Record Keeping

Guide to the Standards for Professional Practice

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Introduction

Record keeping is an essential component of patient care. Physiotherapy records provide patients with evidence of the care that was provided to them, when it was provided and who provided the various aspects of care. Patients have the right to access and control the information contained in their health records. Physiotherapists, or the facilities they work for, act as the custodians of that information1.

The record should document for the patient:

- what was assessed
- an analysis of the results of the assessment
- the recommendations and goals for treatment
- that informed consent was obtained
- the details of the treatment provided and an indication of who provided the treatment
- the results or outcomes (including any reassessments and changes to the treatment or the patient’s condition)
- a summary of the episode of care upon discharge

Record keeping is also a requirement for professional practice. The record can assist physiotherapists in demonstrating their competence, and that they have met their professional and regulatory obligations by providing physiotherapy care that is in the best interests of the patient. A record that is complete and documented in a timely fashion can assist physiotherapists to reliably recall events and decisions made during a course of treatment. The overall goal of record keeping is to include sufficient detail for another practitioner involved in or assuming the care of a patient to follow the plan of care and provide ongoing treatment.

Legibility of records is vital. Even if all the requirements of the Standard for Record Keeping are met, if a record is not legible it is impossible to comprehend the care that was provided. This renders the record useless to the patient or any individual with authorized access.

Discretionary Issues

The College often receives enquiries on components of record keeping that are not outlined in the Standard for Professional Practice: Record Keeping and for which the College does not have specific requirements. Physiotherapists, facilities and/or employers can use their discretion and make their own decisions regarding:

- The format, organization or style of the record (e.g. use of SOAP, DAR, FOCUS or other method); however the College does recommend that a consistent method be used to ensure that all relevant information is included.
- The use of care maps or other tools (e.g. charting by exception), provided that the care map or charting by exception guide includes all required information and can be retrieved throughout the entire retention period2. It should also be made clear in the patient’s record that a care map

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1 Personal Health Information Protection Act, 2004 (PHIPA)
2 In most cases the retention period will be 10 years. See section 6(1) of the Standard for Professional Practice: Record Keeping as well as FAQs 6d, 6e.
was followed, what version of the care map was used (these tools can and should be updated), and a reference to where the particular version of the care map can be found (ideally a copy of the care map would be in the chart).

- **The colour of ink to be used when documenting.** Keep in mind that the content of the record should be retrievable and reproducible for the entire retention period.

- **The method of recording or storing information and the media used** (e.g., paper vs. electronic), provided that the complete record can be retrieved and reproduced throughout the retention period; an audit trail of persons who have made entries or changes (and the changes made) can be identified and authenticated; and a method of protecting both confidentiality and data integrity exists.

- **List of abbreviations** The College requires that reasonable means be provided for those who access the record to understand the meaning of acronyms and abbreviations used in charting. The College does not specify which abbreviations are acceptable for use or how this information is maintained. For example, a term may be written out in full the first time it is used with the acronyms/abbreviations and their meanings could be referenced and maintained for the duration of the retention period.

Frequently Asked Questions

The following questions about record keeping are frequently received by the College. The reference number following each question identifies the section of the Standard for Professional Practice: Record Keeping where performance expectations are described.

1. **General**

   a. **What are the components of a physiotherapy record?** (See Definitions “Clinical Record”)

   A physiotherapy record consists of all information related to the provision of physiotherapy care i.e. clinical information, the identification of all persons providing care and a record of financial information. Equipment maintenance records are also required. (See also FAQs 1l; 2b, c, f, i, j, k; 3b; 4a; 6a, b, c.)

   b. **Why should I audit my own record-keeping practices?** 1(4)

   Periodic evaluation of all components of the physiotherapy record or self-audit is an important activity for quality practice and is required by the College. Setting a reasonable time frame for regular review based on your practice environment and then auditing your own clinical, financial and equipment records against the professional standard can help you determine whether you are meeting your legal, professional and employer obligations. The review process may be done in a formal way with a procedure manual and evaluation forms, or in a less formal manner (e.g., upon conclusion of the therapeutic relationship when reviewing the record in order to summarize the episode of care and record a discharge summary).

3 The Quality Management Peer Onsite Assessment Program of The College of Physiotherapists of Ontario has an onsite assessment tool that includes an evaluation of record keeping practices that is available online at www.collegept.org. The College of Physicians and Surgeons of Ontario also has a similar tool.
c. Why is it important to identify the Health Information Custodian? 1(5a)

