Chapter 10 Record Keeping

CHAPTER OVERVIEW

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Purpose of Record Keeping

The term "record" means information in any form or medium that includes notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers and papers and any other information that is written, photographed, recorded, or stored in any manner (1 - 3).

Record keeping involves activities related to the creation, maintenance and disposition of records and is an important aspect of the practice of all Registered Dietitians and Registered Nutritionists. Clear, comprehensive, and accurate records are essential to communicate the delivery of professional services and to support professionals in responding to accountability issues. Record keeping is best approached in an organized and systematic manner that will support the creation of efficient records, maintain their confidentiality, and prevent unauthorized disclosure.

KEY PRACTICE POINT

Clear, comprehensive, and accurate records are essential to communicate the delivery of professional services and to support professionals in responding to accountability issues.

The key purposes of record keeping are as follows:

Documentation of Daily Practice Activities

Records play an important role in assisting Registered Dietitians and Registered Nutritionists in their daily practice by providing an account of what has been planned and the services that have been provided.

Communication with colleagues/the Inter-Professional Team

Records are useful for communicating with other members of the inter-professional team. Clear, complete, accurate and timely documentation in a client health record is essential to ensure that all members of the inter-professional team involved in the care of a client have access to reliable, pertinent, and current information from which to plan and evaluate their treatment interventions. Physicians, nurses, therapists, and other health care providers frequently refer to documentation entered in the client health record by other professionals as they develop their treatment plans or implement nutrition care plans. The information in a client record assists health care providers in providing continuity of care to clients. Records that are incomplete, incorrect, or entered too late can result in inappropriate treatment decisions (4). Records can also play an important role in the education of students and medical residents.

Professional Accountability

Good record keeping practices are valuable in demonstrating that the knowledge, skills, attitudes and judgment of the Registered Dietitian or Registered Nutritionist have been applied in accordance with the *Code of Ethics* and *Standards of Practice*. Good record keeping practices not only reflect the services provided, but also demonstrate professional accountability.

The obligations of Registered Dietitians and Registered Nutritionists related to record keeping are reflected in Section 3.4 of the College of Dietitians of Alberta *Code of Ethics* which states the following:

> **"3.4 Records**
>
> (1) The dietitian makes and retains complete, accurate records of professional services and signs and dates records that they create.
>
> (2) The dietitian stores and disposes of paper, electronic and other records in a manner that ensures the security and confidentiality of the records.
>
> (3) The dietitian plans for the proper transfer or disposition of records when closing practice or in case of their death."[70]

[70] College of Dietitians of Alberta. *Code of Ethics*; 2007.

Professional obligations related to record keeping are also stated in the *Standards of Practice.* The applicable Standard is as follows:

> **"Standard 14. Record Keeping**
>
> **Standard**
> Registered Dietitians document and manage client records and /or other data in compliance with applicable legislative, regulatory, and/or organizational/employer requirements.
>
> **Indicators**
> To demonstrate this standard, Registered Dietitians will:
> a) Document, sign, and date complete, accurate, timely records related to professional services.
> b) Maintain, retain, share, transport, store, and dispose of all paper and/or electronic documentation and records in compliance with applicable legislative, regulatory, and organizational/employer requirements.
> c) Secure all personal client information through appropriate use of physical, technical, and electronic safeguards to protect the privacy and confidentiality of client information.
> d) Maintain complete and accurate financial records for all relevant professional services.
> e) Maintain equipment service records (e.g., preventative maintenance logs) according to applicable legislative, organizational/employer, and manufacturer recommendations.
> f) Plan for and ensure the transfer or disposition of records when leaving a position or ceasing to practice."

The importance of the client record as a legal document cannot be overemphasized. The client record may be entered as evidence at a trial or professional conduct hearing, providing an account of the services and care that were provided, including but not limited to the following:

- Record of dates / times and events that occurred
- Whether or not orders were carried out
- If services provided were appropriate and timely
- If professional and ethical standards of care were met (e.g. obtaining or withdrawal of consent; performance of a restricted activity)
- The client's progress with the plan of care

Proper documentation of the services provided is the best defense in the event of any legal proceedings: "Most adjudicators will have serious difficulty rejecting a client's claim that something was not done if the chart has no record of it, regardless of evidence provided by the dietitian. Similarly, most adjudicators will generally accept that something did occur if the dietitian recorded it, regardless of evidence to the contrary provided by a client." [71]

Preparation of Reports

Records are commonly used to prepare reports that may be used for various purposes. For example, reports can be used in making funding and resource management decisions. Records may also be used for audits, health care billing, professional conduct reviews, accreditation surveys, in clinical research and in the assessment of the quality of services provided in quality improvement / risk management programs. The information included in such reports may be used by a variety of individuals including other health care professionals, insurance providers, employers, and lawyers (4).

