

Standard for Professional Practice: Record Keeping

Introduction

Record keeping is an essential part of physiotherapists' practice regardless of the practice setting. Records provide the ability to track the patient's course, determine future care needs and give evidence of and rationale for the care provided. Records also serve as an important communication tool to allow others to understand the patient's past and current status. All this is done to facilitate safe, quality care and to improve efficiency, consistency and coordination.

Records are not just a memory aid for the documenting clinician. Records tell the patient's story by providing a record of each encounter including: what was done, by whom, when, where, why, the outcome and any recommendations for additional care or follow up.

Appropriate records demonstrate professional accountability by documenting assessments and analyses, discussions related to proposed interventions and consent, decisions and plans to implement care and compliance with the standards of practice of the profession, other laws and ethical obligations.

While the media (e.g., paper, computer hard drives or networks) and the tools (e.g., pen, keyboard or voice recorder) used to maintain records may vary from practice to practice, the essential principles of record keeping remain constant. This Standard describes the essential elements and desired outcomes to be achieved by maintaining appropriate records. The details of how the elements can be achieved will vary according to practice setting, provider choice and patient need.

This Standard reflects the expectations of the College and the standard of practice of the profession when registrants act as Health Information Custodians (HIC) as defined in the Personal Health Information Protection Act (PHIPA) or as agents of HICs .

Standard Statement

Physiotherapists will maintain clinical records and other records that document the management of their practices in order to:

- facilitate reasonable and effective care of their patients
- enhance outcomes and safety for their patients
- provide information to enable collaboration, continuity and smooth transfer of care for their patients
- ensure their accountability to patients, payors, the College, the profession and other health care providers
- demonstrate their judgment, reasoning and adherence to the standards of practice of the profession
- meet any other requirements mandated by the organizations they are associated with or where required by law

Physiotherapists will comply with relevant legislation intended to protect the privacy and confidentiality of personal information and personal health information.

Performance Expectations

A physiotherapist demonstrates the Standard by taking reasonable steps to periodically audit records and ensuring that the following elements are achieved.

1. Accurate, Objective and Relevant

- Entries are dated and late entries are marked as such (i.e., entries should be dated the day they are made)
- Evidence and measurement tools are used wherever possible/appropriate
- Information can be linked to individuals (i.e., the patient and all providers are identifiable)
- Appropriate, respectful and non-judgmental language is used

2. Understandable

- Entries are legible (readable), chronological, systematic and organized
- Terms, abbreviations, acronyms and diagrams are defined or described to promote understanding for others who may access a record
- Records are maintained in either English or French

3. Comprehensive/Complete

- There is a method to record the dates of every patient encounter
- All relevant information is included in sufficient detail to allow another health care provider involved in or assuming care of the patient to follow the plan of care. For example,
 - patient demographic information, history, concerns and consent
 - results of tests/investigations, assessments and measures
 - a record of analyses, diagnoses, goals, plans and interventions (including authorized activities and care provided collaboratively with other health care providers)
 - progress notes, reassessments and resulting changes to the intervention plan
 - instructions, recommendations, referrals, transfers of care and discharge summaries
 - discussions, communications and advice provided to patients
 - consultations and correspondence with other health care providers
 - care refusals and missed appointments
- Records of inspection, maintenance and servicing of equipment are created (where there is a risk of harm if the equipment is not properly maintained)
- Details of financial transactions are recorded

4. Timely

- Information is entered within a reasonable time period to ensure accuracy
- Updated information is entered at appropriate intervals (frequency) whenever there are significant changes or relevant new information is received

5. Secure

- Entries are permanent (i.e., systems are in place to ensure that content is not lost, changed or deleted)
- Records are retained for the appropriate period of time
 - Clinical and financial records should be maintained for a minimum of 10 years from the date of the last entry in the record or 10 years from the date that the patient reached, or would have reached, 18 years of age (except when any other Act or regulation sets out a different retention period that would take priority)
 - Equipment records should be maintained for five years
- Additions or corrections to content ensure that the original content remains readable and audit trails of persons entering information can be created
- Collection, storage, use, transmission and disposal of personal health information maintains patient privacy and confidentiality (e.g., through the use of physical controls, passwords and/or encryption)

6. Retrievable/Accessible

- Clinical and financial records are retrievable and reproducible for each individual patient throughout the designated retention period
- Reasonable steps are taken to ensure that records meet the obligations outlined under privacy legislation when acting as either the Health Information Custodian (HIC) or as an agent of the HIC
- Patients are made aware of who the HIC is and how information will be managed on their behalf
- Individuals with appropriate authority/consent are able to access a record from the HIC in a timely way (a reasonable fee may be charged)

Definitions

Agent:

In relation to a Health Information Custodian, a person who is authorized by the custodian to act for or on behalf of the custodian in respect of personal health information. This action is 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
- 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) 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, as well as many other kinds of organizations such as 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.

References and Resources

College Resources

- Briefing Note for Physiotherapists' Privacy Requirements in Ontario
- Briefing Note to the Health Care Consent Act
- Essential Competency Profile for Physiotherapists in Canada, National Physiotherapy Advisory Group, October 2009
- Standard for Professional Practice: Performance of Authorized Activities
- Standard for Professional Practice: Physiotherapists Working with Physiotherapist Support Personnel
- Standard for Professional Practice: Conflict of Interest

Legislation

- Health Care Consent Act (HCCA)
- Personal Health Information Protection Act (PHIPA)
- Personal Information Protection and Electronic Documents Act (PIPEDA)
- Regulated Health Professions Act (RHPA)

Date Approved: March 2007

Revised: June 2012, March 7, 2013