

## Position Statement – NC Board of Physical Therapy Examiners

### 11. Documentation - Discharge Summary /Episode of Care

Approved at June 26, 2003 Board Meeting

Updated January 19, 2010

Reviewed by the Board – September 23, 2010, June 17, 2015, June 6, 2018, September 2, 2020, June 8, 2022

Revised to reflect re-codified statutes April 1, 2019

**Question 1:** Can a PTA write a discharge summary or discharge from an episode of care?

**Response:** **No.** In accordance with 21 NCAC 48C .0102 (*quoted below*), only a physical therapist may write a Discharge Evaluation Summary that includes a summary of the patient's progress toward meeting the established goals and the determination that treatment is to be discontinued. It would be acceptable for a PTA to write a Brief Discharge Note (eg, A physical therapist evaluates a patient and writes a Discharge Evaluation Summary, but requests the PTA to see the patient for one or two more visits to complete a specific goal. After the PTA has seen the patient for 1 or 2 visits and the patient has met the goal, the PTA can write a Brief Discharge Note to that effect.)

**Question 2:** If a patient discharged by a physician (*eg, in a hospital setting*) has only been seen by physical therapy services on a limited basis, is a Discharge Evaluation Summary or summary of the episode of care required?

**Response:** No. A Brief Discharge Note written by the PT or PTA that indicates the patient was discharged before a Discharge Summary could be performed is acceptable.

#### 21 NCAC 48C .0102 RESPONSIBILITIES

- (a) A physical therapist shall determine the patient care plan and the elements of that plan appropriate for delegation.
- (b) A physical therapist shall determine that those persons acting under his or her supervision possess the competence to perform the delegated activities.
- (c) A physical therapist may delegate responsibilities to physical therapist assistants, including supervising physical therapist or physical therapist assistant students.
- (d) A physical therapist shall enter and review chart documentation, reexamine and reassess the patient, and revise the patient care plan if necessary, based on the needs of the patient.
- (e) A physical therapist shall establish a discharge plan that includes a discharge summary or episode of care for each patient.
- (f) The physical therapist shall provide all therapeutic interventions that require the physical therapist's expertise, and may delegate to a physical therapist assistant or physical therapy aide the delivery of service to the patient when it is safe and effective for the patient.
- (g) A physical therapist's responsibility for patient care management includes first-hand knowledge of the health status of each patient and oversight of all documentation for services rendered to each patient, including awareness of fees and reimbursement structures.

- (h) A physical therapist shall be immediately available in person or by telecommunication to a physical therapist assistant supervising a physical therapy aide or student engaging in patient care.
- (i) A physical therapist who is supervising a physical therapy aide or student shall be present in the same facility when patient care is provided.
- (j) A physical therapist shall clinically supervise only that number of assistive personnel, including physical therapist assistants, physical therapy aides, and students completing clinical requirements, as the physical therapist determines is appropriate for providing safe and effective patient interventions at all times.
- (k) If a physical therapist assistant or physical therapy aide is involved in the patient care plan, a physical therapist shall reassess a patient every 60 days or 13 visits, whichever occurs first.
- (l) A physical therapist shall document every evaluation and intervention or treatment including the following elements:
- (1) authentication (signature and designation) by the physical therapist who performed the service;
  - (2) date of the evaluation or treatment;
  - (3) length of time of total treatment session or evaluation;
  - (4) patient status report;
  - (5) changes in clinical status;
  - (6) identification of specific elements of each intervention or modality provided.  
Frequency, intensity, or other details may be included in the plan of care and if so, do not need to be repeated in the daily note;
  - (7) equipment provided to the patient; and
  - (8) interpretation and analysis of clinical signs, symptoms, and response to treatment based on subjective and objective findings, including any adverse reactions to an intervention.
- (m) At the time of reassessment the physical therapist shall document:
- (1) the patient's response to therapy intervention;
  - (2) the patient's progress toward achieving goals; and
  - (3) justifications for continued treatment.
- (n) A physical therapist shall, upon request by the patient of record, provide the original or copies of the patient's treatment record to the patient, or to the patient's designee. As permitted by G.S. 90-411, a fee may be charged for the cost of reproducing copies. The documents requested shall be provided within 30 days of the request and shall not be contingent upon current, past, or future physical therapy treatment or payment of services.

*History Note: Authority G.S. 90-270.90; 90-270.92; 90-270.98; 90-270.34; 90-411;  
Eff. December 30, 1985;  
Amended Eff. February 1, 2015; July 1, 2013; December 1, 2006; August 1, 2002; August 1,  
1998; January 1, 1991*

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