EIGHT

College of Dietitians of Ontario

# Record Keeping

## AT A GLANCE



## SCENARIOS



## TABLES



## NEED TO KNOW

1. Keeping appropriate records is important for client care and enabling dietitians to respond to accountability issues.

2. There are various acceptable ways of keeping records, so long as dietitians have access to the necessary information when needed.

3. Records must be kept secure, confidential, available for professional use, and available for clients to review and correct if necessary.

4. Employers/payers may establish reasonable procedures for access to information by clients, as long as these do not create unnecessary barriers for clients.

## The Client Health Record

Record keeping is important for all businesses and professional practices. Dietitians working in industry would certainly document their analysis and recommendations to their employers. While some of the principles discussed in this chapter would apply to all dietitians, the focus is about keeping client health records. Keeping an accurate health record will assist in four areas:

1. Day-to-day practice;
2. Communicating with team members;
3. Preparing reports; and
4. Accountability.

### 1. DAY-TO-DAY PRACTICE

The primary use for a client health record is to assist dietitians in their day-to-day practice. Obviously, this use is more important for ongoing treatment plans than for one or two-visit encounters. In follow-up visits, dietitians need to review:

- the reasons for treatment;
- the details of the treatment plan;
- progress to date;
- baseline data with subsequent data; and
- the discharge plan.

### 2. COMMUNICATING WITH TEAM MEMBERS

Good record keeping will also be useful to the other members of a health or residential care team such as physicians, nurses, therapists and food service workers. These individuals will refer to dietetic entries in a client's chart when preparing their own treatment or when implementing nutrition care plans. Often, dietitians never know that others have reviewed their records. Omitting information, or recording it incorrectly or late, may result in inappropriate treatment decisions.

### 3. PREPARING REPORTS

Records are commonly needed to prepare assessment, treatment and prognosis reports. Clients are entitled at any time to a dietitian's reports, and may request them for use by insurers, employers and lawyers. Failure to provide an adequate report because of poor records may lead, at best, to professional embarrassment for the dietitian. At worst, failing to provide a report when requested to do so is also professional misconduct, according to the College's *Professional Misconduct Regulation:*

> 24. Failing, without reasonable cause, to provide a report or certificate relating to an assessment or treatment performed by the member, within a reasonable time after a client or his or her authorized representative has requested such a report or certificate.

### 4. ACCOUNTABILITY

The axiom, "if it wasn't recorded, it wasn't done," is not that far from the truth. Records are critical in a dietitian's accountability for services. Clients, employers, payers and the College will rely heavily on a dietitian's record in assessing the adequacy of a dietitian's conduct or competency. Adjudicators will rely on records in dealing with client claims, even more so than on evidence provided by either the clients or dietitian.

Accountability is not restricted to disputes with clients. A dietitian's record is often the focus of risk management and quality supervision by employers. In its Quality Assurance Program, the College may also rely upon those charts. The quality of a dietitian's records is generally seen as a good barometer of the quality of his or her practice.

## Common Objections to Keeping Health Records

Some health professionals minimize the importance of record keeping by suggesting that it detracts from the real practice of dietetics, and that it signifies the usurping of the profession by lawyers. However, as noted above, record keeping is an integral part of a high quality practice.

Is keeping accurate health records time consuming and tedious, taking time away from other "pressing" work such as client contact or meetings? During a busy day, it can certainly seem so. The fact that the health records may not be urgently needed, and that years can pass before an entry becomes critical, further conceals the importance of keeping records. However, once dietitians become familiar with a record keeping system, charting can be done quite efficiently. A system might include references to other documents, a set of usual abbreviations and possibly use of a preprinted form. With experience, you will learn what is significant to record (see *What Should be Recorded* below).

Some health professionals worry that thorough record keeping means that mistakes will be recorded as well, resulting in easier legal liability. While theoretically possible, the reality is that for every case where a dietitian might regret recording a detailed note, there will be a thousand cases where they will be thankful, and wish that even more had been recorded.

## What Should be Recorded?

There is an element of professional judgment as to what should be recorded in a client's record, which depends partly on the nature of the dietitian's practice, who has access to records, and what forms of accountability the dietitian is most likely to face.

