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I. INTRODUCTION

Record keeping tells a story of the care and services an RD has provided to clients. It is an integral part of an effective dietetic practice. Clear, comprehensive and accurate documentation provides a record of how Registered Dietitians (RD) exercise their professional judgment and critical thinking in an evidence-based, interprofessional dietetic practice.

Approaching record keeping in an organized and systematic way supports collaborative practice, confidentiality and prevents unauthorized disclosure of health information. It can also help RDs play an important role in ensuring that workplace systems, processes and policies facilitate the documentation of dietetic services.

The content of a record depends upon:

- the nature of the dietetic practice;
- the dietetic services provided;
- the purpose of the records;
- who relies on the records; and
- the accountability required of the RD.

This guide discusses the legal requirements and professional principles for record keeping which apply to all dietetic settings and situations, including clinical and non-clinical settings, individual clients or groups and where dietetic services may include nutrition care plans, counselling and education.

This guide focuses on the legal and professional requirements for record keeping that supports the delivery of safe, ethical and competent dietetic services in all areas of practice. It does not address the documentation required for business plans, strategic planning, program planning and other such organizational services that are part of some RDs' practices.



Elements that are mandatory for RD practice are identified with a yellow triangle in the margin.

Should you have additional questions or concerns relating to record keeping obligations for Registered Dietitians, contact the College's Practice Advisory Service:

practiceadvisor@collegeofdietitians.org

416-598-1725 / 1-800-668-4990, ext. 397

Acknowledgements

The Record Keeping Guidelines for Registered Dietitians in Ontario represents a collaborative effort between the College of Dietitians of Ontario and its members. The College extends its gratitude to the many dietitians who contributed to the guidelines by posing good questions and reviewing the content.

II. PURPOSE FOR DOCUMENTING

Good record keeping allows RDs practicing dietetics in all areas of practice to meet their professional, legal and ethical obligations. It provides a means for sharing information with other health care providers to avoid duplication and to facilitate effective interprofessional collaboration.

Whether providing services to individuals, groups, organizations, populations, or the public at large, documentation helps provide a clear picture of the needs or goals of the client, the RD's actions based on the assessment of needs as well as the outcome and evaluation (as applicable) of those actions.

1. Daily Practice

Record keeping helps RDs track their day-to-day practice. In clinical settings it allows them to review the reasons for treatment, the details of a treatment plan, progress and the discharge plan. While a record is important for ongoing treatment plans with clients, it is also important to keep a record of the processes used for evidence-based nutrition services, research and education in other areas of dietetic practice.

2. Communicating with Colleagues

Good record keeping is essential for optimizing interprofessional collaboration. Other members of the health care team, physicians, nurses, therapists and food service personnel rely on an RD's entries in a client health record when implementing nutrition care plans or implementing their own treatment plans. Integrated and well maintained health records facilitate communication between the health team members, prevent duplication, and enhance coordination to optimize safe and efficient health care.

3. Reports

Client health records are commonly needed to prepare reports. Clients have the right to access the information contained in their health records. They may need the information for others, such as insurers, employers and lawyers, for legal proceedings, such as a disability claim, motor vehicle accident, or a discrimination suit on the basis of disability.

- ▲ Failure to provide an adequate report because of poor records may increase the likelihood of being asked to testify in court as a witness. Failing to provide a report is also considered 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."¹

4. Accountability

Records are critical for accountability of dietetic services rendered. Record keeping demonstrates the RD's knowledge, skills, judgment and commitment to providing safe, effective and ethical dietetic services. Clients,

employers, payers and the College rely heavily on health records to assess the adequacy of an RDs conduct or competency when there are complaints or reports made about their dietetic practice. The axiom

"if it wasn't recorded, it wasn't done" is close to the truth. For example, it is difficult to reject a client's claim that something was not done when it has not been documented in the client's health record, regardless of the evidence provided by an RD. Similarly, it is generally accepted that something was done if the RD recorded it, regardless of a client's claims to the contrary.

Accountability is not restricted to disputes with clients. An RD's record is often the focus of risk and quality management by employers. In its Quality Assurance Program, the College may review charts. The quality of an RD's records is generally seen as a good barometer of the quality of their practice.

5. Reflective Practice

Critically analyzing record keeping habits is an effective way for RDs to learn and grow in their practice. Entries are most often made in real time and are grounded in the knowledge gained through interacting with clients, their substitute decision-makers, their families and others on the health care team. By examining their documentation practices, RDs can reflect on their knowledge and skills to identify areas for professional development in their dietetic practice. They can also evaluate their record keeping practices against professional, legal and employer obligations and make adjustments to improve their documentation where needed. Professional judgment and critical thinking reflected in client records can add significant value to evidence-based dietetic practice.²

Reflecting on your record keeping habits can be a learning goal for your annual Quality Assurance Program Self-Directed Learning Tool.

6. Research

Good records are vital to the scientific process.³ Documentation can be used for research purposes to assess nutrition interventions and evaluate outcomes and document issues to advance evidence-based practice. In addition, proper record keeping is important to the integrity of the research data.

Good research documentation and records include much more than data; they also include protocol descriptions, data analysis, research methods, personal interpretations, reflective notes and important decisions among researchers and others.

7. Documenting Consent

There are three key considerations for documenting consent:

1. The legal requirements under the Health Care Consent Act, 1996;
2. Professional judgment; and
3. Organizational policies.

 RDs must comply with the [*Health Care Consent Act*](#) to ensure that they have obtained informed consent for nutrition assessments and treatments.

The College does not stipulate when informed consent can be implied, written or verbal. Exercise professional judgment to determine when written or verbal consent is most appropriate, depending on the level of risk to a client for following or refusing treatment. In many cases, implied consent is adequate and RDs may use their professional judgment about when to document implied consent. Verbal and written consent should always be documented.

Consider organizational policies for obtaining and documenting consent. Some organizations have standardized processes for documenting consent among all health care providers. Be familiar with the consent agreements signed by clients when they are admitted to a care facility (e.g., hospital, long-term care home, etc.).

Refusing or Withdrawal of Treatment

Clients have the right to refuse treatment or withdraw consent to treatment at any time. When a client does not have the capacity to provide consent, their substitute decision-maker assumes the right.

Follow organizational policies regarding a refusal of treatment or withdrawal of consent by a client and clearly document it in their health record indicating:

- the nature of information relayed to the client or their substitute decision-maker to ensure that the refusal or withdrawal was informed;
- discussions with the client or their substitute decision-maker that ensued;
- questions posed by the client or their substitute decision-maker; and
- the reason(s) for the refusal or withdrawal of consent to treatment.

Cancelled or Missed Appointments

Cancelled or missed appointments should be documented in the client health record. Document efforts made to help clients overcome barriers to making their appointment and efforts made to remind clients of their appointment. The reasons for cancelled or missed appointments can provide insight into underlying issues that may be impeding client progress. Sometimes, cancelled or missed appointments are a sign that a client is refusing treatment or withdrawing consent to treatment. Even if they have been referred to an RD and have an appointment booked, clients still have the right to refuse dietetic services.

Use reminder mechanisms—phone calls, emails or texts — to decrease missed appointments due to client forgetfulness. Obtain client consent and document that the client has accepted appointment reminders through their preferred communication method.

8. Verbal Orders

The College does not have restrictions for RDs transcribing verbal or telephone orders from other health care providers (e.g., physicians). This also applies to orders received through email, fax or other means.

Verbal orders can expedite the implementation of nutrition care plans and facilitate efficient client-centred care. Consult the organizational policies for the correct facility protocols for verbal (or other) orders in your work place. Make sure that there are no policies restricting RDs from transcribing verbal (or other) orders from physicians or other authorized professionals.

Public Hospitals

The [Hospital Management Regulation](#) under the *Public Hospitals Act*, (1990) clearly states that verbal orders can be taken by anyone designated by the administrator of a public hospital. This could be any number of employees, including an RD:

“24. (2) A physician, dentist, midwife or registered nurse in the extended class may dictate an order for treatment or for a diagnostic procedure [e.g., labs] by telephone to a person designated by the administrator to take such orders.”²⁴

In addition, the regulation also requires that every order dictated should be authenticated by the person who dictated it as soon as possible:

“24. (1) Every order for treatment or for a diagnostic procedure of a patient shall, except as provided in subsection (2), be in writing and shall be dated and authenticated by the physician, dentist, midwife or registered nurse in the extended class giving the order.

