



GUIDELINES: PHYSICAL THERAPY DOCUMENTATION OF PATIENT/CLIENT MANAGEMENT

BOD G03-05-16-41 [Amended BOD 02-02-16-20; BOD 11-01-06-10; BOD 03-01-16-51; BOD 03-00-22-54; BOD 03-99-14-41; BOD 11-98-19-69; BOD 03-97-27-69; BOD 03-95-23-61; BOD 11-94-33-107; BOD 06-93-09-13; Initial BOD 03-93-21-55] [Guideline]

PREAMBLE

The American Physical Therapy Association (APTA) is committed to meeting the physical therapy needs of society, to meeting the needs and interests of its members, and to developing and improving the art and science of physical therapy, including practice, education and research. To help meet these responsibilities, APTA's Board of Directors has approved the following guidelines for physical therapy documentation. It is recognized that these guidelines do not reflect all of the unique documentation requirements associated with the many specialty areas within the physical therapy profession. Applicable for both hand written and electronic documentation systems, these guidelines are intended to be used as a foundation for the development of more specific documentation guidelines in clinical areas, while at the same time providing guidance for the physical therapy profession across all practice settings. Documentation may also need to address additional regulatory or payer requirements.

Finally, be aware that these guidelines are intended to address *documentation of patient/client management*, not to describe the provision of physical therapy services. Other APTA documents, including APTA Standards of Practice for Physical Therapy, Code of Ethics and Guide for Professional Conduct, and the Guide to Physical Therapist Practice, address provision of physical therapy services and patient/client management.

APTA POSITION ON DOCUMENTATION

Documentation Authority For Physical Therapy Services

Physical therapy examination, evaluation, diagnosis, prognosis, and plan of care (including interventions) shall be documented, dated, and authenticated by the physical therapist who performs the service. Interventions provided by the physical therapist or selected interventions provided by the physical therapist assistant under the direction and supervision of the physical therapist are documented, dated, and authenticated by the physical therapist or, when permissible by law, the physical therapist assistant.

Other notations or flow charts are considered a component of the documented record but do not meet the requirements of documentation in or of themselves.

Students in physical therapist or physical therapist assistant programs may document when the record is additionally authenticated by the physical therapist or, when permissible by law, documentation by physical therapist assistant students may be authenticated by a physical therapist assistant.

OPERATIONAL DEFINITIONS

Guidelines

APTA defines a "guideline" as a statement of advice.

Authentication

The process used to verify that an entry is complete, accurate and final. Indications of authentication can include original written signatures and computer "signatures" on secured electronic record systems only.

The following describes the main documentation elements of patient/client management: 1) initial examination/evaluation, 2) visit/encounter, 3) reexamination, and 4) discharge or discontinuation summary.

Initial Examination/Evaluation

Documentation of the initial encounter is typically called the "initial examination," "initial evaluation," or "initial examination/evaluation." Completion of the initial examination/evaluation is typically completed in one visit, but may occur over more than one visit. Documentation elements for the initial examination/evaluation include the following:

Examination: Includes data obtained from the history, systems review, and tests and measures.

Evaluation: Evaluation is a thought process that may not include formal documentation. It may include documentation of the assessment of the data collected in the examination and identification of problems pertinent to patient/client management.

Diagnosis: Indicates level of impairment, activity limitation and participation restriction determined by the physical therapist. May be indicated by selecting one or more preferred practice patterns from the Guide to Physical Therapist Practice.

Prognosis: Provides documentation of the predicted level of improvement that might be attained through intervention and the amount of time required to reach that level. Prognosis is typically not a separate documentation elements, but the components are included as part of the plan of care.

Plan of care: Typically stated in general terms, includes goals, interventions planned, proposed frequency and duration, and discharge plans.

Visit/Encounter

Documentation of a visit or encounter, often called a progress note or daily note, documents sequential implementation of the plan of care established by the physical therapist, including changes in patient/client status and variations and progressions of specific interventions used. Also may include specific plans for the next visit or visits.

Reexamination

Documentation of reexamination includes data from repeated or new examination elements and is provided to evaluate progress and to modify or redirect intervention.

