

Record Keeping

Guide to the Standard for Professional Practice

Record Keeping

Records tell a patient's story. The record should document for the patient:

- what was assessed
- an analysis of the assessment findings
- the recommendations and goals for the proposed intervention
- the details of the care provided and by whom
- the outcomes of care, including any reassessments, changes to the plan or changes in the patient's condition
- a summary of the episode of care when care has been completed

Patients have the right to access the information contained in their health records and the right to expect that accurate, complete, timely and confidential records will be created and securely maintained for their benefit.

Physiotherapists are the keepers of the information. A physiotherapist may be the designated Health Information Custodian (HIC) or may be an agent acting on behalf of a Health Information Custodian. These and other responsibilities regarding the collection, use and disclosure of patients' health information are found in the **Personal Health Information Protection Act (PHIPA)**.

The goal of record keeping is to include enough detail for another provider involved in the care or assuming the care of a patient to follow the care plan and provide ongoing treatment.

Tips for Use

Review the Standard Statement and understand the scope of the Performance Expectations outlined in the **Standard for Professional Practice: Record Keeping**. Consider the context in which care is being provided, things such as practice setting, patient acuity and employer expectations for example. Apply professional judgment to determine the optimal way to manage personal health information in the best interests of patients. The following Frequently Asked Questions provide additional guidance.

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- a. What is a Health Information Custodian (HIC)?
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- a. Can I include information collected by another health professional (for example, assessment findings)?
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- d. What if a patient asks me to not include something?
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6. Storage, Retention and Disposal of Records

- a. Can the clinical record be a combination of paper and electronic data?
- b. If a record is converted from paper to an electronic format does the original paper copy need to be kept?
- c. What should I consider when storing the record in a patient's home or other facility?
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- e. How should records be stored when they are no longer active?
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Frequently Asked Questions

1. General

a. What is a Health Information Custodian (HIC)?

A Health Information Custodian (HIC) is responsible for collecting, using and disclosing personal health information on behalf of patients. A HIC can be an individual or an organization. The Personal Health Information Protection Act, 2004 (PHIPA), sets out the rules for the collection, use and disclosure of health information and the responsibilities of the Health Information Custodian.

Visit the government of Ontario e-laws website to review PHIPA at www.e-laws.gov.on.ca.

The HIC may have an “agent” that acts on their behalf with respect to personal health information.

Visit the website of the Office of the Information and Privacy Commissioner of Ontario to learn more about the roles and responsibilities of HICs and agents at www.ipc.on.ca.

The College has a Briefing Note called Physiotherapists’ Privacy Requirements in Ontario available on the College website at www.collegept.org.

b. Why is it important to identify the Health Information Custodian (HIC) in the patient record?

Under the Personal Health Information Protection Act (PHIPA), physiotherapists can be either a Health Information Custodian (HIC) or an agent of a HIC. For example, a physiotherapist operating a solo practice would be the HIC, but a physiotherapist employed by a hospital (or other organization defined in PHIPA) would be an agent. The HIC is responsible for ensuring patients’ personal health information is collected, used, disclosed, stored and disposed of appropriately. In the solo provider and hospital examples, the HIC is defined by law. In other cases, there may be doubt as to who is acting as the HIC; for example, a physiotherapist working as an independent contractor, or working as an employee of a clinic or agency. In these examples, either party (the physiotherapist, clinic or agency) may act as the HIC. It is in everyone’s best interest to clarify and document in the patient record who is the HIC responsible for protecting patients’ health information. Physiotherapists who are not HICs but act as agents will want to ensure that both they and their patients will be able to access the health record even after care has ended. (See also questions 1m and 5b).

c. I work in an interprofessional team. What should we consider if we keep joint or combined records?

