COLLEGE OF PHYSIOTHERAPISTS of ONTARIO

Record Keeping Checklist

To help physiotherapists meet the performance expectations outlined in the Standard for Professional Practice: Record Keeping, some of the key performance expectations have been highlighted in the form of a checklist.

Different than the Standard, the checklist is organized by record type: patient records, financial records and equipment maintenance records.

This list of expectations is not exhaustive but rather is meant to provide an optional tool that can be used to help apply the Standard in practice or assist when auditing one's own records.

The checklist should be used in conjunction with the Standard and Guide as there may be legislative or employer requirements not covered in the checklist.

Patient Records

Identification

Is there a way to uniquely identify the following individuals?

- ☐ Patients
- ☐ Providers
- ☐ Health Information Custodian (HIC)

General

- ☐ Are entries legible?
- ☐ Are abbreviations, acronyms and care maps described or referenced?
- ☐ Are entries dated and chronological?
- ☐ Do changes to the record maintain original content?
- ☐ Are records created, stored and disposed of in a way that keeps information secure?
- ☐ Can a complete record be retrieved for each patient?
- ☐ Is there a way to ensure the privacy of information and limit who can access the record?
- ☐ Are records audited from time to time?

Clinical

Have the following items been included and with enough detail?

- ☐ Patient demographic information
- ☐ Relevant health, family and social history
- ☐ Information about who else provides care to the patient
- ☐ Patient subjective concerns
- ☐ Assessment and test results (including objective measures)
- ☐ An analysis, care plan and goals
- ☐ A description of the care that was provided (including aspects of care that were assigned to or provided by another person)
- ☐ Dates of all interactions with the patient (including care refusals and missed appointments)
- ☐ Information on all relevant communications with the patient and other providers (written, verbal and electronic)

Consent

- ☐ Is informed consent obtained and documented for the assessment, treatment and involvement of other care providers?
- ☐ Is patient consent obtained before releasing any information?

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Progress Notes

- ☐ Are progress notes made at a reasonable frequency?
- ☐ Do progress notes include the following?
  - ☐ Objective measures
  - ☐ Results achieved
  - ☐ Changes to the care plan (including the reason for change)

Discharge or Care Summaries

- ☐ When care ends, is there a summary of the reason, the patient's status and any other relevant details?

Collaborative Records

- ☐ Are you able to access records now and in the future?
- ☐ Are you able to determine who made which entry in the record?

Financial Records

Do financial records include the following?

- ☐ Identity of both patient and provider
- ☐ Description of the care, service or product provided
- ☐ Date of service
- ☐ Fee information

Equipment Maintenance Records

- ☐ Are records of equipment inspection, maintenance and service available?

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