

Physical therapy records management: record keeping, storage, retrieval and disposal

Guideline

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WCPT guidelines are produced to assist member organisations and others to raise the quality of physical therapy. They may provide guidance on standards criteria or courses of action in areas relevant to physical therapy education research practice or policy. They are not mandatory but designed to assist the implementation of WCPT's policies.

Physical therapy records management: record keeping, storage, retrieval and disposal

1 Context

1.1 Introduction

WCPT intends that this international guideline for physical therapist record keeping, storage, retrieval and disposal is used worldwide within the framework set out by national and local legislation. It may be used for curriculum planning, and in internal and external service quality assurance processes. It has been prepared to support the implementation of WCPT's policy statement on records management: record keeping, storage, retrieval and disposal.¹

While the guideline has been developed with input from and specific reference to the Member Organisations of WCPT, the intent is that it may also be used by countries where physical therapy associations do not currently exist and where the profession is not represented in WCPT. It is designed to be relevant to all physical therapists.

In some areas of practice, and in some countries, the use of multi-professional records is more prevalent. In these circumstances WCPT still expects this guideline to be implemented to ensure the quality of the physical therapy contribution and to lead by example. Whether physical therapists practise alone, as part of clinical practices or large institutions, there should be a record keeping, storage, retrieval and disposal policy in place.

A physical therapy record consists of all information related to the provision of physical therapy services and is a legal requirement. Failure to maintain accurate physical therapy records is deemed to be negligence.

With physical therapists working in public health, health promotion and consultancy roles records should encompass assessments, such as environmental and occupational health, which may not be specific to individuals but situations; the outcomes of these and the resulting advice and actions require documentation.

Ownership of the record is not always clearly set out in legislation. As a general principle the information and data contained in the record is owned by the individual that it relates to and others are permitted to use it for the legitimate purposes of service provision and patient/client care.

1.2 Standards

WCPT's policy statement and guidelines for standards for physical therapy practice set out expectations regarding documentation (Box 1).²⁻³

Box 1 Standards for documentation

WCPT guideline for standards of physical therapy practice (page 10) ²

2.5 Documentation

- 2.5.1 The physical therapist clearly documents all aspects of the patient/client management including the results of the initial examination/assessment and evaluation, diagnosis, prognosis/plan of care, intervention/treatment, response to interventions/treatment, changes in patient/client status relative to the interventions/treatment, re-examination and discharge/discontinuation of intervention, and other patient/client management activities.
- 2.5.2 Physical therapists ensure that the content of documentation:
- is accurate, complete, legible and finalised in a timely manner
 - is dated and appropriately authenticated by the physical therapist
 - records equipment loaned and/or issued to the patient/client
 - includes, when a patient/client is discharged prior to achievement of goals and outcomes, the status of the patient/client and the rationale for discontinuation
 - includes reference to appropriate outcome measures, where possible
- 2.5.3 Physical therapists make sure that documentation is used properly by ensuring it is:
- stored securely at all times in accordance with legal requirements for privacy and confidentiality of personal health information
 - only released, when appropriate, with the patient's/client's permission
 - consistent with reporting requirements
 - consistent with international and national data standards where possible

2 General record keeping guidance

This section covers general requirements.

2.1 General content

- 2.1.1 A record is required for every visit/encounter.
- 2.1.2 All records must comply with national legislation and local policies and shall be kept in accordance with professional standards of record keeping. Special consideration may be required for additional and specific legislation covering defined populations, such as children, prisoners or those with mental impairments*
- 2.1.3 Electronic records and paper records must both contain the same information.
- 2.1.4 The record includes all information related to the management of individuals, including, but not limited to: written documents, computer files, audio tape, e-mails, faxes, video tapes, photographs and other electronic media.

* Throughout the document where legislation and guidelines are referred to this should take account of international, national, state, territorial and local legal requirements and guidelines.

