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Medical Record Documentation: The Quality of Physiotherapy Entries

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Abstract

This study evaluated the standard of in-patient medical record documentation by physiotherapists at the Royal Adelaide Hospital (RAH), Adelaide, South Australia, during 2003. The impact of patient characteristics (ie primary diagnosis and length of stay in hospital) and physiotherapist features (e.g. employment classification level and years of employment at the RAH) on the standard of documentation was also explored. One hundred medical records were randomly selected for review and 224 physiotherapy entries were audited. The audit tool was based on the RAH Physiotherapy Department Guidelines for Documentation, which was comprised of five sections. Each section contained several items, which were scored as complete, incomplete, absent or not applicable. The total number of completed scores was calculated for each section of the audit form. A standard of 100 per cent completed was expected for the two sections containing those requirements considered mandatory according to the RAH Physiotherapy Department Guidelines, whereas a lower completion rate was considered acceptable for the remaining sections. The standard of documentation varied considerably, with only five items (4.3%) achieving a rate of 100 per cent completion, namely 'date', 'heading physiotherapy', 'signature', 'page includes patient details' and 'after the first attendance'. In total, 94 items (81.7%) were at least 50 per cent completed, which was considered a reasonable overall standard. The patient diagnosis was the only patient or physiotherapist characteristic that significantly affected the standard of documentation ($p = 0.03$). While the overall standard of documentation was deemed acceptable, it was clear there was room for improvement.

Introduction

Medical record documentation is an important legal and professional requirement for all health professionals.¹⁻⁴ Appropriate documentation facilitates the communication of patient information to all members of the health care team, which is vital to ensure holistic patient care.⁵⁻¹¹ In addition, medical records can be used for research and quality activities, and for medico-legal purposes¹¹⁻¹⁴ Despite the importance of medical record documentation, there has been little published research evaluating the overall standard of medical record documentation by allied health

professionals, including physiotherapists.^{7,9} In particular, to date, there appears to be no published evidence concerning the quality of medical record documentation by Australian physiotherapists.

The aim of this study was to evaluate the standard of medical record documentation and identify areas for improvement in a sample of Australian physiotherapists. In addition, this study sought to determine whether patient or physiotherapist characteristics had any impact on the standard of documentation.

Method

The Royal Adelaide Hospital (RAH), Adelaide, South Australia, is a major tertiary level hospital (approximately 760 beds, including acute and rehabilitation beds) within the Central Northern Adelaide Health Service in South Australia. While the Physiotherapy Department provides in-patient, out-patient and community services, the majority of physiotherapy interventions are provided to in-patients. The Physiotherapy Department has separate written guidelines for documentation for in-patients and out-patients. In the absence of any national Australian guidelines for physiotherapy documentation, these guidelines were developed by a number of senior physiotherapists at the RAH over the past 15 years. While the RAH Physiotherapy Department has specific written guidelines for documentation, there are no standardised forms (eg that provide a check list of prompts regarding assessment) used within medical records to assist with documentation. Prior to this study, no large scale audit had been formally undertaken to determine the overall standard of physiotherapy in-patient documentation, nor how well these guidelines were being adhered to.

A retrospective audit of in-patient's medical records was undertaken. All in-patients who received physiotherapy during the calendar year of 2003 were identified by retrieving their medical record numbers. Each in-patient medical record was allocated a sequential number and, from a random numbers table generated using the statistical software package SPSS Graduate Pack 2001 (11.0 for Windows), 100 medical records were randomly selected. Any medical record that was unavailable for auditing was withdrawn from the study and replaced with another randomly selected medical record. To date, there is not a requirement within the RAH Physiotherapy Department that an entry be made in the medical record for each and every physiotherapy visit. Instead, while an initial and discharge / transfer entry is considered mandatory, other entries are made whenever the patient's condition or physiotherapy treatment changes, or at least weekly for long term patients. As each medical record could therefore contain more than one physiotherapy entry, depending on the number of times and length of time they were treated by a physiotherapist, the first, penultimate and ultimate medical record entries were audited to ensure a standardised procedure.

The audit tool used in this study was adapted from the RAH Physiotherapy Department Guidelines for Documentation. The audit tool had five sections: 'basic' requirements, 'mandatory' requirements, 'minimal' requirements, 'other items as appropriate' and 'ongoing or discharge entry' requirements. The minimal requirements were only assessed once per medical record as they were an overall assessment of the entire standard of documentation within each medical record. The remaining

four sections were assessed for the initial, penultimate and ultimate physiotherapy entries within each medical record.

The 'basic' and 'mandatory' requirements of the audit tool comprised items that were considered compulsory for physiotherapy medical record documentation. The 'basic' requirements section comprised seven items, each deemed a necessary requirement for documentation according to the RAH Physiotherapy Department Guidelines for Documentation. These seven items were: legibility, date of consultation, time of consultation, heading indicating professional discipline (ie 'Physiotherapy'), physiotherapist's signature, printed surname and that the page included the patient's name and medical record number. Most items in this section were scored as complete, incomplete or absent. One item, 'physiotherapist's printed surname' was also scored as 'not applicable' as, provided the physiotherapist's signature was legible, the physiotherapist was not required to print his/her surname. Therefore, the highest possible total number of completed items for the 'basic' requirements section was seven. The 'mandatory' requirements section contained items that were considered compulsory for all initial entries in medical records, as per the RAH Physiotherapy Department Guidelines for Documentation. There were nine items in this section, with each item scored as complete, incomplete or absent. These nine items were: age, reason for referral for physiotherapy including relevant dates, relevant past medical history, patient's overall general appearance, conscious / cognitive state, physiotherapy-related attachments, baseline objective assessment, description of intervention and plan for ongoing intervention. The highest possible total number of completed items for the 'mandatory' requirements section was nine.