Under the Personal Health Information Protection Act (PHIPA) physiotherapists are defined as Health Information Custodians (HICs) in certain circumstances (e.g., solo practitioner in private practice) but are defined as agents of the HIC in other circumstances (e.g., when employed by a hospital or other organization defined in PHIPA). In these cases the HIC is clearly identifiable. In other circumstances there may be some doubt as to who is acting as the HIC (e.g., in the case of an independent contractor, working for a clinic or other agency). In this circumstance either the physiotherapist or the clinic may act as the HIC. Where the circumstances do not make it clear who the HIC is, it is in the best interest of both the patient and the physiotherapist to clearly identify the HIC in the health record in order to verify who is responsible for maintaining privacy for the collection, use, disclosure, storage, and disposal of personal health information. It is also important to identify the HIC in order to ensure that both the physiotherapist and the patient can retain access to the health record after the therapeutic relationship has concluded.

d. I work in a multidisciplinary setting. Can we keep joint or combined records? 1(5b), 9

Yes, joint or combined records are permissible. Standards for record keeping do not change with practice setting or with multiple providers. The record should document who provided care, when the care was provided and a rationale as to why the care was provided. It is also necessary to be able to ascertain which team members were responsible for each entry in the record. Physiotherapists documenting in a multi-disciplinary care record should ensure that entries in the record pertaining to the services they provide are accurate, can be attributed to them, comply with their professional standards and that the physiotherapist retains access to the records for the duration of the retention period. Other regulated health professionals have similar requirements. Grouping profession-specific information into one area of a form, initialing entries and/or the use of profession-specific sections with headings followed by a signature can facilitate the identification of who provided various aspects of care. (See also Applied Practice Scenario 1 on page 15.)

e. Is there anything different about electronic records? 1(9a-c)

Although the principles associated with the management of health information and the expectations regarding record keeping do not change regardless of the medium in which the records are kept, there may be some peculiarities associated with the medium chosen. Key considerations for electronic records include ensuring:

- Privacy and confidentiality by protecting against unauthorized access (password protection and/or encryption)
- Audit trails identifying the date and time of an entry and who made the entry or change (and the changes made), while preserving the original content
- Security is maintained when transmitting records electronically, or when using portable storage devices (by encryption of information or avoiding the use of portable equipment in public places)

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4 Personal Health Information Act, 2004 (PHIPA)
5 The Canadian Alliance of Physiotherapy Regulators has a Guideline for the Collection, Maintenance Transmission and Destruction of Electronic Health Information.
6 The Information and Privacy Commissioner of Ontario issued an order (HO-004) in March 2007 regarding the requirements for the safeguarding of personal health information stored on electronic devices.
• Adequate data backup to prevent loss of information
• The record remains retrievable and reproducible for the duration of the retention period (e.g., technological advances may mean records stored in certain electronic formats may no longer be accessible) (See also FAQ 6a)
• Confidential methods for complete disposal (e.g., purging the information or destroying the hardware so that the information cannot be retrieved vs. simply deleting the files) (See also FAQ 6f)

Identifying Patients and Care Providers

f. Why do I need two pieces of information (e.g. patient’s name and birth date) on every part of the record? Can I use a unique identifier? 1(6)

In any practice setting, physiotherapists may be providing care to individuals with the same or similar names. To ensure the integrity of information (when making entries or if a page should become separated from a file) and assist in maintaining confidentiality, a system to uniquely identify each individual (such as name and birth date) should be clearly documented on all parts7 of the patient record, including attendance, financial and clinical records. Alternatively, a file number that relates to and identifies a single individual (unique identifier) may be used.

g. Do I need to sign my full name every time I make an entry or can I use initials? Do I have to include my title every time? 1(5c), 1(5d), 1 (7b)

The physiotherapy record should clearly identify the physiotherapist responsible for care. The full name and title of the physiotherapist should be documented at least once in the record. For subsequent entries, the use of initials without title is permissible as long as the initials link back to a single health care provider. When multiple care providers who share the same initials are making entries in the health record, the use of initials alone does not identify who made the entry and another method of signing the record is needed. For example, when a physiotherapist and an occupational therapist (or a physiotherapist and a physiotherapist support personnel) with the same initials both document the care provided to the same patient, the use of title along with initials would clearly identify the care provider. However, when two physiotherapists with the same initials are documenting in the same record a method other than the use of initials and title would be needed to clearly identify who made the entry (e.g., registration number or full signature).

h. Can I use an electronic signature? 1(7b), 1(9c)

When making an entry in the health record it is important to identify the person who made the entry. Physiotherapists may choose to affix electronic signatures to their records and reports provided that adequate safeguards are implemented to prevent unauthorized use of the electronic signature and ensure that a document cannot be modified once the electronic signature has been affixed. (See also FAQ 1e)

i. Can I use a signature stamp? 1(7b)

Physiotherapists should use their professional judgment to determine whether use of a signature stamp is appropriate in their specific setting and circumstances. Physiotherapists are responsible for materials bearing their signature regardless of whether they actually signed their name or a signature stamp was

7 In this context, “part” means discrete component of the record, for example an individual page.
used. A signature stamp is often used to save time particularly when there are numerous documents to sign and/or the documents appear to be standard in nature (e.g., billing forms prepared by administrative personnel). Physiotherapists are encouraged to analyze the risks associated with the use of a signature stamp, particularly if the stamp is lost, stolen or used without authorization. Where a physiotherapist chooses to use a signature stamp, it is recommended that:

