College of
Occupational Therapists
of British Columbia

COTBC Practice Standards for Managing Client Information

Overview

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Note to Readers

Throughout these practice standards, reference is made to the following support documents. Please check that you have the most recent versions, and if necessary, download these from the College website or contact the College for updates.

Association of Canadian Occupational Therapy Regulatory Organizations. (2011). *Essential competencies of practice for occupational therapists in Canada* (3rd ed.). Retrieved from http://www.cotbc.org/PDFs/EssentialCompetenies3rdEd_WebVersion.aspx

College of Occupational Therapists of British Columbia. (2017, October 2). *College of Occupational Therapists of British Columbia Bylaws.* Retrieved from https://cotbc.org/wp-content/uploads/JustBylaws-NoFormsQuickPosting-10.20.2017.pdf

To ensure timeliness and accuracy, updates to practice standards will be made when necessary. Suggestions and questions regarding the content or application to practice should be forwarded to:

info@cotbc.org

Tel: 250-386-6822 or toll-free in BC 866-386-6822

Practice standards in this series: *Managing Client Information* (2014)

1. Collecting and Recording Client Information
2. Protecting Client Information (Privacy and Security)
3. Client Access to the Occupational Therapy Record
4. Disclosing the Occupational Therapy Record
5. Records Respecting Financial Matters
6. Retention and Destruction of the Occupational Therapy Record

Preamble

In the *Health Professions Act* (RSBC 1996, c. 183), the Occupational Therapists Regulation acknowledges occupational therapists as autonomous professionals. The College of Occupational Therapists of British Columbia (COTBC) regulates the practice of British Columbia occupational therapists "to serve and protect the public."

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COTBC practice standards are published by the College to assist the occupational therapist in meeting the *Essential Competencies of Practice in Canada* (3rd ed.) by

- defining registrant responsibilities;
- describing minimal expectations for occupational therapy practice; and
- defining safe, ethical, and competent occupational therapy practice.

Preamble

The COTBC *Practice Standards for Managing Client Information* replace a prior document, *Practice Guideline: Collecting, Recording and Protecting Client Information* (March 2006).

These practice standards were developed by occupational therapists in British Columbia who work in a variety of practice settings and serve on the COTBC Standards Committee. The committee reviewed the previous guideline as well as parallel documents from Canadian occupational therapy and health regulatory organizations, and considered practice questions, issues, and concerns presented by registrants and others.

These practice standards include information contained in federal and provincial legislation. Cross-referencing to other COTBC documents and to provincial and federal legislation appears throughout.

A draft of these practice standards was reviewed by the College's legal counsel, Lovett & Westmacott. The final document was approved by the COTBC Board in June 2014.

The College Bylaws cite other relevant legislation that affects your collection, recording, protection, access, disclosure, retention, and destruction of client-related documentation.
Review Part 7: Registrant Management of Patient Records.

Statement of Purpose

These practice standards clarify the occupational therapist's accountability and the College's expectations respecting the occupational therapist's management of client information. They are designed to assist the occupational therapist to identify and reduce the risks inherent in managing client information, thereby protecting clients from harm.

Managing client information requires compliance with legislation and the legal requirements as set out in the COTBC Bylaws. The College's focus is on the quality and content of the information contained in the occupational therapy record, as well as on how the occupational therapist collects, records, protects, and ensures access to client information. The College acknowledges that different occupational therapists perform these tasks in different ways within different practice contexts and settings.

Managing client information is important because of the many ways in which the occupational therapy record is used. It is a legal document and source of evidence that can demonstrate compliance with the standards of the profession as well as with other standards, laws, and ethical considerations.

Statement of Purpose

The occupational therapy record:

Describes the occupational therapy process

Because the occupational therapist collects and records client information to plan, implement, and carry out a systematic, client-centred care plan, the occupational therapy process must be reflected in the occupational therapy record. Collecting, recording, protecting, and ensuring access to client information can allow the occupational therapist to demonstrate that safe, ethical, and competent care was delivered to the client. The record can also make explicit the therapist's critical thinking, reasoning, and decision-making.

Facilitates client participation

The client can expect involvement in collecting and recording information that becomes part of the occupational therapy record, and can be assured that the privacy of client information is maintained in accordance with all applicable legislation. The client's right to access current, legible, accurate, and complete records of occupational therapy services within statutory limits will be facilitated. The occupational therapy record will be retained and when no longer required, will be properly destroyed. The management of client information also aids the occupational therapist to communicate effectively with the client, the primary caregivers, and the family.

