



College of Dietitians of Ontario
Update *and* Feature Presentation

Fall 2008



Feature Presentation

*Electronic Records and Dietetic
Practice*





Outline

- Definition - Electronic Client Health Record
- Record Keeping Obligations
- Purpose of Record Keeping
- CDO Record Keeping Resources
- Your Questions
- Scenarios

Although there are many terms used for electronic charting (electronic medical record), we will use the term electronic health records (EHR) throughout the presentation slides.

Electronic Documentation

- Records which are created or stored in computer or other electronic means/device
 - Client Health Records
 - Financial Records (client care)
 - Equipment Service Records (client care)



•It is important to understand what we mean by electronic documentation: using computer or other electronic devices or electronic means to fulfill your record keeping requirements or obligations.

•These obligations could include client health records, or other record keeping like equipment service records (scales, etc.), or financial records (private practice).

Client Health Record Includes...

- Assessment notes and information
- Progress notes
- Orders (physician's orders)
- Laboratory results
- Diagnostic Imaging Reports
- Consults



•In some organizations, the client's complete health record is not all stored in one concrete place. For example, orders may be entered in one module of a computer system, while results of lab and other diagnostic tests may be stored in a separate module.

•Assessments and progress notes may be housed in yet another place.

•These separate pieces, taken as a whole, are considered to make up the entire client health record.

•In most cases, a Registered Dietitian's (RD's) notes are one part of a client health record. In private practice, the RD's notes could be the entire health record.

Record Keeping Obligations

- The RD's responsibilities for documentation do not change with the format (paper or electronic). These obligations are outlined in law through several documents
 - Professional Misconduct Regulation
 - Proposed Record Keeping Regulation
 - PHIPA (refer to Chapter 5 in the Jurisprudence Handbook, 2008)



- *Professional Misconduct Regulation* on first few pages of the 2008 *Jurisprudence Handbook for Dietitians*.
 - *Draft Proposed Regulation Records Relating to Members' Practices* on the website under *Resources > Regulations*.
 - *Personal Health Information Protection Act (PHIPA)*
- Some questions have come up in workshops around what are an RD's legal obligations? The College would ensure that all requirements outlined in the following three documents are upheld:
- *Professional Misconduct*;
 - *PHIPA*; and
 - *Draft Proposed Regulation Records Relating to Members' Practices*

Professional Misconduct Regulation

- Failing to keep records as required
- Falsifying a record
- Failing to provide a report when requested
- False or misleading statements
- Failing to make appropriate arrangements for records when terminating practice



•Clients have right to access their health information. Consult organization policies surrounding this.

•CDO has recently included a new question on the member's renewal form. Members in private practice are asked about their plans for client records in the event of untimely death or incapacity. The purpose of this question is to raise awareness of the need to do this. CDO will be providing education to RDs on how they could meet this requirement.

Proposed Record Keeping Regulation

Records Pertaining to Members' Practice

- Accurate/Relevant
- Equipment Service & Financial Records
- Individual Health Record Information
 - Individual nutrition assessment and counselling
 - List of what must be included
 - Every part must identify client and person making entry
 - Retention
 - College access to records



•This slide is a summary of the *Draft Proposed Regulation Records Relating to Members' Practices* that RDs should follow to ensure appropriate documentation. Refer to the regulation at the following link on the CDO website: (<http://www.cdo.on.ca/en/pdf/BylawsRegs/ProposedRegulations/recordsRelated.pdf>)

Record Keeping in Public Health

- Diverse settings and programs
- Personal health information → PHIPA
- Collect relevant information
- Document relevant unattained information
- No personal health info → follow organizational policies



- Public Health Dietitians/Nutritionists often work in a variety of settings and programs that may not fall into the definition of a classic one-on-one client health record (e.g., Telepractice, schools, community centres, etc.)

- A comprehensive review of record keeping obligations in public health settings can be found in *résumé* (Spring 2007). Here are some points to note:

- If you are collecting personal health information you will need to follow the *Personal Health Information Protection Act* (PHIPA).

- Note: even a brief notation that contains personal health information is subject to PHIPA.

- Only if you are doing a full assessment as outlined in the *Draft Proposed Regulation Records Relating to Members' Practices* do you need to follow the health record information regulations for an individual client health record.

- If assessment forms created specifically for a particular program exist, it is not necessary to keep a separate record, provided all the required info is included on the form.

- Information collected must be relevant. Any relevant info that was unattained should be documented that efforts were made to obtain this info.

- No personal health info-- follow organizational policies for storage and retention.

