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DOCUMENTATION

Completing comprehensive documentation in a timely manner can be challenging. However, inadequate documentation is risky for both your client and for you as the physical therapist. In BC, complaints brought to the College often involve documentation issues such as lack of timeliness, lack of completeness, and lack of documented consent. Documentation should be comprehensive, well organized, and completed in a timely manner that is consistent with the Documentation Standard of Practice.

What constitutes "Failing to Document" and "Poor Quality" documentation?

During investigation of complaints, we have seen instances where the documentation demonstrates lack of completeness and/or has omissions. For example:

- Sometimes the records don't include the type of treatment the physical therapist provided for a client, or a modality might be noted but is missing the parameters.
- "Exercise" may be documented but exactly what exercises may not be specified. Sometimes there is simply no documentation of a specific treatment session at all.
- Using "as previous" or "continue" (or similar phrases) in a clinical record does not meet the expectations set out in the Documentation Standard of Practice. Using these phrases is especially problematic if done repeatedly.
- In Electronic Medical Records (EMR), copying and pasting, or using shortcuts for phrases that don't accurately reflect what occurred in the client interaction that day is also problematic. Did the client report no changes? Did you ask them any questions regarding their health concern? The treatment plan could be (for example) to repeat the same set of exercises or provide dry needling to the same points, but it's likely the conversation with the client differed from the last session.

The documentation that describes the interactions with the client must include sufficient detail to allow another physical therapist to understand what treatments you were providing, the clinical reasoning behind those treatments, and whether they were effective.

"The Write Stuff" eLearning Module

Since we get questions and concerns from physical therapists regarding documentation, and because there is a high rate of documentation issues found during investigations, we collaborated with regulatory colleges across the country to develop an online module entitled *The Write Stuff* to address those questions and concerns. Some of the key learning objectives covered in the module include the importance of contemporaneous, comprehensive, and organized documentation, how consent is documented, and special documentation considerations when working with a physical therapist support worker.

FAQs regarding Documentation

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1. How do I document conversations with or about clients?

You must document the nature of the conversations you have regarding any of your clients. Often clients have others involved in their care (doctors, case managers, massage therapists, family members, etc.) and if you speak to any of them regarding your client you should document that conversation. You don't need to transcribe the exact conversation, but it should be clear what was discussed and the specific information or advice you provided related to client care.

Example of an appropriately documented conversation:

> *Phone conversation with Dr. Abbud. Discussed Mr. Murphy's poor sensation in bilateral lower extremities. Voiced concern regarding the changes as testing did not indicate any MSK pathology. Discussed testing for circulatory impairment or peripheral neuropathy. Will continue to follow Mr. Murphy as Dr. Abbud coordinates further testing*.

2. What about texting or emailing clients?

Any electronic communication should be included in the clinical record. Most EMRs can do this easily by inputting the communication directly into the clinical record. Printing out screenshots of a text exchange or printing off emails and adding them into the paper record also works well and fulfills performance expectations around documentation.

3. I treated one of my colleague's clients today and when I opened the clinical record it was blank, despite the client having attended for multiple sessions. What do I do?

The Documentation Standard of Practice requires that the clinical record include sufficient detail to allow the client to be managed by another physical therapist. It's an unfortunate position to be in, but with no record of assessment or treatment, as the covering physical therapist you would need to conduct an initial assessment and obtain consent for the treatment plan for that day.

If you need additional information or have specific questions, contact the Professional Practice Advisors at CHCPBC.

CPTBC would like to thank and acknowledge the College of Physical Therapists of Alberta for their permission to adapt this article.