Advances quality occupational therapy services

The management of client information aids the occupational therapist to communicate effectively with other health professionals involved in the care of the client. Client information may be used to advance the profession's evidence and knowledge base through education and research activities. It can also be used by administrators, planners, and the College for decision-making, quality improvement activities, and reflection on practice.

Definitions

Attest/Attestation The process of assigning responsibility and authorship for an activity, usually by applying a signature. (COTO, 2008)

Care pathway/Clinical pathway/Care protocol An outline of anticipated care with time frames to address how a client's conditions or symptoms will be addressed from initial contact to anticipated outcome.

Client An individual, family, group, community, organization, or population who participates in occupational therapy services by direct referral or contract, or by other service and funding arrangements with a team, group, or agency whose work includes occupational therapy. Client is synonymous with patient or consumer and means a recipient of occupational therapy services. (Townsend & Polatajko, 2007)

Client information All personal information about a client as defined in the *Freedom of Information and Protection of Privacy Act* (FOIPPA) and Personal Information Protection Act (PIPA).

Client representative In most cases, a family member or partner. He or she may also be considered a substitute decision maker. This individual may be selected by the client or appointed by the court or Public Guardian and Trustee of British Columbia, and in this case is considered an authorized client representative.

Definitions

Confidentiality The ethical and professional obligation not to disclose personal information without the consent of the person whom the information is about.

Electronic health record (EHR) A computer-based electronic file that resides in a system specifically designed to support users by providing accessibility to complete and accurate health data, alerts, reminders, clinical decision support systems, links to medical knowledge, and other aids. (Canadian Health Information Management Association, n.d.a)

Electronic signature A signature or attestation applied by electronic means. (COTO, 2008)

Encryption The process of transforming information to make it unreadable to anyone except those possessing a password or key.

Health record A compilation of pertinent facts of an individual's health history, including all past and present medical conditions, illnesses, and treatments, with emphasis on the specific events affecting the client during the current episode of care. The information documented in the health record is created by all health care professionals providing the care. (Canadian Health Information Management Association, n.d.b)

Definitions

Locked document A document may be "locked for editing" or "read only," which means that the author or system administrator has disabled the means to edit the document in electronic form.

Managing client information The process by which the occupational therapist collects, records, uses, stores, and discloses the personal information of the client.

Occupational therapy record A compilation or any written or computerized text information and audiovisual media generated by the occupational therapist or individuals supervised by him or her, and that relate to the occupational therapy services provided to the client. It may also include appointment recording, equipment administration, and financial records pertinent to the individual client. An occupational therapy record may be part of an overall health record.

Occupational therapy service Direct care, research, education, consultation, or administration.

Personal information Anything collected about the client for the purpose of the occupational therapy record.

Definitions

Practice/Service The overall organizational and specific goal-directed tasks for the provision of activities to the client, including direct client care, research, consultation, education, or administration.

Privacy The ethical and professional obligation to ensure that personal information is secure from unauthorized access, use, and disclosure.

Record Includes books, documents, maps, drawings, photographs, letters, vouchers, papers, and any other thing on which information is recorded or stored by graphic, electronic, mechanical, or other means, but does not include a computer program or any other mechanism that produces records. (*Freedom of Information and Protection of Privacy Act*, Schedule 1, 1996)

Security The administrative, physical, and technological safeguards in place to prevent accidental or intentional disclosure by inappropriate access or by unauthorized individuals. It also includes the mechanisms in place to protect the information from alteration, destruction, or loss. (COTO, 2008)

Definitions

Sign/Signature The occupational therapist's signature or attestation, including an electronic signature as long as the occupational therapist takes reasonable steps to manage the process by which it is affixed. (COTO, 2008)

Stakeholder Someone who has a valid interest in the outcome of a decision involving the client. Examples of stakeholders include family members, other health care team members, physicians, insurance companies, legal representatives, and third-party payers. (COTO, 2008)

Unique identifier A number assigned to a case file to identify a unique individual and to distinguish him or her from others. (COTO, 2008)

References Used in These Practice Standards

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Freedom of Information and Protection of Privacy Act (FOIPPA), Revised Statues of British Columbia (1996). Retrieved from the BC Laws website: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96165_00

Health and Safety Executive. (1999). *Five steps to risk assessment.* Caerphilly, UK: Author.

