College of Audiologists and Speech-Language Pathologists of Ontario
Ordre des Audiologistes et des Orthophonistes de l'Ontario

# DOCUMENTATION STANDARDS

The following outlines the requirements for information to be included in the patient record and documented in a timely fashion. What is considered timely should be determined based on the nature of the speech, language, swallowing, and/or hearing difficulty, and the practice context.

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| Standard 1 | Members must document all aspects of the provision of services. |

All documentation by members must conform to the Records Regulation (2015).

This includes the following:

- Background information such as reason for the referral/service, relevant history, pre-existing conditions, etc.
- Activity limitations and participation restrictions as well as behavioural observations
- Assessment procedures, including any risk-mitigation strategies, where appropriate (e.g. where there are significant swallowing issues, where cerumen management may pose significant risk)
- Assessment results
- Interpretation and analysis of assessment results
- Recommendations, including general suggestions, specific treatments and/or devices
- Follow-up services, including education and/or counselling

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| Standard 2 | Members must document communication and collaboration with other professionals in the planning or delivery of services. |

Communication and collaboration with other professionals in the planning or delivery of services must be documented. The content of what the member documents depends on professional judgement, but the member should take into consideration risk related to the level of detail captured. In some instances, this would mean increased detail (e.g. specific type and model of a hearing aid to be prescribed, food texture required for a swallowing patient), in other circumstances this may mean less detail (e.g. reason for a psychiatric referral). This would include referrals to other providers.

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| Standard 3 | Members must ensure that records are securely stored. |

Records must be stored securely in accordance with CASLPO's Records Regulation (2015) and any other relevant legislation, such as the *Personal Health Information Protection Act,* 2004. Reasonable steps must be taken to ensure that personal health information in the member's custody of control is," …protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal." PHIPA 2004, c. 3, Sched. A, s. 12 (1).

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| Standard 4 | Members must, when working with others, take all reasonable steps to ensure that the patient's records are up to date, accurate and complete. |

When working on an interprofessional team, all members of the team may contribute to a single patient record. Members must, however, take reasonable steps to ensure that the record is up to date and made, used, maintained, retained and disclosed in accordance with CASLPO's Records Regulation (2015). For further information please refer to the Interprofessional Record Keeping Resource.

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