College of
Occupational Therapists
of British Columbia

COTBC Practice Standards for Managing Client Information, 2014

Overview

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Note to Readers

Throughout these practice standards, reference is made to the following support documents. Please check that you have the most recent versions, and if necessary, download these from the College website or contact the College for updates.

Association of Canadian Occupational Therapy Regulatory Organizations. (2011). *Essential competencies of practice for occupational therapists in Canada* (3rd ed.). Retrieved from http://www.cotbc.org/PDFs/EssentialCompetenies3rdEd_WebVersion.aspx

College of Occupational Therapists of British Columbia. (2001, April 6). *College of Occupational Therapists of British Columbia Bylaws.* Retrieved from http://www.cotbc.org/PDFs/COTBC_Bylaws.aspx

To ensure timeliness and accuracy, updates to practice standards will be made when necessary. Suggestions and questions regarding the content or application to practice should be forwarded to:

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Tel: 250-386-6822 or toll-free in BC 866-386-6822

Practice standards in this series: *Managing Client Information* (2014)

1. Collecting and Recording Client Information
2. Protecting Client Information (Privacy and Security)
3. Client Access to the Occupational Therapy Record
4. Disclosing the Occupational Therapy Record
5. Records Respecting Financial Matters
6. Retention and Destruction of the Occupational Therapy Record

Preamble

In the *Health Professions Act* (RSBC 1996, c. 183), the Occupational Therapists Regulation acknowledges occupational therapists as autonomous professionals. The College of Occupational Therapists of British Columbia (COTBC) regulates the practice of British Columbia occupational therapists "to serve and protect the public."

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COTBC practice standards are published by the College to assist the occupational therapist in meeting the *Essential Competencies of Practice in Canada* (3rd ed.) by

- defining registrant responsibilities;
- describing minimal expectations for occupational therapy practice; and
- defining safe, ethical, and competent occupational therapy practice.

Be careful not to intrude to an unreasonable extent upon the personal affairs of the client concerned. (COTBC Bylaws 74[b][ii]

Preamble

The COTBC *Practice Standards for Managing Client Information* replace a prior document, *Practice Guideline: Collecting, Recording and Protecting Client Information* (March 2006).

These practice standards were developed by occupational therapists in British Columbia who work in a variety of practice settings and serve on the COTBC Standards Committee. The committee reviewed the previous guideline as well as parallel documents from Canadian occupational therapy and health regulatory organizations, and considered practice questions, issues, and concerns presented by registrants and others.

These practice standards include information contained in federal and provincial legislation. Cross-referencing to other COTBC documents and to provincial and federal legislation appears throughout.

A draft of these practice standards was reviewed by the College's legal counsel, Lovett & Westmacott. The final document was approved by the COTBC Board in June 2014.

The College Bylaws cite other relevant legislation that affects your collection, recording, protection, access, disclosure, retention, and destruction of client-related documentation. Review Part 6: Registrant Management of Client Records.

Statement of Purpose

These practice standards clarify the occupational therapist's accountability and the College's expectations respecting the occupational therapist's management of client information. They are designed to assist the occupational therapist to identify and reduce the risks inherent in managing client information, thereby protecting clients from harm.

Managing client information requires compliance with legislation and the legal requirements as set out in the COTBC Bylaws. The College's focus is on the quality and content of the information contained in the occupational therapy record, as well as on how the occupational therapist collects, records, protects, and ensures access to client information. The College acknowledges that different occupational therapists perform these tasks in different ways within different practice contexts and settings.

Managing client information is important because of the many ways in which the occupational therapy record is used. It is a legal document and source of evidence that can demonstrate compliance with the standards of the profession as well as with other standards, laws, and ethical considerations.

Statement of Purpose

The occupational therapy record:

Describes the occupational therapy process

Because the occupational therapist collects and records client information to plan, implement, and carry out a systematic, client-centred care plan, the occupational therapy process must be reflected in the occupational therapy record. Collecting, recording, protecting, and ensuring access to client information can allow the occupational therapist to demonstrate that safe, ethical, and competent care was delivered to the client. The record can also make explicit the therapist's critical thinking, reasoning, and decision-making.