The remaining three sections of the audit tool comprised items that contained the details regarding each patient's assessment and treatment, and as such were deemed non-compulsory according to the RAH Physiotherapy Guidelines for Documentation items. The 'minimal' requirements section assessed the standard of documentation over the entire medical record (ie not restricted to the initial, penultimate and ultimate entries) and consisted of five items. The five items were: that an entry had been made after the first attendance, whenever the patient's condition or physiotherapy treatment had changed or weekly, on noting any factor which warranted documentation, on discharge or transfer to another physiotherapist's care and that the word 'physiotherapy' had been written on the casemix summary sheet. The highest possible total number of completed items in the 'minimal' requirements section was five. The 'other items as appropriate' section was comprised of 21 items that included smoking history, previous level of mobility, relevant medications, respiratory assessment, range of

movement and a neurological assessment. The highest possible score for the 'other items as appropriate' section was 21. The final section of the audit tool, namely the 'ongoing or discharge' requirements section, will not be reported as all of the items within this section have been covered in other sections.

Characteristics of the patient whose medical record was being reviewed and the physiotherapist whose documentation was being audited were also collated. For the patient, this information consisted of the primary diagnosis (categorised as medical, surgical or trauma) and their length of stay in hospital. For the physiotherapists it consisted of the number of years employed at the RAH, employment classification (Professional Services Officer [PSO] level) and the team they were working in at the time of the audit. During 2003, a number of entry level undergraduate physiotherapy students also completed clinical placements within the in-patient areas of the RAH. As the requirements for medical record documentation by students were the same as those of graduated physiotherapists, medical record entries made by students (and counter-signed by clinical educators) were audited if and when they were identified in the random selection process used in the current study. To ensure that the identity of the physiotherapists and students remained confidential, each person was allocated a number that was used for identification and recording purposes.

Data were collected using the audit form and entered onto an spreadsheet (Microsoft Excel 97). The data were analysed descriptively using the SPSS Graduate Pack 2001 for the frequency of complete, incomplete, absent or not applicable responses for each of the individual sections of the audit form for the initial, penultimate and ultimate medical record entries. To determine whether the patients' and physiotherapists' characteristics affected the standard of documentation of the basic or mandatory requirements sections, Chi Square and analysis of variance (ANOVA) was performed.

Reliability study

To assess the inter-rater reliability of the audit tool, two of the investigators (AP and KS) independently assessed the physiotherapy documentation for the initial, penultimate and ultimate entries in three medical records. One month later, the principal investigator (AP), who performed all of the audits during the study, re-audited the same medical record entries to determine intra-rater reliability. Based on all items within the audit form, the percentage of complete agreement between raters was 96.2 per cent, while the intra-rater percentage agreement was 93.0 per cent. This level of reliability was considered acceptable.¹⁵

Results

A total of 224 physiotherapy medical record entries within the 100 randomly selected medical records were audited. The basic descriptive information for the 224 medical record entries audited, including the patients' and physiotherapists' details, is provided in Table 1. In total, 38 physiotherapists and nine entry level undergraduate physiotherapy students were responsible for these 224 entries.

The results of the audit for the 'basic' and 'mandatory' requirements sections of the audit are shown in Figures 1 and 2 respectively. As can be seen in Figure 1, an 80 per cent or greater completion rate was achieved for all but one item in the 'basic' requirements section, with the exception being the time of consultation which was only completed in 40 per cent of the medical record entries audited. The standard of documentation for the 'mandatory' requirements section was more variable, with five of the nine items being completed in at least 80 per cent of the entries audited. The item relating to the patient's overall general appearance ('Appearance' in Figure 2) was the most poorly documented in this section, with only six per cent of entries completing this requirement.

TABLE 1 Descriptive information regarding the 224 medical records entries audited

Medical record entry – number (%)	
Initial	100 (44.6)
Penultimate	54 (24.1)
Ultimate	70 (31.3)
Initial	100 (44.6)
Penultimate	54 (24.1)
Ultimate	70 (31.3)
Patients Characteristics	
Primary Diagnosis – number (%)	
Medical	39 (39.0)
Surgical	30 (30.0)
Trauma	31 (31.0)
Length of stay (days)	
Mean	13.4
Standard deviation	15.2
Range	1 – 78
Physiotherapists' Characteristics	
PSO1	161 (71.9)
PSO2	35 (15.6)
PSO3	9 (4.0)
Under-graduate student	19 (8.5)
Years of employment at RAH	
One year or less	117 (52.2)
More than one year	88 (39.3)
Team	
Acute Care and Surgery	94 (42.0)
Burns, Hands and Lymphoedema	11 (4.9)
Medicine and Neurosurgery	60 (26.8)
Orthopaedics	59 (26.3)
<i>* In South Australia, physiotherapists are classified according to Professional Services Levels (PSO), with Level 1 indicating the basegrade level, and Levels 2 and 3 progressively more senior positions.</i>	

