

Record Keeping Checklist

Introduction

To assist kinesiologists in meeting the performance expectations outlined in the Practice Standard-Record Keeping, some key elements have been highlighted in the form of a checklist. This list is not exhaustive; it is intended to provide kinesiologists with an optional tool that can be used to facilitate the application of the standard into clinical practice and/or assist in auditing their own records. The checklist should not be used in isolation. The Standard and Guideline provide additional information and there may also be legislative or employer requirements that are not covered in the checklist.

Patient/Client Records	
Identification – Is there a system to uniquely identify Custodian?	patients, providers and the Health Information
Patients/Clients Health Information Custod	lian (HIC) Providers
General – Have the following areas been managed appropriately?	
Legibility of entries	Additions or changes to the record
Use of abbreviations (e.g. having a master list/legend of abbreviations/acronyms)	Storage, retention, and disposal of records
Signatures	Access and privacy policies
Dates	Self-Audit mechanism
Professional Intervention – Have the following items been included and captured in appropriate detail?	
Patient/client demographics	Assessment results (including objective measures)
Relevant health, family and social history	☐ Treatment/intervention goals
_	☐ Treatment/intervention plan
Referral (as required)	Assessment rationale
Patient/client subjective concerns	☐ Treatment/intervention provided

 ☐ Advice to patient/client ☐ Components of care that were assigned to another provider ☐ Dates of all patient interactions 	Copies of or notes documenting all relevant communications (written, verbal and electronic)Authorization for delegated acts (where necessary)
Consent - Was informed consent obtained and documented for the following?	
Assessment	☐ The involvement of other care providers
☐ Treatment/intervention	providere
Billing	Collection, use and disclosure of information
Progress Notes – Do progress notes appear at an appropriate frequency and do they include the following?	
Outcomes measures used	☐ Date of encounter
Results achieved	
Subsequent changes to the treatment	Assessment results
plan	Advice to patient/client
☐ Treatment/intervention provided	
Discharge Summaries – Are discharge summaries routinely completed and do they include the following?	
Reason for discharge	Advice to patient/client
Status at discharge	Other details as appropriate
Collaborative Records – Do collaborative records allow kinesiologists to meet the performance expectations outlined in the standard including (records will be maintained for 10 years):	
Retaining ongoing access	Ensuring all entries can be attributed to the appropriate care providers

of kinesiologists, the legislation governs.