# PATIENT CARE SELF-ASSESSMENT TOOL

**Member name:**_____

**Registration #:**_____

**Completion year:**_____

**Patient record Unique identifier*:**_____

* To respect privacy laws please do not enter any information on this form that could enable patient identification. Instead, please create a unique identifier (word/code) to identify the patient record being reviewed.

## Patient scenario/information

1. Why did this client (guardian) seek physiotherapy? *(What was the client's main diagnosis/condition, main impairment, activity limitation or participation restriction that required them to receive physiotherapy services?)*

## Patient assessment

2. Reflecting on the client history completed, would additional information have helped determine a more comprehensive diagnosis or treatment plan? If so, what other information could have been collected? *(This may include situations where more information was required from client or guardian, or recorded by others elsewhere in a clients chart)*

3. Did you discuss with the client or guardian their expectations for physiotherapy during the initial visit? Were the expectations reasonable and mutually accepted?

4. Indicate whether your care/management plan was influenced by anything unique or special about this individual such as past medical history, co-morbid conditions, psychosocial issues, compliance, availability of support systems, resources, and employment status.

5. Why did you choose the assessment tools /methods you did?
   - Discuss to what extent the selection was based on evidence, theory or practice guidelines
   - Discuss what you know about the tools/ methods used in the assessment.
     *(i.e. measurement properties, validity, specificity, sensitivity, better for screening or diagnosis)*

6. In retrospect what, if any other measures, could you have used to establish the physiotherapy diagnosis/ clinical impression? *(e.g. research, guidelines etc.)*

   Discuss why they would have been helpful in this situation.

## Physiotherapy diagnosis /clinical impression and intervention planning

7. What was your physiotherapy diagnosis/clinical impression?
   From what was charted, can you support your diagnosis/ clinical impression?

   What led you to your conclusions?

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   What led you to your conclusions?

9. Reflect on the treatment interventions. Discuss extent that:

- Interventions were informed by client needs
- Treatment interventions were informed by evidence/ theory
- Dosage parameters were informed by evidence

Would you make any changes to the treatment plan for clients with similar conditions?

What would those changes be?

## Implementation and evaluation of physiotherapy intervention

10. What aspects of care, if any, did you assign to support staff or family?
    - How did you ensure that support staff adequately cared for your client?
    - How did you know the client /guardian/ family understood and carried through the components of treatment assigned to them?
    - Are there other aspects of the supervision process or procedural issues you need to address for future clients with similar conditions?

11. How often did you see this client and for what duration?

12. What were the optimal time lines for achieving the client's treatment goals?

    Did this client meet their treatment goals in a timely Manner? If not discuss why.

13. Discuss how you determined if your physiotherapy treatment was effective.
    - Did you use standardized measures to monitor your treatment outcomes?
    - At which points during the treatment did you perform the measures
    - Were your judgements of improvement based on established criteria such as clinically relevant score changes?

14. At what point did you approach discharge planning with the client/ guardian?
    What steps did you take to assist with:
    - Self management following discontinuation of treatment
    - Community integration
    - Communication with other care providers

## Collaboration and practice management

15. Would it have been beneficial to involve other physiotherapists or health professionals in the care plan at the outset or during the course of care for this client?

    Are there barriers or facilitators to collaborative practice that need to be addressed to improve care for other clients with similar conditions?

16. Knowing what you know now what, if anything do you need to learn to optimize care of other clients with similar conditions?