



AUSTRALIAN
PHYSIOTHERAPY
ASSOCIATION

Guidelines for writing clinical notes

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Overview

The Australian Physiotherapy Association has prepared these guidelines for writing clinical notes as a foundation for all practicing physiotherapists.

Our aim is for these guidelines to be useful for all physiotherapists, from students and new graduates to experienced physiotherapists, managers and educators. They have been written with a variety of practice fields and workplace settings in mind, and are applicable equally for paper-based and electronic notes.

The principles and concepts for writing reliable and consistent notes are based on the following key elements:

- we understand our client and their evolving story, and this shapes their physiotherapy management and their health
- we use our notes as a reflection of our delivery of professional, ethical, safe and effective physiotherapy
- we demonstrate that we are accountable for our actions.

Members can access this material a number of ways depending on their needs:

- interactive webpage—summarising key principles and concepts with associated case studies
- quick reference guides—ideal resources as desktop summaries
- full background document—ideal for managers and educators.

How to apply the guidelines

The guidelines are descriptive, not prescriptive

The guidelines describe general recommendations to help physiotherapists meet their professional purpose, obligations and responsibilities when they record the various aspects of their client interactions.

Our intent is to express the guidelines in ways that ensure they are illustrative and descriptive, rather than prescriptive.

The guidelines are applicable across a variety of settings and in complex and changing environments. They also support safe, competent and accountable practice and help to maintain the good standing and autonomy of the physiotherapy profession.

The guidelines and support materials are a growing resource. The intention is to illustrate how we can apply the key concepts in general, rather than specific clinical circumstances.

The guidelines can be utilised as a foundation—as a set of principles and actions which physiotherapists and their teams further enhance to accommodate setting- and practice-based needs. Workplace-specific resources, to assist with the adherence to good clinical notes practice, may also be developed in combination with these guidelines and the support materials. We anticipate that many workplaces will create locally applicable versions of the material.

Navigation of the guidelines

We have written the section headings with careful consideration for easy navigation. We have designed the contents to provide the reader with an overview of the key elements for consideration when writing reliable and consistent clinical notes.

The guidelines are divided into sections:

- Part 1: The purpose of clinical notes**
- Part 2: When we write clinical notes**
- Part 3: What we write in clinical notes**
- Part 4: We consider where the clinical encounter occurs**
- Part 5: We identify the people involved**
- Part 6: Clinical notes reflect our client's consent**
- Part 7: Clinical notes reflect our reasoning and our actions**
- Part 8: Clinical notes reflect our commitment to our client's privacy**
- Part 9: We document group-type visits**
- Part 10: We use clinical notes as part of our site-based quality improvement**
- Part 11: We consider the benefits and risks of the digital domain**
- Part 12: Our clinical notes demonstrate our commitment to accountability**

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Introduction

We practise physiotherapy in diverse settings, across a variety of modalities and models of care. Some physiotherapist-client interactions are comparatively straightforward while others are complex in nature.

In the context of this range of situations, our members have asked us to provide them with guidelines on writing clinical notes.

The Australian Physiotherapy Association (APA) guidelines for writing clinical notes describe best practice principles for a number of health record-documentation behaviours and actions. We have based these behaviours on the APA Code of Conduct. They speak to the essence of why we, as physiotherapists, choose to work with people in our communities—helping them live healthier lives. Documenting our interactions with our clients helps validate the purpose of our professional work.

Clinical notes can be on paper or in electronic form. The key principles for writing good clinical notes apply for both paper-based and electronic clinical notes systems. Thus, we anticipate that these guidelines will continue to be useful as physiotherapists move into a digital health environment that includes the use of electronic health records.

For the purpose of these guidelines, we refer to the individuals who seek our help and procure our services as 'clients'. However, we note that 'clients' can equally be patients, individuals, consumers or customers, and we expect that when applying these guidelines to your area of practice, you will appropriately apply your preferred term.



PART 1: The purpose of clinical notes

Among their many purposes, including their role in communication and demonstrating safe and quality practice, clinical notes are a recording of our client encounters: from assessment and treatment to clinical handover; from education and research to safety and quality improvement. We also write notes to meet the [Physiotherapy Board of Australia's Code of Conduct](#), our [APA Code of Conduct](#), and to meet our legal obligations. As a result, clinical notes need to record the 'when', 'what', 'where' and 'who' of clinical encounters.

Clinical notes describe how we understand our client(s)

While clinical notes themselves act as a memory aid, they also reflect a quality, purposeful conversation. Our connection with clients is a foundation for our understanding of our clients as people and their individual circumstances. As a result, we have the opportunity to obtain complete and accurate information to assist our clinical reasoning.

Clinical notes facilitate safe, high-quality care

At the level of the client interface, clinical notes are a communication tool to facilitate the delivery of safe, high-quality, client-focused healthcare.¹

At the clinical governance level, we can use clinical notes to review professional practice—as part of quality improvement activities. Clinical notes are also a valuable source of data for research and resource allocation (eg, where to target service enhancements).