- the stamp be secured and that access to the stamp be restricted
- the physiotherapist review all documentation prior to the affixation of the signature stamp
- the actual placing of the stamp on documentation should only be performed by the physiotherapist or by a person(s) designated by the physiotherapist

Physiotherapist Support Personnel


Yes, having the actual provider of physiotherapy care (the PSP) document the aspects of care they provided in the health record is not only acceptable, it is preferable. (Some employers may require PSPs to document) Physiotherapists should determine the knowledge and skill level of the PSP, provide appropriate support and training, and ensure on an ongoing basis through an audit system that documentation complies with College standards and applicable legislation. (See also FAQ 1b, 1k)

k. Do I need to co-sign the PSP entries?

No, the College does not require physiotherapists to co-sign entries recorded by support personnel. Physiotherapists may adopt the practice of co-signing entries as a communication mechanism to indicate to support staff that they have read the entry and are aware of the status of the patient. In such cases, the entry is an integral component of the communication system between the physiotherapist and the PSP. (See also FAQ 1j, 1b)

l. We have several PSP who apply/remove modalities, hot packs, ice etc.. How do we record who does what? 2(4f, g), 1(5c, d)

The following two situations apply when:

i. It is known in advance which PSP is to be assigned a task.

In this situation, the patient’s record should reflect the interventions that were assigned, the frequency and time frame during which those services were to be performed and that appropriate consent was obtained for the PSP to whom the task was assigned.

ii. It is not known in advance which PSP will be providing the assigned tasks.

The patient’s record should reflect the interventions that were assigned, the frequency and time frame during which those services were to be performed and that appropriate consent was obtained for multiple providers.

In either circumstance, a record of who actually performed the intervention is required. This
information may be documented in the clinical record or can be managed in other ways (e.g., through the use of a workload measurement system or flow sheets whereby each provider signs off on the treatment aspects they provided). This information should be available for the duration of the retention period and retrievable for each patient. (See also Applied Practice Scenario 3 on page 15.)

Making Changes

m. If I make an error or need to alter an entry what do I do? 1(8)

Changing the record to reflect a new perspective or new information is permissible provided the original content remains intact. Corrections can be made either by striking out the incorrect information in a way that does not obliterate the information, or by labelling the information as incorrect. The correct or new information can then be added to the record with a clear identification of the date when the change is made, the person making the change and the reason for the change. (See also FAQ 5c and Applied Practice Scenario 5 on page 16)

2. Clinical Records

What to include

a. Can I document information from another health professional (e.g., a diagnosis) in my assessment and/or progress notes? 2(2)

Yes, it is permissible to include findings established by other professionals, or to include a diagnosis as reported directly by patients or their substitute decision-makers. These findings should be recorded accurately and include a reference to the source of the information.

b. Do I need to document advice or information provided by telephone and/or email? 2(4i)

Specifics of telephone and/or email advice or information should be recorded if the advice or information relates to the patient’s condition or the provision of clinical care. It is important to document information relating to any changes in symptoms, condition, or treatment provided in order to understand the care that was provided. For example, it would be important to record information from a patient who telephoned or emailed to report an exacerbation of symptoms following the addition of a new exercise as part of their home program, as well as any advice provided regarding the alteration of the exercise program. Information on process or advocacy issues that do not relate to the patient’s condition such as how to submit an insurance claim form or changing an appointment time need not be documented. (See also FAQs 2c, 2f)

c. What other reports or communication should be documented? 2(11), 2(12)

Every written report sent or received respecting the patient’s care is a component of the clinical record and should be included (e.g., physiotherapist reports, progress notes or discharge summaries sent to another health care provider, insurer or payer etc.). Copies or notes documenting other forms of communication (e.g., telephone or email) relevant to the patient’s condition or the care provided are
also part of the clinical record. (See also FAQs 2b, 2f)

d. Is an analysis of assessment results or clinical impression statement required? 2(4b)

Yes, physiotherapists are expected to document a summary statement analyzing the assessment findings and determining a clinical impression. It is important for anyone accessing the record to be able to understand not only the assessment(s) performed and the treatment provided but also the process of how the two are related. The analysis statement or clinical impression should identify the need for the physiotherapy intervention. The level of detail required for documentation will vary with circumstances.

e. Do patient goals need to be recorded in the chart? 2(4c)

Yes, the clinical record should show evidence of patient-centered goal setting, including the documentation of measurable outcomes. How these goals and outcomes are recorded may vary. The skills used for goal setting with patients are the same skills used for setting ongoing professional development goals. The SMART formula (specific, measurable, action-oriented, realistic and time bound) is one example.

f. How much detail should be included when documenting the treatment provided? 2(4e)

