

Record Keeping

College publications contain practice parameters and standards which should be considered by all Ontario physiotherapists in the care of their patients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

Introduction

Record keeping is an essential part of physiotherapists' demonstration of professional accountability for the services they provide or assign. The creation and maintenance of the required records enhances patient outcomes, facilitates the smooth transfer of patient care to other providers and documents the management of the physiotherapy practice. The recording of patients' histories, and physiotherapists' assessment and treatment of their patients facilitates safe, effective and appropriate patient care. Records help ensure continuity of care and the management of multiple health conditions by multiple providers. The key purpose of record keeping is to manage information relevant to the patient's care for the benefit of the patient.

Appropriate records also demonstrate professional accountability by documenting assessments, treatment decisions, consent to treatment discussions and compliance with the standards of practice of the profession and other standards, laws and ethical requirements.

While the media (e.g., paper or computer hard drives) or the tools (e.g., pen or keyboard) used to maintain records may vary from practice to practice, the essential principles of record keeping remain constant. This standard describes the obligations of registrants on record-keeping. It 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, or as agents of HICs (see section 8)¹.

Standard Statement

In the event of any inconsistency between this standard and any legislation that governs the practice of physiotherapists, the legislation governs.

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

- facilitate the care of their patients
- enhance outcomes and safety for their patients
- facilitate discharge planning of their patients
- provide information to enable continuity of care for their patients
- ensure their accountability to patients, payors, the College, the profession, and other health

1 See also "Briefing Note for Physiotherapists' Privacy Requirements in Ontario", College of Physiotherapists of Ontario.

- care providers
- demonstrate their 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

Registrants will comply with relevant legislation intended to protect the privacy and confidentiality of personal information and personal health information².

Performance Expectations

A physiotherapist demonstrates the standard by ensuring that:

General

1. Records are accurate, legible and comprehensive, and are maintained in accordance with the expectations in this standard.
2. Records are maintained in one of the two official languages of Canada (French or English).
3. When it is reasonably foreseeable that patients, health care providers or others will not understand the meaning of abbreviations, acronyms or diagrams used in the record, a reasonable means is provided for those who access the records to understand the meanings of these terms³.
4. Reasonable steps are taken at periodic intervals to audit required records to ensure they are maintained in accordance with the College's expectations and professional standards.
5. Every clinical record must include the following information in a reasonably accessible place in the record:
 - a. the name of the health information custodian for whom the person who makes the entry is working
 - b. an indication of whether the record documents care provided in a interdisciplinary care model
 - c. the full name of any individual who provides physiotherapy care
 - d. the title and, if it is restricted, the restricted version of the title of any individual who provides physiotherapy care
6. Every part⁴ of any clinical record includes a clear identification of the patient to whom the record pertains (e.g., patient's name and birth date, or a unique identifier).

² While for many physiotherapists the relevant legislation is the Personal Health Information Protection Act, other legislation may apply in particular circumstances. Other applicable laws may include the Personal Information Protection and Electronic Documents Act, the Workplace Safety and Insurance Act, the Occupational Health and Safety Act, the Freedom of Information and Protection of Privacy Act, the Municipal Freedom of Information and Protection of Privacy Act, etc.

³ Reasonable in this context might mean either providing a reference source that explains the meaning of abbreviations, acronyms or diagrams that is maintained in the same physical location as the records (this could be part of a policies and procedures manual, since these are updated frequently) or writing out the term in full the first time it is used and having the abbreviation in brackets following it.

⁴ In this context, "part" means a discrete component of the record, for example an individual page.

7. Every entry to any part of any clinical record includes the following information:
 - a. the date the entry was made
 - b. a clear identification of the person(s) who made the entry⁵

8. Any change, late entry or addition made in any record is documented in a manner that clearly marks it as such, retains the content of the original entry, and includes a clear identification of the person who made the change, late entry or addition and the date it was made.