Clinical notes demonstrate our accountability for our practice

As physiotherapists, we need to build 'real trust' with our clients.² In so doing, we are accountable for managing our own behaviour. By supporting our peers, we assist in ensuring this accountability. Good clinical notes are one way of demonstrating that we are accountable for our actions and that we can be trusted by our clients.

PART 2: When we write clinical notes

Key points

Preferably, we write clinical notes at the same time as the clinical encounter or at the very least when the encounter is fresh in our minds.

We record the date for all encounters and, as appropriate, the time of the encounter.

We record clinical notes when they add value, and this is generally for each clinical interaction, including brief clinical encounters (phone, email and incidental contact) and cancelled or missed appointments where relevant.

We reflect three different types of encounters in our clinical notes: initial, progress and discharge notes.

We write notes when the recount is fresh

Clinical records are made contemporaneously with the provision of care (ie, preferably at the same time or, where this is not feasible, as soon as practicable afterwards). Clinical notes demonstrate our clinical reasoning and this is a reflective process best recorded when our thoughts and memory of the encounter are fresh in our minds.

We write notes on date and time

The date and time at which a clinical encounter occurs can be important influences on health outcomes and the decisions made by our client, their carers and their treating team. The date of the encounter also helps us, peers, clients and third-party funders understand health trajectories over time. Various clinical circumstances or workplace procedures may require the time to be recorded as well, (eg, in hospital settings or where clinical change is occurring comparatively quickly).

We write notes when they add value

Our first intention is to document our activities following each time we are engaged in our client's management, whether through brief or long consultations, including, for example, one-to-one consultations, group-type visits, telephone calls, emails, multidisciplinary team meetings, case conference, professional and third-party communications, eHealth (video link/phone/apps). We also record cancelled or missed appointments where relevant.

In saying this, it is common for physiotherapists in inpatient rehabilitation or aged care settings to write clinical notes only for remarkable interactions (eg, an adverse event or a change in a client's functional status). In these cases, if we do not write notes following each interaction, we must actively decide when and why this is justifiable.

We actively decide when writing notes adds value

As far as the law is concerned and the quandary whether we need to document every single interaction, we need to actively decide when writing notes adds value. While 'the law' considers the content, quality and contemporaneity of records, it does not necessarily follow that the failure to record anything and everything is going to cause legal problems for physiotherapists. The key issue is that we are able to justify our decision not to make the record, and an adequate justification supports our defence if our notes are scrutinised. In other words, if our peers would regard the practice of not making a note as appropriate and reasonable in a particular instance, then it is unlikely to pose a problem legally.

We actively decide the timing of writing notes

The concept of 'contemporaneity' tends to focus on generating the text as soon as reasonably practicable after the relevant treatment episode. In most cases, delaying the writing of notes would not meet the legal requirements that records are made contemporaneously with the provision of care (ie, preferably at the same time or where this is not feasible, as soon as practicable afterwards). However, in specific circumstances, such as unremarkable clinical interactions, delaying the writing of clinical notes may not cause any legal problems.

We write notes for unremarkable interactions funded by third parties

In circumstances where client interactions are unremarkable, we may need to write notes when our service for these interactions is funded by third parties (eg, National Disability Insurance Scheme, WorkCover, Motor Accident, Medicare, Department of Veteran's Affairs etc.) The value we add in writing notes is that we demonstrate that we delivered the service (despite unremarkable outcomes or activities).

We write notes to reflect three different types of encounter:

1. Initial notes

Our initial notes record all the data obtained from evaluating our client on their first visit or interaction. It may include a problem list, pattern recognition and clinically relevant aspects of the documentation framework, such as SOAP (see Part 7).

We establish collaborative goals with our client if this is appropriate at the initial visit, and the goals are listed in order of importance for both the physiotherapist and the client. Depending on the field of practice, a care or management plan may also be developed. However, we may not confirm these plans in areas such as aged care and complex/chronic disease until we have a better understanding of our client as a whole. It may take a number of further client interactions to establish these plans.

There is varied and often extensive information to consider at this initial interaction. Setting-specific templates developed by local physiotherapists and their teams can assist to guide the client interview. They can assist to ensure that we consider all relevant examination data points.

It is important to be mindful, however, that a template is a support, not a substitute, for the application of clinical acumen to an individual situation.

2. Progress notes

We record subsequent visits as progress notes.

Documentation reflects the way in which we review goals from the last treatment/interaction and the changes that occur during the period between consultations.

Documentation may also include new pieces of information and new problems where we may decide that a reassessment of our client as a whole is required, rather than an incremental review of current and planned outcome measures.

Progress notes demonstrate the trajectory of our clients' health. We record changes in outcome measures correlated with initial assessments. This will help us identify our clients' improvement, lack of improvement or deterioration. Each time we assess the relevance of the measures this triggers and informs our further action, which may include modification of management plans, discharge or referral to other providers. We also understand that lack of improvement may be an expected outcome for our client who has a predictable deterioration trajectory.