### 1. EQUIPMENT SERVICE RECORDS

These are important where the equipment can have health consequences, or where the accuracy of measurements taken from the equipment is vital. Include a record of the date of inspection or service, and who did it, (which can be crucial if a problem develops), and a reliable reminder system for such inspections or maintenance.

### 2. FINANCIAL RECORDS

When billing occurs, financial records are needed. Audits of financial payments are a fact of life in both the private and the public sector. Typically, they include:

- a client identifier;
- the date, time, nature, and length of service;
- the method of determining the fee, if it is not uniform in the practice (units of time, block fee, fee schedule, based on a prior estimate, etc.); and
- the actual fee and the method and date of payment.

### 3. A RECORD OF CONSENT

A record of consent obtained from a client for any risky, invasive or otherwise significant service is valuable. As noted in Chapter 7, a signed consent form is desirable, though not necessary. What really counts is evidence that the client was given the necessary information and provided consent. It is often sufficient to record in the client health record that informed consent was obtained after a discussion with the client. Both a signed consent form and a dietitian's note of obtaining consent in the chart are legally recognized ways of demonstrating that actual consent was obtained.

### 4. A CLIENT HEALTH RECORD

Client health records have the most extensive content requirements. It should give a clear idea of what happened during a visit and why, and describe:

- the client's condition;
- the dietitian's assessment and treatment plan;
- progress of any ongoing interventions, including modifications of treatment; and
- pertinent discharge information if there was ongoing care.

Furthermore, a health record contains documents obtained from others, such as referral slips, consultation reports and laboratory results.

Perhaps the most commonly omitted entries are those that relate to:

- the goal of the treatment plan, e.g. increasing a client's weight to an ideal

body weight or increasing intake of certain nutrients;
- monitoring and evaluation, such as noting that the client is tolerating the diet well; and
- discharge planning, e.g., recording the follow-up required.

Here is a detailed list of what should be recorded in a client record:

(a) the client's full name and address;
(b) the date of each of visit to or by the member;
(c) the name and address of primary care physician and any referring health professional if applicable;
(d) the reason for referral, if applicable;
(e) the client's relevant medical history, including medical and social data related to the nutrition intervention, and a reference to the appropriate document;
(f) the assessment conducted, the findings obtained, the problems identified, the goals for nutrition intervention, and the nutrition care plan;
(g) the recommendations made by the member for diet orders, nutrition supplements, and test and consultations to be performed by another person;
(h) progress notes containing a record of services rendered and any significant findings, including those resulting in changes to the nutrition care plan;
(i) relevant reports received by the member in respect of the client's health;
(j) particulars about discharge planning, including the referral of the client by the member to another health professional when applicable;
(k) any relevant reason a client may give for cancelling an appointment or refusing the service of a member, when applicable;
(l) particulars of nutrition care that was commenced but not completed, including reasons for non-completion;
(m) copies of reports issued to other sources;
(n) copies of any written consent provided by the client;
(o) a notation of any controlled act performed for the client and the authority for performing it; and
(p) a copy of any written communication sent to the client.

There are also other clinical record keeping issues to consider, such as the making and signing of entries by dietetic interns and the co-signing of those records. Different approaches can be taken so long as they are clear and reasonable. For example, if a dietitian co-signs an entry made by a dietetic intern, she or he should indicate the meaning of the co-signature. Does the co-signature mean:

- that the matter was used as a teaching experience?
- That the dietitian is verifying the accuracy of the entry? or
- That the dietitian agrees with the care provided? [1]

It is not necessary to keep all records in the same place. For example, equipment records can be kept with the equipment or in a separate file organized by piece of equipment rather than by client. Financial records can be kept in a dedicated financial record. So long as the information can be readily obtained and, where necessary, cross-referenced to the client, the system is adequate.

## Record Keeping Methods

**HANDWRITTEN NOTES ON BLANK PAPER**
This method is fine and provides maximum flexibility (if not maximum legibility).

**PRE-PRINTED FORM WITH HEADINGS AND CHECKLISTS**
Forms save time and help ensure that information is not forgotten. However, diligence is needed so that points are not checked off thoughtlessly, resulting in inaccurate records. Inaccuracies might include ticking off a series of boxes without reading them, or omitting information because the form does not have a specific space for it.

