College of Physiotherapists of Manitoba

PRACTICE DIRECTION

Current and updated as of: September 17, 2024

4.17 Documentation

Standard

The physiotherapist maintains client records that are accurate, legible, and complete, written in a timely manner.

Expected Outcome

Clients can expect that their physiotherapy records are confidential, accurate, complete, and reflect the physiotherapy services provided.

Performance Expectations

The Physiotherapist must:

A. Maintain legible, accurate, complete, and **contemporaneous** client records related to all aspects of client care and interactions.

B. Complete documentation as soon as reasonably possible to promote client safety and effective clinical care.

Components of a Complete Client Record

A complete client record must be created for every client for whom a physiotherapist provides or supervises physiotherapy care.

C. The Physiotherapist must ensure that the following is retained as part of a complete client record for each client:

   i. All Details of Clinical Care.

   ii. Records of Client Attendance, including date of each encounter as well as declined, missed, or cancelled appointments, telephone, or electronic contact.

iii. Financial Records, in situations where fees for services or products have been charged.

iv. Details or copies of all incoming or outgoing verbal or written communication, including electronic communication with or regarding the client.

Details of Clinical Care

D. The physiotherapist must include the following detailed chronological information in the client record:

i. At least two unique identifiers on each page or discrete part of the client record.

ii. Client Contact information.

iii. Name of primary healthcare provider, if any.

iv. Name of consenting parent or guardian (when applicable).

v. Client's reason for attendance
- including any relevant referral information, and information regarding any health professional to which the client was referred to by the Physiotherapist.

vi. Client's subjective concerns

vii. Client's relevant health, family, and social history

viii. Date of each treatment session or professional interaction including declined missed or cancelled appointments, telephone, or electronic contact.

ix. Date of chart entry if different from date of treatment session or professional interaction.

x. Assessment findings including objective measures, relevant clinical tests, and diagnostic reports.

xi. Physiotherapy diagnosis

xii. Treatment plan and goals

xiii. Documentation of obtaining informed consent and relevant details of the consent process reasonable for the clinical situation.

xiv. Details of treatment provided and client response to treatment, including results of reassessments, in sufficient detail to allow client to be managed by another physiotherapist.

xv. Details of tasks assigned to physiotherapy support workers/assistants.

xvi. Details of relevant communication or involvement with other health care professionals, third party payers, family members or those with decision making power with regards to the client's care plan.

xvii. Details of all client education, advice provided and communication with or regarding the client.

xviii. Documented rationale when client is discharged from physiotherapy.

xix. Documentation is to be completed after each treatment session or patient encounter if there are any changes in assessment findings or treatment provided.

xx. The frequency of reassessment is relevant to the treatment provided and goals of therapy. Regular and consistent reassessment should be carried out to allow for review of effectiveness of interventions, monitor progress and ensure continuity of care.

E. Ensure that the individuals delivering physiotherapy services are clearly identified in all documentation.

   i. Ensure that all entries can be easily identified as a physiotherapy entry in a multidisciplinary record.

F. Retains or ensures ongoing access to copies of care pathways or protocols in addition to client records in circumstances where client care delivery and documentation is according to a care pathway or protocol.

Quality of Documentation

The Physiotherapist must:

G. Confirms that documentation entered into the treatment record accurately reflects the assessment, treatment, goals, advice, and client encounter that occurred.

   i. Pre-printed forms (i.e., assessment forms) may be used and must include relevant information.

H. May reference rather than duplicate information collected by another regulated healthcare provider that the physiotherapist has verified as current and accurate.

I. Uses terms, abbreviations, acronyms, and diagrams which are defined or described to promote understanding of or others who may access a client's record.

   i. If abbreviations or acronyms must be used, writes out full word or phrase followed by the abbreviation in parenthesis the first time it is use in the document or component of the chart.

J. Clearly document changes, revisions or additions made to the client record clearly identifying who made the change and the date of the change.

   i. Never deletes information from client record. Errors should be crossed through with a single line.

   ii. Entries must be made in ink or have the ability to be printed in a timely fashion.

Financial Records

Where fee for service is provided a physiotherapist must maintain a financial record for every client.

K. The physiotherapist must maintain accurate and complete financial records related to fees charged for the provision of physiotherapy services and sales of products. The financial record may be kept separate from the clinical record and must be retrievable for the duration of the retention period in compliance with *The Personal Health Information Act (PHIA)*

L. Financial records must include the following:

   i. Identification of all service providers and the organization, date of service and physiotherapy or product provided.

   ii. Unique identification of the client to whom the product or service was provided.

   iii. Fee for physiotherapy service or product, including but not limited to fees for missed appointments, interest charges or discounts provided.

   iv. Method of payment, date payment was received, and Identity *of payer.*

   v. Any balance owing.

   vi. Identification of any agency used for the collection of an outstanding balance.

vii. Identification of any fees related to external charges such as delivery fees or credit card processing fees.

viii. Identification of any fees paid and/or insurance claims made on behalf of the client.

ix. Identification of rationale if fees are reduced or waived.

Electronic Medical (Client) Records

Each client's Electronic Medical Record must include all Components of a Complete Client Record and all Details of Clinical Care.

M. A physiotherapist who uses an electronic medical record must ensure that they employ appropriate safeguards to protect the confidentiality and security of information, including but not limited to, ensuring:

i. An unauthorized person cannot access identifiable health information on electronic devices.

ii. Screen lock features are employed so that confidential information is not displayed indefinitely.
   - Authorized users must log out when not accessing the electronic medical record.

iii. Each authorized user can be uniquely identified.

iv. Each authorized user has a documented access level based on their role.

v. Appropriate password controls and data encryption are used.

vi. Audit logging is always enabled such that access and alterations made to the client record identify the date of access or change, the change or addition made, and the identity of the individual accessing or changing the record.

vii. Where electronic signatures are used, the authorized user can be authenticated.

viii. Identifiable health information is transmitted or remotely accessed securely with consideration given to the risks of non-secured structures.

ix. Secure backup of data occurs consistently.

x. Data recovery protocols are in place and tested regularly.

xi. Data integrity is protected such that information is accessible.

xii. Practice continuity protocols are in place in the event that information cannot be accessed electronically.

xiii. When hardware is disposed of that contains identifiable health information, all data is removed and cannot be reconstructed.

xiv. All electronic records are in a secure electronic environment in order to maintain confidentiality, security, and integrity standards in compliance with *The Personal Health Information Act (PHIA)*.

Signing of Client Records:

N. The Physiotherapist must:

i. Clearly identify the writer as the physiotherapist responsible for the entry into the client's record

ii. Sign using the full name and protected title of the individual signing.

- Signatures may be electronic or stamped providing the physiotherapist ensures that only they authorize the use of the stamp. Initials are not permitted.

iii. Co-sign entries of Physiotherapy Students they are supervising.

Definitions:

Contemporaneous – occurring or originating during the same time period. In the physiotherapy context, contemporaneous is determined by the practice context, other expected or predictable uses of the record. In the PT context, documentation that does not occur during the same time period poses a risk to the client and is generally, less accurate and more likely to be questioned.

The term **Client** can be interchanged with the term **Patient**. "Clients are recipients of physiotherapy services, and may be individuals, families, groups, organizations, communities, or populations. An individual client may also be referred to as a patient.

Related Standards:

• Privacy and Record Retention
• Assessment, Diagnosis, Treatment
• Funding, Fees, and Billing
• Risk Management and Safety