

## SP 22.0 Patient Files/Records/Charting Requirements

Effective June 1, 2006  
Amended January 1, 2009

### **Purpose and Objective**

As a regulated and primary care provider, it is a requirement to demonstrate competency in the area of keeping appropriate patient records.

### **Definition(s)**

In order for patient records to meet minimum standards they must be dated, accurate, legible, and comprehensive. Patient records must include the following documentation:

#### History

- Must accurately document facts about the patient's personal and health history

#### Physical exam findings

- Both positive and negative results must be recorded
- Findings must support the Diagnosis

#### Written diagnosis

- Written diagnosis (working diagnosis and/or index of suspicion) must be recorded
- VSC must identify the segmental level(s) and components of the "complex".
- ICD codes alone are not an appropriate diagnosis and are insufficient to meet the standard

#### Written treatment plan

- Must include all proposed treatment methods (adjustments, ultrasound, electrical stimulation, controlled exercise plan, and lifestyle counseling, as appropriate)

#### Appropriate progress notes

- Must include dates, subjective information, objective information, assessment notes, and treatment rendered and/or proposed (eg. SOAP notes)

### **Enforceability**

Any member identified to the Complaints Director as non-compliant in the Standard of Practice related to patient files/records/charting requirements is subject to the investigations and complaints process under Part 4 of the *Health Professions Act*. Identification of non-compliance may occur as a result of Practice Visit process, patient complaint or any other means by which this information may be brought to the attention of the Complaints Director.

