College of Dietitians of Ontario

Professional Practice Standard:
Record Keeping for Registered Dietitians in Ontario

GLOSSARY

Agent: In a health care context, persons who are not Health Information Custodians (HICs) (see below) are often termed "agents" with certain obligations under the *Personal Health Information Protection Act, 2004* (PHIPA). An agent is any person who is authorized by a HIC to perform services or activities on the HIC's behalf. HICs may designate agents to collect, use, disclose, retain or dispose of personal health information in a private and confidential manner on their behalf. Agents are only permitted to engage in the above-mentioned activities as required to carry out their duties as assigned by their HIC.[1,2]

Client Health Record: Documentation created or gathered that provides information of the care that was provided to an individual by a Registered Dietitian and others, as applicable.

Documentation: Information in an electronic or paper format intended to record the actions, events, facts and/or thought processes of dietetic practice. Client health records are one component of documentation.

Health Information Custodian (HIC): A person or organization listed in PHIPA that has custody or control of personal health information. A HIC is responsible for collecting, using, disclosing, retaining and securely destroying (as necessary) personal health information in a private and confidential manner on behalf of clients. [1,2] Personal health information remains the responsibility of the HIC at all times, even when that information is used by an agent (see above) on behalf of the HIC.

INTRODUCTION

Record keeping is integral to safe, effective and competent dietetic services; it provides a means to demonstrate how RDs exercise their critical thinking and professional judgment in an evidence-based, accountable and client-centered manner. Whether providing services to individuals, groups, organizations or the public at large, documentation helps provide a clear picture of the dietetic services provided.

Approaching record keeping in an organized and systematic way supports individual RD recall, collaborative practice and communication with other health providers and compliance with relevant legislation, including protecting the privacy and confidentiality of personal health information.

The *Professional Practice Standards for Record Keeping* can be used for a number of purposes including:

1. To fulfill the College's regulatory mandate of public protection;
2. To inform the public, employers, other health care providers and College members about the minimum expectations that RDs must meet in their dietetic practice when keeping records;
3. To provide performance assessment criteria regarding record keeping for the College's Quality Assurance Program;
4. To help guide the College's decision-making in record keeping matters related to professional conduct and competence; and
5. To support compliance with the required behaviours and performance expectations of RDs surrounding record keeping when practicing the dietetic profession in Ontario.

The *Professional Practice Standards: Record Keeping for Registered Dietitians in Ontario* include the required elements and performance expectations that RDs must achieve when maintaining records in dietetic practice. It also reflects the professional obligations when RDs act as Health Information Custodians or as agents as defined in the *Personal Health Information Protection Act, 2004* in relation to record-keeping.

Each area of dietetic practice has its own unique characteristics. As such, the performance expectations articulated in these Standards may not all apply to every area of dietetic practice; their application will depend on client factors and the dietetic practice setting.

STANDARDS FOR RECORD KEEPING

1. RDs must ensure their documentation is accurate, objective, and reflective of the dietetic services provided.

A registered dietitian demonstrates the standard by ensuring the following:

a) Documentation is legible in either written or electronic format.
b) Language, terms and abbreviations are acceptable to the area of practice and facility in which they practice.
c) Avoiding statements that are false, misleading or unprofessional.
d) The record is maintained in either English or French.

2. RDs must document in a systematic and timely manner.

A registered dietitian demonstrates the standard by ensuring the following:

a) Documentation is completed by the RD, except in collaborative practice settings when verified and signed by the RD.
b) Documentation is completed at the earliest possible opportunity that is appropriate to the practice setting, following the delivery of dietetic services or when significant changes occur.
c) Documentation is chronological.
d) If documentation occurs after the date of intervention/service, the record includes the date the entry was made and the date that the dietetic services occurred.
e) Documentation is organized to facilitate timely retrieval and use of the information.

3. RDs must ensure a comprehensive client health record is maintained when individual nutrition assessments and treatment/intervention are provided.