Types of Records

Records are kept in all practice settings; the types of records kept will vary from organization to organization. In dietetic practice, records typically relate to equipment, finances, and client care. Details of each are as follows:

Equipment Service Records

Equipment service records, including preventative maintenance records, are of importance, particularly where proper function of a piece of equipment is critical to client health and safety. For example, dishwashing machines are serviced regularly to ensure that they wash and sanitize dishes properly. A record that includes the date, the inspection or service that was provided and who completed the inspection or service becomes critical if a problem develops later. Equipment service records can also serve as a useful reminder when inspections or preventative maintenance are required (4).

Financial Records

Systems must be in place to monitor and manage the finances of an operation. Accurate records must be kept of revenues and expenditures; good records are essential for the preparation of financial statements which are used in assessing profitability and in making decisions related to operation. Financial records are also used in the preparation of budgets and for tax related purposes as required by Revenue Canada.

[71] Steinecke, Richard, LLB and the College of Dietitians of Ontario, *The Jurisprudence Handbook for Dietitians in Ontario*, Ontario; 2003, p. 65.

For Registered Dietitians and Registered Nutritionists who work in private practice or non-publicly funded settings, financial records are also important in relation to client billing. Typically, financial records would include the following (4):

- A client identifier
- The date
- The nature of the service provided
- The length of time required to provide the service
- The actual fee charged and the method of payment

The *Standards of Practice* outline obligations related to Fees and Billing are as follow:

"Standard 10. Fees and Billing

Standard

Registered Dietitians ensure that fees and billing for professional services and/or products are fair, transparent, and in compliance with legislative and regulatory requirements.

Indicators

To demonstrate this standard, Registered Dietitians will:

a) Be responsible and accountable for all billing under their registration number.
b) Ensure that fees charged for professional services and/or products are fair, reasonable, and justifiable.
c) Disclose fee schedules for all applicable professional services and/or products including accepted methods of payment, potential additional fees (e.g., cancellation fees, photocopying, mailing), and the process for fee dispute resolution, prior to provision of professional services.
d) Maintain comprehensive records regarding the provision of professional services and/or sale of products."

Client Health Records

The client health record serves as a basis for planning client care, documenting communication among health care professionals contributing to the care of the client, assisting in protecting the legal interests of the client and the health care professionals responsible for the care of the client, and documenting the care and services provided to the client. The goal of entries made on the client health record is to provide a clear and accurate account of what occurred during a visit with the client, when it occurred, and who was involved.

KEY PRACTICE POINT

The goal of the client health record is to provide a clear and accurate account of what occurred during a visit with a client, when it occurred, and who was involved.

The *Operation of Approved Hospitals Regulation* under the *Hospitals Act* states the following:

> "**Medical records**
>
> **13(1)** The board of each approved hospital shall cause to be kept by the attending health practitioner a record of the diagnostic and treatment services provided in respect of each in-patient and out-patient in order to assist in providing a high standard of patient care.
>
> **(2)** For each admission, a record of diagnostic and treatment services shall be maintained that shall
>
> (a) identify the patient, and
>
> (b) provide sufficient information to justify the diagnosis and warrant the treatment given, including
>
> (i) provisional and final diagnosis,
>
> (ii) reports of diagnostic and treatment procedures,
>
> (iii) reports of consultations,
>
> (iv) surgical reports,
>
> (v) progress notes,
>
> (vi) orders for treatment,
>
> (vii) discharge summary as applicable, and
>
> (viii) the signature of the attending health practitioner."[72]

[72] Province of Alberta. *Operation of Approved Hospitals Regulation*; 1990.

When considering the content of documentation in a health record, it is important to to first follow all facility-specific policies, governing rules, regulations, or legislation for documentation. The development of organization-specific policies around record keeping is important to manage a variety of issues, such as maintaining confidentiality of client health records and facility-approved abbreviations. As always, what is recorded by the Registered Dietitian should be dictated by purpose as much as professional, legal, and ethical reasons for documentation. Not all information from the client health care record need be reiterated in the nutrition care notes (4).

In practice settings where Registered Dietitians and Registered Nutritionists are working with other health professions, the full record in its entirety makes up the complete client health record. For Registered Dietitians working in private practice or as sole practitioners, documentation may be more extensive for a comprehensive client health record. The following guideline lists the components for inclusion in a comprehensive client health record [adapted from College of Dietitians of Ontario (4) and the Physiotherapy Alberta College and Association (5)]:

- The client's full name and address;
- The name and address of the primary service provider and any other referring health professional, if applicable;
- Every part of a client health record must have a reference identifying the client or client health record;
- The client's relevant health history including medical, social, familial, and economic data related to the nutrition assessment. When background health information is provided by another practitioner, it need not be duplicated; however, a reference to the appropriate section should be included;
- Chronological information including:
    - The date of each of the client's visits to the RD;
    - The reason for RD referral, if applicable;
    - Record of consent obtained or withdrawn (whether implied, verbal or written);
    - The assessment conducted, the findings obtained, the problems identified, the goals for nutrition intervention and the nutrition care plan;
    - All recommendations made and/or implemented by the RD including, but not limited to, diet orders, enteral nutrition, nutrition/vitamin/mineral supplements, nutrition-related

medications, diagnostic tests, consultations to be performed by any other professional, and/or education/counseling provided;

