



DRAFT PROPOSED REGULATION

RECORDS RELATING TO MEMBERS' PRACTICES

GENERAL

1. Members shall take reasonable steps to maintain a complete and accurate record of all services provided to clients.
2. The record shall include information relevant to a member's involvement with the client.
3. Reasonable steps under section 1 shall include the verification by the member, at reasonable intervals, that the records are kept in accordance with this regulation.
4. The member shall take reasonable steps to maintain an equipment service record that sets out the servicing for every piece of equipment used to assess or treat clients.
5. A financial record shall be kept for each client whenever fees may be charged, and must contain the following:
 - (a) the full name of the client;
 - (b) the date, type and duration of the service rendered;
 - (c) the fees charged and method of payment, and
 - (d) where the fees were charged to a third party, the full name and address of the third party.

HEALTH RECORD INFORMATION

6. A client health record need only be kept for each client that receives individual nutritional assessment and counselling from the member.
7. The client health record must include the following:
 - (a) the client's full name and address;
 - (b) the date of each of the client's visits to the member or by the member;

(c) the name and address of primary care physician and any referring health professional if applicable;

(d) the reason for referral if applicable;

(e) the client's relevant medical history including medical and social data related to the nutrition intervention. When background health information has been provided by another practitioner, it need not be duplicated; however, a reference to the appropriate document must be included;

(f) the assessment conducted, the findings obtained, the problems identified, the goals for nutrition intervention and the nutrition care plan;

(g) the recommendations made by the member for diet orders, nutrition supplements, test and consultations requested to be performed by any other person;

(h) progress notes containing a record of services rendered and any significant findings including those resulting in changes to the nutrition care plan;

(i) relevant reports received by the member in respect of the client's health;

(j) particulars about discharge planning, including the referral of the client by the member to another health professional when applicable;

(k) any relevant reason a client may give for cancelling an appointment or refusing the service of a member when applicable;

(l) particulars of nutrition care that was commenced but not completed, including reasons for non-completion;

(m) copies of reports issued to other sources;

(n) copies of any written consent provided by the client;

(o) a notation of any controlled act performed for the client and the authority for performing it; and

(p) a copy of any written communication sent to the client.

8. Every part of a health record must have a reference identifying the client or client health record. Every entry must be dated and the identity of the person who made the entry must be identifiable.

RECORDS RETENTION

9. (1) The member may store a client record at a client's residence, including an institutional residence so long as the following requirements are met:

- (a) the client, or the client's substitute, consents,
- (b) the client, or client's substitute, understands and appreciates the reasonably foreseeable consequences of maintaining the record at the client's residence and has identified a reasonable plan for safeguarding the record,
- (c) the client, or the client's substitute, agrees that the member has access to the record or, in the alternative, the member shall keep an up-to-date copy of the complete record with the member's other records,
- (d) the client, or the client's substitute, agrees to retain the record for the period required under these regulations and then securely destroy it or, in the alternative, the member keeps an up-to-date copy of the complete record with the member's other records,
- (e) a reasonable clinical purpose is served by keeping the record there,
- (f) either the record kept at the client's residence or the record kept with the member's other records, or both, is a complete and up-to-date copy of the record and both records indicate which is the complete, up-to-date copy of the record, and
- (g) unless the member keeps an up-to-date copy of the complete record with the member's other records, the member shall keep a copy of the following information with the member's other records:
 - a. the name and contact information for the client,
 - b. the location of the record,
 - c. the essential, up-to-date, clinical information about the client including significant assessment results, a summary of the nutrition care plan and the major milestones in the implementation of the nutrition care plan, and
 - d. documentation of compliance with clauses (a) to (f).

(2) The member may store personal health information at a storage facility other than one under the control of the member or the member's employing custodian or the client's residence so long as the following requirements are met:

- (a) the client, or the client's substitute, consents,
- (b) the storage facility has a privacy policy consistent with the *Personal Health Information Protection Act, 2004* and the College's record keeping regulation,
- (c) the storage facility provides the member with a written privacy assurance that it will safeguard the record and will only use or disclose the record at the express direction of the member,
- (d) the member describes the fact that he or she uses a storage facility in his or her privacy policy,
- (e) the storage facility is not a private residence,
- (f) the member contracts with the storage facility to retain the record for the period of time required under this regulations before it will destroy the record in a secure manner,
- (g) the member keeps the account with the storage facility current at all times so that the records are not discarded or destroyed prematurely, and
- (h) the member keeps, with his or her other records, a list identifying the client, the nature of the record kept at the storage facility, the location of the file in the storage facility (e.g., file box number), documentation of compliance with clauses (a) to (g) and the name and contact information for the storage facility.

(3) If the member is an agent of a health information custodian as defined in the *Personal Health Information Protection Act, 2004*, the member may comply with the custodian's privacy policies on storing records at a client's residence or a storage facility rather than this regulation so long as the policies are substantially similar to this regulation.

10. Every health record maintained by a member shall be retained for at least 10 years following

- (a) the date of the last intervention with the client; or
- (b) if the client was less than 18 years old at the time of the last intervention with the client, the day the client became or would have become 18 years old.

11. If any other Act or regulation sets out different retention period for the member's health records from those set out in section 10, such provisions shall prevail over section 10.

COLLEGE ACCESS TO THE RECORD

12. The member shall ensure that the method of keeping the records required by this regulation provides:

- (a) ready access to an authorized investigator, inspector, assessor or representative of the College, for the inspection of records; and
- (b) that equipment must be readily available for the making of hard copies of the record at no expense to an authorized investigator, inspector, assessor or representative of the College.