Text

Description automatically generated with medium confidence

**Record Keeping Checklist**

**Your Name:**

**Date:** *(mm/dd/yyyy)*      

**Identify your record:**

Do not include the patient’s name but include enough details that you could locate the record again.

## Instructions:

* **Yes (✓)** – the listed item is present in your patient’s record (Great!)
* **No** **(⌧)** – the listed item is not present in your patient’s record (That’s okay, no one is perfect. Now you know where you need to improve. Make a note about what you plan to do to fix the problem)
* **Not applicable (NA)** – the listed item does not apply to the record you selected; if you are not sure, check the [Record Keeping Standard and Resources](https://www.collegept.org/rules-and-resources/record-keeping), reach out to a PT colleague, a co-worker, or contact the [practice advisory service](mailto:advice@collegept.org) for help. Make a brief note why this doesn’t apply.

If the record you are reviewing is a multidisciplinary record, you only need to review notes related to the physiotherapy care.

| **Record Review Documentation Checklist** | | **Yes, No  or Not Applicable (NA)** | **Comments** (If No, describe your plans to address the issue. If NA, add brief explanation) |
| --- | --- | --- | --- |
| **Identifying information:** | |  | |
| 1 | Patient’s demographic information (at minimum, must have the patient’s full name, date of birth and contact information) |  |  |
| 2 | At a minimum one unique way to identify the patient (e.g., name and date of birth, unique patient number, etc.) |  |  |
| 3 | The record clearly identifies who provided the physiotherapy care, by name and title, or by a unique identifier. |  |  |
| **Well organized** | | | |
| 4 | Each entry is dated. |  |  |
| 5 | Late entries include both the date of the item being recorded and the date the entry was made, and who made the entry. |  |  |
| 6 | The date of every patient encounter, including missed appointments is recorded. |  |  |
| 7 | If the person making the entry is different from the person providing care, they are also identified by name and job title, or by unique identifier. |  |  |
| **Understandable** | |  | |
| 8 | Entries are legible. |  |  |
| 9 | Records are written in either English or French. |  |  |
| 10 | If specialized terms, abbreviations, or diagrams are used, they must be understood by others who may be involved in the care (e.g., the chart includes a list of what the terms or abbreviations mean). |  |  |
| 11 | Notations are respectful and non-judgmental. |  |  |
| **Accurate** | | | |
| 12 | Changes to the entries are dated and signed or initialled by the member. |  |  |
| 13 | Original entry is visible or retrievable. |  |  |
| **Documentation of the  therapeutic process** | |  | |
| Clinical record includes: | | | |
| 14 | Patient’s health, family and social history. |  |  |
| 15 | Patient’s reported subjective data. |  |  |
| 16 | Record of the assessment(s) conducted |  |  |
| 17 | Results of tests, investigations or measures |  |  |
| 18 | Reports received about the patient’s care, if any |  |  |
| 19 | An analysis of the collected data |  |  |
| 20 | Clinical impression and physiotherapy diagnosis |  |  |
| 21 | Patient goals |  |  |
| 22 | Treatment plan |  |  |
| 23 | Treatments performed |  |  |
| 24 | Details about any care that has been assigned to another person (e.g. which specific elements of the treatment plan were assigned to another person) |  |  |
| 25 | Ongoing monitoring of the patient’s status and progression in meeting the goals |  |  |
| 26 | Any updated information about the patient’s condition or relevant new information received is captured in the record |  |  |
| 27 | Changes or modifications to the treatment plan |  |  |
| 28 | Discussions and communications with the patient including instructions, recommendations and advice |  |  |
| **Discharge summary** | | | |
| 29 | Reassessment findings, if appropriate |  |  |
| 30 | Reason for discharge |  |  |
| 31 | Recommendations and patient instructions |  |  |
| **Informed Consent** | | | |
| 32 | Record of informed consent for assessment and treatment |  |  |
| 33 | Record of informed consent for involvement of other care providers |  |  |
| 34 | Care refusals |  |  |
| 35 | Relevant information about the substitute-decision maker, if applicable |  |  |
| 36 | Evidence the informed consent process is ongoing (e.g. when treatment has changed or diverged from the originally confirmed plan) |  |  |
| **Involvement of Other Health Providers** | | | |
| Referral or consultation | | | |
| 37 | Note about referrals and transfers to another health provider |  |  |
| 38 | Reports about the patient’s care sent to another health provider, if any |  |  |
| **Financial records** | | | |
| Invoices/receipts include: | | | |
| 39 | Name of the patient |  |  |
| 40 | Date of service |  |  |
| 41 | Name and title of the PT, PTA, and others who provided care under the PT’s supervision |  |  |
| 42 | Description of the care, service or product provided |  |  |
| 43 | Amount of the fee for the care, service or product |  |  |
| 44 | Any payment received |  |  |

**Privacy Requirements**

If you are completing this checklist for a Quality Assurance Screening Interview, you are not required to complete this section.

Physiotherapists must comply with all legislation that protects the confidentiality of personal information and personal health information.

**Here are some things physiotherapists must know related to privacy:**

* I know who the Health Information Custodian is for my patient’s records.
* I understand my duties as either the Health Information Custodian or an agent of the Health Information Custodian (for example, by reviewing the College’s privacy resources).
* I have/follow policies and practices that protect patient confidentiality in the course of collecting, storing, using, transmitting and disposing of personal health information.
* My patients are aware of who has custody and control of their personal health information (i.e. who is the Health Information Custodian) and how their personal health information will be managed.
* I obtain explicit consent from patients before disclosing their personal health information to someone who is not a health provider involved in their care.
* I know how to respond to a request to access a patient’s health records (for example, by reviewing information from the Information and Privacy Commissioner).