Practice Notes: New and Improved? Making the Shift to Electronic Records

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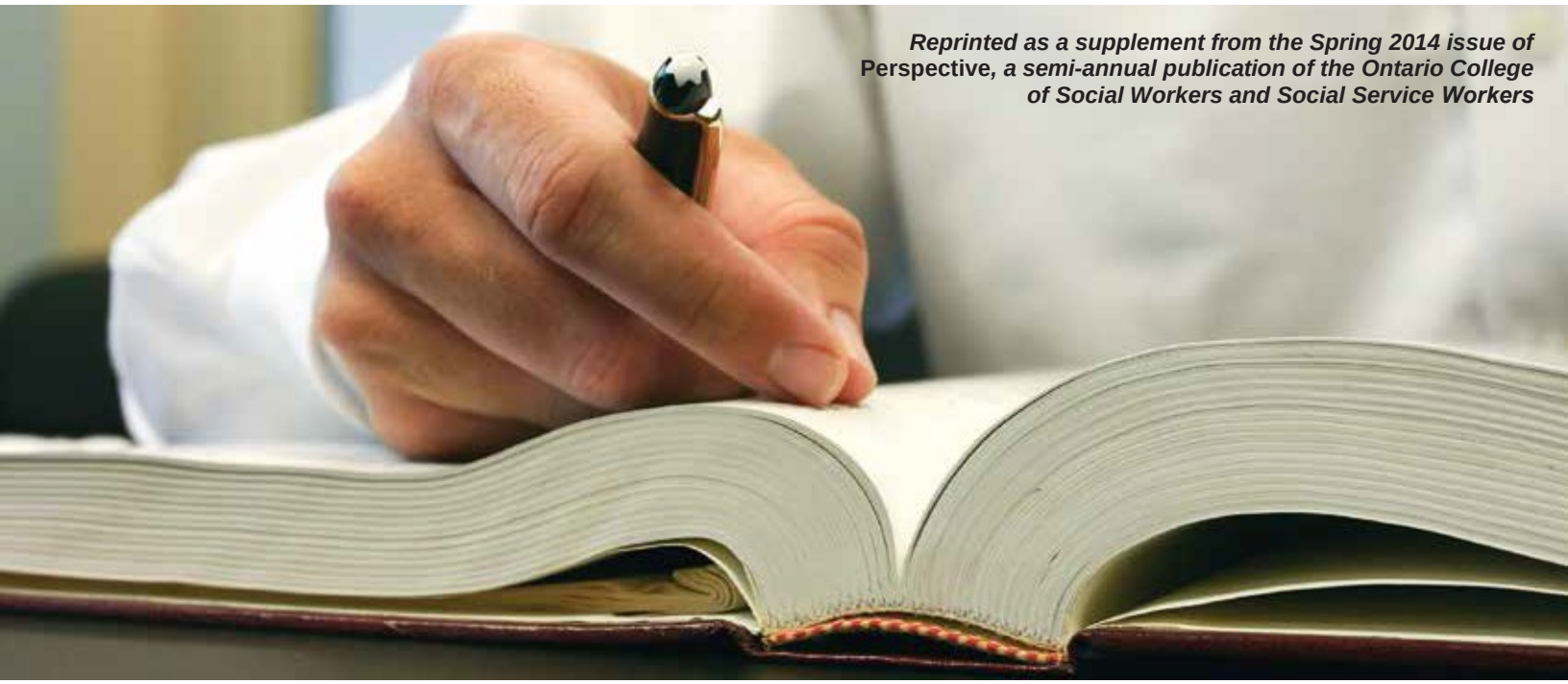

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Practice Notes is designed as an educational tool to help Ontario social workers, social service workers, employers and members of the public gain a better understanding of recurring issues dealt with by the Professional Practice Department and the Complaints Committee that may affect everyday practice. The notes offer general guidance only and members with specific practice inquiries should consult the College, since the relevant standards and appropriate course of action will vary depending on the situation.