Discharge or Discontinuation Summary

Documentation is required following conclusion of the current episode in the physical therapy intervention sequence, to summarize progression toward goals and discharge plans.

GENERAL GUIDELINES

- Documentation is required for every visit/encounter.
- All documentation must comply with the applicable jurisdictional/regulatory requirements.
- All handwritten entries shall be made in ink and will include original signatures. Electronic entries are made with appropriate security and confidentiality provisions.
- Charting errors should be corrected by drawing a single line through the error and initialing and dating the chart or through the appropriate mechanism for electronic

- documentation that clearly indicates that a change was made without deletion of the original record.
- All documentation must include adequate identification of the patient/client and the physical therapist or physical therapist assistant:
 - The patient's/client's full name and identification number, if applicable, must be included on all official documents.
 - All entries must be dated and authenticated with the provider's full name and appropriate designation:
 - Documentation of examination, evaluation, diagnosis, prognosis, plan of care, and discharge summary must be authenticated by the physical therapist who provided the service.
 - Documentation of intervention in visit/encounter notes must be authenticated by the physical therapist or physical therapist assistant who provided the service.
 - Documentation by physical therapist or physical therapist assistant graduates or other physical therapists and physical therapist assistants pending receipt of an unrestricted license shall be authenticated by a licensed physical therapist, or, when permissible by law, documentation by physical therapist assistant graduates may be authenticated by a physical therapist assistant.
 - Documentation by students (SPT/SPTA) in physical therapist or physical therapist assistant programs must be additionally authenticated by the physical therapist or, when permissible by law, documentation by physical therapist assistant students may be authenticated by a physical therapist assistant.
 - Documentation should include the referral mechanism by which physical therapy services are initiated. Examples include:
 - Self-referral/direct access
 - Request for consultation from another practitioner
 - Documentation should include indication of no shows and cancellations.

INITIAL EXAMINATION/EVALUATION

Examination (History, Systems Review, and Tests and Measures)

History:

Documentation of history may include the following:

- General demographics
- Social history
- Employment/work (Job/School/Play)
- Growth and development
- Living environment
- General health status (self-report, family report, caregiver report)
- Social/health habits (past and current)
- Family history
- Medical/surgical history
- Current condition(s)/Chief complaint(s)
- Functional status and activity level
- Medications
- Other clinical tests

Systems Review:

Documentation of systems review may include gathering data for the following systems:

- Cardiovascular/pulmonary

- Blood Pressure
- Edema
- Heart Rate
- Respiratory Rate
- Integumentary
 - Pliability (texture)
 - Presence of scar formation
 - Skin color
 - Skin integrity
- Musculoskeletal
 - Gross range of motion
 - Gross strength
 - Gross symmetry
 - Height
 - Weight
- Neuromuscular
 - Gross coordinated movement (eg, balance, locomotion, transfers, and transitions)
 - Motor function (motor control, motor learning)

Documentation of systems review may also address communication ability, affect, cognition, language, and learning style:

- Ability to make needs known
- Consciousness
- Expected emotional/behavioral responses
- Learning preferences (eg, *education needs, learning barriers*)
- Orientation (person, place, time)

Tests and Measures:

Documentation of tests and measures may include findings for the following categories:

- Aerobic Capacity/Endurance

Examples of examination findings include:

 - Aerobic capacity during functional activities
 - Aerobic capacity during standardized exercise test protocols
 - Cardiovascular signs and symptoms in response to increased oxygen demand with exercise or activity
 - Pulmonary signs and symptoms in response to increased oxygen demand with exercise or activity
- Anthropometric Characteristics

Examples of examination findings include:

 - Body composition
 - Body dimensions
 - Edema
- Arousal, attention, and cognition

Examples of examination findings include:

 - Arousal and attention
 - Cognition
 - Communication
 - Consciousness
 - Motivation

