Dietetic Record Keeping Q&A
Updated April 23, 2024

Q1: When working in an interdisciplinary setting (such as public health), can I provide nutrition advice to another health professional that will then be relayed onto a client, when I'm not involved in the care of the client? What is my involvement and documentation requirement around this? When is documentation not required?

Providing specific, individualized nutrition advice without assessing the client is in violation of of the Dietitian specific Code of Ethics Standard3 (a): "*Collaborate with clients, interprofessional colleagues, workplace leaders, client's family, caregiver, guardian, or substitute decision maker to give quality services*" as well as Standard 4(a)(i and ii): "*Act as a credible and reliable source of evidence-based food and nutrition information [and] Provide safe, client-centered services using knowledge, skills, judgement and professional attitude.*"
Whether interacting directly with a client or indirectly via another healthcare professional, you are responsible for performing an assessment before providing specific nutrition information to a client.

The other regulated health professional may be in violation of his/her own College by (1) not requesting an RD consult, and (2) practicing outside his/her scope of practice by disseminating nutrition-related education to a client.

In receiving a request to consult, you would be required to screen the client, providing an assessment and any individual nutrition education required, as well as document as per the Standards for Record Keeping set out by the Dietetic Bylaws.

In the absence of an RD consult request, assessment and documentation are not needed when you provide education that consists solely of generic information, accessible to the public on the Internet.

Q2: Why don't the Dietetic Standards of Practice have any detailed guidelines on documentation?

The Standards of Practice, which are part of Dietetic bylaws, were purposely written in general terms to apply to all areas of practice. They refer only to section 9: *"A Dietitian communicates in a clear, concise and respectful manner."* For more guidelines around documentation, refer to Standards for Record Keeping.

The College does not state how that documentation is to be recorded. Health Authorities and/or facilities have their own template or format for documentation; it is an employment requirement to document in the manner expected. You are required to accurately document your practice as soon as reasonably possibly after each patient interaction.

If you want to include continuing education about record keeping in your Continuing Competence Program (CCP), the following Standards refer to documentation:

Standard 9 Communication & Collaboration: *"A Dietitian communicates in a clear, concise and respectful manner."*

Standard 15 Client-centered Services: *"A Dietitian maintains clear and accurate records that document communications and the provision of professional services."*

There are various Indicators included within these Standards that may meet your record keeping learning needs.

Q3: Does the College have documentation guidelines specifically for privacy considerations for working on-call?

On-call work can be difficult to record, especially when hard copy records are not accessible remotely. You are encouraged to review any workplace requirements for record keeping when working remotely. You should also review the Dietetic Privacy Guide, specifically the section pertaining to Guidelines for Protecting Clinical Records Outside the Practice.

Dietitians working in public healthcare settings must consider privacy as it relates to FIPPA (the Freedom of Information and Protection of Privacy Act), which governs public sector employees including hospitals and health authorities. FIPPA principles are included in workplace organization policies for documentation and transfer of patient information and also within the Dietetic Standards for Record Keeping.

It is reasonable for you (at home) to document on paper or on your electronic device (remotely), some of the details such that you can provide appropriate handover to the regular dietitian. The details of unofficial and temporary documentation at home, should avoid the use of personal information, unless you can temporarily hold it and later dispose of it securely.

FIPPA defines personal information as "*recorded information about an identifiable individual other than contact information*". Dietitians may want to consult their health authority policy on information and privacy and any practice guidelines (possibly also in the form of an on-line course) on how to communicate and demonstrate accountability for managing personal patient information among coworkers (i.e. what is allowable and what is not). These standards are also based on FIPPA requirements and will define how health professionals are required to manage and communicate personal information within and outside of their health authority. In the instance that any required personal information must be recorded remotely by the on-call dietitian, it is expected that, as per the Dietetic Standards for Record Keeping:

> "*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).*"

For example, perhaps you are required to consult on a new tube feed start without being on-site. You could need to record the patient's name as initials, age, gender, and their medical record number (MRN). An MRN is a site-specific number that helps identify the patient accurately and isn't relevant outside of the health authority. A personal health number (PHN) is a provincially assigned number for the purpose of identification and billing of medical services. Unless needed for billing purposes, collecting PHN for on-call care is likely not needed. The patient is identifiable in as much a confidential manner as possible in this case because full name and date of birth were not collected. In this manner, you can still complete the requested consult and handover patient-specific information to the regular dietitian, while meeting the Standards for Record Keeping, which state:

> "*Dietitians document in a systematic and timely manner. A dietitian demonstrates the standard by ensuring the documentation:... (b) Is completed diligently, at the earliest possible opportunity following the client interaction/dietetic services to prevent any delay in care or service, and (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*."