3. Discharge notes

Discharge documentation reflects the circumstances that lead to our client's health status when ceasing contact with us, and often includes:

- a summary of the presenting condition, course of treatment and response
- a summarised comparison between the final status and initial status
- the reason for discharge or discontinuation
- a follow-up plan or referrals to other support

We write notes for brief clinical encounters

Writing notes for brief interactions can be a particular challenge. Although the time spent in the interaction may be short, there is nonetheless an important obligation to create an effective record of the encounter.

The purpose of a short encounter is usually to focus on progressing with a client's care. As a result, it will often involve a reappraisal of our client's circumstances compared to a comprehensive reassessment in a one-to-one encounter. The clinical notes written for short encounters provide:

- a thread to our client's evolving narrative, ongoing clinical reasoning, formulation or affirmation of hypotheses
- evidence to support our clinical judgements for modification of management plans and appropriate participation in groups and classes, for example.

We write a record of each clinically relevant brief interaction with our client, including telephone calls and other electronic interactions (such as email, text messages and video conferences) in the clinical notes. Where appropriate, we also include interactions with third parties (eg, a carer, another member of the treating team or a representative from a compensation scheme).

An interaction with a third party presumes prior agreement with our client about the parameters of information sharing or an overriding legal obligation. Informed consent is obtained from the client prior to the interaction. We identify the 'other party' in the notes as well as the nature and outcome of the interaction.³

Recording phone and email contact may be structured using a condensed SOAP format, including relevant warnings and precautions. We recognise that we may not undertake some aspects of the 'objective' section, such as clinical outcome measures. However, documentation of client goals and functional status may be relevant.

PART 3: What we write in clinical notes

Key points

We write notes that are legible, factual and accurate and we write in ways that allow another health professional to understand the content.

Our clinical notes are written as a series of 'snapshots', and may be written in a way that creates a coherent 'narrative'/story of our client's care over time.

Our notes also capture other material and information needed and used in our client's care (eg, screening tools, referrals).

We consider the four audiences of our client's clinical record and respect the documentation requirements of third-party funders.

We write sound medicolegal reports and targeted letters and reports to other team members.

Our notes demonstrate our effective communication.

The form of our notes will reflect the nature of our collaborations on client care and may be in shared formats.

We write notes that are legible, factual and accurate

Clinical notes are legible, meaning another person can read the text (including scanned documents).

Clinical notes are factual, consistent and accurate. We write in ways that allow another health professional to understand the content and in ways that mean that our client can understand agreed actions, planning and outcomes. The level of detail is appropriate for the individual client's case.

We use permanent ink for paper-based notes. We cross through any spare lines or spaces so that we cannot make later entries in these areas. We briefly substantiate amendments and date, time and sign our entry. We ensure that the original entry remains visible. All entries are accurate statements of fact or statements of clinical judgement.

Our notes provide both a snapshot and a narrative

Snapshot

Each client interaction or occasion of service reflects the health status of the client in the past, on the day, in real time and between subsequent occasions. Accordingly, a single client interaction is driven by the client's circumstances over time. In this sense, documentation of the client interaction is process-driven and represents a snapshot description of the elements of the physiotherapy service. Some physiotherapists work in clinical areas where this snapshot is particularly important, as the occasion itself is important (eg, in emergency departments).

Although our professional and ethical requirements drive the documentation of each single occasion, it is not until the narrative unfolds that we begin to know our client and how our actions can have the resounding impact in our work. Consequently, the purpose of documentation is more than providing a snapshot representation of immediate circumstances.

Narrative

Physiotherapy is quite frequently a longitudinal mode of care rather than a form of care in which a client sees a physiotherapist on a single occasion. In these circumstances, our client's health record becomes a narration. The narrative is both a picture of an unfolding story within a single occasion of care as well as the connectedness of the occasions over time.

Documentation assists to make the narrative of our client's journey explicit through their recovery, their rehabilitation, their enablement, or even their end-of-life journey, and the impact of these on their lives, family and carers.

Documentation of our client's narrative demonstrates continuity of care.

Continuity of care is characterised by three threads:

- continuity of information
- being 'on the same page' or management continuity
- continuity of relationships⁴

Continuity of information

Information is the common thread linking care from one provider to another and from one healthcare event to another. This information can be condition and/or client-focused, identifying changes in their condition or information about our client's preferences, values and context, for example.

We often accumulate knowledge on continuity of care in our memory, but both the frailty of memory and turnover of staff mean that this knowledge needs to be recorded.

Being 'on the same page' or management continuity

Management continuity is achieved when all the people involved in care are 'on the same page' and not working cross-purpose. This means that clinical notes need to express relationships between actions at a single encounter (the snapshot) and the overarching goals of care documented at a previous encounter. This is particularly the case when more than one health professional is involved in the care of the client and we all need to be 'on the same page'.

The presence of incremental professional reflections (objective and/or subjective) about the relationship between the single occasion and overall strategy makes it easier for a physiotherapist to reorient themselves when memory of a previous encounter is limited.

Continuity of relationships

An ongoing therapeutic relationship between a client and one or more providers is often optimal for achieving the best health outcomes, in chronic and complex care especially.

Clinical notes provide a critical safeguard for circumstances when this continuity of relationships is disrupted.