A registered dietitian demonstrates the standard by ensuring an individual client health record, in its entirety, includes:

i. The client's full name and address.
ii. The date of each of the client's visits.
iii. The name and address of primary care provider and any referring health professional, as applicable.
iv. The reason for referral, as applicable.
v. The client's relevant medical history and social data related to the nutrition intervention.
vi. Express consent (and implied consent as per RD's professional judgment) obtained for nutrition assessment, treatment and/or the collection, use and disclosure of personal health information (or refusal/withdrawal of such consent).
vii. The assessment conducted, including the tools used and performance of controlled acts under the scope of dietetic practice or through medical directives/delegations.
viii. The assessment findings obtained, the issues identified, the goals for nutrition intervention and the nutrition care plan.
ix. The recommendations or orders made (including via medical directives as per facility requirements) for diet orders, nutrition supplements, tests and consultations requested to be performed by any other person.
x. Progress notes containing a record of services rendered and any significant findings including those resulting in changes to the nutrition care plan.
xi. Reports received in respect of the client's health.
xii. Particulars about discharge planning, including the referral of the client to another health professional, as applicable.
xiii. Particulars of nutrition care that was commenced but not completed, including reasons for non-completion.
xiv. A summary (or copies, as applicable) of any telephone, email, other online or written communication with the client.
xv. Any relevant coordination of care and services to enable client-centered care.
xvi. Any reason a client may give for cancelling an appointment or refusing the service of a member, as applicable.
xvii. Copies of reports issued to other sources.
xviii. The RD who made the entries is clearly identified using their practice name as indicted in the College's Register of Dietitians and professional designation (RD or Registered Dietitian).

4. RDs must maintain financial records whenever billing occurs in dietetic practice.

A registered dietitian demonstrates the standard by ensuring:

a) Receipts are issued for dietetic services and/or products sold to clients, either directly or indirectly through a third party;
b) Records of receipts issued and payments received are documented in either the client health record, the RD's accounting records or both (as applicable);
c) A system is in place for the secure retention of financial records for individual counselling services:
    i. 10 years after the date of the client's last visit; or
    ii. If the client was younger than 18 at the date of the last visit, 10 years after the date that the client turns or would have turned 18 years of age; and
d) A system in in place for the secure retention of financial records in dietetic practice outside of individual counselling services for the duration required by the Canadian Revenue Agency.

5. RDs must ensure reasonable measures are in place to maintain the security of client health records.

A registered dietitian demonstrates the standard by ensuring the following:

a) Entries are permanent;
b) Systems are in place to ensure that content is not lost/deleted;
c) Additions or corrections to an RD's documentation preserve the original content;
d) In interprofessional settings, an audit trail of persons entering information can be created;
e) Collection, use, storage, disclosure, transmission and disposal of personal health information maintains the client's privacy and confidentiality (e.g. through the use of physical controls, passwords and/or encryption, as applicable);
f) RDs follow privacy legislation when acting as a Health Information Custodian (HIC) or an agent of a HIC; and
g) A system is in place for the secure retention of client health records for:
    i. 10 years after the date of the client's last visit; or
    ii. If the client was younger than 18 at the date of the last visit, 10 years after the date that the client turns or would have turned 18 years of age.

CONCLUSION

RDs must understand their legal and professional requirements for record keeping. It is expected that all RDs will comply with the *Professional Practice Standard: Record Keeping for Registered Dietitians in Ontario* when practicing dietetics. RDs are required to meet the Standards that are relevant to their practice environment and practice functions. Where RDs fall below the College's expectations, Standards of Professional Practice will be used as a basis for assessments or investigations and may guide the development of remediation plans.

REFERENCES

1. Personal Health Information Protection Act, 2004. S. 2 & 3. Available from: https://www.ontario.ca/laws/statute/04p03#BK4
2. Information & Privacy Commissioner of Ontario. (2015). Frequently Asked Questions Personal Health Information Protection Act, Sept 2015. Available from: https://www.ipc.on.ca/wp-content/uploads/Resources/phipa-faq.pdf

ADDITIONAL RESOURCES

College

Jurisprudence Handbook for RDs in Ontario, Chapter 8 – Record Keeping

Privacy of Personal Information Dietetic Practice Tool Kit for Registered Dietitians in Ontario

Standards of Consent to Treatment and for the Collection, Use and Disclosure of Personal Health Information

Record Keeping Guidelines for RDs in Ontario

Legislation

Professional Misconduct Regulation, *Dietetics Act, 1991*

Health Care Consent Act, 1996

Personal Health Information Protection Act, 2004