CNA HealthPro and HPSO
Risk Control Self-assessment Checklist for Physical Therapists

Self-assessment criteria	Yes	No	Actions needed to reduce risks
Scope of practice			
I refer to my state's physical therapy practice act to ensure that I understand my legal scope of practice.			
If a job description, contract, or set of policies and procedures appears to violate my state's laws and regulations, I bring this discrepancy to the organization's attention and refuse to practice in violation of these laws and regulations.			
If necessary, I use the chain of command or the legal department regarding patient care or practice issues.			
If I am unsure about physical therapy scope of practice, I contact the state board and request an opinion or position statement.			
I refer to the profession's standards of practice and code of ethics.			
Clinical specialty and competencies			
I practice or work in an area that is consistent with my education and experience.			
My competencies (including experience, training, education and skills) are consistent with the needs of my patients.			
When I am asked to work with different patient populations (e.g., when I am providing coverage to a practice area), I ensure that my competencies and experience are appropriate for patients for whom I will be providing care or I refer the care to those more qualified.			
I receive an orientation or skills check-off whenever I am covering a different patient care area or specialty.			
I obtain continuing education and training to maintain and further my competence and professional development.			
I decline an assignment or request to treat a patient, or refer the patient to another therapist, if my competencies are not suited to the patient's needs.			
Communication with patients and families			
I consider the best means of communication (e.g., written versus spoken, words versus pictures, in person versus by telephone) when interacting with practitioners, patients and family members.			
When transferring care to another therapist, I provide handoff communication to the receiving therapist and provide an avenue for questioning (e.g., telephone, pager, etc.).			
I follow organizational protocols for obtaining translation/interpreter services, when necessary.			
I follow organizational protocols and HIPAA regulations/requirements when communicating with patients or transmitting any protected health information via e-mail or social media platform.			
I obtain the patient's written permission before sharing any protected health information with family members or significant others.			
I request that patient and family members repeat back or paraphrase important information or demonstrate specific home treatment programs to ensure comprehension.			
I recognize nonverbal cues from patients, such as grimacing, flinching, pallor or diaphoresis.			
I notify the appropriate practitioners and healthcare team members of the patient's clinical responses to therapy, including any adverse events, an increase or unexpected change in symptoms, or a lack of progress.			
I assume responsibility for obtaining ongoing feedback from the patient and document patient statements relevant to care in the patient's health information record.			

Self-assessment criteria	Yes	No	Actions needed to reduce risks
Informed consent process			
Before providing care to a patient, I initiate an informed consent process, which includes the following elements:			
- I discuss known risks and benefits, as well as alternatives to the recommended treatment plan.			
- I address anticipated consequences of declining the proposed treatment or intervention.			
- I explain the necessity of extensive touch whenever it is a component of the clinically indicated treatment and allow the patient to request a chaperone (an extra person in the room).			
- I respond to questions from patient and family until all are satisfied and have sufficient information to give or refuse consent.			
- I confirm that the patient can repeat back the information provided and agrees to or declines the recommended treatment.			
- I provide patient education materials when appropriate.			
- I document the communications and educational material provided in the patient's record.			
Specific clinical risks associated with the patient's condition, general health and interventions			
If the patient was referred by a healthcare professional, I contact the referring practitioner to answer any questions or provide clarification regarding the patient's medical or post-surgical status, the requested treatment, signs and symptoms, or findings from the examination that raise concerns (red flags). I document the discussion and its outcome.			
I cease treatment immediately if a patient has an adverse response to treatment or another adverse event/emergency situation occurs. In this situation, I also swiftly contact the referring practitioner and document the event in the patient's health information record. Any incident reports would be completed and not placed in the patient's record.			
I initiate emergency procedures, activate the emergency medical system (EMS) if indicated and arrange emergency transportation for the patient to the nearest emergency department in case of fractures, other suspected injuries or medical/psychiatric emergencies.			
I assess the level of the patient's compliance with agreed-upon goals and interventions.			
I make an effort to prevent burns by taking the following steps:			
- I assess a patient's risk for burns when making a decision about including certain treatment modalities in a patient's plan of care.			
- I examine the skin both prior to and following any treatment that may pose a risk of burns.			
- I closely supervise support personnel and students who assist in providing assigned duties related to the patient.			
I respond to a decline in the patient's condition or lack of expected improvement by taking the following actions:			
- I use objective measures to determine positive or negative changes in the patient's condition.			
- I promptly report any negative changes or findings to the referring practitioner, if there is one.			
- I continue to contact the referring practitioner until I get a response that is appropriate to the patient's change in condition or failure to improve.			
- I use the chain of command if the referring practitioner fails to respond promptly and appropriately to my findings.			
- If the patient's condition worsens or does not improve, I refer the patient back to the referring practitioner or to a practitioner with appropriate expertise.			