To ensure privacy, the temporary documentation recorded at home must be disposed of securely, in a permanent manner. For example, you could use the confidential shredding service available at the hospital/clinic at your earliest opportunity.

Q4: Given that on-call work can be remote, what are the considerations for adequacy of documentation?

Adequacy of documentation for all dietetic care, whether remote or in-person is referred to in the Dietetic Standards for Record Keeping. When considering the potential documentation requirements for on-call dietitians, it is key to compare on-call work to virtual dietetic care. In the case of on-call dietetic care, dietitians are asked to determine if adequate dietetic care can be provided over the phone, indirectly, in collaboration with another health professional versus direct in-person care. In the case where a dietitian provides virtual care, for example for a new tube feeding start, or clarity on a diet order, over the phone, virtual care is deemed equivalent by the dietitian as in-person care, with the exception of documentation.

It is understood that on-call dietitians, who are often speaking to nursing professionals on the phone, will have their recommendations documented in the health record by the nurse. This may be sufficient if the nurse and the dietitian agree that the nurse will document the call and the resulting care in the patient's permanent health record (and clearly identify the dietitian). However, in the case of a more complex situation that requires critical thought and information collection (again, consider a tube feed start), relying on documentation by nursing may not be enough. In this

case, it is recommended that a process for comprehensive and permanent documentation be developed and implemented for use in virtual on-call dietetic care.

For example, in the context of paper health records, this could be in the form of a pre-formatted form that is completed by the on-call dietitian, whether an assessment, or a chart note that captures data, assessment and plan of the current reason for the consultation, and the on-call dietitian's identity. Once completed, the note could be sent to the unit dietitian or the nurse, who would then place it in the permanent medical record at the earliest reasonable time.
Another example for electronic records, would be for the on-call dietitian to remotely sign into the charting system with a secure unique identifier and directly chart the on-call intervention in the patient's permanent record.

Q5: How long must client records be kept? Is there a standard for discarding/destroying records?

The answers depend on your practice setting. The following information can be found in Dietetic Standards for Record Keeping (standard 5h(a,b,c)).

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

In community care and assisted living, according to section 92 of the Residential Care Regulation, resident health records must be kept a minimum of 2 years after discharge.

In private practice, according to section 35 of the Personal Information Protection Act, information used to make a decision that directly affects the individual must be kept at least one year after using the information (gives the individual an opportunity to access the information).

Health care facilities/Health Authorities may have policies that have longer timelines than the minimum duration stated in legislation. There are no prescribed methods for record destruction. Commonly accepted destruction methods include cross-shredding of paper records, incineration of non-paper records and erasure of data, including any backup copies, for electronic records. Whatever method used, client privacy must be ensured.

Q6: I am providing a group session, such as a grocery store tour, or a workshop. What is my documentation requirement?

Consider whether you are developing a therapeutic relationship with your participants.

You are **not developing therapeutic relationships** if:

- There is a one-way delivery of information (i.e., you are presenting to a group),
- No full nutrition assessments are completed, and

- Questions asked by participants do not elicit a requirement for a personalized response. (i.e., “My blood sugars are always high in the morning. How should I use your recommendations to tailor my breakfast?”).

If you are not establishing a therapeutic relationship with your participants, **documentation of the session information you provide would include, among other details, client attendance, date, and the name of the dietitian presenting the session. This would meet the College Record Keeping Standards and fulfill the record needs of an inspection, in the event of a complaint against you.**

If you are collecting personal health information, doing a nutrition assessment, and/or providing tailored nutrition advice in a nutrition care plan, you are developing a therapeutic relationship. In this circumstance, you must document your full assessment and plan in a client record. In this circumstance, you can consult the Dietetic Standards of Record Keeping for details of documentation requirements.