Release Date: Dec 2024
Rev: 24.02

Clinical Record Keeping and Charting for Kinesiologists

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 We thank Katherine Chesher, BCAK Practicing Kinesiologist, for her contributions to the content for this guide.

Contents

Introduction

The delivery of professional kinesiology client care services requires kinesiologists to implement appropriate record keeping practices for the services they provide, including maintaining a consent history for those services. The terms medical record, healthcare record and healthcare chart can be used somewhat interchangeably to describe the structured and systematic approach to the documentation of a single client's healthcare history and care during the time a particular healthcare provider or team of healthcare providers provides care to a client. Record keeping must be purposeful and comply with applicable laws, regulations and standards which serve the interest of clients and the healthcare practitioners providing care to their clients. Note: This guide contains reference to legislation related to record keeping practices. For additional information on the legislation, please refer to the BCAK Jurisprudence Guidebook.

Purpose

The purposes of this manual are to:

1. Establish the primary criteria which constitute appropriate client record keeping and charting practices for Kinesiologists providing services in British Columbia (BC), Canada.
2. Assist BC Association of Kinesiologists (BCAK) members, and aspiring members, in developing and maintaining appropriate record keeping practices to provide a high standard of client care and safety, while meeting legal professional, institutional and ethical obligations.
3. Explain the critical role these practices play in the delivery of competent, safe, and ethical client care, and in meeting legal requirements.

Definitions

- **Charting or Clinical Charting** means - the process of recording a client's health information, including assessments, plans, and observations, to share with other healthcare team members.
- **Client/Patient (further referred to as "client")** means – a person under your care; this includes a person who may be waiting for this care, receiving it, or may have already received it.
- **Client Care** means – the practice of managing all aspects of caring for clients, including providing quality services, showing concern and appreciation, building a positive client relationship, meeting the emotional needs of the client, and fostering an appropriate client-practitioner relationship.
- **Clinical Record Keeping** means – the practice of creating and maintaining a client's health record. The client record can be in the form of written notes, electronic records, or a combination of both.
- **Communication** means – the exchange of information and instructions between healthcare workers and/or between healthcare workers and clients or family members.
- **Data Breach** means – the unauthorized access to, or disclosure of, client records or personal information, often due to theft, hacking or IT system compromise.
- **Doctor** means – a qualified practitioner of medicine, also referred to as a physician.
- **OIPC** means – Office of the Information and Privacy Commissioner of BC.

The Importance of Clinical Record Keeping and Charting

Proper record keeping practices support openness and transparency and the delivery of high-quality services and programs, which inform decision making and help meet organizational goals. Kinesiologists providing healthcare services should maintain paper or electronic records that are legible, grammatically correct, and comprehensive in reflecting all relevant information and all care provided. Clinical charting notes and other documentation that forms part of a client healthcare record must be prepared in a timely manner and maintained in compliance with applicable legislation and practice standards. The maintenance of client records serves the following purposes.

Client Care

Concise and complete records allow for the delivery of high-quality client care. Healthcare records detail the events, interactions, and transactions that occur between clients and kinesiologists. This information is essential for informed decision-making regarding client current and future care, including tailoring care to meet a client's individual needs, preferences and lifestyle; establishing realistic time-based goals; assessing the viability of those goals; and determining when a client's recovery or care has plateaued and/or there is no longer evidence to support continued provision of care, and the client can be safely discharged. From a legal perspective, the axiom of "***not documented, not done***" is often applied to establish whether a chart is complete. The information contained in a client record should include the following information when/where applicable:

(1) the mechanism of injury,
(2) the relevant client health/medical history,
(3) client consent records and notes,
(4) client goals,
(5) client assessment objectives,
(6) subjective client reports,
(7) clinical observations made during an assessment,
(8) important objective and subjective assessment/test findings and results,
(9) treatment strategy/plan,
(10) the effects or perceived effects of any interventions over time, including how long an intervention was utilized and when it was modified, replaced or discontinued.

Communication and Continuity of Care

In many cases, multiple healthcare providers are involved in a client's care, whether in a multidisciplinary or interdisciplinary work environment. Kinesiology care records serve to assist the overall care a client receives from other healthcare providers, such as primary care physicians, specialists, nurses, occupational therapists, physiotherapists, chiropractors, massage therapists, psychologists, counsellors, and others (including other kinesiologists). Accurate charts facilitate communication and collaboration among healthcare professionals, ensuring that everyone has current information and is able to make informed decisions to provide effective client care. Regardless of whether these professionals have direct access to the kinesiologists' charts or not, the ease and accuracy of sharing information is greatly increased when charts are well-maintained. In addition,

complete and accurate records significantly enhance the facilitation of client transfers, locum arrangements, and/or coverage when the kinesiologist is absent during illness, leave or on vacation.

Client Safety

Accurate charts help reduce the risk of unsafe and/or inappropriate treatment. When kinesiologists have complete and up-to-date information, they are less likely to err in their clinical reasoning and decision-making and more likely to ensure safe practices and policies are followed (such as appropriate infection prevention and control policies).

Treatment Funding/Reimbursement

Client care funding in many healthcare settings is supported by third-party payers and payment and/or reimbursement for services is tied to special approval based on the accuracy and completeness of client records. Failure to maintain accurate records and charts can result in the denial of claims and/or payment, resulting in denial or delay of treatment, along with financial hardship for the client, the kinesiologist and/or the healthcare funding organization.

Quality Assurance

Accurate charts are essential for enhancing the quality of care and driving improvements in evidence-based kinesiology practice. Complete and accurate records help in monitoring client progress, improving exercise progression regimens, including identifying complex care modifications, which help to establish evidence-based practice standards or enhance those which already exist.

Review and Education

The critical review of client records can serve to identify care and documentation practices that can be improved to enhance client safety, outcome measures and client satisfaction. Accurate and comprehensive record keeping practices also serve to improve the training of kinesiology interns during their professional practice (work integrated learning) placements. This can benefit both the employer and the intern kinesiologist, through an accelerated rate at which the student comprehends important learning outcomes, reducing the time required for placements, or allowing for additional learning to occur during placements.

Professional Accountability & Compliance

Practicing and Non-practicing members of the BCAK are required to adhere to the association's practice standards[1]. These documents establish the minimum standard of care and the general expectations that members will strive to achieve to provide an 'optimal' standard of care when possible. These documents include the Professional Practice Standards, Scope of Practice, Code of Ethics (Code of Conduct), Infection Prevention and Control and Privacy Guidelines, and more. The documents underscore the commitment for kinesiologists, and BCAK members in particular, to deliver competent, safe, client-centered care following evidence-based practices and the safeguarding of all confidential client information acquired or produced through professional interactions.

[1] BCAK Professional Guiding Documents

Legal and Ethical Obligations

BCAK members and other kinesiologists are legally obligated to maintain accurate clinical records in the delivery of client services. Accurate and concise documentation provides transparency and helps to protect the rights of the client, and the kinesiologist should compliance issues, legal disputes, insurance claims, or complaint-driven investigations materialize.

Kinesiology Scope of Practice Restriction on Diagnosis

The scope of practice for BCAK members and other kinesiologists lies within the public domain. This means that kinesiologists are not permitted to perform any restricted activities defined under the Health Professions Act or Regulations[2] unless delegated by an authorized regulated healthcare professional.

One of the primary restrictions relating to the delivery of healthcare services in relation to communication and recording keeping is that of rendering a medical diagnosis. A medical diagnosis is defined as the process of identifying a disease, condition, or injury based on a client's signs, symptoms and assessment results, or any combination of these, and communicating the diagnosis to the client or another person verbally or in writing. A medical doctor (physician) provides a medical diagnosis that addresses the condition that is causing a client's symptoms. The medical doctor deals primarily in defining diseases, injuries, and chronic conditions that can compromise a client's health, function, and overall well-being. In this context, a medical doctor would provide the diagnosis of a torn ligament, or of Parkinson's disease. These diagnoses describe the underlying cause of the client's symptoms and can only be made by a qualified medical doctor or other healthcare provider authorized to render and communicate a diagnosis by their regulatory college under the health professions regulation.