Integrated patient records can facilitate communication, prevent duplication, enhance coordination and promote safe, quality care. The standards for record keeping remain the same when care is provided in a team environment. The record should document who provided care, when the care was provided, a rationale as to why the care was provided and the outcomes that were achieved. It is important to be able to determine who made which entry in the record. Team members will want to clarify who will act as the HIC and ensure that they and their patients will have access to the records even after care has ended. Other regulated health professionals will have similar but not identical requirements. Teams will need to work together to ensure each team member can meet their professional standards.

d. What should I consider when creating, storing and transmitting electronic information?

The principles for managing personal health information and the expectations regarding record keeping are the same for paper and electronic records. However, there will be special considerations for each type of media. Some key considerations for electronic records include:

- **Completeness**—the entire record (clinical, financial and attendance information) should be retrievable and reproducible so that patients and other authorized individuals can access the information.
- **Confidentiality**—unauthorized access should be prevented; for example, by using password protection and/or encryption. This is particularly important when transmitting records electronically (such as by email), when storing patient information on portable devices (such as flash drives) or using technology in public places (such as tablets or smart phones).
- **Audit trails**—the date, time and identity of persons making an entry should be clear. When entries are changed, the original content should be preserved.
- **Systems to prevent loss of information**—data should be backed up and should remain retrievable throughout the retention period (for example, should technology change or become obsolete).
- **Secure disposal**—information should be completely purged or the hardware destroyed so that information cannot be retrieved rather than simply deleting files.

The Canadian Alliance of Physiotherapy Regulators has a Guideline on the Collection, Maintenance, Transmission and Destruction of Electronic Health Information at www.alliancept.org.

The Office of the Information and Privacy Commissioner of Ontario website has information on safeguarding personal health information stored on electronic devices at www.ipc.on.ca.

e. Why am I expected to audit my records? How often should I audit?

Taking time to review what and how you document and evaluate your record keeping practices against professional, legal and employer obligations, is an important activity for quality practice and is required by the College (tools are available on the College website). Set a reasonable time frame to regularly review records. The frequency will depend on your practice environment, how quickly practices change and whether there are other systems of checks and balances in place to help you feel confident that clinical, financial and equipment maintenance records meet standards.

f. What should I consider when using abbreviations, care maps, exercise flow sheets, charting by exception or other time-saving documentation tools?

Tools that promote standardization and efficiency should include enough information so that individuals who access the record can understand the care that was provided. Often that will mean including a copy of the care map or charting by exception tool or spelling out abbreviations in full the first time they are used. When documents are referenced that are not part of the patient record it should be made clear where and how the reference document can be obtained.

g. What does it mean to be able to uniquely identify individuals?

In any healthcare setting, there will be patients with the same or similar names. It is important to ensure that health information is linked to the correct person. A system that distinguishes or uniquely identifies patients (and providers) with the same or similar names should be used on all parts of the physiotherapy record including attendance, financial and clinical records. Using patient name together with a birth date or using a file number that relates to and identifies a single patient (also called a unique identifier) are examples of such systems. Care providers should also be uniquely identified.

h. Do I need to sign my full name and title every time I make an entry?

When making an entry in the health record it is important to be able to identify who made the entry in the record. Your full name and title should be documented at least once in the record. For subsequent entries, an abbreviated version can be appropriate as long as the entry can be linked back to you. 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.

i. What should I consider when using an electronic signature or signature stamp?

You are responsible for materials bearing your signature. You will want to analyze the risks associated with allowing another individual to apply your signature (either electronically or with a stamp) and implement adequate safeguards to prevent unauthorized use. Signatures should never be applied to documents in advance and you will want to review all materials that bear your signature.

j. What information should be documented about the care assigned to support personnel or assistants?

When assigning care to support personnel or assistants, you should refer to the **Standard for Professional Practice: Physiotherapists Working with Support Personnel** at www.collegept.org.

When documenting care assigned to support personnel or assistants, you will want to include a description of the care assigned, the frequency and time frame during which care is to be performed and that appropriate consent was obtained for the involvement of a support person or assistant. The patient should be aware of the name(s) of the support person(s) or assistant(s) who will provide care.

k. What information should support personnel or assistants document? Do I need to co-sign entries?