9. The choice of media (e.g., paper or electronic) used to record clinical records enable the registrant to meet the expectations set out in this standard and ensures that:
 - a. a complete record or any component of it can be retrieved, copied or printed
 - b. any change or addition to the record can be made in a manner that does not obliterate the original entry
 - c. person(s) who have made any change or additions to any record can be identified and authenticated (an audit trail exists or can be created)

Clinical Records

2. In every circumstance in which the registrant either provides or supervises physiotherapy care, assessment or treatment, he/she ensures that a record is created to document clinical care and all professional encounters with patients. This includes care that is provided by physiotherapist support personnel. At a minimum, the record will include the following components, where they are relevant:
 1. The patient's demographic information including name (or other unique identifier), address, telephone number, birth date and gender.

 2. The patient's relevant health and family and social history when the patient has indicated concern(s). In circumstances where this information has been collected by another practitioner and is still current, it need not be duplicated but should be referenced.

 3. The name and contact information of the patient's primary health care provider, if this information is available⁶.

 4. A chronological record of the patient's concern(s), assessment, re-assessment and treatment including sufficient detail on the care provided to enable the patient to be managed by another physiotherapist. At a minimum this will include:
 - a. The patient's concerns
 - b. The assessment and/or evaluations performed on the patient and the analysis of the assessment results. In circumstances where the physiotherapist is basing components of his/her assessment on the relevant assessment results of another practitioner, a copy of, or a reference to, the appropriate document should be included
 - c. The treatment goals of the patient
 - d. The patient's treatment plan

⁵ This can be done through the use of initials that reference one individual whose full name is documented elsewhere in the record.

⁶ The currency of this information may be time limited; however some registrants also keep this kind of contact information in other ways, such as a computerized contact management system.

- e. The treatment provided to the patient including, where applicable, the modalities used, the exercise components prescribed, their duration and intensity, and any home programs
 - f. The date(s) of each professional encounter with the patient, including telephone or electronic encounters⁷
 - g. Information on any aspect of patient care that has been assigned to physiotherapist support personnel and sufficient additional information that would permit the assigning physiotherapist to determine the support personnel who provided, or assisted in the provision of this care
 - h. Dates of any cancelled or missed appointments and the reason, where relevant
 - i. Particulars of clinical or health care advice provided, including telephone or e-mail advice, that is relevant to the patient's condition⁸
 - j. Particulars of treatment(s) that was commenced but not completed, including reasons for noncompletion
 - k. Information on any delegated controlled act that he/she performed for a patient⁹ in keeping with the College's Standard for Professional Practice: Performing Controlled Acts
 - l. Results of reassessments
 - m. Progress notes that document patient outcomes, how these outcomes were measured, and any amendments to the treatment plan that resulted from these outcomes or changes in the patient's condition
5. A discharge summary that includes the reason for ceasing treatment¹⁰ and, if applicable, other information including:
- a. patient status at discharge or the last time seen
 - b. the goals and outcomes attained
 - c. recommendations given to the patient for post-discharge self-management or education
6. A record of a patient's reassessment and treatment that is updated every time the patient is reassessed or every time his/her treatment plan is amended. In circumstances where a patient has not been discharged from treatment and treatments occur at intervals of less than three months (e.g., once a week), a reassessment must be documented at least every three months.
7. When conducting an assessment or evaluation of a person's condition for the purpose of providing an opinion in the absence of the patient that is based on the assessment results of another practitioner, maintaining copies of the document(s) upon which he/she based his/her analysis and any reports issued on the basis of this analysis.
8. When providing a course of treatment according to a care map, clinical pathway or similar plan and documenting patient progress according to this plan, ensuring that the record of the patient receiving the care contains a clear reference to this specific plan and that a copy of the plan and any

7 This component of the record can be maintained in various ways, depending of the practice of a physiotherapist or the facility in which he/she works. One method suggested by the College is that registrants use or maintain a daily appointment and/or workload measurement record to verify the date, time and duration of each patient encounter.

8 This information could also be maintained through the use of workload measurements records that identify the physiotherapist support personnel who interacted with the patient on a specific day.

9 In circumstances where the controlled act is performed in conjunction with another activity, e.g., when oxygen titration is performed as a sub-component of suctioning, this expectation may be met by documenting the elements of the activity that are performed under delegation at least once in the record.

