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2. Hard wire connection (blue cable) is better than Wi-Fi
3. Check your speakers are firmly plugged in
4. If you have problems with sound, try going out of Adobe and re-entering

College of Audiologists and Speech Language Pathologists of Ontario

CASLPO e-Forum: Records

November 23rd 2016

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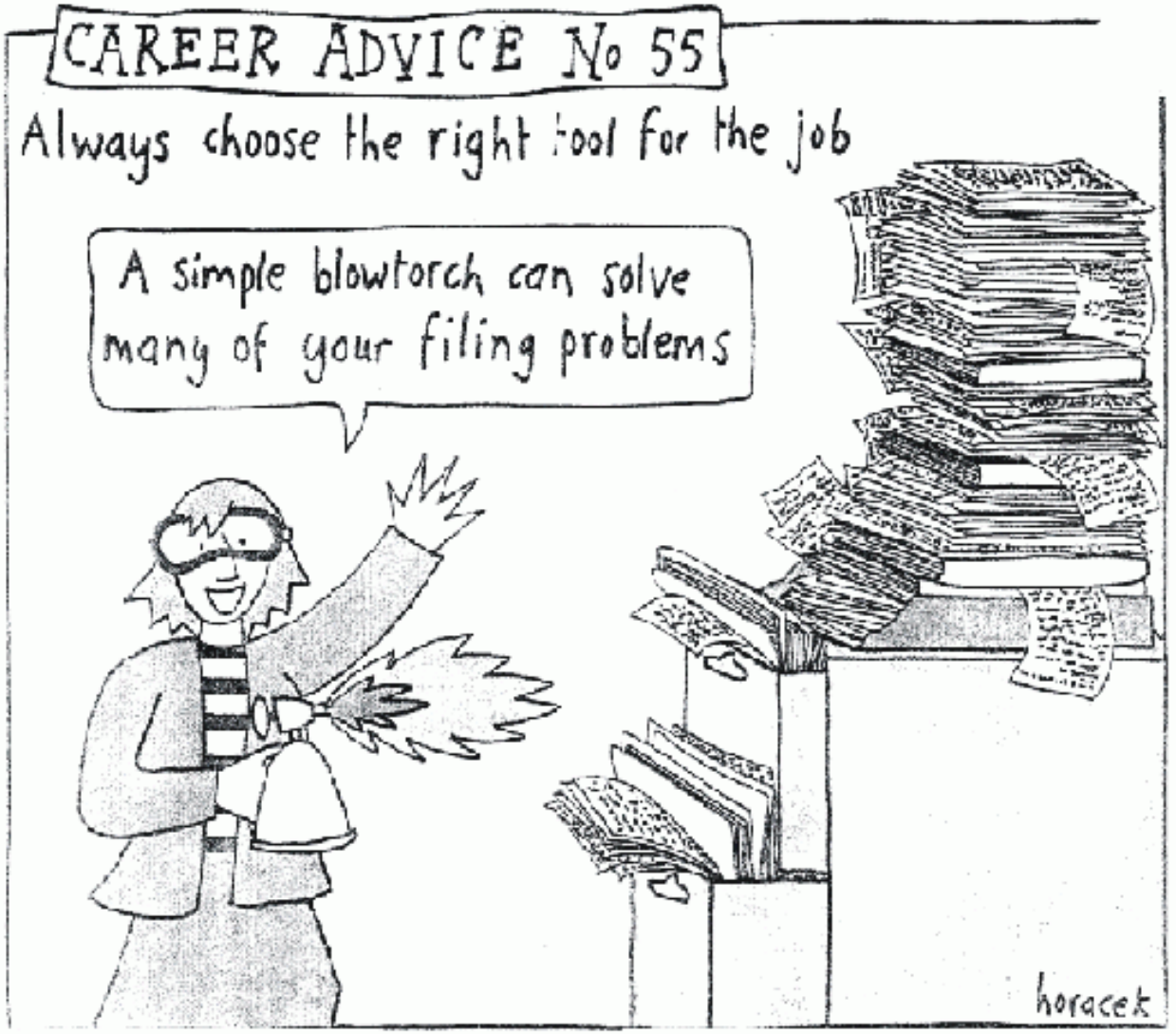
Agenda

- When do I need to create a patient record (chart)?
- What needs to be in the patient record?
- When don't I need a patient record?
- Are there different requirements for an electronic record?
- If I'm not keeping a record, do I need to document anything?