Having support personnel or assistants document the care that they provided can be an efficient and appropriate use of resources. To ensure that records maintained by support personnel or assistants meet standards, you will want to determine the knowledge and skill level of the support person or assistant, provide appropriate support and training, and audit performance from time to time. You are not required to co-sign entries recorded by support personnel or assistants.

l. How should I correct errors or make changes to an entry?

Changing a record to reflect a new perspective or new information is permissible as long as the original content can still be read. Corrections can be made either by striking out the incorrect information in a way that does not destroy the information or by labelling the information as incorrect. The correct or new information can then be added to the record making sure to identify the date the change is made, the person making the change and the reason for the change. (See also question 5c).

m. I am retiring or changing jobs; what should I do with the patient records?

If you are the Health Information Custodian (HIC), you are responsible for the collection, use, disclosure, storage, disposal and privacy of patients' personal health information. When retiring or changing practice location, you may choose to relocate the records to a storage facility or transfer the records to another HIC. (See also Section 6: Storage, Retention and Disposal of Records).

If you are an agent of the HIC, you will want to ensure that the HIC will maintain the records as required under the Personal Health Information Protection Act (PHIPA) and that you and your patients will be granted access even after you have left the workplace.

The Office of the Information and Privacy Commissioner of Ontario website has information on the responsibilities of HICs related to storing personal health information at www.ipc.on.ca.

2. Clinical Records

a. Can I include information collected by another health professional (for example, assessment findings)?

Yes. You can include findings made by other health professionals or information reported by patients or substitute decision-makers. This information should be recorded accurately and include a reference to the source of the information.

b. Why do I need to include advice or information provided by telephone or email?

The specifics of telephone and email advice or information should be recorded when it relates to the patient's condition or clinical care. Information relating to changes in symptoms, condition or treatment provided should be documented in order to understand the care that was provided and the impact. For example, information from a patient who telephoned or emailed to report an exacerbation of symptoms when a new exercise was added to their home program and any advice given should be included. Information that does not relate to the patient's condition or care, such as how to submit an insurance claim form or where to obtain recommended equipment, need not be documented.

c. What other reports or communication should be included?

Every written report sent or received regarding the patient's care is a component of the clinical record and should be included. Progress notes or discharge summaries sent to or received from another healthcare provider, insurer or payer etc.; copies or notes documenting other forms of communication (for example, telephone or email) relevant to the patient's condition or the care provided are part of the clinical record. Patient education material, home programs, telephone and email advice, flow charts, etc. should be included.

d. What if a patient asks me to not include something?

Under the Personal Health Information Protection Act (PHIPA) patients are able to withhold or withdraw their consent for the collection, use or disclosure of their personal health information. Patients may provide express instructions to not use or disclose personal health information. These are known as lock-box provisions. Health Information Custodians (HICs) are required to respect the decisions of patients regarding how their health information is collected, used and disclosed. The Office of the Information and Privacy Commissioner of Ontario has more information regarding lock-box obligations for HICs on their website at www.ipc.on.ca.

e. Is an analysis statement, clinical impression or diagnosis required?

Yes. Physiotherapists are expected to document a summary statement analyzing the assessment findings and determining a clinical impression or diagnosis. It is important for anyone accessing the record to understand not only the assessment and interventions but also how the two are related. The analysis statement, clinical impression or diagnosis should be based on the assessment findings and identify the need for the physiotherapy intervention.

f. Do patient goals and outcomes need to be documented in the chart?

Yes. The clinical record should include patient-centered goals, as well as objective measurement of outcomes achieved. How these goals and outcomes are recorded will vary based on situation and context.

g. How much detail should be included when documenting treatment?

When documenting the care provided, you will want to include enough detail to allow other health care providers to understand the care that was provided and allow them to assume and continue to manage the patient's care.

h. What information should be included in a discharge summary or end of care note?