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Office of the Information and Privacy Commissioner for British Columbia. Retrieved from https://www.oipc.bc.ca/

Personal Information Protection Act (PIPA), Statues of British Columbia (2003). Retrieved from the BC Laws website:http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_03063_01

Personal Information Protection and Electronic Documents Act (PIPEDA), Statues of Canada (2000). Retrieved from the Department of Justice website: http://laws-lois.justice.gc.ca/eng/acts/P-8.6/

Privacy Act, Revised Statues of Canada (1985). Retrieved from the Department of Justice website: http://laws-lois.justice.gc.ca/eng/acts/p-21/

Townsend, E. and Polatajko, H. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being and justice through occupation.* Ottawa, ON: CAOT Publications ACE.

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COTBC Practice Standards for
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Practice Standard #1: Collecting and Recording Client Information

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Practice Standard #1: Collecting and Recording Client Information

The occupational therapist will ensure that an accurate record of occupational therapy services is created and includes receipt of referral, informed client consent, assessment, intervention, discharge, and follow up.

Practice Expectations

The occupational therapist will ensure that the following information is collected and is part of the occupational therapy record:

1. Contact information for the source of the client's referral, including self-referral.
2. Reason for the referral.
3. Confirmation that client consent was obtained.
4. Confirmation of the accuracy and currency of the information provided about the client on the referral.
5. Client's full name, address, date of birth, and unique identifier (if applicable).
6. Client information that is necessary and pertinent to the purpose of the occupational therapy assessment and intervention.

Practice Standard #1: Collecting and Recording Client Information, continued

The occupational therapist is responsible for the content of the client record related to occupational therapy services and will ensure that the content accurately reflects the occupational therapy services provided.

Practice Expectations

The occupational therapist will include the following information on the client record:

1. Consent as obtained, dated, and maintained.
2. Occupational therapy assessments including the assessment procedures, results obtained, and conclusion or professional opinion regarding the client's status.
3. Documentation of the occupational therapy intervention plan, formulated in collaboration with the client.
4. Clear reference to any specific care pathway or similar assessment and intervention plan.
5. Progress notes indicating the outcome of an intervention, changes in the client's condition, problem formulation, or the intervention plan and goals.
6. Name, designation, and supervision plan when the occupational therapist assigns a component of the intervention plan (e.g., to students or support personnel)
7. Cancelled or missed appointments.
8. Discharge information, which may include the client's status at discharge, reason for discharge, summary of outcome attained, recommendations such as home program, referral, and an explanatory note when interventions initiated were not completed.

Practice Standard #1: Collecting and Recording Client Information, continued

The occupational therapist will ensure that records are legible, understandable, complete, and prepared and maintained in a timely and systematic manner.

Practice Expectations

The occupational therapist will ensure the following:

1. Records are organized in a logical and systematic fashion to facilitate retrieval and information use.
2. Documentation is completed in a timely manner appropriate to the client and clinical situation.
3. All documents identify the client and the client's unique identifier, such as date of birth, record number, or claim number. It must be possible to identify the client in any part of the record.
4. The date of each professional encounter of any kind with the client, regardless of the medium (email, fax, telephone, or in person), is recorded.
5. If email has been used by the occupational therapist to make decisions, sufficient detail is documented and retained as part of the record (electronic or paper). This may include the need to print or scan a document to have it preserved.
6. The date of the receipt and disclosure of client information is recorded.

Practice Standard #1: Collecting and Recording Client Information, continued

Practice Expectations, continued

7. Abbreviations, acronyms, and diagrams used in the client record have a supporting reference available for those who access the records, to ensure consistency of interpretation.

8. Every entry is dated and signed and includes the name of the person who made the entry. The signature includes the occupational therapist's full name and designation. Electronic signatures are protected and linked to a user ID and password.

9. The occupational therapist who contributes to a combined disciplinary notes or reports, identifies the portion of the note or report for which he or she is responsible and accountable.

10. When two occupational therapists contribute to the same record, the signature of each is included. The record clearly indicates the author of each entry and who provided the services.

11. Copies of a record distributed without an original signature by the occupational therapist clearly indicate where the original signed record is located.

12. Drafts of documents if kept are retained as part of the record and released upon request. Draft notes may be destroyed if not needed, but if they exist at the time that access is sought to the record, they are considered a legal part of the client's record.