10 The College recognizes that in some circumstances the decision to discharge a patient from care may be partially or completely beyond the control of the physiotherapist(s) treating the patient.

updates to it are reasonably available and are retained for the same length of time as the records.

9. A record of referral information relevant to the patient including:

- a. the reason for the referral
- b. the name and contact information of the source(s) of the patient's referral, if any
- c. the name and contact information of any health professional or facility to whom the patient was referred

10. A record documenting the obtaining of informed consent from a patient or his/her authorized representative for any activity for which consent is required including, where relevant, a copy of any written consent¹¹.

11. Copies of all written communications or reports received from, or provided to, the patient or his/her authorized representatives or other health care professionals involved in the patient's care.

12. Copies of, or notes documenting, other forms of communications (e.g., e-mail or telephone) in which relevant information has been received from, or provided to, the patient or his/her authorized representatives or other health care professionals involved in the patient's care.

Financial Records

3. In every circumstance in which a registrant assesses or treats a patient, renders any service, or sells or provides any product where a patient or other person or agency is directly billed for the service, ensuring that a record is created that documents the financial transaction. At a minimum the records will include the following components, where relevant:

- a. a clear identification of the person(s) who provided the product or service and his/her restricted title
- b. a clear identification of the patient or client to whom the service or product was provided (e.g., name and birth date, or a unique identifier)
- c. the date the product or service was provided
- d. details on the product or service
- e. the fees charged for each service or product
- f. any differential fees charged for services provided by physiotherapist support personnel to demonstrate compliance with the payment policies of payors, if any
- g. the date of the receipt of payment and the method of payment
- h. the reason(s) why a fee may have been reduced or waived
where the fees were charged to a third party, the full name and address of the third party;
- j. any balance due or owing
- k. information that documents the retaining of an agency for the collection of an outstanding balance

¹¹ The requirements to obtain informed consent and the process for how it is to be obtained are dictated by the Health Care Consent Act (and in some circumstances by common law), not by the College. The expectation to document the obtaining of informed consent reflects physiotherapists' obligations to understand and comply with these external requirements. See A Briefing Note to the Health Care Consent Act, College of Physiotherapists of Ontario, for more information.

Equipment Service Records

4. The registrant takes reasonable steps at reasonable intervals to ensure or attempt to ensure that records of the inspection, maintenance and servicing of every piece of equipment used to assess or treat patients or to sterilize other equipment or tools and which, if not properly serviced, may create a risk of harm to patients or a risk of affecting the accuracy or efficacy of the assessment or treatment results have been created and maintained.

Confidentiality of and Access to Records

5. The registrant establishes or uses processes that maintain the privacy, confidentiality and security of patient records while permitting appropriate access to the records¹². At a minimum, these processes will:
 1. Permit, unless a recognized exception applies, and document how patients or their authorized representatives may:
 - a. upon payment of a reasonable fee, view, copy or otherwise obtain information from their records
 - b. request corrections or add statements of disagreements to their records
 - c. obtain information on his/her record keeping procedures
 2. Establish a mechanism to provide other health care professionals with access to patient information in circumstances where the collaborative management of a patient requires it, unless the patient refuses to permission.
 3. Ensure a reasonable level of access to records in circumstances where the registrant has closed or left the practice in which he/she was working. At a minimum, access is to be maintained for the longer retention period laid out in this standard or any retention period specified in law.
 4. Permit timely access to patient records by an authorized investigator, inspector, assessor or representative of the College, for the inspection, copying or removal of records.
 5. Permit timely access to patient records by an authorized investigator from another college established under the Regulated Health Professions Act for the inspection, copying or removal of records.
 6. Prevent anyone other than the patient or his/her authorized representative from examining any component of the physiotherapy clinical record or from obtaining or from copying any information from a physiotherapy clinical record except if it is permitted or required by law or this standard.

¹² See “Briefing note for Physiotherapists’ Privacy Requirements in Ontario”, College of Physiotherapists of Ontario, for more information.