- Orientation to time, person, place, and situation
 - Recall
- Assistive and adaptive devices
 - Examples of examination findings include:
 - Assistive or adaptive devices and equipment use during functional activities
 - Components, alignment, fit, and ability to care for the assistive or adaptive devices and equipment
 - Remediation of impairments, activity limitations and participation restrictions with use of assistive or adaptive devices and equipment
 - Safety during use of assistive or adaptive devices and equipment
- Circulation (Arterial, Venous, Lymphatic)
 - Examples of examination findings include:
 - Cardiovascular signs
 - Cardiovascular symptoms
 - Physiological responses to position change
- Cranial and Peripheral Nerve Integrity
 - Examples of examination findings include:
 - Electrophysiological integrity
 - Motor distribution of the cranial nerves
 - Motor distribution of the peripheral nerves
 - Response to neural provocation
 - Response to stimuli, including auditory, gustatory, olfactory, pharyngeal, vestibular, and visual
 - Sensory distribution of the cranial nerves
 - Sensory distribution of the peripheral nerves
- Environmental, Home, and Work (Job/School/Play) Barriers
 - Examples of examination findings include:
 - Current and potential barriers
 - Physical space and environment
- Ergonomics and Body mechanics
 - Examples of examination findings for *ergonomics* include:
 - Dexterity and coordination during work
 - Functional capacity and performance during work actions, tasks, or activities
 - Safety in work environments
 - Specific work conditions or activities
 - Tools, devices, equipment, and work-stations related to work actions, tasks, or activities
 - Examples of examination findings for *body mechanics* include:
 - Body mechanics during self-care, home management, work, community, or leisure actions, tasks, or activities
- Gait, locomotion, and balance
 - Examples of examination findings include:
 - Balance during functional activities with or without the use of assistive, adaptive, orthotic, protection, supportive, or prosthetic devices or equipment

- Balance (dynamic and static) with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment
 - Gait and locomotion during functional activities with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment
 - Gait and locomotion with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment
 - Safety during gait, locomotion, and balance
- Integumentary Integrity

Examples of examination findings include:

Associated skin:

 - Activities, positioning, and postures that produce or relieve trauma to the skin
 - Assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment that may produce or relieve trauma to the skin
 - Skin characteristics
- Wound
 - Activities, positioning, and postures that aggravate the wound or scar or that produce or relieve trauma
 - Burn
 - Signs of infection
 - Wound characteristics
 - Wound scar tissue characteristics
- Joint Integrity and Mobility

Examples of examination findings include:

 - Joint integrity and mobility
 - Joint play movements
 - Specific body parts
- Motor Function

Examples of examination findings include:

 - Dexterity, coordination, and agility
 - Electrophysiological integrity
 - Hand function
 - Initiation, modification, and control of movement patterns and voluntary postures
- Muscle Performance

Examples of examination findings include:

 - Electrophysiological integrity
 - Muscle strength, power, and endurance
 - Muscle strength, power, and endurance during functional activities
 - Muscle tension
- Neuromotor development and sensory integration

Examples of examination findings include:

 - Acquisition and evolution of motor skills
 - Oral motor function, phonation, and speech production
 - Sensorimotor integration

- Orthotic, protective, and supportive devices
Examples of examination findings include:
 - Components, alignment, fit, and ability to care for the orthotic, protective, and supportive devices and equipment
 - Orthotic, protective, and supportive devices and equipment use during functional activities
 - Remediation of impairments, activity limitations, and participation restrictions with use of orthotic, protective, and supportive devices and equipment
 - Safety during use of orthotic, protective, and supportive devices and equipment

- Pain
Examples of examination findings include:
 - Pain, soreness, and nociception
 - Pain in specific body parts

- Posture
Examples of examination findings include:
 - Postural alignment and position (dynamic)
 - Postural alignment and position (static)
 - Specific body parts

- Prosthetic requirements
Examples of examination findings include:
 - Components, alignment, fit, and ability to care for prosthetic device
 - Prosthetic device use during functional activities
 - Remediation of impairments, activity limitations, and participation restrictions with use of the prosthetic device
 - Residual limb or adjacent segment
 - Safety during use of the prosthetic device

- Range of motion (including muscle length)
Examples of examination findings include:
 - Functional ROM
 - Joint active and passive movement
 - Muscle length, soft tissue extensibility, and flexibility

- Reflex integrity
Examples of examination findings include:
 - Deep reflexes
 - Electrophysiological integrity
 - Postural reflexes and reactions, including righting, equilibrium, and protective reactions
 - Primitive reflexes and reactions
 - Resistance to passive stretch
 - Superficial reflexes and reactions

