

CHART AUDIT CHECKLIST

NAME: _____

CRITERIA	Charts				
	1	2	3	4	5
<i>Indicate whether each criterion has been achieved by Yes or No</i>					
1. Chart contains client details including: name, address, gender, age, name of GP and contact information. Client name and identifier should be on every page.					
2. All chart entries are in chronological order, legible , permanent, dated, and signed with professional designation. Physiotherapy notes are clearly identifiable in multi-disciplinary charts.					
3. Corrections or alterations shall be struck through with one line and initialed.					
4. Relevant medical history has been acknowledged and is noted in chart.					
5. Documentation of your client's reported of problems, symptoms and interaction with other health care professionals are included.					
6. Evaluation includes evidence of assessment tools and techniques used, screening and safety tests, as well as the findings.					
7. Client problems are identified, analyzed and a physiotherapy diagnosis is charted and reviewed with client.					
8. Goals, long and short term, are client-centered, discussed with client and documented.					
9. Treatment plan notes include specific treatment provided, including: <ul style="list-style-type: none"> • Modality or technique used, along with , frequency, intensity, time and site • Home program charted with frequency, intensity time and use of aids • Client /care giver education with regard to care, exercise prescription and responsibilities documented. 					
10. Informed consent, as per NSCP Practice Standard , for initial assessment, treatment and changes to treatments PC/VC <ul style="list-style-type: none"> • Written permission to communicate with a third party or individual outside the "circle of care "(Reference the <i>Personal Health Information Act</i>). 					
11. Note of actual treatment provided and the results, including any adverse results.					
12. Evidence of timely ongoing review of client, analysis of findings, and modifications to treatment as indicated.					
13. Outcome measures used are charted.					
14. Recommendations regarding ongoing care, transfer to other discipline, transfer to a physiotherapist with different expertise or discontinuation of treatment as appropriate, are discussed and documented.					
15. Student or ancillary personnel present or involved in any treatment recorded and notes co-signed. If yes, was consent obtained					
16. Copies of any written communication that is received, sent with, about, or from your client are attached to client notes/chart. Client Records are kept for 7 years.(See guideline) Discharge Summary is present where appropriate.					

GUIDELINES – CHART AUDIT

To achieve 'YES' all components must be correct. Yes No or NA

1. Current clinical record to contain:
 - name of client and identifier at top of each sheet
 - address, age gender each patient
 - name client's physician
 - copy of referral if applicable.
2. PT notes should be chronological, clearly identified in the chart with PT designation (as opposed to BScPT , DipPT, and PTA), and in writing that is easily read and legible.
3. Correction fluid can only be used in the guidelines, not clinical record.
4. Relevant client history noted. (or acknowledge that you reviewed chart and had no other comments).
5. Subjective - Assess client's perception of functional status and quality of life;
Communicate with client and/or other health team members as necessary.
6. Assessment- Appropriate PT evaluation and documentation- Evaluation includes evidence of the assessment tools and/or techniques used.
7. Client problems identified, analyzed and a diagnosis is established (where appropriate).
8. Client-Centered Goals – must show that client / therapist discussion has taken place;
 - long and short term goals and anticipated duration of treatment noted..
9. Treatment plan includes description of treatment to be provided including frequency and duration, any modality parameters, manual techniques, client/caregiver education, etc.
 - Home program documented including: time, walk aids, exercise equipment, intensity etc.
 - Dosages – exercise prescription
 - Time and method of heat / ice applications etc.
 - Client or caregiver's input and documentation of plan explained to client/caregiver.
10. Informed consent must be obtained and documented; (Parent consent if child involved)
 - PCVC suffices (i.e. precautions, contra-indications, verbal consent).but should be initialled
11. Documents details of actual treatment, anticipated duration of treatment, and any adverse results.
12. Evidence of ongoing, timely reviews with analysis of findings and treatment modifications.
13. Outcome measures used are documented in chart.
14. Recommendations regarding ongoing care, transfer to other disciplines or physiotherapists, discontinuation of treatment etc., are discussed and documented.
15. Are auxiliary personnel used? Are they identified and has permission for their intervention been received and documented?
16. Charts / Files Storage
 - All communications and documents received as well as D/C summary should be present
 - Clinics must maintain patient records for 7 years after date of last entry, or 7 years past the 18th birthday in the case of minors.
 - Hospitals are required to meet the same criteria.
 - Meditech/computer files will be stored following the same criteria.