- Any/all restricted activities performed; if prescribing parenteral nutrition and related Schedule I drugs, ensure prescription is clear, comprehensive, and communicated verbally to team members as required;

- Progress notes containing a record of services rendered, subjective and objective evaluation/re-evaluation and changes in the client's nutritional status, or client goals;

- Every written report received by the RD with respect to examinations, diagnostic tests and consultations;

- Particulars about discharge planning, including referral of the client by the RD to another health professional, when applicable;

- Any reason a client may give for cancelling an appointment or refusing the service of an RD, as applicable;

- Particulars of nutrition service that was commenced but not completed, including reasons for non-completion;

- Copies of reports compiled by the RD that are issued to other sources (e.g., health care providers/organizations) with appropriate consent forms, where applicable;

- Sufficient detail to allow the patient/client to be managed by another RD

- RDs must clearly identify themselves when documenting their dietetic services, including their name and professional designation.

Records of Consent to Treatment

"Consent to treatment" refers to the consent or agreement of a client to undergo an assessment process or treatment intervention, after gaining an understanding of the relevant facts and risks involved. A record of consent to treatment should be obtained from a client or substitute decision maker who is legally authorized to provide consent on behalf of a client prior to providing dietetic services (4)

Please refer to Chapter 9 Consent to Treatment for further information.

Other Records

Organizations may keep other records for legal or tracking purposes. Such records may include, but not limited to: safety audits, health inspection reports, staff schedules, performance reviews and management, recruitment records, research/clinical trial records, contract documents for third party providers, incident reports, business plans, and/or FOIP requests.

Record Keeping Systems and Methods

While many organizations continue to use paper-based record keeping systems, electronic record keeping systems are becoming the norm. Regardless of whether an organization uses a paper based or electronic record keeping system, the principles of good record keeping practices must be maintained. Information recorded must be organized in such a way that it provides a clear, accurate and honest account of what occurred, when it occurred and who was involved.

KEY PRACTICE POINT

Registered Dietitians and Registered Nutritionists have a responsibility to follow the record keeping directives established by their employers.

Most organizations have record keeping policies, procedures, guidelines, systems, methods, and forms / software in place; all Registered Dietitians and Registered Nutritionists have a responsibility to follow the record keeping directives established by their employers. Although the College does not promote one documentation style over another, some of the record keeping systems commonly used to document client care activities are described below.

Written Narrative

The actions of health care professionals and client responses are recorded in chronological order, describing the care that was provided. Records may be handwritten on paper or typed in an electronic format.

Forms / Checklists

Pre-established forms / checklists can provide a quick and efficient method for recording client information. Such forms / checklists may be completed in paper or electronic mediums. While forms / checklists save time, health care professionals must be cautious to ensure that they are completed carefully and accurately. Extra space should also be provided for the addition of information that is not captured by a particular form / checklist.

Dictation

Dictation involves creation of a verbal record of information that will be later transcribed into a written / typed paper or electronic record. As there is potential for errors related to word recognition / interpretation during the transcription

process as well as the possibility of misfiling or loss of the record, Registered Dietitians and Registered Nutritionists are advised to track dictated records carefully and to review and sign all records to ensure accuracy.

Record keeping methods used are generally outlined in the policies and procedures of each individual facility/organization. Registered Dietitians are encouraged to review their employers' documentation policies and procedures. Various methods of documenting client care information exist including ADIME (Assessment, Diagnosis, Intervention, Monitoring and Evaluation), DARP (Data, Action, Response, Plan), PIE (Problem, Intervention, Evaluation), SOAP (Subjective, Objective, Assessment, Plan), among others. Some of the methods of record keeping commonly used to document client care activities are described below.

Charting by Exception

"Charting by Exception" is an approach in which only unusual or out of the ordinary events are documented, thereby reducing repetition and time that is spent documenting. Clearly written protocols are important to specify what is and what is not implied by a lack of chart entries (4).

Charting by Reference

"Charting by Reference" is an approach in which the documentation of a health care provider refers to a medical directive, assessment protocol or established treatment regime. Accurate record keeping using this method relies on references that are accurate and complete (4).

Standardized Nutrition Language: International Dietetics and Nutrition Terminology (IDNT)

The adoption of the Nutrition Care Process (NCP) and International Dietetics Nutrition Terminology (IDNT) is becoming commonplace in many health care facilities in Alberta. The College supports its use as it has the potential to facilitate consistent, safe, and quality dietetic record keeping across a variety of dietetic practice environments. There are several advantages for using standardized nutrition language (4):

- Systematic approach – Encourages critical thinking and problem solving;
- Client-Centred Care – Emphasizes a client-centred approach that facilitates interprofessional collaboration;
- Enhanced Communication – Clear, concise and consistent approach to documenting essential nutrition information;
- Prioritization – Enables RDs to identify and prioritize nutrition problems;

- Applicability – Can be used in a variety of dietetic practice settings including those targeting individuals and groups to enable clear and consistent documentation;

- Continuous Quality Improvement – Uses an evaluation framework to identify the effectiveness of intended goals and interventions that demonstrate success;

- Research – Supports evidence-based practice and can facilitate large-scale data collection on the efficacy of nutrition intervention; and

- Streamlined Training & Education – Provides clear documentation expectations for RDs during workplace orientation, performance evaluations and/or College practice assessments.