Figure 1: Standard of documentation for the 'basic' requirements section

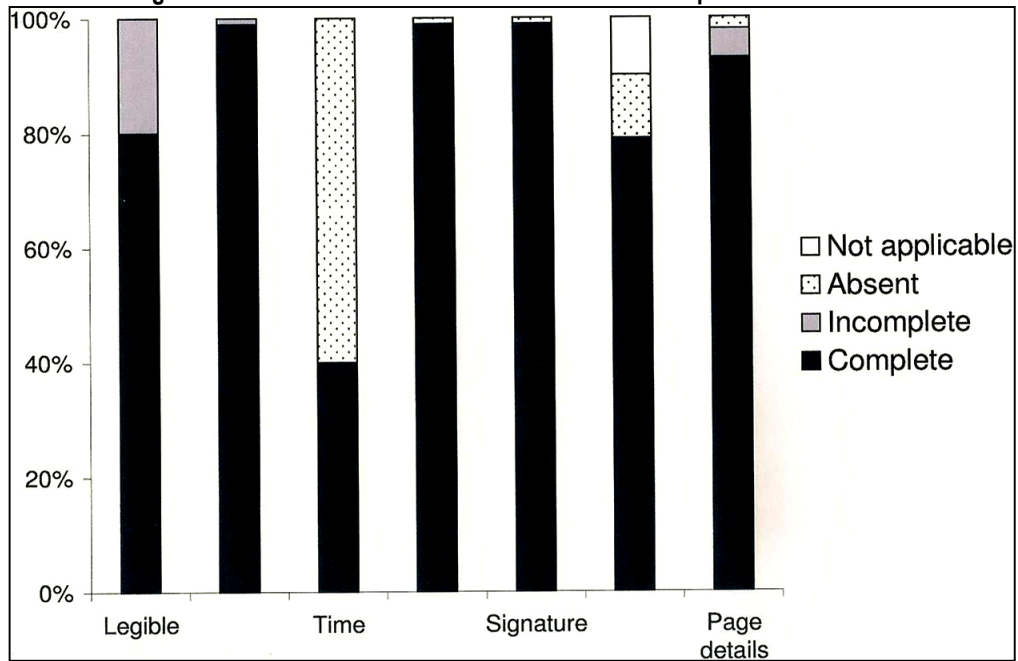
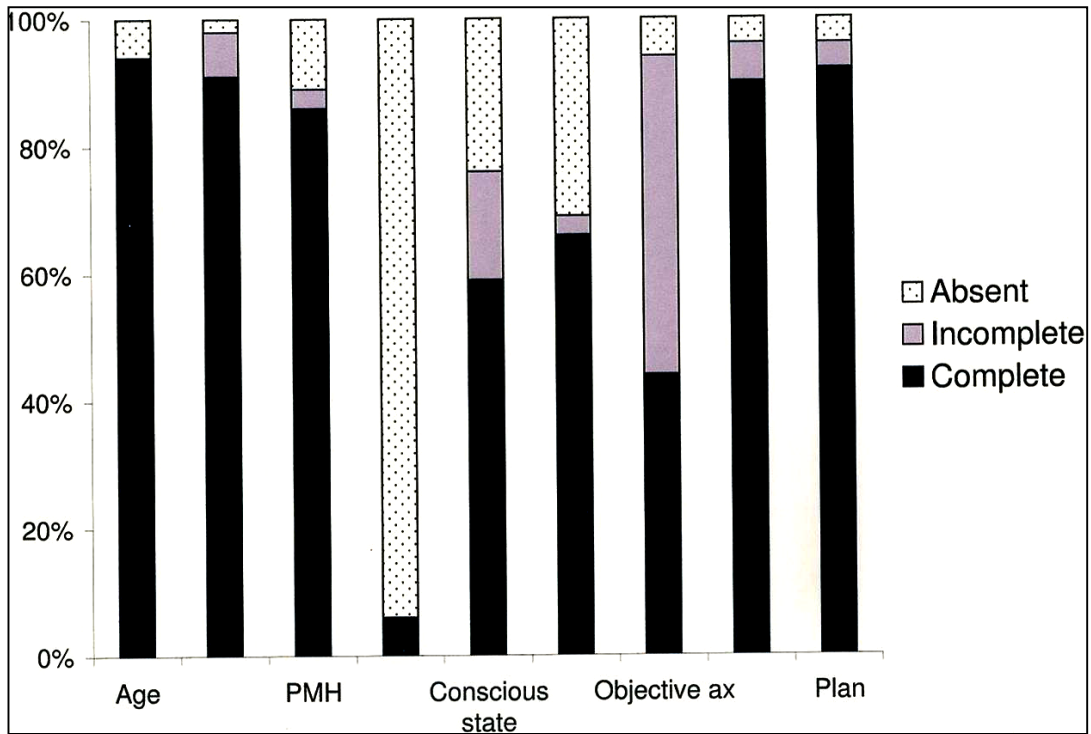