Our client stories are fundamental to the purpose of our work. Through a chain of evidence and an evolving narrative encompassing our client stories, values and beliefs, we work in partnership with our client to individualise the most suitable, safe and acceptable solutions. Our client's narrative also opens opportunities to help us recognise relevant supporting or additional services, providing a whole-of-person approach to care.

A range of other documents and materials can become a part of our clinical record

There are a range of documents and materials that support our clinical notes. Some will become a part of the health record. These may include:

- management and care plans
- screening and clinical assessment tools
- client-reported outcome and experience measures
- customised client handouts.

- surveys
- compensable forms
- referral forms
- letter and report writing
- medical certificates
- clinical team meeting and case conference writing
- family meeting writing
- video recordings.

Organisational policy, procedure and guidelines supporting the collection of these types of documents will vary between work settings.

We consider the four audiences for clinical notes

Our client's clinical record is an adjunct to our practice. It not only reminds us of certain aspects of our care and helps us stay on track—it is also a tool used by other audiences of our documentation. The need to communicate effectively with these audiences influences the content and structure of our clinical documentation.

Broadly, there are four audiences of clinical notes:

- the writer
- our client
- our peers
- third parties.

The writer

Clinical notes are important to us as the writer.

As a contemporaneous act, they provide the opportunity to reflect on our clinical reasoning, our rapport and purposeful conversations with our clients.

As a record, they provide a useful safeguard against future error and an opportunity to refer back to our notes to inform further action, and remind us of any risks that we need to consider and mitigate. In his seminal article on human error, Reason argues that the basic premise in the system approach to safety is that "humans are fallible and errors are to be expected, even in the best organisations."⁵ One area of human frailty is memory and one strategy to reduce diagnostic error is to reduce the reliance on memory.⁶ Clinical notes are such a strategy.

Our client

In most circumstances, our clients have a legal right to access their physiotherapy clinical notes, although this does not happen very often.⁷

Our client may have readily available access to their health information through My Health Record.⁸ This is a communication tool which, in very explicit ways, is designed to give our client increased access

to the records by and about them, and increased autonomy and usability. Consequently, we need to consider how we write the notes that we can upload to this record in time to come.⁹ The way we write the notes for My Health Record will have an impact on client readability and usability.

We need to reflect on our clinical reasoning and technical knowledge and skill in our clinical notes, because our peers and other professionals may also need to rely on our notes. As a result, some aspects of our notes may be less well-understood by our clients.

Rather than compromise on the ability to convey important information to our peers and other team members, where our client requests access to their records, it can be useful to have a purposeful conversation with our clients and help them better understand any aspect of our notes which is challenging for them to understand.

There is a range of tools that can help structure our discussions with clients.¹⁰ These tools can help our clients integrate technical information with their own 'mental map'¹¹ of their health and life circumstances. Using these tools and recording their use and the discussions around them in our client's file can help ensure that our treatment and our notes are clear to our clients. As physiotherapists, we are well placed to help our clients understand the safeguarding role that notes play as a communication tool. We can help them understand why our notes might include technical information, for example.

Our peers

As members of a workforce community, we hold each other to account. Recording our notes with a view that a peer may read them can assist us to write clear notes. Providing good notes can also safeguard our peers from harm, including error, as well as be a safeguard for our clients. For example, writing unambiguous clinical notes can reduce the likelihood that our peers are involved in an adverse event.¹²

Third parties

We are accountable for the services we provide our clients. We are also accountable to third parties who may protect client safety, protect our professionalism or fund our services. An important aspect of this is that our notes are available, if required, in part or whole to third parties involved in the delivery of our services. Disclosure of client information is undertaken with due consideration of our obligations to client confidentiality and the privacy laws.

Examples of third parties that may request client notes may include:

- Funding bodies: organisations such as Medicare, Department of Veterans' Affairs, National Disability Insurance Scheme, Aged Care Funding Instrument, private health insurers, workers' compensation and Motor Accident Insurers
- Professional indemnity insurers: clinical notes may be used as supporting evidence in the case of a claim of malpractice or complaint of professionalism and conduct.
- Legal entities: court of law, police and solicitors, for example. Clinical notes may be used to support a case where a physiotherapist is an expert witness or defending their action relating to an alleged criminal offence in a court of law, or where the client's injuries are the subject of a compensation claim (eg, industrial accident/motor vehicle collision etc.)

We respect the needs of third-party funders

We have a number of obligations in our day-to-day professional practice. Our priority is to our client and our provision of safe and quality practice. Consultation fees are the primary source of revenue in the primary care sector and private practice. In the public sector, physiotherapists need to consider activity-based funding and the documentation requirements of their employer/health service to assess the activities delivered.

In private practice, our clients are sometimes the direct funders of our service; however, private practice typically relies on a mix of revenue sources that underpins its business model.¹³ A significant number of our services are reimbursed or subsidised by insurance schemes, including:

- private health insurance
- state-based workers' compensation and transport accident schemes
- Medicare Benefits Schedule
- National Disability Insurance Scheme
- Aged Care Funding Instrument
- Department of Veterans' Affairs.

