

A Record Keeping Checklist for Insurers

Physiotherapists are required to keep clinical records about their patients, and other records required by the College of Physiotherapists of Ontario, by law and by other organizations.

Here is a checklist to help you understand if a physiotherapist’s records meet College requirements.

**Please note that not every item is required in every chart entry.** PTs should use their professional judgement and clinical reasoning to determine what information is relevant to include in the record.

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| **Clinical Records** | |
| Patient information | * Unique identifier (i.e. Chart number) * Demographic information * Health, family and social history * Patient-reported subjective data (description of pain, injury, etc.) |
| Assessment and Care | **Consent**   * Evidence that consent has been obtained for assessment, treatment and involvement of other care providers (i.e. PTA) * Care refusals |
|  | Dates of every patient encounter (including missed appointments).  **There does not need to be an entry in the patient’s record for every encounter.** |
|  | **Assessment and Treatment**   * Assessment (tests, investigations, assessments, measures, reports received from other sources) * Analysis and physiotherapy diagnosis * Patient goals * Treatment plan * Treatment performed |
|  | **Tracking progress**   * Progress notes * Outcomes * Reassessments * Any changes to the treatment plan |
|  | **Discussions and communications with the patient**   * Instructions (i.e. home exercise program) * Recommendations * Advice |
|  | Ending or transferring care |
|  | Referrals and transfers of care to other health providers, and any reports sent to other providers |
|  | **Discharge summaries**   * Reassessment findings * Reason for discharge * Other recommendations |
| Information about the care providers | * Unique identifiers for all providers involved in the patient’s care (this should include the names of any PT assistants or students involved in the care) * Details about care assigned by the physiotherapist to another person * Details about care provided collaboratively with other health providers (including consultations and correspondence) |
| **Bottom Line:** Any health provider involved in the patient’s care should understand what conversations took place with a patient, the extent of any assessment performed, what treatment was provided, treatment progress and the clinical reasoning was used to support care decisions. | |
| **Do the financial records include?** | |
|  | * Name of the patient * Name of providers: the physiotherapist, physiotherapist assistant, and others who provided care under the PT’s supervision * Date of service * Description of the care, service, or product provided * Amount of the fee for the care, service or product * Any payment received |
| **Records should be:** | |
|  | **Well organized:**   * Entries are dated * For late entries, both date of item and date of entry are included * Ability to uniquely identify who provided the care and/or who made the entry * Understandable * Entries are legible * Specialist terms, short forms and diagrams are defined in the record or a list of definitions is available * Records are in either English or French * Language is appropriate, respectful and non-judgmental * Accurate * Information is entered within a reasonable time period * Entries are permanent (by ensuring that content is not lost or deleted) * Additions or corrections can be made but * Original content remains readable, * Who made the addition/correction * Date of the addition/correction * Reason for the addition/correct * Information is updated when there are significant changes in the patient’s condition, or relevant new information is received |
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# [Record Keeping Standard](https://www.collegept.org/rules-and-resources/record-keeping)

### The Purpose of Record Keeping

Clinical records are important communication tools that allow the physiotherapist and others to track the patient’s past and current status, determine future care needs, give evidence of the care provided, collaborate when providing care, and transfer a patient’s care smoothly. Good record keeping enhances outcomes and safety for patients.  
  
Physiotherapists also keep records for other purposes, such as to demonstrate that they are accountable to patients, payers, the College, and other health care providers, and to meet any reporting requirements required by law or by organizations.  
  
The requirements in this Standard apply to records in any medium, such as paper, electronic, audio, video, and photographs.

### 1. Responsibility and accountability

Physiotherapists must maintain clinical records about their patients, and other records that are required by the College, by law, or by other organizations.

### 2. General requirements for all records

Records must be *well organized*, ***understandable***, and *accurate*.  
  
**Well organized:**

* Entries must be dated.
* Late entries must include both the date of the item being recorded and the date the entry was made.
* The person who provided the care and/or made the entry must be identified by name and job title, or by a unique identifier.

**Understandable:**

* Entries must be legible.
* Specialized terms, short forms, and diagrams must be understandable to anyone who may be involved in the care. This can be done by defining the terms, short forms, and diagrams in the record, or having a list of definitions available.
* Records must be in either English or French.
* Records must use appropriate, respectful, and non-judgmental language.

**Accurate:**

* Information must be entered within a reasonable time period.
* Entries must be permanent. That means there must be a way to ensure that content is not lost or deleted.
* If there are additions or corrections, the original content must remain readable. The new content must indicate who made the addition or correction, the date, and the reason for the addition or correction.
* If there are significant changes in the patient’s condition or relevant new information is received, this must be entered as updated information.

### 3. Requirements for clinical records

Information in clinical records must support physiotherapists’ rationale for the care that they provide.  
  
Clinical records must contain objective data, evidence, and outcome measures whenever possible and appropriate. They should also include information to help anyone who may be involved in the care interpret the data or measure where necessary.  
  
Clinical records must contain relevant information about a patient's care in enough detail to allow another health provider to assume care of the patient or to follow the plan of care.  
  
