Effective September 2015; Revised June 2022

Standard Area 4.0

Practice Management

4.3 Documentation and information Management

Standard

A **regulated member** of ACSLPA maintains clear, confidential, accurate, legible, **timely** and complete **records**, in compliance with legislation and regulatory requirements.

The fundamental expectation of documentation is that anyone reviewing a **client** record must be able to determine what care was provided, to whom it was provided, by whom and when the care was provided, why the care was provided, and any evaluation of the care that was provided.

Indicators

To demonstrate this standard, the regulated member will:

a) Maintain and disclose all documentation, correspondence, and records (e.g., paper based and electronic) in compliance with applicable legislation and regulatory requirements including confidentiality and privacy standards.
b) Document using language that is free of **bias** which might imply prejudicial beliefs or perpetuate assumptions regarding the individual(s) being written about.
c) Record events, decisions, outcomes, etc. in chronological order.
d) Include in the record:
    i. Name and professional designation of the person documenting the information.
    ii. Name and professional designation of the person taking professional responsibility for the work
    (if not the person who created the record).
    iii. Names and titles of assisting professional service providers and assisting unregulated **support personnel.**
    iv. First and last name of the client that the record pertains to, and a tracking number (if one is used). Client identification in the form of either a name or a tracking number should be included on each page of the record.
    v. Date that procedures and records were completed.
    vi. Time that procedures were completed, if clinically relevant.
    vii. Notation of any change in therapist or support personnel.
    viii. Notation of chart closure.
    ix. Evidence of **informed consent**, whether that be a signed consent form or documentation of a conversation with the client regarding consent, and the resulting outcome.

continued on next page ...

continued from previous page ...

e) Include as part of documentation requirements:
   i. Relevant case history information, including health, family, and social history.
   ii. Presenting concern.
   iii. Dates and entries related to any communication to or with the client, family and/or decision-makers, including missed or cancelled appointments, telephone, or electronic contact.
   iv. Notation of any **adverse or unusual events** during the course of assessment or intervention.
   v. **Assessment** findings (including screenings).
   vi. Plan of care outlining **intervention** goals and strategies.
   vii. Communications with referring providers and/or care partners.
   viii. Response to interventions and progress toward achieving goals documented in the plan of care.
   ix. Recommendations.
   x. Transition/discharge plans, including the reason for discharge.
   xi. Referrals to other professionals, reports and correspondence from other professionals, equipment, and other services provided.
f) Include sufficient detail in the record to allow the client to be managed by another speech-language pathologist or audiologist.
g) For late entries, will include the current date and time, a notation that the entry is late, and the date and time of the events described in the late entry. Appropriate features of the electronic documentation system will be used, as required, to make corrections or late entries. In some situations, this may mean providing an additional entry that is dated for the day the correction is made, indicating which section of the record is being revised and why.
h) Ensure that the software used for electronic documentation leaves an audit trail that can reveal who accessed the record, what changes were made, when, and by whom.
i) Ensure that any abbreviations and acronyms used are written out in full, with the abbreviation in brackets the first time it is stated in any continuous document entry (i.e., a formal report would constitute one continuous document entry, as would daily chart notes). Subsequent use of the abbreviation in the continuous document is acceptable.
j) Ensure that all correspondence (e.g., electronic communication, social media) and documentation is professionally written in compliance with applicable legislation and regulatory requirements.
k) Avoid using social media as a means for communicating directly with clients due to privacy and confidentiality reasons.
l) Secure all personal and health information contained in paper or electronic records, during use, while in storage or during transfer, through the appropriate use of administrative, physical, and technical mechanisms (e.g., passwords, encryption, locked file cabinets, etc.) to protect the privacy of client information.
m) Ensure the back-up of electronic records to ensure continuity of care in the event records are compromised.
n) Access and disclose information only as needed and in compliance with relevant legislation.
o) Make a reasonable effort to confirm that all professional correspondence is sent to the intended recipient.
p) Retain or ensure access to copies of care pathways or protocols in addition to client records in circumstances where client care delivery and documentation is according to a protocol, or where charting by exception is employed.

continued on next page ...

continued from previous page ...

