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ANCILLARY DIVISION HOSPITAL POLICIES AND PROCEDURES MANUAL APPROVAL MATRIX	Page No. of
Policy Title: **POLICY ON MANAGEMENT ,STORAGE AND DISPOSAL OF RECORDS**	Section / Department **PT AND REHABILITATION MEDICINE**

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I. Statement Policy

There shall be a written guideline regarding the proper management, storage and disposal of the Section's records to ensure quality service.

II. Policy Guidelines

General Guidelines on PTRM Patient's Records Management

1. Records management is mandatory and is a primary responsibility of the physical therapists until such time the records are to be disposed and are endorsed to the General Medical Records Section.
2. Records documentation should be systematic which includes patient's history, and care during the whole duration of the Physical Therapy Intervention.
3. Physical Therapy Medical record of a particular patient is confidential and his/her right to privacy must be respected at all times.
4. Medical records must be maintained for every individual who receives care by physical therapist whether out-patient or as inpatient.
5. All patients' records shall remain in the custody of the Physical Therapy Section during the entire duration of the Physical Therapy management.
6. In-Patient records containing physical therapy assessment and notes along with other medical records concerning physical therapy will be made two copies, one will remain in the custody of nursing services during the entire stay of the patient in the ward, and the other one shall be in the custody of the Physical Therapy Section.
7. The author of every entry in physical therapy medical records shall be identified through signatures, names and designation (trodat stamp).
8. The author of every entry must make sure that every entry fulfills the following criteria
    a. Date of entry
    b. Time of entry
    c. Authenticated by his/her legible name, signature and designation

9. After discharge/death/referral, physical therapy records shall remain in the custody of the Physical Therapy Section until such time the records are to be disposed.
10. Patient Physical Therapy Record must contain:
    a. Patient general information with hospital number, date and time of admission
    b. Duly signed informed written consent
    c. Rehabilitation Doctor Medical Assessment
    d. Physical Therapy Initial Evaluation
    e. Plan of care shall be formulated.
    f. All progress notes must include the patient's Subjective symptoms; the Objective findings, the physical therapist's current Assessment, and further management Plan (i.e. SOAP)
    g. For in –patients, chronological details of provided care and interventions done during entire stay of patient in hospital ward
    h. Patient Disposition

General Guidelines regarding PTRM Patient Charts

1. The Physical Therapist Staff-in-Charge shall:

1.1. Classify and separate patient records whether as active or inactive file
1.2. Maintain separate filing areas of the following in the filing cabinets
    1.2.1. Inactive files for the present year
    1.2.2. Inactive files for the previous two years

1. All records must be stored securely until minimum retention periods have expired. Staff should refer to the retention schedule of records.(5 years) base on *the DOH circular Number of 2021-00226*.

1.3.
1.4. Arrange the patients charts alphabetically
1.5. Classify and label the records in the cabinet according to year and surname initials
1.6. Forward to the General Medical Records Section for proper disposal of all records beyond the retention period

1.7. Document the transfer made to the General Medical Records Section

General Guidelines regarding PTRM Logbooks, daily census, and other records

1. The secretary/clerk shall:

1.1. Place and file all logbooks, census and records in the filing cabinet
1.2. Place and file all logbooks, census and records that are no longer in use along with the inactive records files
2. Classify and label the records according to type and date
2.1. Forward to the General Medical Records Section for proper disposal all records beyond the retention period
2.2. Document the transfer made to the General Medical Records Section