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- 2.1.5 Each page/file of a record shall include a unique identifier that clearly links the record to the named individual.
 - 2.1.6 Records must identify who provided the advice/care/intervention/treatment, along with who made the actual record. A register of signatures should be held in the work place.
 - 2.1.7 Whether electronic or paper records are used, it must be possible to identify who has made any entries or changes, and what those changes are. Any changes made must be clearly dated and initialled. No information previously recorded should be removed from the record.
 - 2.1.8 Any physical therapy support personnel providing advice/care/intervention/treatment under the supervision of the physical therapist should make appropriate entries in the same clinical record. Those physical therapy support personnel permitted to make entries in records will be determined by relevant national authorities. The supervising physical therapist is responsible for ensuring that the support personnel have the appropriate level of knowledge and skills. There should be an indication that the supervising physical therapist has read the record of any intervention carried out on their behalf or under their instruction in accordance with local/national guidelines.⁴
 - 2.1.9 Use of abbreviations shall be limited to those commonly in use by the profession and/or institution and set out in local policies. The language used should be easily understood by all.
 - 2.1.10 Records shall be made in a timely manner as soon as possible after each patient/client visit/encounter or service provision and not exceeding 24 hours.
 - 2.1.11 Whenever possible the physical therapy record and any supplementary files (eg equipment loan form) shall be part of the same record or at least shall be filed together with the other documentation as one clinical record.
 - 2.1.12 Full details shall be included of any equipment loaned and/or issued to the patient/client and any maintenance requirements. Sufficient information needs to be collected (eg supplier and batch number details) for recall and audit purposes.
 - 2.1.13 In a setting in which a patient/client is being managed by two or more health professionals, separate physical therapy records or multi-professional records may be used. Whichever format is used these guidelines are relevant, as are the expectations set out in any professional standards and rules of professional conduct.
 - 2.1.14 No details of complaints, investigations, and/or medico-legal correspondence shall be contained within the patient/client record other than a reference to the fact that a complaint or claim has occurred. Such records must be kept in a separate confidential, secure file.
 - 2.1.15 Patients/clients shall have the right to access their health information from records, as required by national legislation, and should be made aware of this right.
 - 2.1.16 Parents or guardians of children should be made aware of their rights to access records.
 - 2.1.17 Full record shall be kept of any fees paid/insurance claims made on behalf of the patient/client.
 - 2.1.18 Effective and efficient communication procedures should be in place between all parties sharing patient/client records.
 - 2.1.19 Any paper with patient/client record details, whether hand written or printed, should not be recycled but disposed of in accordance with local guidelines.
 - 2.1.20 Patients/clients may move across international boundaries requiring that a copy of their records is transferred with them. Special consideration will need to be given to translation and interpretation issues and close cooperation is important between the healthcare providers involved. In addition, safeguards for the protection of the data need to be sufficiently robust.

2.2 Handwritten records

- 2.2.1 All handwritten records must be legible, accurate, and appropriate.
- 2.2.2 All handwritten entries must be made in permanent ink and include original signatures, printed names and date. It may also be appropriate to record the time. A log of all physical therapists' signatures and initials should be maintained for audit and cross reference purposes.
- 2.2.3 All errors must be crossed through with a single line; correction fluid must not be used. They should be initialised by the physical therapist that made the error and amendment.
- 2.2.4 Systems should be in place for secure user access, restricted by user authentication, which complies with national legislation.

2.3 Electronic records

- 2.3.1 Electronic entries shall be made with appropriate security and confidentiality provisions, such as full encryption (ie no personal identifiable information should be stored on a personal computer or laptop hard drive unless it is encrypted).
- 2.3.2 The software used for electronic records should provide for an audit trail which can identify who made the entry or change and what those changes were, whilst safeguarding the original content.
- 2.3.3 System backups for electronic records should be done preferably offsite (eg to avoid risk of on-site fire damage) or in secure environments to avoid loss of data. The frequency of backups should be determined by local guidelines and regularly checked for complete restore of data.
- 2.3.4 Mechanisms should be in place for secure user access, restricted by user authentication and passwords.
- 2.3.5 Security procedures should ensure that any patient/client identifiable data being transferred to other agencies should be encrypted and secure.
- 2.3.6 The technological systems in use should ensure that the data can be retrieved for the length of the retention period, set out in legislation and guidelines, and can accommodate technological advances.
- 2.3.7 Procedures for disposal of records should ensure complete removal from all systems/hardware. All hard or removable drives which have been used to store electronic patient/client data should be cleaned or destroyed to ensure that no data trail remains on the drive.
- 2.3.8 Technological advances need to ensure that older electronic records are still accessible for the required period of time. This is particularly important for the length of time that paediatric records are required to be kept.

