

PRACTICE STATEMENT

Number: 4.17

Original Date: February 14, 2002
Revised Date: November 9, 2010
Review Date: November 9, 2015
Approving Body: Council
Authority: Chair, Treasurer
Implementation: January 20, 2011
Applies to: All Practicing Members

TOPIC: RECORD KEEPING

Introduction:

Record keeping is considered an essential legal component of the physiotherapist's demonstration of professional accountability. The main purpose of record keeping is to manage information relevant to the client's care for the benefit of the client. The creation and maintenance of the required records is essential for enhancing client outcomes, facilitating the smooth transfer of client care to other providers and documenting the management of physiotherapy practice. Records help ensure continuity of care and the maintenance of multiple health conditions by multiple providers. Safe, effective and appropriate client care is promoted when physiotherapists record the client's history, the physiotherapist's assessment and the treatment provided.

Physiotherapists should also adhere to guidelines set out by the institution or health authority by which they are employed.

Ensuring proper recording keeping is described in the Essential Competency Profile for Physiotherapists in Canada¹

Practice Statement:

For every client for whom a physiotherapist either provides or supervises physiotherapy care a complete and accurate client record must be created. This record should be sufficiently detailed and legible to allow any physiotherapist to continue to manage the care of that patient. The physiotherapist documents all aspects of patient care including informed consent, assessment, treatment, change in patient status, re-assessment and discharge.

A. Clinical Record Guidelines

A physiotherapist demonstrates the practice standard by:

1. Including the full name and title of the individual who is providing physiotherapy care.
2. Ensuring that all entries are
 - a) Legible and understandable
 - b) Revisions must be signed or initialed. Correction fluid must not be used to make revisions; errors should be crossed through with a single line.
 - c) Dated
 - d) In ink or able to be printed promptly (see electronic records below)
 - e) English or French
 - f) Objective
 - g) Chronological: any late entries or additions must be clearly documented.
 - h) Timely: information should be recorded as soon as possible after each encounter and not exceeding 24 hours.
 - i) An accurate reflection of the interaction
 - j) Never removed from the record
 - k) Made by the person who was directly involved in the interaction. Another person (e.g. physiotherapy assistant or student) can create the entry providing the person involved is assigned by the physiotherapist to create the entry and the physiotherapist co-signs the entry. The physiotherapist must determine the accuracy of the entry before signing.
 - l) Authenticated (signed or initialed) by the person who made the entry: their identity must be evident. Signatures may be electronic or stamped providing the physiotherapist ensures that only he/she can authorize the use of the stamp. A log of all physiotherapists' signatures should be kept for reference purposes as a means to link signatures to initials.
 - m) Made using accepted terminology or abbreviations: abbreviation should be written in full the first time used in any record. Site policies regarding abbreviations should be followed.
 - n) Kept respecting the confidential nature of the material including parts of the record NOT generated by the physiotherapist such as the referral or reports from others.
 - o) Clearly referenced as required. For example: when providing treatment according to a care map, the documentation should include a reference to the specific care map. Copies of the care map should be readily available and retained for the same length of time as the client record.

3. Including all relevant patient identification information:
 - a) Full name (or other unique identifier)
 - b) Current address
 - c) Telephone number and any alternate contact numbers
 - d) Date of Birth
 - e) Gender
 - f) Emergency contact person.
 - g) Name of primary health care provider, if any
 - h) Name of consenting parent or guardian (when applicable)

4. Providing a record of referral information relevant to the client:
 - a) The name and contact information of any source of referral including self referral
 - b) The reason for the referral
 - c) The name and contact information of any health professional or facility to which the patient was referred.

5. Providing documentation that includes:
 - a) Details of the physiotherapy examination which must include the following whenever applicable:
 - i. Patient demographics (example: age, sex, education, BMI, language)
 - ii. Family history
 - iii. Social situation (support systems)
 - iv. Living environment
 - v. General health status
 - vi. Medications
 - vii. Other clinical tests
 - viii. Principle medical diagnosis (if provided)
 - ix. Chief complaint
 - x. Record of all tests and outcome measures performed including results. Where available, standardized outcome measures should be used.
 - xi. Pre printed examination forms may be used, but should include appropriate identification.
 - b) an evaluation: evidence of clinical judgments or conclusions regarding the patient's status, including any contraindications or precautions that may be present.