Information that is relevant to a patient’s care includes, but is not limited to:

* unique identifiers for the patient and for all providers involved in that patient’s care
* information about the patient: demographic information, health, family, and social history, and patient-reported subjective data
* discussions with the patient to obtain ongoing consent to assessment, *treatment,* and involvement of other care providers
* care refusals
* the date of every patient encounter, including missed appointments
* results of tests, investigations, assessments, measures, and any reports received regarding the patient’s care
* details about analysis, diagnosis, patient goals, treatment plan, and treatments performed
* progress notes, outcomes, reassessments, and resulting changes to the treatment plan
* details about any care that has been assigned to another person, or care provided collaboratively with other health providers, including consultations and correspondence
* discussions and communications with the patient including instructions, recommendations and advice
* referrals and transfers of care to another health provider, and any reports sent regarding the patient’s care
* discharge summaries including reassessment findings, reason for discharge and other recommendations.

### 4. Requirements for financial records

Physiotherapists who charge [**fees**](https://www.collegept.org/rules-and-resources/fees-billing-and-accounts) for the care, service, or product provided must ensure there are financial records that contain:

* the name of the patient
* the name of the physiotherapist, [physiotherapist assistant](https://www.collegept.org/rules-and-resources/working-with-physiotherapist-assistants), and others who provided care under the physiotherapist's [supervision](https://www.collegept.org/rules-and-resources/supervision)
* date of service
* a description of the care, service, or product provided
* amount of the fee for the care, service or product
* any payment received.

### 5. Record retention

Clinical and financial records must be retained for at least ***10******years*** from the **later** of the following two dates:

* the date of the last patient encounter, or
* the date that the patient reached, or would have reached, 18 years of age.

It must be possible to retrieve and reproduce a complete clinical and financial record for each patient throughout the retention period.

### 6. Privacy requirements

Physiotherapists must comply with all legislation that protects the ***confidentiality***of personal information and personal health information. [**The Personal Health Information Protection Act (PHIPA)**](https://www.ontario.ca/laws/statute/04p03)sets out the duties physiotherapists have as either Health Information Custodians (HIC) or agents of a Health Information Custodian.  
 **Here are some of the requirements in the Personal Health Information Protection Act:**

* Physiotherapists must maintain patient confidentiality in the course of collecting, storing, using, transmitting and disposing of personal health information. Examples of secure storage and access include physical controls such as locks, and electronic controls such as passwords and encryption.
* Patients must know who has custody and control of their personal health information (the Health Information Custodian) and how their personal health information will be managed.
* Physiotherapists must obtain and record patient consent before disclosing a patient’s personal health information to someone who is not a health provider involved in the patient’s care.
* Physiotherapists must ensure that those who have the authority or patient consent can access a patient record in a timely way. A [reasonable fee](https://www.ipc.on.ca/health/access-and-correction) may be charged for providing the record.

The College’s [privacy resources](https://www.collegept.org/rules-and-resources/privacy) provide more detailed information about privacy requirements. 

## Glossary

***Treatment:***To determine whether the activity performed by the physiotherapist assistant was treatment, ask yourself if the activity was part of the physiotherapist’s treatment plan, for example applying modalities, exercises, gait training, etc. Things such as tidying the treatment area, removing an ice pack or escorting patients to and from the treatment area would likely not be classified as treatment.

***Confidentiality:***The obligation of a regulated health care provider not to disclose information obtained from a patient in a therapeutic relationship without the consent of the patient, or his or her authorized agent, or as required or permitted by law.

***Understandable:***Being clearly laid out and written in language that is easy for the average person to understand.  
  
***10 Years:***  
There may be circumstances where physiotherapists would want to keep their records for longer than the minimum 10-year period. For example, some liability claims or legal proceedings may be initiated for up to 15 years after the fact, for which the records may be needed. If you are not sure how long you should keep your records for, you may wish to speak to your employer or a lawyer about it.

## College of Physiotherapists of Ontario Record Keeping Resources

* [Record Keeping Standard](https://www.collegept.org/rules-and-resources/record-keeping)
* [Record Keeping E-Learning Module](https://www.collegept.org/Assets/website/elearning/Record_Keeping_Module/story_html5.html)
* [Record Keeping Frequently Asked Questions](https://www.collegept.org/registrants/practice-advice/record-keeping-faqs)
* Helpful Links:
  + [The Power of the Unwritten Standard: What Are They?](https://www.collegept.org/rules-and-resources/unwritten-standard)
  + [The Go-To Clinical Skill - Communications](https://www.collegept.org/rules-and-resources/communication-skills)
  + [Records Can Make or Break Your Case](https://www.collegept.org/rules-and-resources/record-keeping/records-can-make-or-break-your-case)
  + [Personal Health Information Protection Act](https://www.ontario.ca/laws/statute/04p03)
  + [Information and Privacy Commissioner of Ontario](https://www.ipc.on.ca/?redirect=https://www.ipc.on.ca/)
  + [IPC Fact Sheet — Succession Planning to Help Prevent Abandoned Records](https://www.collegept.org/docs/default-source/default-document-library/succession-planning-to-help-prevent-abandoned-records.pdf?sfvrsn=4347c0a1_2)
* Have a Question? Contact the [Practice Advisor](mailto:advice@collegept.org) or review the [Practice Advice & Frequently Asked Questions](https://www.collegept.org/registrants/practice-advice)
* Complete the [complaint form](https://www.collegept.org/patients/HowToMakeComplaint) or contact the College if you have a concern about a physiotherapist:

[investigations@collegept.org](mailto:investigations@collegept.org)

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