We have accountability to our funders to provide effective and safe services, and we reflect this in our clinical notes.

Under the various funding mechanisms, we have specific accountabilities such as compliance to scheduled progress reports (eg, Medicare Benefits Schedule) or 'treatment approval' forms (eg, WorkCover). The purpose of these guidelines is not to expand upon the various requirements of each of these third-party funders; however, if we document our client interactions aligned with these guidelines, the submission of clinical information for each compliance activity is usually straightforward, effective and efficient.

We write sound medicolegal reports

We may receive requests for the preparation of physiotherapy medicolegal reports from our client, solicitors, insurer, statutory authority (eg, WorkCover), employer, police or a court of law. We can only provide a response to a request from a third party where:

- our client specifically consents
- the response is legally permitted (eg, where our client has signed a broad consent form in favour of a third-party insurer and the insurer than seeks to rely on that consent)
- we are otherwise legally required to do so.

Essentially, we have an ethical and professional obligation to provide such a report, but only where it is lawful and proper for us to do so.

Medicolegal reports may contain the following:

- client identifiers
- report purpose and requesting party's name and date of request
- physiotherapist's credentials
- clinical facts ('opinion' is only reported if appropriate)
- response to questions
- sign and date the report.

To provide an adequate report we refer to our clinical notes and not to our memory. It is also essential to we make our scope of practice and knowledge clear. A physiotherapist generates a medicolegal report with the assumption that the content may be publicly tested and challenged in court.¹⁴

We write targeted letters and reports to other team members

Our referrals, letters and reports to third parties are important communication documents which contain sufficient information to facilitate optimal and safe collaborative client care. We write them in a targeted manner for the recipient's readability and applicability, where we describe the content and technical information at the appropriate level for the audience. They contain sufficient information so that the recipient is appropriately informed, and to help them understand the past and current health status and/or make decisions for continued healthcare.

These documents are a key tool in integrating our client-focused strategy with external healthcare providers, our clients themselves and other key parties. We write them with client confidentiality in mind without disclosing sensitive client health information that is not relevant to the referral.¹⁵

Formal letters use a letter format that may include the following structure:

- addressed to a specific person
- professional greeting and closing
- each paragraph is focused, it may follow a framework such as iSoBAR, and includes detailed information on why we are writing the letter
- the final paragraph includes a note of thanks for reading and/or considering the information or request
- our contact information (full name, address, phone number and electronic forms, eg, secure messaging contact name for Argus¹⁶ or Healthlink¹⁷).

Referral letters and client progress reports may also include the following:

- clear and concise information which is as brief as possible without losing pertinent information
- brief client history of facts that are directly relevant to the topic at hand
- bullet points and bolded key items for quick and easy reference.

Our notes demonstrate our effective communication

Effective communication is an essential skill in everyday physiotherapy practice, with key areas of communication known to influence quality and safety outcomes throughout our client's journey.¹⁸ Our communication skills span clinical handover (Part 7), as well as communication with our client and key people involved in the care of our client.

With the growing complexity-of-care trajectories and chronic conditions, we are faced with increasing demands for sophisticated and effective communication. Communication styles that facilitate the involvement and participation of clients in the consultation are associated with positive therapeutic alliances.¹⁹ We are responsible for adapting our interventions, including our approach to communication so that it takes into account our client's health literacy.²⁰

Throughout our client's health record, we have the opportunity to demonstrate our effective communication with key people and our client. For example, we can record informed consent, shared decisions, client-written goals, use of resources appropriate for the health literacy of our client and record the other actions we have taken to support our communication strategies.

We contribute to shared care

Some clinical presentations, such as some chronic conditions, aged care and presentations where psychosocial issues are significant can be more complex than others.

To provide the best opportunity for our client to achieve their goals, our client may benefit from a referral to other healthcare providers within a well-coordinated team.²¹ If our client accesses a number of health services, this requires collaboration with a multidisciplinary team of people including but not limited to our client, family members and carers, physiotherapy team members and other health professionals.²²

High-quality, person-centred, chronic disease management requires 'a longitudinal and preventive orientation manifested by well-designed, planned interactions between a practice team and a client in which the important clinical and behavioural work of modern chronic illness care is performed predictably'.²³

If enablers and barriers to the participation in shared care planning are addressed, person-centred and team-based care is likely to be less fragmented. It is likely that the safety and quality of care will be enhanced and the benefits of team-based collaborative care more likely to be achieved.

Ideally, this requires an integrated and coordinated approach to writing notes and access to notes is available within the multidisciplinary care team.

As an example, a shared care plan for a client using a Health Care Home is designed to:

- get clients more involved in their own care
- improve the coordination of the services they receive inside and outside the Health Care Home.²⁴

As a result, a continued and deliberate approach to the ways we can facilitate appropriate sharing of our notes needs to be a part of the way we discharge our duty of care.

Increasingly, integrated electronic information systems are the preferred tools for achieving management continuity with our client and significant others. They are integral to upholding the safeguarding role of multidisciplinary care. Shared care planning tools such as CDMNet²⁵ and My Health Record²⁶ are being used to achieve the goal of creating a coordinated approach across teams.