24. (3)(b) The physician, dentist, midwife or registered nurse in the extended class who dictated the order shall authenticate the order on the first visit to the hospital after dictating the order.”²

Outside of Public Hospitals

RDs working outside of a public hospital may accept verbal (or other) authority to perform a controlled act or a restricted activity (e.g., ordering labs) and follow the same protocol as outlined in the Hospital Management Regulation. In settings where RDs do not have direct contact with MDs, alternative authentication processes can be put in place (e.g., via email/fax, etc.). When a verbal order is transcribed, the documentation should include:

- The order itself;
- The name of the physician or other authorized professional giving the order;
- The date and the time of receiving the order; and
- The name, credentials and signature of the person transcribing the order (i.e., the RD).

9. Performing Capillary Skin Pricks

RDs have specific documentation requirements when performing the controlled act of skin pricking as outlined in the College’s professional practice standard for [Collecting Capillary Blood Samples through Skin Pricking & Monitoring the Blood Readings \(Point of Care Testing\)](#).

Existing RD-Client Relationships

For existing RD-client relationships, RDs should clearly document all aspects of performing capillary skin pricks and interpreting the results, including:

- Informed client consent, as appropriate;
- The date and time of obtaining the capillary blood sample and the results;

- The clinical significance and impact of the results on nutrition assessment and monitoring;
- Any follow-up care and educational materials provided;
- Referrals to other health care providers, as appropriate; and
- Any special circumstances/modifications used in obtaining capillary blood samples and analyzing or interpreting the results.

Public Screening Clinics

The documentation requirements for RDs performing capillary skin pricks and analyzing the results in public screening clinics differ from requirements for existing RD-client relationships. In public screening clinics, RDs are responsible for documenting according to organizational or program requirements (e.g., keeping stats for the number of tests performed, educational resources provided and other relevant details, as appropriate).



10. Authority Mechanisms – Medical Directives & Delegations

Medical directives and delegations give RDs the authority to perform tasks to support the effective delivery of client-centred services. These authorities should be recorded in the client health record. Documentation of the authority mechanism ensures that all members of the health care team know that the appropriate authority is in place permitting an RD to order treatment and diagnostic procedures (in a public hospital setting) and/or perform controlled acts that are outside of the dietetic scope of practice.

The [Federation of Health Regulatory Colleges of Ontario](#) has developed two resources that may assist RDs in developing medical directives/delegations within their dietetic practice:

- [Guide to Developing Medical Directives and Delegations](#): Includes guidelines, templates and frequently-asked questions.
- [IPC e-Tool](#): Designed to assist teams to coordinate care, optimize roles and responsibilities and services to enable client-centred care.

11. Documenting Referrals

The College does not require a referral for an RD to see a client. In some facilities, there are requirements for a physician's referral or order for an RD to assess and treat a client. Follow employer policies, as applicable.

RDs are not obligated to accept every client that is referred to them, especially where a lack of time and resources will affect a client's care. An RD may need to determine specific criteria to set priorities for which clients will be seen.

When a referral is received and a client is not seen, the College recommends that RDs document why (was it due to workload, human resource shortages or an inappropriate referral, etc.). If ever asked why a client was not seen, a clear reason would be indicated in the client health record. The documentation does not need to be lengthy; a simple statement is sufficient, e.g., high client load, client discharged prior to RD seeing patient, inappropriate referral, etc.

In the interest of interprofessional collaboration, the College recommends that facilities develop policies regarding client referrals outlining the RD prioritization process. These policies can be developed in collaboration with other health care providers based on their professional requirements and can be

implemented for the entire team, RDs, OTs, SLP, PTs, etc. It is important to communicate the policies broadly to ensure that everyone on the care team is aware of the process for referrals to RDs.

12. Quality Assurance

Auditing

Chart reviews or audits are conducted for various reasons: organization-specific quality assurance programs, the College's Quality Assurance Program, hospital accreditation and inspections by the Ministry of Health and Long-Term Care in Long-Term Care facilities. A review of client health record can contribute to a body of evidence to support nutrition services and provide valuable information on nutrition interventions and outcomes.

Charts may also be assessed in a workplace performance review to evaluate an RD's ability to:

- Follow institutional processes and procedures to create accurate records, for example, by using the correct forms or format and making sure that the record is dated and signed;
- Assess clients through the collection of appropriate and accurate information; and
- Use critical thinking to create an appropriate and reasonable plan for a client based on the information gleaned from the assessment.

College's Quality Assurance (QA) Program - Peer & Practice Assessment

When selected, RDs are required by law to participate in the QA Peer & Practice Assessment and cooperate fully with the QA Committee and the College Assessor.

 This means RDs:

- Permit the assessor to enter and inspect the premises where they practice;
- Permit the assessor to inspect their client records;
- Give the QA Committee or the assessor information requested with respect to the care of clients or with respect to their client records in the form the Committee or assessor specifies; □ Confer with the QA Committee or the assessor if requested to do so.

If an RD does not fulfill the terms of the Peer and Practice Assessment, the QA Committee may refer the matter to the College's Inquiries, Complaints and Reports Committee for consideration of professional misconduct.

III. WHAT IS A RECORD?

13. Different Types of Records

Individual Client Health Records

These guidelines apply to all dietetic practice settings regardless of the type of documentation system or method that is used. The goal of the individual client health record is to give clear information of the nutrition service that was provided. Since nutrition can have a direct impact on the services delivered by other members of the care team, keeping an accurate health record ensures that everyone on the team, including health providers and others, are kept informed of the dietetic services a client has received. This is a key component for effective interprofessional collaboration.

RDs must ensure documentation is accurate, legible, understandable and identifiable. It must also be entered in a timely and systematic manner.

- ▲ Follow all facility-specific policies, governing rules, regulations or legislation for documentation. The development of organization-specific policies around record keeping is encouraged to manage a variety of issues, such as maintaining confidentiality of client health records and facility-approved abbreviations. As always, what is recorded should be dictated by purpose as much as professional, legal and ethical reasons for documentation.

Not all documentation in a client health care record need be included in the nutrition care notes. In practice settings where RDs are working with other health professions, the full record in its entirety makes up the complete client health record. For RDs working in private practice or sole practitioner settings, documentation may be more extensive for a comprehensive client health record. A comprehensive client health record should include:

- ▲
 - a. The client's full name and address;
 - b. The date of each of the client's visits to the RD;
 - c. The name and address of the primary service provider and any other referring health professional, if applicable;
 - d. The reason for referral, if applicable;
 - e. The client's relevant health history including medical, social, familial, and economic data related to the nutrition assessment. When background health information is provided by another practitioner, it need not be duplicated; however, a reference to the appropriate section should be included;
 - f. The assessment conducted, the findings obtained, the problems identified, the goals for nutrition intervention and the nutrition care plan;
 - g. Recommendations made by the RD for diet orders, nutrition supplements, nutrition-related medications, diagnostic tests and/or consultations to be performed by any other professional;
 - h. Progress notes containing a record of services rendered, subjective and objective evaluation/reevaluation and changes in the client's nutritional status;
 - i. Every written report received by the RD with respect to examinations, diagnostic tests and consultations;

- j. Particulars about discharge planning, including referral of the client by the RD to another health professional, when applicable;
- k. Any reason a client may give for cancelling an appointment or refusing the service of an RD, as applicable;
- l. Particulars of nutrition service that was commenced but not completed, including reasons for non-completion;
- m. Copies of reports compiled by the RD that are issued to other sources (e.g., health care providers/organizations) with appropriate consent forms, where applicable;
- n. Every part of a client health record must have a reference identifying the client or client health record;
- o. Every entry must be dated; and
- p. RDs must clearly identify themselves when documenting their dietetic services, including their name and professional designation.