Contextually, there is a difference between a medical diagnosis as explained above and providing a functional diagnosis, which can confuse both clients and other healthcare providers. It is recommended that kinesiologists approach the use of this term cautiously, as the kinesiologist is in essence providing a 'functional interpretation' based on a client's objective and subjective assessment findings, which are rooted in movement. As the term implies, a functional interpretation will describe movement or posture as being normal (typical) or abnormal (atypical) and which may have a causal relationship with a client's symptoms, without reference to the cause. Again, it is prudent for a kinesiologist to avoid use of the term 'diagnosis' when communicating with the client, their representative, other healthcare practitioners, including when recording information in a client record. To mitigate the risk of being accused of inappropriately providing a medical diagnosis, a kinesiologist should follow the simple rule of informing clients that "*it is not within a kinesiologist's scope of practice to provide a medical diagnosis and should the client desire or require a formal diagnosis, they should discuss their symptoms and the kinesiologist's assessment findings with their physician/medical doctor or other primary care provider who is authorized to provide a medical diagnosis, to obtain this information.*

[2] Health Professions General Regulation – Restricted Activities

It is also essential to know which regulated healthcare practitioners are permitted to render a diagnosis. For example, a physical therapist's scope of practice is the assessment, diagnosis, and treatment of the human body, its diseases, disorders and conditions associated with physical function, and acute or chronic injury or pain[3]. Based on this definition of scope, provided by the Canadian Physiotherapy Association, it is not appropriate for a physical therapist to provide a diagnosis of lung cancer, for example. If a client exhibits signs and symptoms suggestive of lung cancer, it can be within the physical therapist's scope of practice to identify and provide a functional diagnosis of a breathing disorder that may be caused by the presence of lung cancer.

Again, the functional interpretation approach differs from a doctor's medical diagnosis but can be a powerful tool in the development and implementation of an effective, customized approach to injury, mobility and pain management. For example, a kinesiologist may be tasked to deal with the range of movement limitations and compensatory postures that occur as the result of a torn ankle ligament, and/or address the gait and balance training necessary to help a client manage their Parkinson's disease. In each case, the kinesiologist concerns themselves with the functional aspects of the body, the ways and extent in which function is impaired and employs evidence-based methods likely to resolve the impairments.

In summary, to avoid encountering potential allegations of inappropriately rendering a diagnosis, kinesiologists should focus their charting language and terminology on detailing functional impairment measures, observations, and test values/results without attempting to relate the findings to an underlying disease, condition, injury or illness. If a medical practitioner authorized to render the diagnosis in accordance with the health profession regulations has already rendered a diagnosis, the kinesiologist is permitted to refer to it as the doctor's diagnosis', however kinesiologists are not permitted to contradict the diagnosis based on their assessment and treatment findings. The findings and the client must be referred back to the issuing practitioner for re-evaluation if an alternate cause is suspected.

Healthcare Record Keeping Practices

Effective Documentation - Accuracy, Brevity and Clarity

Kinesiologists must understand 'how' to appropriately write a client's healthcare documentation based on the general purposes of (1) recording the client care components, (2) providing the basis for funding (reimbursement) of client care by treatment funders, when the client is not funding personally and (3) creating a legal record of client care.

Reference Terminology

Client/Patient

In charting records, the client is to be referred to as the 'client' or 'patient', rather than by name. Proponents for using the term 'client' state that it empowers the client as a partner in the decision-making process regarding the healthcare they receive, and that the client's physical, psychological, cultural, spiritual and medical needs are more appropriately reflected by using the term. Historically, the term "patient" has its

[3] Physiotherapy Scope of Practice: Optimizing Care for People In Canada, Scope of Practice Definition Statement (pp. 04)

origins in the Latin term “patiens”, which comes from “patior”, meaning ‘to suffer or bear’. Patient, in this context, is a passive term meaning the person who suffers and is under the care and control of another person providing healthcare. In BC’s healthcare team environment, the term ‘client’ is being used more frequently and is viewed as a more collaborative term. Considering the various roles kinesiologists play with clients, it is important to consider the context of the situation and recognize that kinesiologists may be providing care for a person who is suffering (e.g., “a patient”) or providing care for a person (e.g., “a client”) who wants to improve their health, such as reducing their risk of cardiovascular disease or improving physical performance in a sport or other activity.

Regardless of which term you choose to use, be mindful of the meaning each term may elicit in people and take the time to explain your choice of terminology to the people you serve. In public healthcare settings, the term “patient” continues to be the dominant term used, while in private healthcare the term “client” is being used more frequently and interchangeably with the term “patient”. BCAK continues to recommend kinesiologists use the term ‘the client’ rather than ‘the patient’ when working in private healthcare settings, however the decision is up to the individual kinesiologist to determine themselves based on their working environment.

It is also important to refer to clients by their preferred pronoun and gender identity. If a kinesiologist fails to follow this process, they risk allegations of discrimination resulting from shame or humiliation and potential investigation by the BC Human Rights Tribunal. For a growing segment of the population the terms him/he, her/she, do not fit with their gender identity or expression. In situations where the preference is unknown, it is appropriate to refer to a client using non-gendered or nonbinary pronouns, such as they/them/their used in singular, if they do not see themselves as being either male or female. It is acceptable to politely ask a client what pronoun they wish to be referred by. Similarly, if the need arises, use of the terms “person”, “individual”, “sibling” and “child” are preferred over “woman”, “man”, “sister” and “son”. Similar language should be used by kinesiologists when referring to a person’s employment role, to avoid gender bias. Examples are listed below.

Avoid	Use
fireman	firefighter
policeman	police officer
Foreman	Supervisor
Mailman	Letter carrier
Stewardess, steward	Flight attendant
Warehouseman	Warehouse worker
Cleaning lady, maid	Cleaner

Avoid	Use
Secretary	Assistant
ombudsman	ombuds, ombud or ombudsperson

When referring to clients in reports, it is acceptable to refer to the client by their surname, preceded by either their first initial or their preferred title. The traditional titles include 'Sir', 'Mr.', 'Mrs.', 'Miss' and non-binary titles include 'Ms.' and 'Mx.'. Other terms used in general society include 'Misc' for miscellaneous, and 'Msr' as a combination of 'Miss' and 'Sir'.

Kinesiologist (clinician)

When referring to oneself as the clinician or practitioner, the kinesiologist should do so in the third person. When referring to any findings or observations, one should use the term 'this kinesiologist'. The same applies if the kinesiologist is working under dual scope of practice, such as acting as a rehabilitation assistant under the direct supervision of another healthcare practitioner (e.g., a physical therapist). The terminology used would be "this physical therapy assistant/PTA", or "this physical therapy support worker/PTSW", as this is the correct terminology used under the BC College of Health and Care Practitioners in the physical therapy professional practice standards.

TIP - use a date format that cannot be interpreted to be 2 different dates. E.g. '01/02/24', can be interpreted as January 2, 2024, or February 1, 2024, and result in confusion as to when the client received care, if care is not being delivered on a regular and frequent basis.

Authentication - Date, Signature and Credential

Each entry into a client's chart/record requires authentication (the date of entry, signature or initials) by the clinician and their credential. Similar requirements apply for student kinesiologists who are assisting with client care, who should use identifying terms that differentiate their notes from those of the clinician. Individual clinics may establish their own terminology and coding, so kinesiologists need to ensure they understand the necessary procedures when taking on a new employment role. It is recommended that BCAK kinesiologists use the initials of their first and last name and include a middle initial if there is another practitioner in the same clinic which has the same first and last name initials. For professional designation, use the acronym 'PK' for "Practicing Kinesiologist'. Student kinesiologists should use the abbreviation 'SPK" for "Student Practicing Kinesiologist"

Date/clinician ID/credential – Example (02-Feb-2024 – *JB, PK)*

Language and Grammar

Accuracy

Accuracy is about more than correct spelling and punctuation – it is also how client-related information is entered, or not entered, into the chart. For example, when a kinesiologist is assessing a client, they might watch the client walk across the room and the inclination is to report, the '*client walked across the room without difficulty*'. This terminology might mean something to the kinesiologist if they have knowledge of the exact distance across the room. However, if they only estimated the distance and did not accurately measure and report the distance, this becomes a guessing game for the kinesiologist and potentially others who rely on the information in the client record. Inaccuracy can lead to treatment coverage being declined, early discharge when the client does not meet the necessary demands, or potential injury to the client if the kinesiologist overestimates the walking distance and then assigns exercise based on their 'guess' as to their walking tolerance.

Avoid the fluff by being thorough, relevant, focused, and clear, more is not always better.

There are also other instances where the kinesiologist is expecting a predetermined outcome and, knowingly or unknowingly, inserts a bias component that will inherently minimize or exaggerate a client's performance. This bias is reflected in the documentation as a means to influence the decision-making process on client care either in favor of extending treatment or causing an early discharge. Even if this is done with altruistic motives, intentionally entering inaccurate and misleading information is fraudulent. A deliberate act of this type can result in disciplinary action against the kinesiologist by their professional regulatory body or association if it becomes known or is suspected. Again, it is important to remember that chart notes and records are part of a permanent legal document, and they can be used in a court of law, either to the kinesiologist's benefit or detriment.

Common Sources of Error

- Incorrect facts - for example, guessing how much a box weighs when testing lifting tolerance, rather than accurately weighing the box prior to testing.
- The use of incorrect, inaccurate, or vague language - poor word choice can be misleading or misinterpreted, such as 'the client walked farther today than last week'.
- Errors can be related to grammatical mistakes with spelling, syntax or punctuation. Grammatical mistakes can be confusing and are unprofessional.

