HACKETTSTOWN MEDICAL CENTER
PHYSICAL/OCCUPATIONAL THERAPY PROCEDURE MANUAL
CHARTING

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Effective Date: July, 1984	**Policy No: 5200-2.001/5300-2.001**
Cross Referenced:	**Origin: Physical/Occupational Therapy**
Reviewed Date: 09/12, 03/16	**Authority: Therapy Services Manager**
Revised Date:	**Page: 1 of 1**

PURPOSE

1. **General Purpose:**

   a. To serve as a memoranda of treatment, tests, and patient status so that in case the therapist is absent the information will be adequate for another therapist to take over the treatment without negative effects on the quality or consistency of care being given to the patient.

   b. To supply physicians with information that will enable them to judge the condition of the patient and effects of prescribed treatments.

   c. To aid in diagnoses if the patient returns for treatment at a future date.

   d. To demonstrate effectiveness or non-effectiveness of a certain therapy program.

2. **Legal Purpose:**

   a. Accurately document services rendered and client response in case patient brings suit.

   b. To aid in a fair legal judgment, as following an accident where compensation is demanded.

3. **Educational Purpose:**

   a. Compilation of medical statistics.

   b. Comparison of effects of treatments.

   c. Index to therapist's observation and documentation skills; review of notes can assist with professional growth.

   d. For study and research projects.

   e. Improve communication techniques.

PROCEDURE

1. Refer to subsequent sections for specific guidelines. Each outpatient will have a department/facility file folder, which will include initial and subsequent therapy referrals, evaluation and progress reports, and copies of home programs. Inpatient records will be charted in the patients chart under the section heading "Progress Notes".

2. General rules for charting:
   a. All written entries are made with pen.

   b. Letters and words are legible and neat.

   c. Be accurate in your statements. Never record treatment until after it has been given.

d. Use professional language and approved abbreviations.

e. Statements must be so clear and concise that they cannot be misconstrued.

f. If in doubt about anything which you record, place a question mark (?) after it.

g. When correcting errors in charting, draw one line through the error and print the word "error" above it. The correct statement is then printed on the line below. Always date and sign in the margin next to the error. Never erase any error or use correction fluid.

3. All medical records are kept in strict confidence. Medical records are available to other parties only on signed release of the patient through the Medical Records Department.

a. Outpatient records are located in the file closet in the Therapy Center. The file cabinet and the closet are locked during non-working hours.

b. Inpatient therapy records are recorded in the hospital HIS system.

4. The following persons will be permitted to make entries on the patient's medical record:
Physical Therapist
Physical Therapist Assistant
Occupational Therapist
Occupational Therapist Assistant
Student from an accredited therapy program (under supervision and co-signed by Clinical Instructor

Signatures on charts will consist of first name, last name and professional designation, followed by professional license number. All notations by an assistant will be co-signed by a licensed therapist. All entries with signature shall also include signature date and time.