Equipment Service Records

Equipment service records are important where the equipment can have health consequences or where the accuracy of measurements taken from the equipment is vital to the nutrition service provided. RDs should know where the equipment service records are kept, should they ever need to access them. Equipment service records should include:

- a record of the date of inspection or service and by whom it was done;
- a reliable reminder system for inspections and maintenance; and
- A means to easily access service data upon request.

Financial Records

Financial records should be maintained when billing occurs. Audits of financial payments are a fact of life in both the private and the public sector. The College recommends that copies of receipts issued to clients be kept in the client's health record. Financial records of business practices can be kept according to guidance from an RD's accountant and from Revenue Canada. Typically, financial records and the receipts given to clients should include:

- The RD's name and College ID number;
- A client identifier;
- The date, time, nature and the length of time for the service;
- The method of determining the fee if it is not uniform in the practice (e.g., units of time, block fee, fee schedule, based on a prior estimate, etc.); and
- The fee, method of payment and when the payment was made.

14. Documentation Formats

The College does not recommend any specific documentation system or method. Adhere to the organizational systems and formats that are in place for documentation in your work place. Organizations and private-practice RDs may combine elements from different systems, styles and methods to document service effectively. Common documentation methods include (but are not limited to):

- SOAPIER
- SOAP
- DAP
- Care Mapping

Regardless of the system or method used, provide a clear picture of the nutrition assessment, planning, intervention and evaluation that has occurred in providing your dietetic services.

Standardized Nutrition Language

The adoption of the Nutrition Care Process (NCP) and International Dietetics Nutrition Terminology (IDNT) is becoming commonplace in many health care facilities in Ontario. The College supports its adoption as it has the potential to facilitate consistent, safe and quality dietetic record keeping across a variety of dietetic practice environments.⁵

There are several advantages for RDs when using standardized nutrition language:

- Systematic approach – Encourages critical thinking and problem solving;
- Client-Centred Care – Emphasizes a client-centred approach that facilitates interprofessional collaboration;
- Enhanced Communication – Clear, concise and consistent approach to documenting essential nutrition information;
- Prioritization – Enables RDs to identify and prioritize nutrition problems;
- Applicability – Can be used in a variety of dietetic practice settings including those targeting individuals and groups to enable clear and consistent documentation;
- Continuous Quality Improvement – Uses an evaluation framework to identify the effectiveness of intended goals and interventions that demonstrate success;
- Research – Supports evidence-based practice and can facilitate large-scale data collection on the efficacy of nutrition intervention; and
- Streamlined Training & Education – Provides clear documentation expectations for RDs during workplace orientation, performance evaluations and/or College practice assessments.

For more detailed information on Standardized Nutrition Language, including incorporation into electronic health records refer to [Dietitians of Canada](#) and the [Academy of Nutrition and Dietetics](#).

Charting by Exception

Charting by exception is a documentation method designed to promote more efficient use of health care providers' time. It is based on an assumption that the patient has a normal response to all interventions unless an abnormal or concerning response is charted. Only abnormal or relevant information to nutrition service is documented when charting by exception.

To be effective, charting by exception for nutrition requires clearly written protocols that specify what is and what is not meant by a lack of entry. The chart should state explicitly that charting by exception is being used to ensure that all care providers are familiar with the protocol and that it is consistently followed. It is also important that someone is available to interpret the charts for others who may need to access the health records, e.g., clients, substitute decision-makers, other service providers, College investigators and the courts.

Charting by Reference

Charting by reference is also acceptable. For example, referring to a standing directive, a written assessment protocol, a recurring consent to treatment information sheet, a laboratory/diagnostic test result, or a known treatment regime can be a helpful and efficient way of incorporating a lot of information in a very brief entry. Charting by reference can also reduce transcription errors.

There may be circumstances when it would be more appropriate for an RD to explicitly transcribe pertinent information into the nutrition care notes, e.g., when communicating a critical value to a physician or other member of the health care team). Use your professional judgment to determine when charting by reference would be appropriate or when it should be used with caution as it would further complicate reading the chart by other health care providers. In all cases, to ensure credibility, it is imperative that the reference be accurate and complete.

Abbreviations

RDs may use of abbreviations as long as they are recognizable by the others who rely on the client health records. It is advisable to develop a master list of abbreviations for reference by others on the team who are not familiar with the terms and to outside readers of the records (when copies of the records are sent to the client or someone else at the client's request). Establish a formal organizational policy to:

- institute a master list of abbreviations for reference;
- ensure effective understanding and communication of all approved abbreviations; and
- list the abbreviations or types of abbreviations that are not permitted.

15. Dictated Records

Dictated records are acceptable but resource intensive; someone needs to transcribe the notes unless voice recognition computer software is used. The number of steps in dictating and transcribing records can lead to errors, misfiling or even record loss. It is important to review the transcribed notes later to ensure that they are accurate and to indicate that they have reviewed by signing the transcribed record. If this is not possible, at a minimum, run a spot check on transcribed records to ensure that they are generally accurate and that systemic errors are caught. When dictated notes are not read, this should be noted.

16. Narrative Notes & Pre-Printed Forms

Narrative notes are certainly acceptable. Pre-printed forms with headings and checklists save time and help ensure that information is not forgotten. However, diligence is needed when completing the forms so that points are not checked off thoughtlessly, resulting in an inaccurate record. Inaccuracies might include ticking off a series of boxes without reading them or omitting to record information because the form does not have a specific space for it. Pre-printed forms should contain a section for narrative or free-flow text for pertinent information not covered within the pre-printed form.

17. Electronic Health Records

In many dietetic practice environments electronic documentation is becoming the norm. There are numerous benefits to using electronic documentation including:

- Improved legibility
- Increased privacy and security
- Improved audit trail
- Increased access to records
- Improved efficiency in documentation to ensure safe client-centred care
- Enhanced interprofessional collaboration – facilitates sharing of information/may rely on information documented by others
- Avoids duplication
- More efficient access to results, referrals, reports
- Ability to track statistics for funding, research and other purposes

An RD's professional obligations for record keeping do not change with the format, be it paper, electronic or a combination of both.

Format

Pre-established computerized forms can be helpful and efficient when documenting dietetic services with drop-down menus, check boxes, and the like. There are several advantages to computerized forms including monitoring trends, transmitting specific information for accreditation purposes and collecting statistics for evaluation and research.

Electronic documentation systems typically also include a section for RDs to document narrative or free-flow text to provide an opportunity to capture relevant information not covered in drop-down menus or check boxes. As long as the relevant information is recorded, facilities and individual RDs in all areas of practice can find electronic documentation systems that meet their needs.

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 is made up of 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.

Transitioning from Paper to Electronic Records

In transitioning from paper to electronic records, information can be transferred manually or scanned into the electronic system. 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 confidentiality.

Individual Logins, Audit Trails & Electronic Signatures

Multi-user electronic documentation systems should contain individual logins that clearly identifies each user accessing a record. They should also include an audit trail to demonstrate when and who viewed or accessed the records and by whom the documentation was completed.

Many systems have electronic signatures built into the user's login for easy signing of the health care provider's name, credentials, date, and time. An electronic signature should correspond to the name under which an RD practises dietetics and include their professional designation (Registered Dietitian or RD).

Correction Processes

An appropriate correction process should be established within any electronic documentation system. Records should have a means to indicate when corrections are made and ensure that viewing of the incorrect/original documentation is easily available in case anyone should need to access it.

Back-Up System

A reliable back-up system should be put in place to ensure electronic health records are retrievable in the event of theft, power failures or other system issues that may have an impact on client health record accessibility.

18. Private Records

Legally, a client health record is made up of all health information that a facility or individual service provider has about the person. Ideally, the client health record should be kept in one location. Where this is not possible, records that are kept in different places should be formally linked. A client has the right to access their full health record upon request.