TIP - NEVER record false, exaggerated, minimized or fabricated information in a healthcare record.
In plain talk: ***No Fiction and no Fairy Tales.***

Accuracy – Scenario Objective

Your client has just carried a 10 lb. milk crate (box) the length of the gym without pain or loss of balance. If the length of the gym is 100' and, because you were too busy to measure the length of the gym, you guessed at (and entered) 50', how might this impact your client?

- *What if the gym length was only 25' and you entered 50'?*
- *What is the best approach to take regarding this situation above?*
- *What is it called when we document that the client needs continued treatment when, in fact, they have met their goals?*

Clarity

It is important to use words and phrases that have consistent meaning. This includes avoiding the use of contractions, such as "Isn't", "Won't" and "Didn't". Terms that have multiple meanings, such as the word 'got', should be avoided. A statement such as 'the client got to see his doctor today' can have two interpretations: either that they 'were able to see their doctor' or that they 'need to see their doctor'. The difference between the two interpretations are significant and the lack of clarity could result in negative ramifications.

Brevity

It is important for kinesiologists to avoid the use of terms that are persuasive and trendy to make their point in healthcare charting and record keeping. This style of writing can be valuable if you are writing a suspense novel and looking to create a sense of importance, however it can be catastrophic for a client if it makes finding relevant information difficult. In cases where chart notes ramble on, there is a strong temptation by the reader to skim the notes and hope to find what they are looking for. This can result in valuable and/or crucial information being overlooked and further highlights the importance of being complete and thorough, and also concise with documentation.

Brevity Scenario

Pierre is a 54-year-old office manager who sustained a soft tissue injury to his right lower leg and ankle while crossing the road in a crosswalk at an intersection when he was knocked down by a car that was making a right turn.

During his third approved treatment session with the kinesiologist since completing the initial assessment, Pierre is asked on his arrival how he has been doing since his most recent session five days prior. Pierre proceeds to report;

"I continue to have some increased ankle pain in the morning while walking the 10 minutes it takes me to catch the bus to work. Then I ride the bus for about 45 minutes and eat my breakfast, which consists of an apple, 2 granola bars and 2 pieces of cheese. And then I catch up on emails on my phone. Once I arrive at my final stop, I get off the bus, and by this time my ankle pain has gone away. Then I walk the final 3 blocks to the office building I work at and climb the three flights of stairs to get to my office, as I don't like to take the elevator. My ankle and shin are usually good for the rest of the workday, but my knee swells slightly in the afternoon and my ankle soreness returns and is mild for the evening hours".

How does one take the client's story and condense it into the key elements that will allow the kinesiologist to report the client's symptoms in a concise, clear and relevant fashion, without documenting every word the client said?

> *Review - Pierre has indicated that he experiences 'some' increased ankle pain while walking to the bus in the morning? What context does 'some' have. Does it mean that it is dull and continuous, intermittent and repetitive, inconsistent and sharp, or a combination of these? Having the client qualify his definition of 'some' is essential to properly reporting the symptoms the client is experiencing. This requires additional questioning of the client to characterize what 'some' means. Suppose that Pierre reports that 'some' means there is no pain when starting his morning walk to the bus but that the pain steadily increases in both intensity and frequency up to the point where it becomes continuous, and then subsides while on the bus ride. Writing a simple descriptive and relevant explanation better serves the client than simply repeating what the client said and writing 'some'. A clear and relevant description will help the kinesiologist and other team members in assessing for a causal relationship, as additional comments are collected and analyzed to help determine suitable evidence-based practice options for effective client care.*

There are multiple acceptable ways to list the client's symptoms in the chart notes. One example is provided below.

> *"Client reports ankle pain symptoms that progressively intensify and become more frequent during his 10 min walk to the bus but resolve after 45 min of rest, while sitting. Additional walking does not cause a recurrence of symptoms, however mild increase in ankle and shin pain is reported by the end of the day upon returning home."*

Again, the notes should focus on quantifying and qualifying the symptoms the client is experiencing, including the intensity, duration/frequency and how long they remain or when/if they subside. Note that the extraneous information regarding what he ate for breakfast has not been included. Including this type of information can cause another person reading the chart to lose track of what it is they are looking for related to the client's subjective pain reporting. It is also important to recognize that if a client incorporates multiple pieces of extraneous information, the ability to discern what items are important becomes more difficult. To improve understanding and chart entry, the kinesiologist must revisit any details that appear unclear with the client before moving on.

Avoid The Use of Slang Terms

Slang words are specific words or phrases that have a culturally significant definition that differs from the literal definition. The use of slang terms should generally be avoided, however there are times when a kinesiologist needs or wants to record the client's exact words, even though they may include slang words or phrases. When quoting a client, the kinesiologist must always enclose the client's statement in quotation marks, to ensure the statement is identified as something the client stated.

Some examples of slang words and phrases that may be heard when providing client care are:

Word/Phrase	Form	Description	Example: Client statements…
Basic	Adjective	An insult meaning that something is boring or uncool	*"This exercise program I have to do is basic"*
Bussin	Adjective	Amazing, really good	*"Sport drinks like Red Bull® are bussin"*
Ditch	Noun	To leave a person or place unexpectedly or to not show to a planned event	*"I ditched my rehabilitation session today"*
For Real	Phrase	To agree with someone, emphasize a statement or ask if someone is serious.	*"Is this exercise program for real?"*
Salty	Adverb	To overreact	*"My boss got salty after I showed up late for work"*
Shook	Adjective	Stunned, shocked	*"Getting hit by the car has me shook"*

The above list offers a small example of slang words and phrases commonly used in current society. Whenever slang words are used, the kinesiologist needs to contextualize what is being stated by the client, so other healthcare providers can adequately interpret the meaning of the statement. If this is not achievable, it is best practice to quote the client's comments verbatim.

Specialized Terms, Short-Forms (Abbreviations) and Acronyms

The use of specialized medical terminology, abbreviations and acronyms can help to shorten a client record, making it easier to locate necessary information. Use should be limited to generally recognized terms understandable to anyone who may be involved in a client's care. Special terms are not permitted for use in all healthcare settings or organizations, placing the onus on the kinesiologist to verify the current policy. If an organization or independent kinesiologist uses specialized terms, they should have a standard and/or pre-approved list of abbreviations that can be used. If a kinesiologist is working for themself, they must prepare a list of abbreviations that they plan to use and supply the list along with any client record that is shared with other practitioners/clinicians or with a third-party. Kinesiologists should not attempt to make up their own specialized terms, abbreviations or acronyms but should look to adopt those which are universally recognized in the medical/healthcare community, or which are commonly defined in their professional setting. If a kinesiologist is not familiar with a term or abbreviation and its precise meaning, they should not use it, instead they should write out the full term. Terms, abbreviations and acronyms should be committed to memory for consistent use and, if a kinesiologist is unsure of a term, abbreviation or acronym, they should refer to a medical vocabulary text for verification of use and context.

Common Abbreviations to Avoid

Abbreviations for terms that can have multiple meanings must be avoided. A prime example is the abbreviation "PT". It would make common sense that a physical therapist could use this when referencing their physical therapy services and work that they have performed, however "PT" can also mean prothrombin time (a test measuring how many seconds it takes for a clot to form in a blood sample), personal trainer/training. If another healthcare professional is reviewing a client record and misinterprets "PT" as being

physical therapy when it was referencing prothrombin time, this can mean the client ends up in the gym and not being assessed for clotting time or being referred to a personal trainer rather than a physical therapist. Below is a list of some common examples more commonly encountered in public healthcare settings.

Abbreviation	Potential Problem/Conflict
PT	Mistaken for physiotherapist, physiotherapy, personal trainer, patient or prothrombin
U or u (unit)	Mistaken for "You", or "0", or the number "4" when handwritten
IU	Mistaken for IV (intravenous) or the number 10 when handwritten
Q.D., QD, q.d. qod (daily)	Mistaken for each other, write "daily"
MS	Mistaken for multiple sclerosis, morphine sulphate or magnesium sulfate

For examples of commonly used and well accepted healthcare charting abbreviations, please refer to Appendix A at the end of the guide.

Avoid Derogatory Terminology

When recording a client's health history, it is important to use clear and unbiased language. Use of terminology that either validates or stigmatizes a client's comments, choices or actions is to be avoided. For example, when recording the health history of a client who has openly shared their past history of frequent alcohol and recreational drug use during his intake assessment, the terminology must be factual and not infer the legitimacy or illegitimacy of the client's use of alcohol or recreational drugs. Chart entries which refer to the client as being a "pot user", "heavy partier" are derogatory. Simply stating that the 'client reports a history of alcohol and illicit substance use' is more appropriate as it does not suggest support for, or opposition to, the client's history of drug use. Only in circumstances where the kinesiologist assesses the client and suspects a current substance use disorder that will negatively affect potential treatment and be a barrier to recovery, should additional action be taken to obtain additional healthcare support for the client or to consult with other client care team members to determine the best approach to assisting the client.