3 Storage guidance

- 3.1 Physical therapists should ensure that procedures are in place for the safe storage and retrieval of all records both written and electronic. These procedures should protect the information from loss, theft, unauthorised access or disclosure and tampering.
- 3.2 Physical therapists, wherever they practice (eg lone workers, departments, clinics, practices), are responsible for implementing the safe storage and retrieval procedures where there is no central records management procedure such as in a hospital/institution/primary health care setting.
- 3.3 Security and ease of access need to be considered, but only authorised personnel should have access to records.

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- 3.4 Records (including advanced directives/living wills) pertaining to the patient/client shall be kept in chronological order and shall be kept for the minimum time required for storage of records in accordance with national legislation and/or local guidelines.
 - 3.5 Where patient/client held records are part of a record storage practice (eg in community health services) duplication of records is appropriate to ensure the physical therapist has a copy to refer to whilst with patients/clients.
 - 3.6 Procedures should comply with local/national requirements for periods of storage and destruction processes.

4 Retrieval guidance

- 4.1 Data held in patient/client records may be used for clinical audit purposes during or following an episode of care. Reports of audit results should always ensure that individual patients/clients can not be identified.
- 4.2 Patient/client records may be retrieved for new care episodes and management purposes, such as reviews of waiting times and the quality of recorded information. Procedures for retrieval and review should comply with national legislation and local guidelines.
- 4.3 Where patient/client data are retrieved for entry into national registers (eg diabetes or cancer register, transplant database, reporting of critical incidents such as adverse responses to interventions) it is used for management and public health perspectives and should comply with national legislation and local guidelines.
- 4.4 Patient/client records may be retrieved for education purposes and used with physical therapists, students, support personnel and other health professionals, with the appropriate consent. Patient/client confidentiality should be ensured and the data used in line with national legislation and local guidelines.
- 4.5 Procedures for retrieving data for research purposes must comply with national legislation and local guidelines. There may be specific documents pertaining to the use of data for research purposes which should also adhere to national and local requirements (eg ethical approval for the use of patient/client data).⁵ Research often involves international collaboration. Special consideration should be given to international agreements, procedures and legal requirements ensuring adequate protection of personal data.

5 Disposal guidance

- 5.1 Destruction of records shall be made in accordance with national legislation and the policies and/or guidelines of the practice or institution. Such policies should make provisions for the period of time that records should be held, who is responsible for records disposal and the procedures for disposal.

6 Confidentiality and data protection guidance

- 6.1 Confidentiality is essential whether records are handwritten or electronic.
- 6.2 Any personal information given and collected for one purpose may not be used for a different purpose or passed on to any other person without the consent of the person providing the information.
- 6.3 A policy and clear procedures should be in place in line with national/local legislation and local guidelines to manage requests for access to records.
- 6.4 Contents of records should only be available to those directly involved in patient/client care and in line with the advice on retrieval given in section 4. Other than this, disclosure is only undertaken with written consent from the patient. Exceptions to this are where the contents are subpoenaed or at the request of a Judge, or where legislation overrides patient confidentiality.

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- 6.5 All identifiable information about a patient's/client's health status, diagnosis, prognosis and treatment and all other personal information must be kept confidential.
- 6.6 Confidential information can only be disclosed if the patient/client gives their explicit consent or if it is expressly provided for in law. Information can be disclosed to other professionals for legitimate purposes if they are involved in the management of the patient/client.

7 Content guidance

7.1 As a minimum the physical therapy record shall include the following components of the patient/client physical therapy management:

7.1.1 Personal data:

- basic data should be recorded and in line with any requirements for common data recording set out in local/national legislation or guidelines (eg full name, date of birth, address, contact numbers, unique ID number, general/family practitioner)

7.1.2 Consent:

- The clinical record should indicate that informed consent was obtained for both examination/assessment and treatment/interventions.
- It should be clear whether the consent is expressed (written or verbal), implied or provided by a proxy (eg parent or guardian of a child, next of kin of an individual with limited mental capacity). If consent is implied it should be clear what information has been used to infer consent.
- Signed consent forms should be held with the patient/client record.
- Any agreement in respect of the financial implications of the episode of care should be recorded.