Documentation of the treatment provided should include sufficient detail to enable another physiotherapist to understand the care that was provided in order to assume and continue to manage the patient’s care. This includes providing copies of, or reference to, any patient education material, home programs, telephone/email advice, flow charts or other information given to the patient. (See also FAQs 2b, 2c)

g. What do I need to document when I perform a controlled act under delegation? 2(4k)

When documenting the performance of a controlled act under delegation, the details of the formal transfer of authority (whether under direct order or medical directive) for performance of that controlled act should be documented. This includes the name of the authorizer and the date the order was written (for direct orders), or the number and version of the written medical directive that was followed. When subsequent versions of a medical directive are developed or updated, previous versions should be retained and retrievable during the entire retention period (similar to care maps).

h. What should be included in a discharge summary? 2(5)

The details required to be recorded as part of a discharge summary are directly related to the reasons for ceasing treatment. For example, if the treatment is ceasing by mutual agreement between patient and provider because goals have been achieved, then the discharge summary should include all the components listed in the standard (e.g., status at discharge, goals and outcomes attained and recommendations for post-discharge self-management). If however, treatment ceases for reasons beyond the physiotherapist’s control (e.g., the patient never returned for treatment, died or was transferred to another facility) a notation outlining the circumstances may be sufficient.

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8 Resources for writing SMART goals are available on the College website www.collegept.org under Quality Management, Professional Portfolio

9 The College’s expectations are defined in the Standard for Professional Practice: Performing Controlled Acts. Additional information to facilitate understanding of performance expectations is also provided in the accompanying Guide. Both are available in the Registrants Guide section on the College website www.collegept.org.
When to Make an Entry

i. Do I need to make an entry in the clinical record for every visit? 2(4f)

No, it is not required to document in the clinical record at every visit; however, there should be evidence of each professional encounter. This can be managed with the use of an appointment book or workload measurement system provided that the information is retrievable for each patient and is maintained for the duration of the retention period. (See also FAQs 2j, 2k.)

j. Why do I have to record any missed or cancelled appointments and the reason? 2(4h)

Documenting and then examining the pattern of attendance along with the reasons for missed or cancelled appointments may provide important information about the patient’s condition and outcomes of treatment (e.g., a patient with poorly controlled diabetes who cancels appointments frequently because of low blood sugar likely should be encouraged to follow up with their physician to ensure appropriate blood glucose control rather than merely be encouraged to attend more regularly). The most appropriate interventions can only be determined if all the information is documented. The level of detail needed to record the reasons for cancellation will vary with the circumstances. Appointments cancelled for reasons unrelated to the patient’s condition, such as a snow storm or lack of child care, may require minimal detail. However, the fact that an appointment was missed should be recorded as the pattern of cancelled appointments may provide valuable information (e.g., a patient who complains about lack of improvement but has cancelled 7 of the last 10 appointments). (See also FAQs 2i, 2k)

k. How often should an entry be made in the clinical record? 2(6)

An entry should be made in the clinical record every time a patient is re-assessed or every time the treatment plan is amended. The frequency for documenting progress notes will depend upon the individual patient, the type of care provided and the requirement to accurately record the events of the episode of care. Physiotherapists are expected to exercise their professional judgment appropriately when considering this requirement.

If treatment is provided at intervals of less than three months (e.g., three times a week or twice a month), a reassessment should be documented not less than every three months. If treatment is provided at intervals greater than every three months (such as in a school environment or with long-standing stable disease processes where follow-up may be once or twice each year), then documentation should occur with every visit. (See also FAQs 2i, 2j)

Consent

l. What are the requirements for the documentation of informed consent? 2(10)

The College requires that informed consent be documented for both assessment and treatment activities. The Health Care Consent Act\(^\text{10}\) outlines the requirements for obtaining informed consent for all health care professionals. Although the College requires that physiotherapists need only to document that consent was obtained and not the details or specifics of how it was obtained, they are required

\(^{10}\) Health Care Consent Act, 1996
3. Financial Records

a. How long should financial records be kept once the account is paid in full? 6(1)

The financial record is a component of the clinical record and should be kept for the duration of the retention period (in most cases 10 years). (See also FAQ 6d, 6e.)

b. Does the financial record need to be kept with the clinical record?

No, the financial record may be kept separately from the clinical record. For example, the clinical record may be kept and stored in paper form while the financial record is stored in electronic form. Again, the entire record should be retrievable for the duration of the retention period. (See also FAQ 6a.)

4. Equipment Service Records

a. Why do I need to keep equipment maintenance logs?