Private records (sometimes termed soft notes) are entries that are not included in the official chart of the facility or employer. The College discourages RDs from keeping private records for several reasons:

- **Risk management:** Any relevant nutrition service information should be documented within the full client health record. Failure to do so may compromise client safety as documentation would be considered incomplete.
- **Limits communication with team members:** Information pertaining to nutrition service should be accessible to all other team members; many other health care providers rely on nutrition care notes. This can prevent effective interprofessional collaboration.
- **Incomplete access:** If a client wishes to exercise his or her right to see the entire file, the facility or employer may unknowingly provide only part of the file, omitting the RD's private records. This may place the facility or employer in contravention of the law. This would also apply to a legal proceeding when an investigator requests a copy of the client health record.
- **Security:** Records need to be kept private and confidential. Private records should be stored in a secure paper or electronic format that ensures privacy and confidentiality. Additional information outside the main client health record may present challenges for RDs to ensure that their private records are kept in a secure manner.
- **Retention:** Private records would need to be retained for the appropriate retention period (refer to the 'Record Retention' section for more information).

In rare circumstances, there are reasons why an RD keeps private records:

- The official record is inconvenient to access for various reasons (e.g., working in remote locations, the procedures or the length of time it takes to retrieve the record are long or because others are often using it);

- The RD believes that the facility's or employer's client health information handling policies do not permit compliance with College regulations or other legal requirements (e.g., providing adequate access to clients);
- An RD's private records tend to contain details and calculations and may not be in a form that is useful or appropriate for others on the health care team to see;
- The RD 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 (refer to the section titled [Lock-Box Provision](#)); and
- The employer or facility is privately owned and does not respect confidentiality.

When it is not possible to avoid keeping private records, the College advises RDs to:

- Keep private records to a minimum.
- Destroy duplicate information and/or rough working notes once they have been transcribed in the client health record.
- Advise the facility or employer that private records are being kept and negotiate appropriate policies and procedures to ensure access, security and the ability to move or remove private records if necessary.
- Discuss the reasons for keeping private records with the facility or employer so that any underlying issues are appropriately addressed and/or resolved.

19. Telephone & Internet-Based Counselling & Communication

In today's technologically-centred landscape, the traditional model of in-person health care delivery may be replaced or supplemented with the provision of professional dietetic services to individual clients or groups via telephone, e-mail, SMS (text), Internet-based video conferencing, social media or a combination thereof. As technology advances, new opportunities for dietetic service delivery may also emerge. An RD's professional obligations are the same for services delivered in-person or via technology. This includes obligations for documentation, consent, access to records, privacy, confidentiality, security and retention of records. The information outlined under the section [Individual Client Health Record](#) would apply to services delivered by telephone or via the internet, too.

Informed Consent

Clients or their substitute decision-makers need to consent to telephone or Internet-based counselling and communication. They should be well informed of how the communication and the delivery of dietetic services will occur using the technology. Discuss all security issues and potential risks of transmitting personal health information over such devices (e.g., hackers, lost emails, etc.). In the client health record, clearly document the client's informed consent to the use of the telephone, email and social media for the delivery of your dietetic services and communications.

Communication via Email & Social Media

Where possible, limit the amount of personal health information that is being communicated with clients via email or social media, take extra security measures and encrypt all email correspondence with clients.

Document all electronic communication with clients. If they exist, follow the organizational policies relative to the documentation of email and social media communication in your workplace. In the absence of organizational policies:

- a) Summarize the email or social media correspondence with your client in their health record;
- b) Cut and paste, or attach email or social media correspondence in the electronic client health record;
or
- c) Print paper copies of the electronic correspondence and file in the client health record.

For more information on using social media in dietetic practice, refer to the e-learning module titled: [Pause Before You Post: Professional Obligations for Regulated Healthcare Professionals](#).

Access to the Electronic Records

Records may be retained in an electronic format but there should be attention given to the capacity to retrieve and print the record throughout the full record retention period, even as technology changes. When using password protected logins for emails and social media, make sure that the original information is accessible (as appropriate) for the required retention period. In addition, plans should be in place to ensure access to electronic records by others in the event that an RD is not available (e.g., sudden incapacity or death).

Confidentiality & Security for Information Technology

Understand the security risks inherent in the use of information technologies such as the telephone or Internet-based communication and 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 technology, the protocols and documentation are designed to protect against loss, tampering, interference or unauthorized access. RDs are encouraged to consult with experts in the field of information technology regarding confidentiality and security of information.

20. Group Education, Presentations & Workshops

RDs are not required to keep individual client health records where clients are receiving public education, group education or group services at community presentations, public speaking events, workshops, supermarket tours, etc. In these situations, it is important to think about the purpose for record keeping. Documentation obligations mainly depend on the program requirements.

Attendance

While a record of attendance is recommended, in some cases, taking attendance can deter participation in a program. An organization or individual RD has to balance their purpose for taking attendance with the need to encourage participation in a program.

Accountability

Consideration should be given to how the information will reflect on an RD's accountability in the provision of services, including the groups' needs assessment, actions taken and evaluation of the outcomes of the action. Consider these points to ensure that the purpose for documentation of services is clear:

- An assessment of the group/community needs;
- The purpose, objectives or expected outcomes of any meeting/presentation;
- The plan for meeting the objectives;
- The interventions/education (e.g., class content, location, etc.) to execute the plan;
- Materials and handouts used in the presentation;
- Frequently asked questions to guide content and highlight topics that require further resource development;
- An evaluation of the interventions, outcomes and future plans; and
- Program attendance statistics.

It is not necessary to record all of these points every time a group session is conducted, but it may be useful to have this documentation done initially and periodically reviewed to support the need, purpose and method for each type of group session. Although it may be necessary to do some type of evaluation each time a group session is conducted, a more formal evaluation can be done periodically based on program needs.

Individual Encounters in Group Sessions

The type of information that should be recorded for individual encounters in group sessions depends on the nature of the interaction with the client.

For a general interaction with a group member, it may not be necessary to document any information aside from a note in your program records that you had a discussion with an individual, the nutrition topic discussed and any resources provided. Programs may also have processes in place for managing individual encounters within group education sessions by directing participants to external resources when inquiries are deemed outside the scope of the program education or intended services.

On occasion, an interaction with a group member may be very individualized and beyond the purpose of the group session. When an individualized comprehensive assessment is conducted, even if it occurs within a group setting, a good rule is to complete an individual client health record. If a conversation feels like a nutrition assessment - you have asked a nutrition history or medical information of an individual group member and then provided nutrition advice - then you are conducting an assessment and need to create an individual health record with the client's name, date, topics discussed and any resources provided. An individual client assessment within a group requires the same level of applicable record keeping as those described in the section titled [Individual Client Health Record](#).

 In all cases, personal health records that connect a person's name and contact information with any health information need to be kept private and confidential. Refer to the section titled [Privacy Legislation & Record Keeping](#) for more information.

21. Record Keeping in Public Health & Other Non-Clinical Settings

Individual Client Health Records

RDs working in public health settings often have varying documentation requirements due to the nature of their work. Where RDs are conducting individualized counselling, a client health record must be created according to the requirements outlined in section titled 'Individual Client Health Records'.

Creating an individual client health record need not be laborious. Depending on the practice setting/program, an RD's assessment may be very specific (e.g., determining the need for vitamins and minerals only) versus assessing overall nutrition status. For the former, the individual health record would contain less information than one would expect to see for a more comprehensive nutrition assessment.

Some public health programs have streamlined the documentation process by creating assessment forms designed for a specific purpose. Where RDs have such forms, they do not need to create a separate individual client health record to meet College requirements. The forms make up the client health record.

There are instances where some of the "must have" information listed in the section titled [Individual Client Health Record](#) are not relevant. According to the *Personal Health Information Protection Act* (PHIPA), 2004, RDs should only collect and record relevant information and the College fully acknowledges this. For more information on protecting personal health information, refer to the section titled [Privacy Legislation & Record Keeping](#).

Group Education in Public Health

Follow the organization's policies on record keeping and documentation for group education in public health settings. In the absence of organizational policies and procedures, RDs can play an important part in assisting their organization to develop them. Refer to the section titled [Group Education, Presentations and Workshops](#) for further guidance.

Non Client-Care in Public Health

In other areas of public health where RDs work (e.g., management, staff training, public policy, program planning, strategic planning, etc.), documentation requirements depend on program needs and settings. RDs and their colleagues familiar with their work environment, program offerings, funding structure and other details would be best suited to determine the level of documentation required.

