

PRACTICE SUPPORT DOCUMENT ON RECORD KEEPING

The Saskatchewan College of Psychologists provides practice support documents to assist registrants with identifying issues for consideration with respect to a particular aspect of psychology practice. Practice support documents are intended to provide general guidance in dealing with a practice issue but they cannot anticipate all variables that might be relevant to a member's decision-making. Practice support documents are not meant to be exhaustive and the College accepts no responsibility for any errors and omissions. The information in these documents is not legal advice, and does not replace governing legislation or professional standards of practice that take precedence over practice support documents to the extent of any inconsistency. In addition, the practice support documents do not establish binding standards of practice or impose mandatory requirements to the extent that such requirements are not already established by governing legislation and professional standards. Registrants are responsible for any decision made respecting their practice of psychology and practice support documents are not intended to be a substitute for professional judgment. This document must not be copied in part, and any copy of its entirety must retain this disclaimer and attribute this document to the Saskatchewan College of Psychologists. Practice support documents are current to the date published on the respective document.

There are many important reasons to create and maintain full and accurate practice records. For the registrant who created the record, their notes are an aide-memoire of what occurred during a treatment session or interview, but records are not just for the registrant who created them. Records may be necessary for continuity of care should the registrant be unable to continue providing professional services, or in the event the client chooses to obtain services from another healthcare provider. Clients are also entitled to request a copy of a registrant's practice record. They may need information related to the treatment they received or their mental health status at a particular point in time, or they may desire a copy of the record for some other purpose. Practice records are also an important way for registrants to demonstrate professional accountability, to meet institutional/organizational requirements, and to enable them to respond appropriately in the event they are subject to a complaint.

For registrants, detailed records are an important part of risk management, as they provide documentation of what occurred during the process of obtaining informed consent, during treatment, or over the course of an assessment. If there are concerns about the professional services provided by a registrant, their practice record can be an important source of evidence when they respond to such concerns.

A registrant's practice record should provide an account of the professional service from initial contact through to the end of services, and this record should stand on its own without the need to explain and supplement the record. Registrants should maintain their records such that they are prepared to respond promptly to a request for records under governing legislation, a court order, or the College in the course of investigating a regulatory complaint.

Checklist

The following checklist is intended to assist registrants in ensuring their record keeping practices are consistent with professional standards.

My practice record for each client contains:

- ☐ the name of and contact information for the client, and other identifying information as appropriate;
- ☐ the presenting problem or purpose of the consultation;
- ☐ the date and substance of each professional service, including relevant information on original informed consent and emergent informed consent issues such as when changing a service originally agreed to, interventions, progress, and termination;
- ☐ notes related to any interviews conducted as part of an assessment service;
- ☐ notes related to any observation sessions conducted as part of an assessment service;
- ☐ any test results or other evaluative results obtained, and any basic test data from which results were derived;
- ☐ a copy of all reports prepared as part of the professional relationship;
- ☐ notations and any results of formal consultations with other service providers;
- ☐ copies of emails, texts, and any other communications with the client or related to the client's file;
- ☐ a copy of all documents relied upon in the course of providing the service or, if the registrant is prevented by legal or contractual circumstances from keeping copies of documents and the records are held by an institution, the identification and location of all documents relied upon;
- ☐ a clear description of any agreements entered into by the client, including the service to be provided, anticipated uses of information obtained, limits of confidentiality, their acceptance of risks and benefits of a proposed course of action, their acceptance of a supervised service, their acceptance of an innovative service, etc.;
- ☐ any releases or consents signed by the client;
- ☐ any informed assents obtained for the service;
- ☐ the fee arrangement; and
- ☐ a clear record of all fees billed and received, including:
 - the identification of the service provider and the service recipient; ○ the date, nature, and unit fee of the service provided; ○ the total charged and the payment received; ○ the date and source of payment; and ○ any other information needed by the client to obtain insurance reimbursement.

If I am providing services to two or more clients who are related to each other, I will:

- ☐ carefully determine whether the unit (e.g., the couple or the family) is my client and all of my records are appropriately contained within a single file, or the nature of the service and/or legal considerations require me to consider creating and maintaining separate files for each of the parties; and
- ☐ ensure my informed consent process includes clear information regarding my record keeping in the case and how I will handle any future requests for release of information.

My record keeping practices will reflect a consideration of:

- ☐ the length of time for which I need to maintain my records, including:
 - seven years past the date of last service for adult clients;

- ten years after the date of the last episode of care or until age twenty, whichever period is longer, for minor clients;
 - whether legal requirements specify that I must keep records for a longer period of time than captured by the previous two bullets; and
 - whether in my professional view the circumstances are such that I should appropriately keep the records for longer than specified in the previous bullets.
- the location of my records, including that:
 - my records are under either my sole control, the control of another appointed registrant, or in a professional storage facility obligated to provide confidential and secure storage;
 - my records are secured and access to them is strictly limited;
 - electronic records are password protected and reasonably secure from loss, tampering, interference, and unauthorized use or access; and
 - confidentiality of my records is maintained at all times, including while they are being created, stored, disposed of, accessed, transferred, or copied;
- contingency planning, including:
 - I have named a professional executor who will take control of my practice records in the event of my unexpected incapacity or death;
 - I have provided my professional executor with all of the information needed to take control of my records, whether electronic or hardcopy; and
 - I have ensured that my personal executor/family/staff/whoever is relevant is aware of the requirement that my professional executor take control of my records in the event of my incapacity or death.

If my records are part of a common filing system, such as in a multidisciplinary setting, including when I am working as part of a professional team, I will:

- exercise care when placing information in a common file in order to ensure my opinions, reports, findings, and/or recommendations are not misunderstood by registrants of other disciplines;
- work with my employer to develop written policies and procedures that ensure maintenance, storage, and access to my practice records complies with privacy legislation and professional standards;
- in the event of a conflict between institutional/organizational requirements and my professional obligations, clarify the nature of the conflict, make known the conflicting obligation and my commitment to complying with professional standards, and to the extent feasible seek to resolve the conflict in a manner that permits full adherence to professional standards;
- educate others in the setting as appropriate regarding my professional obligations and the requirements of privacy legislation, and require a confidentiality agreement for others who may come into contact with my practice records;
- establish written policies and procedures for handling, copying, and destroying psychology practice records to protect their confidentiality;
- ensure a written succession plan is established to cover practice records in the event of my departure from the setting;
- include information regarding record keeping and relevant confidentiality issues in the setting as part of obtaining informed consent with prospective clients; and

- ☐ assume responsibility for the appropriate management of any psychology tests purchased under my name and qualifications, including by: ensuring written policies and procedures exist for storage and handling in accordance with contractual obligations, privacy legislation, and professional standards; ensuring the policies take into account future changes in psychology staffing; and educating others in the setting regarding requirements for maintenance and storage of test materials and test results.

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