For more detailed information on Standardized Nutrition Language, including incorporation into electronic health records refer to Dietitians of Canada and the Academy of Nutrition and Dietetics.

The Nutrition Care Process may be used in conjunction with other documentation formats as follows (6):

ADIME
A = Assessment
D =Diagnosis or PES statement
I = Intervention
Nutrition prescription
Nutrition Intervention
Goal
M = Monitoring
E = Evaluation

PIE
P = Problem
Diagnosis or PES statement
I = Intervention
Nutrition Intervention
Goal
E = Evaluation
Monitoring

DARP
D = Data
Diagnosis or PES statement
A = Action
Nutrient Prescription
Nutrition Intervention
Goal
R = Response
P = Plan
Monitoring and Evaluation

SOAP
S = Subjective data
O = Objective data
A = Assessment
Diagnosis or PES statement
Nutrient Prescription
P = Plan
Nutrition Intervention
Goal
Monitoring

Adapted from A. Skipper, 2007 (6)

Joint and Private Records

Most Registered Dietitians and Registered Nutritionists work in settings where they use a "joint record" or record that is used by all members of the inter-professional team. Joint records are an important component of the communication process necessary to ensure that all members of the inter-professional team involved in the care of a client have access to reliable, pertinent, and current information upon which to plan and evaluate their treatment interventions. The joint record keeping practices of all Registered Dietitians and Registered Nutritionists should be consistent with the directives stated in legislation and established by their employer.

Registered Dietitians and Registered Nutritionists who are employed in privately operated facilities or programs may find less formalized record keeping policies and procedures in place. In such settings, extra efforts are often required to ensure that record handling practices meet the minimum professional expectations; practitioners are advised to follow the principles listed below (4):

- Ensure the security of all records
- Ensure confidentiality of all records (Please refer to Chapter 8)
- Provide reasonable client access to records (Please refer to Chapter 8)
- Implement and follow an appropriate policy for correction of documentation errors
- Retain records for a minimum of 10 years following the date of last service; in the case of minor clients, records should be kept for at least two years past the age of majority or for 10 years, whichever is longer
- Ensure a reasonable plan for transfer of records should the facility or program close

Some Registered Dietitians and Registered Nutritionists may keep their own private records of assessment notes, calculations, treatment plans, etc. apart from the joint record keeping system. This practice is not recommended for the following reasons (4):

- It is generally more difficult to ensure the security and confidentiality of such records
- Information that may be valuable to other members of the inter-professional team is inaccessible to them
- The legislated obligations of the facility related to record keeping practices, record retention and destruction of records may not be met

- In the event that the record is required in a legal proceeding, all pertinent information must be included in the official record

Overall, in terms of keeping private records, Registered Dietitians and Registered Nutritionists are advised to carefully consider the following options (4):

- Do not keep private records. All information that should be documented should be recorded in the official client record or chart, or

- If keeping private records is approved by the employer, maintain such records in compliance with established policies and procedures that include appropriate record keeping practices, ensuring the security and confidentiality of all records.

KEY PRACTICE POINT

All pertinent information that should be documented, should be recorded in the official client record.

Ensure that sufficient detail is documented in the official record to allow another Registered Dietitian to manage that client/patient without the need of a private record (5).

Record Keeping Guidelines – Good Communication Practices

Many complaints against health care practitioners are related to miscommunication; the following record keeping guidelines are helpful in reducing the risk of legal liability of Registered Dietitians and Registered Nutritionists by optimizing communication (4,5,8):

- Record entries should include the date, time, name and professional designation of the person documenting the information

- Record accurately, precisely, objectively, and legibly, ensuring that information is supported by facts; avoid judgmental or derogatory remarks

- Record clearly, ensuring the absence of any ambiguity

- Record concisely, including only that information which is relevant and essential; do not duplicate information found elsewhere in the health record

- Record events chronologically

- Record immediately or as soon as possible; if a late entry is made, it should include the current date and time, identification that the entry is late and the date and time that the intervention occurred

- Documentation must be made by the person who was directly involved in the event recorded; never chart or sign on behalf of another individual

- Use correct spelling and terminology that is understood by others

- Avoid using abbreviations that could lead to misunderstanding (Please refer to Appendix 7 for further information on "Health Quality Council of Alberta - Improving Patient Safety by Eliminating Unsafe Abbreviations from Medication Prescribing".)

- Co-sign record entries completed by dietetic interns in accordance with the established policies and procedures of the workplace to verify the accuracy of the entry

KEY PRACTICE POINT

All records must provide a clear, accurate and honest account of what occurred and when it occurred.

