Documentation Standards– Physiotherapy

Also See Documentation Policy

This standard describes how physiotherapists document patient/resident care.

The primary purposes of the health record are to provide a record of patient/resident care and to serve as a communication tool with other care providers. Physiotherapists are required to document their assessment of patient/resident status, interventions carried out, the results of these interventions and future care plans.

Documentation must be consistent with organizational and professional requirements and legal standards.

Documentation supports quality improvement initiatives, enables practice audits, facilitates benchmarking and supports tracking of statistics and utilization of resources.

1. All assessments and interventions for all patients/residents must be recorded in the patient record.
2. If the clinical record does not contain an entry regarding an action taken by a physiotherapist regarding the assessment or treatment of a patient then it is presumed that none occurred.
3. Written documentation must be legible. Use black or blue ballpoint ink for handwritten notes. Highlighters are not to be used on official documentation.
4. For Electronic documentation in CST Cerner, the physiotherapist must identify their role under "Relationship". When not using electronic documentation , the physiotherapist's full printed name (first and last names), signature, initials and credentials should be documented on the Signature Sheet of each patient/resident and entries on all forms are accompanied by the full signature or initial (where required on a specific form). Physiotherapists on interim licenses should add their designation as "Interim registered physiotherapist" whether documenting electronically or in written record.
5. All entries are to include the date and time. This is automatic in the electronic record but must be added to all written records with the care provider's name and professional designation, or initialed (if required on a specific form). Individuals who use an e-signature must abide by the Electronic Signature Terms of Agreement.
6. Changes to the CST Cerner electronic record must be corrected by the required process, i.e. 'select, 'modify', enter reason' and 'sign'. Errors in documentation in the written record must be corrected by drawing a single line through the error (the original entry must remain legible). The author's initials must be written beside the line. The word "error" is written above the line.
7. The patient's/resident's full name and unique identifier must be on each page of the health care record. If it is not pre-printed on the form, the physiotherapist/designate will manually apply an identifier label.
8. Interdisciplinary progress notes must be in chronological order. If an entry is made out of the chronological order of care in the electronic record, the required process must be followed. If a written record is used, the entry must be labelled as a 'late entry'.

9. Abbreviations should be avoided. Only abbreviations that are listed on the PHC Physiotherapy Guidelines for Standard Abbreviations and that are recognizable to health professionals in your work area should be used.
10. Physiotherapy students will include their designation as 'student' whether recorded electronically or on the written record (and on the signature sheet in the written record). The supervising clinician must countersign each of the student's entries in the clinical record (both in the initial assessment and ongoing records).
11. Record of consent to specific physiotherapeutic intervention must be documented. Consent can be expressed orally, in writing, or nonverbally by the patient/resident or their legal representative or guardian. Refusal to consent must be recorded and the consequences of the refusal explained. (Refer to the CPTBC Practice Standard on Consent for specific details). Ongoing consent, where there is a change in treatment, must occur and be documented.

PROCEDURE

1. Patient/resident data required by several disciplines is collected once and to the minimal extent possible, entered electronically into CST Cerner. If the physical therapist utilizes information from the records of another health professional the source of that information must be referenced in the clinical record.
2. Patient/resident data is recorded on the most appropriate assessment form(s).For CST Cerner, these will be available as PowerForms or paper forms from FormFast. All relevant fields must be completed.
3. In a written record, there should be no blank lines between entries. To avoid leaving blank lines, a straight or diagonal line is drawn through full or partial blank lines so that no additional entries can be made.
4. Documentation must occur as close as possible to the time of the event or care. Entries are dated and timed and made in chronological order. In a written record, standardised date format should be used; day, month, year, e.g. 07 JAN 2019 and the 24 hour clock format, e.g. 0800. If an entry is late, or not in the order care was provided, the words "late entry" should be added next to the note.. For example, if you are charting at 11 am for a patient whom you saw at 9 am you would write "11:00 , late entry for 09:00. If information is entered after a significant period of time has elapsed, such as the next shift, then a short explanation is required (the reason should be included in both electronic and written records).
5. Documentation is professional – legible, concise, accurate, clear, factual and uses precise language. Generalizations and labeling are avoided.
6. Documentation of assessment must include: consent (initial and ongoing), history of presenting complaint, relevant medical history*, current prescribed medications* (* these can be captured under "Chart Reviewed"), subjective findings (using standardized measures as available), objective findings (using standardized measures as available) [normal, abnormal]and physiotherapist diagnosis and treatment plan.
7. Issues identified during the patient assessment are documented as "goals" in CST Cerner and "foci" in the written interdisciplinary progress notes. Refer to Appendix A.

8. Precautions and/or contraindications to assessment and treatment must be documented.
9. The documentation of interventions should include: reproducible details of the treatment provided (Including parameters of application for electrophysical agents) and the clients response. Details of all education and advice should be included. Interventions/observations are documented in the electronic record in Dyn Doc, iView, PowerForms as appropriate and in the written record on the assessment form, flow sheet, and/or interdisciplinary progress note.
10. Tasks assigned to supervisees must be documented. These must include provisions for ongoing communication and supervision. Details may be noted by referring to a standardized process.
11. If the physiotherapist is documenting in a written record that may be completed by more than one physiotherapist or by clinicians from multiple disciplines, the portion(s) completed by the physiotherapist(s) need to be identified by the PT'(s) initials, or the electronic signature.
12. The clinical record must contain documentation of any change in patient status and/or any change in treatment provided, including advice given to the patient. Frequency of documentation will be based on the frequency that the patient's/resident's status changes or the treatment changes.
13. The clinical record must include referrals and any communication about the patient with third parties. A reasonable effort must be made by the PT to confirm that all professional correspondence is sent to the intended recipient.
14. The PT must comply with process that ensure security of all personal information so as to protect the privacy of the patient/resident's information.
15. If alterations are made to a record (regardless of whether it is an electronic or written record, it should be clear who made the change, when it was made and why it was made.
16. Any near misses and/or adverse events must be documented in Patient Safety Learning System (PSLS)
17. When the physical therapist discharges a patient, the clinical record must contain an entry that reflects the reasons for ceasing treatment.
18. For electronic records, when the CST Cerner system is unavailable (Code Grey or Downtime) the required procedures must be followed (e.g. use of the 24/7 computers, appropriate downtime forms and patient labels).
19. CPTBC requires that patient records be kept for a minimum of 16 years. See Health Record policy.

Related Documents

1. B-00-07-10008 - Documentation Acute Care
2. BCD-11-11-41002 - Documentation Policy (CST)
3. CPTBC Practice Standard #1 Client Assessment, Diagnosis, Interventions
4. CPTBC Practice Standard # 4 Communication
5. CPTBC Practice Standard #7 – Consent
6. CPTBC Practice Standard #8 – Documentation and Record-keeping

7. CPTBC Practice Standard #13 Privacy/Confidentiality
8. CPTBC Practice Standard #17 Safety
9. CPTBC Practice Standard #18 - Supervision

Appendix A: List of Standardized Foci

Systems	**Functional**
Integument (skin)	Nutrition
Neurological	Elimination
Respiratory	Activity / Mobility
Hematological	Sleep-rest
Cardiovascular (CV)	Hygiene
Endocrine	Safety
Gastrointestinal (GI)	
EENT	**Other**
Genitourinary (GU)	Admission / Discharge Planning
Psychosocial	Mental Health
Immune	Communication (shift report)
Musculoskeletal	Education
	Managing Health & Illness
Treatments	Pastoral Care
Dressing & Incision Pain	
IV Therapy Tubes	
Special Treatments	
Medication Therapy	

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