Figure 2 Standard of documentation for the 'mandatory' requirements section



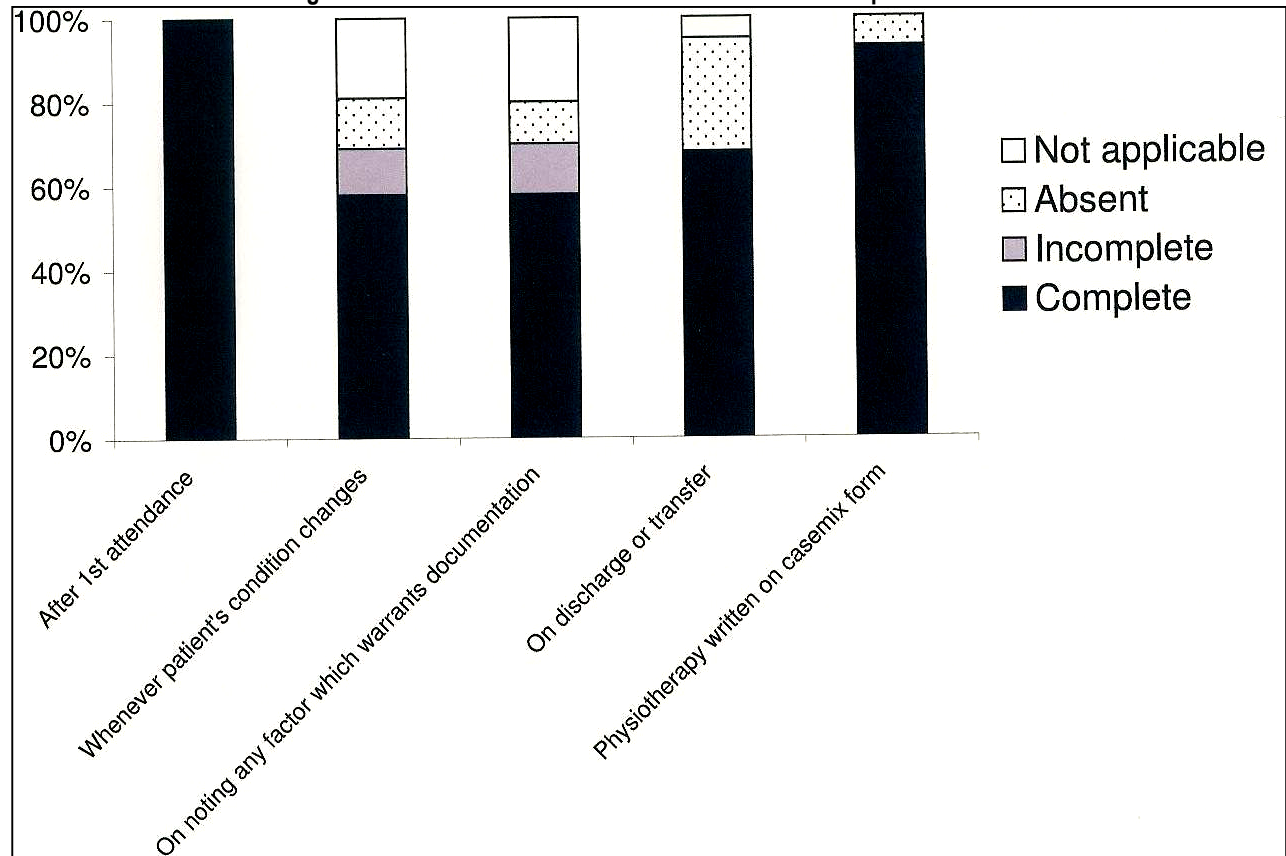
Figures 3 and 4 depict the results for the 'minimal' requirements and 'other items as appropriate' sections of the audit form. As can be seen, high levels of completion

were found for two of the items in the 'minimal' requirements section (ie documentation after the first attendance and that 'physiotherapy' had been written on

the casemix form). While the completion rates were lower for the other three items in this section, for two of these items approximately 20 per cent of entries were also scored as 'not applicable'. Similarly, if the 'not applicable' scores are taken into account in the 'other items as appropriate' section, the rate of incomplete and/or absent

documentation is relatively low, with only four of the 21 items scoring more than 50 per cent incomplete / absent – these four items were: smoking history, usual sputum production, range / strength of affected limb(s), range / strength of unaffected limb(s).