- c) a physiotherapy diagnosis: identification of existing or potential impairments, activity limitations, participation restrictions and environmental factors.
 - d) identification of client goals.
 - e) a plan of care: interventions planned in order to reach the goals, expected outcomes, length of time anticipated to reach the goals, any collaboration or involvement with other health care professionals or individuals.
 - f) the treatment provided to the patient:
 - i. patient education, including advice provided by telephone or electronically.
 - ii. interventions may include but are not limited to: exercise, manual therapy, electrotherapeutic modalities, airway clearance techniques, physical agents.
 - iii. the details should be sufficient to enable the patient to be managed by another physiotherapist.
 - g) any change in the client's status
 - h) reassessment performed and results.
 - i. If treatment is provided at intervals of less than three months (i.e. three times a week or twice a month) a reassessment must be documented at least every three months.
 - ii. If treatment is provided at intervals greater than every three months (such as in a school environment or with long-standing stable disease processes where follow-up may be once or twice a year), then documentation should occur with every visit.
 - i) patient response to treatment.
 - j) the delegation of any aspect of patient care to physiotherapy support personnel, including the identification of the person who provided the care.
 - k) any relevant verbal communication (including telephone calls) with the client or with other health care professionals, family members, third party payers, or those with decision making power with regards to the client's care plan.
6. Ensuring that the client record includes:
- a) documentation of informed consent for assessment and treatment, or refusal to treatment (Practice Statement 4.3: Informed consent).

- b) informed consent for release of personal information
 - c) identification of the client on each page of the record with at least two pieces of information (i.e. name and date of birth) or a unique identifier.
 - d) a copy of every written report sent or regarding the client
 - e) copies of all external documentation including correspondence from referring physicians, other practitioners, attorneys, various third party payers, diagnostic reports etc. Originals should be kept when available.
 - f) a discharge plan that includes:
 - i. the date of discharge
 - ii. the discharge summary. Other information such as patient status at discharge, goals achieved, home program and recommendations given to the patient should be included if applicable.
7. Allowing a patient to examine and receive a copy of their clinical record. *Part 2 of the Personal health and Information Act (PHIA)* provides direction regarding client access to personal health information.

B. Electronic Record Guidelines

Records may be kept using an electronic system providing the principles of record keeping are maintained.

A physiotherapist demonstrates the practice standard by:

1. Ensuring that an electronic record provides:
 - a) a visual display of the complete record
 - b) availability; a means to access, copy or print the client's complete record promptly by an authorized user
 - c) a verifiable signature. If an electronic signature is used, a signature standard must be used to verify the identity of the signer
 - d) the ability to make amendments while preserving the original record
 - e) integrity; capability to offer reasonable protection against unauthorized access. Access should be restricted by user authentication and passwords
 - f) automatic back up of files or reasonable protection against loss, damage tampering or inaccessibility of information

2. Ensuring that all electronic records are in a secure electronic environment in order to maintain the confidentiality, security, and integrity standards of *The Personal Health Information Act (PHIA)* (Practice Statement 4.19: Retention and Transmission of Electronic Health Information)
3. Ensuring that all electronic transfer of patient information is managed to maintain security including when using portable devices (by encryption of information or avoiding the use of portable equipment in public places) (Practice Statement 4.19: Retention and Transmission of Electronic Health Information).
4. Maintaining data for the full length of the retention period in compliance with *The Personal Health Information Act (PHIA)* (Practice Statement 4.19: Retention and Transmission of Electronic Health Information).
5. Providing a method for disposal of records that ensures complete removal from all systems/hardware. No data should remain on either a permanent or removable drive (Practice Statement 4.19: Retention and Transmission of Electronic Health Information).

