COLLEGE OF DIETITIANS OF BRITISH COLUMBIA

Standards for Record Keeping

Introduction

In accordance with section 73 of the CDBC bylaws, registrants must keep records for clients to whom they provide dietetic services.

Record keeping is integral to safe, effective and competent dietetic services. It provides a means to demonstrate how Registered Dietitians (RDs) exercise their critical thinking and professional judgement in an evidence-based, accountable and client-centered manner. Record keeping provides a clear picture of the dietetic services provided.

Approaching record keeping in an organized and systematic way supports individual RD understanding and recall, collaborative practice and communication with other health providers and compliance with relevant legislation, including protecting the privacy and confidentiality of personal health information.

The Standards for Record Keeping can be used for a number of purposes including to:

- Support RDs in minimizing risk of practice errors and omissions
- Promote continuity of care in interprofessional work settings
- Promote client-centered care and prevent client prejudice (not respecting client rights and interests)
- Fulfill the College's regulatory mandate of public protection
- Inform the public, employers, other health care providers and College members about the minimum expectations that RDs must meet in their dietetic practice when keeping records
- Provide performance assessment criteria regarding record keeping for the College's Quality Assurance Program
- Guide the CDBC Inquiry and Discipline Committees' decision-making in record keeping matters related to professional conduct and competence
- Support compliance with the required behaviours and performance expectations of RDs surrounding record keeping when practicing dietetics in British Columbia

The Standards for Record Keeping include the required elements and performance expectations that dietitians must achieve when maintaining records in dietetic practice.

Much of the Standards for Record Keeping relate to individual client health records. However, many of the overarching principles within the standards also apply to other types of records found in work settings such as public health, food service management, private practice, nutrition research and food and pharmaceutical industries, etc.

Each area of dietetic practice has its own unique characteristics. As such, the performance expectations articulated in these standards may not all apply to every area of dietetic practice; their application will depend on client factors and the dietetic practice setting. In addition to complying with the Standards for Record Keeping, dietitians are expected to follow workplace policies and procedures.

The College of Dietitians of British Columbia thanks the College of Dietitians of Ontario for their generous permission to quote and adapt, in whole or in part, from their "Professional Practice Standards for Record Keeping" publication.

STANDARDS FOR RECORD KEEPING

1. Dietitians ensure their documentation is accurate, comprehensive, objective, and reflective of the services provided. A dietitian demonstrates the standard by ensuring the documentation:

a) Is legible in either written or electronic format.

b) Includes language, terms and abbreviations that are acceptable to the area of practice and facility in which they practice.

c) Avoids statements that are false, misleading or unprofessional.

d) Addresses any potential, real or perceived conflict of interest and how it was managed (Conflict of Interest and Sales Policy).

2. Dietitians document in a systematic and timely manner. A dietitian demonstrates the standard by ensuring the documentation:

a) Is completed by the RD, except during shared appointments whereby another provider documents dietitian services that were provided which are then verified and signed by the RD.

b) Is completed diligently, at the earliest possible opportunity following the client interaction/dietetic services to prevent any delay in care or service.

c) Includes the date the entry was made and the date that the interaction/dietetic services occurred, if documentation occurs after the date of interaction/service.

d) Is chronological.

e) Is organized to facilitate timely retrieval and use of the information.

3. Dietitians ensure a comprehensive client health record is maintained when individual nutrition assessments and interventions are provided. A dietitian demonstrates the standard by ensuring an individual client health record, in its entirety, includes:

a) The client's full name and address or unique identifier linking the record to the client, as applicable.

b) The date of each of the client's visits.

c) The name of the client's primary care provider, as applicable.

d) The name of any referring health professional, as applicable.

e) The reason for the client's referral, as applicable.

f) The client's relevant medical history and social data related to the nutrition intervention.

g) Consent, or refusal/withdrawal of such consent to care or service, from the client/substitute-decision maker obtained for nutrition assessment, treatment and/or the collection, use and disclosure of personal health information (Consent to Nutrition Care Policy, Guideline).

h) If the client is a minor, consent is obtained in accordance with Part 2 of the *Infants Act*.