**COMPUTERIZED OR ELECTRONIC RECORDS**
Electronic records are becoming the norm. They can work well and are legible. However, for their own protection, dietitians should use a program that leaves an audit trail to demonstrate when each change was made and by whom. Again, pre-established computerized forms can be helpful, but take care not to cut and paste information from other files that does not apply, and take special security measures.

**CHARTING BY EXCEPTION**
This is feasible as long as clearly written protocols specify what is meant by a lack of entry or an exception. Dietitians must ensure that they are familiar with and consistently follow the protocol. If it can be established by other records that a dietitian did not consistently follow the protocol, the record will not be considered reliable and the benefit of having it will be lost.

**CHARTING BY REFERENCE**
This method is acceptable. Referring to a medical directive, a written assessment protocol, a recurring consent to treatment information sheet or a known treatment regime can be a handy and quick way of incorporating a lot of information in a very brief entry. To be credible, it is important that the reference be accurate and complete.

**ABBREVIATIONS**
Abbreviations are acceptable as long as they are recognizable by others on your team who share access to the client health records (or by outside readers). Have a master list of usual abbreviations for reference.

**DICTATION**
Dictation is acceptable but resource intensive because someone needs to transcribe the tape, unless voice recognition computer software is used. In addition, the many steps in this system of record keeping can lead to errors, misfiling, or even record loss. A dietitian should review and sign off on the transcribed records to ensure accuracy. If this is not possible, at a minimum, transcribed records should be spot-checked to ensure that they are generally accurate and catch systemic errors.

## Joint Records

### SCENARIO 8-1
Joint Records

You work in a public health unit and participate in a Canada Pre-natal Nutrition Program for high-risk expectant mothers. The program is operated by an independent community agency and the clients are those of the agency, not the public health unit. Your notations are kept only in a record on the premises of the agency. You know that the agency does not follow the College's expectations for chart security and retention. Are you at risk for this record keeping approach?

Dietitians often work in settings where they are expected to use a joint record, because this makes practical and clinical sense for a team practice. However, this places some obligation on the dietitian to ensure that the record keeping practices of the facility, employer or team are consistent with the expectations of the College and the dietetic profession. Professionals in public facilities such as hospitals, government departments or settings where only health practitioners work are more likely to share values and approaches. Even in these situations, dietitians should check record keeping practices to ensure their quality.

Where the employer, facility or program is privately operated, the dietitian may need to exercise a higher degree of scrutiny of the record keeping practices. In Scenario 8-1, *Joint Records*, the records are partially those of the dietitian, so he or she has to ensure that the facility meets minimal professional expectations (Checklist 8-1, *Joint Record Keeping,* next page). Usually this can be achieved by communication between the parties.

Where the facility, employer or program does not meet the record keeping expectations of the dietetic profession, the dietitian must advocate for a change to the practices or, failing to reach compliance with the College's regulation, may need to keep separate records. This should not be done secretly (see *Private Records* below).

### CHECKLIST 8-1
Joint Record Keeping

- ☐ Chart kept securely;
- ☐ Confidentiality maintained - only those with express or implied consent of the client may access the chart (see Chapter 6);
- ☐ Reasonable client access to record;
- ☐ Appropriate policy for correction of errors;
- ☐ Records maintained for a minimum of 10 years;
- ☐ Dietitian will have reasonable access to the chart both before and after leaving the job or facility;
- ☐ Reasonable plan for transfer of records if facility or program closes.

It is important to resolve record keeping issues when starting a position. If you are already in a job where you have these issues, resolve them now. Once a relationship ends or a dispute arises, it is very difficult to resolve them. In some private practices, the records are a crucial component of "goodwill" and their ownership can be contentious. The employment or partnership agreement should discuss who owns the records, and how a departing dietitian will obtain necessary access. If the owner of the records is not a dietitian, there should be explicit agreement by the owner to comply with the College's expectations and the *Personal Health Information Protection Act*, 2004. For non-profit operations, the record keeping obligations for security and retention can be onerous.