Practice Standard #1: Collecting and Recording Client Information, continued

Practice Expectations, continued

13. The record may be created and maintained in a computer system if it has the following characteristics:

    i. Provides a visual display of the recorded information.

    ii. Provides a means of access to the record of each client by the client's full name and a unique identifier, and the record can be validated by confirming additional reliable key indicators such as date of birth.

    iii. Provides a means to view and print recorded information promptly and in chronological order for each client.

    iv. Allows more than one author or contributor to sign or attest.

    v. Maintains an audit trail which

    a. records the date and time of each entry of information for each client;

    b. indicates the identity of the person who made the entry;

    c. indicates any changes in the recorded information; and

    d. preserves the original content of the recorded information when changed or updated.

    vi. Provides reasonable protection against unauthorized access. All systems will have user ID and password protection with mechanisms to prevent unauthorized changes to documents (e.g., document locking, read-only access, firewalls, encryption, password).

    vii. Automatically backs up files at reasonable intervals and allows the recovery of backed-up files or provides reasonable protection against loss of, damage to, and inaccessibility of information. A process is in place to reliably provide recorded information if due to unforeseen or scheduled downtimes of the system,
    the electronic record is not available.

Additional Resources

College Resources	Links
COTBC Bylaws Part 7: Registrant Management of Patient Records	Office of the Information and Privacy Commissioner for British Columbia (OIPC)
Essential Competencies Unit 5: Communicates and Collaborates Effectively Unit 7: Manages Own Practice	
Advisory Statements Use of Title (2018)	

COTBC thanks the College of Occupational Therapists of Ontario for permission to adapt content from their *Standards for Record Keeping* (2008).

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COTBC Practice Standards for
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Practice Standard #2: Protecting Client Information (Privacy and Security)

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Practice Standard #2: Protecting Client Information (Privacy and Security)

The occupational therapist will take measures to ensure client confidentiality and the security of client information in order to prevent unauthorized access.

The occupational therapist has a responsibility to understand and apply the legislation that applies to his or her practice and determine personal roles and responsibilities within the context of the practice.

The occupational therapist is expected to consult the relevant legislation, provincial and federal, to determine his or her role in this context (FOIPPA, PIPA, *E-Health Act*, *Privacy Act*, PIPEDA).

Privacy relates to the right of individuals to determine when, how, and to what extent they share their personal information.

Security refers to those mechanisms that restrict unauthorized access and preserve the integrity of information.

Practice Standard #2: Protecting Client Information (Privacy and Security), continued

Practice Expectations

The occupational therapist will do the following:

1. Develop protocols for storage, access, retention, and destruction of client records in keeping with all applicable legislation and COTBC Bylaws.
2. Store all occupational therapy records in locked filing cabinets and ensure password-protected computer access.
3. When travelling, limit the amount and visibility of client information being transported (on paper or portable electronic devices).
4. Place a notice at the bottom of all emails and fax transmissions regarding confidentiality and procedures if the information is sent to the wrong address or phone line inadvertently.
5. Obtain client consent regarding what information can be communicated by email.
6. Ensure that client information to be delivered by mail is sealed, addressed accurately, and marked “confidential.”
7. Make reasonable efforts to notify the individual involved if his or her information has been lost or stolen, or accessed without his or her authorization.

Additional Resources

College Resources	Links
Essential Competencies Unit 5: Communicates and Collaborates Effectively	Freedom of Information and Protection of Privacy Act (FOIPPA) 1996 Personal Information Protection Act (PIPA) 2003 E-Health (Personal Health Information Access and Protection of Privacy) Act (E-Health) 2008 Privacy Act 1985 Personal Information Protection and Electronic Documents Act (PIPEDA) 2000
Advisory Statements Remedying a Breach of Security (2010)	

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COTBC Practice Standards for
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Practice Standard #3: Client Access to the Occupational Therapy Record

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Practice Standard #3: Client Access to the Occupational Therapy Record

The occupational therapist will know and understand legislative obligations and organizational policies and procedures respecting client records so as to be able to help the client access his or her occupational therapy information.

Practice Expectations

The occupational therapist will do the following:

1. Respond within 30 days to requests by the client or a legally authorized representative for access to the client's occupational therapy record.
2. If organizational policies do not exist or are insufficient, develop policies or protocols for client access to occupational therapy records in accordance with legislation, COTBC Bylaws, and other published COTBC documents.
3. Not agree to contractual provisions which are inconsistent with his or her statutory obligations (e.g., requests by organizations to restrict client access to information).
4. Provide an opportunity for the client to review and correct personal information in response to any concerns that it is not complete or accurate.