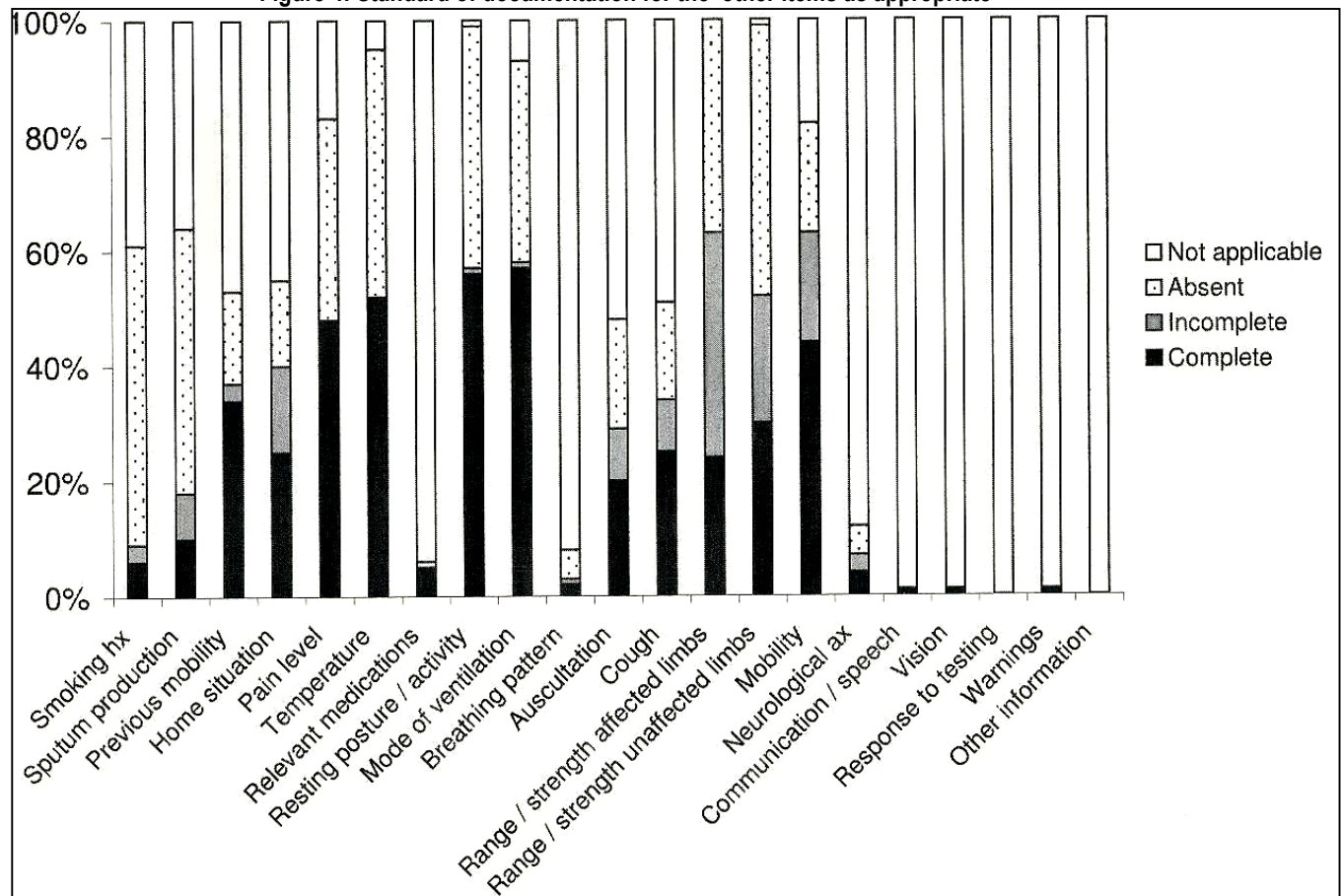
Figure 3 Standard of documentation for the 'minimal' requirements



Statistical analyses regarding the effect of selected patient's and physiotherapist's features on the standard of documentation of the 'basic' requirements section of the audit form, revealed that the patients' primary diagnosis was the only feature that significantly affected the standard of documentation (Chi Square test; $p \leq 0.03$). The number of completed items was higher for patients with a surgical

diagnosis (as compared with a medical or trauma diagnosis) in the initial and penultimate entries. The physiotherapists' characteristics did not have a significant effect on the frequency of completed scores or mean completeness for documentation for the 'basic' or 'mandatory' requirements sections.

Figure 4: Standard of documentation for the 'other items as appropriate'



Discussion

This study found a variable standard of in-patient medical record documentation by physiotherapists in the 224 entries audited from the 100 randomly selected medical records. Many of the items required within the guidelines for documentation were consistently present within the medical records made by physiotherapists. Out of the 42 items in the audit form, only seven were scored as incomplete or absent in 50 per cent or more of the medical record entries. The standard of documentation was significantly affected by the patient's primary diagnosis, whereas other patient or physiotherapist characteristics did not have a significant effect.

The seven items where documentation was frequently incomplete or absent were: time of consultation, patient's general appearance, objective assessment, smoking history, usual sputum production and range/strength of affected and unaffected limb(s). Given that time of consultation was considered in the Departmental Guidelines to be a basic legal requirement, a completion rate of 100 per cent would be expected. While the objective assessment was also scored as incomplete or absent in 56 per cent of medical record entries, it was only

absent in six per cent of records, indicating that the most entries had an objective assessment that was at least partially completed. The item relating to the patient's overall general appearance was absent in 94 per cent of medical record entries, suggesting that staff were unaware of this requirement. Within the 'other items as appropriate section' the poor standard of documentation regarding the range / strength of the affected and unaffected limbs was of most concern, given that this could be considered part of a physiotherapist's 'core business'. There is an expectation at the RAH that these items will be assessed, at least informally, at every physiotherapy visit to ensure safety prior to interventions such as mobilisation.

