Chapter 10

Record Keeping

CHAPTER OVERVIEW

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Purpose of Record Keeping

The term "record" means information in any form or medium that includes notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers and papers and any other information that is written, photographed, recorded or stored in any manner (1 - 3).

Record keeping involves activities related to the creation, maintenance and disposition of records and is an important aspect of the practice of all Registered Dietitians and Registered Nutritionists. Clear, comprehensive and accurate records are essential to communicate the delivery of professional services and to support professionals in responding to accountability issues. Record keeping is best approached in an organized and systematic manner that will support the creation of efficient records, maintain their confidentiality and prevent unauthorized disclosure.

KEY PRACTICE POINT

Clear, comprehensive and accurate records are essential to communicate the delivery of professional services and to support professionals in responding to accountability issues.

The key purposes of record keeping are as follows:

Documentation of Daily Practice Activities

Records play an important role in assisting Registered Dietitians and Registered Nutritionists in their daily practice by providing an account of what has been planned and the services that have been provided.

Communication with the Inter-Professional Team

Records are useful for communicating with other members of the inter-professional team. Clear, complete, accurate and timely documentation in a client health record is essential to ensure that all members of the inter-professional team involved in the care of a client have access to reliable, pertinent and current information from which to plan and evaluate their treatment interventions. Physicians, nurses, therapists and other health care providers frequently refer to documentation entered in the client health record by other professionals as they develop their treatment plans or implement nutrition care plans. The information in a client record assists health care providers in providing continuity of care to clients. Records that are incomplete, incorrect, or entered too late can result in inappropriate treatment decisions (4, 5). Records can also play an important role in the education of students and medical residents.

Professional Accountability

Good record keeping practices are valuable in demonstrating that the knowledge, skills, attitudes and judgment of the Registered Dietitian or Registered Nutritionist have been applied in accordance with the *Code of Ethics* and *Standards of Practice and Essential Competencies for Dietetic Practice*. Good record keeping practices not only reflect the services provided, but also demonstrate professional accountability.

The obligations of Registered Dietitians and Registered Nutritionists related to record keeping are reflected in Section 3.4 of the College of Dietitians of Alberta *Code of Ethics* which states the following:

> **"3.4 Records**
>
> (1) The dietitian makes and retains complete, accurate records of professional services and signs and dates records that they create.
>
> (2) The dietitian stores and disposes of paper, electronic and other records in a manner that ensures the security and confidentiality of the records.

(3) The dietitian plans for the proper transfer or disposition of records when closing practice or in case of their death."[66]

Professional obligations related to record keeping are also stated in the *Standards of Practice and Essential Competencies for Dietetic Practice.* The applicable essential competency and performance indicator statements are as follows:

"**4.0 Applies information management principles and current technology in practice.**

4.1 Documents and maintains information in compliance with established guidelines.

4.2 Maintains accurate, clear, concise and timely documentation of professional services."[67]

The importance of the client record as a legal document cannot be overemphasized. The client record may be entered as evidence at a trial or professional conduct hearing, providing an account of the services and care that were provided, including but not limited to the following:

- Record of dates / times and events that occurred
- Whether or not orders were carried out
- If services provided were appropriate and timely
- If professional and ethical standards of care were met
- If the client was compliant

Proper documentation of the services provided is the best defense in the event of any legal proceedings: "Most adjudicators will have serious difficulty rejecting a client's claim that something was not done if the chart has no record of it, regardless of evidence provided by the dietitian. Similarly, most adjudicators will generally accept that something did occur if the dietitian recorded it, regardless of evidence to the contrary provided by a client." [68]

Preparation of Reports

Records are commonly used to prepare reports that may be used for various purposes. For example, reports can be used in making funding and resource

[66] College of Dietitians of Alberta. *Code of Ethics*; 2007.
[67] College of Dietitians of Alberta. *Standards of Practice and Essential Competencies for Dietetic Practice*: 2007.
[68] Steinecke, Richard, LLB and the College of Dietitians of Ontario, *The Jurisprudence Handbook for Dietitians in Ontario*, Ontario; 2003, p. 65.

management decisions. Records may also be used for audits, health care billing, professional conduct reviews, accreditation surveys, in clinical research and in the assessment of the quality of services provided in quality improvement / risk management programs. The information included in such reports may be used by a variety of individuals including other health care professionals, insurance providers, employers and lawyers (4, 5).

