# SCPT Practice Guideline #5
# Records

## Background

After the initial assessment and at regular intervals until discharge, records are kept to ensure the systematic recording of accurate, objective and relevant information about a client so that physical therapy intervention is accurately documented.

The SCPT Code of Ethics provides:

> 9. Physical therapists shall document the client's history and relevant subjective information, the physical therapist's objective findings, clinical diagnosis, treatment plan and procedures, explanation to the client, progress notes and discharge summary.

## Practice Guideline

Creating Records

1. The physical therapist:

    (1) Creates a clinical record for each client that contains the following components:

    a) client demographic information, including name, address, gender, date of birth, and a copy of the written referral if one was obtained;

    b) documentation of informed consent;

    c) client assessment and treatment information;

    d) information regarding the physical therapy assessment of the client, including medical history, history of present complaint, subjective findings, objective findings, diagnostic reports, physical diagnosis or healthcare objective, precautions and/or contraindications;

    e) proposed treatment plan;

    f) actual treatment plan for the client, including the specific treatment protocol;

    g) progress notes, indicating both subjective and objective measures of the client's response to treatment;

    h) documentation of relevant verbal communication regarding the client's care; and

i) medical information obtained from external sources, such as copies of written and web-based information and reports sent or received respecting the client that have been initially created by other health care professionals (eg. physical reports, laboratory results, WCB notes, etc).

(2) Ensures every part of the clinical record has a reference identifying the client;

(3) Ensures the treatment record entries are dated, signed (or initialled if the therapist's full signature appears at least once in the treatment record) and in chronological order;

(4) Keeps a daily record of appointments or workload, or both, containing the name of each client and the date of the client's visit;

(5) Ensures any record keeping assigned to personnel working under their direction or supervision complies with SCPT bylaws and practice guidelines; and

(6) In multidisciplinary team settings, ensures the physical therapy entries are identifiable in the multidisciplinary treatment record.

Computer Records

2. Where records are maintained in a computer system, the computer system should be able to:

a) display the recorded information visually;

b) enter each client record via the client's name and date of birth, or a unique identifier;

c) print a separate record for each client;

d) visually display and print the recorded information for each client in chronological order;

e) provide reasonable protection against unauthorized access;

f) provide automatic back-up and recovery of files, or otherwise protect against loss of, damage to, and inaccessibility of information;

g) maintain an audit trail, which records the date and time of each entry and subsequent change, preserves the original content when changes are made, and identifies the person making the entry and rendering the service;

h) maintain an electronic image; and

i) create a "read only" file for client records so that patient records cannot be modified

by others

Financial Records

3. Where applicable, the physical therapist keeps a financial record for each client containing:

a) the service and product provided;

b) the cost of each service and product;

c) the date each service and product was provided;

d) the date of receipt of payment; and

e) any outstanding balance.

Interpersonal Requirements

4. The physical therapist informs the client of any fee associated with the release of a record or report at the time the request for its release is made.

Retention Requirements

5. The physical therapist retains all records in a legible form for at least 6 years after the date of the last entry in the record.