The standard of documentation in the current study was significantly affected by the patient's primary diagnosis, with the rate of completion higher for those patients with a surgical diagnosis. This was not unexpected, as in general, the assessment of surgical patients could be perceived as being more straightforward than that required for patients with medical conditions or those admitted after trauma. The fact that other patient or physiotherapist characteristics did not significantly affect the standard of documentation was unexpected as it had been anticipated

that the standard of documentation would be better in those patients with a short length of hospital stay, as their condition and therefore physiotherapy assessment is likely to be less complex. Similarly, it had been anticipated that the standard of documentation would be better in more senior physiotherapists and those who had worked at the RAH for more than one year. Interestingly, the standard of documentation by entry level under-graduate physiotherapy students was not significantly different from experienced graduates.

Comparing the results of the current study to previous research that has investigated the overall standard of medical record documentation by physiotherapists^{7,9} is difficult due to the differing criteria audited. However, for items that allow direct comparison, such as time of consultation, physiotherapist's signature, and documentation on discharge or transfer, similar high rates of completion were reported in the current study and that of Gumery et al.⁷ While the current study had higher completion rates than Gumery et al.⁷ for the item 'reason for referral' (91% vs 60%), items related to respiratory assessment were more frequently completed in the audit by Gumery et al.⁷ (eg usual sputum production, auscultatory findings). This latter finding most likely reflects the nature of the sample audited by Gumery et al.⁷, which included only patients with cystic fibrosis, where respiratory assessment would be considered an essential part of the assessment. While numerous additional articles regarding medical record documentation were identified in a literature search, their results could not be compared to the current study as they did not evaluate the overall standard of documentation.¹⁶⁻²²

The results of this study have been presented to RAH physiotherapy staff, with feedback given regarding the overall satisfactory standard of documentation and the common areas where improvement is required. Modifications have been made to the Department Guidelines regarding the standard of documentation to

simplify the contents, particularly in the 'other items as appropriate' section where items have been grouped into general, respiratory, musculoskeletal / mobility, neurological and other categories. As part of the Physiotherapy Department's quality assurance cycle, a further audit of medical record documentation is planned.

Medical record documentation also provides the opportunity for quality activities.^{11,12-14} These quality activities might include collecting data on the interventions provided to particular patient groups, the frequency of adverse events as a result of specific interventions, the duration and timeliness of input from specific health professionals, and an indication of each health professional's clinical reasoning skills.^{13,23} While individual institutions may develop specific audit tools to assess medical record documentation, the lack of specific Australian physiotherapy standards for documentation currently limits the collection and comparison of documentation and interventions provided by health professionals.

Conclusion

Documentation in medical records forms an essential part of every health professional's daily activities. Consistently high standard medical record documentation is necessary to ensure professional and legal requirements are fulfilled and enhances communication between health professionals. An audit, such as described in this paper, provides a means of evaluating the standard of documentation, which in turn assists in the identification and improvement of medical record documentation. Overall, the standard of documentation by physiotherapists in in-patients' medical records was found to be acceptable, with improvements required in a number of specific items. Enhancing the standard of clinical documentation through regular audit has the potential to benefit all members of the health care team and assist in the quality of patient care and service delivery.

References

1. Anderson E (2000): Issues surrounding record keeping in district nursing practice. *British Journal of Community Nursing* 5: 352-356.
2. Manias E (2003): Medication trends and documentation of pain following surgery. *Nursing and Health Sciences* 5: 85-84.
3. Roberts C (1993): Improving nursing records with audit. *Nursing Standard* 51: 37-39.
4. Walsh C (1998): Patient records improve with unified casenotes. *Nursing Times* 94: 52-53.
5. De Villers M (2003): Documentation of preventive education and screening for osteoporosis. *Outcomes Management* 7: 28-32.
6. Gabbay J, McNicol MC, Spilby J, Davies SC & Layton A (1990): What did audit achieve? Lessons from the preliminary evaluation of a year's medical audit. *British Medical Journal* 301: 526-529.
7. Gumery L, Sheldon J, Bayliss H, Mackle R, Stableforth D, Honeybourne D & Reade C (2001): Do physiotherapy records meet professional standards? *Physiotherapy* 86: 655-659.

