

1.1 PURPOSE

The purpose of this policy is to set standards for keeping clinical records by registered physiotherapists. It is a legal requirement to keep clinical records.

1.2 SCOPE

This policy applies to any person registered to practise physiotherapy in NSW.

1.3 EXPECTED OUTCOMES

This policy is to provide protection of the public in NSW, by specifying the minimum standards for documentation in the physiotherapy clinical record.

1.4 REFERENCES AND RELATED POLICIES

- NSW Physiotherapists Registration Board: Policy on Professional Conduct.
- Department of Health Policy Directive PD2005-127 *Principles for Creation, Management, Storage and Disposal of Health Care Records*.
- Australian Standards for Physiotherapy. Available at www.physiocouncil.com.au

2. POLICY

2.1 An initial assessment and treatment should be recorded in the patient's clinical record.

2.2 Progress notes are to be recorded for each attendance, being completed as soon as practicable after the treatment session and should include:

- Documentation of warnings and results of relevant pre-treatment safety tests (e.g. skin tests, Vertebral Artery)
- Documentation of patient consent to treatment
- Effects of treatment provided

Entries must be legible. They should be dated, and if appropriate the time of consultation included. They must be signed by the treating physiotherapist with the physiotherapist's name clearly printed. If manipulation or another procedure involving significant risk is undertaken, including acupuncture and dry needling, additional documentation must be recorded. This documentation includes: explanation regarding risks; evidence of opportunity given for patient's questions; warnings; explicit consent.

2.3 The physiotherapist should include a dated, written record of all relevant communication that occurs during the course of the treatment including verbal or written communication with health professionals involved in the patient care as well as any communication with the patient.

2.4 All abbreviations, terminology and symbols recorded in the clinical record should be recognisable by physiotherapy peers.

2.5 All errors are to be corrected appropriately i.e. line through and initialled. Liquid paper should not be used for correcting errors.

2.6 As a general guide, records should contain sufficient information to allow a physiotherapist of similar skill to continue the treatment of that patient if required.

2.7 When the progress notes are a separate document from any medical records, as in an outpatient setting or private practice, it is advisable that a discharge summary be included at the end of the final treatment session.

2.8 Where the clinical record is made electronically the same content and standard for the documentation applies. The identity of the physiotherapist making the record must be clear.

2.8 Records are to be stored in a secure manner and for the statutory period. (refer to PD2005_127)