- Include sufficient relevant detail in the record to allow the client to be managed by another RD

Additional Guidelines for Paper Based Record Keeping

- Write legibly in ink; do not use pencils, gel pens or coloured highlighters as they are not permanent

- Do not change pens in the middle of writing an entry; if this becomes necessary, note why the ink has changed

- Record entries should be signed by the person who made the entry including their name and credentials

- If corrections are required, ensure that they are legible. Use the following suggestions for correcting written entries:

    - Draw a single line through the entry so that it is clearly deleted, yet still readable

    - Indicate the location of the correct entry

    - Record the correction with the date and time

    - Sign the correction

    - Never remove pages from the record

- Do not leave blank lines or white space between entries in the record to avoid the risk of additional information being added by another individual

Benefits of Electronic Record Keeping:

- Improved legibility
- Increased privacy and security
- Improved audit trail
- Increased access to records
- Improved efficiency in documentation to ensure safe client-centred care
- Enhanced interprofessional collaboration – facilitates sharing of information/may rely on information documented by others
- Minimizes duplication
- More efficient access to results, referrals, reports
- Ability to track statistics for funding, research and other purposes

Format (4):

Pre-established computerized forms can be helpful and efficient when documenting dietetic services with drop-down menus, check boxes, and the like. There are several advantages to computerized forms including monitoring trends, transmitting specific information for accreditation purposes, and collecting statistics for evaluation and research.

Electronic documentation systems typically also include a section for Registered Dietitians to document narrative or free-flow text to provide an opportunity to capture relevant information not covered in drop-down menus or check boxes. As long as the relevant information is recorded, facilities and individual Registered Dietitians in all areas of practice can find electronic documentation systems that meet their needs.

Individual Logins, Audit Trails & Electronic Signatures (4):

Multi-user electronic documentation systems should contain individual logins that clearly identifies each user accessing a record. They should also include an audit trail to demonstrate when and who viewed or accessed the records and by whom the documentation was completed.

Additional Guidelines for Electronic Record Keeping

- Use an electronic medium that is permanent and cannot be altered; all entries made / stored electronically are considered a permanent part of the client health record and may not be deleted

- Use the appropriate features of the electronic documentation system to make corrections or late entries

- Ensure that the program used leaves an audit trail that can reveal when each change was made and by whom

The Alberta Electronic Health Record.

The *Alberta Electronic Health Record Regulation* (AEHRR) defines the Alberta Electronic Health Record[73] as the integrated health information system established to provide shared access by authorized custodians (e.g., Alberta Health Services, the Minister and the Department, and independent health service providers), to prescribed health information in a secure environment (9).

Under the AEHRR, authorized custodians who use prescribed health information through Netcare must keep an electronic log containing specific user information. A detailed listing of this information and additional details regarding the AEHRR may be accessed by visiting the Alberta King's Printer website at: https://www.alberta.ca/alberta-kings-printer.aspx.

For more information on electronic records, please see below.

Client Requests for Corrections or Amendments to Their Records

As discussed in Chapter 8 Confidentiality, clients have the legal right under the *Health Information Act (HIA)*, *Personal Information Protection Act (PIPA)* and the *Freedom of Information and Protection of Privacy Act (FOIP)* to request access to any record that contains information about that person that is in the custody or control of a health care setting, private sector organization or public body (1 - 3).

Under the *HIA, PIPA* and *FOIP,* if a client believes that their information contains an error or omission, they may request that the custodian who has control of that information correct or amend the record. Applicants must make their request to correct or amend their information in writing. Custodians in health care settings, private sector organizations and public bodies must make every reasonable effort to respond within legislated time frames and assist applicants with their requests. Custodians are obligated to ensure that information

[73] Alberta Government. *Health Information Act: Alberta Electronic Health Record Regulation* (2018). Accessed at: https://open.alberta.ca/publications/2010_118

is accurate and complete; the custodian of the record should consult with the individual who made the entry under question prior to taking any action. If a custodian agrees that a change or amendment is required, they must provide the applicant with written notice that the correction or amendment has been made and where appropriate, send a notice of the correction or amendment to any organization to which the incorrect information had been disclosed. Despite the request of an applicant, custodians should not make a correction or amendment to a professional opinion or observation made by a health services provider, or to a record that was not originally created by the custodian. (1 - 3).

When a correction or amendment is made, the audit trail must not be compromised. Therefore, the original entry should not be obliterated. Rather, the corrected entry or amendment should be inserted indicating the date and the name of the person making the correction or amendment (4).

Under the *HIA*, if a custodian refuses to make a change or amendment as requested by an applicant, the custodian must advise the applicant that they may do one of the following (1):

- Request that the Information and Privacy Commissioner review the decision of the custodian, or

- Submit a statement of disagreement outlining the requested change or amendment and their reasons for disagreeing with the decision of the custodian not to make the change or amendment.

