Documentation of Client Care and/or Services

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Introduction

Documentation of interactions with clients is legally required to ensure accurate records of service delivery, continuity of service, communication, and to maintain professional and agency accountability.

Purpose

To define minimum expectations for all SMDHU employees, students and interns 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 Promotion and Protection Act (HPPA) R.S.O. 1990

Dental Hygiene Act 1991

Dentistry Act, 1991

Dietetic Act, 1991

Nursing Act, 1991

Medicine Act 1991

Policy Definitions and Interpretation

Client – individual, family, community group, agency, business or premise, coalition or community network, professional group, population or any other entity who receive care and/or service by a health unit employee, student or intern.

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, or a student/intern at the health unit. It contains relevant details of care and/or services including purpose, objectives, assessment, planning, implementation, and evaluation. It provides a complete record of care and/or services provided and may include final copies of notes, completed forms about the interaction, 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 components including, but not limited to, education, inspection, health assessment, clinical care, public health advice or recommendations provided to any client toward achieving the mandate of the agency and maintaining or improving the health of the community.

Inactive Records - are original records, which are needed to meet long-term operational or legislative compliance, or historical requirements, and are no longer used on a routine basis.

Official Records - Records that have ongoing value or are necessary for legal, financial, operational, historical and other official requirements, including:

- all recommendations and decisions along with complete supporting documentation
- interactions with clients, consultants, vendors, partners, agents except those restricted to routine directions and advice
- significant face-to-face and phone discussions
- legal agreements of any kind along with complete supporting documentation
- any work done for the Health Unit by consultants and others
- all policy and planning activities
- any transaction where payment is made, services are delivered or obligations incurred
- IT and RM systems, procedures and databases that manage, document, control and maintain the security and integrity of the Health Unit's information.

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 Long-Term Care Act, 1994 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.

Policy

All SMDHU employees, students and interns will create and maintain a client record for all clients who receive care and/or services from the agency. 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 and practices related to records management.

Documentation of care and/or services must meet the following expectations:

- Use approved documentation tools, forms or systems. The agency Request For Service (RFS) forms (Individual and community) provided in PP0105 Request for Service are the default.
- 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.
- Include comprehensive details of care and services provided to the client and should include purpose, objectives, assessment, planning, implementation 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.
- Document care and/or services provided within three working days of provision.
- Ensure all entries are clear and legible, including all edits.
- Ensure that the person who made the entry or provided the care and/or service is identifiable (e.g. name, signature, initials, unique ID).
- When required by your specific profession or program, ensure preceptors' review of documentation and co-sign entries made by students or interns.
- Use agency and/or program approved, acceptable abbreviations that are recognizable, and understandable.
- Maintain security of the record and of personal and personal health information at all times. Refer to SMDHU policy IM0102 confidentiality agreement.
- Ensure cross program service provision documentation is contained within one single record as required by SMDHU policy PP0105 Request for Service (RFS) policy (Section 10).
- Ensure records are retrievable, stored, retained and destroyed according to agency Records Management policies. Programs that approve documentation tools or software must ensure these systems meet this expectation.

Program Manager/Supervisor will ensure that additional program-specific documentation guidelines, policies or documentation tools, forms or systems:

- Incorporate the expectations of this policy;
- Support the requirements of the regulated health professionals employed in that service area;
- Include expectations regarding content, format of documentation, and program-specific abbreviations;
- Are available in program manuals/guidebooks on the SMDHU intranet; and
- Have been developed with input from applicable Leadership Designate(s).

Program Managers/Supervisors will provide orientation to agency documentation expectations within the first month of employment.

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.

Leadership Designates may provide additional information or materials and direction to support documentation for their professional group.

Directors will ensure that:

- A documentation review process that focuses on continuous quality improvement is included in performance appraisal processes.
- A process to ensure records are readily retrievable will be established for service area 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.

Service areas/programs that implement electronic documentation systems must first ensure the following:

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

Procedures

1. When client care and/or service delivery is initiated, employees, students or interns will create a client record using approved documentation software or appropriate forms. The RFS form will be the default when no other process is identified for documenting the client interaction. RFS form will be completed by the lead for cross program care and/or service requests.
2. Removal of a hard copy client record from the filing system into the possession of employee, student or intern will be documented in the established tracking system to identify who has the client record so that it remains retrievable.
3. Employee, students or interns will return hard copy client records for storage when not actively in use and also when it 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

IM0102_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

Information Management policies IM0101 through IM0108
Records Management IM0110
Request for Service from External Clients PP0105
Nursing Documentation Manual 2012
RD Documentation Guidelines
Guidelines (RCDSO) Dental Recordkeeping, Revised May 2008 and Electronic Records Management, March 2012
Dental Hygiene Records *T:\Oral Health\CDHO\RecordsReg[1].pdf*
D42002 Food Premise Inspection Documentation
Clinical Service Guideline for Transporting Hard copy Client Records By Staff
Clinical Service Sending client Records and/or Lab Slips via Courier
TEO Documentation Procedures

Final Approval Signature: _____

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