It is well-recognized that accurate and timely documentation is an essential component of effective and ethical social work and social service work practice.[1] Good record-keeping facilitates communication, ensures coordination, continuity and quality of care, establishes accountability for and evidence of services provided, permits evaluation of the quality of services, and provides information which can be used for research and education.[2] Increasingly, good documentation is also recognized as an important risk-management tool which protects clients, practitioners and employers.[3] Accurate documentation is not only important in clinical practice, but also in supervision, management and administration.[4]

Previous Practice Notes called "The Broken Record" emphasized the crucial importance of record-keeping.[5] They discussed some of the issues to be considered by members, some of whom may view documentation as something that takes them away from their primary role of helping clients.[6] This article focuses on issues raised by the shift from paper to electronic records. It addresses the issues of access to the record, client confidentiality and record format in the electronic context, from the perspective of the Code of Ethics and Standards of Practice. It should be noted that there are various laws which may also affect the privacy of, access to, correction of and disclosure of both paper and electronic records, depending upon the context in which a member

1 Cumming, Sue, Eileen Fitzpatrick, Donna McAuliffe et. al., "Raising the Titanic: Rescuing Social Work Documentation from the Sea of Ethical Risk" in *Australian Social Work*: Volume 60, No. 2, June 2007, pp. 239-257. See also *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle IV: The Social Work and Social Service Work Record (general statement).
2 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle IV: The Social Work and Social Service Work Record (general statement).
3 Reamer, Frederic, "Documentation in Social Work: Evolving Ethical and Risk-Management Standards", Social Work, Volume 50, Number 4, October 2005, p. 325.
4 Ibid., p. 326.
5 Blake, Pamela, Practice Notes: "The Broken Record", *Perspective*, Spring 2010. http://www.ocswssw.org/docs/record_keeping.pdf
6 Cumming et al., p. 241.

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practises and the records are created. It is beyond the scope of this article to address members' obligations under those privacy laws[7], but it is important that members maintain an awareness of any privacy and other laws applicable to their practice which may impact the social work or social service work record, and that they obtain legal advice concerning those obligations, as appropriate.

Members are strongly encouraged to review Principle IV: The Social Work and Social Service Work Record in the *Code of Ethics and Standards of Practice Handbook, Second Edition, 2008* in its entirety to ensure that they are familiar with the minimum standards expected of them. While there are unique aspects to electronic record-keeping, members should note that the standards of practice are equally relevant and applicable to paper and electronic records.

RECORDING SENSITIVE CLIENT INFORMATION

In the course of their work with clients, social workers and social service workers are frequently privy to highly sensitive information. They have a professional and ethical obligation to handle this information with care, and to protect client confidentiality. At times, members may be concerned that other staff in their setting are able to access such information inappropriately. This concern may be heightened when a central electronic record is easily accessed by all staff. Consider the following scenario:

> A member working in a small, multiservice community agency contacted the Professional Practice Department with concerns about what should be included in the electronic record. She believed that her detailed assessments and progress notes should not be included in the electronic record because these could be viewed by others, including administrative staff. She had decided to maintain a parallel paper file, in which she intended to keep more sensitive client information. The member wondered if this practice was acceptable and met College standards.

Because of their format, electronic records may centralize client records and enable multidisciplinary access in a way which was not always possible with paper files. The member is certainly justified in carefully considering the issues that arise from this significant change.

The standards of practice require members to "respect the privacy of clients by holding in strict confidence all information about clients and by complying with any applicable privacy and other legislation".[8] They also state that the purpose of the record is, in part, "to document services in a recognizable form in order to ensure continuity and quality of service".[9] Members must "comply with any applicable privacy and other legislation … (and) obtain consent to the collection, use or disclosure of client information including personal information unless otherwise permitted or required by law".[10] Members are required to "inform clients early in their relationship of the limits of confidentiality of information"[11] including "the need for sharing pertinent information with supervisors, allied professionals and paraprofessionals, administrative co-workers, social work or social service work students, volunteers and appropriate accreditation bodies".[12]

If the member believes that it is inappropriate for others on her team to access client records, she is bound by the standards of practice to raise this concern with her employer and to find ways to advocate for workplace policies and conditions that are consistent with College standards.[13] Before doing so, however, she should consider whether some access to the file by others on her team may in fact be appropriate, desirable and allowable. It may be in clients' best interests for other members of the multidisciplinary

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7 Such as the *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F.31, the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. M.56, the *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5 and the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3.