- If records contain a small amount of personal health info (i.e., a caller wanted info on a particular topic so you documented their name and sent them info) you do not need to retain documents, but you should follow your organizational policies.

- If you are concerned about the liability of your record then retain records as appropriate.

- If not, follow organizational policy and destroy confidentially as applicable.

- Use professional judgment re: retention or records in public health.

Record Keeping in Public Health

Consider:


1. Purpose of the program
2. Assessment of the group or community needs
3. Objectives or outcomes
4. Plan for meeting objectives
5. Interventions to execute the plan
6. Evaluation and future plans
7. A list of materials and handouts

(Reference: *résumé* article Spring 2007)

•For public health programs, such as services to groups, follow organizational policies for record keeping and consider the following:

1. Purpose of the program
2. Assessment of the group or community needs
3. Objectives or outcomes
4. Plan for meeting objectives
5. Interventions to execute the plan
6. Evaluation and future plans
7. A list of materials and handouts

•Info should be documented at the start of the program and then updated as applicable when significant changes are provided.



Privacy Obligations

Personal Health Information Protection Act (PHIPA)

Purpose of the Act (Provincial Legislation)

- Rules for collection, use and disclosure of personal health Information
- Right of access, correction and amendments
- Means for independent review and resolution of complaints
- Way to deal with contravention of the Act itself

- PHIPA is provincial privacy legislation that deals specifically with personal health information. These rules apply and should not be impeded by the documentation method or systems in place.
- Whether records are kept electronically or on paper, the same rules apply.
- Sets rules for employer/organization, versus employees.

- Dietitians who are self employed (Private Practice) must be aware of all of the PHIPA obligations.
- Dietitians who are employees must make sure that they are aware of the organization/employer's privacy policies.

www.ipc.on.ca



- Information and Privacy Commissioner Ontario website
- Privacy Commissioner is Dr. Ann Cavoukian
- Contains all the PHIPA info.

Purposes for Documenting

- Day-To-Day Practice
- Communicating with Team Members
- Preparing Reports
- Accountability



• Understanding the purposes for documentation may help you to understand the rationale behind the various laws, regulations and to develop your policies and procedures where they do not yet exist.

• Refer to the 2008 *Jurisprudence Handbook for Dietitians in Ontario* (page 91).

Purpose for Documenting

- Day to Day Practice
 - To assist RDs in their practice and provision of care
 - Provides an objective account so that there is no need to rely on memory
 - Evidence of high quality care provided
 - Documents the client involvement along with care team involvement



Purpose for Documenting

- Communicating with Team Members
 - To communicate to other members of Care Team what has been done for the patient/client re: assessments and treatments; communicate a plan of care
 - Ensures continuity and quality of care for patients/clients; transfer information about the client's health





The following slides answer some of the commonly-asked questions throughout the workshop sites.

Your Questions/Issues

- My biggest concern is the time it takes to complete electronic documentation. This takes away from time with the patients



- Transition to EHR often takes time to get used to the system. In time, EHR will make things more efficient.
- May need to take a course or complete an online tutorial to improve typing skills.
- Liaise with colleagues to determine tips for navigating through programs more efficiently.
- RDs often take rough notes and then transcribe them into the complete assessment forms/progress notes within the paper chart.
- The same may apply with EHR except the full assessment/progress note is then typed up electronically vs writing it out on paper.

Your Questions/Issues

- Can I email colleagues/clients information?
- I travel with a laptop, what security measures do I need to think about?




Email:

- The Information and Privacy Commissioner of Ontario's (IPC) website has a great deal of information regarding emailing and encryption.
- The IPC does not have mandatory encryption standards; encryption can be done in many formats.
- The IPC recommends sophisticated software be used to encrypt personal health information when it is being transported via email or on a laptop/USB key.
- Where applicable, contact your IT department within the facility you work for more information and guidance on encryption.
- Where this is not possible, you need to ensure that any personal health information being transmitted over email or being transported on laptops or other electronic storage devices is encrypted in some manner.
- This can be done via any number of methods such as ID codes, initials, etc.
- Ensure that you have a decryption key available.

Travelling:

- If you travel with laptops and/or USB keys with identifiable health information, the privacy commissioner requires that identifiable information be encrypted or stored in a manner that ensures the information is anonymous.
- During travel, health information must be stowed in the locked trunk of the vehicle.
- If you are afraid of theft, take the documents/electronic sources with you if you leave your vehicle.
- Ensure that laptop is password protected.