As a result, it is likely that physiotherapists will increasingly need to consider the way that they prepare clinical notes in the context of these integrated electronic systems. We use shorthand with caution and expand on information or data points where there may be a risk of ambiguity (see Part 10).

PART 4: We know where the clinical encounter occurs

Key points

The location at which the clinical encounter takes place is clear in our notes.

We infer the location of the client encounter from other information, and if we cannot infer the location, then we record where the clinical encounter occurred.

Where the client encounter occurs, may have significant influence on our assessment process, the type of outcomes measures selected, the proposed management plan and the expected results. We also value how our client's circumstances may change depending on the environment within which we have the encounter.

We infer the location of the clinical encounter from other information

In many cases, we can infer the location of the clinical encounter from other information. For example, it is obvious that a clinical encounter occurs in a hospital if our client is an inpatient or that the sort of service provided means that the encounter occurred at our clinic.

We may record where the encounter occurred

Some services, however, provide physiotherapy in a range of locations; for example, they are 'mobile' services or we might see our client at their home or at our client's workplace. In these contexts, or where the site might be otherwise ambiguous, it is valuable to record details of where the clinical encounter occurred.

PART 5: We identify the people involved

Key points

We ensure that there is no ambiguity about the identity of our client.

We use at least three unique identifiers (family name, given name and date of birth) to identify our client.

We provide our client with the opportunity to identify with sex and/or gender.

We seek to identify the Aboriginal and/or Torres Strait Islander status of our clients and record this in their clinical notes.

We ensure that the identities of the people authorised to be involved in our client's care are clear.

It is our duty of care to recognise our client's right to be treated with respect and dignity. By the collection of diverse data, including name, address, date of birth, sex and/or gender, Aboriginal and Torres Strait Islander and cultural backgrounds, we can start to understand how our client may wish to be treated, building trust through our responsive and sensitive approach.

Our client is identified

The first record entry contains unique client identifiers such as name, date of birth or client ID number (if applicable). In entries thereafter, we repeat appropriate identifiers on each page of a paper-based system to mitigate the risk of unidentified or misplaced records.

Care must be taken to uniquely identify clients who have the same name. We do this through the use of other data such as address and other contact numbers.

Our client identifies with sex and/or gender

We recognise that individuals may identify and be recognised within the community as a gender other than the sex they were assigned at birth or during infancy, or as a gender which is not exclusively male or female. A commonly held view²⁷ is that sex/intersex²⁸ is a fixed concept that is biologically determined and gender²⁹ is socially constructed. A person's gender identity may or may not be consistent with their sex at birth.

Most often, we capture data on sex and/or gender when our client fills out the client information form or it is already collected prior to our interaction with them, such as in hospital settings. When collecting data by personal interview, asking the sex of the respondent is usually unnecessary and may be inappropriate, or even offensive. It is usually a simple matter to infer the sex of the respondent through observation, or from other cues such as the relationship of the person(s) accompanying them or their first name.³⁰

We are aware of the purpose for which this information is collected and we respect our client's privacy (see Part 8). We openly and properly address our client's healthcare needs with respect to the sex and/or gender with which they identify.³¹

We are consistent in the classification system we use to record sex and/or gender and we provide opportunity for our client to change how they identify at any point in time.

The key terms of classification for sex and/or gender identity are:

- M= male
- F= female
- X= indeterminate/intersex/unspecified.

There is a variety of terms used for X, such as non-binary, transgender, gender diverse, gender queer, pangendered, androgynous and intergender. Some cultures may have their own terms for gender identities outside male and female; for example, 'sistergirl' and 'brotherboy' are used by some Aboriginal and Torres Strait Islander people.

Although sex and gender are conceptually distinct, these terms are commonly used interchangeably, including in legislation.

We know if our client identifies as an Aboriginal and/or Torres Strait Islander

It is important for our services to be culturally appropriate and responsive to the needs of Aboriginal and Torres Strait Islander people—individuals, families and communities.

As a result, it is vital to routinely identify the Aboriginal and/or Torres Strait Islander status of each client and to record this.

To do this, we need to have the skills needed to raise the subject routinely when new clients come into our service. We also need to consider the design features of our service.

The people involved in our client's care are identified

In order to ensure the safety and quality of care, to assist in facilitating continuity, and to ensure our client's privacy, clinical notes need to identify the people involved in the client's care.

In the case of the treating physiotherapist, this can be evident when they sign the record of care.

The identity of members of the treating team may be clear through their involvement in a shared health record. Their involvement may be clear from documents (eg, a referral), which become part of the clinical notes. It is valuable for them to be named where the record is not shared or other confirmation of their involvement is absent, as this information assists to protect privacy and facilitate their involvement.

Later in these guidelines (Part 6) we discuss the importance of identifying carers who are involved and especially those who have a decision-making role. It is important to document this in the clinical notes to ensure that there is continuity of involvement (and authority where this exists) and the privacy of our client is protected.

