PRACTICE ADVICE

RECORDS AND SIGNING RECORDS

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RECORDS AND SIGNING RECORDS: CHARTING IN COMPLEX TIMES

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We want to help you understand and integrate charting and signing requirements for the patient record in an ever changing practice environment.

Please note:

Patient record, record and chart are synonymous terms.

The term "patient" is used to describe an individual who receives health care intervention from a speech language pathologist or audiologist and is synonymous with "client" or "student". The use of the term "Patient" mirrors the language used in the *Regulated Health Professions Act, 1991* and by the Ministry of Health and Long-Term Care.

For many of us, gone are the days of being the only speech language pathologist (SLP) or audiologist to work with a patient and having a paper record to chart our intervention. The work environment has changed considerably, we are now charting in multiple formats, including electronic; using support personnel; seeing patients in groups; or seeing patients with other regulated or unregulated professionals. How does this impact charting in the patient record?

It is worthwhile looking at the underlying principles and purposes of record keeping to help negotiate the different practice environments.

WHAT IS A RECORD AND WHAT IS ITS PURPOSE?

A patient record is the official record of events from the initial referral to your last contact with the patient. In other words, who did what, why, where, when and to whom. CASLPO's Proposed Records Regulation 2011 outlines what must be included in the record from the College's perspective.

The purpose of patient records is to protect the public by ensuring minimum standards are maintained and safe and ethical practice occurs across all service settings.

COLLEGE PRINCIPLES AND REQUIREMENTS

Following a principled approach to regulation and charting, all patient records, regardless of the environment, must be accessible, complete, correct and retained.

- Accessible: The entire patient record must be accessible for the patient, for any SLP or audiologist taking over the care of your patient and for the College in the event you are selected for peer assessment or are undergoing an investigation relating to a report or complaint. Different sections of the chart can reside in different places, for example, you may have financial computer software for billing purposes which is kept separately from your record of intervention, or you may chart electronically, but store those test forms you want to keep in hard copy. These practices are acceptable, as long as it is clear where each section of the chart resides and all sections are accessible.
- Complete: Refresh your memory regarding what must be included in the chart to make it complete by reviewing the Proposed Records Regulation 2011. Complete also includes being up to date.
- Correct: The expectation is that you will chart accurately at all times. However, if a mistake is made, or you are requested to change the record, follow the advice in these two Practice Advice articles: Changing the Record 2009, and Correcting Mistakes 2012.
- Retained: The Proposed Regulations includes the following requirements regarding record retention:

  > 8. (1) Financial and patient/client health records shall be retained following the patient's/client's last contact for the following periods of time:
  >
  > (a) For patients/clients who are 18 years of age or older at the time of the last contact: a period of at least 10 years.
  >
  > (b) For patients/clients who are less than 18 years of age at the time of the last contact: period of at least 10 years following the date at which they would have become 18 years of age.

MEMBER PRINCIPLES

From your perspective, the principles of charting include being a vehicle of reliable communication, demonstrating clinical judgement and accountability and risk management.

- Vehicle of reliable communication: When you are charting in the patient record, it is useful to ask yourself, "If I left my position tomorrow, would a colleague be able to pick up this patient record, know what the patient's goals are, what I have done, and why, how the patient has progressed, and what I plan to do next?" In other words, your patient record is a vehicle of reliable and complete communication.

  Should a patient have a question about a particular visit, or if another party, such as an Insurance Company, requested confirmation concerning visit dates, the information is accessible and reliable.
- Clinical judgement: As SLPs and audiologists, you use your knowledge, skill and clinical judgement at every stage of your intervention with patients. Charting your clinical impressions and assessment interpretations helps to formulate a plan of care to propose

to the patient and family. As you implement your plan of care, documentation of information used to inform your ongoing clinical judgement and conclusions shows that you make balanced and informed decisions based on all available evidence.

- Demonstrate accountability: Documenting in the patient record is the most effective method to demonstrate your accountability. As a clinician, you may do all the right things, however, without documentation it is difficult to show accountability for activities. For example, it shows that you have obtained consent for all phases of intervention and to collect, use and disclose personal health information. If you have had discussions with patients, families and other professionals or made referrals to other services, the date, discussion summary and rationale for referral are all accessible.

  If you supervise support personnel, your documentation shows that the patient consented to receive services from support personnel, that you developed the plan of care, regularly communicated with the support personnel and adjusted the therapy plan accordingly.

- Risk management: In this day and age it behooves us all to consider risk management. One of the best ways you can mitigate any risk regarding patient care and patient interactions is to document in the patient record. Also, there is potential risk of harm to the patient if there is missing documentation, and another member has to take over the patient's care.

FREQUENTLY ASKED QUESTIONS

Q: We have moved to electronic records, what are my requirements regarding my signature?

