



**Service Priorities and Programmes**  
**Electronic Presentations**

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**Submitting author:** Ms Betty Choi Wah CHAN

**Post title:** Physiotherapist I, SH, NTEC

**A continuous quality improvement program in secure physiotherapy record management**

*Chan CW(1), Lam SL(1), Fung MF(1), Lai WK(1)*

*(1)Physiotherapy Department, Shatin Hospital*

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Medical record security

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**Introduction**

Security of patient medical record is essential as it contains patient's privacy data. When patients attend training in Physiotherapy Department, Physiotherapy records would be taken out of the ward to follow patient and returned to ward on completion. There are risks of mismatching on return and misplacement or loss of patient records. A continuous quality improvement exercise was conducted, aimed to review the workflow, identify problems and propose solutions. A department guideline has been revised in May 2017 to provide guidance for management of physiotherapy record.

**Objectives**

An audit was carried out to check for the compliance of physiotherapists with department guideline on handling of in-patient physiotherapy records.

**Methodology**

It was a prospective observational audit done in December 2017. Physiotherapist handling of physiotherapy records in ward and in main physiotherapy gymnasium was observed. Five records from each therapist were randomly selected in ward. The audit criteria were based on the standards set in the department guidelines. These were 1) placement of physiotherapy record in patient's main medical record in ward; 2) entry of physiotherapy treatment notes in the computerized system or in the treatment reminder; 3) marking of physiotherapy records being taken away and returned to ward; 4) usage of designated zipped bag for transportation of records and 5) close attention of the physiotherapy record when taken out of the ward to prevent loss.

**Result**

19 physiotherapists and 95 physiotherapy records were audited. Most of the standard set in the department guidelines were met. 84% physiotherapy records were found in the patient's master medical records in ward. The remaining (16%) were found in the nursing chart-boards in ward. Most physiotherapists (89%) did not bring the physiotherapy records away from ward. 74% physiotherapists entered the treatment notes in the computerized system and 15% physiotherapists used the physiotherapy

treatment reminder for reference in physiotherapy gymnasium. The remaining (11%) physiotherapists brought the physiotherapy records to gymnasium for cross-reference. The compliance rates were 100% for other criteria 3, 4 & 5 (document handling out of ward and returning to ward). Suggestion for improvement: The overall compliance rate to the guideline was high. The reason might be physiotherapists had a prior notice of the audit, though date not specified. In future, Surprise audit is recommended to reflect more the real situation. Electronic documentation is proposed to facilitate timely and comprehensive patient care. Placement of physiotherapy records back in patient medical records is reinforced, as patient medical records are securely placed in a locked cart in ward.