The details included in an end of care note or discharge summary will vary with the reasons for ending treatment. For example, if the treatment has ended because patient goals have been achieved, the discharge summary should include the patient's status at discharge, the goals and outcomes that were attained and any recommendations for ongoing self-management. However, if treatment ends for reasons beyond the physiotherapist's control, for example, the patient did not return for treatment, died or was transferred to another facility, a note outlining the circumstances may be sufficient.

i. How often should an entry be made in the clinical record?

The patient record should include evidence of every professional encounter. This can be managed with the use of an appointment or attendance log or workload measurement system as long as the information can be retrieved for each patient. You should be able to generate a list of attendances for each patient, rather than a list of patients for each day.

An entry should be made in the clinical record every time a patient is re-assessed and every time there is a change in the interventions provided. The frequency for documenting such progress notes will depend upon the individual patient, the type of care provided and the need to ensure enough information is recorded to allow another healthcare provider to understand the care provided. Physiotherapists should use their professional judgment to determine appropriate frequency.

j. Why do I have to document missed or cancelled appointments?

Documenting missed or cancelled appointments can provide important information. Examining the pattern of attendance and reasons for missed or cancelled appointments may provide insight into the patient's condition and outcomes of care. For example, a patient with poorly controlled diabetes who frequently cancels appointments 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. Attendance patterns and reasons for missed or cancelled appointments can also help determine the most appropriate physiotherapy interventions. For example, a patient who complains about lack of improvement but has cancelled 7 of the last 10 appointments will require a different intervention than a patient who is not progressing but has attended all scheduled appointments.

k. Why do I have to document that informed consent was obtained?

The Health Care Consent Act outlines the requirements for obtaining informed consent for all healthcare professionals. The College requires that physiotherapists also document that informed consent was obtained. Consent should be obtained and documented for assessment and treatment activities and for the involvement of support personnel or assistants. You are required to follow the process outlined in the Health Care Consent Act and to document that you did so. You should use your professional judgment to determine the level of detail that should be documented. Visit the government of Ontario e-laws website to review the Health Care Consent Act at www.e-laws.gov.on.ca.

3. Financial Records

a. What information should be included in a financial record?

The financial record should include: the name of the patient and care provider, a description of the care, product or service that was provided, the date the service was provided, as well as the amount that was charged and received for the service.

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 in paper format while the financial record is stored in electronic format. Keep in mind that the entire record should be retrievable for each patient during the entire retention period. (See also question 6a and 6d).

c. Someone else completes and submits all the invoices, what should I be careful of?

Having someone else, such as an employer, receptionist or billing clerk manage the business aspects of practice can be an efficient use of resources, but there are risks. You will want to analyze the risks associated with allowing someone else to complete invoices on your behalf and implement adequate safeguards. Remember, you are responsible for materials submitted on your behalf. If someone else is completing invoices on your behalf, you should be aware of the fees being charged for your services and have a system in place to monitor for accuracy. (See also questions 1e and 1i).

4. Equipment Service Records

a. Why are equipment maintenance records needed?

Documenting the inspection, maintenance and servicing of physiotherapy equipment provides evidence that the necessary steps have been taken to ensure that equipment is safe for patient use. You should take reasonable steps to ensure that the equipment used in clinical practice is properly maintained and calibrated according to manufacturer recommendations and that appropriate infection control procedures are in place. See the Standard for Professional Practice: Infection Control available on the College website at www.collegept.org.

Even if you do not have direct control over the maintenance of equipment, for example, your employer is responsible; you are expected to take reasonable steps to ensure the safety of the equipment.

5. Confidentiality and Access

a. What should I do if a patient or someone else wants access to a record?

Patients should have an understanding of how their personal health information will be collected, used and disclosed and how they may access their health records. If a patient requests a copy of his or her record, a copy should be provided within a reasonable time period. A fee may be charged to recover costs, but should be reasonable.

