confidentiality and Privacy
ACOTRO Essential Competencies of Practice for Occupational Therapists in Canada http://cotm.ca/upload/COTM_Essential_Comptencies_3rd_Ed_Web.pdf Unit 5: Communicates and Collaborates Effectively Unit 7: Manages Own Practice
Links
MB Laws – Personal Health Information Act, 1997 http://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php

Guideline #5: Records Respecting Financial Matters

Guideline #5.

The occupational therapist will ensure that a financial record is kept for every client to whom a fee is charged by the occupational therapist.

Financial records may be kept separate from clinical records, and may provide a way to track services offered on an ongoing basis.

Practice expectations
In order to meet the above requirements, the occupational therapist's financial records will have the following characteristics:
5.1. – Identify the client to whom the service or product was provided.
5.2. – Identify the person(s) who provided the product or service, the job title(s), and the fee of each provider.
5.3. – Give a description of the service or item sold, a cost of the item or service, and the date provided.
5.4. – Identify the date and method of payment received.
5.5. – Provide an accurate fee schedule for the services rendered.
5.6. – Identify the reason a fee may have been reduced or waived.
5.7. – Where the fees were charged to a third party, provide the full name and address of the third party.
5.8. – Identify any balance owing.
5.9. – Provide information that documents the retention of a collection agency.

Guideline #6: Equipment Records

Guideline #6.

The occupational therapist will ensure that preventative and service maintenance records are kept for equipment used in the provision of care if that equipment has the potential to cause harm or impact the accuracy of assessment results.

The equipment and assessment tools used by OTs require periodic maintenance and inspection for safety, efficacy and accuracy by a qualified person(s). OTs have a responsibility to ensure that records of these activities are maintained, even if this activity and the associated record keeping are completed by a facility maintenance department. These records are different than those related to specific client equipment such as wheelchairs and equipment clients purchase for activities of daily living. Records about specific client equipment should generally be kept in the individual client record.

Practice expectations An occupational therapist will:
6.1. – Ensure that equipment maintenance activities such as inspection and servicing are documented. Note: OTs who own and operate their own equipment are responsible to develop equipment service protocols and maintenance records. OTs who are not directly accountable for equipment maintenance processes are responsible to confirm that appropriate records are maintained. For example, an OT working in a hospital is responsible to know and adhere to the equipment maintenance procedures of the organization.

Guideline #7: Retention and Destruction of the Occupational Therapy Record

Guideline #7.

If the occupational therapist is the information manager, he or she will establish a process for the retention and destruction of records that ensures that regardless of the medium used, records are maintained for the required period of time and destroyed in accordance with legislative retention and destruction requirements.

If the occupational therapist is not the information manager, he or she will ensure that the record is maintained and that he or she will have access to it during the minimum retention period, and be knowledgeable about the organization's policies and procedures for occupational therapy record retention and destruction.

Practice expectations

The occupational therapist will, in meeting the above requirements, ensure the following:

7.1. – A client record is retained safely and securely stored for at least 10 years from the date of the last entry in the record or in the case of a minor, the date 10 years after the day on which the client reached or would have reached 18 years old, whichever is later.

7.2. – The record is maintained after the 10-year period if the occupational therapist reasonably knows that a piece of health information will be required after this time for a valid reason (e.g., ongoing care, legal proceeding).

7.3. – Destruction of electronic and paper records is done in a secure manner that prevents anyone from accessing, discovering, or otherwise obtaining the information (e.g., cross-shredding, incinerating, erasing, or destroying files from personal computers and servers).

7.4. – A list of names and dates for those records that have been destroyed is maintained in perpetuity or until no longer necessary in accordance with statutory requirements.