Your Questions/Issues

- Can I use short forms/abbreviations in my documentation?

The College of Dietitians of Ontario's stance on the use of abbreviations is that they are acceptable. However, there are a few important points to consider:

1. Use abbreviations that are recognizable by others who share access to the records.
2. Develop a master list of the usual abbreviations for reference by others on the team who are not familiar with them and to outside readers of the records (e.g., when copies of the records are sent to the client or someone else at the client's request and/or when records are transferred to another facility). This is also helpful for new staff members to be familiar with the list of abbreviations commonly used in the facility.
3. Keep in mind that it's possible that various health professions may have similar abbreviations for different words, therefore, the meaning of the abbreviation may be misinterpreted.
4. Try to involve all disciplines who will be using the abbreviations in developing the master list to ensure that there is no overlap/misinterpretation.

Your Questions/Issues

Is an electronic signature acceptable?

Can information be emailed through a secured website?



- Electronic signatures are acceptable.
- Systems track users via unique ID which leaves an audit trail.
- Not acceptable to use another person's login.

- Information can be emailed through a secure website (i.e. Intranet).
- Clients need to be made aware that personal health information is being transmitted via the Internet that may not be 100% secure.
- Client consent would be required to email through standard Internet as this may not have the same security measures in place that internal (Intranet) sites do.

Your Questions/Issues

- Work in a group with many doctors and sites, half use EHR.
- Physicians do not want lengthy notes in chart.
- Systems have minimal features (no drop-down menus, separate sections, etc.)
- Using many systems.
- Access to all parts of chart not always possible
- Hybrid of paper and EHR



- Many issues here to bring to the attention of everyone – very valuable.
- Ironing out this issues may be a long process that happens over time
- Suggest meet with RD, SLP, PT, Nurses, etc., to determine what each discipline's record keeping requirements
- Determine where the system is failing you (find the gaps) with respect to meeting your professional obligations
- Consider: Can the electronic system be fixed to meet your record keeping obligations, if not, then need to use paper chart or a combination of paper and EHR
- If using both paper and electronic documentation, need to be mindful of both forms to make sure that access to complete health records for clients/patients is not impeded

A helpful reference:

Hogge LB, Michael MA, Houston SM, and Ayres EJ, *Electronic Health Record: Where Does Nutrition Fit In?* Journal of the American Dietetic Association. 2006; 106:1688 – 1695.

Your Questions/Issues

- FHT uses electronic charting. I still have a hard copy file for nutrition care plans. We have 2 satellite offices not connected. Use electronic record keeping and then print a copy and fax it to their offices.
- My main issue is over-charting. I would like to be clear on meeting the basic data obligations so that I can decrease my documentation load and save time.

- Need to document this in the electronic chart that the you have a paper copy, and visa versa for the paper notes. This indicates that neither the EHR or the paper chart are complete.

- If the EHR is complete, the paper copies are simply duplicates which can be destroyed confidentially.

- RE: over-charting: Are there duplicates? If so, destroy confidentially.

- If you document electronically at one site to have copies at another without electronic access then duplicates may be required since paper copy is the only option at the satellite site.

- If you have a paper copy at satellite office, it may not be necessary to have electronic copies.

- May be helpful to document electronically at main office since satellite may more towards electronic documentation in the future, and easy to access chart to refer to in case you are at the main office and need to refer to the client chart at the satellite office.

Other Questions/Issues?

- Difficult to make eye contact and build trust (especially in vulnerable/high risk populations) when charting electronically.



- Can document using rough notes/point form and then type into electronic system thereafter.
- Talk to person, then type main points. Will take some time to get used to new charting format.
- Explain to client that this is a new process and make take time to adjust.
- Be open to change, give yourselves time to adjust to electronic format and communicate openly with client. May become more efficient as time progresses and one becomes more comfortable with electronic charting.
- Can be situational – trust your professional judgment. Some clients may not mind you charting electronically, others may prefer documenting rough notes on paper then transcribing them electronically.

Scenarios

Is the RD able to meet their professional obligations?

1. Consider purposes for documentation.

- Day to Day Practice
- Communicating with Team
- Preparing Reports
- Accountability

2. Privacy/Confidentiality Issues

- Safety/Security of information
- Client Access

3. Other issues?



•Try to determine if the following scenarios create issues with meeting professional obligations.

•Use the three points on this slide to help solve the issues in the following scenarios.

Scenario 1

- Electronic Signatures
 - I work in a new Family Health Team. We are in the process of developing our electronic health record. At present, I do not have my own unique password for accessing the EHR to chart. One of the physicians has suggested that I use his in the mean time. Is this acceptable?