Records and Research

An RD may provide information or copies from a client health record to a person for research purposes if:

- Anything that could identify the client is removed from the information or copies;
- The information or copies are to be used for health administration or planning or health research or epidemiological studies;
- The use of the information or copies is in the public interest as determined by the Minister; or
- Written client consent is provided to disclose client health information.

Section 44 of the Personal Health Information Protection Act (PHIPA) states that researchers who wish to obtain personal health information from a Health Information Custodian (HIC) without client consent must submit to the HIC a written application, a research plan that meets the requirements of PHIPA, and a copy of the decision of the Research Ethics Board that approves the research plan.⁵ RDs working in research studies

where personal health information is being collected need to ensure records are kept private and confidential according to the policies and protocols as outlined in the study's REB application.

Researchers must also comply with the requirements in subsection 44(6) of PHIPA, and enter into an agreement with the HIC whereby the researcher(s) agrees to comply with the conditions, restrictions, if any, that the HIC imposes relating to the use, security, disclosure, return or disposal of personal health information.^{5,6}

22. Business & Industry

The College recognizes the variety of positions RDs may hold in the area of business & industry. RDs may work as employees or consultants engaging in (but not limited to):

- Media work for particular commodities, brands, organizations or public relations companies
- Product sales and product promotion/marketing
- Development of educational resources and product promotional materials
- Work for food service procurement companies
- Work for institution-based food service departments (e.g., hospital-based food services)

Marketing, Media, Sales & Communications

RDs working in marketing, product promotion, media, sales, or communications, need to be mindful that they are being asked for their expert opinion on nutritional issues. Employers, clients and the public at large are relying on their expertise to provide accurate and evidence-based nutrition information.

Any information that RDs communicate, either verbally or through written resources in any media should always be evidence-based. If asked, RDs should be able to provide the appropriate evidence-based documentation to substantiate any claims, perspectives on health and nutrition issues or expert opinions. RDs cannot rely on trends or hearsay; they need concrete evidence that supports their nutrition recommendations and advice.

For more information on Evidence-Based Practice, RDs can refer to the College's 2012 e-learning module titled: [Evidence-Based Practice – Regulatory and Professional Obligations for RDs](#).

Institution-Based Food Services

RDs working in institution-based food service settings have different documentation requirements depending on the nature of their work. Their documentation aligns with organizational policies, health and safety requirements, relevant legislation, and other factors impacting clinical food services. For the purposes of accountability, pay considerable attention to recording information that demonstrates the delivery of safe food services where there is a potential for error and risk to clients. Depending on the practice setting, RDs should consider documenting:

- Needs assessments
- Nutritional content of menu items and/or ingredient lists
- Menu development and modification principles
- Compliance of menu items with standards for therapeutic diets
- Compliance with health, food safety, sanitation and infection control protocols

- Technical requirements and equipment service records (e.g., calibration of temperatures on refrigerators, ovens, etc.)
- Contracts with foodservice suppliers, including compliance with safety standards
- Purchasing, receiving, storage, inventory control and disposal activities
- Food production and distribution procedures
- Costing/financial reports
- Staffing needs/scheduling/performance reviews
- Complaints received from the Patient Advocacy Office re: food services and any remedy action taken
- Quality assurance and quality improvement mechanisms



23. Mandatory Reports

RDs are required under the Regulated Health Professions Act, 1991 and other statutes to make certain reports. The table below specifies who is responsible for making the report and under various conditions.

Where an RD makes a mandatory report, it would be prudent to document the details of what led to the trigger of such a report in the client's health record or elsewhere, as appropriate.

TABLE 1: Mandatory Reporting for RDs

What Must Be Reported	Legislation/ Legal	Trigger for Report	Who is Responsible	Report To
Sexual relations, touching, behaviour or remarks of a sexual nature between a registered health practitioner and a client where you know the name of the alleged abuser.	<i>Regulated Health Professions Act, 1991</i>	Reasonable grounds obtained either in: 1. The course of practising your profession; or 2. Operating a health facility.	1. Dietitian; or 2. Facility Operator (CEO, administrator, or their delegate).	The Registrar of the College to which the person belongs.
Professional misconduct: incompetence or incapacity of a registered health practitioner.	<i>Regulated Health Professions Act, 1991</i>	You are terminating employment; 2. You are revoking, suspending or imposing restrictions on privileges; 3. You are dissolving a partnership or association; or 4. You intended to terminate or revoke, and the person quits first.	Any person who meets the trigger must make the report.	The Registrar of the College to which the person belongs.
Incompetence or incapacity of a regulated health practitioner.	<i>Regulated Health Professions Act, 1991</i>	You operate a facility and have reasonable grounds to believe that a registered practitioner is incompetent or has an incapacity.	Facility Operator (CEO, administrator, or their delegate).	The Registrar of the College to which the person belongs.
Offence details, professional negligence or malpractice details in a finding by a court.	<i>Regulated Health Professions Act, 1991</i>	An RD is the subject of a finding by a court.	Self-report must be made by the RD who has been the subject of the finding by the court.	The Registrar of the College of Dietitians of Ontario.
Incidents of unsafe practice or unethical conduct by another RD.	Professional Misconduct Regulation, <i>Dietetics Act, 1991</i>	Not stated. Probably reasonable grounds.	Registered Dietitian	Any appropriate authority.
That a child (under 16) is in need of protection as defined in the Child and Family Services Act (e.g., suffering abuse or neglect).	<i>Child and Family Services Act, 1990</i>	Reasonable grounds to suspect.	Any person who meets the trigger must make the report.	Children's Aid Society. The report must be personal; cannot be delegated.
That a resident of a long-term care or retirement home has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care, neglect, or misuse or misappropriation of a resident's money or of funding provided, among other events.	<i>Long-Term Care Homes Act, 2007, Nursing Homes Act, 2010</i>	Reasonable grounds to suspect.	Any person who meets the trigger must make the report, other than another resident.	The Director at the Long-Term Care Home or the Registrar of the Retirement Home Regulatory Authority (for retirement homes)
That an identifiable person or group is at substantial risk of serious harm or death from another person.	Case law "Duty to Warn"	Reasonable grounds.	Registered Dietitian	To an appropriate authority such as the police, the Public Guardian and Trustee, or in some circumstances, the primary care physician and, possibly, the intended victim.

IV. MAINTAINING RECORDS

For record keeping, it is important to distinguish between a workplace policy, an Act, a regulation or College requirements or standards for the retention and maintenance of records. Legislation and College requirements always take precedence over work place policies.

Retain client health records for a reasonable period of time, not only for the purposes of ongoing care, but also for accountability. It is in an RD's best interest to have the client records available should there be any question about the dietetic services that were provided.

24. Retention of Individual Client Health Records

Keep individual client health records for at least 10 years following:

- the date of the client's last visit; or
- the date at which the client turns 18 years of age (the limitation period for a child suing an RD does not begin until the child turns 18 years of age).

Even where the client dies, retain the record for the remainder of the retention period described above. The estate of the client may have questions about the service received. The RD might need the chart if sued. The RD would still be accountable to the College even though the client is deceased.

Where a particular statute (e.g., the *Public Hospitals Act*, *Nursing Homes Act*, *Long-Term Care Homes Act*, *Mental Hospitals Act*, and *Private Hospitals Act*) specifies a different retention period for contents within client health records, 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. It is presumed that the findings of such diagnostic imaging are summarized in the client health record.

25. Retention of Electronic Health Records

Maintain the records in a format that ensures retrieval for the duration of the retention period. If the records are kept in an electronic format, they should be retrievable throughout the full retention period, even as technology changes.

Ensure that electronic records have a reliable back-up system in place. This is as important to the independent practitioner as it is for large organizations. Hard drives can "crash" affecting access to records, and computers (and other mobile devices) are targets for theft, including the information on hard drives. Where there are multiple sites and practitioners, procedures to maintain secure access and security of records for the full retention period must be written in policy.

26. Record Retention Requirements for Group Education or Non-Client Care

With the exception of individual client health records, there is no specific record retention policy for RDs providing group education or non-client care. RDs and/or the administrators of the organizations where they work may choose a retention period that is most appropriate for their purposes.