Retention and Disposal

6. He/she establishes records retention and disposal processes that ensure that records are maintained for the required period of time and are disposed of in an appropriate manner. At a minimum, these processes will:
 1. Ensure that the clinical and financial components of physiotherapy patient records are 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 for the records that would take priority¹³.
 2. Ensure that equipment service records are maintained for a minimum of five years from the date of the last entry.
 3. Ensure that any other records required for appropriate management of a physiotherapy practice are kept for at least the minimum required legal retention period.
 4. Ensure that records are:
 - a. not disposed of until they have met their minimum retention requirements
 - b. not disposed of, sold or recycled until they have been physically destroyed in an irreversible, secure manner that retains the privacy and confidentiality of the information in the records

When Contracting as a Health Care Service Provider

7. When providing health services on a contractual basis to a health care service agency, ensuring that the terms of his/her contract cover:
 - a. registrants' obligations for record keeping in general
 - b. an indication as to whether the registrant is acting as an agent of a Health Information Custodian (HIC) as defined in the Personal Health Information Protection Act, or whether he/she is a Health Information Custodian on his/her own behalf

When Acting as an Agent of a Health Information Custodian

8. If a registrant is an agent of a Health Information Custodian as defined in the Personal Health Information Protection Act, he/she will take all reasonable steps to ensure that the records maintained by the Health Information Custodian for those patients or clients for whom he/she provides services are maintained in accordance with this standard, or where other law(s) specific to the setting apply, as specified in that law¹⁴.

Collaborative Care Records

9. In circumstances where he/she keeps records jointly with other health care providers to deliver

13 For example, the Long-Term Care Act sets out different retention requirements in some circumstances Confidentiality of and Access to Records

14 Reasonable in this context might mean ensuring that the registrant has a contract with the HIC that ensures the HIC is aware of the requirements of the Personal Health Information Protection Act, any additional expectations defined in this standard and is willing to maintain records in a manner that ensures that a registrant meets these obligations. It may also mean that the registrant arranges to conduct periodic audits to make sure that his/her obligations are being met.

services including assessments or care, consultative or peripheral patient services or group training or screening services, the registrant will, at a minimum, contribute to and retain access to joint records that meet the expectations set out in this standard, or where other law(s) specific to the setting apply, as specified in law.

Resignation from the College

10. Before resigning registration with the College, a registrant who is a Health Information Custodian (HIC) will ensure that patients retain their right of access to the records of which the registrant has custody by:
 - a. Maintaining these records for, at a minimum, the retention period defined in this standard or any other relevant statute or regulation
 - b. Transferring the records to either another person who is legally authorized to hold the records or to a successor health information custodian in keeping with the provisions defined in the Personal Health Information Protection Act¹⁵

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 like hospitals, independent health facilities and nursing homes

(See the Personal Health Information Protection Act for a complete definition.)

¹⁵ Section 3(11) of PHIPA indicates that a HIC retains the custody of personal health information until complete custody and control of the record, where applicable, passes to another person who is legally authorized to hold the record. Section 42 (2) indicates that a HIC may transfer records of personal health information about an individual to the custodian's successor if the custodian makes reasonable efforts to give notice to the individual before transferring the records or, if that is not reasonably possible, as soon as possible after transferring the records.

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

- Briefing Note for Physiotherapists' Privacy Requirements in Ontario, College of Physiotherapists of Ontario, 2006
- Briefing Note to the Health Care Consent Act, College of Physiotherapists of Ontario
- Essential Competency Profile for Physiotherapists in Canada. Canadian Alliance of Physiotherapy Regulators, July 2004

Legislation

- Health Care Consent Act (HCCA)
- Personal Health Information Protection Act (PHIPA)
- Regulated Health Professions Act (RHPA)
- Standard for Professional Practice: Performing Controlled Acts, College of Physiotherapists of Ontario
- Standard for Professional Practice: Physiotherapists Working with Physiotherapist Support Personnel, College of Physiotherapists of Ontario
- Standard for Professional Practice: Conflict of Interest, , College of Physiotherapists of Ontario

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