DRAFT Standards of Practice

Documentation

COLLEGE OF PHYSIOTHERAPISTS OF ALBERTA

Standard

The physiotherapist maintains client records that are accurate, legible, complete, and 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:

- Maintains legible, accurate, complete, and **contemporaneous** client records in English for all aspects of client care.
- Completes documentation as soon as reasonably possible to promote client safety and effective clinical care.

Components of a complete client record

The physiotherapist:

- Confirms that the following information is retained as part of a complete client record:
  - Details of clinical care
  - Records of client attendance, including declined, missed, or cancelled appointments
  - Financial records, in situations where fees for services or products have been charged
  - Details or copies of all incoming or outgoing verbal or written communication with or regarding the client

Details of clinical care

The physiotherapist:

- Includes in the client record detailed chronological information including:
  - Unique client identifier on each discrete part (each page) of the client record
  - Client's reason for attendance
  - Mechanism of service delivery (e.g., virtual, in-person)
  - Client's relevant health, family, and social history
  - Date of each treatment session or professional interaction including declined, missed, or cancelled appointments, telephone, or electronic contact
  - Date of chart entry if different from date of treatment session or professional interaction
  - Assessment findings
  - Treatment plan and goals
  - Documentation of informed consent and relevant details of the consent process reasonable for the clinical situation
  - Details of treatment provided and client response to treatment, including results of reassessments, in sufficient detail to allow the client to be managed by another physiotherapist
  - Details of tasks assigned to physiotherapist support workers
  - Details of all client education, advice provided, and communication with or regarding the client
- Ensures that the individual delivering physiotherapy services is clearly identified in all documentation.
- 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:

- Confirms that documentation entered into the treatment record accurately reflects the assessment, treatment, advice, and client encounter that occurred.
- May reference rather than duplicate information collected by another regulated health-care provider that the physiotherapist has verified as current and accurate.
- Avoids use of abbreviations and acronyms. If acronyms must be used, writes out the full word or phrase followed by the abbreviation in parenthesis the first time it is used in the document or component of the chart.
- Clearly documents changes or additions made to the client record, clearly identifying who made the change and the date of the change.

Financial records

The physiotherapist:

- Maintains accurate and complete financial records related to fees charged for the provision of physiotherapy services and sales of products.
- Financial records must include:
  - Identification of the service provider and the organization, date of service, and physiotherapy service or product provided

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  - Client's unique identification
  - Fee for a physiotherapy service or product, including any interest charges or discounts provided
  - Method of payment, date payment was received, and identity of the payer
  - Any balance owing

Electronic medical records

The physiotherapist:

- Employs appropriate administrative, physical and technical safeguards when using an electronic medical record to protect the confidentiality and security of health information, including but not limited to, ensuring:
  - An unauthorized person cannot access identifiable health information on electronic devices.
  - Screen lock features are employed so that confidential information is not displayed indefinitely.
  - Each authorized user can be uniquely identified.
  - Each authorized user has a documented access level based on their role.
  - Appropriate password controls and data encryption are used.
  - Audit logging is always enabled such that access and alterations made to the client record clearly identify the date of access or change, the change or addition made, and the identity of the individual accessing or changing the record.
  - Where electronic signatures are employed, the authorized user can be authenticated.
  - Identifiable health information is transmitted or remotely accessed as securely as possible with consideration given to the risks of non-secured structures.
  - Secure backup of data occurs consistently.
  - Data recovery protocols are in place and regularly tested.
  - Data integrity is protected such that information is accessible.
  - Practice continuity protocols are in place in the event that information cannot be accessed electronically.
  - When hardware is disposed of that contains identifiable health information, all data is removed and cannot be reconstructed.

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 physiotherapy context, documentation that does not occur during the same time-period poses risk to the client and is generally seen to be less accurate and more likely to be questioned.

Related Standards

- Assessment, Diagnosis, and Treatment
- Funding, Fees, and Billing
- Privacy