27. Destroying or Deleting Records

Once the record retention period has elapsed and they are no longer needed, the records must be destroyed or deleted promptly. The continuing existence of the client health record is a security risk.

Destroy paper records confidentially via shredding and dispose of them through a reliable recycling company or other confidential manner. Delete electronic records from computer hard drives, servers, mobile devices and from back-up systems that are in place. Ensure that computer desktop recycling bins are emptied to verify the deletion of the records.

Record when individual client health records were destroyed. At a minimum, this record should note:

- name of the client;
- file number;
- date of the last treatment; and
- date the file was destroyed or deleted.

28. Requests for Record Changes & Correcting Records

Record correction can come at a client's request, from an RD identifying an error in their own documentation, or from another team member requesting a correction that the RD agrees with.

Client Requests for Changes in their Record

Section 55 of the Personal Health Information Protection Act (PHIPA), 2004, clearly states that if a client believes that their health record is inaccurate or incomplete, they may request that a correction be made.⁵ Follow organizational policies surrounding the process for handling requests for record changes. RDs who work in private practice or in facilities where there are no policies for record changes, should endeavor to implement a process that aligns with PHIPA.

Typically, the policies require clients to submit the requested change in writing to the organizations Health Information Custodian or Privacy Officer. Under PHIPA, when an RD agrees that the record is inaccurate, a correction should be made within 30 days of the request unless the client has been notified that an extension is needed. Where possible, corrections should be made by the RD who originally made the entry.⁵

A correction should not be made when an RD maintains that the entry is correct. 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 RD's explanation, the client should be allowed to file a statement of disagreement in the client health record. Depending on the nature of the issue, the RD might also send the statement of disagreement to those who have had access to the entry in the past year.

Process for Correcting Records

For audit trail purposes, the original entry should not be obliterated. Indicate that the original entry was made in error, strike it out with one line so that it is still legible, and insert a corrected entry indicating both the date and the person making the correction. Electronic records may require special programming in order to make sure that the original entry can be retrieved for corrections if necessary.

In some cases, it may be appropriate to clearly communicate, through verbal or written means, any corrected information in a client health record to those who have had access to the erroneous one within the past year.

RDs can only make corrections to their own documentation. Make corrections openly and honestly using the following process:

- 1) Make a single line through the error ensuring that the correction and the original note are both legible. Correction tapes and fluids are not appropriate as they obscure the original documentation.
- 2) A signature and date are always necessary when a correction is made. In some cases, the time of the day may also be required.
- 3) Depending on the urgency of the correction, communicate the correction to other health care providers by means other than the correction noted in the chart.

29. Late Entries

Documentation should happen as soon as possible after seeing a client, typically on the same day or where not possible, within 24 hours. Typically, a late entry is defined as documentation that takes place 24 hours after an intervention has occurred. Organizations are encouraged to develop policies for late entries and include a definition for "late" in order to avoid confusion.

Late entries happen if an RD is unable to locate the client's health record on the day that the intervention occurred or due to workload or other unforeseen circumstances. A late entry should include:

- 1) The current date and time;
- 2) Identification that the entry is late; and
- 3) The date and time that the intervention occurred.

30. Interprofessional Collaboration

Combined Documentation

Collaboration is seen as a process that requires relationships and interactions between health professionals regardless of whether they are members of a formalized team or a less formal or virtual group of health professionals working together to provide comprehensive health services to clients. Joint or integrated client records can facilitate communication, prevent duplication, enhance coordination and promote safe, quality service.

Work collaboratively with other health professions to ensure appropriate documentation of dietetic services provided within an interprofessional context.

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

- Record keeping practices that respect the clients' views, values and wishes;

- Documenting who provided service, when the service was provided, a rationale as to why the service was provided and the outcomes that were achieved;
- Who made which entry in the record;
- Who will act as the Health Information Custodian and ensure that they and their clients have access to the records even after service has ended;
- Recognize that other regulated health professionals will have similar but not identical requirements and reflect those needs in the record keeping policy; and
- Ensure that all team members can meet their professional standards for record keeping.

RDs should consider the following questions for planning and documenting client care in a shared health record:

- Who is the most appropriate health care provider (RD or other) to document the joint counselling session?
- Are RDs accepting accountability for all of the information within the combined documentation? Or, are RDs only accountable for the information related to nutrition?
- Is there a risk if another professional records information pertaining to nutrition? If so, how can this risk be alleviated?
- How can RDs verify that they agree with the content of the combined documentation?

If another health care provider documents the combined counselling session, including the nutrition intervention, RDs should thoroughly review all information, agree with the content and sign-off on the record.

31. Consultation Reports, Transfer of Care Notes & Discharge Summaries

RDs may be required to write consultation reports, transfer of care notes or discharge summaries to referring health care providers, other third parties or for the purposes of fulfilling specific program requirements. Such reports or summaries can enhance interprofessional collaboration and communication with other health care providers as well as serve as an accountability and program evaluation function. Consider the audience and purpose of the report, note or summary to help inform the content.

Consultation Reports

The type of information provided in consultation reports to referring health care providers or other third parties will depend on the nature of the dietetic services provided. Normally, the following information would be included:

- A summary of the nutrition assessment;
- An outline of the nutrition care plan and current goals for the client; and
- Any adjustments and progress, to date.

Transfer of Care Notes

The College doesn't have any mandatory requirement for transfer of care notes from one RD to another. In some cases the accepting RD simply reviews the transferred client health record. Certainly, care notes can facilitate more effective client-centred care, but this may not always be possible due to time constraints and human resource shortages.

An employer can develop specific policies to determine when an RD would be required to create a transfer of care note, and what should be included in the note for both internal and external client transfers. The information provided in a transfer of care report may vary depending on the dietetic services provided. Consider including the information outlined in the Consultation Reports section above.

Discharge Summaries

Similar to consultation reports, the details included in a discharge summary may vary depending on the reasons for ending treatment. For example, if the treatment has ended because the client's goals have been achieved, the discharge summary should include the client's condition at discharge, the nutritional goals, outcomes that were obtained, and any recommendations for ongoing self-management or follow-up service.

If dietetic services ended for reasons beyond an RD's control, for example, the client stopped coming to appointments, funding ceased, they died, were transferred to another facility, or sought nutrition services elsewhere, a brief note outlining the circumstances may be sufficient. Efforts to assist clients to seek follow-up dietetic services should also be documented.

32. Signing and Co-Signing Documentation

Signing Documentation

A fundamental reason for signing a record is to demonstrate accountability. Signatures with date, time and credentials (RD) are important to demonstrate accountability by showing when service was provided and that it was provided by a regulated health professional. In addition, as per the College's Registration Regulation, RDs are required by law to use the RD title in both verbal and written communication.

RDs are required by law to use their RD title in both verbal and written communication.

Co-Signing Dietetic Intern Entries

As dietetic interns are not members of the College of Dietitians of Ontario, the College does not have policies or guidelines regarding the documentation expectations for dietetic interns, or whether RDs must co-sign their documentation. It is up to the work setting, internship program or organization where dietetic interns are being trained to develop these guidelines and policies.

It is, however, reasonable to expect that dietetic interns learn about records that RDs are required to keep and model their own records accordingly. It is also reasonable to expect that as dietetic interns work towards seeing clients independently, they make their own records and sign them. RDs may co-sign records created by dietetic interns, but the reasons for co-signature should be clear and documented in policy. Reasons could be to confirm teaching, to verify that the information in the note is correct, or to denote that the service has been reviewed and that the RD agrees with content of the note.

Documenting Nutrition Service by Non-RDs

As nutrition managers, food service supervisors, nutrition assistants, diet technicians and diet aides are not members of the College of Dietitians of Ontario, they are not required to adhere to the College's record keeping guidelines. In documenting nutrition service, they are free to follow similar practices as RDs.

It is recommended that RDs not document service that has been provided by other service providers or nutrition support personnel. A better practice is to have the person who provided the service complete the necessary documentation. An RD may co-sign the entry if required (e.g., if an organizational policy exists that states clearly what that co-signature means).