7.1.3 Examination:

7.1.3.1 Personal Factors:

- demographics (eg sex, age, race/ethnicity, body mass index, occupation, leisure, primary language, education level, health literacy and habits)
- growth and development (eg developmental history, hand dominance)
- family history (eg risks associated with family health)

7.1.3.2 Environmental Factors:

- technical assistance devices and equipment, home modifications, nature of and access to physical environments, access to information, personal assets
- social situation (eg family and caregiver support, wider community support systems, cultural beliefs behaviours and attitudes)
- living environment (eg community characteristics, availability of relevant services, systems and policies)

7.1.3.3 Health Condition:

- general health status - self-report, family report, caregiver report (eg general health perception, physical function, psychological function, role function, social function)
- medical/surgical history (cardiovascular, endocrine/metabolic, gastrointestinal, gynaecological, integumentary, musculoskeletal, neuromuscular, obstetrical, psychological, pulmonary, prior hospitalizations, prior surgeries, pre-existing medical and other health related conditions, allergies, as appropriate to the episode of care)

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- medications (for the current condition, previously taken for current condition and for other conditions) with effects and side effects
 - other clinical tests (eg laboratory and diagnostic tests, review available records, review other clinical findings)
 - principle medical diagnosis, if provided, including date of onset and associated medical conditions

7.1.3.4 Body Function / Structure:

- current impairments/chief complaints (eg concerns leading to seek physical therapist services, current therapeutic interventions, mechanisms of injury or disease, onset and pattern of symptoms, expectations and goals for the therapeutic interventions, emotional response to current clinical situation, previous occurrence of chief complaints, prior therapeutic interventions)
- screenings of the body systems: cardiovascular/pulmonary, musculoskeletal, neuromuscular, sensory, and integumentary systems, and where necessary genito-urinary and reproductive systems and any relevant referrals
- communication ability, affect, cognition, language, and learning style
- record of all tests and outcome measures performed and results thereof and where available standardised outcome measures should be used

7.1.3.5 Activities & Participation:

- abilities (including intellectual abilities, managing daily routine, movements (such as changing body position, walking, using transportation, effective communication, self-care and independent living))
- functional status and activity level (eg current and prior functional status in self-care, work activities and home management including activities of daily living and instrumental activities of daily living)
- involvement in purposeful daily activities, such as home duties, education, employment, community, social and leisure pursuits, as selected as relevant by the person
- contextual evaluation (performance of functions within the person's usual environment)

7.1.4 Evaluation:

- evidence of clinical judgments made regarding the patient/client (according to the international classification of functioning)

7.1.5 Diagnosis:

- formulate a physiotherapeutic diagnosis that results in the identification of existing or potential impairments, activity limitations, participation restrictions, and environmental factors, as well as the patient's/client's resources to cope with the diagnosis

7.1.6 Prognosis:

- determine patient/client expected outcomes and identify the most appropriate intervention strategies for patient/client care/management
- identify the patient/client goals that will resolve potential impairments, activity limitations, participation restrictions and environmental factors

7.1.7 Plan of care:

- interventions/treatment to be utilised to reach goals and expected outcomes and determined in consultation with the patient/client or others (eg family, caregiver, teacher, other health professional) and delivered within available resource
- length of time anticipated to reach goals and expected outcomes
- collaboration with patients/clients, family members, payers (eg social system, insurance companies, patient/client self-pay), other professionals, and other individuals

7.1.8 Interventions/treatment:

- coordination, communication, and documentation provided for patient/client
- patient/client-related instruction
- procedural interventions provided to patient/client may include but are not limited to:
 - lifestyle and well being advice
 - therapeutic exercise
 - functional training in self-care and home management
 - functional training in work, community, and leisure activities
 - manual therapy techniques
 - prescription, application, and as appropriate, fabrication of devices and equipment
 - airway clearance techniques
 - integumentary repair and protection techniques
 - electrotherapeutic modalities
 - physical agents and mechanical modalities