8. Maggs J (1995): Auditing practice. An information management approach using problem oriented medical records. *Physiotherapy* 81: 213-216.
9. M'kumbuzi VRP, Eales CJ & Stewart A (2002): An analysis of the completion of physiotherapy clinical records in Gauteng Province. *South African Journal of Physiotherapy* 58: 18-27.
10. Morrison LG, Lam S, Sutherland M, Kefala K, Morse T & Bell D (2001): A unitary patient record improves admission documentation in a medical assessment unit in a major teaching hospital. *Health Bulletin* 59: 3-12.
11. Tobin A & Judd M (1998): Understanding the barriers. *Physiotherapy* 84: 527-529.
12. Scholey M (1985): Documentation: a means of professional development. *Physiotherapy* 71: 276-278.
13. Barnard S (1995): Wessex region physiotherapy audit project. Models for intervention audit. *Physiotherapy* 81: 202-207.
14. Johnston G, Crombie IK, Davies HTO, Alder EM & Millard A (2000): Reviewing audit: barriers and facilitating factors for effective clinical audit. *Quality in Health Care* 9: 23-36.
15. Portney LG & Watkins MP (2000): Foundations of Clinical Research. Applications to Practice. (2nd ed.) New Jersey: Prentice-Hall.
16. De Villers M (2003): Documentation of preventive education and screening for osteoporosis. *Outcomes Management* 7: 28-32.
17. Gahimer J, Lyons L, McAtee S, Utterback E (1997): Documentation of patient education in physical therapy practice: are physical therapists documenting what they are teaching? *Journal of Physical Therapy Education* 11: 7-10.
18. Manias E (2003): Medication trends and documentation of pain following surgery. *Nursing and Health Sciences* 5: 85-94.
19. Opila DA (1997): The impact of feedback to medical housestaff on chart documentation and quality of care in the outpatient setting. *Journal of General Internal Medicine* 12: 352-360.
20. Pessian F, Beckett HA (2004): Record keeping by undergraduate dental students: a clinical audit. *British Dental Journal* 197: 703-705.
21. Soto CM, Kleinman KP, Simon SR (2002): Quality and correlates of medical record documentation in the ambulatory setting. *BMC Health Services Research* 2:22-28.
22. Troiani JS, Finkelstein SM, Hertz MI (2005): Incomplete event documentation in medical records of lung transplant recipients. *Progress in Transplantation* 15: 173-177.
23. Woolliscroft J, Calhoun J, Beauchamp C, Wolf F & Maxim B (1984): Evaluating the medical history: Observation versus write-up review. *Journal of Medical Education* 59: 19-23.

Appendix 1

RAH PHYSIOTHERAPY DEPARTMENT MEDICAL RECORD AUDIT FORM

PATIENT NUMBER

PATIENT'S DETAILS

UR number:

Date of admission: / /03

Primary diagnosis:

Length of stay:

INITIAL MEDICAL RECORD ENTRY

Date of UR entry being audited: / /03

Ward:

PT'S DETAILS

PT's name:

PT's work unit: AC&S NMed Ortho BHL

BASIC REQUIREMENTS

		COMPLETE	INCOMPLETE	ABSENT	N/A
1	Legible	☐☐	☐	☐☐	
2	Date of consultation	☐☐		☐☐	
3	Time of consultation	☐☐		☐☐	
4	Heading 'Physiotherapy'	☐☐		☐☐	
5	PT signature	☐☐		☐☐	
6	PT printed surname if the signature is illegible	☐☐		☐☐	☐☐
7	Page includes patient's name and UR no.	☐☐	☐☐	☐☐	

MINIMAL REQUIREMENTS

		COMPLETE	INCOMPLETE	ABSENT	N/A	COMMENTS
8	After the first attendance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
9	Whenever the patient's condition or PT treatment changes, or weekly for long term patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10	On noting any other factor which you think warrants documentation (eg missed injury, patient dissatisfaction, delay in routine progression of treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11	On D/C or T/F to another PTs care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12	Physiotherapy written on Casemix Summary Sheet	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

MANDATORY REQUIREMENTS

		COMPLETE	INCOMPLETE	ABSENT	COMMENTS
13	Age	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
14	Reason for referral ie surg, trauma, medical condition inc relevant dates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15	Relevant PMH such as muscskel, neuro or resp disorders. There is no need to list med history that is already documented in the case notes. If need be, write 'PMH noted'.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16	General appearance eg relative wellness, level of distress, pallor	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
17	Conscious / cognitive state eg awake, alert, oriented, obeying verbal commands, drowsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18	PT related attachments eg HR traction, CPM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19	Baseline objective assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20	Description of intervention (inc advice given)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21	Plan for ongoing intervention inc, as approp, patient goals, relevant medical orders and how conveyed eg PWB D2 acc to protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

OTHER ITEMS INCLUDED AS APPROPRIATE

		COMPLETE	INCOMPLETE	ABSENT	N/A	COMMENTS
22	Smoking history (eg current, reformed, non)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23	Usual sputum production (eg vol, colour, freq)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24	Previous level of mobility (eg method, distance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

		COMPLETE	INCOMPLETE	ABSENT	N/A	COMMENTS
25	Home situation inc community supports / occupation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26	Pain level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27	Temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28	Recent relevant medication eg sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
29	Resting posture and activity eg lying quietly, no spont movt, moving all 4 limbs restlessly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
30	Mode of ventilation (intub status, type of mech vent, FIO ₂)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31	Breathing pattern (<i>if in resp distress eg laboured, access ms</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32	Auscultation (breath sounds, added sounds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
33	Cough (effective/non-effective, strong/weak, dry/moist) and nature of secretions (vol, colour)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
34	Active / active ass range / pass physiol and access range / strength (+/- m chart) of affected limbs (inc face / neck)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
35	Active / active ass / pass range / strength (+/- m chart) of non-affected limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
36	Mobility eg bed, T/Fs, gait (inc aids and WB status, degree of assist req, distance, terrain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37	Neurol assessment eg m tone, reflexes, sensation, response to P/S, co-ord, balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
38	Communication / speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
39	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40	Response to sensation / allergy tests (for electrotherapy, hot / ice packs, taping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
41	Warnings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
42	Other information acc to specialist area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Other comments (inc overall setting out and use of abbreviations)

