



College of
Occupational Therapists
of British Columbia

**COTBC Practice Standards for
Managing Client Information, 2014**

**Practice Standard #1:
Collecting and Recording Client
Information**

#402-3795 Carey Road
Victoria, BC V8Z 6T8

Tel: (250) 386-6822
Toll-Free BC: 1 (866) 386-6822
Fax: (250) 386-6824

Practice Standards for Managing Client Information

Practice Standard #1: Collecting and Recording Client Information



The occupational therapist will ensure that an accurate record of occupational therapy services is created and includes receipt of referral, informed client consent, assessment, intervention, discharge, and follow up.

Practice Expectations

The occupational therapist will ensure that the following information is collected and is part of the occupational therapy record:

1. Contact information for the source of the client's referral, including self-referral.
2. Reason for the referral.
3. Confirmation that client consent was obtained.
4. Confirmation of the accuracy and currency of the information provided about the client on the referral.
5. Client's full name, address, date of birth, and unique identifier (if applicable).
6. Client information that is necessary and pertinent to the purpose of the occupational therapy assessment and intervention.

Practice Standards for Managing Client Information



Practice Standard #1: Collecting and Recording Client Information, continued

The occupational therapist is responsible for the content of the client record related to occupational therapy services and will ensure that the content accurately reflects the occupational therapy services provided.

Practice Expectations

The occupational therapist will include the following information on the client record:

1. Consent as obtained, dated, and maintained.
2. Occupational therapy assessments including the assessment procedures, results obtained, and conclusion or professional opinion regarding the client's status.
3. Documentation of the occupational therapy intervention plan, formulated in collaboration with the client.
4. Clear reference to any specific care pathway or similar assessment and intervention plan.
5. Progress notes indicating the outcome of an intervention, changes in the client's condition, problem formulation, or the intervention plan and goals.
6. Name, designation, and supervision plan when the occupational therapist assigns a component of the intervention plan (e.g., to students or support personnel)
7. Cancelled or missed appointments.
8. Discharge information, which may include the client's status at discharge, reason for discharge, summary of outcome attained, recommendations such as home program, referral, and an explanatory note when interventions initiated were not completed.

Practice Standards for Managing Client Information



Practice Standard #1: Collecting and Recording Client Information, continued

The occupational therapist will ensure that records are legible, understandable, complete, and prepared and maintained in a timely and systematic manner.

Practice Expectations

The occupational therapist will ensure the following:

1. Records are organized in a logical and systematic fashion to facilitate retrieval and information use.
2. Documentation is completed in a timely manner appropriate to the client and clinical situation.
3. All documents identify the client and the client's unique identifier, such as date of birth, record number, or claim number. It must be possible to identify the client in any part of the record.
4. The date of each professional encounter of any kind with the client, regardless of the medium (email, fax, telephone, or in person), is recorded.
5. If email has been used by the occupational therapist to make decisions, sufficient detail is documented and retained as part of the record (electronic or paper). This may include the need to print or scan a document to have it preserved.
6. The date of the receipt and disclosure of client information is recorded.

Practice Standards for Managing Client Information



Practice Standard #1: Collecting and Recording Client Information, continued

Practice Expectations, continued

7. Abbreviations, acronyms, and diagrams used in the client record have a supporting reference available for those who access the records, to ensure consistency of interpretation.
8. Every entry is dated and signed and includes the name of the person who made the entry. The signature includes the occupational therapist's full name and designation. Electronic signatures are protected and linked to a user ID and password.
9. The occupational therapist who contributes to a combined disciplinary notes or reports, identifies the portion of the note or report for which he or she is responsible and accountable.
10. When two occupational therapists contribute to the same record, the signature of each is included. The record clearly indicates the author of each entry and who provided the services.
11. Copies of a record distributed without an original signature by the occupational therapist clearly indicate where the original signed record is located.
12. Drafts of documents if kept are retained as part of the record and released upon request. Draft notes may be destroyed if not needed, but if they exist at the time that access is sought to the record, they are considered a legal part of the client's record.

Practice Standards for Managing Client Information



Practice Standard #1: Collecting and Recording Client Information, continued

Practice Expectations, continued

13. The record may be created and maintained in a computer system if it has the following characteristics:
 - i. Provides a visual display of the recorded information.
 - ii. Provides a means of access to the record of each client by the client's full name and a unique identifier, and the record can be validated by confirming additional reliable key indicators such as date of birth.
 - iii. Provides a means to view and print recorded information promptly and in chronological order for each client.
 - iv. Allows more than one author or contributor to sign or attest.
 - v. Maintains an audit trail which
 - a. records the date and time of each entry of information for each client;
 - b. indicates the identity of the person who made the entry;
 - c. indicates any changes in the recorded information; and
 - d. preserves the original content of the recorded information when changed or updated.
 - vi. Provides reasonable protection against unauthorized access. All systems will have user ID and password protection with mechanisms to prevent unauthorized changes to documents (e.g., document locking, read-only access, firewalls, encryption, password).
 - vii. Automatically backs up files at reasonable intervals and allows the recovery of backed-up files or provides reasonable protection against loss of, damage to, and inaccessibility of information. A process is in place to reliably provide recorded information if due to unforeseen or scheduled downtimes of the system, the electronic record is not available.

Practice Standards for Managing Client Information

Additional Resources



College Resources	Links
<p data-bbox="208 505 413 539">COTBC Bylaws</p> <p data-bbox="305 562 892 628">Part 7: Registrant Management of Patient Records</p>	<p data-bbox="1020 505 1387 722">Office of the Information and Privacy Commissioner for British Columbia (OIPC)</p>
<p data-bbox="208 714 544 748">Essential Competencies</p> <p data-bbox="305 768 869 833">Unit 5: Communicates and Collaborates Effectively</p> <p data-bbox="305 896 734 931">Unit 7: Manages Own Practice</p>	
<p data-bbox="208 1011 502 1045">Advisory Statements</p> <p data-bbox="305 1065 564 1099">Use of Title (2018)</p>	

COTBC thanks the College of Occupational Therapists of Ontario for permission to adapt content from their *Standards for Record Keeping* (2008).