Similarly, if a client does not provide approval for the kinesiologist to proceed with the assessment or a specific test, the kinesiologist needs to use the correct terminology to reflect the client's right to refuse assessment or treatment. For example, if a client does not agree to participate in an aerobic treadmill test and there are no absolute or relative contraindications that support the client not to be able to complete the test, and the client has received the explanation of the potential risks and benefits, the kinesiologist should record in the client's chart 'Client ***declined*** to perform the aerobic treadmill test procedure' and not 'Client ***refused*** to perform the aerobic treadmill test procedure'.

It is important that kinesiologists remain objective by stating only known facts and thinking carefully about language and terminology used to describe a person's age, gender, race, creed, sexual orientation, lifestyle, appearance, disabilities, habits, and so on. They should avoid subjective descriptions of a person's appearance such as "attractive," "unfit," or "chunky". They should focus descriptions on neutral, quantifiable characteristics, choose clinically appropriate language, and respect the person when describing them, their actions or habits. Below are some examples of terminology that should be followed.

- Use “mobility impairment” or “functional impairment” and not “disabled”
- Use “Client uses recreational cannabis”, not “Client has a drug habit” or “Client is a drug addict”
- Use “Client with alcohol use disorder”, not “Alcoholic client”
- If a client exhibits signs of distress, uses exaggerated hand gestures or body language when explaining their current health circumstances or symptoms, avoid referring to their actions as theatrical, excessive, uncontrolled or undisciplined. Instead, use terms that respect the client’s lived experience, with terms such as ‘*enhanced pain expression*’, or ‘*hand gestures used to express pain level*’ or other terms that are neutral, yet informative to healthcare professionals who may also interact with the client.

Use of Quotation Marks

Quotation marks must always be used when writing verbatim statements made by clients or others.
It is important to remember that the information being recorded by the kinesiologist belongs to the client and is for their benefit. Clients have the right to view and request changes to any healthcare records or information that pertains specifically to them. If client information is in some way derogatory, making them feel ashamed, unintelligent, or otherwise inferior, the client has grounds to file a human rights complaint, or file a complaint with the professional governing body for the healthcare professional who created the information, in addition to requesting that the information be amended.

TIP - Word choice and tone matter in healthcare records and reports as healthcare records are often the best evidence in describing and defending the care provided to a client.

Components of a Complete Client Record

Client Information

A complete client record will include elements related to client management, including:

- Client demographic information, such as name, birthdate, biological sex (and/or gender identify when pertinent to treatment or service delivery[4]), preferred language of communication, address, contact details, work history.
- Reason for seeking treatment, pertinent medical history, referral form/diagnosis (if any), medical reports provided (if any), health screen and activity questionnaires and emergency contact details.

It is essential that this information is kept up to date.

Assignment of a unique client identifier, such as an alpha, numeric or alphanumeric code, should be utilized on each page of the client record as opposed to name and personal health number or other identification number. This will help protect client confidentiality (privacy) if one or more pages of a client record are

[4] British Columbia Health Information Standards - Gender, Sex and Sexual Orientation (GSSO) Health Information Standard and Guidance

misplaced, lost or otherwise made accessible to persons who are not authorized to access a client's personal information. The identifier used should be unique to the organization or provider (if a sole proprietor) delivering the service(s) and may incorporate components of a client name, treatment location or type which, if in the hands of a third-party, will not readily identify the client to whom the information contained on the document applies, and which cannot be easily reverse engineered by an external party to determine who the information belongs to.

Informed Consent Documentation

The documentation of informed consent is a continuous process and requires the kinesiologist obtain the client's voluntary agreement for service provision after they have been fully informed about the nature of the services, the potential risks and benefits, and any available alternatives to the recommended services at each step in the care process, and any time a change is made. Prior to initiating client care, it is essential to obtain a client's consent to create and maintain records, share personal information, assess and treat for a defined term or ongoing basis. In addition to the completion of any intake consent forms, the consent recording process must be written and integrated with the chart entries, regardless of whether the consent was obtained in written or verbal form. Consent details should encompass assessments, progress tracking, referrals, and any other record-keeping activities, such as communication with other healthcare practitioners involved in their care.

Elements of Client Management

The main elements of client management to be included in a client record are: Initial assessment – Examination & Evaluation; Prognosis; Intervention; Visit/Session/Encounter details; Re-examination; Conclusion/Discharge or Discontinuation of Care Summary. The actual elements of client management may vary depending on the kinesiologists work environment and whether the care is being provided in an interdisciplinary, multidisciplinary or individual care setting.

Initial Assessment – Examination & Evaluation

When documenting the initial assessment (encounter) with a client, it is typically referred to as the initial (or intake) assessment - examination or evaluation and should be referenced accordingly either in full words or with an accepted abbreviation. The initial assessment and associated record keeping should be completed by a single fully trained kinesiologist unless the kinesiologist is part of an interdisciplinary or multidisciplinary team where a single clinician from each profession completes a respective assessment or evaluation based firstly on competency and secondly on applicable team policies. The work of assistants during assessments must be limited to setting up equipment, machinery or testing apparatus and activities that support the fully trained kinesiologist; assistants must not be delegated to conduct examination or assessment procedures or record findings in the client record. The initial assessment is typically completed in one visit but may occur over 1 or more visits based on a client's needs. The kinesiologist should record the measures, observations or results of all examination/evaluation procedures completed, including noting in a nonjudgemental fashion, when and why a client declines to participate in evaluation procedures for which participation is deemed safe and in the best interest of the client. Documented assessment findings should align with the kinesiologist's

subjective scope of practice, encompassing the duties, responsibilities, and tasks the kinesiologist is qualified and authorized to perform.

Examination

Objective Assessment

Objective assessments are those which the kinesiologist conducts in the presence of the client, and which provide measurable, palpable or observable data related to the client's physical condition and function (e.g. muscle strength testing, range of motion testing, cardiorespiratory fitness testing, gait analysis, functional movement screen, etc.). When recording the objective examination findings, in addition to specific measures, the kinesiologist should also record their professional opinion, using standard writing convention, whether the findings are deemed to be within normal ranges, limited (low, reduced, hypomobile) or augmented (high, excessive, hypermobile) and the magnitude of any apparent abnormalities in function. As mentioned previously, not recording an assessment result accurately, can result in errors in treatment planning and result in client injury or failure of a treatment plan to achieve the desired results. Assessment details recorded should cover both acute (isolated) and gross (compound) measures and observations observed by the kinesiologist. This may include comments on limitations in joint articulation (range of motion), resting muscle tone (resting length), using appropriate terms such as laxity, tightness or spasticity, observed deformities in tissues such as hypertrophy (enlargement, growth), atrophy (withering, loss) or atypical static or dynamic posture as examples.

Subjective Assessment

Subjective assessments are those which the client completes that provide data related to their perceptions and accounts of their physical condition, function, pain and wellbeing (examples include: a Pain Diagram, PHQ-9, Oswestry Low Back Pain Disability Questionnaire, Neck Disability Index, etc.). When recording details of the subjective assessment findings, any standardized perceived disability, and/or pain management forms that are completed by the client must include the client identifier and the date and time of day when the form(s) were completed. Scoring or rating applicable to the test forms also needs to be fully completed and not left for a later date.

Evaluation

The evaluation process is where the kinesiologist utilizes critical thinking and professional judgment to understand and interpret the assessment findings and determine a prognosis consistent with the scope of practice of the kinesiology profession and the kinesiologist's individual competence. While completing this process It is relevant to consider whether there is importance in documenting the evaluation process in the client record. In cases of complex care, the process used to analyze the assessment data collected during the examination and used to identify pertinent client anomalies, strengths, weaknesses and other traits, can have significant client value should the preferred treatment need to be reconsidered if the anticipated results of client care are not being realized.

Evaluation Scenario #1

You are preparing to report the assessment findings for a client you are seeing for the first time. They have sustained a fall injury to their right shoulder. In observing the client perform a variety of active movements, you

note the following – the client cannot reach overhead, either to the front or to the side – however in supine, the client is able to achieve full ROM when assisted by the kinesiologist – In addition, the client reports stiffness and pain in or around the acromion and glenohumeral joint on palpation. Which of the following statements best reflects an accurate and concise report of the findings?

Option A: Client exhibits signs of muscle weakness when trying to raise their arm overhead, limited range of motion, joint stiffness and reports pain in the shoulder.

Option B: Client demonstrates limited ability to actively abduct or flex the right shoulder to more than 60 degrees of range while standing or sitting erect, exhibits and reports no restriction for assisted flexion and abduction of the affected shoulder in supine, and reports stiffness with localized pain in the anterolateral region of the R acromion during movement and on palpation. No other anomalies or restrictions for shoulder movement are apparent.