Self-assessment criteria	Yes	No	Actions needed to reduce risks
Delegating patient care			
Before assigning patient care services to PTAs or physical therapy aides who assist me in patient care, I ensure that the assigned services are within their scope of practice or work.			
I never assign patient care or related responsibilities to an individual whose training and competencies do not meet the patient's needs or practice act requirements.			
I always follow the organization's policies and procedures and the standards of practice of my profession regarding assignment of patient care to PTAs or physical therapy aides.			
I maintain primary responsibility for my patients because I am the Therapist of Record (refer to APTA position).			
If I assign care to PTAs or physical therapy aides, I monitor my patient's condition or a failure to respond positively to treatment.			
I monitor services provided by PTAs or physical therapy aides, supervising the treatment plan, progress and outcome.			
I ensure that PTAs or physical therapy aides document the care they provide to my patients and the patient's response to treatment as indicated, based on the state practice act.			
I remain on the premises and readily available at all times when a PTA or physical therapy aide provides services to my patient, if required by the state practice act.			
Professional conduct			
I speak to patients, families and staff in a courteous and professional manner.			
I am sensitive to and respectful of cultural differences in patients/families.			
I refrain at all times from inappropriate interactions and/or personal relationships with patients and family members.			
I explain procedures and treatments to patients; describe any touching they can anticipate during the assessment, monitoring and treatment process; and obtain their permission before proceeding.			
I offer patients the option of having a chaperone during treatment.			
I include a chaperone during treatments if the patient requires treatment in sensitive areas, has expressed embarrassment or fear, or has demonstrated unusual behaviors.			
I respect the patient's rights throughout the episode of care and am attentive to his/her wishes and feelings.			
I refrain from harsh touching, movement and language with patients at all times.			
I monitor the environment of care to maximize patient safety, being careful to			
- secure entrances and exits			
- maintain unobstructed hallways and treatment areas			
- restrict access to hazardous substances and areas not used for patient care			
- conduct preventive maintenance and periodic safety checks on all equipment, per manufacturer guidelines and organizational policy			
- test equipment prior to patient use, removing any equipment that appears to be broken, unreliable or unsafe			
- sequester any equipment that is involved in patient injury and initiate investigation/root cause analysis			

Self-assessment criteria	Yes	No	Actions needed to reduce risks
Documentation			
I consistently document according to organizational policies and procedures, professional standards, and all applicable laws and regulations with respect to			
- date, time, signature and credentials for each entry			
- patient complaints, statements and ongoing concerns relating to the treatment plan, such as progress and pain control			
- discussion regarding the informed consent process, and I include the organization's signed informed consent form in the patient care record, where applicable			
- findings of initial and ongoing patient examinations			
- results of diagnostic procedures			
- patient responses to therapy			
- conversations/communication with other healthcare practitioners			
- discussions regarding diagnosis, treatment options and expected patient care outcomes with patient, family and healthcare team members			
- patient education and discharge instructions, noting the patient's ability to return demonstration and correctly repeat instructions			
- objective clinical facts related to any patient accident, injury or adverse outcome			
In addition, I consistently meet these standards for documentation:			
- I refrain from documenting inappropriate subjective opinions, conclusions or derogatory statements about patients, colleagues or other members of the patient care team.			
- I never remove any information, documentation or element from a patient health information record.			
- I never go back and alter a written or electronic health information record that was previously completed. Corrections made at the time of the documentation comply with organization policies and procedures.			
- I ensure that any correction of documentation errors and/or late entries conforms to organizational policies and procedures.			
- I contact my manager, risk management or legal department/counsel for assistance with documentation concerns or questions related to possible liability or regulatory compliance.			
I document concurrently and only make a late entry if it is necessary for the safe continued care of the patient, ensuring that it is appropriately labeled as a late entry.			
I understand that the patient's health information record is a legal document. Therefore, I do not remove patient health information records (paper or electronic) from the patient care unit, clinic or office; make entries from home or other inappropriate locations; or access the patient's health information record without a "need to know" and proper authorization according to HIPAA regulations.			
If provided with a laptop, electronic tablet or electronic PDA, I do not allow any other individual access to this equipment and never share my passwords or access codes.			

YOUR ROLE AND RESPONSIBILITIES IN MANAGING A PROFESSIONAL LIABILITY CLAIM

- If you carry your own professional liability insurance, immediately contact your carrier if
  - you become aware of a filed or potential professional liability claim against you
  - you receive a subpoena to testify in a deposition or trial
  - you have any reason to believe that there may be a potential threat to your license to practice physical therapy
- If you carry your own professional liability insurance, report possible claims-related actions to your insurance carrier, even if your employer advises you that the organization will provide you with an attorney and/or will cover you for a professional liability settlement or verdict amount.
- Refrain from discussing the matter with anyone other than your defense attorney or the claim professionals managing your claim.
- Promptly return calls from your defense attorney and the claim professionals assigned by your insurance carrier. Contact your attorney or claim professional before responding to calls, e-mails or requests for documents from any other party.
- When reporting a possible claim, provide your insurance carrier with as much information as you can, being sure to include contact information for the risk manager at your organization and the attorney assigned to the case by your employer.
- Never testify in a deposition without first consulting your insurance carrier or, if you do not carry individual professional liability insurance, your organization's risk manager or legal counsel.
- Copy and retain the summons and complaint, subpoena and attorney letter(s) for your records.
- Maintain signed and dated copies of all employment contracts.

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