- Self-care and home management (including activities of daily living and instrumental activities of daily living)
Examples of examination findings include:
 - Ability to gain access to home environments

- Ability to perform self-care and home management activities with or without assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment
- Safety in self-care and home management activities and environments
- Sensory integrity
 - Examples of examination findings include:
 - Combined/cortical sensations
 - Deep sensations
 - Electrophysiological integrity
- Ventilation and respiration
 - Examples of examination findings include:
 - Pulmonary signs of respiration/gas exchange
 - Pulmonary signs of ventilatory function
 - Pulmonary symptoms
- Work (job/school/play), community, and leisure integration or reintegration (including instrumental activities of daily living)
 - Examples of examination findings include:
 - Ability to assume or resume work (job/school/plan), community, and leisure activities with or without assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment
 - Ability to gain access to work (job/school/play), community, and leisure environments
 - Safety in work (job/school/play), community, and leisure activities and environments

Evaluation

- Evaluation is a thought process that may not include formal documentation. However, the evaluation process may lead to documentation of impairments, activity limitations, and participation restrictions using formats such as:
 - A problem list
 - A statement of assessment of key factors (e.g., cognitive factors, comorbidities, social support) influencing the patient/client status.

Diagnosis

- Documentation of a diagnosis determined by the physical therapist may include impairment, activity limitation, and participation restrictions. Examples include:
 - Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Localized Inflammation (4E)
 - Impaired Motor Function and Sensory Integrity Associated With Progressive Disorders of the Central Nervous System (5E)
 - Impaired Aerobic Capacity/Endurance Associated With Cardiovascular Pump Dysfunction or Failure (6D)
 - Impaired Integumentary Integrity Associated With Partial-Thickness Skin Involvement and Scar Formation (7C)

Prognosis

- Documentation of the prognosis is typically included in the plan of care. See below.

Plan of Care

- Documentation of the plan of care includes the following:

- Overall goals stated in measurable terms that indicate the predicted level of improvement in functioning
- A general statement of interventions to be used
- Proposed duration and frequency of service required to reach the goals
- Anticipated discharge plans

VISIT/ENCOUNTER

- Documentation of each visit/encounter shall include the following elements:
 - Patient/client self-report (as appropriate).
 - Identification of specific interventions provided, including frequency, intensity, and duration as appropriate. Examples include:
- Knee extension, three sets, ten repetitions, 10# weight
- Transfer training bed to chair with sliding board
- Equipment provided
 - Changes in patient/client impairment, activity limitation, and participation restriction status as they relate to the plan of care.
 - Response to interventions, including adverse reactions, if any.
 - Factors that modify frequency or intensity of intervention and progression goals, including patient/client adherence to patient/client-related instructions.
 - Communication/consultation with providers/patient/client/family/ significant other.
 - Documentation to plan for ongoing provision of services for the next visit(s), which is suggested to include, but not be limited to:
 - The interventions with objectives
 - Progression parameters
 - Precautions, if indicated

REEXAMINATION

- Documentation of reexamination shall include the following elements:
 - Documentation of selected components of examination to update patient's/client's functioning, and/or disability status.
 - Interpretation of findings and, when indicated, revision of goals.
 - When indicated, revision of plan of care, as directly correlated with goals as documented.

DISCHARGE/DISCONTINUATION SUMMARY

- Documentation of discharge or discontinuation shall include the following elements:
 - Current physical/functional status.
 - Degree of goals achieved and reasons for goals not being achieved.
 - Discharge/discontinuation plan related to the patient/client's continuing care. Examples include:
 - Home program.
 - Referrals for additional services.
 - Recommendations for follow-up physical therapy care.
 - Family and caregiver training.
 - Equipment provided.

Explanation of Reference Numbers:

BOD P00-00-00-00 stands for Board of Directors/month/year/page/vote in the Board of Directors Minutes; the "P" indicates that it is a position (see below). For example, BOD P11-97-06-18 means that this position can be found in the November 1997 Board of Directors minutes on Page 6 and that it was Vote 18.

P: Position | S: Standard | G: Guideline | Y: Policy | R: Procedure