Types of Records

Records are kept in all practice settings; the actual types of records kept will vary from organization to organization. In dietetic practice, records typically relate to equipment, finances and client care. Details of each are as follows:

Equipment Service Records

Equipment service records are of importance, particularly where proper function of a piece of equipment is critical to client health and safety. For example, dishwashing machines are serviced regularly to ensure that they wash and sanitize dishes properly. A record that includes the date, the inspection or service that was provided and who completed the inspection or service becomes critical if a problem develops later. Equipment service records can also serve as a useful reminder when inspections or preventative maintenance are required (4, 5).

Financial Records

Systems must be in place to monitor and manage the finances of an operation. Accurate records must be kept of revenues and expenditures; good records are essential for the preparation of financial statements which are used in assessing profitability and in making decisions related to operation. Financial records are also used in the preparation of budgets and for tax related purposes as required by Revenue Canada.

For Registered Dietitians and Registered Nutritionists who work in private practice or non-publicly funded settings, financial records are also important in relation to client billing. Typically, financial records would include the following (4, 5):

- A client identifier
- The date
- The nature of the service provided
- The length of time required to provide the service
- The actual fee charged and the method of payment

Client Health Records

The client health record serves as a basis for planning client care, documenting communication among health care professionals contributing to the care of the client, assisting in protecting the legal interests of the client and the health care professionals responsible for the care of the client, and documenting the care and services provided to the client. The goal of the client health record is to provide a clear and accurate account of what occurred during a visit with the client, when it occurred, and who was involved.

KEY PRACTICE POINT

The goal of the client health record is to provide a clear and accurate account of what occurred during a visit with a client, when it occurred, and who was involved.

The *Operation of Approved Hospitals Regulation* under the *Hospitals Act* states the following:

> "**Medical records**
>
> **13(1)** The board of each approved hospital shall cause to be kept by the attending health practitioner a record of the diagnostic and treatment services provided in respect of each in-patient and out-patient in order to assist in providing a high standard of patient care.
>
> **(2)** For each admission, a record of diagnostic and treatment services shall be maintained that shall
>
> (a) identify the patient, and
>
> (b) provide sufficient information to justify the diagnosis and warrant the treatment given, including
>
> (i) provisional and final diagnosis,
>
> (ii) reports of diagnostic and treatment procedures,
>
> (iii) reports of consultations,
>
> (iv) surgical reports,
>
> (v) progress notes,
>
> (vi) orders for treatment,
>
> (vii) discharge summary as applicable, and
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> (viii) the signature of the attending health practitioner."[69]

[69] Province of Alberta. *Operation of Approved Hospitals Regulation*; 1990.

Section 7 of the *Proposed Records Regulation* developed by the College of Dietitians of Ontario provides the following comprehensive listing of what Registered Dietitians and Registered Nutritionists should document in a client record (6):

- The full name and address of the client
- The date of each visit with the client
- The name and address of the primary care physician and any applicable referring health professionals
- The reason for the referral, if applicable
- Relevant medical history and social data
- Details of the assessment conducted, findings of the assessment, problems that were identified, goals for nutrition intervention and the nutrition care plan
- Recommendations for diet orders, nutrition supplements, tests / consultations to be performed by other members of the inter-professional team
- Progress of ongoing interventions, significant findings and resulting modifications to the treatment plan
- Relevant reports related to the health of the client
- Information about discharge planning and client referrals to other health care professionals
- Reasons for client cancellation of appointments or refusal of dietetic services
- Details of nutrition care that was initiated but not completed
- Copies of reports issued to health care professionals and / or the client
- Copies of appropriate consent to treatment forms
- Notation of any restricted activities that were performed for the client

The above listing of items that should be documented in a client record is consistent with the expectation for Registered Dietitians and Registered Nutritionists who practice in the province of Alberta.

Records of Consent to Treatment

"Consent to treatment" refers to the consent or agreement of a client to undergo an assessment process or treatment intervention, after gaining an understanding of the relevant facts and risks involved. A record of consent to treatment should be obtained from a client or substitute decision maker who is legally authorized to provide consent on behalf of a client prior to providing dietetic services (4, 5).

Please refer to Chapter 9 for further information on consent to treatment.

Record Keeping Systems and Methods

While many organizations continue to use paper based record keeping systems, electronic record keeping systems are becoming the norm. Regardless of whether an organization uses a paper based or electronic record keeping system, the principles of good record keeping practices must be maintained. Information recorded must be organized in such a way that it provides a clear, accurate and honest account of what occurred, when it occurred and who was involved.

KEY PRACTICE POINT

Registered Dietitians and Registered Nutritionists have a responsibility to follow the record keeping directives established by their employers.