Security and Confidentiality of Records

As noted above and in Chapter 8 Confidentiality, the three key pieces of privacy legislation that set rules for how information is to be collected, protected, used, disclosed, and amended in Alberta are: the *Health Information Act (HIA);* the *Personal Information Protection Act (PIPA);* and *The Freedom of Information and Protection of Privacy Act (FOIP).* For more information on these Acts please refer to Chapter 8 Confidentiality.

Regardless of whether records are in a paper based or electronic format, all health care professionals are obligated to maintain the security and confidentiality of all records at all times. Section 2.4 of the *Code of Ethics* of the College of Dietitians of Alberta (the College) states the following:

"2.4 Confidentiality

(1) The dietitian respects the confidentiality of information obtained in providing professional services.

(2) The dietitian discloses confidential information only when the client consents to disclosure, when disclosure is required or permitted by law, or when disclosure is necessary to protect the client

KEY PRACTICE POINT

Regardless of whether records are in a paper based or electronic format, all health care professionals are obligated to maintain the security and confidentiality of all records at all times.

or another individual from harm. See Duty to Report.

(3) The dietitian avoids indiscreet or public conversations about the client or their treatment.

(4) The dietitian does not access information in databases or records about individuals who are not clients or information that is not required to provide professional services.

(5) The dietitian limits access to professional records by others to preserve confidentiality of information."[74]

Professional obligations for Registered Dietitians and Registered Nutritionists related to maintaining the security and confidentiality of all records are also outlined in the *Standards of Practice* which states the following:

"Standard 11. Privacy/Confidentiality

Standard
Registered Dietitians uphold and protect clients rights to privacy and confidentiality of information collected during the provision of professional services by complying with applicable legislative and regulatory requirements.

Indicators
To demonstrate this standard, Registered Dietitians will:

e) Ensure client consent is obtained prior to collecting or disclosing personal, organizational, and/or business information, unless duty to report obligations is required.
f) Access and collect only the client information that is essential to carry out the provision of safe, competent, ethical services.
g) Use physical, technical, and administrative safeguards (e.g., locked filing cabinets, passwords, encrypting documents, laptops and PCs) to protect paper-based, audio, video, electronic or other client information.
h) Avoid conversations about clients and/or professional services provided that can be overheard and/or breach privacy and confidentiality."

And

"Standard 14. Record Keeping

Standard
Registered Dietitians document and manage client records and /or other data in compliance with applicable legislative, regulatory, and/or organizational/employer requirements.

Indicators

[74] College of Dietitians of Alberta. *Code of Ethics*; 2007.

To demonstrate this standard, Registered Dietitians will:

a) Document, sign, and date complete, accurate, timely records related to professional services.
b) Maintain, retain, share, transport, store, and dispose of all paper and/or electronic documentation and records in compliance with applicable legislative, regulatory, and organizational/employer requirements.
c) Secure all personal client information through appropriate use of physical, technical, and electronic safeguards to protect the privacy and confidentiality of client information.
d) Maintain complete and accurate financial records for all relevant professional services.
e) Maintain equipment service records (e.g., preventative maintenance logs) according to applicable legislative, organizational/employer, and manufacturer recommendations.
f) Plan for and ensure the transfer or disposition of records when leaving a position or ceasing to practice."

Security and Confidentiality of Information Collected Electronically in Private Practice

The above Standards apply to information collected and documented using both traditional face to face consultations / paper charting, and electronic consultations / documentation. There are however additional risks to the confidentiality and privacy of information online. Chapter 8 Confidentiality outline technical security measures to take to ensure client health information remains protected.

Registered Dietitians and Registered Nutritionists who store personal client information on personal computers, laptops, or mobile devices must ensure that the information is protected in case the device is lost or stolen. Registered Dietitians and Registered Nutritionists must take measures to guard against unauthorized access to information. Safeguards include password protection, anti-virus/malware software, and encryption of personally identifying information. For mobile devices specifically, ensure the device is set to auto-lock when not in use, and is locked to furniture or stored securely when left unattended (9).

Communicating with clients via email

According to the *HIA*, any custodian or affiliate (in this case the Registered Dietitian) has the duty to protect the privacy of clients and the confidentiality of health information within their custody or control (7).

Emailing clients can improve quality of care and efficiency when sending out appointment reminders, sharing information and resources or following up on treatment plans, however there are risks associated with email transmission of information including the following (7):

- Interception: information intended for the client, is read by a family member;
- Misdirection: two clients have similar email addresses, and sensitive health information is sent unintentionally to the wrong client

- Alteration: lab results sent to a client are altered and passed on to another health care professional as reliable information

- Loss: electronic information is lost by providers

Registered Dietitians and Registered Nutritionists must mitigate these risks by encrypting data and limiting the amount of health information sent in an email (see below for more information).

As noted above, Registered Dietitians and Registered Nutritionists must consider the retention of information collected. For example, is a copy of an email required as part of the health record? Refer to the next section for more information on retention of records.

For more information on confidentiality, please refer to Chapter 8.

The security and confidentiality of records is at increased risk when records are transmitted from one location to another. Health care professionals should ensure that all necessary steps are taken to reduce such risk. The following guidelines are helpful in reducing the risks to the security and confidentiality of records during transmission processes.