- Not acceptable due to privacy of login/password in the long-term.
- You are logging in as physician with all the same privileges.
- When you have dual systems (electronic and paper) ensure that you document in the EHR that paper notes exist and in the paper notes that there are electronic notes.
- Possible solution: record on paper and scan into electronic chart at a later date when you have EHR access.
- Once documents are entered/scanned into electronic nutrition care plan, shred paper copy to avoid duplicates.

Scenario 2

- Diet office information
 - Am I required to retain the information about a client that is collected for the diet office, like allergies, food preferences, meal patterns, and patient menus/meal tickets? This information is currently stored in our menu processing program (e.g. CBORD, Computrition, MedDietary, Pisces) and is deleted 5 days after the client is discharged.



- This info is considered rough notes which you are not required to keep provided pertinent points are summarized in the patient's chart.
- Need to destroy rough notes confidentially – do not keep information that is not needed.

Scenario 3

- Rough Notes containing client/patient information
 - I started a new job and inherited a drawer full of what appears to be food patterns and preferences, menus, notes about telephone calls made to and from clients/patients, copies of emails to and from clients and some electronic diet order sheets. I am not sure what to do with these records. Should I keep them? If so, how long? How can I prevent this practice myself?



- Determine if they are duplicates: call previous RD or check chart to see if notes are in chart.
- If they are not duplicates, they should be filed with the official chart and kept for the required time period.

Scenario 4

- Use of “fill in the blank” forms for charting
 - My workplace is developing a new electronic charting form, with preprinted information and check boxes. Does the College have a stance on this? Do I have to make an entry in every blank or check box?
 - What should I record if a client refuses to provide information that is relevant and the Colleges recommends be included.

- The use of “fill in the blank” and check box formats are perfectly acceptable ways to record assessments and nutrition care plans.
- Policies and guidelines can ensure that blank check boxes to make sure that blank boxes do not indicate missed information.
- If client refuses to provide relevant info and you have explained why the info is needed, you need to clearly document the refusal to provide information in your notes.

Scenario 5

- Multidisciplinary Record Keeping
 - We are starting to consider having one electronic record that all disciplines contribute to at our hospital. How can I account for my contribution to the record? Do I sign everywhere I make notes? Am I liable for information gathered by others?



- Contribution to EHR via individual login numbers track users.
- Usually your login will correspond with a date/ID but depends on program, may need to state date/ID on some programs.
- Not liable for incorrect info gathered by others as corresponds to their unique ID. However, you are accountable for the information you use in your assessment as you need to use professional judgment as to whether you can rely on information collected by others.

Scenario 6

- The Electronic Health Record (EHR)
 - Our organization is planning to scan all existing hard copy records for storage? Is this acceptable? Do we need to notify clients?
 - How do we accomplish the “Lock Box” principle in the EHR?




- Do not need to contact clients as this an acceptable and common practice to transition into EHR.
- Once all info is scanned in electronic format, you can destroy paper records confidentially.
- Lock Box principle is where a client provides information a health professional and asks them not share this with one or more members of the health care team.
- Lock box be done via unique ID login to access a separate section of EHR where only you can access it.
- If this is not possible with the EHR, then make a note in the EHR that there is lock box information elsewhere in a separate secure paper file.
- If info pertains to client care, can inform MD (or other health care professional) that you have info in lock box that may affect client care.
- MD can ask patient for access to this information if they feel that providing treatment without it would be too risky.

Scenario 7

- The Electronic Health Record (EHR)
 - The EHR is limiting what I feel is needed for my nutrition care notes, should I keep private notes to supplement what is allowed in the EHR?
 - How frequently should EHR be backed up?



- Only keep paper notes where necessary.
- Contact IT dept to indicate that you need more space, etc.
- It is better to enhance the EHR to meet your needs Vs filling gaps with paper notes.
- If using both paper and EHR, need to indicate this in both places so that team members are aware and access to the full chart for clients/patients is not impeded.
- EHR should be backed up as frequently as possible, up to organization and private practice RDs to have plans in place



- **Reference:**
Hogge LB, Michael MA, Houston SM, and Ayres EJ, *Electronic Health Record: Where Does Nutrition Fit In?* Journal of the American Dietetic Association. 2006; 106:1688 – 1695.

If you have any further questions or concerns relating to electronic documentation or other practice issues, please feel free to contact the College with your inquiries.

www.cdo.on.ca



THANK YOU.