Analysis: Despite being longer, the language in Option B focuses on describing functional limitations and ability rather than using generalized unquantified terms that provide little future value for comparison when needing to reassess the client's functional abilities. Option B also better describes the location and extent of the client's symptoms. In both options A and B, the language does not imply a medical diagnosis, however Option B provides more quantitative information that can better convey relevant information about the client's current condition, and which another healthcare practitioner or an insurance adjuster can more accurately rely on when making decisions on treatment funding.

Evaluation Scenario #2

A new client who has been diagnosed by their physician with patellofemoral syndrome of the right knee, comes to you for treatment, Which of the following options is most appropriate for the kinesiologist to enter into the client record?

Option A: The assessment confirmed the client's diagnosis of patellofemoral pain syndrome, as pain was evident during the walking and running tests performed by the client and when lateral pressure is applied to the patella while the knee is actively extended, the pain symptoms corelate with those typical of patellofemoral syndrome,

Option B: The client exhibited moderate ipsilateral weakness of the right hip abductors and external rotators. Ober's test was positive for the right hip and during a two-legged squat, the client exhibited right knee valgus between 30 and 60 degrees of hip flexion.

Analysis: In Option B, the focus is on identifying the functional limitations and specific deficits in strength and/or flexibility that can be addressed by the kinesiologist, rather than confirming the medical diagnosis. It is important to remember that the kinesiologist is not being sought by the client to confirm the diagnosis, a process which can be referred to as a "differential diagnosis". They are being sought to assist the client in identifying the deficits contributing to their medical diagnosis and helping the client overcome those deficits through exercise or other treatment modalities. Avoiding the pitfalls of rendering a diagnosis rather than finding solutions to a client's injury or disease is essential for the kinesiologist to be successful.

Prognosis, Impairment Level and Intervention Planning

The evaluation outcome guides in determining the client impairment level, prognosis for recovery, and intervention strategies. These should be well documented as they are an integral component of the care (treatment) plan. Taking the time to record appropriate details during the early stage of care can enhance future decision making to improve client outcomes.

Session/Encounter Details

Session encounter details should be recorded during or shortly after a session is completed, and on the session day unless there are extenuating circumstances. The session details should also follow a standardized method of documentation that is familiar to other healthcare providers and/or care team members. There are two common charting styles of documenting client encounters, they include "SOAP" notes charting style (inclusive of its variations as covered below) and "Narrative" charting style. In kinesiology practice, SOAP notes, or one of the variations, are the most commonly used.

TIP - The general short-term nature of kinesiology treatment favours the use of SOAP notes style of charting over narrative charting.

SOAP Notes

SOAP notes are a widely used method of documenting client information for healthcare professionals. The acronym 'SOAP' stands for Subjective, Objective, Assessment, and Plan. This method of note taking provides for a highly structured means for kinesiologists to organize and communicate client information effectively and in a concise manner.

Subjective (S): This section includes the client's subjective information, primarily that which is reported by the client. It often contains the client's chief complaint (CC), their current symptom, or symptoms, since their last session with the kinesiologist, and any information the client provides about their condition. This section focuses on the client's feelings, perceptions, and opinions.

Subjective, often displayed as the capital letter 'S' with a circle around it or 

followed by your comments in point form. Similar display convention also applies to the other 3 components,

Objective (O): This section is dedicated to objective, measurable data, practitioner observations, and the objective actions or activities of the client during the session. It should contain only what objectively occurred or what can be observed and measured (quantified/qualified). Observations should include observed and measurable changes in motor control, gait, dynamic posture, and other parameters of interest. This section should include a record of the activities completed by the client or which were performed by the kinesiologist on the client if manual, electrical or other types of modalities were utilized (unless they are otherwise included under the next category, integrating Assessment and Activity). This ensures that the notes provide a comprehensive account of the treatment process. It also assists in correlating client symptoms experienced and reported during a treatment session, or following a treatment session, and reported at the subsequent

session. These details can assist in establishing a causal relationship between activities and symptoms, including time delay in symptom onset, and helps with future monitoring for changes between the relationship parameters. This combined information then facilitates considerations for progression, including volume, frequency, duration, effort, and symptom levels with the principles of functional progression/regression always in mind. A detailed client record helps the kinesiologist make informed decisions regarding the treatment method of the interventional activities.

Some kinesiology practitioners incorporate a client's 'activity' related treatment under Assessment rather than under the Objective charting section.

Assessment (A): This section includes assessment/reassessment findings that are completed following the initial assessment. This may include physical testing, questionnaires and forms completed by the client related to subjective assessments, such as Oswestry, Neck Disability, Ransford Pain Diagram, and other tests that have quantifiable or measurable outcomes.

Plan (P): This section outlines the proposed or ongoing course of client care/treatment. It typically includes the kinesiologist's recommendation for treatment, intervention, activity plan, recommended schedule for follow-up appointments (frequency, duration), homework given, education provided, and any other necessary steps for successful treatment. It should be a clear and detailed account to guide the treatment.

SOAP Note Variations

The SOAP method of charting has been in use since the 1970's, and many clinicians, clinics and healthcare facilities have identified weaknesses in this documentation method. Because this method does not integrate time into its framework, it does not allow for the tracking of changes in evidence-based practice over extended periods of time, such as changes in diagnosis and treatment methods that occur due to advancements in technology and clinical research. Another identified issue is that over time the volume of information that can and is maintained in a client record has expanded significantly due to the adaptation of electronic record storage and the use of digital charting. This can make it difficult for a busy clinician to quickly locate clinically important data in a client record that could be hundreds or thousands of pages in volume. To circumvent some of the issues identified with the traditional SOAP method, modified versions of SOAP notes have been introduced in some settings and are discussed below.

SOAP (where A is for Activity)

Subjective, Objective, Activity, Plan - has been implemented in some settings practice settings to enhance details of the activity done in the session. This is a common SOAP note variation employed by kinesiologists as it provides a dedicated area in the chart to record the details of exercises completed by the client. Some kinesiologists choose to use this section to record exercises, rather than in the 'Objective" section.

SOATP

Subjective, Objective, Assessment, Treatment, Plan - has been implemented in some settings to help separate the actual treatment and activities performed by the client from the objective (observations of changes in client function).

SOAPE

Subjective, Objective, Assessment, Plan, Evaluate – has been implemented in some settings to remind clinicians to assess how well the plan is executing or working for the client's recovery.

APSO

Assessment, Plan, Subjective, Objective - this variation rearranges the order from SOAP to APSO and has been adopted by practitioners who believe that it provides information in a more logical order that better reflects the sequence in which each item is encountered during a client treatment session.

Narrative-Style Note Taking

Narrative-style note taking is a form of standard documentation practice that provides a detailed, written account of a client's medical history, chief complaint, current symptoms, and treatment. Unlike structured or template-based note taking methods such as SOAP notes, narrative notes typically follow the flow of activities and discussions that transpire with the client from the start to the end of the client session. This type of charting may be more time-consuming, as it does not allow for point form entries to the extent that a template style allows for. They are written in a narrative or paragraph format and offer a narrative 'story telling' description of the events occurring during the client's session and the entire program.

The key elements of narrative notes are similar to SOAP notes but will typically be presented in the chronologically structured paragraph or multiple paragraphs and include:

Subjective Information: A summary of the client's current chief complaint, symptoms, and any relevant background information, including related changes. This information provides context for the kinesiologist's involvement, what assessment should be conducted, and activities performed.

Assessment Information: Assessment data, including test findings, such as range of motion, strength and other measurable variables, and any completed client assessment forms.

Objective Findings: The narrative format will then include the observations of the kinesiologist and qualitative comments on movement, function, apprehension or pain inhibition, as examples. Also included will be a record of activities performed by the client during the session and advice provided to a client regarding home exercise adherence, activities which may benefit or exacerbate a client's condition, and details on a client's home program, if applicable.

Plan: The narrative method concludes with the proposed or ongoing plan for the client's care. This section outlines what treatment, interventions, exercise options, etc., are recommended and the rationale behind these choices, along with recommended follow up intervals.

Narrative notes can also be useful in documenting client progress over extended periods of time, or in delivering complex care, such as for clients who will be receiving preventative treatment for years or decades. This allows for the recognition of changes relating to maturation or aging that are typically more significant in both younger and older populations and helps the kinesiologist differentiate the age-related changes from those related to the condition, injury or illness for which care is being provided. They can allow the kinesiologist to provide a more holistic view of client health and can be used to convey complex information to other healthcare professionals or for legal and insurance purposes. They must be written with clarity and accuracy to ensure effective communication and understanding among a broad range of healthcare providers.

Narrative notes are subject to the same legal and ethical considerations and kinesiologists must ensure that their narrative notes adhere to applicable legal and ethical standards for client documentation including client confidentiality and accuracy in effect at the time they are produced.

