Documentation of Client Care and/or Services

Reviewed Date		**Number**	*IM0109*
Revised Date	*April 10, 2024*	**Approved Date**	*October 23, 1996*

Introduction

Documentation of interactions with clients is an essential component of professional practice and is legally required to ensure clear, complete, accurate and timely records of client care and/or service delivery. Documentation enables continuity of client care and/or service, supports interprofessional communication and collaboration, and is required to maintain professional and agency accountability. Documentation records will also be used to prepare reports, support data collection, research, evaluation, and/or for quality assurance and quality improvement. Accordingly, client documentation records are subject to this policy and the procedures outlined herein.

Purpose

To define minimum expectations for all SMDHU employees, students, interns and volunteers for documenting interactions with clients to ensure compliance with legislation and optimal provision of care and/or services.

Legislative Authority

Regulated Health Professionals Act 1991 (RHPA)

Municipal Freedom of Information and Protection of Privacy Act, 1991 (MFIPPA)
Personal Health Information Protection Act, 2004 (PHIPA)

Health Care Consent Act, S.O. 1996

Health Promotion and Protection Act (HPPA) R.S.O. 1990

Substitute Decisions Act, S.O. 1992

Dental Hygiene Act 1991

Dentistry Act, 1991

Dietetic Act, 1991

Nursing Act, 1991

Medicine Act 1991

Other department and/or program specific legislation may apply.

Documentation is also required in accordance with the practice standards set out by regulatory colleges in Ontario.

Policy Definitions and Interpretation

Client – individual, family, group or community (e.g., agency, business/workplace, facility or premise, municipality, community coalition/network) or any other public entity who receives care and/or service by a health unit employee, student, intern or volunteer.

Substitute Decision Maker – a person identified by the Health Care Consent Act who may make a decision concerning care and service for someone who is incapable of making their own decision. The substitute decision maker is usually a spouse, partner or relative.

Client Record – a paper or electronic record used to document details of care and/or services provided to a client, by a health unit employee, student, intern or volunteer at the health unit. It contains relevant details of care and/or services including purpose, objectives, assessment, planning, implementation/interventions, and evaluation. It provides a complete record of care and/or services provided and may include objective and subjective data, final copies of notes, completed forms about the interaction, significant communications, correspondence, minutes, reports, photographs, or other relevant recorded information regardless of the medium.

Health Unit Care and/or Services – delivery of a program or any of its interventions toward achieving the mandate of the local public health agency. This includes, but is not limited to, health assessment, health education, inspection, clinical care, public health advice, recommendations and/or referrals provided to any client to prevent deterioration of health and/or maintain or improve health. Health unit care and/or services may be provided by an individual employee, student, intern, or volunteer or through coordinated, collaborative and/or interprofessional care with multiple health professionals.

Record: Any record of information however recorded. This includes correspondence, minutes, reports, photographs, computer tapes and disks, files, and any other recorded information regardless of medium or format.

Official record - A legally recognized document that provides evidence of business activities, decisions, and transactions. These records are required to meet financial, legal, regulatory, operational, historical, or other legislative obligations. Examples of Official Records: key internal and external communications including, briefing notes, policies, directives, approved minutes, formal plans, contracts. Official records include active and inactive records.

> ***Active records:*** Official records currently in use and/or referred to and must be immediately available for reference.
>
> ***Inactive record:*** Official record that is needed to meet long-term operational, legislative compliance or historical requirements, and does not need to be available for immediate access.

Unofficial record: includes transitory and non-records

> ***Transitory Records -*** Records that have temporary, limited or no business value or significance for the Health Unit and are not required for financial, legal, operational, historical, and other official requirements. Examples include drafts, copies, miscellaneous administrative notices.
>
> ***Non-records -*** Documents that are not considered a Health Unit record and would include personal messages or publicly published and available items such as books, brochures, or superseded or obsolete blank forms or templates.

Personal Health Information - means identifying information about an individual in oral or recorded form, if the information:

- relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,
- relates to the providing of health care to the individual, including the identification of a

person as a provider of health care to the individual,

- is a plan of service within the meaning of the Fixing Long-Term Care Act, 2021 for the individual,
- relates to payments or eligibility for health care in respect of the individual,
- relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance,
- is the individual's health number, or
- identifies an individual's substitute decision-maker.

Personal Information - means recorded information about an identifiable individual, including:

- information relating to the race, national or ethnic origin, colour, religion, age, sex, sexual orientation or marital or family status of the individual,
- information relating to the education or the medical, psychiatric, psychological, criminal or employment history of the individual or information relating to financial transactions in which the individual has been involved,
- any identifying number, symbol or other particular assigned to the individual,
- the address, telephone number, fingerprints or blood type of the individual,
- the personal opinions or views of the individual except if they relate to another individual,
- correspondence sent to an institution by the individual that is implicitly or explicitly of a private or confidential nature, and replies to that correspondence that would reveal the contents of the original correspondence,
- the views or opinions of another individual about the individual, and
- the individual's name if it appears with other personal information including personal health information relating to the individual or where the disclosure of the name would reveal other personal information including personal health information about the individual.

Documentation Audit – an objective and systematic check for compliance of documentation of health unit care and/or service to specified requirements (i.e. legislation, health unit policy and procedures), standards and guidelines as set by the professional's regulatory college, as well as department and/or program expectations. Audits may be completed on both active and inactive client records.

Quality Assurance – focuses on documentation outputs or data for adherence with established documentation requirements and/or processes. Quality assurance operates on a pass/fail basis – either documentation was done correctly or not.

Quality Improvement – a systematic approach to making changes that lead to better outcomes, stronger system performance and enhanced professional development.