Practice Standard #3: Client Access to the Occupational Therapy Record, continued

Practice Expectations, continued

5. The client may request corrections to his or her occupational therapy records, but does not have the right to demand that the correction be made. If the occupational therapist does not agree that there is an error or omission, he or she must record the client's request for the correction in the record.

6. Charge only a reasonable fee to cover the costs of copying and, where appropriate, staff time in retrieving and reproducing the requested record.

7. Take reasonable measures to ensure the preservation, security, and ongoing access to client occupational therapy records in the event that the agency or organization in which the occupational therapist is employed ceases to operate.

Additional Resources

College Resources

COTBC Bylaws 75–86

- The client may request that a record be corrected if he or she believes that the record has an error or omission. Bylaw 76(1),(2)
- Client information may be disclosed or shared under only certain conditions. Bylaw 78(1)(a–n)
- The client has the right to access personal information. Bylaw 86

Advisory Statements

Providing Client Access to and Releasing Occupational Therapy Information (2009)

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Practice Standard #4: Disclosing the Occupational Therapy Record

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Practice Standard #4: Disclosing the Occupational Therapy Record

The occupational therapist will know and understand legislative obligations and organizational policies and procedures about making and releasing copies of client occupational therapy information.

The occupational therapist will respond to requests by stakeholders for access to and or copies of personal information in accordance with legislative obligations.

The occupational therapist will transfer, share, or disclose personal information only with the express consent of the client unless otherwise permitted to do so by law.

Practice Standard #4: Disclosing the Occupational Therapy Record, continued

Practice Expectations

1. If organizational policies do not exist or are insufficient, the occupational therapist will develop policies or protocols for stakeholder access to occupational therapy records in accordance with legislation, COTBC Bylaws, and other published COTBC documents.

2. The occupational therapist may disclose personal information under only those conditions outlined in COTBC Bylaw 78(1–2) and other relevant legislation.

3. The occupational therapist may refuse to provide copies from a client record or a portion of the client record under those conditions outlined in COTBC Bylaw 86(3) or other legislation (FOIPPA, PIPA) where a reason for refusal applies.

4. With client consent, the occupational therapist will allow another health professional external to the occupational therapist's employment organization or agency to examine the client's clinical record. The occupational therapist will also give a health professional any information from the record and which that professional is legally entitled to receive.

Practice Standard #4: Disclosing the Occupational Therapy Record, continued

Practice Expectations, continued

5. Where the client directs that part of the information be withheld, the occupational therapist will respect that request. If it is deemed reasonably necessary to disclose the withheld information for the provision of or to assist in the provision of health care to the client, the recipient must be notified that part of the information has been withheld.

6. The occupational therapist will record what information has been released to the client or others and when, and will inform these individuals of the use and disclosure of the client information.

7. The occupational therapist may charge a reasonable fee to cover costs for photocopying and, where appropriate, staff time in retrieving and reproducing the document (COTBC Bylaw, 86[5]).

Additional Resources

College Resources	Links
Essential Competencies Unit 5: Communicates and Collaborates Effectively	Freedom of Information and Protection of Privacy Act (FOIPPA) 1996 Personal Information Protection Act (PIPA) 2003

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Practice Standard #5: Records Respecting Financial Matters

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Practice Standard #5: Records Respecting Financial Matters

The occupational therapist will ensure that a financial record is kept for every client to whom a fee is charged by the occupational therapist.

Financial records may be kept separate from clinical records, and may provide a way to track services offered on an ongoing basis.

Practice Expectations

The occupational therapist's financial records will do the following:

1. Identify the client to whom the service or product was provided.
2. Identify the person(s) who provided the product or service, the job title(s), and the fee of each provider.
3. Give a description of the service or item sold, a cost of the item or service, and the date provided.
4. Identify the date and method of payment received.
5. Provide an accurate fee schedule for the services rendered.
6. Identify the reason a fee may have been reduced or waived.
7. Where the fees were charged to a third party, provide the full name and address of the third party.
8. Identify any balance owing.
9. Provide information that documents the retention of a collection agency.

