

*A COMPARISON OF STUDENT
RECORD KEEPING WITH THE
EUROPEAN CORE STANDARDS*

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*European Core Standards of
Physiotherapy Practice*

- 22 Standards .
- Adopted Gen. Meeting European Region of WCPT, Hungary- May,2002
- Irish Society of Chartered Physiotherapists -June 2002
- Standards are accompanied by a patient record audit tool

Documentation
Standard 14

- **To facilitate patient management and satisfy legal requirements, every patient who receives physiotherapy must have a record which includes information associated with each episode of care.**

Aim;

- To compare student physiotherapist's record keeping practice with the European Core Standards of Physiotherapy Practice.

Objectives

- To assess whether record keeping practice standards are being met
- To identify strengths and weakness of students record keeping

Chart Sample

- All patient records completed by 3rd and 4th year students in the OPD of a large teaching hospital in Dublin during the academic year Oct 2001 and June 2002.
- Approval for the study was granted by both the Hospital and College involved.

Methodology

- The audit tool evaluates record keeping under 10 different headings;
 - Informed consent
 - Assessment
 - Examination
 - Analysis

- Treatment planning
- Implementation
- Evaluation
- Transfer of care/discharge
- Documentation
- Patient and Physiotherapist safety

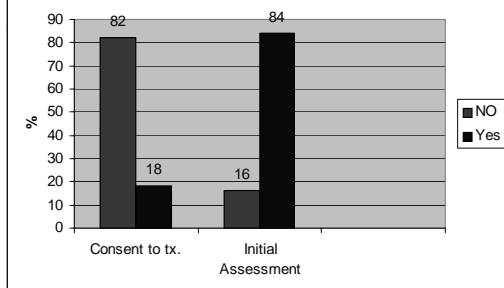
Pilot study

- Become familiar with the audit tool and chart retrieval.
- Review categories within the tool to determine applicability for use in the out-patient department
- To ensure interrater reliability of information retrieval

