Patient Record Data Collection Form

Definition: A patient record data collection form is a written form of communication that permanently documents information relevant to health care management of a patient's treatment

Description:
The patient record data collection form measures standards and criteria for which the patient record provides 'evidence' of compliance, for example that the patient's treatment plan is documented. Much of physiotherapy practice is recorded in the patient record and needs to be of a high quality to ensure continuity of care and fulfill legal requirements.

References: The Chartered Society of Physiotherapy 2000
http://www.csp.org.uk/uploads/documents/SOPPaudit.pdf

GUIDELINES

Structure

Document the patient's consent (see Examples: tips on informed consent), written permission which states how the data will be used, who will view it etc.

Complete one form for each patient record

Please photocopy as many forms as necessary

Assessment: Write evidence of a compilation of data consisting of:

a. the patient's perceptions of their needs

b. the patient's expectations

c. demographic details

d. presenting condition / problems

e. past medical history

f. current medication / treatment

g. contraindications / precautions / allergies

h. social and family history/lifestyle

i. relevant investigations

Examination: Write evidence of a physical examination that includes:

a. observation

b. use of specific assessment tools / techniques

c. palpation / handling

The result of the outcome measurement is recorded at the end of the episode of care

Analysis: Write evidence of:

Identified needs / problems

Subjective markers being identified

Objective markers being identified

A clinical diagnosis

Guidance: This is the physiotherapist's assessment of the problem (not the medical diagnosis)

Treatment planning: The plan documents:

a. time scales for implementation / review

b. goals

c. outcome measures

d. the identification of those who will deliver the plan

Implementation: Implement interventions according to the treatment plan

Record all advice / information given to the patient

Loan and issue a record of equipment to the patient

Evaluation: Write evidence that:

a. the treatment plan is reviewed at each session

b. subjective markers are reviewed at each session

c. objective markers are reviewed at each session

Document all changes, subjective and objective

Document any changes to the treatment plan

Measure outcome at the end of the treatment programme

Transfer of care / discharge

Record arrangements for transfer of care / discharge in the patient's record

Relay information, when transferred, to those involved in their ongoing care

Send discharge summary in accordance with agreed local policy

Documentation

Start patient records at the time of the initial contact
Write patient records immediately after the contact with the physiotherapist or before the end of the day of the contact

Patient records should not be added to after the time of writing

Patient records conform to the following requirements:

a. concise

b. legible

c. logical sequence

d. dated

e. signed after each entry / attendance
f. name is printed after each entry / attendance
Guidance: Where patients are treated by the same physiotherapist throughout, it is sufficient for a printed name to appear once on each side of each page

g. no correction fluid is used

h. written in permanent ink suitable for photocopying

i. errors crossed with a single line

j. errors initialled

k. both sides of every page is numbered
l. patient's name and either date of birth, hospital number or NHS number are recorded on each page

m. abbreviations are contained within a locally agreed glossary

Retain patient records securely:

written records

computer records

audio tapes

emails

faxes

video tapes

photographs

Patient and physiotherapist safety

Write evidence of a risk assessment

Write evidence that action has been taken as a result of the risk assessment

Locally defined audit questions

This page has been provided to allow for optional locally defined audit questions to be added if necessary:

Reflection Log

If you do not meet some of the standards you wanted to achieve, please now explain:
Why were these standards not met?
How you can you prove you are competent for this competency if these standards are still missing?
What are your new plans for development? (see PDP: Personal Development Plan)

Reflection:

Examples (URLs)

Office for Protection from Research Risks.
http://www.hhs.gov/ohrp/humansubjects/guidance/ictips.htm

Tips on informed consent: Informed Consent Checklist - Basic and Additional Elements. Web-Based Instruction on Informed Consent.
http://www.hhs.gov/ohrp/humansubjects/assurance/consentckls.htm

http://www.research.umn.edu/consent/orientation.html
This site provides information on the informed consent process and also a tool to help you create a consent document.