Nova Scotia College of Physiotherapists

Chart Audit Checklist

Your Name: ______________________________

CRITERIA *Indicate whether each criterion has been achieved by* ***Y****es or* ***N****o or* ***NA*** *not applicable*

Select 5 patient charts at random and complete this Audit Checklist on each.	**Charts**				
	1	**2**	**3**	**4**	**5**
1. Chart contains: patient name on each page, address, gender, age, contact info,GP name:					
2. All chart entries are in chronological order, legible, permanent, dated, and signed with professional designation:					
Physiotherapist's notes are clearly identifiable if in multi-disciplinary chart:.					
3. Corrections or alterations are struck through with one line and initialed:					
4 Your evaluation and the patient's of problems, symptoms and goals of treatment are noted:					
5. Relevant medical history has been noted in chart:					
6. Evaluation includes evidence of the assessment tools used and screening/safety tests:					
7. Patient problem identified, analysis and physiotherapy diagnosis charted and reviewed:.					
8. Goals are patient centered and noted. Discussion with patient regarding goals is noted:					
9. Treatment plan notes include description of treatment to be provided:					
and duration / frequency, modality parameters, manual techniques, education provided:					
and home program charted with time, walk aids, exercise etc and:					
modalities, dosages, exercise prescriptions, time and method of heat/ice applications etc:					
Evidence that patient's/caregiver's responsibilities are documented and explained to them:					
10. Informed consent, is noted as per NSCP guidelines:					
prior to assessment / first treatment:					
with each change in Rx PC/VC:					
written permission to communicate with MD, a third party or another health professional:					
11. The chart notes the treatment you provided and the results including any adverse results:					
12. The chart notes timely review of the patient's condition:					
including: modifications and updates:					
and discontinuation of treatment as appropriate:					
13.The chart notes recommendations regarding ongoing care:					
or transfer to other discipline or physiotherapist with different expertise:					
14. Outcome measures used are documented on the chart :					
15. Student or ancillary personnel present or involved in treatment are recorded on chart: Y /N/ NA					
16. If yes, consent obtained and noted:					
17.Copies of any written communication received or sent with, about or from your patient are					
kept with or attached to patient notes/chart					
Patient Records are kept for the legal time frames (see Guideline 17 below:					

GUIDELINES – CHART AUDIT

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

1. Current clinical record to contain:
   - name of patient on each sheet
   - address, age gender each patient
   - name of patient's physician
   - copy of referral if applicable.
2. PT notes should be clearly identified (as opposed to MT, OT, and PTA)
3. Correction fluid can only be used in the guidelines, not clinical record.
4. Assessment
   - Appropriate PT evaluation and document.
   - Communication with patient and/or other health team members as necessary.
   - Assess patient's perception of functional status and quality of life.
5. Relevant patient history noted.
6. Evaluation includes evidence of the assessment tools and/or techniques used.
7. Patient problems identified, analyzed and a diagnosis is established (where appropriate). There is evidence of ongoing review and analysis of findings and treatment modifications.
8. Patient-Centred Goals – must show that patient / therapist discussion has taken place.
   - long and short term goals
   - anticipated duration of treatment should be noted.
9. Treatment plan includes description of treatment to be provided including frequency and duration, modality parameters, manual techniques, patient/caregiver education, etc.
   - Home program including: e.g. time, walk aids, exercise equipment
   - Dosages – exercise prescription
     - time and method of heat / ice applications etc.s
   - Patient's or caregiver's input
     - documentation of plan explained to patient /caregiver.
10. Informed consent
    - prior to assessment / first treatment
    - with each change in treatment
    - PCVC suffices (i.e. precautions, contra-indications, verbal consent)
11. Includes details of ongoing treatment.
12. There is evidence of ongoing review and analysis of findings and the related treatment modifications
13. To 16. As described in Chart Audit Checklist
17. Charts / Files Storage
    - 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.