8 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle V: Confidentiality. See also Principle IV: The Social Work and Social Service Work Record.

9 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle IV: The Social Work and Social Service Work Record (general statement).

10 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle V: Confidentiality, interpretation 5.1. See also Principle IV: The Social Work and Social Service Work Record, interpretations 4.2.1 and 4.2.2.

11 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008,* Principle V: Confidentiality, interpretation 5.4.

12 Ibid., interpretation 5.4.

13 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle II: Competence and Integrity, footnote 10.

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team to have access to important information contained in social work or social service work notes. This information could assist them in making important decisions about a client's care, or in managing a crisis, for example. Similarly, it is reasonable and allowable for administrative colleagues to access parts of the record for specific purposes, such as scheduling appointments.[14]

Under the *Personal Health Information Protection Act, 2004* (PHIPA) clients have a right to request that all or part of their record be "locked".[15] Members should ensure that they are responding to the client's wishes rather than their own concerns when locking information, however. Clients should be informed that sharing of information between team members enhances their care. In the scenario described above, the member had not fully described the agency's record-keeping, privacy or administrative practices to her clients, nor had she fully discussed the limits of confidentiality. She was reminded that this is an important element of contracting with all clients.

In this case, rather than putting clients' information in a "lock box", the member had decided to keep more sensitive information in a "parallel" file which she stored in her office. While it has been common practice for members in some settings to keep such parallel files, the shift to electronic records has led many agencies (and members themselves) to examine this practice. Storing important information outside the electronic record where it cannot be easily accessed by others providing care may not be in clients' best interests, may jeopardize client care, and may not be in accordance with the standards of practice. Members must carefully consider their rationale for keeping certain information from others on the team. What are the implications of other providers not being fully informed? Why is this information more "sensitive" than that gathered by other providers? How might the member justify this decision if ever her practice was called into question?

Some agencies have developed clear policies prohibiting "personal", "shadow" or "parallel" files. Unless an employer policy conflicts with the College's standards of practice, a member would be expected to follow it.[16]

In the absence of such policy, members may choose to store the tools or data they have used to develop a professional opinion (such as personal notes, memos, messages, genograms, etc.) in a separate, hard-copy file. It should be noted that this kind of information is usually supplemental and not critical to the client's care. In the official, electronic record, the members must be sure to "keep systematic, dated, and legible records for each client or client system served".[17] These records should contain current, accurate, and relevant information about clients.[18]

After some discussion about these issues, the member decided (with the support of her manager) to initiate a discussion about confidentiality and access to sensitive client information with others on her team. Her manager was in a position to determine what information was being accessed and by whom,[19] in order to decide whether there was a broader problem that needed to be addressed within the agency. The member also realized that it was possible that she had been making inappropriate judgments about the motivations of other staff, and had perhaps underestimated the value of certain information in the overall care of her clients. The member decided to limit her use of a parallel file, and to ensure that she included sufficient information

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14 *Privacy Toolkit for Social Workers and Social Service Workers, Guide to the Personal Health Information Protection Act, 2004 (PHIPA)*, Ontario College of Social Workers and Social Service Workers, 2005, page 31. Members who practise in environments where PHIPA applies should note that this legislation generally allows others on the team who are providing or assisting in providing health care to a client (those healthcare providers in the client's "circle of care" — a term which is not used specifically in the legislation) to access the client's personal health information. PHIPA Toolkit, p. 32.

15 PHIPA Toolkit, p. 32.

16 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle II: Competence and Integrity, interpretation 2.2.10. See also Principle I: Relationship with Clients, interpretation 1.7.

17 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle IV: The Social Work and Social Service Work Record, interpretation 4.1.3. Footnote 1 in Principle IV notes that "the same standards with respect to confidentiality, security and destruction [must be observed with respect to the parallel file] as with the social work and social service work record". Members should be aware that in the event of a court order or subpoena, they may be required to disclose information from both the electronic file and the parallel (paper) file.

18 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle IV: The Social Work and Social Service Work Record (general statement).

19 An electronic system should permit an audit trail which can assist an organization in determining who has accessed a file and when. The standards of practice require electronic record systems to have security features which maintain an audit trail. *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle IV: The Social Work and Social Service Work Record, footnote 7.

in the electronic file so that others on the team would be able to respond appropriately to clients' needs based on her assessment and interventions.