## Private Records

The temptation by practitioners to keep their own records separate from the central record keeping system is illustrated in Scenario 8-2 *Keeping Private Records*. This practice is not recommended. The difficulty is that keeping private records prevents the facility or organization from meeting its own record keeping obligations, e.g. maintaining security, providing access to clients, and destroying the record in accordance with an established retention policy.

Private records consist of entries that are not included in the official chart of the facility or employer for whom a dietitian works. Unlike rough notes, which can be destroyed after they have been completely transcribed onto the official chart, these records are typically maintained by a dietitian for some time for private use. There are a number of reasons why a dietitian might wish to keep a private record:

- The official chart requires a form that does not lend itself to recording all of the information the dietitian wishes to record;
- The employer or facility discourages the extensive recording of information that the dietitian wishes to do or that is required by the College;
- The official record is inconvenient to access, because of the procedures, the length of time it takes to retrieve the record, or because others are often using it;
- The dietitian believes that the information handling policies of the facility or employers do not permit compliance with College regulations or other legal requirements (e.g. providing adequate access to clients);
- A dietitian's private record tends to be messy and not in a form that is useful or appropriate for others on the health care team to see;
- On rare occasions, the dietitian may be concerned about the lack of privacy afforded to the official record, e.g., where very private information is revealed that a client does not want the entire team to know, or where the employer or facility is privately owned and does not respect confidentiality; or
- The dietitian is concerned that a copy of or access to the official record will not be given when leaving the facility or the job.

### SCENARIO 8-2
Keeping Private Records

You work at a facility with other health professions. The facility has an approved form that it expects all members of the health care team to follow. You place the traditional information (medical history, major findings on assessment, treatment plan) on the approved form. However, there is not an appropriate space to put your detailed meal plan calculations and energy intake notes; these entries are rough and messy, and you would be embarrassed to put them in the central chart. They would be of no use to anyone but you. Can you keep those notations in a separate file that you keep as long as you are seeing the client and then discard?

However, serious problems can arise when a dietitian maintains private records without the knowledge and authority of the facility or employer:

- It is difficult for the information policies of the facility or employer to apply to a dietitian's private record, e.g., it might not be kept with the same degree of security as the official record;
- Valuable information may be inaccessible to the rest of the health care team; and
- The legal obligations of the facility or employer cannot be fulfilled. If a client wishes to exercise his or her right to see the entire file, the facility or employer cannot provide this access where it has no knowledge of the dietitian's private record. Or if the entire chart is required to be produced in a legal proceeding, the private record will not be included, placing the facility or employer in contravention of the law.

Some solutions to these competing considerations include:

- Do not keep private records. Record everything that needs to be recorded in the official chart.
- Advise the facility or employer that you are keeping private records and negotiate appropriate policies and procedures respecting them, such as access by others, security and ability to remove private records when leaving, etc.
- Discuss with the facility or employer the reasons for keeping private records in the first place, so that any underlying issues are appropriately addressed.

## Safeguards for Securing Personal Information

While health records must be securely maintained, no uniform approach or simple set of rules guide dietitians. So much depends on the nature of the practice and the record keeping system chosen (e.g., paper or electronic). In some sense, that ambiguity is positive; dietitians have a lot of flexibility in developing a system of safeguards. On the other hand, the lack of guidance in developing security measures leaves little doubt that some organizations, particularly smaller private ones, have minimal safeguards.

Dietitians must ask themselves whether the system in place in their facility provides adequate safeguards to allow only authorized persons to have access to records. A system of safeguards should cover the matters identified in Checklist 8-2, *Safeguards for Securing Personal Information*, on the previous page.

Access to records must be on a need-to-know basis within the organization. Sharing of information should have at least the implied consent of the client, and any external disclosure should be with consent or with other legal authority (see the discussion of the implied consent and the "circle of care" in Chapter 6).