7.5. – Prior to the occupational therapist's resignation, cancellation, or suspension of registration with COTM, the client retains the right to access his or her record. The occupational therapist will do one of the following:
Maintain the client record for, at a minimum, the retention period defined in this practice standard or any other relevant statute or regulation, and notify the client at the last known address that the occupational therapist intends to resign or is no longer able to provide occupational therapy services, and provide information on how the client can obtain copies of the record; or
Transfer the records to either another person who is legally authorized to hold the records, or a successor in keeping with the provisions defined in privacy legislation (PHIA); and when transferring the record, make reasonable efforts to notify the client at the last known address before transferring the record, or as soon as possible after transferring the record.

Additional Resources related to Retention and Destruction of the Occupational Therapy Record

COTM Resources
Links
Guidelines for Preparing Your Professional Will (American Psychological Association) http://www.apapracticecentral.org/business/management/sample-professional-will.pdf
MB Laws – Personal Health Information Act, 1997 http://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php

Guideline #8: Discontinuation or Transfer

Guideline #8. If the occupational therapist is the Trustee, he or she will take reasonable steps to ensure that clients retain right of access to their records prior to the discontinuation of practice.

OTs, who are trustees under the Personal Health Information Act, are required to have a plan in place to manage client records upon planned or unexpected discontinuation of their practice, for example, resignation, revocation of COTM registration, death, disability or leave of absence.

Practice expectations The occupational therapist who is a trustee under PHIA will:
8.1. – Develop and when appropriate implement a plan for management of client records for planned and unexpected discontinuation of practice to ensure client access to their records. The plan may include secure retention and storage of the documents, or transfer of the client records to another person who is legally authorized to hold the records or to a successor trustee in keeping with the provisions defined in PHIA.
8.2. – Make reasonable efforts to notify the client to inform them about how they can access their record.

Guideline #9: Participation in Occupational Therapy Research

Guideline #9.

If the occupational therapist is disclosing client information to a researcher, he or she will establish a process for consent and disclosure in accordance with legislative consent and disclosure requirements and in all cases consider what clients would expect.

If the occupational therapist is a researcher, he or she will ensure that the record is maintained and that organization policies and procedures are in compliance with the personal health information record retention and destruction provisions related to research.

Additional Resources related to Participation in Occupational Therapy Research

COTM Resources
Links
MB Laws – Personal Health Information Act, 1997 http://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php

A Risk Assessment / Analysis and Risk Management Tool – An approach to clinical and professional reasoning regarding managing client records.

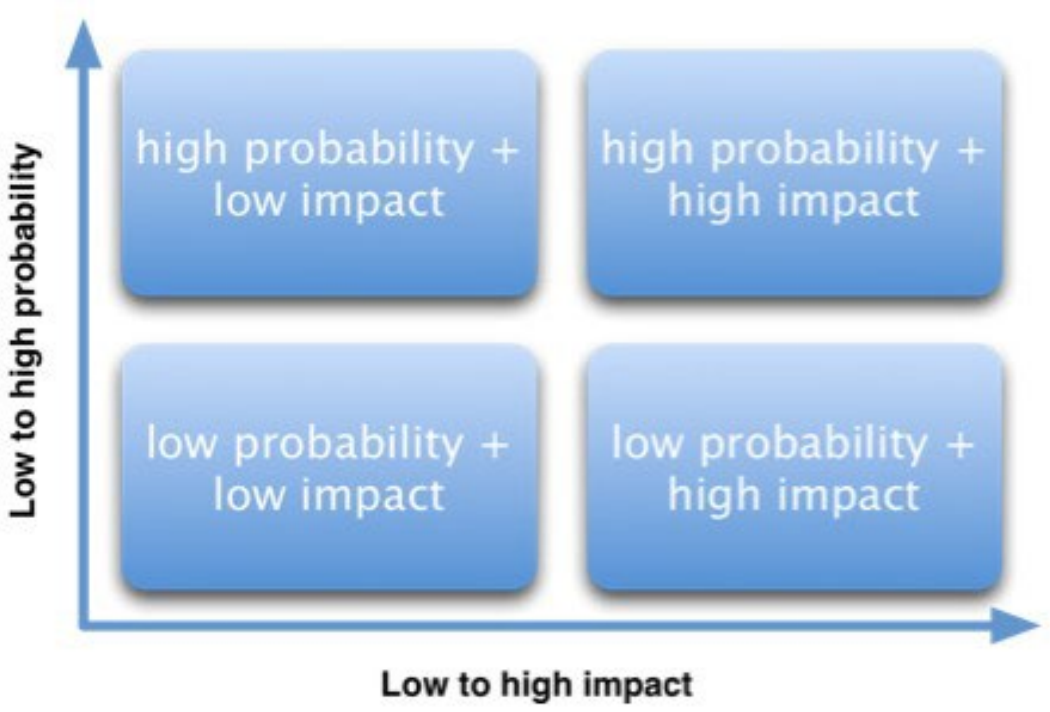
Safe management of client information requires that the occupational therapist make reasoned decisions regarding which information to collect, how to record it, and how to protect it. A risk management approach to managing client information throughout the care continuum is recommended to prevent harm.