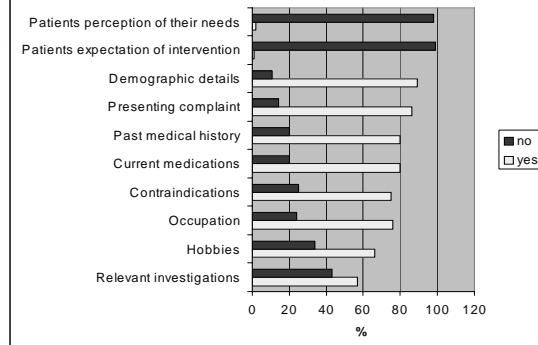
Results

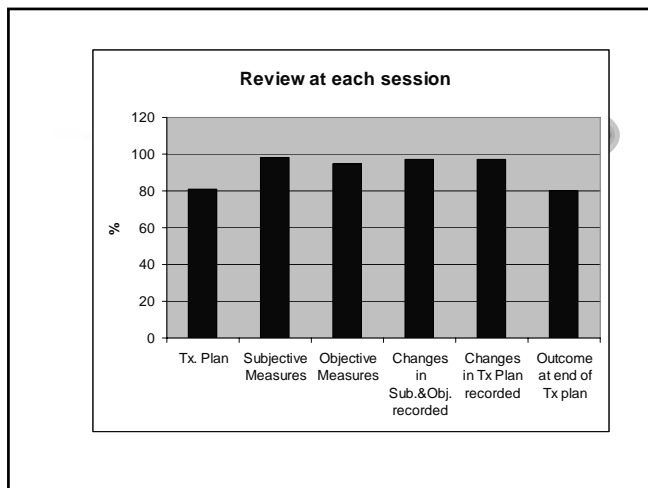
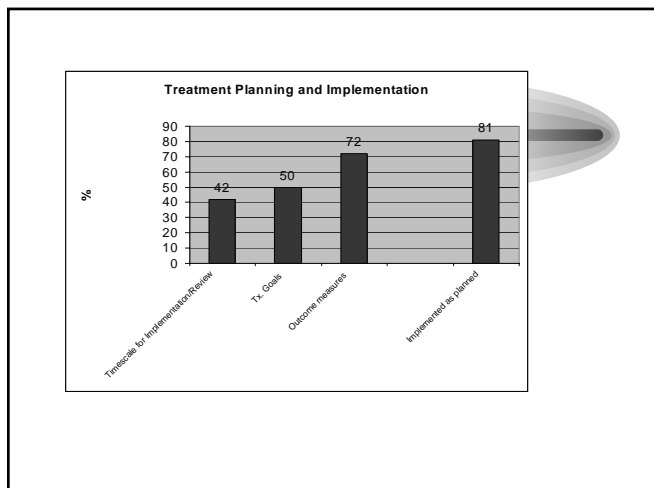
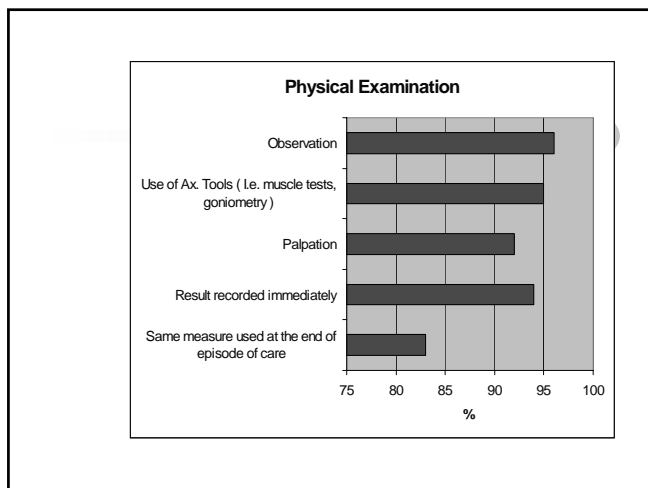
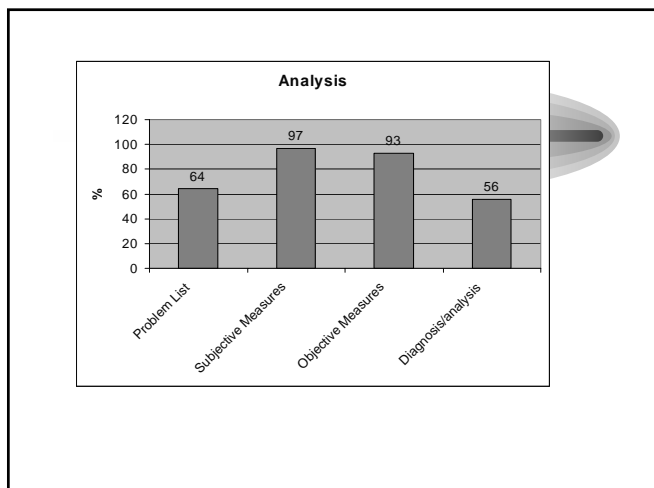
- 29 students
- Episode of care -The period of time when one patient is in the care of one student physiotherapist.
- 167 episodes of care were identified and for each of these a data collection form was completed

Written evidence of Consent and Assessment



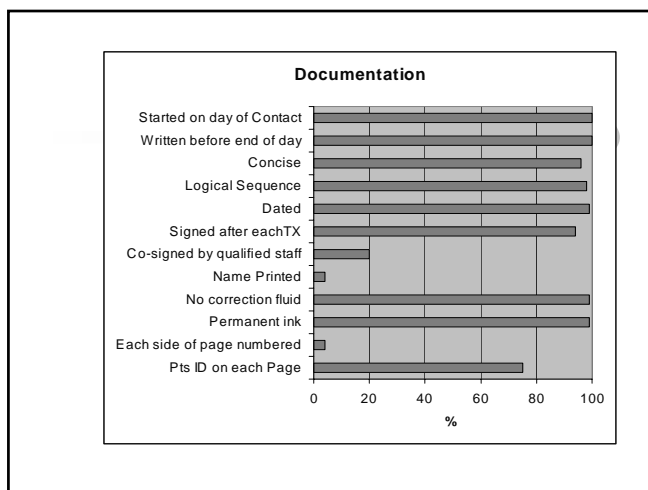
Written Evidence of Assessment





Transfer of Care/Discharge

- 73% (n=122) of patients were transferred to another therapist of these 75% (n=92) had transfer arrangements written up
- Of the 73% , 64% had a transfer summary written up
- 27% (n=45) of patients were discharged from physiotherapy Of these only 27% had a recorded that a discharge summary was sent to the referring doctor



Risk Assessment

- 59% (n=99) of patients had electrotherapy or cryotherapy.
- Only 57% of charts documented risk assessment in relation to modalities used

Conclusions

- The audit provided a clear picture of student record keeping in OPD and allowed the identification of strengths and weaknesses
- High standards were observed in the areas of subjective and objective assessment and the use of outcome measures.

- The most significant weakness is the poor standard of documentation of Informed consent , the patients perceptions and expectations
- This was the first stage of the audit cycle it generated a list of recommendations that need to be enforced prior to re-audit

Recommendations

- Change proforma -consent and investigations
- Issues students with Core Standards
- Dedicated time to goal setting and recording patients perceptions and expectations
- Re-audit