### CHECKLIST 8-2
**Safeguards for Securing Personal Information**

- ☐ Have a written *Privacy and Access Code* for the organization.
- ☐ Provide a copy of the *Privacy and Access Code* to staff of the organization upon the hiring or retaining of new staff.
- ☐ Train staff about the confidentiality of personal information. Access is on a need-to-know basis.
- ☐ Train staff in the methods of maintaining security of personal information.
- ☐ Require staff to sign a confidentiality statement.
- ☐ Require that personal information that is not in a secure area be locked or otherwise protected from unauthorized access.
- ☐ Require personal information in paper form to be shredded or otherwise destroyed before its disposition.
- ☐ Require the use of password protection and other recognized security measures for electronic information.
- ☐ Mobile devices need to be encrypted.
- ☐ Require that electronic data be destroyed before the hardware holding the data is discarded.

Where a dietitian is not responsible for the information practices of an organization, changes to those practices should be advocated to redress security issues. In the long run, a dietitian should not give client information to an organization that has ongoing, serious security weaknesses.

**WHAT ABOUT EMAIL?**
As a general rule, it is not acceptable to send personal health information through regular email. Acceptable options include obtaining the person's consent to use email, encrypt the email, or make the information anonymous. Sometimes consent can be inferred by the fact that the person has initiated the communication by email, or has asked the dietitian to respond by email.

SCENARIO 8-3
Email Communications

You work in public health and communicate with a lot of clients by email. Some of those emails deal with individual health concerns (in some cases, concerns about third parties) and with sensitive matters (e.g. sexually transmitted diseases). What considerations arise here?

However, the dietitian should ensure that the consent was "informed", in that the recipient knows the sensitivity of the type of information that will be contained in the email. Also, keep in mind that the consent of the recipient does not apply to any third person discussed.

Retention of the email is another important issue. If the information in the email must be noted in the client file, for instance, a recommendation for a diet order, then a copy of the email must be kept on file. Even if the information is not required for College purposes, it should be kept for other reasons. For example, if the client has follow-up questions or challenges your advice, having a copy of the email is important.

## Client Access and Correction Rights

A client has the right to access his or her complete chart, under case law [2] and the *Personal Health Information Protection Act*, 2004. Exceptions are rare and relate primarily to any serious safety concerns for third persons or the client. This right of access applies to the entire chart, including consultation reports and any documents provided by other practitioners.

A client's right of access extends to persons authorized by the client to access the chart, including family members, other practitioners and lawyers. Where a client is incapable, a substitute decision-maker would authorize the access (see Chapters 5 and 6).

Reasonable fees or administrative obligations can be imposed on a client's access rights. Before allowing clients to view the records, for instance, dietitians may require that the entries be reviewed with them to explain any abbreviations or technical terms. However, fees and administrative obligations should not be barriers to prompt and easy access to records by clients. Unless the entries are particularly sensitive, dietitians should consider providing a copy of the chart at cost.

A client will occasionally challenge some of the entries. Where a request relates to a factual entry and the dietitian agrees that the record is inaccurate, then a change should be made. However, for audit trail purposes, the original entry should not be obliterated. Rather, indicate that the original entry was in error, striking it out with one line so that it is still legible (or some reasonable equivalent for electronic records, such as a link containing the corrected information). Insert a corrected entry indicating the date and the name of the person making the correction. It would be appropriate for the dietitian to send the corrected entry to those who have had access to the erroneous information within the past year.

If the dietitian does not believe that the entry is wrong, then make no correction. This is particularly true where the entry contains an

evaluative component or an expression of professional opinion. However, if the client continues to dispute the entry after the dietitian's explanation, the dietitian should permit the client to file a statement of disagreement in the chart. Depending on the nature of the issue, the dietitian might also send the statement of disagreement to those who had access to the entry in the past year.

Where there is a joint record, the custodian of the record should consult with the person making the entry before taking any corrective measures. For example, it would be unfortunate if an office manager decided to change the results of an assessment recorded by a dietitian at the request of a client, without first discussing the matter with the dietitian.

## Retention of Records

Records need to be retained for a reasonable period, not only for ongoing care but also for accountability. Indeed, it is in a dietitian's own interest to have the record available should there be any question about the intervention. A client health record should be kept for at least 10 years following:

- The client's last visit; or
- The date at which the client turned 18, if the client was less than 18 at the time of the last visit. (This is in recognition of the fact that the limitation period for a child suing a dietitian does not begin until the child turns 18.)

