

LEGIBILITY OF CHARTS AND NOTES

The Nova Scotia College of Physiotherapists issues Advisory Statements to provide guidance to members on practice issues. This Advisory addresses the required legibility of all notes and entries.

WHAT ARE YOUR OBLIGATIONS?

(Ref: Professional Practice Standards for Physiotherapists)

Under Responsibility II - Communication ...The Physiotherapist must be effective in both verbal and written communication. They must maintain a complete and accurate clinical record which includes a record of examination and evaluation results, treatment plan, goals set, interventions used, outcomes achieved and any errors made, along with dates of all visits or communications as appropriate for the practice setting. Entries are signed and completed in a timely fashion

- Standard 7: Criteria
- a. Maintain a complete and legible client record, including copies of referrals and correspondence with other parties and ensure that the patient's name is on each page.
 - b. Document information about delegation of tasks, interventions used, and the patient's response, including errors or adverse reactions.

WHAT DOES THIS MEAN?

A physiotherapist, as a regulated health professional, must be capable of clear communication. This means that all your entries must be legible to anyone authorized to read your chart. It could be a physiotherapist filling in for you in your absence, it could be an expert witness trying to read your notes in a court of law, it could be a peer assessor, or it could be your client who has requested a copy of their file. (*Abbreviations and shorthand are fine for your personal notes but must not be transcribed into chart notes/entries unless there is a legend of accepted abbreviations for your clinic that accompanies the chart.*)

DO I HAVE OPTIONS?

If you have illegible writing you should consider dictation and transcribing, or moving to electronic charting. It is essential that your writing be legible to anybody reviewing your charts.