i) The assessment conducted, including the tools used (e.g., swallowing assessment) and performance of restricted activities under the scope of dietetic practice or through medical directives/delegation (e.g., tube feeding insertions).

j) The assessment findings obtained, the issues identified (i.e. nutrition problem/ nutrition diagnosis), the goals for nutrition intervention and the nutrition care plan.

k) The recommendations or orders made by the RD (including via medical directives as per facility requirements) for diet orders, nutrition supplements, tests and consultations requested to be performed by any other person.

l) Progress notes containing a record of services rendered and any significant findings including those resulting in changes to the nutrition care plan.

m) Reports received in respect of the client's health.

n) Particulars about discharge planning, including the referral of the client to another health professional, as applicable.

o) Particulars of nutrition care that was commenced but not completed, including reasons for non-completion.

p) A summary (or copies, as applicable) of any telephone, email, text, other online or written communication with the client.

q) A summary (reference or copies, as applicable) of any educational resources provided to the client.

r) Any relevant coordination of care and services to enable client-centered care.

s) Any reason a client may give for cancelling or not showing up for an appointment, or refusing the service of a member, as applicable.

t) Copies of reports issued to other sources.

u) The RD who made the entries is clearly identified using their practice name and title as indicated in the College's Public Register and the CDBC registration number if required by the RD's workplace.

4. Dietitians maintain financial records whenever billing occurs in dietetic practice. A dietitian demonstrates the standard by ensuring:

a) Receipts are issued for dietetic services and/or products sold to clients, either directly or indirectly through a third party.

b) Records of receipts issued and payments received are documented in either the client health record, the RD's accounting records or both (as applicable).

c) Records are not false and misleading.

d) A system is in place for the secure retention of financial records.

5. Dietitians ensure reasonable measures are in place to maintain the security of client health records. A dietitian demonstrates the standard by ensuring the following:

a) Entries are permanent and authentic.

b) Systems are in place to ensure that content is not lost/deleted.

c) Additions or corrections to an RD's documentation preserve the original content.

d) In interprofessional settings, an audit trail of persons entering information can be created.

e) There is no separate parallel client record (ghost chart) kept by the RD.

f) Collection, use, storage, disclosure, transmission and disposal of personal health information maintains the client's privacy and confidentiality (e.g. through the use of physical controls, passwords and/or encryption, as applicable).

g) RDs follow privacy legislation (Privacy Guide, PIPA and FOIPPA).

h) A system is in place for the secure retention of client health records:

   a. According to the *Limitation Act*, hospital medical records must be retained for a minimum period of sixteen (16) years from either the date of the last entry or from the age of majority, whichever is later, except as otherwise required by law (Limitation Act).

   b. According to section 35 of the *Personal Information Protection Act* (e.g., private practice), information used to make a decision that directly affects the individual must be kept at least one (1) year after using the information (PIPA).

   c. According to section 92 of the *Residential Care Regulation (Community Care and Assisted Living)*, resident health records have to be kept a minimum of two (2) years after discharge (Residential Care Regulation).

i) A system is in place to ensure client access to health records (PIPA, FOIPPA, Clinical Record Documentation and Guide to BC PIPA)

Examples of Records Maintained by RDs

Clinical Nutrition
- Nutritional assessment forms
- Progress notes (e.g., ADIME, SOAP)
- Nutrition care plans
- Enteral/ parenteral nutrition forms

Public Health
- Needs assessment survey
- Consultation and progress notes
- Statistical analyses and reports
- Impact study report and policies

Food Service Management
- Safety and risk audit forms and reports
- Personnel hiring and appraisal forms
- Satisfaction surveys
- Emergency policies and procedures

Food and Pharmaceutical Industry
- Food testing report
- Statistical analyses and report
- Clinical trial documents and results
- Journal publications

Definitions

- Clinical Client Record: Documentation created or gathered that provides information regarding the health care that was provided to an individual by a Registered Dietitian and others, as applicable.
- Non-clinical Record: Documentation created or gathered that provides information regarding the services provided to individuals, groups or a facility in a non-clinical work environment, by a Registered Dietitian and others, as applicable.
- Documentation: Information in electronic or paper format that provides evidence of the actions, events, facts, thought processes, and/or decisions within dietetic practice.