TIP - Write as if you are about to take an extended leave from practice and another kinesiologist will be stepping in to take over treatment of your client. This necessitates providing sufficient detail in your chart entries so that others will be able to quickly and easily identify the client's history of care, symptoms, concerns, and current functional abilities

Phone Call and Email Communication

An accurate and complete client record will include dates and details of telephone discussions, email correspondence, and text communications to/from the client that are of a clinical nature. Examples include appointment scheduling, discussions regarding missed or canceled sessions, information regarding third-party funders, and information regarding other healthcare practitioners involved with the file.

Communication entries should include the date (day, month, and year), and in many cases, the time of day, especially in public hospital practice settings or where the time of communication is relevant to care delivery.

Use of Electronic Health Record (EHR) Keeping

Whether a kinesiologist chooses to maintain traditional paper records or utilize an electronic health records "EHR" system, such as JaneApp, Embodia, ClinicMaster, ClinicSense, eClinicalWorks or other provider, the clarity, comprehensiveness, and security of their records remain the primary concerns. Kinesiologists should select one method and adhere to it consistently. Avoid switching between paper and electronic records, as this disrupts the orderly maintenance of client records in a clear, chronological sequence.

There are pros and cons to using both paper and electronic EHR systems and there are important considerations that kinesiologists should assess when considering which to choose. Kinesiologists should have a good understanding of;

- How to properly use the record keeping system, including adequate training, to ensure data is properly recorded in the correct client file and section to which it applies and to identify when entries have not been recorded or saved.
- How to quickly access assistance from the EHR system's technical support staff should it be necessary.
- Who has access to the information in the organization's EHR system, including access policies for other healthcare professionals and staff within the organization.
- The security measures and protocols in place and how to report a real or potential breach to either their personal access or to a client file that appears to have been breached, is missing. or has incorrect information, such as information relating to another client.
- Where the client records are stored. There are risks and benefits to storage in different locations. Cloud based storage may be subject to fewer risks of information loss due to fire or other physical peril, however cloud storage may present a higher risk for fraudulent access due to phishing attempts or data corruption, particularly if adequate back up processes are not in place. The location where data is stored is important, as privacy legislation in BC and Canada require information to be securely stored within Canada and not elsewhere in the world.
- Whether there are any paper records and if so, how to access them, should this become relevant to care provision or otherwise necessary.

TIP - SOAP notes are commonly integrated with electronic health records (EHR) systems, simplifying the storage, retrieval, and sharing of client/patient information. Dedicating time to creating a customized template that suits your needs, and practice can be time well spent and helps deliver thorough and efficient kinesiology care.

Altering a Client Record

Altering the information in a client record can present serious consequences for the healthcare professional, including allegations of fraud or professional misconduct, and can make professional liability (malpractice) claims difficult to defend. Despite this, healthcare professionals are only human, and mistakes will occur from time to time and need to be addressed.

Many of the standards applicable to modifying records apply to both paper and electronic records., such as not obscuring or removing the original information that requires altering, making timely corrections and signing all entries. The altering of EHRs has additional factors that must be considered, including the EHR interface (how information is displayed and recorded), as well as the system's ability to track user actions through meta data and audit trails. Information on how the kinesiologist is to properly amend records should be detailed in the record keeping policy of the organization, and should be referred to prior to making any changes.

The process of correcting a client record becomes more complex when the health professional that created the original entry is no longer available or working with the client. The following list details some of the factors the kinesiologist must consider when correcting or amending a client record:

1. Ensure the revisions to the client record comply with federal and provincial laws.
2. When making a revision specify when a correction, addendum, or late entry is made, including (a) the date and time of the revision, (b) the name of the person making the revision, (c) a clear explanation of what information was changed, and (d) the rationale for the modification.
3. Ensure the revision will not overwrite the original entry and that the original entry shows as being revised or is ~~struck through~~ to identify it as being incorrect but remains part of the record.
4. If making a revision to a client EHR, confirm the system will recognize and flag this to identify the entry as a revision or a late entry.
5. If a revision is being made to correct a client health record based on a request under FIPPA or PIPA, ensure that this information is noted in the file and also follow through with notifying the client of the exact details of what was entered into the record after the alteration is made.
6. If the kinesiologist is not the health professional who made the initial entry in the client health record, they must ensure the original author of the record is notified so they can verify that the amendment is appropriate and necessary.
7. If a revision cannot be made in a record of the original content, ensure that the original content identifies where the revision exists and how it can be located.
8. Ensure that records are not altered at the request of a lawyer or family member of a client without discussing with the client or their legal representative, and the original author of the entry.
9. Ensure to their best ability, that the revision does not contain non-factual information or that it is fraudulent.

Other Records

Treatment Plans

Kinesiologists working in clinical practice will frequently be asked to prepare treatment plans for their clients. A treatment plan is a type of report that outlines the interventions, exercises, and modalities that a kinesiologist will employ with the client's consent in an attempt to improve their condition. It is a collaborative document forming part of a client record that serves as a roadmap for both the client and the kinesiologist.

TIP: As a major employer for kinesiologists in BC, the Insurance Corporation of BC (ICBC) provides resources on their Business Partners page (https://partners.icbc.com/health-services/providers/kinesiologists) that has information on how to complete an ICBC Treatment Plan.

Reports

Kinesiologists may be asked to provide professional or other reports for a variety of purposes. All types of reports will have a defined logical structure and contain technical information on the wellbeing of the client.

Professional Reports

- **Treatment/Assessment** - provides detailed client information on assessment results and observations, potential barriers to recovery and suitability for kinesiology care, anticipated duration and frequency of treatment and prognosis for recovery based on the provision of evidence-informed kinesiology care to the client.
- **Medical Legal** – also referred to as a medico legal report, provides medical evidence for legal cases, which assists the court to determine the extent of an injury or illness and to determine appropriate compensation.
- **Functional Capacity Evaluation** – also referred to as an "FCE" report, provides recommendations regarding a client's ability to return to work, return to work with restrictions, or the need for accommodations to safely return to work following the completion of a detailed and often lengthy assessment.
- **Job Demands Analysis** – also referred to as a "JDA", provides objective descriptions of the physical, cognitive, and psychosocial demands required to perform a particular job or role.
- **Return to Work Support Services Report** – also referred to as a "RTWSS", the report details the implementation and success of a client's return to work plan, either during or upon completion of the return-to-work plan schedule at the time of discharge.

Professional reports require the writer to be able to organize their thoughts to address the issues to be reported, while maintaining a logical structure. These reports require a contents list that maintains good structure and allow the information to be read and understood by the reader. A poorly structured report is unlikely to adequately inform the reader of what is intended and will require additional time and investment of the kinesiologist to otherwise communicate content that was not written clearly. A typical professional (technical) report will have content in the following progressive order.

- Introduction
- Background and Context
- Technical detail
- Results
- Discussion and conclusion
- When applicable, details on assessment procedures, ratings, rankings or abbreviations will be included as appendices.

TIP - As you write the technical part of the report, it can be helpful to maintain a separate list of key items that are appropriate for reference in the conclusions section. The key to your conclusions is then provided by the list.

Style and Presentation

All reports should be written in the third person, as an objective observer. Avoiding terms such as "*I had the client perform the 6-minute walk test*", and instead write "*The client performed the 6-minute walk test*". It is also important to consider who the intended report reader is, including their knowledge and competency

relating to technical terminology used in the report, to ensure you communicate your thoughts and ideas effectively. As with charting, information should be portioned into bite-sized pieces presented in a progressive fashion that allows the intended reader to digest, compile and summarize the information from each portion to understand the greater picture. Use of tables and charts is another consideration for reports, as they can add visual balance by breaking up long sections with tables, figures or diagrams.

Form

The components of form include spelling, grammar, use of plain language, and avoidance of jargon. These topics have been discussed previously related to the general principles for record keeping related to language and grammar. Kinesiologists should also avoid the excessive use of capital letters, focusing on the use of capitals only for proper nouns, such as the names of places, company names, and when using acronyms, the first point at which the acronym is used, it should be defined and then may be freely used.

Conclusions

When writing conclusions, the kinesiologist must inform the reader of the key issues. In addition to reporting current functional ability, conclusions may also include the inherent limitations in the assessment findings that allowed the kinesiologist to come to a conclusion, as well as other factors such as potential physical or societal barriers to recovery. References should be tailored to address the issues and questions outlined in the introduction as these define the purpose of the report.

Quality Control

Reports are legal documents, and avoidable errors can cause harm to the client or bring disrespect to the kinesiologist if proper quality control measures are not implemented. Quality control is the responsibility of the kinesiologist preparing the report and no one else.