7.1.9 Re-examinations performed and results thereof.

7.1.10 Outcomes and recording of achievement of goals and expected outcomes, including patient expectations

7.1.11 Recording of any adverse reactions related to the treatment given and any action taken by the physical therapist

7.1.12 Information on referral received (if any) and referrals made to other sources/personnel.

7.1.13 Recording of delegated/assigned activities/interactions/interventions to support personnel

7.1.14 Home programme, education and equipment provided

7.1.15 Date of any cancelled or missed appointments and reasons where relevant

7.1.16 Discharge plan

7.1.17 Date of discharge or discontinuation from physical therapy and discharge or discontinuation summary

7.2 Sufficient detail should be included in the record of the patient/client management to enable another physical therapist to understand what interventions/treatments have been provided, the outcomes achieved and to continue the episode of care. This includes advice or information provided by telephone or electronically (eg via e-mail), as well as in person.

8 Template for record keeping, storage, retrieval and disposal policy

8.1 When developing the record keeping, storage, retrieval and disposal policy, in addition to the above, it may help to consider the following headings for a document template:

- policy context – national, local and professional policies, legal instruments and standards
- record types
- record formats
- storage procedures
- recording requirements/standards
- retention requirements
- confidentiality and data protection
- access procedures
- disposal requirements

Glossary (www.world.physio/resources/glossary)

Clinical Record

Documentation

Informed consent

Physical therapy record

Record

Acknowledgements

WCPT used the following resource in preparing these guidelines and gratefully acknowledges its valuable contribution:

European Region of the World Confederation for Physical Therapy. European Core Standards of Physiotherapy Practice. Brussels, Belgium; 2008. www.physio-europe.org/download.php?document=71&downloadarea=6 [Accessed 4 November 2008]

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Related WCPT Policies:	<p>WCPT policy statements:</p> <ul style="list-style-type: none"> • Quality services • Standards of physical therapy practice • Relationship with other health professionals • Support personnel for physical therapy practice • Description of physical therapy • Records management: record keeping, storage, retrieval and disposal <p>WCPT Guidelines:</p> <ul style="list-style-type: none"> • Standards of physical therapy practice

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Appendix 1: Useful resources

A-Z of physical therapy abbreviations on-line resources:

- physicaltherapy.about.com/od/abbreviationsandterms/a/PTabletabbreviations.htm
- Dreeben, O. (2007) Physical Therapy Clinical Handbook for PTAs. Jones & Bartlett Publishers. Section 2-4 [Abbreviations and Symbols used the most in physical therapy](#)

[ARMA International www.arma.org/](http://www.arma.org/)

ARMA International is a not-for-profit professional association and the authority on managing records and information – paper and electronic. It covers many settings, including the public sector and healthcare.

[International Organization for Standardization www.iso.org/iso/home.htm](http://www.iso.org/iso/home.htm)

ISO 15489-1: 2001 Information and Documentation – Records Management – Part 1: General

This standard provides guidance on creating records policies, procedures, systems and processes to support the management of records in all formats.

ISO/TR 15489-2: 2001 Information and Documentation – Records Management – Part 2

This technical report provides information on records management policies and responsibilities and processes, controls and training for records management. This technical report, ISO/TR 15489-2, is supplementary to the standard ISO 15489-1 providing further explanation and one methodology for implementation of the standard. Both ISO 15489-1 and this technical report apply to records in any format or media, created or received by any public or private organisation during the course of its activities.

Connelly, JC. [The new international records management standard: Its content and how it can be used.](#) Information Management Journal, Jul 2001

Stephens, DO. [The world's first international records management standard.](#) Information Management Journal, Jul 2001

[International Records Management Trust www.irmt.org/](http://www.irmt.org/)

The International Records Management Trust was established in 1989 to develop new strategies for managing public sector records. It helps governments and organisations move to the electronic environment by building trustworthy records systems as a foundation for data integrity, service improvements and management information systems.

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