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Practice Standard #6: Retention and Destruction of the Occupational Therapy Record

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Practice Standard #6: Retention and Destruction of the Occupational Therapy Record

If the occupational therapist is the primary record keeper,
he or she will establish a process for the retention and destruction of records that ensures that regardless of the medium used, records are maintained for the required period of time and destroyed in accordance with legislative retention and destruction requirements.

If the occupational therapist is not the primary record keeper,
he or she will ensure that the record is maintained and that he or she will have access to it during the minimum retention period, and be knowledgeable about the organization's policies and procedures for occupational therapy record retention and destruction.

Practice Standard #6: Retention and Destruction of the Occupational Therapy Record, continued

Expectations 1 and 2 are aligned with the *Limitation Act*.

Practice Expectations

The occupational therapist will ensure the following:

1. A client record is retained safely and securely stored for at least 16 years from the date of the last entry in the record or in the case of a minor, the date 16 years after the day on which the client reached or would have reached 19 years old, whichever is later.

2. The record is maintained after the 16-year period if the occupational therapist reasonably knows that a piece of health information will be required after this time for a valid reason (e.g., ongoing care, legal proceeding).

Practice Standard #6: Retention and Destruction of the Occupational Therapy Record, continued

Practice Expectations, continued

3. Prior to the occupational therapist's resignation, cancellation, or suspension of registration with COTBC, the client retains the right to access his or her record. The occupational therapist will do one of the following:
    i. Maintain the client record for at a minimum the retention period defined in this practice standard or any other relevant statute or regulation, and notify the client at the last known address that the occupational therapist intends to resign or is no longer able to provide occupational therapy services, and provide information on how the client can obtain copies of the record; or
    ii. Transfer the records to either another person who is legally authorized to hold the records, or a successor in keeping with the provisions defined in privacy legislation (FOIPPA, PIPA, and COTBC Bylaws 80–84); and when transferring the record, make reasonable efforts to notify the client at the last known address before transferring the record, or as soon as possible after transferring the record.
4. Destruction of electronic and paper records is done in a secure manner that prevents anyone from accessing, discovering, or otherwise obtaining the information (e.g., cross-shredding, incinerating, erasing, or destroying files from personal computers and servers).
5. A list of names and dates for those records that have been destroyed is maintained in perpetuity or until no longer necessary in accordance with statutory requirements.

Additional Resources

College Resources	Links
COTBC Bylaws Refer to Bylaws 75–86 for other important regulations on protecting client information, such as when information can be disclosed, what to do when you stop practising and/or sell your business, and how to dispose of client information.	Freedom of Information and Protection of Privacy Act (FOIPPA) 1996 Limitation Act (2012). (PIPA) 2003

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Risk Assessment and Management

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Risk Assessment and Management

Safe management of client information requires that the occupational therapist make reasoned decisions regarding which information to collect, how to record it, and how to protect it. A risk management approach to managing client information throughout the care continuum is recommended to prevent harm.

Risk management is "nothing more than a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm" (Health and Safety Executive, 1999).

Risk Assessment and Management, continued

The 1st step is to identify potential risk factors

Nature of Referral

- Accuracy and quality of information from other sources (e.g., other professionals, client's family members or significant others).
- Pressure on or coercion of client to respond or behave in a certain way.
- Power of referral source to influence funding of services.

Complexity of Client's Presentation

- Complexity of condition including physical, mental, and social dimensions.
- Stability of condition.
- Capacity to authorize release of information, give consent for direct care, or make informed health care decisions.
- Fluctuating performance in different situations due to fatigue, pain, medications, stress, distractions, etc.
- Cultural beliefs and values.
- Ability to give and receive accurate information: language barriers; speech deficits; minimal dominant hand use which prevents proper signature; or problems with reading, seeing, understanding complex information, or retaining information.

Risk Assessment and Management, continued

More Risk Factors

Environmental Conditions

- Time (or funding) allowed for documentation.
- Pressure from others on the client or the occupational therapist to document findings and recommendations in a certain way.
- Access to client information by unauthorized persons (e.g., in home office, car).
- Media or data storage or sharing integrity.
- Software reliability.

Occupational Therapist's Skills and Knowledge

Lack of or insufficient

- Knowledge of current legislation (e.g., requirements surrounding consent, privacy, access to records, confidentiality).
- Clinical knowledge to proceed with the occupational therapy service required.
- Knowledge of use of technology in controlling confidentiality of transmitted information, or storing and protecting information (e.g., encryption, firewalls).
- Level of experience in report writing and other documentation procedures.
- Ability to communicate information to the client or client representative.
- Accuracy of testing and analysis of assessments.
- Therapeutic or trusting relationship with the client.
- Skill to be able to identify possible impaired capacity of the client.