Proof Reading

The primary method kinesiologists can employ for quality control is proof reading. This requires the kinesiologist to review the report as if it is something completely new to them. Even with this approach, it is easy for the mind of the writer to miss common spelling and grammatical errors, while the mind is focusing on conveying meaning when preparing technical documents. The fact that these types of errors often occur even with the use of grammar and spell checkers, is that the human brain sometimes skips ahead in the thought process, as it already knows the desired outcome and will ignore a mistake.

Peer Review

The value of a peer review is that the mind of a peer is much better at picking up nuances, emotions, tones, inflections, and meanings as they were not involved in the assessment process and determining the conclusions. A competent kinesiologist remains superior to the artificial intelligence features of a word processing program or other system in conducting a secondary peer review.

Consent and Confidentiality

Client consent to release the information in the report is an important part of the process, even if it is not an intrinsic component of the report itself. Prior to releasing a report, the contents of the report should be reviewed with the client to ensure they want the information released.

Following are the elements that a kinesiologist must address prior to submitting a client report:

1. Confirm the client is aware of the purposes for which an employer or third-party has requested a report.
2. Discuss and confirm, to the best ability, the client's understanding of the context and potential outcomes that may result from the submission of a report, including the writer's obligation to be objective in preparing the report for an employer or third party.
3. Seek the client's agreement for releasing the content of any sensitive personal information conveyed about them to employers or third parties that they may not already be aware of, ensure they are aware that they have the right to withhold consent for release of some or all of the information, and that they can revoke consent at any time prior to the release of the information should they wish to do so.
4. Formally obtain written informed consent from the client for the disclosure of the personal information agreed to, and make a record that the client has been informed of their right to refuse consent.

Incidental Reports

These reports are typically less formal, however each will often have a defined structure.

- **Client "Handover"** – These reports are often required when transitioning a client from one healthcare practitioner to another, such as the case of retirement of the existing practitioner. They ensure a smooth client transition and include information about the client, such as their current functional ability, improvements, common symptoms, observed barriers to recovery and client preferences, goals, and expectations.

- **Medical Incident** – These reports are required internally by organizations following the injury of a client while in the care of the organization or, specifically, the kinesiologist. Medical incident reports may have a defined structure based on an organization's internal policies, WorkSafeBC legislation, or other government legislation if there is suspected transmission of a communicable disease. The kinesiologist is responsible for ensuring the reporting requirements are complied with if the incident involves a client who was under their care at the time the incident occurred. The organization will collect healthcare incident data with the goal to improve client safety and care quality. Ideally, they will identify safety hazards and guide risk management policy development or change, thereby reducing harm.

Financial Records

Kinesiologists who charge fees for their services are required to maintain financial records in addition to client health records. The financial record contains billing information for services, equipment, supplies or products provided to the client, either billed directly to the client or indirectly through a third-party who is paying for some or all of the client's treatment or care.

A financial record includes:

- Full name, client
- Full name, kinesiologist + registration number if applicable
- Date of service, equipment, or product provided

- A description of service provided - e.g. kinesiologist-directed active rehabilitation session, 60 min; kinesiologist-directed virtual active rehabilitation session, 45 min, etc.
- Description of any equipment or product provided to the client - e.g. TheraBand, foam roller, home exercise program, etc., and whether the product was provided for a fee or free of charge
- Itemized unit costs for services, equipment, or product provided and a cumulative total
- Itemized government excise tax (GST) charged on each service, equipment or product (if applicable)
- Business Number of the kinesiologist / company
- Payment receipt/balance of the client account
- Payment terms

Records Retention Practices

Each kinesiologist must assess their individual situation and establish an appropriate retention policy. It is important to recognize that the record retention requirements of the Canada Revenue Agency (CRA) differ from the requirements to retain records under the privacy legislation in BC.

The CRA requires you to keep all required financial records and supporting documents for a period of six years from the end of the last tax year they relate to, plus the current year. The tax year is the fiscal period for corporations and the calendar year for individuals.[5]

Privacy laws relating to personal information in BC require that records be kept no longer than necessary to serve the purpose for which the records were created. This requirement is relatively vague and does not provide a hard line as to how long records should be kept or how to determine when a record is no longer required and should be securely destroyed. The Limitations Act of BC does however provide more specific timelines on how much time a person has to make a claim for damages, such as professional or general liability for damages related to improper client care. The Limitations Act specifies a maximum of 16 years from the date the record was created, in addition to a discovery period and the time until a person reaches the age of 19 years.

The current general recommendation from the BCAK is to retain financial and other business records for a minimum of 7 years, unless they are related to the provision of health services and then the recommended retention period is a minimum of 16 years from the date of discharge or the number of years until the client reaches the age of 19 plus 16 years.

In contrast, in Ontario, the College of Kinesiologists of Ontario (CKO) requires that every client health record and every financial record must be retained for a period of at least 10 years for clients who are 18 years of age or older at the time of the last contact, and for a period of at least 10 years following the date at which the

[5] Where to keep your records, for how long and how to request the permission to destroy them early (2023). Canada Revenue Agency. https://www.canada.ca/en/revenue-agency/services/tax/businesses/topics/keeping-records/where-keep-your-records-long-request-permission-destroy-them-early.html

client would have become 18 years of age for clients who are less than 18 years of age at the time of last treatment/contact[6].

This variation in provincial requirements for records retention demonstrates the importance for kinesiologists who work with clients who reside in other provinces, territories or countries, to ensure they have legislative knowledge on the requirements applicable to each of their clients based on where they reside.

Records Processes When Retiring or Discontinuing Practice

As part of the process of closing or transferring a practice, the kinesiologist should take reasonable steps to ensure records are stored or transferred securely. More details on this are included in the BCAK Jurisprudence Guidebook and should be referenced for further details.

Artificial Intelligence (AI) use in Record Keeping and Charting

Having a strong understanding of the uses of artificial intelligence (AI) in record keeping and charting is becoming increasingly important. The use of AI can enhance client care; however, it can also introduce additional risk factors, including ethical considerations, system malfunctions, privacy protections and consent for data repurposing as they relate to the AI systems continuously learning from the entries it has created. In addition to the use of AI in record creation, it can also be used to classify record entries into different areas of an EHR, assist in digitization of the record and for storage, retrieval and disposal (destruction) purposes.
The use of AI can have a positive impact on care when its use reduces the time required to create meaningful, transparent and informative entries, however it can also create increased risk for the kinesiologist if, through the algorithms used, it introduces bias, improper translation of the spoken word and other errors if the system becomes infected with a virus. Kinesiologists using AI assistance in record keeping must review a record entry they are preparing thoroughly, to ensure both the content and grammar effectively portray what is intended by the writer.

The kinesiologist must remember that the content of the client record serves is a direct reflection of the practitioner and demands compliance with legal and ethical obligations. It is essential to conduct a comprehensive review of AI-generated content to guarantee precision.

Record Keeping Variations In The Work Environment

Kinesiologists can be employed in a broad range of public and private healthcare settings and encounter a variety of organizational structures[7] that bring with them different record keeping laws, responsibilities and priorities. Kinesiologists should expect to encounter differences in record keeping standards depending on

[6] Practice Standard - Record Keeping (2017). College of Kinesiologists of Ontario. https://www.coko.ca/wp-content/uploads/2020/12/Practice-Standard-Record-Keeping-Revised-June-2017.pdf

[7] Refer to Business Law section of the BCAK Jurisprudence Guidebook for additional information on organizational structure

whether they work in private practice, corporate, government, health authority, not-for-profit, post-secondary or other environments.

It is also not unusual for kinesiologists in BC to find themselves working multiple jobs or working in multifaceted occupational settings with conflicting responsibilities. Consequently, kinesiologists need to maintain an understanding of the differences that being employed in federal vs provincial and public vs private work environments may bring. The different work environments mandate slightly different standards for record keeping and custodianship of client records.

Generally, the requirements for record keeping in the various work environments serve similar purposes, however public-sector records often serve a broader public health perspective aimed at improving healthcare outcomes for all people, while still prioritizing and maintaining the client care and privacy standards for individual persons.

Record Keeping Data Breaches

The incidence of healthcare data breaches worldwide has been increasing over the past decade as more and more governments and providers utilize EHR client management systems. This does mean however that incidents of unauthorized access are limited to hacking or IT system breaches, as unauthorized access to physical records that are left unattended, misplaced or stolen from a bag or vehicle does not occur.

Kinesiologists must either establish their own policies and procedures or be well-informed about the existing protocols within their organization. These guidelines, once created, are crucial for proactively averting information incidents and for ensuring a swift and effective response in the event that such incidents arise. Neglecting to safeguard client information and failing to respond effectively to breaches can lead to legal ramifications including fines and damage to the kinesiologist's reputation.

The following is a list of common data breach causes:

1. **Inadequate Cybersecurity Measures** - A hacker gains access to a kinesiologist's device(s) used for recording and storing client EHR data via the internet and accesses the personal health records of the kinesiologist's clients.