The treating physiotherapist

The treating physiotherapist is the primary person responsible for clinical documentation. When documentation is finalised, the treating physiotherapist writes their name and signs the record. If we omit a note, we make a further entry under the last note by recording 'addit' and again record name, sign and date the record.

In the case of electronic notes, the treating physiotherapist has identifiable login details for initiating each entry.

A register of signatures and login details are kept securely at the workplace and updated when appropriate.

Physiotherapy assistants

In clinical programs where allied health or physiotherapy assistants (PTAs) are involved, the treating physiotherapist may delegate some tasks to the PTA.

Some physiotherapists handover clinical information to the PTA using the clinical handover framework iSoBAR (Part 7). Other physiotherapists use a 'warm' handover method where the physiotherapist instructs and explains key aspects of the delegation in real time with the PTA and their client together.

It is useful for services to have a clinical governance framework³² which guides the delegation of tasks. Within this framework, guidelines on clinical handover are used to outline the key aspects of undertaking the tasks and the safeguards implemented. For example, the delegating physiotherapist:

- understands the capabilities of the PTA
- clearly communicates tasks to be delegated
- assesses that the PTA understands the delegation.

Within this clinical governance framework, we may delegate the documentation of some aspects of a client interaction, to the PTA. This may be appropriate in supervised exercise work, for example. When we delegate a task, we share the responsibility for safe and effective care between us, the assistant and the employer.

PTAs write notes of their client interaction for the same reason that physiotherapists do. PTAs have a professional obligation and duty of care to obtain informed consent when appropriate and treat health information with confidentiality. They are guided by the same basic inclusions as physiotherapy clinical notes such as client ID, date, timely notes, legibility etc. However, the treating physiotherapist remains accountable for the quality and the safety of the treatment provided and the appropriate recording of the intervention. The treating physiotherapist is also accountable for the practice of monitoring and ongoing evaluation of a PTA's documentation and the standard of the work performed.³³

PTAs generally use the SOAP framework for writing clinical notes (see Part 7).

The PTA is likely to document the interview or subjective assessment (S) at each PTA-client session and obtain information about the client-reported experience or observation. If the client's response is positive, the PTA may continue with the intervention developed by the physiotherapist and client.

If the response is negative, the PTA is likely to discontinue with the planned activities and contact the supervising physiotherapist. At this point the client's circumstances or health status are reconsidered by the physiotherapist before the continuation of intervention. New or varied client circumstances or health status may prompt a reassessment by the treating physiotherapist and intervention modifications made prior to recommencement of PTA-facilitated activity.

Physiotherapy students

Typically, students write in clients' clinical notes. The student signs their name and states their role as a student.

Similar to the delegation process of PTAs above, it is important the supervising physiotherapist clearly understands what appropriate delegation to the student is in the specific setting/situation. There needs to be a clinical governance framework for student placement and everyone adheres to it.

The supervising physiotherapist remains accountable for the quality and the safety of the treatment provided and the appropriate recording of the intervention. The supervising physiotherapist is also accountable for the practice of monitoring and ongoing evaluation of a student's documentation and the standard of the work performed.

Therefore, the supervising physiotherapist must countersign the student's notes following an audit of the notes and satisfaction for quality. The supervising physiotherapist may also make an additional note, sign and date the entry.

In private practice settings, supervising physiotherapists need to be aware of any possible restrictions of students treating clients while claiming under third-party payment schemes. In the cases where there are restrictions, the student may observe if appropriate. If the student continues to treat the client, then the business absorbs the whole cost of the treatment or the client pays the whole cost if a rebate/subsidy would normally be available.

PART 6: Clinical notes reflect our client's consent

Key points

Clinical notes reflect:

- our client's consent to being touched
- our client's informed consent to proceed with a given action
- the discussions we have with our clients about their views on the benefits and material risks of care, as well as our views
- the way we shape our communications to accommodate the health literacy of our client
- the systematic approach to assessing and considering a non-adult client's legal competence to provide consent
- the identity of any person who is authorised by our client (or otherwise) to support our client in their decision-making (or to make health-related decisions when our client does not have this ability)
- our client's consent to the costs of care, as appropriate
- our systematic approach ensures that we are 'on the same page' with our client about the collection, use and disclosure of their personal information.

Our notes record our client's consent

In most situations, physiotherapists seek consent before assessing and treating a client.³⁴ Seeking our client's consent reflects our adherence to the ethical principle of respecting our client's autonomy and it meets important legal obligations.³⁵

Clients consent to, and need to consent to, a range of things: being touched, the clinical care they receive, the costs of their care, and the collection and use and disclosure of their information. Often this consent is clear in the way our client acts and reacts.

Some aspects of the area of consent have changed over time and continue to change. Thus, it can be important to reflect on our processes and check that they incorporate the contemporary thinking about consent.

An overarching approach to consent can be to verbalise the internal dialogue we are having while with our client: 'I think it would help if you took your shirt off. I need to hold your shoulder and assess the range of motion.' These explicit statements are examples of how we determine what we write in our notes to demonstrate consent. The reaction of our client can be appraised as the interaction progresses.

