

Other Considerations

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A. Confidentiality

It is very important that the documentation of a patient's/client's care is kept confidential. All patient/client documentation must be kept in a secure area with access limited to appropriate staff. Documentation in hard copy or electronic formats must not be accessible/readable by unauthorized individuals. If there is a name on the chart, it should be kept face-down so the name is not displayed, and the chart should never be left unattended. Therapists should be careful not to discuss patient/client cases in open/public areas such as elevators or lunch rooms.

The Health Insurance Portability and Accountability Act (HIPAA) addresses the security and privacy of protected health information (PHI) in all mediums. It includes provisions for establishing and maintaining proper access, use and disclosure of PHI and electronic protected health information (EPHI), which includes patient/client care documentation and related data such as billing records. Some of the main objectives of HIPAA are to decrease fraud and abuse and protect patient's/client's rights including the privacy of health-related data. It is important that you have procedures in place related to HIPAA and that you know the regulations for governing you as a covered entity for releasing any patient/client information.

There are other specific agreements such as the HIPAA Business Associate agreement that you may encounter. The definition of a business associate is a person or organization that performs a function or activity on behalf of a "covered entity" such as an interpreter service that is providing interpretation services for your patient/client.

In Pediatric settings, PT's who provide services to children in federally funded school settings to which the Individuals with Disabilities Education Act (IDEA) applies, should follow the provisions of the Family Educational Rights and Privacy Act (FERPA) governing educational records. FERPA is a Federal law that protects the privacy of student educational records. Physical therapy documentation in this setting would be considered a part of the child's educational record. You can access information about FERPA at the following web site: <http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html>

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B. Incident Reporting

As noted above, incident reports should not be included as part of a patient's/client's medical record. For additional information on the topic, check out these resources:

- The September 1996 *PT Magazine* article titled “Incident Reports: Protecting the Record.”
- The Joint Commission Web site at <http://www.jointcommission.org/> and the Commission on Accreditation of Rehabilitation Facilities Web site at <http://www.carf.org/>. If you are Joint Commission or CARF accredited, you will definitely want to be sure you are in compliance with any standards or requirements they may have regarding incident reporting. If you are not accredited by either of these groups, you may still find their standards and guidelines useful as you craft/review your policies and procedures in this area.
- If you have workers' compensation insurance (WCI) for your staff, then you might find it useful to contact your WCI carrier to see if they have any particular forms or information that they look for on incident reports.

Finally, following are some general Dos and Don'ts related to incident reporting, excerpted from [*Risk Management in Physical Therapy: A Quick Reference*](#), an APTA publication.

What you should do...

- DO follow the incident reporting policy that is in place in your workplace and alert the risk manager and/or immediate supervisor to what has happened as soon as possible.
- DO notify the referring physician or other health care provider immediately whenever an injury occurs, existing signs or symptoms worsen, or new signs or symptoms develop.
- DO ensure that the patient/client receives appropriate care after an incident. Most facilities provide this care at no cost.
- DO listen to your patient's/client's concerns, be supportive, and be calm.
- DO record only factual information regarding the incident when you fill out an incident report. Once you complete an incident report, it should be given directly to the supervisor or risk manager, and you should wait for further direction before doing anything else.
- DO isolate, tag, and secure any equipment involved in an incident so that it will not be used again until it has been certified as completely safe.
- DO be available for follow-up as needed after the incident. If it seems likely that the incident is going to lead to a claim, you will want to consult with your risk manager/supervisor and notify your professional liability carrier, who can provide guidance.

What you should not do...

- DO NOT discuss the relative guilt or innocence of anyone involved in an incident or problems with any piece of equipment used.
- DO NOT make inferences related to cause in your incident report. When completing an incident report or an unusual occurrence report, it is critical that you only report factual information regarding the incident.
- DO NOT enter your incident report into the patient's/client's chart.
- DO NOT attempt or document attempts to do further investigation into the cause of the incident. This is the responsibility of your organization's risk manager and/or designated attorney. Any notes or documents may be discoverable (to what extent will vary by state). This is the reason a risk manager or attorney should be responsible for the investigation.

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C. Electronic Patient Records

No discussion of current trends influencing documentation standards would be complete without mention of electronic patient records. All trends point to electronic communications, including patient medical records, becoming more prevalent in health care. Electronic documentation can have many benefits for physical therapists, but careful consideration should be given to what type of system would work best for your practice.

In November 2005, APTA created a document, [Risks, Benefits, and Responsibilities Related to the Use of Electronic Communication Within Patient Care](#), to help practitioners be ethical, legal, and informed users of electronic communications within patient/client care. Because the use of electronic communications and other technology within patient/client care is growing and technical and regulatory standards are continually evolving, this document is intentionally non-prescriptive. Rather, it provides an orienting framework to general risks and benefits associated with the use of electronic communications, as well as the risks, benefits, responsibilities, and considerations specific to four pertinent topics—security and encryption, scope of practice, ethics and legal issues, and reimbursement. Information about this document and other electronic communications/telehealth can be found on the [Practice web page](#).

In the summer of 2006, APTA launched [APTA CONNECT](#), a point-of-care, computerized patient/client record system that combines the clinical expertise of the American Physical Therapy Association and its members with the technological capabilities of Cedaron Medical, Inc. This system incorporates patient/client documentation with various clinic management programs. APTA CONNECT was designed with the assistance of more than 50 physical therapists who are well known and highly respected in their areas of expertise. It is also the platform for the first national outcomes database for physical therapy services.

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D. Documentation Tools

- [Sample Documentation Review Checklist](#)
- [Documentation Elements](#)

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