COLLEGE OF PHYSIOTHERAPISTS of ONTARIO
Regulating Physiotherapists

Record Keeping Standard

Date Approved: September 28, 2017

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The Purpose of Record Keeping

Clinical records are important communication tools that allow the physiotherapist and others to track the patient's past and current status, determine future care needs, give evidence of the care provided, collaborate when providing care, and transfer a patient's care smoothly. Good record keeping enhances outcomes and safety for patients.

Physiotherapists also keep records for other purposes, such as to demonstrate that they are accountable to patients, payers, the College, and other health care providers, and to meet any reporting requirements required by law or by organizations.

The requirements in this Standard apply to records in any medium, such as paper, electronic, audio, video, and photographs

1. Responsibility and Accountability

Physiotherapists must maintain clinical records about their patients, and other records that are required by the College, by law, or by other organizations.

2. General Requirements for All Records

Records must be well organized, understandable, and accurate.

Well Organized:

- Entries must be legible.
- Specialized terms, short forms, and diagrams must be understandable to anyone who may be involved in the care. This can be done by defining the terms, short forms, and diagrams in the record, or having a list of definitions available.
- Records must be in either English or French.
- Records must use appropriate, respectful, and non-judgmental language.

Understandable:

- Entries must be legible.
- Specialized terms, short forms, and diagrams must be understandable to anyone who may be involved in the care. This can be done by defining the terms, short forms, and diagrams in the record, or having a list of definitions available.
- Records must be in either English or French.
- Records must use appropriate, respectful, and non-judgmental language.

Accurate:

- Information must be entered within a reasonable time period.
- Entries must be permanent. That means there must be a way to ensure that content is not lost or deleted.
- If there are additions or corrections, the original content must remain readable. The new content must indicate who made the addition or correction, the date, and the reason for the addition or correction.
- If there are significant changes in the patient's condition or relevant new information is received, this must be entered as updated information.

3. Requirements for Clinical Records

Information in clinical records must support physiotherapists' rationale for the care that they provide.

Clinical records must contain objective data, evidence, and outcome measures whenever possible and appropriate. They should also include information to help anyone who may be involved in the care interpret the data or measure where necessary.

Clinical records must contain relevant information about a patient's care in enough detail to allow another health provider to assume care of the patient or to follow the plan of care.

Information that is relevant to a patient's care includes, but is not limited to:

- unique identifiers for the patient and for all providers involved in that patient's care
- information about the patient: demographic information, health, family, and social history, and patient-reported subjective data
- discussions with the patient to obtain ongoing consent to assessment, *treatment,* and involvement of other care providers
- care refusals
- the date of every patient encounter, including missed appointments
- results of tests, investigations, assessments, measures, and any reports received regarding the patient's care
- details about analysis, diagnosis, patient goals, treatment plan, and treatments performed
- progress notes, outcomes, reassessments, and resulting changes to the treatment plan
- details about any care that has been assigned to another person, or care provided collaboratively with other health providers, including consultations and correspondence
- discussions and communications with the patient including instructions, recommendations and advice
- referrals and transfers of care to another health provider, and any reports sent regarding the patient's care
- discharge summaries including reassessment findings, reason for discharge and other recommendations.

4. Requirements for Financial Records

Physiotherapists who charge fees for the care, service, or product provided must ensure there are financial records that contain:

- the name of the patient
- the name of the physiotherapist, physiotherapist assistant, and others who provided care under the physiotherapist's supervision
- date of service
- a description of the care, service, or product provided
- amount of the fee for the care, service or product
- any payment received.

5. Record Retention

Clinical and financial records must be retained for at least 10 years from the later of the following two dates:

- the date of the last patient encounter, or
- the date that the patient reached, or would have reached 18 years of age.

It must be possible to retrieve and reproduce a complete clinical and financial record for each patient throughout the retention period.

6. Privacy Requirements

Physiotherapists must comply with all legislation that protects the confidentiality of personal information and personal health information. The Personal Health Information Protection Act (PHIPA) sets out the duties physiotherapists have as either Health Information Custodians (HIC) or agents of a Health Information Custodian.

Here are some of the requirements in the Personal Health Information Protection Act:

- Physiotherapists must maintain patient confidentiality in the course of collecting, storing, using, transmitting and disposing of personal health information. Examples of secure storage and access include physical controls such as locks, and electronic controls such as passwords and encryption.
- Patients must know who has custody and control of their personal health information (the Health Information Custodian) and how their personal health information will be managed.
- Physiotherapists must obtain and record patient consent before disclosing a patient's personal health information to someone who is not a health provider involved in the patient's care.
- Physiotherapists must ensure that those who have the authority or patient consent can access a patient record in a timely way. A reasonable fee may be charged for providing the record.

The College's privacy resources provide more detailed information about privacy requirements.

Glossary

Treatment:

To determine whether the activity performed by the physiotherapist assistant was treatment, ask yourself if the activity was part of the physiotherapist's treatment plan, for example applying modalities, exercises, gait training, etc. Things such as tidying the treatment area, removing an ice pack or escorting patients to and from the treatment area would likely not be classified as treatment.

Confidentiality:

The obligation of a regulated health care provider not to disclose information obtained from a patient in a therapeutic relationship without the consent of the patient, or his or her authorized agent, or as required or permitted by law.

Understandable:

Being clearly laid out and written in language that is easy for the average person to understand.

10 Years:

There may be circumstances where physiotherapists would want to keep their records for longer than the minimum 10-year period. For example, some liability claims or legal proceedings may be initiated for up to 15 years after the fact, for which the records may be needed. If you are not sure how long you should keep your records for, you may wish to speak to your employer or a lawyer about it.