RDs using information provided by nutrition support personnel for assessing, planning, implementing or evaluating nutrition service, may either reference or state the source of the information or record the data gathered by the nutrition support personnel in their own notes.

33. Checklist for Good Record Keeping



Records must be an accurate and honest account of what occurred and when it occurred with attention to purpose and clarity. The following tips will help ensure accuracy, clarity, legibility and accountability of records.

Although the focus here is on the individual client health record, the inherent principles apply to all types of documentation and record keeping in any dietetic practice setting.

Records must be an accurate and honest account of what occurred and when it occurred with attention to purpose and clarity.

- Clear – Uses appropriate language, including acronyms and abbreviations that are defined and accepted within a particular work setting.
- Concise and Complete - Includes the essential information to fulfill the purpose.
- Accurate – Free of error (to the best of the RD's ability).
- Relevant - Reflects important issues regarding service(s).
- Objective - Based on observations and supported by facts; may also include relevant subjective assessment data (e.g., SOAP) based on professional judgment.
- Retrievable – Information is easy to locate within the client health record.
- Confidential - Respects the confidentiality and privacy of the client and others. This includes invoking the "Lock-Box Provision" when needed.
- Client-Centred - Incorporates client and/or family goals.
- Setting-Specific - Use forms, methods or systems approved in the organization in which an RD works.
- Timely - Information is recorded in charts and consult reports are sent out in appropriate time frames.

- ❑ Chronological – Records events are recorded in the order that they occurred.
- ❑ Professional – Respectful of others and their entries by sharing and seeking accurate information and in particular referencing sources of the information.
- ❑ Non-judgmental and respectful - Avoid derogatory remarks about clients.
- ❑ Verified - Signed (name and credentials) by the individual who saw the client.
- ❑ Permanent - Changing a record to reflect a new perspective or new information is permissible as long as the original content can still be read.
- ❑ Transparent Corrections - Corrected by date, initial and an explanation of the corrections. Original entries should still be legible. Clients and other authorized individuals can have access the information.

V.PRIVACY LEGISLATION & RECORD KEEPING

Privacy principles reinforce the concept that personal health information belongs to the client, not the practitioner. The practitioner acts as a trustee, holding the information only for the benefit of the client. Whenever RDs are collecting personal health information they need to ensure adherence to the laws that govern privacy.

 The federal legislation, [*Personal Information Protection and Electronic Documents Act*](#) (PIPEDA), applies to personal information, including health information, collected and used for commercial activities in Canada. The provincial legislation, [*Personal Health Information Protection Act*](#) (PHIPA), outlines the rules for the collection, use and disclosure of personal health information in Ontario. Both Acts build on the same set of privacy and access principles, and both require information policies and practices to be transparent.

RDs must ensure documentation systems are maintained with appropriate security mechanisms according to the *Personal Health Information Protection Acts*, 2004.

PIPEDA and PHIPA set out the principles that organizations, individual, associations, partnerships and trade unions must follow when collecting, using and disclosing personal information in the course of providing health care and/or commercial activity. This includes making and supplying a commercial product or service.

Both acts are similar and require that an RD:

- Inform patients about the collection, use or disclosure of their personal information;
- Obtain consent to disclose information to third parties, when appropriate;
- Provide an individual with access to his or her own personal records;
- Provide secure storage of information and implement measures to limit access to client records;
- Ensure the proper destruction of records that are no longer necessary; and
- Inform clients of health information-handling practices through various means (e.g., posting of notices, brochures, pamphlets and discussions between a client and a health care provider).

RDs should also realize that they have confidentiality and privacy obligations that arise from other sources including provisions within the College's [*Professional Misconduct Regulation*](#), their contracts with their clients and, sometimes, their employer. The [*Personal Health Information Protection Act, 2004: A Guide for Regulated Health Professionals, \(2013\)*](#), will help RDs develop policies that comply with privacy of personal information legislation; the resource includes helpful forms and templates.

34. Health Information Custodians and Their Agents

Under the Personal Health Information Protection Act (PHIPA), RDs can be either a Health Information Custodian (HIC) or an agent of a HIC. For example, an RD in private practice would be the HIC, but an RD employed by an organization (defined in PHIPA) would be an agent.

HIC

A Health Information Custodian (HIC) is responsible for collecting, using, retaining, disclosing and protecting personal health information on behalf of clients. A HIC is generally the institution, facility or private practice health practitioner that provides health care to an individual.⁵

The *Personal Health Information Protection Act, 2004* (PHIPA), sets out the responsibilities of the HIC and the rules for handling health information. This includes requiring HICs to take reasonable steps to ensure personal health information is protected against theft, loss and unauthorized use or disclosure and to ensure that records containing personal health information are protected against unauthorized copying, modification or disposal.⁵ PHIPA defines health care as "any observation, examination, assessment, care, service or procedure that is done for a health-related purpose and is carried out or provided to diagnose, treat or maintain an individual's physical or mental condition; to prevent disease or injury or to promote health; or as part of palliative care."⁵

Agents of a Health Information Custodian

Persons who are not HICs are often termed "agents" and are required to meet the obligations of agents under the Act. PHIPA defines an agent as any person who is authorized by a HIC to perform services or activities on the HIC's behalf and for the purposes of that HIC. An agent may include an individual or company that contracts with, is employed by, or volunteers for a HIC, and may have access to personal health information. This includes:

- Employees and consultants
- Health care practitioners (e.g. RDs)
- Students
- Researchers
- Volunteers
- Independent contractors (including physicians and third party vendors who provides supplies or services)

PHIPA permits HICs to provide personal health information to their agents only if the HIC is permitted to collect, use, disclose, retain and dispose of the information.

When RDs are employed or contracted to provide services as agents of a facility under PHIPA, the HIC (or their designated privacy officer) must ensure that all agents of the HIC are appropriately informed of their

duties, which may include record keeping practices and the signing of confidentiality forms. Depending on the circumstances, RDs are to comply with PHIPA as well as policies in place by the HIC for whom they work.

The Health Information Custodian in Private Practice

 In almost every instance, a private practice RD is the Health Information Custodian (HIC) responsible for the privacy, confidentiality and the appropriate retention of health records. In the event of an RD's sudden incapacity or death, it would be prudent to have designated who will be responsible for their client health records and how they should be managed. These provisions may be stated in a business plan or specified in a will or testament.

The person designated for managing the records does not necessarily need to be an RD. They can be a spouse, another family member, a friend, or colleague. The designated person will have the legal responsibility to maintain the records according to Ontario laws and College guidelines. Therefore, it is important to make sure that the person understands and is prepared to assume their responsibilities as the new HIC.

Instructions for Health Information Custodians

 While record retention obligations may be apparent to an RD, it may not be so for their designated HIC. The business plan or will should clearly explain that the records must be kept confidential, secure and retained for the appropriate retention period. Most importantly, the records need to be accessible to clients when they ask for them and to the College or police should they need access to them during an investigation.

Records must be kept confidential, secure and be retained for the appropriate retention period.

The instructions ought to direct the designated HIC to:

1. Notify the College in writing of the RD's incapacity or death. In the letter to the College, indicate the location of the records and how clients may access their record. 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 RD's sudden incapacity or death. Specify the retention period and where the records will be kept if clients should ever need to access their information.
3. Provide resources to help clients access nutrition information and find follow-up dietetic services (e.g., direct clients to Eat Right Ontario and the "Find a Dietitian" section of the Dietitians of Canada website).

The above information can be outlined in a form letter addressed to clients to be sent by the designated HIC (see sample letter on the next page). A telephone script may also be developed by the designated HIC to inform each client that their record has been transferred.

Private Practice RDs – 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 and can no longer continue his/her dietetic practice>. The purpose of this letter is to notify 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 Registered Dietitians as set out by the College of Dietitians of Ontario:

- For Adults: 10 years after the date of the client's last visit.
- For Children: 10 years after the date that the client reaches, or would have reached 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 RDs in your local area according to postal code: www.dietitians.ca

For general questions regarding healthy eating and nutrition issues, please feel free to contact Eat Right Ontario, a free telephone and email/website service provided by RDs. You can contact Eat Right Ontario by calling 1-877-510-5102 or visit their website at: <http://www.eatrightontario.ca/en/default.aspx>

The College of Dietitians of Ontario has a record of where <RD's 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>

35. Privacy Breaches

 A privacy breach occurs whenever there is unauthorized collection, use or disclosure of any personal health information. This includes theft, loss and unauthorized copying, modification or disposal. In the event that an RD is made aware of a real or potential privacy breach, they have a responsibility to inform their information officer. The organization will then implement their privacy breach protocol.