Most organizations have record keeping policies, procedures, guidelines, systems, methods and forms / software in place; all Registered Dietitians and Registered Nutritionists have a responsibility to follow the record keeping directives established by their employers. Some of the record keeping systems commonly used to document client care activities are described below.

Written Narrative

The actions of health care professionals and client responses are recorded in chronological order, describing the care that was provided. Records may be handwritten on paper or typed in an electronic format.

Forms / Checklists

Pre-established forms / checklists can provide a quick and efficient method for recording client information. Such forms / checklists may be completed in paper or electronic mediums. While forms / checklists save time, health care professionals must be cautious to ensure that they are completed carefully and accurately. Extra space should also be provided for the addition of information that is not captured by a particular form / checklist.

Dictation

Dictation involves creation of a verbal record of information that will be later transcribed into a written / typed paper or electronic record. As there is potential for errors related to word recognition / interpretation during the transcription process as well as the possibility of misfiling or loss of the record, Registered Dietitians and Registered Nutritionists are advised to track dictated records carefully and to review and sign all records to ensure accuracy.

Record keeping methods used are generally outlined in the policies and procedures of each individual facility. Some of the methods of record keeping commonly used to document client care activities are described below.

Various methods of documenting client care information exist including ADIME (Assessment, Diagnosis, Intervention, Monitoring and Evaluation), DARP (Data, Action, Response, Plan), PIE (Problem, Intervention, Evaluation), SOAP (Subjective, Objective, Assessment, Plan), among others.

Charting by Exception

"Charting by Exception" is an approach in which only unusual or out of the ordinary events are documented, thereby reducing repetition and time that is spent documenting. Clearly written protocols are important to specify what is and what is not implied by a lack of chart entries (5).

Charting by Reference

"Charting by Reference" is an approach in which the documentation of a health care provider refers to a medical directive, assessment protocol or established treatment regime. Accurate record keeping using this method relies on references that are accurate and complete (5).

International Dietetics and Nutrition Terminology (IDNT)

The Nutrition Care Process (NCP) and International Dietetics and Nutrition Terminology (IDNT) are recommended by Dietitians of Canada and by the International Confederation of Dietetic Associations as the framework for the provision and documentation of nutrition care. The IDNT is a standard set of nutrition care terms and definitions that are used to describe nutrition assessment data, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation. Nutrition diagnosis identifies and describes the specific nutrition problem that the RD aims to improve or resolve through nutrition intervention. The nutrition diagnosis is communicated as a PES statement (P = problem; E = etiology; S = signs and symptoms).

The Nutrition Care Process may be in conjunction with other charting formats, as follows:

Table. General Guidelines for incorporating NCP into common documentation methods:

ADIME
A = Assessment
D =Diagnosis or PES statement
I = *I*ntervention
Nutrition prescription
Nutrition Intervention
Goal
M = Monitoring
E = Evaluation

PIE
P = Problem
Diagnosis or **P**ES statement
I = Intervention
Nutrition Intervention
Goal
E = Evaluation
Monitoring

DARP
D = Data
Diagnosis or PES statement
A = Action
Nutrient Prescription
Nutrition Intervention
Goal
R = Response
P = Plan
Monitoring and Evaluation

SOAP
S = Subjective data
O = Objective data
A = Assessment
Diagnosis or PES statement
Nutrient Prescription
P = Plan
Nutrition Intervention
Goal
Monitoring

Adapted from A. Skipper, 2007 (7)

Joint and Private Records

Most Registered Dietitians and Registered Nutritionists work in settings where they use a "joint record" or record that is used by all members of the inter-professional team. Joint records are an important component of the communication process necessary to ensure that all members of the inter-professional team involved in the care of a client have access to reliable, pertinent and current information upon which to plan and evaluate their treatment interventions. The joint record keeping practices of all Registered Dietitians and Registered Nutritionists should be consistent with the directives stated in legislation and established by their employer.