Transmission of Records

The security and confidentiality of records is at increased risk when records are transmitted from one location to another. RDs should ensure that all necessary steps are taken to reduce such risk (4).

Records Being Transmitted Via Mail or Courier

- Place information in a sealed envelope, clearly identified as confidential.

- As a tracking mechanism, document the date that mail was sent in the client's record.

Records Being Transmitted Via Facsimile

- Use secure and confidential systems. If possible, use encryption technology or other technology to secure fax transmissions.

- Ensure that the facsimile will be retrieved immediately or stored in a secure area where unauthorized persons cannot see the documents. If there is no appropriate location, someone should be watchful of the machine while in operation.

- Verify fax numbers and distribution lists prior to transmitting.

- Check activity reports to verify successful transmission.

- Include a confidentiality statement on the cover sheet stating that the information is confidential, to be read by the intended recipients only and a request for verification that facsimiles received in error were destroyed without being read.

- Be aware that your fax number can be re-assigned once you give it up. It is possible to "purchase" the rights to that line so that the number is never re-assigned.

Records Being Transmitted Electronically

- Use secure and confidential systems.

- If possible, use encryption technology to ensure safe transmission.

- Password protection of electronically transmitted files containing personal information may be considered in situations where files are not encrypted, but one has control over both the sending and receiving ends of the electronic exchange.

- If necessary, for the purposes of transmission, consider removing identifying information (e.g., individual identifier numbers, last names) from email messages or electronically transmitted reports (e.g., when you are sending a draft report to someone else to review content). This information can be re-entered once confirmed and then a final copy can be sent via a more secure approach.

- Verify email addresses of intended recipients prior to transmitting.

- Request an acknowledgement of receipt.

- Include a confidentiality statement stating that the information is confidential, to be read by the intended recipients only, and that the email and any attachments are to be deleted if received in error.

Note that personal information that is transferred to another country (i.e., stored on a server in another country) is subject to the laws of that jurisdiction. Information about where cloud technology is housed should, therefore, be disclosed to clients. (9)

Records Being Transmitted Via Mail or Courier

- Place information in a sealed envelope, clearly identified as confidential
- Use a system to track the delivery and receipt of items

Record Retention and Disposal

Policies related to the storage, retention, and disposal of various types of records will differ depending upon the type of documents and the practice setting / organization. Registered Dietitians and Registered Nutritionists are responsible to follow the policies for storage, retention and disposal of records as established by their employers.

KEY PRACTICE POINT

Registered Dietitians and Registered Nutritionists should ensure that client records are retained for a minimum of 10 years following the date of last service; in the case of minor clients, records should be kept for at least two years past the age of majority or for 10 years, whichever is longer.

The *Operation of Approved Hospitals Regulation* under the *Hospitals Act* states the following:

> **"Retention of medical records**
>
> **15(1)** Diagnostic and treatment service records shall be retained by the hospital for
>
> (a) a period of 10 years from date of discharge from hospital, and
>
> (b) in addition, in the case of the patient being a minor, for a period of at least 2 years following the date on which the patient reached the age of 18 years."[75]

Client records should be retained according to these guidelines even in the event that a client passes away, as the estate of the client may require information related to the care and services that a client had received (4).

When the appropriate amount of time has elapsed, records should be destroyed, using a method that will ensure the security and confidentiality of the records during the disposal process. A record should be kept of the name of the client, file number, the last date of treatment and the date that the file was destroyed (4).

Closing or Transferring a Practice

Registered Dietitians and Registered Nutritionists may leave their practice for a number of reasons which may include health problems, retirement, relocation and even unexpected death. Practitioners who work in private practice settings in particular must ensure that the necessary arrangements are in place to provide continuous care for their clients upon closure

[75] Province of Alberta. *Operation of Approved Hospitals Regulation*; 1990.

of a practice. Records must also be dealt with in an appropriate manner upon closure of the practice. The College of Physicians and Surgeons of Alberta has established guidelines for managing client records upon closure of a medical practice. Based on these guidelines, Registered Dietitians and Registered Nutritionists who are in private practice settings are advised to consider the following in the event that they close their practice (8):

Practitioners who work in private-practice settings are responsible for ensuring that records are dealt with in an appropriate manner upon closure or transfer of the practice. The following guidelines are recommended (8,9):

- A regulated member who closes or leaves a private practice is responsible for the secure storage and disposition of the patient records from that private practice.

- Records should be transferred, as necessary, to another Registered Dietitian.

- In the case where a Registered Dietitian's business is sold to a new owner, custody of records can be transferred to the new owner. This should be stipulated in the contract for the sale of the business and should specify that the new owner retain the files in a manner consistent with the requirements of privacy legislation and the Standards of Practice.

- Clients should be informed of file transfers and should also be given the option of having their records transferred to an RD of their own choice.

- If the clinician is unable to provide ongoing management or storage of the client records on their own premises, they are responsible for the secure storage and disposition of the client records, including placing them in commercial storage for custody as appropriate.