Documenting the inspection, maintenance and servicing of equipment used to provide physiotherapy care provides evidence that physiotherapists are taking the necessary steps to ensure that the equipment they use is safe and accurate, thereby minimizing the risk of harm to patients. Physiotherapists should take reasonable steps to ensure that the equipment they use in their clinical practice is properly maintained and calibrated according to the equipment manufacturer’s recommended maintenance schedule where there is a risk of harm for patients if this equipment is not properly maintained (e.g., hydrocollators, treadmills, interferential and ultrasound units etc.). Certain pieces of equipment carry a low risk of harm (e.g. goniometers and measuring tapes) and other pieces of equipment may be visually inspected with each use (e.g. crutches and stethoscopes). In these cases it may not be appropriate to formally record the evaluation and calibration of these pieces of equipment. However, in all situations, the use of appropriate infection control procedures is essential

b. What if my employer is responsible for the equipment?

In circumstances where the physiotherapist does not have direct control over the maintenance of equipment (such as when working in a hospital) it is expected that the physiotherapist take reasonable steps to attempt to ensure that the employer maintains equipment appropriately.

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11 See also the Briefing Note to the Health Care Consent Act in the Registrants’ Guide on the College website www.collegept.org
12 The College’s expectations are outlined in the Standard for Professional Practice: Infection Control and is available in the Registrants’ Guide on the College website www.collegept.org
5. Confidentiality of and Access to Records

a. What if a patient wants access to their record? 5(1a)

Patients have the right to access and control the information contained in their health records. The obligations of health information custodians (HICs) related to the collection, use, disclosure, storage, access and disposal of personal health information are outlined in PHIPA\(^\text{13}\). These obligations include making written information about the HIC’s information practices available to patients, as well as information on how patients may access their health records. It is the responsibility of physiotherapists to be familiar with the content and implications of the laws applicable to their practice. Information to support physiotherapists is available in the Registrants’ Guide on the College website\(^\text{14}\).

b. Can the patient request to have their record amended? 5(1b)

Yes, according to PHIPA, the patient has the right to identify anything within the record that may be inaccurate, incomplete or misleading and to request correction of the record. The patient has a right to ask the physiotherapist to change factual information but the patient’s rights are less clear in relationship to the physiotherapist’s observations or opinions. Unless the physiotherapist’s analysis and opinion is substantially based on information that is later proven to be inaccurate, the physiotherapist should exercise judgment in addressing patient concerns about opinion. The physiotherapist has the right to disagree with the patient\(^\text{15}\).

c. How should the record be amended? 5(1b), 1(8)

There are two options for amending the clinical record outlined in PHIPA. The physiotherapist will decide how to amend the record based on the level of agreement about the change. If the physiotherapist agrees with the requested change, it may be made directly in the record. The change should be clearly marked as such and the previous wording should remain legible. The date and person making the change should also be identified. Alternatively, if the physiotherapist does not agree with the change, a patient or their representative may place a patient statement in the clinical or financial record to correct anything that the patient feels is inaccurate, incorrect or misleading. The statement should be titled “patient’s statement”, dated and signed by the patient or their representative. The physiotherapist may also add a physiotherapist’s statement\(^\text{16}\). (See also FAQ 1m and Applied Practice Scenario 5 on page 18.)

d. Who should have access to the records? 5(3), 5(4), 5(5)

There are three groups of people who have the right to access the records:

1. The patient or their authorized representative

Physiotherapists should ensure that they and the patient continue to have access to the record for the duration of the retention period, even if they leave or change practice settings, retire or stop practising.

\(^{13}\) Personal Health Information Protection Act, 2004 (PHIPA)

\(^{14}\) Physiotherapists Privacy Requirements in Ontario: Registrants’ Guide on the College website www.collegept.org

\(^{15}\) Frequently Asked Questions: Health Information Protection Act, Information and Privacy Commissioner of Ontario www.ipc.on.ca

\(^{16}\) A Guide to the Personal Health Information Protection Act, Information and Privacy Commissioner of Ontario www.ipc.on.ca
The records can be transferred to another HIC when the physiotherapist (as a HIC) leaves a practice, retires or dies; however access should be retained for the entire retention period. If the records are not transferred, the HIC or the Estate of the HIC continues to be responsible for the retention of the records17.

2. The care providors within the circle of care

“Circle of care” is not a defined term under PHIPA. It is a term of reference used to describe HICs and their authorized agents who are permitted to rely on an individual’s implied consent when collecting, using, disclosing or handling personal health information for the purpose of providing direct health care. For example, in a hospital, the circle of care includes: the attending physician, medical residents, consulting physicians, nurses, x-ray and laboratory technicians, physiotherapists, social workers etc. who have direct responsibilities to provide care to the individual. The circle of care also includes health care providers involved in the follow-up care of the individual (e.g. at the rehabilitation or long-term care facility where the patient is to be transferred). The circle of care does not include health care providers who are not part of the direct or follow-up treatment, nor does it include professionals who are not covered by PHIPA (e.g., teachers, in the case of children who receive physiotherapy services in a school environment). (See also Applied Practice Scenario 4 on page 17.)