q) Maintain complete and accurate financial records for services rendered or products sold when working in private practice or non-publicly funded settings.
Financial records must include:
   i. Client name or identifier.
   ii. Name and credentials of the professional, including the practice permit number.
   iii. Date(s) on which the service was provided.
   iv. Nature of the service provided (e.g., assessment, treatment, intervention, etc.).
   v. Length of time required to provide the service.
   vi. The actual fee charged and method of payment.
   vii. Date payment was received and identity of the payer.
   viii. Any balance owing.

r) Amend records according to requirements outlined in the applicable privacy legislation.
   i. If a correction is required, a separate notation in the record is made and the initial entry is left intact.

s) Retain records according to the length of time specified by applicable legislation and regulatory requirements:
   - Adult records are retained for 11 years and 3 months since the date of last service.
   - Records for "**persons under disability**" are retained for three years and three months after the individual's death.
   - Records for minors are retained for 11 years and 3 months after the client turns 18.
   - Equipment service records should be maintained for 10 years from the date of the last entry.
   - The retention period for financial records required to determine tax obligations and entitlements as per the Canada Revenue Agency is six years.

t) Retain records in a manner that allows the record to be retrieved and copied upon request, regardless of the medium used to create the record.

u) Provide a copy of the complete clinical and financial record to the client or their authorized representative upon request and appropriate consent.

v) Take action to prevent abandonment of records (e.g., when closing a practice).

w) Dispose of records in a manner that maintains security and confidentiality of personal information.

x) Maintain a log of destroyed files (either paper or electronic), which is kept indefinitely, that includes the following information:
   i. Name of each client
   ii. File number (if available)
   iii. Last date of treatment
   iv. Date that the record or file was destroyed.

y) Be aware and inform employers, support personnel, and others of their professional obligations regarding documentation and record keeping.

Expected Outcomes

Clients can expect that their speech-language pathology and/or audiology records are clear, confidential, accurate, legible, complete and comply with applicable legislation and regulatory requirements.

glossary on next page ...

Glossary

Adverse event	refers to "an event that results in physical and/or psychological harm to the client and is related to the care and/or services provided to the client, rather than to the client's underlying medical condition."
Assessment	refers to "the rehabilitation process for gathering in-depth information to identify the individual's strengths and needs related to body function, body structure, activity and participation, tounderstand the individual's goals and then to determine appropriate services and interventions based on these. It is initiated when there are questions about a client's needs and how best to meet these needs. It includes both formal and informal measures ranging from administering standardized assessment tools to observing a client in a specific setting or listening to family concerns."
Bias	refers to 'an implied or irrelevant evaluation of (an) individuals(s) which might imply prejudicial beliefs or perpetuate biased assumptions.
Client	refers to "a recipient of speech-language pathology or audiology services, and may be an individual, family, group, community or population. An individual client may also be referred to as a patient."
Informed consent	refers to when "a client gives consent to receive a proposed service following a process of decision-making leading to an informed choice. Valid consent may be either verbal or written unless otherwise required by institutional or provincial/territorial regulation. The client is provided withsufficient information, including the benefits and risks, and the possible alternatives to the proposed service, and the client understands this information. The client can withdraw informed consent at any time."
Intervention/ intervention strategy	refers to "an activity or set of activities aimed at modifying a process, course of action or sequence of events in order to change one or several of their characteristics, such as performance or expected outcome." In speech-language pathology and audiology, intervention is a term used to describe the various services provided to clients, including but not limited to individual and group treatment, counselling, home programming, caregiver training, devices, discharge planning, etc."
Professional services	refer to "all actions and activities of a regulated member in the context of professional practice".
Record	refers to "information in any form or medium, including notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers and papers and any other information that is written, photographed, recorded or stored in any manner".
Regulated member	refers to "an individual who is registered with ACSLPA in any of the regulated categories of membership prescribed by *ACSLPA Bylaws*, the *Health Professions Act* and our Regulations."
Support personnel	refers to "individuals who, following academic and/or on-the-job training, perform activities that are assigned and supervised by a speech-language pathologist or audiologist registered with ACSLPA. Individuals functioning as support personnel may have a variety of working titles. This excludes teachers, volunteers, students training in speech-language pathology and audiology, and family members."
Timely	refers to "coming early or at the right time; appropriate or adapted to the times of the occasion".