- If there is no receiving RD available, records should be transferred directly to the individual client.

- RDs who maintain custody and control of records (or those who are most responsible for records) in a private practice must ensure that there are plans in place for all aspects of record management and maintenance to ensure that client records are not abandoned. Regulated members should appoint another health care professional (preferably a member of the same profession) who agrees to serve as the successor custodian if they cannot fulfill their duties.

Chapter Summary

Record keeping involves activities related to the creation, maintenance and disposition of records and is an important aspect of the practice of all Registered Dietitians and Registered Nutritionists. Clear, comprehensive, and accurate records are essential to communicate the delivery of professional services and to support professionals in responding to accountability issues. Record keeping is best approached in an organized and systematic manner that will support the creation of efficient records, maintain their confidentiality, and prevent unauthorized disclosure. The key purposes of record keeping are as follows:

- Documentation of daily practice activities
- Communication with colleagues / the inter-professional team
- Professional accountability
- Preparation of reports

Records are kept in all practice settings; the actual types of records kept will vary from organization to organization. In dietetic practice, typical records kept include equipment service records, financial records, client health records and consent to treatment records. Regardless of whether an organization uses a paper based or electronic record keeping system, the principles of good record keeping practices must be maintained. Most organizations have record keeping policies, procedures, guidelines, systems, methods, and forms / software in place; all Registered Dietitians and Registered Nutritionists have a responsibility to follow the record keeping directives established in legislation and by their employers. If a client believes that the information in their record contains an error or omission, they may request that the custodian who has control of that information correct or amend the record. Such requests may be accommodated, depending on circumstances as outlined in legislation. Registered Dietitians and Registered Nutritionists are responsible to follow the policies for storage, retention and disposal of records as established by their employers. Regardless of whether records are in a paper based or electronic format, all health care professionals are obligated to maintain the security and confidentiality of all records at all times. Client records should be retained for a minimum of 10 years following the date of last service; in the case of minor clients, records should be kept for at least two years past the age of majority or for 10 years, whichever is longer. Registered Dietitians and Registered Nutritionists who work in private practice are responsible to ensure that records are dealt with in an appropriate manner upon closure of their practice.

Case Scenario 10.1

WW is a 63-year-old female who was admitted to hospital to stabilize her diabetes mellitus. She was seen by FF, the dietitian on the unit who completed a comprehensive nutrition assessment and developed a nutrition care plan that would help WW meet her nutrition goals. After finishing with WW, FF visited a number of other clients. At the end of the day, she returned to the office with her rough notes. She organized all of her notes from the day and advised the diet office and kitchen staff of the various nutrition care plans to be implemented, including WW's new meal plan. FF was concerned about the time as she had tickets for a concert and was already running late. She decided to come in a bit early the next morning and complete her charting at that time – she left her rough notes on her desk as a reminder; she would destroy them after completing her charting. (Hospital policy states that no health care provider will keep private notes.) On her way home from the concert, FF was in an accident and was unable to return to work for one month.

Case Scenario 10.1 Questions

1. Describe any concerns that you might have related to the record keeping practices of FF.

2. Are the record keeping practices of FF in accordance with the *Code of Ethics* and the *Standards of Practice*? If not, identify the specific areas that she would have contravened.

3. In the event that WW filed a complaint against FF and the case went to a professional conduct hearing, would the rough notes left on FF's desk be sufficient to demonstrate professional accountability and the care provided by FF?

4. If FF were a friend of yours, what advice would you give her?

Chapter Quiz

1. All of the following statements are true *except* for the following:

    a) All information that should be documented should be recorded in the official client record or chart.
    b) If a client believes that the information in their record contains an error or omission, they have the legal right to request that the custodian who has control of the information correct or amend the record.
    c) Private records are an important component of the communication process necessary to ensure that all members of the inter-professional team involved in the care of a client have access to reliable, pertinent, and current information upon which to plan and evaluate their treatment interventions.
    d) Good record keeping practices are essential to communicate the delivery of professional services and to support professionals in responding to accountability issues.

2. In the case of adults, client care records should be retained for a minimum of _____ years following the date of last service.

    a) 5
    b) 10
    c) 15
    d) None of the above

3. Which piece of Alberta legislation states what must be recorded in the medical record of hospital patients?

    a) *Health Professions Act*
    b) *Health Information Act*
    c) *Personal Information Protection Act*
    d) *Operation of Approved Hospitals Regulation*

4. All of the following statements demonstrate acceptable practices *except* for the following:

    a) The mother of a Registered Dietitian is admitted to hospital; the Registered Dietitian accesses the electronic health record system to find out the diagnosis and treatment plan for her mother.
    b) A Registered Dietitian forwards a client care report to the attending physician using a courier. The report is in a sealed envelope that is marked "confidential". Arrangements are made to have the delivery and receipt of the envelope tracked.
    c) A Registered Dietitian who is closing their private practice makes arrangements to have their client records put into commercial storage for custody until such time that the records can be destroyed.
    d) All of the above demonstrate good record keeping practices.

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