Alberta College of Speech-Language Pathologists and Audiologists

ACSLPA Standards and Guidelines: What Members Need to Know

Changes to

Documentation and Information Management Standard of Practice

and

Clinical Documentation and Record Keeping Guideline

September 2021

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Today's Learning Objectives

- To obtain an overview of the revised *Documentation & Information Management S of P* and the accompanying *Clinical Documentation & Record Keeping Guideline*.

- To obtain clarity on why documentation & record keeping matters and to ensure your documents incorporate all of the required elements

- To highlight major changes and rationale for said changes

Regulation vs. Advocacy

- Role of the college is first and foremost protection of the public-ensuring that the public receives safe, competent, and ethical speech-language pathology and audiology services through the regulation of *individual practitioners.*

- Advocacy for the professions falls outside the regulatory arena

A Quick Reminder

***Standards of Practice*:**

Are established measures or norms which define the minimum level of professional performance that SLPs and audiologists must demonstrate in their practice.

Guidelines:

Provide guidance to regulated members to support them in the clinical application of Standards of Practice.

In Other Words

A Right Touch Regulatory Perspective

Focuses on the minimum regulatory force required to achieve the desired result

Too little-ineffective

Too much-waste of effort

A Right Touch Regulatory Perspective

- Consider, and minimize, potential hazards, risks, and harms to the client

- In healthcare, harm is physical injury or psychological distress experienced by people through interaction with healthcare practitioners and services.

Right Touch Framework

- Context Matters
- Clinical judgment and decision making are important
- Absolutes are imposed only when necessary

Documentation and Information Management

- Serves as evidence of what did or did not take place in the delivery of SLP and audiology services.
- A key purpose of documentation is communication with clients, with other professionals, and with team members at large.
- Protection of privacy is an integral component of documentation and the sharing/transmission of client records.

Major Revisions

- Electronic documentation and storage of information.
- Timeframes in relation to record retention.
- Record management upon closure or transfer of practice.
- Record disposal.

Major Revisions

ACSLPA's ARADAC

Overarching requirement re: using language that is free of **bias** which might imply prejudicial beliefs or perpetuate assumptions re: the individual being written about.

Electronic Documentation and Storage Standards

- Ensuring the presence of an audit trail- *indicator "h"*
- Avoiding use of social media to communicate directly with clients – *indicator "k"*
- Appropriately securing personal and health information through the use of administrative, physical, and technical mechanisms (e.g., passwords, encryption, etc.)- *indicator "l"*

Record Retention

Standard of Practice - indicator "s"

The regulated member retains records according to the length of time specified by applicable legislation and regulatory requirements.

Clinical Records Retention

- Adult records are retained for 11 years and 3 months since the date of last service.

- Records for “persons under disability” are retained for 3 years and 3 months after their death.

- Records for minors are retained for 11 years and 3 months after the client turns 18.

Other Record Retention

- Equipment service records should be maintained for 10 years from the date of the last entry.

- Financial records should be retained for 6 years, as per Canada Revenue Agency's guidance.

Record Management Upon Closure or Transfer of Practice

Standard of Practice – indicator "v"

The regulated member takes action to prevent abandonment of records (e.g., when closing a practice).

Closure or Transfer of Practice

- Records should be transferred, as necessary, to another SLP or audiologist.
- Transfer of records can be stipulated in the contract for sale of a business.
- Clients should be informed of file transfers and should be given the option of having their records transferred to the SLP or audiologist of their choice.

Closure or Transfer of Practice

- Client records can be put into commercial storage for custody.
- If no receiving SLP or audiologist is available, records should be transferred directly to the client.
- Regulated members should appoint another health care professional who agrees to serve as the successor custodian if they cannot fulfill their duties.

Record Disposal

Standard of Practice – indicator "w"

The regulated member disposes of records in a manner that maintains security and confidentiality of personal information.

Record Disposal

- After the appropriate time has elapsed records should be destroyed.

