COLLEGE OF PHYSICAL THERAPISTS OF BRITISH COLUMBIA

PRACTICE STANDARD

Number 1

Effective: April 1, 2014
Replaces: **Sept 1, 2011**
April 1, 2008
March 1, 2007
January 2000

CLINICAL RECORDS

A patient's **clinical record** created in the course of providing physical therapy services to that patient consists of all of the information created and recorded for the purpose of the physical therapist – patient relationship and includes all records and reports from other health practitioners that were provided to the physical therapist and which were referred to or consulted by the physical therapist for the purpose of providing physical therapy services to the patient by the physical therapist.

This Practice Standard sets out the College requirements for clinical records. The choice of media (paper or electronic) used to document and maintain clinical records must enable the registrant to meet the requirements set out in this Practice Standard.

1. An accurate, legible, permanent, confidential clinical record must be maintained for each patient such that the complete record, or any component of it, can be easily read, retrieved, copied, or printed.

2. If the clinical record contains no entry regarding an action taken by a physical therapist regarding the assessment or treatment of a patient then it is presumed that none occurred.

3. Only abbreviations which are generally recognizable to health professionals in your place of practice may be used in clinical records.

4. Identification that is unique to each patient must appear on every page of that patient's clinical record.

5. The clinical record must contain all consents given by a patient or their legal representative. See the Practice Standard on Consent to Treatment.

6. All entries in a clinical record must be chronological, record the date of the entry, and identify the physical therapist making the entry. Late entries must be recorded as such.

7. Physical therapists who make any changes or additions to the clinical record must be identified and in the case of electronic media, authenticated by an audit trail. Any changes or additions to the clinical record must leave the original entry legible.

8. The physical therapist's first entry in a clinical record must be signed in full and professional title noted. Subsequent entries in the clinical record must be either initialed or signed in full by the physical therapist. Where electronic signatures are used they must be password protected.

9. Information in a clinical record regarding the assessment of the patient must include: history of presenting complaint, relevant medical history, current prescribed medications, subjective findings, objective findings, physical therapy diagnosis.

10. 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.

11. Assessment findings must be recorded. Any conclusions drawn from an assessment and all actions taken by a physical therapist relevant to the assessment or treatment of a patient must be recorded in the clinical record of the patient.

12. Any precautions and/or contraindications communicated to the patient, related to assessment and treatment must be documented in the clinical record.

13. The clinical record must contain a proposed treatment plan. Treatment, the patient's response to treatment, and all subsequent changes to the treatment plan must be documented in the clinical record.

14. The clinical record must contain the initial dosage for a treatment modality and any changes made to the dosage parameters. (See the Practice Standard on Electro-physical Agents)

15. There must be a patient specific record of all physical therapy encounters (including telephone and/or electronic encounters) which identifies the provider. If this record does not form part of the patient record, it must be maintained with the security of a clinical record and a copy be made available upon a patient's request.

16. 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.

17. Where the physical therapist discharges a patient, the clinical record must contain an entry that reflects the reasons for ceasing treatment.

18. Physical therapists documenting in a multidisciplinary record must identify the portion of the record for which he/she is responsible for writing.

19. When the physical therapist assigns a portion of the physical therapy treatment plan, the physical therapist must document the assignment in the clinical record, including provisions for ongoing communication and supervision. (See the Practice Standard on Assignment of Task to a Physical Therapist Support Worker)

20. The physical therapist is responsible for reviewing clinical record entries made by support personnel. (See the Practice Standard on Assignment of Task to a Physical Therapist Support Worker)

21. The physical therapist is responsible for reviewing and countersigning clinical record entries made by physical therapy students.

22. The clinical record must contain evidence of any written referral and any communication about the patient with third parties.

23. The physical therapist must comply with relevant provincial legislation intended to protect the privacy and confidentiality of personal information (see Additional Resources for links to the

Personal Information Protection Act and *Freedom of Information and Protection of Privacy Act*).

Record Retention and Disposal

The right to commence a lawsuit is time limited under the *Limitation Act*, [SBC 2012] chapter 13. Changes were made to the *Limitation Act*, effective June 1, 2013, which have implications for the length of time a physical therapist must retain patient records.

1. The College requirement for retention of appointment, clinical and financial records is a minimum of 16 years from the date of the last entry or the time limitation for actions against a medical practitioner as provided for in the *Limitation Act*, [SBC 2012] chapter 13, as amended, whichever is the greater. The exception to this limitation is regarding minors and newborns. Records concerning minors must be retained until their age of majority is reached (19 years in BC) plus 16 years for a total of 35 years.

2. Physical therapists should assess their own practices and should be aware that there are circumstances in which the usual limitation period of two years, for example, for personal injury can be extended, particularly where the client is not immediately aware that an injury has occurred or where there is an allegation of sexual misconduct. If a registrant has concerns about specific cases, they should seek advice from their insurer and solicitor, and refer to the provisions of the *Limitation Act* [SBC 2012] chapter 13.

3. When a clinical record is destroyed by effective shredding, burning, computer or video erasure it must be done so in a manner that ensures that the confidentiality of the information is maintained.

4. In the absence of an agreement to the contrary the ownership right to a clinical record remains with the clinic/facility/institution where the record was compiled.

Treatment of Clinical Records When a Practice Closes

1. When a physical therapist closes a practice or ceases to practice he/she must transfer his or her clinical records to another physical therapist or make appropriate arrangements to store the records safely and securely. When transferring clinical records to another person for processing, storage or disposal the physical therapist must ensure that the confidentiality and physical security of the records will be maintained.

2. The physical therapist must ensure that the clinical records can be accessed by former patients and their representatives.

3. The physical therapist must notify the College in writing within 30 calendar days of the date of closing a practice or ceasing to practice of the location where the clinical records of the practice are stored.

Additional Resources:
For information on informed consent see the *Health Care (Consent) and Care Facility (Admission) Act* at: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96181_01 and the *Infant's Act* at:
http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96223_01 .

For more information on confidentiality and disclosure see the *Personal Information Protection Act (PIPA*) at http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_03063_01 and the *Freedom of Information and Protection of Privacy Act* (*FOIPPA*) at http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96165_00 or visit the Office of the Information and Privacy Commissioner for BC website at www.oipc.bc.ca . PIPA and FOIPPA Hotline: 250 356 1851.

For more information on record retention see page 8 of the summer 2005 edition of *Update* available on the College website at: www.cptbc.org/pdf/NewsLetters/Summer2005.pdf and the *Limitations Act* at: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96266_01 .