Even where the client dies, the record should be retained for the remainder of the period described above. The estate of the client may have questions about the care received. The dietitian might need the chart if sued. In addition, the dietitian would still be accountable to the College even though the client is deceased.

Once the time period set out in the retention policy has elapsed, the record should be destroyed promptly. The continuing existence of the record is a security risk. Also, any non-compliance with one's privacy policies creates legal risk to the dietitian. A record should be made indicating when client charts were destroyed. At a minimum, the record may note the name of the client, any file number, the date of last treatment and the date the file was destroyed.

Where a particular statute (e.g. *Long-Term Care Homes Act*, *Retirement Homes Act*, or the *Mental Health Act*) specifies a different retention period for client records, the dietitian may follow that provision rather than the College guideline. For example, under the *Public Hospitals Act*, a diagnostic imaging record (other than of the breast) need only be kept for 5 years, and most videotape records do not need to be retained at all.

## Terminating or Transferring a Practice

If a dietitian retires or sells a practice, client records must be dealt with responsibly. While a piece of paper or computer disk may belong to the dietitian, the information on them belongs to the client. The College has developed a requirement in its *Professional Misconduct Regulation* specifying the obligations to clients when a practice is terminated or transferred:

> "26. Failing to take reasonable steps before terminating services to a client or resigning as a member, to ensure that, for each client health record for which the member has primary responsibility,
>
> i. The record is transferred to another member, or
>
> ii. The client is notified that the member intends to resign and that the client can obtain copies of the client health record."

When records physically leave an office, make reasonable efforts to ensure that clients know where their charts are and that they have control over who holds them. "Reasonable" depends on the circumstances. A one-time encounter with a client eight years earlier might not require a letter of notification if the chart is transferred to another dietitian. However, it would be appropriate to send a letter to a client who has received an intensive amount of assistance in recent months, or to one who is still requiring ongoing intervention. Such a

client may direct that their record be transferred to a place of their own choosing.

Under the *Personal Health Information Protection Act*, 2004, a Health Information Custodian also has an obligation to notify clients when the practice has been sold. This enables the client to make decisions about the health record, such as transferring a copy elsewhere.

In any transfer of records, a written agreement should specify what will be done with the records and ensure that the dietitian will have ongoing access where needed to fulfill his or her professional obligations (e.g., responding to a complaint).

**IN THE EVENT OF SUDDEN INCAPACITY OR DEATH**

Dietitians in private practice should have a business plan and/or indicate in their will the designated individual who will be responsible for their client health records in the event of their sudden incapacity or death.

The designated person does not have to be a dietitian. They could be a spouse, another family member, friend, or colleague. Since the designated HIC may not be familiar with the Ontario laws and College guidelines for client health records, it is important to leave instructions about how the client health records should be managed. The instructions should include information about keeping the records private, confidential and secure; appropriate retention periods; and, keeping the records accessible if clients wish to access them, or if the College or police need access to them during an investigation.

The instructions should direct the designated HIC to:

1. Notify the College in writing of the dietitian's incapacity or death. In the letter to the College, indicate the location of the records and how clients may access their chart. This ensures the College has the information to assist clients to access their records should the need arise.
2. Contact each client to inform them of the dietitian's sudden incapacity or death. Specify the retention period and where the records will be kept if clients should ever need to access this information (See sample letter next page).
3. Provide resources to help clients find follow-up dietetic services (e.g., direct clients to the "Find a Dietitian" section of the Dietitians of Canada website or to EatRight Ontario).[3]

## Conclusion

Good client records are needed to support quality dietetic services and health care. As an essential part of a dietitian's accountability to clients, employers, payers and the College, records must capture significant information such as the information described in the College's proposed records regulation. There are many charting styles, including electronic records, and dietitians should be mindful of the opportunities and risks associated with all of these. Dietitians are accountable no matter what charting system or style may be in use.