Risk management is "nothing more than a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm" (Health and Safety Executive, 1999).

The 1st step is to identify potential risk factors. (The following examples are offered; this is not an exhaustive list but is intended to indicate some of the items that an OT may identify when using this process).
Nature of the Referral
Accuracy and quality of information from other sources (e.g., other professionals, client's family members or significant others). Pressure on or coercion of client to respond or behave in a certain way. Power of referral source to influence funding of services.
Complexity of Client's Presentation
Complexity of condition including physical, mental, and social dimensions. Stability of condition. Capacity to authorize release of information, give consent for direct care, or make informed health care decisions. Fluctuating performance in different situations due to fatigue, pain, medications, stress, distractions, etc. Cultural and / or religious beliefs and values. Ability to give and receive accurate information: language barriers; speech deficits; minimal dominant hand use which prevents proper signature; or problems with reading, seeing, understanding complex information, or retaining information.
More Risk Factors
Environmental / External Conditions
Time (or funding) allowed for documentation. Pressure from others on the client or the occupational therapist to document findings and recommendations in a certain way. Access to client information by unauthorized persons (e.g. in home office, car). Media or data storage or sharing integrity. Software reliability.

Occupational Therapist's Skills and Knowledge
Lack of, or insufficient: • Knowledge of current legislation (e.g. requirements surrounding consent, privacy, access to records, confidentiality). • Clinical knowledge to proceed with the occupational therapy service required. • Knowledge of use of technology in controlling confidentiality of transmitted information, or storing and protecting information (e.g. encryption, firewalls). • Level of experience in report writing and other documentation procedures. • Ability to communicate information to the client or client representative. • Accuracy of testing and analysis of assessments. • Therapeutic or trusting relationship with the client. • Skill to be able to identify possible impaired capacity of the client.

The 2nd step is to consider the probability and severity of impact.
Once the factors are identified, the occupational therapist assesses: The probability of each risk (i.e. how likely is it); and The negative impact (i.e. what degree of harm could the risk cause the client). The risks can be classified from low probability and low impact to high probability and high impact.



The 3rd step is to take action.

The goal is to choose an action or precautions that are suitable and sufficient to minimize the risk. There may not be a perfect solution.

In the case of managing client information, this action could include:

- not proceeding with the collection of information;
- expanding the amount of information collected and recorded
- increasing the frequency of information collected and recorded;
- implementing higher security measures to protect the information;
- ensuring adherence to legislated requirements respecting record retention and destruction;
- discussing the occupational therapy record with the client as part of providing access; and
- ensuring client consent prior to disclosing occupational therapy information.

The 4th step is to record your actions.

This risk management process is dynamic and ongoing throughout the care continuum and even after the file is closed.

It is important to record the risk management actions taken, to demonstrate that precautions were taken to protect the client from harm and to minimize risk.

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