Patient consent is needed before releasing information to another person—except in certain circumstances. These circumstances and the responsibilities of health information custodians (HICs) related to the collection, use and disclosure of personal health information are outlined in the Personal Health Information Protection Act (PHIPA) available at www.e-laws.gov.on.ca. Resources are available on the College website at www.collegept.org and the Office of the Information and Privacy Commissioner of Ontario website at www.ipc.on.ca.

b. Who should have access to the records?

There are three groups of people who are able to access patient records without explicit patient consent:

1. The patient or their authorized representative. Patients and anyone to whom they give consent should be able to access the record throughout the retention period.
2. The care providers within the “circle of care”. “Circle of care” is not a defined term under the Personal Health Information Protection Act (PHIPA). It is a term used to describe Health Information Custodians (HICs) and authorized agents who are permitted to rely on an individual’s implied consent when collecting, using or disclosing personal health information to provide direct health care. For more information about ‘circle of care’ please visit the Office of the Information and Privacy Commissioner of Ontario website at www.ipc.on.ca.
3. An authorized assessor or investigator from a College established under the Regulated Health Professions Act (RHPA). Authorized investigators, assessors or representatives of the College of Physiotherapists of Ontario, as well as authorized investigators from another College established under the RHPA are permitted to access patient records in order to fulfill their obligations under the RHPA.

c. Can the patient ask to have his or her record changed?

Yes. According to the Personal Health Information Protection Act (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. Visit the Office of the Information and Privacy Commissioner of Ontario website at www.ipc.on.ca to learn more.

d. What steps should I take to ensure confidentiality?

Records should be stored in a secure environment to safeguard their integrity and confidentiality. This applies equally to paper and electronic records. Reasonable measures should be implemented to protect health information from loss, theft, unauthorized access, use or disclosure and tampering including copying, modification or disposal. This includes all components of the patient record such as attendance records, sign in sheets and exercise programs.

Some examples include ensuring:

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

6. Storage, Retention and Disposal of Records

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

Yes. A clinical record can be a combination of paper 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 storage medium and systems implemented to identify and address these risks. (See also questions 1d and 6d).

b. If a record is converted from paper to an electronic format does the original paper copy need to be kept?

No. There is no need to maintain a duplicate copy when paper records are converted to an electronic format as long as a complete clinical record can be accessed.

c. What should I consider when storing the record in a patient's home or other facility?

The Personal Health Information Protection Act (PHIPA) allows records to be kept at a patient's residence (including an institutional residence) if certain conditions are met. Visit the Office of the Information and Privacy Commissioner of Ontario website at www.ipc.on.ca to learn more.

d. Can portions of the record be kept separately?

Yes. Portions of the record can be kept in separate locations. However, it is important to cross-reference each portion to ensure understanding of all the portions that make up a complete record and where the most up-to-date information may be found. (See also questions 1e, 3b and 6a).

e. How should records be stored when they are no longer active?

Active or not, records must always be stored securely. When storing records in the clinic, at your home, at a third party storage facility or using cloud-based services, appropriate safeguards should be taken to prevent loss, theft, damage and unauthorized access. Patients should be made aware of how they may access their records if needed. (See also question 5d).

f. How long should records be kept?

Clinical and financial records should be kept for at least 10 years after the date of the last entry or 10 years after the patient reaches, or would have reached, the age of 18. This requirement mirrors the Public Hospitals Act, Regulation 965, section 20(3).

Equipment records should be kept for 5 years.

g. How should I dispose of records?

When disposing of personal health information at the end of the retention period, you will want to be sure that information is permanently destroyed in a secure manner. This applies equally to paper and electronic records. Paper records should be physically destroyed before being disposed of or recycled to protect the privacy of patients. Electronic records should be physically destroyed, erased or purged in an irreversible manner that ensures that the information cannot be reconstructed in any way.