Documentation Reference

Introduction

To assist physiotherapists in meeting the performance expectations outlined in: ***Documentation, Privacy and Record Retention, Infection Control, Informed Consent, Client Records When Closing/Moving/Selling a Clinic*** some key elements have been highlighted in this reference sheet. The list provided is not exhaustive but rather is intended to provide physiotherapists with an optional tool that can be used to facilitate the application of the Practice Direction into clinical practice and/or assist in auditing their own records. This reference should not be used in isolation. There may also be legislative or employer requirements that are not covered in this reference.

Patient Records

Identification – Is there a system to uniquely identify patients and physiotherapy providers?

- ❒ Patients
- ❒ Providers - Full name and Title of person providing PT care

General – Have the following areas been managed appropriately?

- ❒ Legibility of entries
- ❒ Use of abbreviations
- ❒ Reference to care maps
- ❒ Signatures
- ❒ Additions or changes to the record
- ❒ Storage, retention, and disposal of records
- ❒ Access and privacy policies
- ❒ Dates

Clinical – Have the following items been included and captured in appropriate detail?

- ❒ Patient demographics
- ❒ Relevant health, family and social history
- ❒ Referral and/or primary health care provider information (where appropriate)
- ❒ Patient subjective concerns
- ❒ Assessment results (including objective measures)
- ❒ Treatment goals
- ❒ Treatment plan
- ❒ Treatment provided
- ❒ Components of care that were assigned to another provider
- ❒ Dates of all patient interactions
- ❒ Copies of, or notes, documenting all relevant communications (written, verbal and electronic)
- ❒ Authorization for delegated acts (where necessary)

Consent – Was informed consent obtained and documented for the following?

- ❒ Assessment
- ❒ Treatment
- ❒ The involvement of other care providers
- ❒ Release of information

Progress Notes – Do progress notes appear at an appropriate frequency and do they include the following?

- ❒ Outcomes measures used
- ❒ Results achieved
- ❒ Subsequent changes to the treatment plan

Discharge Summaries – Are discharge summaries routinely completed and do they include the following?

- ❒ Reason for discharge
- ❒ Status at discharge
- ❒ Other details as appropriate
- ❒ Date of Discharge

Collaborative Records – Do collaborative records allow physiotherapists to meet the performance expectations outlined in the standard including:

- ❒ Retention of Patient Records as required by legislation
- ❒ Ensuring all entries can be attributed to the appropriate care providers
- ❒ Ensuring timely access to patient records in line with PHIA

Financial Records

Financial Records – Do financial records include the following?

- ❒ Identification of both patient and provider
- ❒ Service or product provided
- ❒ Date of service
- ❒ Detailed fee information

Equipment Records

Equipment Records – Do equipment records include the following?

- ❒ Records of equipment inspection, maintenance and service
- ❒ Records of reprocessing and sterilization or reusable critical and semi-critical medical equipment*