Policy

All SMDHU employees, students, interns, and volunteers will create and maintain a client record for all clients who receive care and/or services from the agency in accordance with this policy and its procedures. The client record is an official record of the agency and as such must be created, retained and destroyed in accordance with the SMDHU policies, procedures and practices related to records management.

Health Unit employees that are governed by the *Regulated Health Professions Act* will be aware of and meet the expectations established by their professional governing body.

In the absence of professional standards, or where professional standards of differing regulating bodies do not align, the standard with the highest level of expectation will be followed.

Procedures

A) Creation of Client Records

1. When client care and/or service delivery is initiated, employees, students, interns or volunteers will create a client record using approved documentation software, databases or forms. The SMDHU Request for Service (RFS) form will be the default when no other process is identified for documenting the client interaction. The RFS form will be completed by the lead for cross program care and/or service requests.

2. Documentation of care and/or services must meet the following expectations:
   a) Ensure that the client is aware that a record is being created for collection, and storage of any *personal* or *personal health* information; and for the care and/or services provided.
   b) Include identifying information about the client including full name, address, phone number, and/or unique identifiers such as date of birth, health card number or other identifier as required.
   c) Include the date and time that care and/or service was provided and when it was recorded. Entries are to be ordered chronologically.
   d) Include the method of contact (e.g. in person, telephone, electronic/virtual, etc.).
   e) Include comprehensive details of care and services provided to the client and should include purpose, objectives, assessment, planning, interventions (independent and/or collaborative), and evaluation as well as all necessary documents, forms, resources, and any consents obtained, that provide complete details of care and/or services provided to the client.
   f) Include significant communication with the client, family members/significant others, substitute decision makers and other care providers.
   g) Do not include statements that are false, misleading, or unprofessional.
   h) Document as soon as possible following the delivery of care and/or services, and within no more than three business days.
   i) Ensure all entries are clear and legible, including all edits.
   j) Ensure that the person who made the entry or provided the care and/or service is identifiable (e.g. name, signature, initials, unique ID) and that their professional designation is provided if applicable. If not applicable, include position title.
   k) When required by your specific profession or program, ensure preceptors' review of documentation and co-sign entries made by students or interns.
   l) Use agency and/or program approved, acceptable abbreviations that are recognizable, and understandable.

m) Maintain security of the record and of personal and personal health information at all times. Refer to SMDHU policy IM0101 Personal Health Information Privacy Policy, including (F1) Confidentiality Agreement.

n) Ensure cross program service provision documentation is contained within one single record as required by SMDHU policy PP0105 Request for Service (RFS) policy.

o) Ensure records are retrievable, stored, retained, and destroyed according to agency Information and Records Management policies. Programs that approve documentation software, databased or forms must ensure these systems meet this expectation.

B) Program Managers

1. Ensure that additional program-specific documentation guidelines, policies or documentation tools, forms, or systems:
    a) Incorporate the expectations of this policy;
    b) Support the requirements of the regulated health professionals employed in that department;
    c) Include expectations regarding content, format of documentation;
    d) Clearly identify program or department specific abbreviations and cross-reference to prevent duplication with agency approved abbreviations;
    e) Are available in program policies, manuals and/or guidebooks on the SMDHU intranet; and
    f) Have been developed with input from applicable Leadership Designate(s).
2. Provide orientation to agency documentation expectations within the first month of employment.

C) Leadership Designates

1. Provide additional information or materials and direction to support documentation for their professional group, as needed.

D) Vice Presidents

1. Ensure that a documentation audit process that focuses on continuous quality assurance and quality improvement is included in performance review processes.
2. Ensure that a process to ensure records are readily retrievable will be established for department client records including defined expectations for actions such as regular uploading of content from electronic files, a tracking system for hard copy records which identifies location and staff person currently in possession of a record not present within the filing system.

E) Electronic Documentation

1. Departments/programs that implement electronic documentation systems must first ensure the following:

    a) Successful completion of a Privacy Impact Assessment (PIA) and Threat Risk Assessment (TRA). Refer to agency policy IM0119 Information Privacy and Security Assessment.

    b) A process is in place to ensure continuity between electronic and any related paper records i.e. if there are electronic and hard copy portions of one record, they need to refer to each other. There should only be one official client record.

c) Electronic records are maintained in accordance with SMDHU Records and Information Management Policies.

E) Hard Copy Records

1. Removal of a hard copy client record from the filing system into the possession of employee, student, intern or volunteer will be documented in the established tracking system to identify who has possession of the client record so that it remains retrievable.
2. Employees, students, interns, or volunteers will return hard copy client records for storage when not actively in use and also when the record is to be 'closed' or becomes inactive upon completion of care and/or service, noting such for the reference of the relevant staff person.

Related Forms

IM0101_(F1)_Confidentiality_Agreement

IM0119_F1_Privacy Impact Assessment Threat Risk Assessment

PP0105_F1_Request for Service Individual

PP0105_F2_Request for Service Community

Related Policies

- IM0101 Personal Health Information Privacy Policy
- IM0108 Information Privacy and Security Incident Management Policy
- IM0110 Records Management
- IM0117 Use of Electronic Signatures
- IM0119 Information Privacy and Security Assessment
- IM0120 Fax Policy
- IM0121 Transporting Records
- IM0122 Virtual Meeting Using Microsoft Teams
- IM0123 Electronic Documentation Imaging (EDI) Policy
- PP0105 Request for Service from External Clients
- OP0110 Work from Home Policy
- Nursing and Nutrition Documentation Manual 2018, or as current
- Department and/or Program Documentation Policies

Policy Sign-Off Form

IM0109 Documentation of Client Care and/or Services

Final Approval Signature: _____

Review/Revision History:
September 2010 Policy re-numbered, previous number C4.010
Revised – April 11, 2001
Revised – October 9, 2013
Revised – April 10, 2024