Risk Assessment and Management, continued

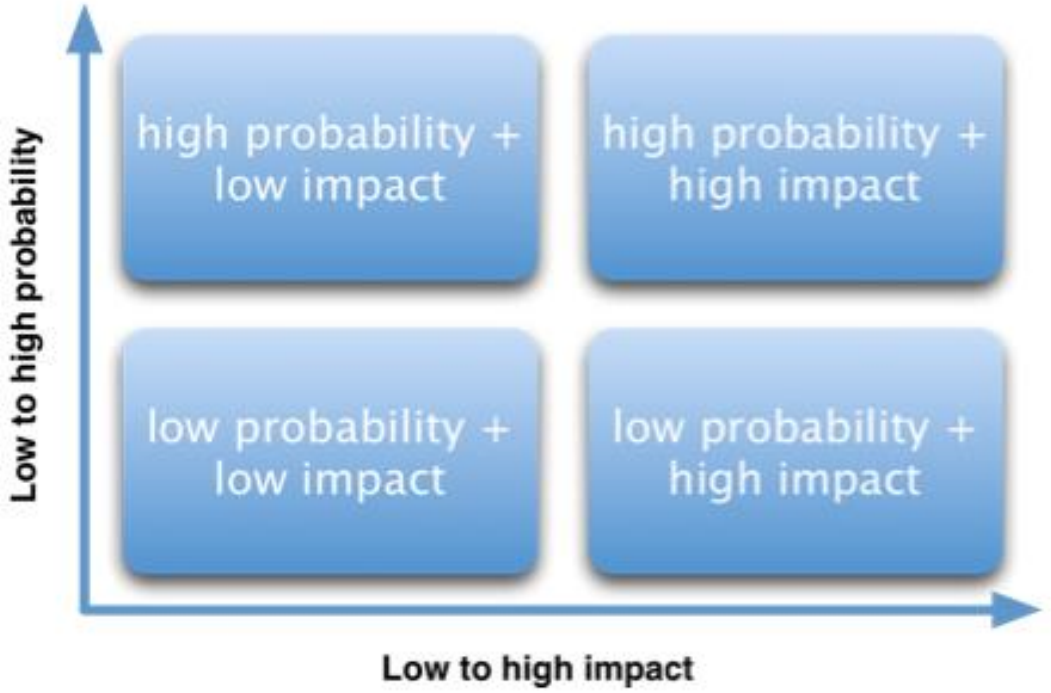
The 2nd step is to consider the probability and severity of impact

Once the factors are identified, the occupational therapist assesses:

1. the probability of each risk (i.e., how likely is it); and

2. the negative impact (i.e., what degree of harm could the risk cause the client).

The risks can be classified from low probability and low impact to high probability and high impact.



Risk Assessment and Management, continued

The 3rd step is to take action

The goal is to choose an action or precautions that are suitable and sufficient to minimize the risk. There may not be a perfect solution.

In the case of managing client information, this action could include

- not proceeding with the collection of information;
- expanding the amount of information collected and recorded;
- increasing the frequency of information collected and recorded;
- implementing higher security measures to protect the information;
- ensuring adherence to legislated requirements respecting record retention and destruction;
- discussing the occupational therapy record with the client as part of providing access; and
- ensuring client consent prior to disclosing occupational therapy information.

Risk Assessment and Management, continued

The 4th step is to record your actions

This risk management process is dynamic and ongoing throughout the care continuum and even after the file is closed.

It is important to record the risk management actions taken, to demonstrate that precautions were taken to protect the client from harm and to minimize risk.

College of
Occupational Therapists
of British Columbia

Practice Standards in this series: *Managing Client Information*
(Revised October 2019, Originally Issued 2014)

1. **Collecting and Recording Client Information**
2. **Protecting Client Information (Privacy and Security)**
3. **Client Access to the Occupational Therapy Record**
4. **Disclosing the Occupational Therapy Record**
5. **Records Respecting Financial Matters**
6. **Retention and Destruction of the Occupational Therapy Record**

For more information regarding this series of practice standards, or other practice supports, please contact the College at:
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