Patient Care Reflection Tool

This practice review activity is aimed at ensuring physiotherapists are on track with delivering quality patient care.

* Physiotherapists value quality patient care. Taking time to systematically examine a patient case in detail helps to challenge clinical reasoning, identify practices that were done well and find areas for improvement.
* All of the questions in the Patient Care Reflection Tool are mapped to expectations set out in the Standards of Practice and/or physiotherapist competency profile.
* Using the patient chart as a starting point for the review assists with recall and allows ones to review their charting practices.

# Instructions

* Find a patient chart. Use the information to recall details about the care delivered to the patient.
* Review the questions and record your answers to applicable areas. Dig deep and examine the depth and breadth of your knowledge as well as any assumptions or biases you may have had regarding the case.
* If completing the Patient Care Reflection resulted in significant, meaningful and sustained improvements in personal competence, and patient care practice or physiotherapy/health-care services, it can be reported on for the Continuing Competence Program’s Self-Selected Activity.

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| 1. **In a few sentences, discuss why the patient (guardian) sought physiotherapy.** Provide details about their presenting complaint, diagnosis/condition, main impairment, activity limitation or participation restriction.
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| 1. **Reflecting on the recorded patient history, discuss whether at the outset sufficient information was collected to establish a comprehensive diagnosis and treatment plan.**
	1. Indicate what, if any, other information would have helped with establishing the diagnosis or care plan (i.e., gathering test results, information from other team members involved in the patients care).
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| 1. **What were the patient’s expectations for physiotherapy?**
	1. Describe your approach at the initial visit to identify and manage the patient or guardian’s expectations for physiotherapy.
	2. Include in your discussion anything unique or special about this patient such as past medical history, co-morbid conditions, psychosocial issues, compliance, availability of support systems, resources or employment status that affected their expectations and needed consideration as you developed your care plan.
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| 1. **Discuss why you chose the assessment tools/methods you did.**
	1. Provide information to support the selection of those assessment methods/tools relating your choices to current evidence, theory or practice guidelines.
	2. Where possible indicate what you know about the tool/methods used in your assessment (i.e., measurement properties, validity, sensitivity, specificity, better for screening or diagnosis).
	3. Include a few citations to demonstrate your awareness of current information supporting your choices.
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| 1. **In retrospect, based on your current knowledge, would any other tools or outcome measures have provided more relevant information to inform your assessment.** If yes, discuss further.
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| 1. **What was your physiotherapy diagnosis/clinical impression?**
	1. Is there sufficient information charted to support your diagnosis/clinical impression?
	2. Discuss which key elements/assessment findings would support your diagnosis/clinical impression.
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| 1. **Review your charted goal statements.**
	1. Discuss whether they were patient-centered, specific and measurable. Indicate whether goal statements addressing the patient's function, activity or participation needs where recorded.
	2. Discuss whether there was anything about the goal setting or writing process that could have been improved.
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| 1. **Describe your selected treatment interventions and rationale behind the selection of those interventions.** Include in your description specific information i.e. citations about:
	1. Current evidence, guidelines or theory to support the chosen intervention(s)
	2. The extent intervention(s) were informed by patient’s needs
	3. The dosage parameters used and rationale to support the parameters. Including a few citations demonstrates your awareness of current resources
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| 1. **In a few sentences describe how you ensured informed consent had been obtained for initial and ongoing treatments.**
	1. Indicate whether consent was document at the outset and for ongoing care. Indicate what risks and benefits of treatment were discussed.
	2. How did you ensure communication about treatments was patient/client-centred and understood?
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| 1. **Discuss the assignment of care to others involved in this patient's case including support workers or family.**
	1. Indicate what components of care were assigned to support workers and/or family and the methods you used to ensure what was assigned was competently delivered.
	2. Indicate whether you were satisfied with the process or what you would change to improve this case.
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| 1. **Indicate how often you saw the patient and the duration of treatment.**
	1. Compare and contrast the actual course of treatment with the ideal (what you expected, published guidelines, pathways etc.).
	2. Discuss whether the patient met their treatment goals in a timely manner and if so why or if not why not.
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| 1. **Discuss how you determined physiotherapy treatment was effective.**
	1. Did you rely on subjective report or standardized measures or both?
	2. If you used standardized measures to monitor outcomes, discuss when you administered the measures and how you used information to judge improvements and guide care decisions (i.e., how you use information such as minimal clinical difference scores, subscale analysis).
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| 1. **Discuss how or whether other physiotherapists or health professionals were involved in the management/care plan.**
	1. Include in your discussion any barriers or facilitators to collaborative practice for this case.
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| 1. **Knowing what you know now, what if anything would you like to address, change or learn to optimize care of other patients with similar conditions?**
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