We are familiar with the concept of signing our name at the end of a chart note or a report to show that we are accountable for the information documented. Some members are uncomfortable that this is missing with electronic charting and have asked if they need to cut and paste a written signature. This is not necessary, with many electronic systems you need a password to access the patient record, and by virtue of this singular access, it is evident who made the entry. This is sufficient evidence that you are accountable for the information you documented in the patient record.

Q: In my role as a school board audiologist, I screen the hearing of all students in senior kindergarten. Do I have to create individual records for all of them, even the ones with no hearing issues?

No, you do not have to create an individual patient record for every child that passes your hearing screen. However, you are required to keep some documentation. Refer to the Proposed Records Regulation 2011 section on Group Screening (6.2 (b,c,d,e)). In this scenario, you must document the patient's name, the group to which they belong (senior kindergarten, Maple Street School) the date of the hearing screen and the results, even, if they are normal. You also need to document that you obtained consent to screen as set out in the Proposed Records Regulation and in Obtaining Consent for Services: A Guide for SLPs and Audiologists.

Some members keep separate sheets for each patient in one folder and others create a form that meets all of the requirements as stated above. Whatever you decide to use, the documentation must be retained according to the Proposed Records Regulation, 8.1.

Q: Do I need to include my full name and professional title when I make a chart entry?

A: The Proposed Records Regulation 2011 states the following:

> 6. (4) The member shall ensure that every entry in a patient/client health record is dated and includes the identity of the person who made or dictated the entry.

Your name (as provided to CASLPO) and professional title (identity) should be visible on the chart. On a paper chart this might be your first patient record entry, e.g., *Alexandra Carling-Rowland, Speech-Language Pathologist.* If the chart is electronic, the information must be included somewhere, so check with your IT department if you are unsure.

Each subsequent signature at the end of your chart note can be abbreviated, even to the extent of using initials, so long as there is a reference somewhere to indicate to whom the initials refer, e.g., *A.C-R, SLP*.

CASLPO has no specific requirements regarding the documentation of your academic credentials or your registration with the College. However, many members like to include this information, e.g., *A Carling-Rowland, Ph.D. SLP, Reg. CASLPO*

Q: There are occasions when I have to call a hearing aid manufacturer to ask a question about a patient's hearing aids or to discuss options for the repair of a patient's hearing aids. Do I need to document these types of communications?

A: Yes. Any and all communication that takes place with regard to one of your patients should be documented in that patient's record. As the Proposed Records Regulation states, Section 6(1)

> (b) the date and purpose of each professional contact with the patient/client, and whether the contact was made in person, telephone or electronically;

Q: When two professionals complete a joint assessment of a patient/client and they use an electronic charting system, who is responsible for documentation in the record?

A: The Proposed Records Regulation 2011 directs you to follow the regulation.

> 1. A member shall, when working with others, take all reasonable steps to ensure that records are made, used, maintained, retained and disclosed in accordance with this Regulation.

However, some of our intervention is interdisciplinary, and, at times, it makes sense to write one joint patient record entry. This is acceptable, as long as you take reasonable steps to ensure that the record is in accordance with the College's regulation. If you decide to document the joint assessment results there is no issue. If it makes sense for the dietitian or occupational therapist (OT), for example, to document the assessment, you should read

their entry to ensure that it is clear that you were part of the assessment, as well as the accuracy of the assessment results:

> 6. 1. (e) the nature and results of each assessment relating to the patient/client, each clinical finding and any recommendations made by the member;

You would then refer to the joint assessment documentation in your section of the patient record. This reference ensures that the patient record is complete and directs you to access the dietitian's or OT's documentation should a patient or third party request a copy of the patient record.

Q: I work with support personnel, am I required to co-sign all of their entries?

A: You are not required to co-sign every entry, as long as there is documentation to reflect that you assigned the activities to the support personnel and that you are maintaining appropriate supervision. Some members like to co-sign as evidence to show supervision. Refer to The Use of Support Personnel by Speech-Language Pathologists , Section C 1 (d), and The Use of Support Personnel by Audiologists, Section E(2)

The member also needs to ensure that there is a clear indication of:

- Who made the entry see Section 6(4) The member shall ensure that every entry in a patient/client health record is dated and includes the identity of the person who made or dictated the entry.
- Who provided the treatment see Section 6(1) (f) "(f) each treatment performed, and the identity of the person applying the treatment if the person applying the treatment was not the member

CASLPO HAS RESOURCES FOR YOU

Visit our website www.caslpo.com

- Proposed Records Regulation 2011
- Practice Advice Articles
- Documentation sections in Practice Standards and Guidelines
- Did You Know… Record Requirements 2013

PRACTICE ADVICE TEAM

Please contact one of us if you have any further questions.

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