ACCESS TO THE ELECTRONIC SYSTEM

Members may also have questions about the use of electronic signatures and standardized templates in electronic record-keeping systems:

> A member of the College working in an outpatient mental health setting called the College because his agency had recently moved to an electronic record system. He explained that he had been giving his student access to the system under his password. The member felt uncomfortable with this practice. He also wondered whether he was required to use an electronic signature in addition to a password when recording in the system, and had questions about the agency's highly-templated record format.

It can be challenging for social workers and social service workers to obtain necessary resources for the students they supervise, given ever-diminishing resources in many settings and the intensive demands associated with making the shift to electronic records. Agencies may not have had time to consider how to handle issues related to students. Members may be hesitant to ask for additional resources and in some cases may be discouraged from doing so. This reluctance may lead to "shortcuts" which may contravene the standards of practice and pose other risks.

The standards of practice require members to document their own actions.[20] They further state that the record must clearly reflect the identity of the service provider.[21] Electronic systems must protect the system from unauthorized access, and members must have a private access code or password.[22] While not all systems permit the use of an electronic signature, it must be clear from the record who provided the service and who made each entry. Only those with the right to access the record should do so, and members must ensure that their passwords or entry codes are protected from unauthorized use.

The use of more highly-templated assessment forms, progress notes and other documents is more common as electronic records become the norm. There are benefits to templates, which may contribute to more uniformity and clarity in recording. Members should ensure that any templates they use capture the minimum requirements for record content set out in the standards of practice.[23] They should also ensure that drop-down menus within the templates do not put them in the position of performing restricted activities (e.g. under the *Regulated Health Professions Act, 1991* or other laws) which they may not have the authority to perform.[24]

As a result of his consultation with Professional Practice staff, the member realized that his discomfort with his agency practices was warranted. He decided to discuss his concerns with others on his team and with his manager in order to find an acceptable solution.

RECORD FORMAT

Members moving from one setting to another may be surprised to find that some agencies have been slower than others to make the shift to electronic records, as in the following scenario:

> A member of the College who had recently obtained employment at a school board contacted the College to discuss her recording practices. She explained that she had been surprised to find that the school board maintained paper files. The member's preference was to document electronically using Word, to save the files to her computer, and to print off her notes

20 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008,* Principle IV: The Social Work and Social Service Work Record, interpretation 4.1.5.
21 Ibid., interpretation 4.1.4.
22 Ibid.,footnote 7.
23 Ibid., footnotes 2 and 3.
24 The *Regulated Health Professions Act, 1991* (RHPA), S.O. 1991, c. 18, restricts the performance of certain controlled acts "in the course of providing health care services to an individual", including the controlled act of "communicating to the individual … or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual … will rely on the diagnosis." The provision of a social work diagnosis falls within the scope of practice for social workers, which includes "the provision of assessment, diagnostic, treatment and evaluation services between a social worker and client".

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on a regular basis. Like her colleagues, she planned to maintain paper files in her office. She wondered if this was an acceptable practice.

Using a computer to type client notes may be a matter of personal preference. However, electronic records must meet minimum standards as set out in Principle IV: The Social Work and Social Service Work Record in the *Code of Ethics and Standards of Practice Handbook*. Specifically, the system must maintain an audit trail that records the date and time of each entry of information for each client, indicate any changes in the recorded information, and preserve the original content of the recorded information when changed or updated. [25] Furthermore, in a shared system, the member must use a private access code or password when making entries. A Word document would not typically afford this protection.[26]

After consulting with the Professional Practice Department, the member decided to continue her practice of recording on the computer, but made several other changes to her practices. These included printing off and signing each note manually, before storing it in a secure manner, under lock and key, in an individual paper file.

IN CONCLUSION

This article has discussed some of the issues that members should consider when recording on an electronic system. While there are some challenges, opportunities and considerations that apply uniquely to electronic records, members are reminded that the requirements set out in the College's standards of practice remain relevant and applicable in this new era.

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25 *Code of Ethics and Standards of Practice Handbook, Second Edition 2008*, Principle IV: The Social Work and Social Service Work Record, footnote 7.
26 Ibid., footnote 7.