Facilitates client participation

The client can expect involvement in collecting and recording information that becomes part of the occupational therapy record, and can be assured that the privacy of client information is maintained in accordance with all applicable legislation. The client's right to access current, legible, accurate, and complete records of occupational therapy services within statutory limits will be facilitated. The occupational therapy record will be retained and when no longer required, will be properly destroyed. The management of client information also aids the occupational therapist to communicate effectively with the client, the primary caregivers, and the family.

Advances quality occupational therapy services

The management of client information aids the occupational therapist to communicate effectively with other health professionals involved in the care of the client. Client information may be used to advance the profession's evidence and knowledge base through education and research activities. It can also be used by administrators, planners, and the College for decision-making, quality improvement activities, and reflection on practice.

Definitions

Attest/Attestation The process of assigning responsibility and authorship for an activity, usually by applying a signature. (COTO, 2008)

Care pathway/Clinical pathway/Care protocol An outline of anticipated care with time frames to address how a client's conditions or symptoms will be addressed from initial contact to anticipated outcome.

Client An individual, family, group, community, organization, or population who participates in occupational therapy services by direct referral or contract, or by other service and funding arrangements with a team, group, or agency whose work includes occupational therapy. Client is synonymous with patient or consumer and means a recipient of occupational therapy services. (Townsend & Polatajko, 2007)

Client information All personal information about a client as defined in the *Freedom of Information and Protection of Privacy Act* (FOIPPA) and Personal Information Protection Act (PIPA).

Client representative In most cases, a family member or partner. He or she may also be considered a substitute decision maker. This individual may be selected by the client or appointed by the court or Public Guardian and Trustee of British Columbia, and in this case is considered an authorized client representative.

Definitions

Confidentiality The ethical and professional obligation not to disclose personal information without the consent of the person whom the information is about.

Electronic health record (EHR) A computer-based electronic file that resides in a system specifically designed to support users by providing accessibility to complete and accurate health data, alerts, reminders, clinical decision support systems, links to medical knowledge, and other aids. (Canadian Health Information Management Association, n.d.a)

Electronic signature A signature or attestation applied by electronic means. (COTO, 2008)

Encryption The process of transforming information to make it unreadable to anyone except those possessing a password or key.

Health record A compilation of pertinent facts of an individual's health history, including all past and present medical conditions, illnesses, and treatments, with emphasis on the specific events affecting the client during the current episode of care. The information documented in the health record is created by all health care professionals providing the care. (Canadian Health Information Management Association, n.d.b)

Definitions

Locked document A document may be "locked for editing" or "read only," which means that the author or system administrator has disabled the means to edit the document in electronic form.

Managing client information The process by which the occupational therapist collects, records, uses, stores, and discloses the personal information of the client.

Occupational therapy record A compilation or any written or computerized text information and audiovisual media generated by the occupational therapist or individuals supervised by him or her, and that relate to the occupational therapy services provided to the client. It may also include appointment recording, equipment administration, and financial records pertinent to the individual client. An occupational therapy record may be part of an overall health record.

Occupational therapy service Direct care, research, education, consultation, or administration.

Personal information Anything collected about the client for the purpose of the occupational therapy record.

Definitions

Practice/Service The overall organizational and specific goal-directed tasks for the provision of activities to the client, including direct client care, research, consultation, education, or administration.

Privacy The ethical and professional obligation to ensure that personal information is secure from unauthorized access, use, and disclosure.

Record Includes books, documents, maps, drawings, photographs, letters, vouchers, papers, and any other thing on which information is recorded or stored by graphic, electronic, mechanical, or other means, but does not include a computer program or any other mechanism that produces records. (*Freedom of Information and Protection of Privacy Act*, Schedule 1, 1996)

Security The administrative, physical, and technological safeguards in place to prevent accidental or intentional disclosure by inappropriate access or by unauthorized individuals. It also includes the mechanisms in place to protect the information from alteration, destruction, or loss. (COTO, 2008)

Definitions

Sign/Signature The occupational therapist's signature or attestation, including an electronic signature as long as the occupational therapist takes reasonable steps to manage the process by which it is affixed. (COTO, 2008)

Stakeholder Someone who has a valid interest in the outcome of a decision involving the client. Examples of stakeholders include family members, other health care team members, physicians, insurance companies, legal representatives, and third-party payers. (COTO, 2008)

Unique identifier A number assigned to a case file to identify a unique individual and to distinguish him or her from others. (COTO, 2008)

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