FAQs about Interprofessional Record Keeping

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Interprofessional record keeping facilitates effective communication and enhances collaboration between the health professions for safe client care. Dietitians are encouraged to work collaboratively with other health professions to ensure that any information recorded in a shared client health record is complete, accurate and timely.

The framework on the following page outlines four elements needed for accurate and timely record keeping in an interprofessional environment. The documentation should:

1. Provide a clear picture of the services provided;
2. Facilitate communication among team members;
3. Support compliance with legislation; and
4. Demonstrate accountability.

WHAT ARE SOME CONSIDERATIONS WHEN USING ELECTRONIC DOCUMENTATION?

In many dietetic practice environments electronic documentation is becoming the norm. An RD's professional obligations for record keeping do not change with the format, be it paper, electronic or a combination of both. Follow the College's Professional Practice Standards for Record Keeping.

Audit Trails & Electronic Signatures

Interprofessional or multi-user electronic, documentation systems should contain individual logins that clearly identifies each user accessing a record. As per the College's Professional Practice Standards for Record Keeping, an audit trail of persons entering information and who viewed or accessed the records can be created. Many systems have electronic signatures built into the user's login for easy signing of the health care provider's name, RD credentials, date, and time. If this is not the case, RDs should document this information manually with each entry.

Confidentiality & Security

The Standards for Record Keeping require a reliable back-up system to be put in place to ensure electronic health records are secure and that when content is deleted accidentally or corrupted by a virus, it can be retrieved from a back-up server. This is as important for large organizations as it is for independent practitioners. Where there are multiple sites and practitioners, procedures to maintain secure access and security of records for the full retention period should be written in policy.

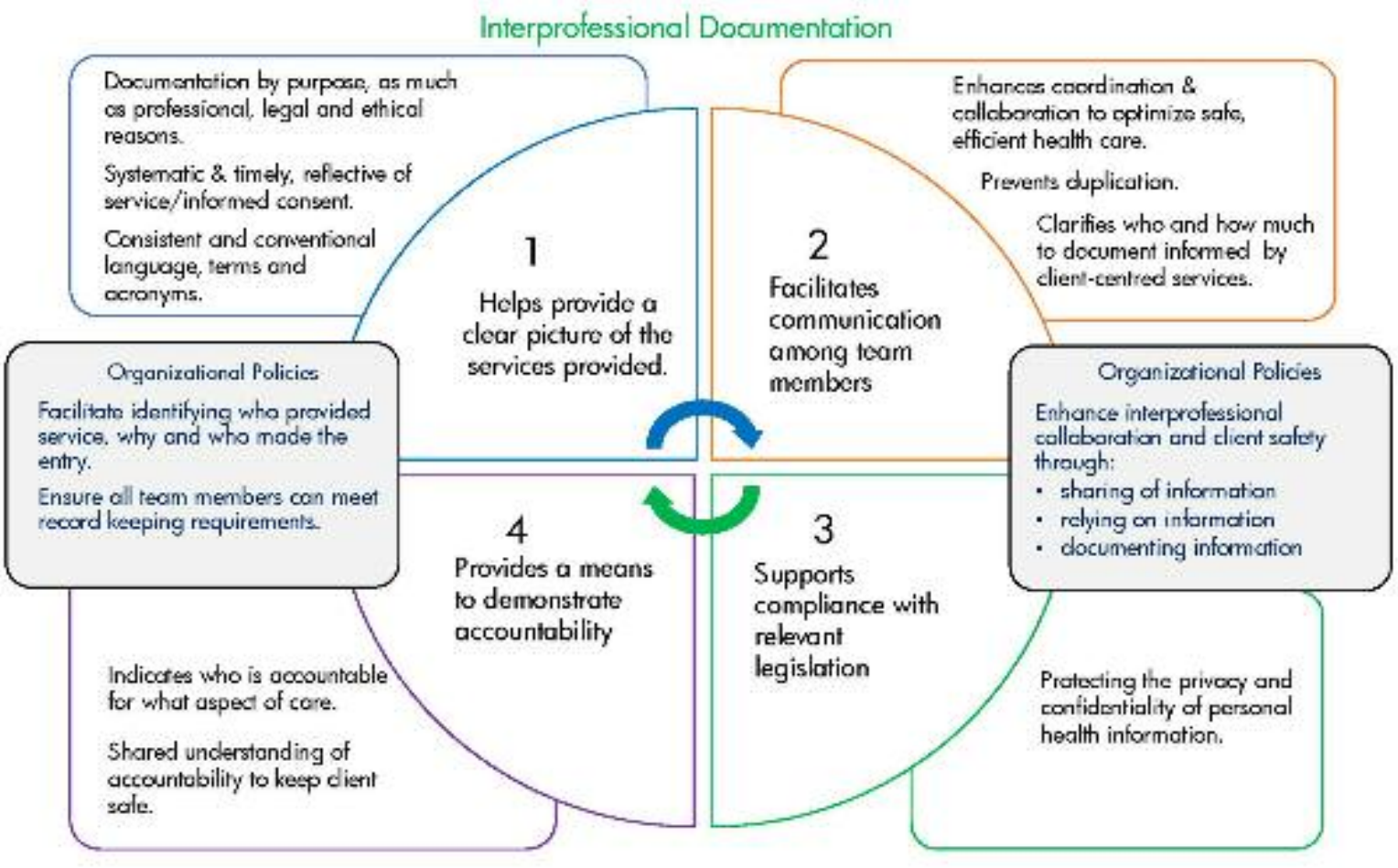
It is important for RDs to understand the security risks inherent in the use of electronic documentation and to work with organizations or do whatever is necessary to manage all risks related to potential breaches of privacy and confidentiality. All reasonable steps should be taken to ensure that the electronic documentation system is designed to protect against loss, tampering, interference or unauthorized access. It is advisable to consult with experts in the field of information technology.