3. An authorized assessor or investigator from a College established under the Regulated Health Professions Act

Authorized investigators, assessors or representatives of the College of Physiotherapists of Ontario, as well as authorized investigators from another college established under the Regulated Health Professions Act (RHPA)18 must also be permitted timely access to records for inspection, copying or removal in order to fulfill their obligations under the RHPA.

e. What steps do I need to take to ensure confidentiality of the health record? 5(6)

Records should be stored in a safe and secure environment to safeguard their physical integrity and confidentiality. Custodians should take reasonable steps to protect health information from loss, theft, unauthorized use or disclosure and tampering including copying, modification or disposal. This includes all components of the patient record including the record of attendance, sign in sheets and exercise cards. Some examples include ensuring:

- Physical security (locked file cabinets, restricted office access, office alarm systems);
- Technological security (password protection, encryption, virus protection, firewalls); and
- Administrative controls (security clearances, access restrictions, staff training and confidentiality agreements).

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17 For more information, go to the Information and Privacy Commissioner of Ontario website at www.ipc.on.ca
18 Regulated Health Professions Act, 1991
6. Storage, Retention and Disposal of Records

Storage

a. Can the clinical record be a combination of hard copy and electronic data?

Yes, a clinical record can be a combination of paper copy and electronic data. However it is important to cross reference each component to ensure clarity of the total record and where the most up-to-date information may be found. The record should be safely stored and retrievable over the retention period regardless of the type of technology used. Attention should be paid to the risks associated with each medium and systems implemented to identify and address these risks. For example, the first generation of fax machine paper faded over time to the point that the information became illegible. In this circumstance, the information stored on certain types of fax paper would need to be converted to another medium so that it would continue to be retrievable for the 10-year retention period. (See also FAQs 1e, 3a.)

b. If a paper chart is converted and stored in an electronic format does the original paper copy need to be kept?

No, provided that the complete clinical record is accessible, there are no requirements to maintain duplicate copies of records (i.e. both hard copy and electronic).

c. Can a record be stored in a patient’s home or other facility?

Yes, PHIPA allows for records to be kept at a patient’s residence (including institutional residence) if:

- a reasonable clinical purpose is met by keeping the record at the patient’s residence and reasonable safeguards are taken
- the patient or substitute decision-maker understands the risks, benefits and consequences of maintaining the record in their home and consents to the storage
- the patient or substitute agrees to retain the record for the required period and allow access to the physiotherapist, or alternatively, the physiotherapist keeps an up-to-date copy of the complete record
- the record is kept in a manner consistent with College standards and governing legislation related to personal health information

If only a portion of the record is kept in the patient’s home there should be a notation indicating where the complete and up-to-date copy can be located.

There are similar expectations related to storing records at a third party facility (i.e. the patient consents, reasonable safeguards are taken and any legislation, College regulations or guidelines are complied with)19.

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19 Personal Health Information Act (PHIPA), 2004
Retention

d. The College has a requirement to retain records for 10 years after discharge for patients over 18 years of age. Where did this number come from? 6(1)

This requirement mirrors the Public Hospitals Act, Regulation 965, section 20(3) which states that the patient’s health record should be retained for at least ten years after the date of the last entry in the record, or ten years after the day on which the patient reaches, or would have reached, the age of 18.

e. Is the retention period in a long-term care home different than the College’s 10-year requirement?

Yes, the Long-Term Care Act requires clinical records to be retained for five years after death, or 20 years after discharge. This is an example where legislation supersedes the College Standard.

Disposal

f. Why should records be physically destroyed in an irreversible and secure manner? 6(4a, b)

When disposing of personal health information at the end of the retention period, the information needs to be physically destroyed in a secure and irreversible manner prior to being disposed of, sold or recycled in order to protect the privacy of patients. This applies equally to both paper and electronic records. Health information custodians who are disposing of electronic records should ensure that such records are permanently destroyed, erased or purged in an irreversible manner that ensures that the information cannot be reconstructed in any way. (See also FAQ 1e)

Applied Practice Scenarios

The following scenarios provide examples of how physiotherapists can meet the performance expectations described in the Standard for Professional Practice: Record Keeping. The scenarios are based on issues and trends commonly arising in College programs. Although the scenarios are presented with reference to a particular practice setting, the principles can be applied to all practice settings.

1. Multidisciplinary Records

I own a multidisciplinary private practice along with a chiropractor and a massage therapist. We contract our services to a large industrial employer as part of a wellness program, and also provide treatment to injured workers. Many times, all three professionals are involved in treating the same client and our assessment procedures are often very similar. We would like to streamline the collection and documentation of common information and maintain a single, combined record. What are some of the risks associated with this practice?

Discussion

In a multidisciplinary setting it may make sense to share information in a combined record rather than repeat the same information in separate sections. However, there are risks when sharing components
of care and components of records. Physiotherapists are expected to consider these risks and formulate appropriate solutions. For example, when relying on information documented by others, there is a risk that the information may be inaccurate or incomplete. Physiotherapists must satisfy themselves that those parts of the records that are documented by other providers are accurate and complete. One way to accomplish this is to verify the information with the patient prior to an assessment or treatment.