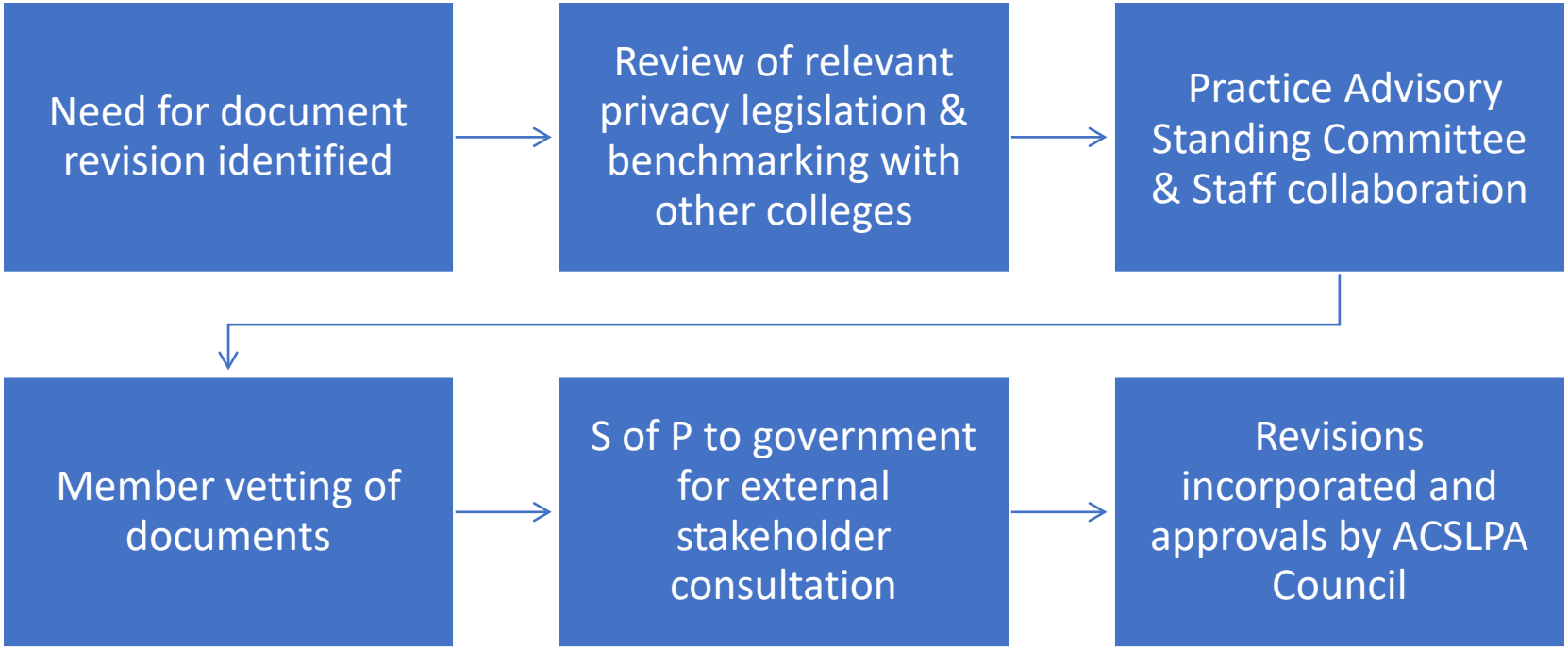
- Generally accepted methods of disposal include shredding of hard copy information and permanently purging files from a computer hard drive (simply deleting files is not enough).

Record Disposal

Standard of Practice – indicator "x"

The regulated member maintains a log of destroyed files which is kept indefinitely, that includes the following information: name of each client, file number, last date of treatment, and date that the record or file was destroyed.

Document Review Process



Additional Aside

- Revised S of P indicators are embedded directly within the guideline so it’s easy to see how they work with and complement the guideline

Supplemental Resources

- Supplemental article

Questions?

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Questions?