Registered Dietitians and Registered Nutritionists who are employed in privately operated facilities or programs may find less formalized record keeping policies and procedures in place. In such settings, extra efforts are often required to ensure that record handling practices meet the minimum professional expectations; practitioners are advised to follow the principles listed below (4):

- Ensure the security of all records
- Ensure confidentiality of all records (Please refer to Chapter 8)
- Provide reasonable client access to records (Please refer to Chapter 8)
- Implement and follow an appropriate policy for correction of documentation errors
- Retain records for a minimum of 10 years following the date of last service; in the case of minor clients, records should be kept for at least two years past the age of majority or for 10 years, whichever is longer
- Ensure a reasonable plan for transfer of records should the facility or program close

Some Registered Dietitians and Registered Nutritionists may keep their own private records of assessment notes, calculations, treatment plans, etc. apart from the joint record keeping system. This practice is not recommended for the following reasons (4):

- It is generally more difficult to ensure the security and confidentiality of such records
- Information that may be valuable to other members of the inter-professional team is inaccessible to them
- The legislated obligations of the facility related to record keeping practices, record retention and destruction of records may not be met
- In the event that the record is required in a legal proceeding, all pertinent information must be included in the official record

Overall, in terms of keeping private records, Registered Dietitians and Registered Nutritionists are advised to carefully consider the following options (4):

- Do not keep private records. All information that should be documented should be recorded in the official client record or chart, or
- If keeping private records is approved by the employer, maintain such records in compliance with established policies and procedures that include appropriate record keeping practices, ensuring the security and confidentiality of all records.

KEY PRACTICE POINT

All information that should be documented should be recorded in the official client record or chart.

Record Keeping Guidelines

Many complaints against health care practitioners are related to miscommunication; the following record keeping guidelines are helpful in reducing the risk of legal liability of Registered Dietitians and Registered Nutritionists (5, 8):

- Record entries should include the date, time, name and professional designation of the person documenting the information
- Record accurately, precisely and objectively, ensuring that information is supported by facts; avoid judgmental or derogatory remarks
- Record clearly, ensuring the absence of any ambiguity
- Record concisely, including only that information which is relevant and essential
- Record events chronologically
- Record immediately or as soon as possible; if a late entry is made, it should include the current date and time, identification that the entry is late and the date and time that the intervention occurred
- Documentation must be made by the person who was directly involved in the event recorded; never chart or sign on behalf of another individual
- Use correct spelling and terminology that is understood by others
- Avoid using abbreviations that could lead to misunderstanding (Please refer to Appendix 5 for further information on "Health Quality Council of Alberta - Improving Patient Safety by Eliminating Unsafe Abbreviations from Medication Prescribing".)
- Co-sign record entries completed by dietetic interns in accordance with the established policies and procedures of the workplace to verify the accuracy of the entry

KEY PRACTICE POINT

All records must provide a clear, accurate and honest account of what occurred and when it occurred.

Additional Guidelines for Paper Based Record Keeping

- Write legibly in ink; do not use pencils, gel pens or coloured highlighters as they are not permanent
- Do not change pens in the middle of writing an entry; if this becomes necessary, note why the ink has changed

- Record entries should be signed by the person who made the entry including their name and credentials

- If corrections are required, ensure that they are legible. Use the following suggestions for correcting written entries:

    - Draw a single line through the entry so that it is clearly deleted, yet still readable

    - Indicate the location of the correct entry

    - Record the correction with the date and time

    - Sign the correction

    - Never remove pages from the record

- Do not leave blank lines or white space between entries in the record to avoid the risk of additional information being added by another individual

Additional Guidelines for Electronic Record Keeping

- Use an electronic medium that is permanent and cannot be altered; all entries made / stored electronically are considered a permanent part of the client health record and may not be deleted

- Use the appropriate features of the electronic documentation system to make corrections or late entries

- Ensure that the program used leaves an audit trail that can reveal when each change was made and by whom

Client Requests for Corrections or Amendments to Their Records

As discussed in Chapter 8, clients have the legal right under the *Health Information Act (HIA)*, *Personal Information Protection Act (PIPA)* and the *Freedom of Information and Protection of Privacy Act (FOIP)* to request access to any record that contains information about that person that is in the custody or control of a health care setting, private sector organization or public body (1 - 3).

Under the *HIA, PIPA* and *FOIP,* if a client believes that their information contains an error or omission, they may request that the custodian who has control of that information correct or amend the record. Applicants must make their request to correct or amend their information in writing. Custodians in health care settings, private sector organizations and public bodies must make every reasonable effort to respond within legislated time frames

and assist applicants with their requests. Custodians are obligated to ensure that information is accurate and complete; the custodian of the record should consult with the individual who made the entry under question prior to taking any action. If a custodian agrees that a change or amendment is required, they must provide the applicant with written notice that the correction or amendment has been made and where appropriate, send a notice of the correction or amendment to any organization to which the incorrect information had been disclosed. Despite the request of an applicant, custodians should not make a correction or amendment to a professional opinion or observation made by a health services provider, or to a record that was not originally created by the custodian. (1 - 3).