- The e-Forum recording and slides will be posted on the Events section of the website


CAREER ADVICE No 55
Always choose the right tool for the job
A simple blowtorch can solve many of your filing problems
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RECORDS

To understand and apply the regulation, examine the basics:

What is a Record and what is its purpose?

RECORDS

- Official record of events documenting your assessments, plans of care, interventions and clinical decisions and the patient's progress

i.e. who did what, why, where, when and to whom

RECORDS

Purpose is to protect the public by ensuring minimum standards and supporting safe and ethical practice across all service settings

CASLPO/Public

- Accessible
- Complete
- Correct
- Retained

Member

- Vehicle of reliable communication
- Clinical judgement
- Demonstrate accountability
- Risk management

- The principles and standards are the same for all types of patient records, electronic or paper

- When do I need to create a patient record?

A patient record is NOT required when:

- Providing general advice to family, friends, colleagues or the public about speech language pathology or audiology
- You are consulting to an education program and are providing training on general strategies
- You are consulting to an SLP or audiology colleague who is providing services to a patient

  The member provides information to a member of the College or a member of another College under the Regulated Health Professions Act, 1991 in the nature of a consultation.

  (Records Regulation 32.4.2)

A patient record IS required when:

- You are providing intervention to a patient including:
  - screening,
  - assessing
  - providing treatment

- You are required to obtain consent for SLP or audiology services

RECORDS

- The minimum standards for record keeping are in the Records Regulation
- You have the responsibility make, use, maintain, retain and disclose records in accordance with this Regulation
- However, the degree of responsibility varies with different clinical situations and whether you have control of the record

Records Regulation 2015

RECORDS

- We won't go through the entire regulation now, just those elements that have given rise to questions

Records Regulation

- Ensure that patient records are up to date
- When practising the profession in collaboration with any other person, take reasonable steps to ensure that the records are up to date
- Records must be legible and written in English or French

Records Regulation

Records Regulation outlines minimum standards for four types or record keeping:

- Screening Process
- All other forms of intervention
- Financial
- Equipment Service

Screening Process

What is screening?

Records Regulation: Definition of Screening

"screening process" means a process where a member applies certain measures that are designed to identify a patient who may have hearing, balance, communication, swallowing or other similar disorders, for the sole purpose of determining the patient's need for a speech-language pathology assessment, an audiological assessment or both.

Records Regulation: Definition of Screening

This does not include:

- Inadvertently noticing possible hearing, balance, communication, swallowing or similar disorder[s],

Or

- Considering information that is shared about an individual's possible hearing, balance, communication, swallowing or similar disorder[s], for the purpose of providing general educational information and/or recommending a referral for a speech-language pathology screening or assessment, an audiological screening or assessment, or both.

Records Regulation: Screening Process

The record keeping requirements for a screening process (individual or group) are less:

- The date, nature and result of every screening process performed by the member on the patient.
- Any action taken by the member as a result of the screening process.
- A record of every consent provided by the patient or by the patient's authorized representative.
- If the patient is part of a group screening process, the patient's name and a reference to the group with whom the patient is identified.

Record Requirements for all other intervention

Records Regulation

The Patient Record must contain:

- 2. The date and purpose of each professional contact with the patient and whether the contact was made in person, by telephone or electronically.

- 4. The patient's health history, including any educational, developmental or other relevant issues concerning the patient.

Records Regulation

- 5. The nature and, if known, the result of,

  i. each assessment relating to the patient,

  ii. each clinical finding relating to the patient,

  iii. any recommendation made by the member to the patient,

  iv. each treatment performed, and

  v. any advice given to the patient, including any pre-treatment or post-treatment advice, and the identity of the person who gave the advice if that person was not the member.

Records Regulation

- 6. The identity of the person who provided any service to the patient, if that person was not the member.

Records Regulation

- 9. Every controlled act, within the meaning of subsection 27 (2) of the *Regulated Health Professions Act, 1991*, performed by the member on the patient.

- 10. If a controlled act has been delegated to the member by a member of a regulated health profession, the name of the other member, the nature of the controlled act and whether the delegated act was performed on the patient.

Records Regulation

- 14. A record of every consent provided by the patient or by the patient's authorized representative.

Financial Record

Records Regulation: Financial Record

- Every member shall maintain a financial record for each patient that contains the following information regardless of whether the member bills the patient directly for professional products or services provided to the patient or bills a third party:

Records Regulation: Financial Records

- 1. The patient's name.
- 2. The member's name.
- 3. If the person who provided the professional product or service was not the member, the name of that person.
- 4. Each professional product or service provided to the patient and the date it was provided.
- 5. The fee charged or received that relates to each professional product or service provided to the patient.
- 6. The total fee charged or received for all of the professional products or services.
- 7. A record of the receipt given by or on behalf of the member, if available.