ON-GOING OR DISCHARGE ENTRY REQUIREMENTS

		COMPLETE	INCOMPLETE	ABSENT	N/A	COMMENTS
43	Details of how patient's condition has changed as relevant to PT involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
44	Updated treatment plan inc updated medical orders and how conveyed eg 'message relayed via CNC from ortho ward round – S/B Mr X – mobilise PWB'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
45	D/C plans as relevant (<i>eg follow up PT, services, equipt</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PENULTIMATE MEDICAL RECORD ENTRY

Date of UR entry being audited: / /03

Ward:

PT'S DETAILS

PT's name:

PT's work unit: AC&S NMed Ortho BHL

BASIC REQUIREMENTS

		COMPLETE	INCOMPLETE	ABSENT	N/A
46	Legible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
47	Date of consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
48	Time of consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
49	Heading 'Physiotherapy'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
50	PT signature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
51	PT printed surname if the signature is illegible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52	Page includes patient's name and UR no.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

MANDATORY REQUIREMENTS

		COMPLETE	INCOMPLETE	ABSENT	NA	COMMENTS
	Age					
	Reason for referral ie surg, trauma, medical condition inc relevant dates					
	Relevant PMH such as musckel, neuro or resp disorders. There is no need to list med history that is already documented in the case notes. If need be, write 'PMH noted'.					
53	General appearance eg relative wellness, level of distress, pallor	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
54	Conscious / cognitive state eg awake, alert, oriented, obeying verbal commands, drowsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
55	PT related attachments eg HR traction, CPM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
56	Baseline objective assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
57	Description of intervention (inc advice given)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
58	Plan for ongoing intervention inc, as approp, patient goals, relevant medical orders and how conveyed eg PWB D2 acc to protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

OTHER ITEMS INCLUDED AS APPROPRIATE

		COMPLETE	INCOMPLETE	ABSENT	N/A	COMMENTS
	Smoking history (<i>eg how recent, no. cigs, no. years</i>)					
	Usual sputum production (<i>eg vol, colour, freq</i>)					
59	Previous level of mobility (<i>eg method, distance</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
60	Home situation inc community supports / occupation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
61	Pain level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
62	Temperature	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
63	Recent relevant medication eg sedatives	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
64	Resting posture and activity eg lying quietly, no spont movt, moving all 4 limbs restlessly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
65	Mode of ventilation (intub status, type of mech vent, FIO ₂)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
66	Breathing pattern (<i>if in resp distress eg laboured, access ms</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
67	Auscultation (breath sounds, added sounds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
68	Cough (effective/non-effective, strong/weak, dry/moist) and nature of secretions (vol, colour)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69	Active / active ass range / pass physiol and access range / strength (+/- m chart) of affected limbs (inc face / neck)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
70	Active / active ass / pass range / strength (+/- m chart) of non-affected limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
71	Mobility eg bed, T/Fs, gait (inc aids and WB status, degree of assist req, distance, terrain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
72	Neurol assessment eg m tone, reflexes, sensation, response to P/S, co-ord, balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
73	Communication / speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
74	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
75	Response to sensation / allergy tests (for electrotherapy, hot / ice packs, taping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
76	Warnings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
77	Other information acc to specialist area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

ON-GOING OR DISCHARGE ENTRY REQUIREMENTS

		COMPLETE	INCOMPLETE	ABSENT	N/A	COMMENTS
78	Details of how patient's condition has changed as relevant to PT involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
79	Updated treatment plan inc updated medical orders and how conveyed eg 'message relayed via CNC from ortho ward round – S/B Mr X – mobilise PWB'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	D/C plans as relevant (<i>eg follow up PT, services, equipt</i>)					
	On D/C or T/F to another PTs care					

Other comments (inc overall setting out and use of abbreviations)

FINAL MEDICAL RECORD ENTRY

Date of UR entry being audited: / /03

Ward:
PT'S DETAILS

PT's name:
PT's work unit: AC&S NMed Ortho BHL

BASIC REQUIREMENTS

		COMPLETE	INCOMPLETE	ABSENT	N/A
80	Legible	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
81	Date of consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
82	Time of consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
83	Heading 'Physiotherapy'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
84	PT signature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
85	PT printed surname if the signature is illegible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
86	Page includes patient's name and UR no.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MANDATORY REQUIREMENTS

		COMPLETE	INCOMPLETE	ABSENT	NA	COMMENTS
	Age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Reason for referral ie surg, trauma, medical condition inc relevant dates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Relevant PMH such as muscstel, neuro or resp disorders. There is no need to list med history that is already documented in the case notes. If need be, write 'PMH noted'.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
87	General appearance eg relative wellness, level of distress, pallor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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91	Description of intervention (inc advice given)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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114	D/C plans as relevant (<i>eg follow up PT, services, equipt</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
115	On D/C or T/F to another PTs care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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