Another risk of relying on information documented by others is the possibility that information required in the Standard for Professional Practice: Record Keeping may not be included. Although most health professions have similar requirements for documentation, physiotherapists are expected to ensure that the documentation provided by other practitioners as part of a multidisciplinary record allows them to meet their professional obligations.

2. Pattern of Practice and Consent for a Program of Care

Our team provides physiotherapy services to a long-term care facility. Most of our patients are referred for general strengthening/exercise programs. Many of our patients also exhibit some level of confusion and we rely on family members to provide consent for treatment. The family members are not always available during treatment times to consent to proposed changes in the treatment program. Because the conditions and interventions are so similar and most patients follow a similar course, can we explain the treatment program once at the beginning in order to obtain and document consent one time only?

Discussion

The most important part of obtaining consent is to have an informed discussion with the patient or substitute decision-maker. The requirements for obtaining consent are outlined in the Health Care Consent Act. One way to ensure that all relevant areas are addressed when obtaining informed consent is to establish a written pattern of practice (similar to a care map). This written pattern of practice outlines the process that is undertaken when obtaining informed consent and can include a discussion of the course of treatment to be provided rather than each individual treatment element (e.g., a discussion of how strengthening exercises will be progressed, i.e. number of repetitions, number of sets, amount of weight etc.). These written patterns of practice should be retained and available for the entire retention period (again, similar to a care map).

3. Documenting the Provision of Care by Physiotherapist Support Personnel (PSP)

A physiotherapist is employed at a regional rehabilitation center, providing services as part of the amputee program. Care is provided in a busy gym with several PSPs available to perform various assigned tasks. The physiotherapist formally reassesses and documents progress weekly and assigns aspects of care to a pool of PSPs, not knowing who will actually perform a task on a given day. How should the physiotherapist document the provision of care? Specifically, information on who had contact with the patient on a given day?

Discussion

The name of the practitioner who provided physiotherapy care should be recorded for each treatment session. The recording method can take various forms other than direct documentation in the clinical record. For example: it could be acceptable to use a flow chart or exercise sheet to record the treatment
that was provided at each session. The person who provided the treatment can date and initial the flow chart or exercise sheet at each session for the component of treatment that they provided (as long as the full name and title of the person using the initials is documented as part of the patient record and that the initials relate to a single provider). The flow chart or exercise sheet should also be either filed with the chart or referenced in the chart and available throughout the retention period.

Another method involves the use of a workload measurement system. Again, it is important that the information be retrievable for each patient for the duration of the retention period. For example, pulling the workload measurement record for Mr. Smith on a given day should reveal which physiotherapy care providers had contact with Mr. Smith that day.

Sometimes these workload measurement systems limit the number of entries for a given day. In this situation, if there are multiple providers seeing the same patient on the same day, it may be useful to consider this as one treatment session. If so, one person would be responsible for the treatment provided to the patient with one entry into the workload measurement system to identify the session date and treatment provider. For example, two PSPs may assist the physiotherapist in providing multiple components of an exercise program at a single session in the gym. This could be considered to be a single session of therapy with the physiotherapist recorded as the provider and not separate therapy attendances/visits. However, if the patient were to receive another session of therapy (for example a PSP ambulating the patient later in the day on the ward) after receiving a morning session of therapy in the gym, then evidence of who provided treatment for this patient in each of the separate sessions should be provided.

4. Circle of Care and Access to Records

A physiotherapist is an independent contractor affiliated with a Community Care Access Centre (CCAC). Her practice is pediatrics and she often assesses children who have recently returned home after a hospital admission following trauma, illness or surgery. One client, a ten-year-old child, has recently re-entered the school system following release from hospital after sustaining multiple injuries in a motor vehicle accident. The child’s mother has provided the teacher with a copy of the report of the assessment completed by the hospital physiotherapist for the insurer. The teacher consults with the community physiotherapist to assist in understanding the recommendations and implications for performance in the classroom. The community physiotherapist wonders about consent to release information to the teacher. What should the physiotherapist do?

Discussion

The Personal Health Information Protection Act (PHIPA) defines Health Information Custodians (HICs) and their authorized agents. “Circle of care” is a concept that describes the HICs and agents who are permitted to assume an individual’s implied consent when collecting, using, disclosing or handling personal health information for the purpose of providing direct health care. For example, in the hospital, the circle of care for the child described in the scenario above would include: the attending physician, medical residents, consulting physicians, nurses, x-ray and laboratory technicians, physiotherapists, social workers etc. who have direct responsibilities to provide care to the child. The circle of care for this child would also include health care providers involved in the follow-up care (e.g., the community physiotherapist assuming the care of the child). The circle of care would not include professionals who are not covered by PHIPA (e.g., the teacher).
Although the report was given to the teacher by the parent and the physiotherapist can reasonably assume that the mother wanted the teacher to have this information to assist in the child’s education, it is still appropriate for the physiotherapist to seek express consent from the parent to review the report with the teacher.