Equipment Service Record

Records Regulation: Equipment Record

Equipment service records

- 34. (1) Every member shall maintain an equipment service record that contains servicing information, including the date of every service, for any instrument or equipment that requires servicing and that is used by the member in the practice of the profession.

Records Retention

Records Regulation: Retention

- Every member shall retain a patient's health record (and equipment record) for at least 10 years following,
  - (a) the date of the member's last professional contact with the patient, if the patient was 18 years or older on that date; or
  - (b) the date that the patient became or would have become 18 years old, if the patient was younger than 18 years on the date of the member's last professional contact with the patient.

Scenarios

Scenario 1

- I work on acute care units of a busy hospital
- Does CASLPO requires me to write discharge reports on all of my patients?

Scenario 1

- Yes?
- No?
- Not sure?

Scenario 1

No

- The regulation does not require you to write ‘reports’, admission, progress or discharge
- You are required to document in the patient record all clinical findings, recommendations, treatments performed, referrals to other health professionals, and advice given to the patient
- If your place of work requires reports, then you are expected to provide them

Scenario 2

- I work on an interprofessional team at a children's treatment centre
- We do multidisciplinary assessments and take it in turns to complete the multidisciplinary report
- Do I have to write a separate SLP assessment report as well?

Scenario 2

- Yes?
- No?
- Not sure?

Scenario 2

No – but . . . .

- The team member documenting the assessment, which includes SLP information, must a be regulated Health Professional under the RHPA

  The member is not required to maintain a record if they are part of a multi-disciplinary team whose purpose is to provide a treatment plan, a report or ongoing services to a patient and the patient's health record is maintained by a person who is part of the team and who is a member of a College under the RHPA

Scenario 3

- I have a private practice providing services to children
- If I retire at 65, do I have to keep patient charts for 10 years after the children I see reach 18 years?
- That would mean I would be 87 years old before I can shred the patient record!

Scenario 3

- Yes?
- No?
- Not sure?

Scenario 3

Yes

- The patient record must be retained and accessible for 10 years after the child turns 18 years
- If you have a paper record you can scan the record and keep it electronically
- You can use a medical records storage company to keep the record

Scenario 3

Yes

If a member intends to close his or her practice, he or she shall do both of the following:

1. Take reasonable steps to give appropriate notice of the intended closure to each patient for whom the member has primary responsibility.

2. Ensure that each patient's health and financial records are,

    i. transferred to the member's successor or another member, if the patient so requests,

    ii. retained in a secure manner, or

    iii. disposed of in a secure manner, subject to the requirements to retain the records

Scenario 4

- I am consulting to a kindergarten class, I work with the teacher to provide general programing. I don’t see individual students for SLP intervention
- I understand that I don’t have to create patient records
- Does CASLPO have requirements for the documentation I keep about the class?

Scenario 4

- Yes?
- No?
- Not sure?

Scenario 4

No

- Your place of work may have a system or requirements to document what you did in the classroom.

Scenario 5

- I am an audiologist in a private clinic
- My receptionist does some very basic hearing aid trouble shooting
- Should she be documenting this in the patient's chart?

Scenario 5

- Yes?
- No?
- Not sure?

Scenario 5

Yes

The Records Regulation requires documentation regarding:

- 2. The date and purpose of each professional contact with the patient and whether the contact was made in person, by telephone or electronically.
- 6. The identity of the person who provided any service to the patient, if that person was not the member.

Scenario 5

Yes

- Your patient has come to your place of work regarding the function of their prescribed hearing aid, a healthcare service and professional contact
- You have trained your receptionist to try a few basic trouble shooting tasks regarding the hearing aid (checking batteries,
- This is considered a clinical task and should be documented

- Questions

Question

- What constitutes a late entry?
- What do you need to include in an entry when it's late?
- What to do if you realize that you missed an entry in your contact notes (for example you wrote a TX note then realized you forgot to chart that you had received a call from mom the previous day giving consent for you to work with a grandparent)?

- What constitutes a late entry?
- It depends on your work environment

- What do you need to include in an entry when it's late?
- You must acknowledge that the entry is late. Write the current date you are documenting and the date of the session you are referring to

- Document the missing information

- Call or email Practice Advice at CASLPO


obrigado
Dank U
Merci
mahalo
Köszi
спасибо
Grazie
Thank you
mauruuru
Takk
Gracias
Dziękuję
Děkuju
danke
Kiitos