AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Good notes by good physios

Below is a brief outline of some of the key elements that we include in our clients' clinical notes as we reflect on the process and outcomes of our interaction. Further support material and case studies are available on the APA website.

Key points	• What we write always reflects our ethical and professional behaviours and actions, and demonstrates that we provide safe and quality practice. • Adequate and contemporaneous notes are required by law.
When, Where, Who, What	We record the following for each clinical interaction; • date (and time if appropriate) • the location that the interaction occurred (if it cannot be inferred) • identity of the people involved • snapshot and/or narrative and clinical reasoning framework eg, SOAP.
Consent & informed consent	We record aspects of informed consent and ensure that our client has an understanding so that they can make informed decisions. We; • undertake a process of client consent to be touched and informed consent and outline the specific procedure for which we obtain consent • indicate that the process of a two-way conversation was undertaken • indicate how we accommodate our client's health literacy, such as the use of plain English resources and/or an interpreter.
SOAP	We record our client interaction using a clinical reasoning framework; • one example is SOAP; subjective (interview), objective (examination), assessment (analysis and action; includes treatment), plan (evaluation, monitor and plan for discharge) • we include precautions, associated risks, and warnings about potential harm or adverse reactions • outcome measures are recorded • abbreviations are used with caution.
Notes and the Law	• We uphold one of the principles of the Physiotherapy Board of Australia Code of conduct (8.4) by writing clinical notes for our clients. • We note the indicative time to review the plan. • We have policies and procedures in place to ensure our client's information is kept secure and confidential. • Our notes are: – contemporaneous and adequate – legible, accurate and factual – able to be easily understood by another practitioner – signed (verified).
Safe and quality practice	Our notes are reviewed and audited for reliability and consistency • we review our own notes as we write and contemplate the process and outcomes of our interaction • our peers review our notes as a process of clinical handover, collaborative care and/or audits • we promote and contribute to a safety culture where we embrace peer review. Our initiation to discuss documentation issues is expected and accepted.