5. Self Audit and Making Changes to a Record

You work on a medical unit of a large hospital. You have been treating an elderly gentleman who was admitted with a diagnosis of pneumonia a number of weeks ago. His course in hospital has included a number of complications which resulted in a significant decline in his physical functioning. Although he has been medically stable for the past several days, he has not been making any progress in regaining his independence. The team wants to discharge him to a nursing home. The family believes that the care he received in the hospital caused the complications and subsequent decline in his physical condition and is considering legal action. When you learn this, you review your entries in the patient’s health record and realize that some information from an incident a number of days ago is missing. How should you enter this information into the record?

Discussion

Periodic evaluation or self audit of record-keeping practices provides physiotherapists with the opportunity to assess whether they are meeting their professional obligations with respect to record keeping standards. Making changes to a record based on new information or adding information at a later date in response to an identified error or omission is permissible provided that the new or additional information is dated the day that it was entered into the record. In other words, when making an entry after the fact, the day or date when the incident, assessment, intervention or conversation took place should be referenced in the body of the new entry, while the date of the entry should always be in real time. Additionally, physiotherapists should consider the amount of time that has elapsed between the occurrence and the entry to ensure accuracy of recall. While it is important to ensure complete and accurate information, there is a risk in this situation of being perceived as trying to make a record look good in response to a legal challenge.

The College’s Professional Misconduct Regulation\(^\text{20}\) describes signing or issuing a document that contains information that is known, or ought to have been known, as false, as an act of professional misconduct. In this situation, adding information to an entry that occurred in the past without dating it appropriately could be viewed as falsifying a record which is an act of professional misconduct.

Definitions

**Agent:** In relation to a Health Information Custodian, a person who, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian, and not the agent’s own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by the custodian and whether or not the agent is being remunerated. (See the Personal Health Information Protection Act for a complete definition.)
Clinical Record: Anything that contains information (in any media) that has been created or gathered as a result of any professional encounter, aspect of care, or treatment by a physiotherapist or a person working under the supervision of a physiotherapist. It may also include information created or gathered by other health care providers. (adapted from the Chartered Society of Physiotherapists)

Health Information Custodian (HIC or Custodian): A HIC is a person or organization that has custody or control of personal health information as a result of or in connection with performing the person’s or organization’s powers or duties. It includes health care practitioners or people who operate a group practice of health care practitioners, community care access corporations, and other organizations including hospitals, independent health facilities and nursing homes. (See the Personal Health Information Protection Act for a complete definition.)

Record: An account that contains information intended to document actions, events or facts. Clinical records are a subcomponent of the broader category of records.

Resources

Legislation
- Personal Health Information Protection Act (PHIPA), 2004 http://www.e-laws.gov.on.ca
- Personal Information Protection and Electronic Documents Act (PIPEDA), 2000 http://lois.justice.gc.ca
- Long Term Care Act, 1994 http://www.e-laws.gov.on.ca

Registrants’ Guide (www.collegept.org)

Regulations
- Professional Misconduct Regulation, Ontario Regulation 388/08

Standards for Professional Qualification
- Essential Competency Profile for Physiotherapists in Canada

Standards for Professional Practice
- Performing Controlled Acts (+ Guide)
- Clinical Education
- Complementary and Alternative Therapies (+ Guide)
- Concurrent Treatment of a Patient by a Physiotherapist and Another Health Care Provider
- Dual Health Care Practices
- Establishing and Maintaining Therapeutic Relationships (+ Guide)
- Infection Control
- Managing Challenging Interpersonal Situations When Providing Patient Care (+ Guide)
- Physiotherapists’ Use of Restricted Titles and Credentials
- Physiotherapists Working with Support Personnel (+ Guide)
• Record Keeping
• Briefing Notes
• The Health Care Consent Act
• Physiotherapists’ Privacy Requirements in Ontario

Online Forms
• Developing SMART Learning Goals
  Available on the College website under For Registrants>Quality Management>Professional Portfolio
• Onsite Assessment Form
  Available on the College website under For Registrants>Quality Management>Onsite Assessment

Other Resources
• Canadian Alliance of Physiotherapy Regulators: Guideline for the Collection, Maintenance, Transmission and Destruction of Electronic Health Information, available at www.alliancept.org
• University of Alberta, Health Law Institute and University of Victoria, School of Information-Science: Electronic Health Records and the Personal Information Protection and Electronic Documents Act http://www.law.ualberta.ca/centres/hli/pdfs/ElectronicHealth.pdf
• Information and Privacy Commissioner of Ontario: A Guide to the Personal Health Information Protection Act, available at www.ipc.on.ca
• College of Physicians and Surgeons of Ontario: Assess Your Own Medical Records, Self–Evaluation Tool available at www.cpsso.on.ca