When a correction or amendment is made, the audit trail must not be compromised. Therefore, the original entry should not be obliterated. Rather, the corrected entry or amendment should be inserted indicating the date and the name of the person making the correction or amendment (4).

Under the *HIA*, if a custodian refuses to make a change or amendment as requested by an applicant, the custodian must advise the applicant that they may do one of the following (1):

- Request that the Information and Privacy Commissioner review the decision of the custodian, or

- Submit a statement of disagreement outlining the requested change or amendment and their reasons for disagreeing with the decision of the custodian not to make the change or amendment.

Security and Confidentiality of Records

Regardless of whether records are in a paper based or electronic format, all health care professionals are obligated to maintain the security and confidentiality of all records at all times. Section 2.4 of the *Code of Ethics* of the College of Dietitians of Alberta (the College) states the following:

"2.4 Confidentiality

(1) The dietitian respects the confidentiality of information obtained in providing professional services.

(2) The dietitian discloses confidential information only when the client consents to disclosure, when disclosure is required or permitted by law, or when disclosure is necessary to protect the client or another individual from harm. See Duty to Report.

KEY PRACTICE POINT

Regardless of whether records are in a paper based or electronic format, all health care professionals are obligated to maintain the security and confidentiality of all records at all times.

(3) The dietitian avoids indiscreet or public conversations about the client or their treatment.

(4) The dietitian does not access information in databases or records about individuals who are not clients or information that is not required to provide professional services.

(5) The dietitian limits access to professional records by others to preserve confidentiality of information."[70]

Professional obligations for Registered Dietitians and Registered Nutritionists related to maintaining the security and confidentiality of all records are also outlined in the *Standards of Practice and Essential Competencies for Dietetic Practice* which states the following:

"3.0 Applies legal and ethical principles in managing information.

3.1 Complies with legislation and established policies in managing information.
May include but is not limited to: freedom of information and protection of privacy acts, personal information protection acts, health information acts

3.2 Protects the confidentiality and security of information throughout collection, storage, use, dissemination and destruction processes.

3.3 Protects integrity, reliability and authenticity of records."[71]

The security and confidentiality of records is at increased risk when records are transmitted from one location to another. Health care professionals should ensure that all necessary steps are taken to reduce such risk. The following guidelines are helpful in reducing the risks to the security and confidentiality of records during transmission processes.

Records Being Transmitted Via Mail or Courier

- Place information in a sealed envelope, clearly identified as confidential
- Use a system to track the delivery and receipt of items

Records Being Transmitted Via Email

- Use secure and confidential systems and protocols
- Transmit records in an encrypted form

[70] College of Dietitians of Alberta. *Code of Ethics*; 2007.
[71] College of Dietitians of Alberta. *Standards of Practice and Essential Competencies for Dietetic Practice*; 2007.

- Verify email addresses of intended recipients prior to transmitting; request an acknowledgement of receipt

- Include a confidentiality statement stating that the information is confidential, to be read by the intended recipients only and that the email and any attachments are to be deleted if received in error

Records Being Transmitted Via Facsimile

- Use secure and confidential systems and protocols

- Try to ensure that the facsimile will be retrieved immediately or stored in a secure area

- Verify fax numbers and distribution lists prior to transmitting

- Check activity reports to ensure successful transmission

- Include a confidentiality statement on the cover sheet stating that the information is confidential, to be read by the intended recipients only and a

- request for verification that facsimiles received in error were destroyed without being read

Communicating with clients via email

According to the *HIA*, any custodian or affiliate (in this case the Registered Dietitian) has the duty to protect the privacy of clients and the confidentiality of health information within his or her custody or control (9).

Emailing clients can improve quality of care and efficiency when sending out appointment reminders, sharing information and resources or following up on treatment plans, however there are risks associated with email transmission of information including the following (9):

- Interception: information intended for the client, is read by a family member;
- Misdirection: two clients have similar email addresses, and sensitive health information is sent unintentionally to the wrong client
- Alteration: lab results sent to a client are altered and passed on to another health care professional as reliable information
- Loss: electronic information is lost by providers

Registered Dietitians and Registered Nutritionists must mitigate these risks by encrypting data and limiting the amount of health information sent in an email.

As noted above, Registered Dietitians and Registered Nutritionists must consider the retention of information collected. For example, is a copy of an email required as part of the health record? Refer to the next section for more information on retention of records.

For more information on confidentiality, please refer to Chapter 8.

