

Record Keeping and Documentation Policy

Purpose

This policy outlines the standards for occupational therapy (OT) record keeping and documentation in accordance with the **Regulated Health Professions Act**, the **Personal Health Information Protection Act, 2004 (PHIPA)**, and the **College of Occupational Therapists of Ontario (COTO) Standards of Practice**. Accurate, timely, and secure documentation supports high-quality care, continuity of services, and legal and professional accountability.

Scope

This policy applies to all occupational therapists, assistants, students, and administrative staff involved in creating, managing, or storing client records for pediatric occupational therapy services, including in-person and virtual care.

Definitions

- **Health Record / OT Record:** The complete clinical record containing documentation related to occupational therapy services provided to a client.
 - **Personal Health Information (PHI):** As defined under PHIPA.
 - **Health Information Custodian (HIC):** The clinic or practice that has custody and control of OT records.
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1. Content of Occupational Therapy Records

OT records must be accurate, objective, legible, and sufficient to support clinical decision-making and continuity of care. At a minimum, records must include the following:

1.1 Client Identification and Administrative Information

- Client's full name and date of birth
- Parent(s)/guardian(s) or substitute decision-maker information
- Referral source and reason for referral

- Consent documentation
- Relevant demographic and contact information

1.2 Assessment Documentation

Assessment records must include:

- Occupational profile and relevant background information
- Assessment methods and tools used
- Clinical observations and findings
- Interpretation and clinical reasoning
- Identified strengths, needs, and priorities
- Assessment results and conclusions
- Recommendations and plan of care

1.3 Progress and Ongoing Intervention Notes

Progress documentation must:

- Describe services provided, including date, duration, and type of intervention
- Reflect measurable goals and progress toward outcomes
- Include the child's response to intervention and caregiver involvement
- Document modifications to goals or treatment plans
- Record communications with caregivers and other professionals, as relevant

1.4 Discharge and Transition Documentation

Discharge records must include:

- Reason for discharge (e.g., goals met, services declined, transition to other services)
 - Summary of progress and outcomes
 - Recommendations for follow-up, home programs, or referrals
 - Date of discharge and clinician signature
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2. Timelines for Documentation (Pediatric Population)

Timely documentation is essential in pediatric practice due to developmental changes, caregiver involvement, and coordination with multiple service providers.

2.1 Assessment Documentation

- Initial assessment documentation should be completed **as soon as reasonably possible** following the assessment and **no later than 7 calendar days** after the assessment date.

2.2 Progress Notes

- Intervention notes must be completed **on the same day as the service** or **within 48 hours** of service delivery.
- Progress summaries should be completed at clinically appropriate intervals, and at minimum every **3–6 months**, or sooner if there is a significant change in the child's status or plan of care.

2.3 Discharge Documentation

- Discharge summaries should be completed **within 7 calendar days** of discharge or service termination.

All documentation must be dated and include the name and designation of the occupational therapist.

3. Storage, Retention, and Destruction of Records

3.1 Storage

- Records may be stored in secure electronic or paper formats.
- Access to records is restricted to authorized personnel only.
- Electronic records must be password-protected and stored on secure, encrypted systems.
- Paper records must be stored in locked filing cabinets in secure areas.

3.2 Retention

Records are retained in accordance with COTO requirements and applicable legislation:

- Pediatric client records must be retained for **at least 10 years after the last date of service OR 10 years after the client reaches 18 years of age**, whichever is later.
- Records involved in ongoing or reasonably anticipated legal proceedings must not be destroyed until the matter is resolved.

3.3 Destruction

- Records are destroyed in a secure and confidential manner once retention requirements are met.
 - Paper records are shredded using secure destruction methods.
 - Electronic records are permanently deleted or rendered irretrievable.
 - A record of destruction (date, method, and type of records destroyed) is maintained.
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4. Ownership of Records

- Occupational therapy records are the property of the **Health Information Custodian** (the clinic or practice).
 - Clients and substitute decision-makers have the right to **access and request copies** of their records in accordance with PHIPA.
 - Original records are not released, except as required by law.
 - Therapists leaving the practice must ensure continuity of custody and control of records in accordance with professional obligations.
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5. Responsibilities

- **Occupational Therapists:** Ensure accurate, timely, and compliant documentation.
 - **Administrative Staff:** Support secure storage, retrieval, and release of records.
 - **Health Information Custodian:** Ensures compliance with legislative and COTO requirements.
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6. Policy Review

This policy is reviewed regularly and updated to reflect changes in legislation, COTO standards, or organizational practices.