Dietitians must take necessary steps to ensure accuracy, security and appropriate access to client records in their entirety. Joint records and private records pose special problems related to access, security and retention. Give careful consideration to managing your client health records to ensure that legal and professional requirements are met in all cases.

1 College of Dietitians of Ontario *Record Keeping Guidelines for Registered Dietitians,(2014)* p. 13.

2 McInerney v. MacDonald (1992), 93 D.L.R. (4th) 415 (S.C.C.).

3 *"Private Practice RDs: Do You Have Plans in Place To Manage Client Health Records?", Summer 2011, p. 7.*

## FIGURE 8-3 PRIVATE PRACTICE DIETITIANS - SAMPLE LETTER TO CLIENTS
### In the Event of Sudden Incapacity or Death

<Date>

<Client Name>
<Address>
<City, Postal Code>

Dear <Client's Name>,

I regret to inform you that your RD <Name> has <been in an unforeseen accident or passed away suddenly>. The purpose of this letter is to inform you that your client health record will be kept at <insert location address>. If you would like a copy of your records you may do so by contacting <insert contact details>. Copies of client health records will incur a fee of <insert amount>.

Records will be kept private and confidential according to the record retention requirements for health professionals in Ontario:

1. For Adults: 10 years after the date of the client's last visit.
2. For Children: 10 years after the date that the client turns 18 years of age.

If you would like to seek further private practice dietetic services, you can do so by going to the "Find a Dietitian" section of the Dietitians of Canada website, where you can search for Dietitians in your local area according to postal code: http://www.dietitians.ca/Find-A-Dietitian/Search-FAD.aspx

For general questions regarding healthy eating and nutrition issues, please feel free to contact EatRightOntario, a free dietitian telephone and email/website service. You can contact EatRightOntario by calling 1-877-510-5102 or visit their website at: www.Ontario.ca/Eatright

The College of Dietitians of Ontario has a record of where RD <Name> records will be kept. If you need assistance accessing your chart you may contact the College at www.collegeofdietitians.org.

If you have any further questions or concerns, please don't hesitate to contact me.

Kind regards,

<insert name of the designated person responsible for the client health records>
<insert contact information for further questions>

## Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. **In Scenario 8-1 "Joint Records", is the record keeping system adequate?**
   a. No, because the records are not kept in accordance with College and professional expectations.
   b. No, because the people who control the record are not regulated health practitioners.
   c. Yes, because the person served is a client of the organization, not the dietitian.
   d. Yes, because the record is maintained according to the criteria of the dietitian's employing agency.

2. **In Scenario 8-1 "Joint Records", what should you do?**
   a. Keep your own records separate and apart from the agency's chart.
   b. Make your entries on the agency's chart but keep a copy for yourself.
   c. Discuss with the agency if it will change its record keeping practices to meet the College's and professional expectations.
   d. Explain the situation to the client and obtain his or her consent to follow the agency's record keeping practices.

3. **In Scenario 8-2 "Keeping Private Records", should you keep separate records and then discard this additional information?**
   a. Yes, as no one else needs this additional information.
   b. Yes, so long as you get the permission of your facility and do not discard the information for 10 years.
   c. Yes, as the official chart contains the minimal information expected by the College.
   d. No, private records are too dangerous to keep.

4. **Which of the following is not a reasonable security measure for client health records?**
   a. Written policies and procedures.
   b. Records will never leave the facility.
   c. All staff sign a confidentiality agreement.
   d. Access to records is on a need-to-know basis.

5. **Client records should be retained for how long?**
   a. 10 years from each visit.
   b. 10 years from the last visit.
   c. 10 years from the last visit or since the client turned 18, whichever is longer.
   d. 5 years for most diagnostic imaging records.

# Resources

## COLLEGE OF DIETITIANS OF ONTARIO

***Record Keeping Guidelines for Registered Dietitians* (2014)**

***résumé articles at www.collegeofdietitians.org. Enter topic in search box to access articles:***

- "Records Relating to Members Practices: Answers to your questions", Fall 2005, 5-6.
- "Where have all the records gone?", Winter 2006, 5 & 11.
- "Destroyed Health Records", Fall 2007, 9 & 11.
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