2. **Lost or Stolen Devices -** A kinesiologist regularly uses an electronic device to record and store client information. They misplace or leave the device unattended and are not able to locate or confirm the whereabouts of the device. The device is suspected to be lost or stolen.

3. **Unauthorized Access –** Healthcare facility staff or third parties access client information without proper authorization and/or legitimate reason.

4. **Human Error -** Accidental disclosure or mishandling of client data, such as sending confidential information to the wrong recipient.

5. **Ransomware Attack –** A cyber-attack where data is compromised and encrypted to prevent use by the rightful custodian or owner, and a ransom is demanded in exchange for access.

Dealing with Information Security Incidents under PIPA Legislation

An information security incident is a suspected, attempted, successful, or imminent threat of unauthorized access, use, disclosure, breach, modification, or destruction of information; interference with information technology operations; or significant violation of responsible use policy.

PIPA legislation requires those who experience an information security incident to follow a 4-step[8] process to manage an information incident

Step 1: Contain the Privacy Breach

- Containment includes preventing further loss, recovering lost records, shutting down the device or system that was breached, revoking or changing security access codes to correct weaknesses in security.
- It also includes reporting the incident to the person in the organization responsible for data privacy and security, typically this will be the corporate privacy officer in the office or location.
- Following this, the incident should be reported to the police, either by the kinesiologist or the privacy officer, as per company policy. Kinesiologists, running their own business as a sole proprietor, *are* the privacy officer for the business.
- Full details on the containment procedures can be found in the OIPC Tools and Resources document linked in the footnotes.
- In addition, the kinesiologist should promptly notify their professional liability insurance carrier, as there may be legal ramifications if any client data is used inappropriately to defraud one or more clients. The insurer should provide details on any coverage available and the steps they should take to mediate any potential loss to their clients.

Step 2: Evaluate The Risks

The kinesiologist should assess the risks associated with the data that was accessed and determine what other steps are necessary to remediate the loss after having completed their assessment. The objective is to minimize potential harm resulting from the incident. The kinesiologist should consider the following:

- What data elements have been breached? Some information is more sensitive than others, such as health information, government issued identification, credit card information. The more information accessed the greater the risk.
- What are the possible uses for the information accessed? Can it be used for fraudulent purposes?
- What context does the personal information have? If the information is available through a public resource directory, such as a phone book or elsewhere online, the risk is less than it is if the information is not available through other sources.

And utilizing this information, the Kinesiologist should determine:

[8] OIPC Privacy Breaches: Tools and Resources for the Private Sector

- The cause of the breach,
- Whether there is an ongoing risk of further exposure
- The extent of the breach, such as how many different pieces of information were obtained for a given client and if applicable, how many clients
- If the information was lost or stolen
- If the information is encrypted or not easily accessible

Step 3: Notification

Once the incident is contained and the extent of the data is known, the kinesiologist must consider whether it is important to notify the individual people affected by the breach. Refer to the Breach Notification Assessment Tool provided by the OIPC for further details on determining when and who should be notified.

Step 4: Prevention

The final step involves a thorough investigation of the cause of the breach. This may involve a security audit. Following completion of the evaluation, review and update policies to reflect the lessons learned. Additional training for staff must be a part of this process, in addition to ongoing monitoring, regular assessments of security protocols, and continuous improvement of practices to safeguard personal information.

Dealing with Information Incidents under FIPPA Legislation

FIPPA legislation also contains a privacy breach notification requirement. If a kinesiologist is an employee of a public body, such as a health authority, public hospital, care clinic, or government organization, and they suspect an information incident or privacy breach has transpired, responding to such an occurrence involves the following steps:

- Immediately report the incident to the direct supervisor, privacy officer, or another designated contact within the organization, and either the kinesiologist or the supervisor must report the Breach. Additional details can be found here through the Privacy Helpline. Once the incident is reported to the appropriate contact within the organization, they will provide guidance on the subsequent steps required to address the incident effectively.
- In situations where containment of the information is possible, such as when requesting an unintended recipient to double-delete an email, it is advisable that the kinesiologist make this request promptly and inform the appropriate contact of the actions they have taken.
- In cases where there is a reasonable risk of significant harm to an individual due to a privacy breach, the head of the public body is obligated to notify both the affected individual and the Office of the Information and Privacy Commissioner (OIPC). This notification empowers the affected individual to take measures to mitigate potential harm.

TIP: An independent contractor working for a public body will be considered an employee of the public body under FIPPA legislation. Therefore, independent contractors should adhere to the same procedures outlined above.

Handling Personal Record Requests & Reviews in Kinesiology Practice

Both PIPA and FIPPA allow clients to request a copy of their personal information held by an organization or government body. In addition, formal legal requests may be made for client records on behalf of a plaintiff or the client by their legal representative, or under agreement by third-party insurers, or another authorized party to review and obtain information from a client record. These requests should be reviewed for legal compliance and authenticity prior to any action being taken by the kinesiologist.

Requests made under PIPA or FIPPA must comply with the applicable legislation and the requirements can be obtained from the Office of the Information and Privacy Commissioner of BC.

Requests made through the courts, by legal representatives or under other agreements, must be carefully reviewed to ensure client personal information is not released or shared without the explicit consent of the client or in compliance with applicable laws. This includes both written communication and potential phone calls that may be received from claim investigators (adjusters) or insurance company representatives.

The release of a client record in whole or in part requires the kinesiologist be presented with (1) a valid authorization signed by the client to release their personal information to a third party, or (2) a document from the court that has been stamped and approved by a judge (affidavit) specifying what information is required to be released, or (3) a completed and verified 'Authorization to Release Medical Records' under FIPPA for publicly held records.

Again, client personal information should only be released once the kinesiologist has:

1. Confirmed the authenticity of the request for information document they have received,
2. Verified that the purposes for which the information requested comply with the privacy legislation,
3. Determined the specific information (e.g. certain period of time) or documents (e.g. initial report, progress reports, kinesiology session notes) which have been requested or authorized, and which the kinesiologist has properly assessed to ensure that the release will not result in harm to the client or another person, and
4. Confirmed the delivery timeline in which the request must be granted, either by the court order, or in accordance with the applicable privacy legislation.

Appendix A

Specialized Terms, Abbreviations and Acronyms Common to Kinesiology Practice

The list of abbreviations, acronyms and diagrams provided below is not exhaustive and should only be used in accordance with the policies and procedures of your employer or organization for which you are providing services. In all cases where a conflict of terms is possible or otherwise expected, use of the terms, abbreviations and acronyms should be avoided.

Commonly Acceptable Charting Abbreviations (sorted alphabetically)

- ADL - activities of daily living
- AROM – active range of motion
- Ax – assessment
- BMI - body mass index
- BP - blood pressure
- BW - bodyweight
- CONC – concentric contraction
- ct – client
- DOMS - delayed onset muscle soreness
- ECC – eccentric contraction
- HR - heart rate
- Hx - history
- IAx – initial assessment
- MSK - musculoskeletal
- PROM - passive range of motion
- pt – patient (Use cautiously as ‘pt’ can have multiple meanings)
- REP - repetition
- RM - repetition maximum
- ROM - range of motion
- RPE - rating of perceived exertion
- RROM - resisted range of motion
- Rx - prescription
- Tx – treatment

Medical Abbreviations (sorted alphabetically)	
ACTH	Adrenocorticotrophic hormone
ADH	Antidiuretic hormone
AIDS:	Acquired immunodeficiency syndrome
CPS	Compendium of Pharmaceuticals and Specialties
CSF	Cerebrospinal fluid
CT	Computed tomography
D5W	Dextrose 5% in water
ECG/EKG	Electrocardiogram
FEV1	Forced expiratory volume – 1 second
FSH	Follicle-Stimulating Hormone
FVC	Forced vital capacity
GI	Gastrointestinal
IM	Intramuscular
IV	Intravenous
Kg	Kilogram(s)
Min	Minutes
mL	Milliliters
MRI	Magnetic resonance imaging
NS	Normal saline
NSAID	Nonsteroidal anti-inflammatory drug
po	By mouth (oral)
RBC	Red blood cell
T2D or T2DM	Type 2 diabetes mellitus
TB	Tuberculosis
VAD	Venous access device
Frequency Abbreviations	
OD	One time per day
BID	Two times per day
TID	Three times a day
TIW	Three times a week

Appendix B

Privacy Resources for Kinesiologists

Resources	
BCAK Professional Guiding Documents & Standards	https://bcak.bc.ca/resources/policies/
Guide to the Personal Information Protection Act (PIPA-BC)	https://www2.gov.bc.ca/assets/gov/business/business-management/protecting-personal-information/pipa-guide.pdf
FOIPPA Foundations Free Online Training	https://mytrainingbc.ca/FOIPPA/
Office of the Information and Privacy Commissioner for British Columbia	https://www.oipc.bc.ca/