Record Retention and Disposal

Policies related to the storage, retention and disposal of various types of records will differ depending upon the type of documents and the practice setting / organization. Registered Dietitians and Registered Nutritionists are responsible to follow the policies for storage, retention and disposal of records as established by their employers.

The *Operation of Approved Hospitals Regulation* under the *Hospitals Act* states the following:

> **"Retention of medical records**
>
> **15(1)** Diagnostic and treatment service records shall be retained by the hospital for
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> (a) a period of 10 years from date of discharge from hospital, and
>
> (b) in addition, in the case of the patient being a minor, for a period of at least 2 years following the date on which the patient reached the age of 18 years."[72]

KEY PRACTICE POINT

Registered Dietitians and Registered Nutritionists should ensure that client records are retained for a minimum of 10 years following the date of last service; in the case of minor clients, records should be kept for at least two years past the age of majority or for 10 years, whichever is longer.

Client records should be retained according to these guidelines even in the event that a client passes away, as the estate of the client may require information related to the care and services that a client had received (4).

When the appropriate amount of time has elapsed, records should be destroyed, using a method that will ensure the security and confidentiality of the records during the disposal process. A record should be kept of the name of the client, file number, the last date of treatment and the date that the file was destroyed (4).

Closing or Transferring a Practice

Registered Dietitians and Registered Nutritionists may leave their practice for a number of reasons which may include health problems, retirement, relocation and even unexpected death. Practitioners who work in private practice settings in particular must ensure that the

[72] Province of Alberta. *Operation of Approved Hospitals Regulation*; 1990.

necessary arrangements are in place to provide continuous care for their clients upon closure of a practice. Records must also be dealt with in an appropriate manner upon closure of the practice. The College of Physicians and Surgeons of Alberta has established guidelines for managing client records upon closure of a medical practice. Based on these guidelines, Registered Dietitians and Registered Nutritionists who are in private practice settings are advised to consider the following in the event that they close their practice (10):

- If a Registered Dietitian or Registered Nutritionist is closing their practice and is unable to provide ongoing management of client records, either personally or through a colleague, the records should be put into commercial storage for custody, transferred as necessary to another Registered Dietitian or Registered Nutritionist, or destroyed at such time that it is appropriate. It is the responsibility of the Registered Dietitian or Registered Nutritionist to arrange for the storage and transfer of records and to ensure that security and confidentiality is maintained throughout these processes. As outlined in the *Operation of Approved Hospitals Regulation,* records should be retained for a minimum of ten years following the date of last service; in the case of minor clients, records should be kept for at least two years past the age of majority or for 10 years, whichever is longer.

Clients should be notified of the closure and of the transfer of their records to another Registered Dietitian or Registered Nutritionist. Clients should also be given the option to have their records transferred to a practitioner of their own choice.

Chapter Summary

Record keeping involves activities related to the creation, maintenance and disposition of records and is an important aspect of the practice of all Registered Dietitians and Registered Nutritionists. Clear, comprehensive and accurate records are essential to communicate the delivery of professional services and to support professionals in responding to accountability issues. Record keeping is best approached in an organized and systematic manner that will support the creation of efficient records, maintain their confidentiality and prevent unauthorized disclosure. The key purposes of record keeping are as follows:

- Documentation of daily practice activities
- Communication with the inter-professional team
- Professional accountability
- Preparation of reports

Records are kept in all practice settings; the actual types of records kept will vary from organization to organization. In dietetic practice, typical records kept include equipment service records, financial records, client health records and consent to treatment records. Regardless of whether an organization uses a paper based or electronic record keeping system, the principles of good record keeping practices must be maintained. Most organizations have record keeping policies, procedures, guidelines, systems, methods and forms / software in place; all Registered Dietitians and Registered Nutritionists have a responsibility to follow the record keeping directives established in legislation and by their employers. If a client believes that the information in their record contains an error or omission, they may request that the custodian who has control of that information correct or amend the record. Such requests may be accommodated, depending on circumstances as outlined in legislation. Registered Dietitians and Registered Nutritionists are responsible to follow the policies for storage, retention and disposal of records as established by their employers. Regardless of whether records are in a paper based or electronic format, all health care professionals are obligated to maintain the security and confidentiality of all records at all times. Client records should be retained for a minimum of 10 years following the date of last service; in the case of minor clients, records should be kept for at least two years past the age of majority or for 10 years, whichever is longer. Registered Dietitians and Registered Nutritionists who work in private practice are responsible to ensure that records are dealt with in an appropriate manner upon closure of their practice.

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