SCPT Practice Resource
Records

Standards of Practice for Physical Therapists and Practice Resources
Along with the implementation of the Standards of Practice document (as of September 1, 2022), Practice Guidelines are being transitioned to Practice Resources. Practice Resources are educational documents for physical therapists when considering broader topics that may involve multiple standards or regulations.

As part of the transition, Practice Guidelines will be renamed Practice Resources until they can be incorporated into new revamped Practice Resources.

The Physical Therapists Act and SCPT Bylaws, which includes the Ethical Code, and the Standards of Practice document are the approved documents for physical therapy practice in Saskatchewan providing the foundation for which practitioners are governed within the regulatory environment.

Background
After the initial assessment and at regular intervals until discharge, records are kept to ensure the systematic recording of accurate, objective and relevant information about a client so that physical therapy intervention is accurately documented.

The SCPT Code of Ethical Conduct provides:

A) Responsibilities to the Client

10. Respect the confidentiality, privacy, and security of client information in all forms of communication.

11. Use electronic communication and social media and other forms of digital technology professionally and respectfully, conforming to confidentiality guidelines.

B) Responsibilities to the Public

5. Act transparently and with integrity in all professional and business practices including fees and billing; advertising of professional services; and real and/or perceived conflicts of interest.

Practice Resource

Creating Records

1. The physical therapist:

(1) Creates a clinical record for each client that contains the following components:

a) client demographic information, including name, address, gender, date of birth, and a copy of the written referral if one was obtained;

b) documentation of informed consent;

c) client assessment and treatment information;

d) information regarding the physical therapy assessment of the client, including medical history, history of present complaint, subjective findings, objective findings, diagnostic reports, physical diagnosis or healthcare objective, precautions and/or contraindications;

e) proposed treatment plan;

f) actual treatment plan for the client, including the specific treatment protocol;

g) progress notes, indicating both subjective and objective measures of the client's response to treatment;

h) documentation of relevant verbal communication regarding the client's care; and

i) medical information obtained from external sources, such as copies of written and web-based information and reports sent or received respecting the client that have been initially created by other health care professionals (eg. physical reports, laboratory results, WCB notes, etc).

(2) Ensures every part of the clinical record has a reference identifying the client;

(3) Ensures the treatment record entries are dated, signed (or initialed if the therapist's full signature appears at least once in the treatment record) and in chronological order;

(4) Keeps a daily record of appointments or workload, or both, containing the name of each client and the date of the client's visit;

(5) Ensures any record keeping assigned to personnel working under their direction or supervision complies with SCPT bylaws and practice guidelines; and

(6) In multidisciplinary team settings, ensures the physical therapy entries are identifiable in the multidisciplinary treatment record.

Computer Records

2. Where records are maintained in a computer system, the computer system should be able to:
    a) display the recorded information visually;

    b) enter each client record via the client's name and date of birth, or a unique identifier;

    c) print a separate record for each client;

    d) visually display and print the recorded information for each client in chronological order;

    e) provide reasonable protection against unauthorized access;

    f) provide automatic back-up and recovery of files, or otherwise protect against loss of, damage to, and inaccessibility of information;

    g) maintain an audit trail, which records the date and time of each entry and subsequent change, preserves the original content when changes are made, and identifies the person making the entry and rendering the service;

    h) maintain an electronic image; and

    i) create a "read only" file for client records so that patient records cannot be modified by others

Financial Records

3. Where applicable, the physical therapist keeps a financial record for each client containing:
    a) the service and product provided;

    b) the cost of each service and product;

    c) the date each service and product was provided;

    d) the date of receipt of payment; and

    e) any outstanding balance.

Interpersonal Requirements

4. The physical therapist informs the client of any fee associated with the release of a record or report at the time the request for its release is made. When charging fees, the practice must provide the applicant with a written estimate of the total fee and may require the applicant to pay a deposit for all or part of the fee before processing the request.

Although there is no fee structure defined in HIPA for providing access to records, it is recommended that trustees utilize the fee structure found in LAFOIP when determining reasonable charges. These fees may be found in section 5 of LAFOIP Regulations.

Retention Requirements

5. HIPA Regulations Section 6 defines a retention period of 10 years from the date of last episode of care (20 years of age for a minor, whichever period is longer) OR a retention schedule that defines all legitimate purposes for retaining the information and the retention and destruction schedule with each purpose. Information should be kept only for as long as necessary to meet the original purposes and in accordance with the retention period noted above.