C. Attendance Record Guidelines

A physiotherapist demonstrates the practice standard by:

1. providing an entry for each client encounter
2. providing a record of any canceled or missed appointments
3. ensuring that although the attendance record may be kept separately from the clinical record, it is still considered as part of the patient's clinical record and is therefore considered confidential information
4. allowing support personnel to assist with keeping patient attendance

D. Financial Record Guidelines

Where fee for service is provided, a physiotherapist demonstrates the practice standard by:

1. keeping a financial record for every client. The financial record may be kept separate from the clinical record (i.e. the clinical record is in a paper format and the financial record is stored electronically). However, the entire financial record must be retrievable for the duration of the retention period.
2. Providing documentation of all financial transactions that includes:
 - a) the identification of the person who provided the product or service
 - b) the identification of the patient to whom the product or service was provided
 - c) the date of the transaction

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- d) a description of the product or service sold
- e) the cost of the product or service sold
- f) the date that payment was received
- g) the method of payment
- h) any balance due

3. Identifying any third party charges.
4. Identifying any agency used for the collection of an outstanding balance.
5. Including a reason why any fee may have been reduced or waived.
6. Identifying any fees paid/insurance claims made on behalf of the patient.

E. Equipment Record Guidelines

A physiotherapist demonstrates the practice standard by:

1. Ensuring that records are kept of the inspection, maintenance and servicing of:
 - a) any equipment used to assess or treat patients
 - b) any equipment that is used to sterilize other equipment or tools that may harm a patient or affect the efficacy of a treatment if not properly serviced.
2. Documenting any equipment loans. Details should be sufficient to recall the equipment. The date of removal and return of the equipment should be recorded. Any fee charged should also be recorded. Equipment loan forms should be kept in with the patient's record.

F. Confidentiality of Records

Health professionals in Manitoba are bound by the provisions of *The Personal Health Information Act (PHIA)*. *Part 3 of PHIA* provides direction regarding the confidentiality, security, accuracy and integrity of health information. A physiotherapist is required to understand his/her obligations under this legislation. Registrants are advised to consult this Act for specific guidelines.

G. Retention and Disposal of Records

The Physiotherapists Act, section 19 Client Records 7(4) states "Physiotherapy client records must be maintained for a minimum of seven years. In addition, records made while a client is a minor must be maintained until the client reaches the age of 25 years."

Health professionals in Manitoba are bound by the provisions of *The Personal Health Information Act (PHIA)*. *Part 3, Section 17 of PHIA* provides direction regarding the retention and destruction of health information. A physiotherapist is required to understand his/her obligations under this legislation. Registrants are advised to consult this Act for specific information.

H. Record Handling When Selling or Closing a Practice

In circumstances where a physiotherapist closes or sells a practice, or has left a practice, please consult the Practice Statement 4.1 “Client Records when Selling /Closing a clinic” for specific information.

I. Records Available to the College

A physiotherapist demonstrates the practice standard by:

1. allowing all records and documents to be available for inspection or copying by a person appointed for the purpose under *The Physiotherapy Act*.
2. not charging a fee for any copies of any records requested by the college.

References:

College of Occupational Therapists of Manitoba. *Practice Guidelines. Client Records in Occupational Therapy Practice*. June 2003.

College of Physicians and Surgeons of Manitoba: By-Law 1-Article 29 Keeping of Medical Records

College of Physiotherapists of Ontario: *Standards for Professional Practice: Record Keeping*. March 2007.

Rozovsky, L. *The Canadian Law of Patient Records*. Butterworth: Toronto, Canada, 1984.

Winnipeg Regional Health Authority. *Regional Physiotherapy Inpatient Charting Guideline*.

World Confederation for Physical Therapy. *Draft Position Statement: Physical Therapy Record Keeping, Storage and Retrieval*. WCPT, London, Awaiting Approval, 2011.

Legislative References:

The Personal Health Information Act

The Physiotherapists Act and Regulations Schedule A – Standards of Practice 7(1), 7(2), 7(3), 7(4)

⁴Essential Competency Profile for Physiotherapists in Canada (October, 2009)

2. Communicator

Key Competency 2.3 – Employs effective and appropriate verbal, non-verbal, written and electronic communications

2.3.1 – Produces and maintains legible, accurate, and appropriate records, in keeping with regulatory requirements (e.g. may be written or electronic and relate to clients or equipment).

2.3.2 – Effectively presents information about client care and physiotherapy service delivery.