The Information and Privacy Commissioner of Ontario has developed a helpful resource titled: [What to do When Faced with a Privacy Breach: Guidelines for the Health Sector](#).⁶ RDs who act as HICs may find this document useful when developing their own privacy breach protocols. It outlines four main steps when attempting to manage privacy breaches:⁷

Step 1: Respond immediately by implementing the privacy breach protocol.

Inform the necessary staff within the organization as well as the Information and Privacy Commissioner's Office, Ontario.

Step 2: Containment - Identify the scope of the potential breach and take steps to contain it.

Assess what and how much information was breached and in what manner (e.g., paper format, electronic format, were copies made, etc.). Implement any necessary action to contain further unauthorized access (e.g., change passwords, identification numbers and/or temporarily shut down a system).

Step 3: Notification - Identify those individuals whose privacy was breached and notify them of the breach. Notify all individuals whose personal health information has been compromised. This includes informing individual of the steps that have or will be taken to address the privacy breach and that the Information and Privacy Commissioner's Office, Ontario has been informed.

Step 4: Investigation and Remediation

Conduct an internal investigation into the matter to identify how and why the privacy breach occurred. Take the necessary steps to implement a plan that strives to avoid a similar privacy breach from occurring in the future. HICs should advise the Information and Privacy Commissioner's Office, Ontario of the investigation findings, proposed future prevention plan and work together to make any necessary changes.

36. Encryption of Mobile Devices

 Electronic documentation on mobile devices is becoming the norm in dietetic practice. When doing so, RDs need to follow the Information and Privacy Commissioner, Ontario's mandatory requirement for health care professionals to encrypt all mobile devices that contain personal health information. This includes all laptops, USB keys, tablets, smart phones and other personal data assistants (PDAs). This requirement also applies to laptops that stay in one office. As these devices are prone to theft, password protection is not enough, encryption is also required.

There are several resources from the Information and Privacy Commissioner, Ontario that may be of assistance to RDs to outline this encryption requirement:

- [Fact Sheet #12 - Encrypting Personal Health Information on Mobile Devices](#)
- [Fact Sheet #16 - Health-Care Requirement for Strong Encryption](#)
- [Safeguarding Personal Health Information When Using Mobile Devices for Research Purposes](#)

37. Options for Encryption

RDs can explore these encryption options and any others to determine which suits their needs best:

- a) Many software programs are available today that provide easy to use encryption.
- b) Many USB keys come pre-loaded with encryption software;
- c) Most versions of Microsoft Word have an encryption option built right into the program.

38. Transporting/Transmitting Client Information

 When confidential client information is transported/transmitted from one place to another (for example by car, mail, courier, email or fax) steps must be taken to ensure that confidentiality is maintained. The following precautions can help to preserve confidentiality during such transmission:

- Obtain informed client consent when transferring client health information, noting if the medium is secure or not;
- Avoid transmitting client health information using unsecured or unencrypted e-mail;
- When faxing to a person outside of an organization or facility within the circle of care, ensure the individual is at the receiving end;
- Client health information sent by regular mail or courier should be clearly identified as confidential;
- Paper records kept in an RD's car should be in a file box or briefcase with a lock. Paper records should not be left in an unattended vehicle, even if locked in the trunk of the car; and
- Electronic records should be encrypted and not left unattended. Electronic records should not be left in an unattended vehicle, even if locked in the trunk of the car.

39. Lock-Box Provision

The Personal Health Information Protection Act (PHIPA), 2004 gives Ontarians control over their personal health information. The law says that clients must give their consent to the collection, use, and the disclosure of their personal health information. It also says that clients have the right to withdraw or withhold this consent.⁵ Generally, disclosure of personal health information can be made to other health care providers within a client's 'Circle of Care' without express client consent, but under the lock-box provision, a client can withhold or withdraw consent or may prohibit or place conditions on this disclosure.⁸

The lock-box provision means that a client is locking all or part of their health information from access by certain health care providers. They are expressly withholding or withdrawing their consent to the use and/or the disclosure of their personal health information for health care.

- According to the Office of Information and Privacy Commissioner, Ontario, this request from clients may be one of the following restricting:
- The use or disclosure of a particular item of information contained in the record;
- The use or disclosure of the contents of the entire record;
- The disclosure of personal health information to a particular Health Information Custodian (HIC), an agent of an HIC, or a class of HICs or agents (e.g., physicians, nurses, social workers, etc.); □ The HIC or their agent or a class of HICs or agents to use personal health information.⁸

Where possible, it is recommended that all health care providers set policies and procedures ahead of time for lock-box provisions. If RDs work within an organization, they should meet with their institution's HIC or designated employee to review its policies for handling lock-box information. In large organizations, this

person will most often be someone in the health records department. RDs may also wish to contact similar organizations to see how they have implemented the lock-box provision.

Maintaining the Lock-Box Record

An RD's professional obligations surrounding record keeping do not change for information that has been locked. The health record itself must be complete in keeping with the requirements outlined in the section titled [Individual Client Health Records](#).

▲ If using paper files, the information can be kept separately and securely away from the main chart, along with clear indications that part of the medical record has been removed under the lock-box provision. Electronic medical records can be designed to add additional checks and balances such as password protection to certain sections within the health record in order to maintain information together but effectively locked from unauthorized use or disclosure. For private practice RDs, where others are less likely to see the record, locked information can be clearly identified in a separate section of the chart that is marked to indicate expressed client consent is required to share its contents with other members of the health care team.

▲ If an RD believes that the locked information is important to the care or health services that others are providing their client, RDs must warn the other practitioners through a note in the chart that the record contains locked information and that they are receiving only part of the file. It would then be the responsibility of the other practitioner or HIC to seek client consent to access the lock-box information.

Transfer of Locked Information

When leaving a position or transferring dietetic services to another RD, always make reasonable efforts to contact clients to let them know that their records will be transferred to someone else and to verify if the client still wants their health information to be kept locked. Clients should always be informed that their 'locked' record will be changing hands.

There are cases where a client is reluctant to permit any transfer of locked information. Thus, if it is expected that a practice may shut down or that records will be transferred to another practice or organization in the future (e.g., in solo private practice), deal with this issue at the time the information is locked by the client. Alternatively, RDs can work to have a lock-box retention plan that satisfies the privacy rights of clients and ensures that RDs meet their record keeping obligations when records are transferred.

When to Disclose Lock-Box Information

▲ Once a client has disclosed information to an RD and asked that the information not be included in the record, the information must be kept locked unless:

- The individual changes their mind and informs the HIC accordingly; or
- The HIC believes on reasonable and probable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons (e.g., Duty to Warn) subject to any applicable constitutional restrictions.

This information may be of a sensitive and personal nature or may be related to illegal activity. An RD needs to determine the relevance of the lock-box information to the nutrition intervention with the client and whether there are any mandatory reporting obligations. If the lock-box information should be reported, a clear

management process becomes very important. The client should be informed that it is necessary to record and report the information and the reasons for this, as required by law.

40. Client Access to Records

A client has the right to access his or her client health record. This right exists under the Personal Information Protection Act, 2004 and the Personal Information Protection and Electronic Documents Act, 2004. Exceptions are unusual and relate primarily to any serious safety concerns for third persons or, in rare cases, the client. This 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.⁹

Reasonable fees or administrative obligations can be imposed on a client's access rights, but should not be barriers to prompt, easy access to records by clients. Before allowing clients to view the records, for instance, RDs may require that the entries be reviewed with them first to explain any abbreviations or technical terms. Viewing a health record in the presence of a health care professional may prevent tampering or altering of that record. Unless the entries are particularly sensitive, RD should consider providing a copy of the chart and may do so at a reasonable cost.

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