Mixed Documentation – Paper & Electronic Records

Where a combination of both paper and electronic records exists, the systems should correspond with one another and be linked. It should be noted somewhere within both formats that the record includes paper and electronic documentation, and that together these two systems make up the full comprehensive record. This ensures that both the paper and electronic formats will be provided upon request.

From Paper to Electronic Records

When transitioning from paper to electronic records, it is not necessary to keep duplicates of paper and electronic records, unless organizational policies dictate otherwise. Once the information is stored in an electronic format, the paper records may be discarded in a way that preserves the confidentially of the client health records.



WHAT DOES AN RD NEED TO KNOW WHEN WORKING WITH AN INTEGRATED HEALTH RECORD SYSTEM?

When using integrated records, it is advisable to establish a policy surrounding charting so that the record keeping process is clear and that everyone who is documenting follows the same practices and has the same understanding of professional accountability. RDs can advocate for policies. In a collaborative environment, the documentation policies should include:

- Who provided service and their credentials;
- When the service was provided, why the service was provided and the outcomes achieved;
- Recognition that other regulated health professionals will have similar but not identical requirements and reflect those needs in the record keeping policy; and
- Ensurance that all team members can meet their professional standards for record keeping.

DOES AN RD HAVE TO ASK CLIENTS QUESTIONS AGAIN IF THEY ARE ALREADY DOCUMENTED IN THE HEALTH RECORD?

RDs do not have to ask clients questions if they are able to access the information from the interprofessional records as long as the documentation is current and complete for the RD's purposes. Interprofessional record keeping is a means to share information within the healthcare team to avoid duplication and to facilitate effective collaboration and client care. Use your professional judgement to assess the information in the chart. Ask yourself: Is the documentation detailed enough? Do I need more information for effective dietetic care? Has something changed that I should ask about? Can I relay on this information?

IF A COMBINED COUNSELLING SESSION IS DELIVERED TO A CLIENT, CAN ONE HEALTH CARE PROVIDER DOCUMENT THE DETAILS OF THE SESSION?

The RD should check the requirements of the other health profession or organizational requirements for documentation. From the College's perspective, if a combined or shared counselling session is delivered to a client, one health care

provider may document the details of the session. If another health care provider documents it, including the nutrition intervention, the College's Professional Practice Standards for Record Keeping stipulates that the RD must thoroughly review all information, verify the content and sign-off on the record with their name and RD credentials.

Consider the following questions for planning and documenting client care in a shared health record:

a) Who is the most appropriate health care provider (RD or other) to document the joint counselling session?

b) Are RDs accepting accountability for all of the information within the combined documentation? Or, are RDs only accountable for the information related to nutrition?

c) Is there a risk if another professional records information pertaining to nutrition? If so, how can this risk be alleviated?

d) How can RDs verify that they agree with the content of the combined documentation?