Consent

Obtaining consent simply means that our client has indicated they are willing to be touched in the way we propose. If they are not willing to be touched, then touching them may result in a claim for battery (sometimes referred to as trespass to the person).

The consent to be touched is often accompanied by a discussion about the material risks of a particular course of physiotherapy; however, some incidents

notified in the context of professional indemnity insurance are not about the quality of care provided or the associated risks, but about our clients objecting to where and how they were touched.

Thus, it is useful to remind ourselves of this starting point in consent.

Informed consent

So-called 'informed consent' requires us to consider other issues and take other steps.

Even though our client may have indicated their willingness to be touched, they may not have understood the risks for a proposed procedure they are about to undergo or the alternative treatment options open to them. We have a duty to exercise reasonable care in the provision of information about the proposed intervention.

Informed consent refers to a process of communication where a physiotherapist provides information to a client about a proposed examination, treatment, management plan or options for care. The client:

- listens to that information
- has a chance to ask questions
- contributes their insights
- participates in the formulation of the action to be taken, and then
- voluntarily provides their agreement based on an appropriate level of understanding.

Consequently, informed consent is very much about the fact that a conversation has taken place. Our clinical notes need to reflect that conversation.

Disclosure is part of informed consent

Informed consent is a person's agreement to allow something to happen based on disclosure of material risks, benefits, side effects, alternatives and consequences of refusal.

A risk is 'material' if:

- in the circumstances of the particular case, a reasonable person in our client's position, if warned of the risk, would be likely to attach significance to it, or
- if the physiotherapist is or should reasonably be aware that the particular client, if warned of the risk, would be likely to attach significance to it'.

Implied consent

Our client's actions or inactions can infer implied consent without consent being stated. This may occur commonly in physiotherapy when our client de-robots to commence an objective assessment. Our client implies through their participation that they have consented to these common procedures. If there is doubt that consent is implied, we obtain verbal or written consent.³⁶

Explicit consent

Verbal and written consent is explicit (ie, our client clearly states their agreement to a procedure or treatment). We obtain explicit consent for any treatment process. Conversations with our client will vary across levels of sensitivity or invasiveness of the proposed treatment or procedure; from mobilisation techniques to cervical manipulation, from education on activating transverse abdominis to a pelvic floor internal examination. Explicit consent also applies when our client has a higher risk of participating in a beneficial activity such as cardiac rehabilitation. We document verbal consent in the clinical notes alongside an accompanying outline of the action to be undertaken. In the case of written consent, our client signs the documentation.

Informed consent form/consent form

A consent form is not, in itself, 'the consent'. The proposed procedure/treatment and the agreement to proceed constitutes consent. The consent form simply documents the evidence that the conversation occurred and that the client agreed to the proposed procedure. Sometimes the form (depending on how detailed it is) may also provide written information for the client about the proposed intervention.

We consider our client's capacity to make decisions

It is our responsibility to turn our mind to the question of whether our client has understood the information provided and help them to understand it better, if in doubt.³⁷ Recognising our client's health literacy level, their indigenous and culturally and linguistic diverse (CALD) background and implementing strategies to address inadequate health literacy, such as purpose-specific resources, will support our client's understanding of the issues related to consent as well as so-called informed consent.

For Aboriginal and Torres Strait Islander peoples, decision-making may also have a 'collective' quality where people of the community are involved.

We consider whether our client needs, or has, support to make decisions

It is important to recognise that there is momentum to move away from the relatively binary notion that a person can give consent or needs a substitute decision-maker, towards the concept of supported decision-making.³⁸ This reflects, in part, our growing understanding that there is a continuum of abilities within people, among which is the ability to understand an issue and its consequences.

As a result, it can be useful to think of all of our clients as being on a continuum with some needing more help than others in some areas in the process of giving consent.

Decision-making supports and arrangements for our clients take many forms along a spectrum, including:

- informal arrangements—usually involving family members, friends or other supporters
- formal pre-emptive arrangements—anticipating future loss of legal capacity through appointment of a proxy; for example, in enduring powers of attorney (financial/property), enduring guardianships (lifestyle) and advance care directives (health/medical)
- formal arrangements in connection with healthcare-related decisions that follow the loss of legal capacity where this has not been anticipated and the decision-making powers assigned to another party (eg, guardianship by the state).

The concept of supported decision-making may be described as involving a range of processes to support individuals to exercise their legal capacity, including:

- effective communication, including in the provision of information and advice to a person and through ensuring that a person is able to communicate their decisions to others (which involves understanding their health literacy and its implications for our 'conversation' about risk and consent)
- spending time to determine a person's preferences and wishes
- identifying and considering informal relationships of support between a person and members of their social networks
- identifying agreements or appointments that indicate that a relationship of support exists
- ensuring that we recognise statutory relationships of support—whether through private or court/tribunal appointment.

In circumstances in which an adult client does not have the capacity to consent or communicate their consent, there is specific guardianship legislation enacted in each Australian state and territory which provides for consent from a substitute decision-maker.³⁹

A lawfully recognised substitute decision-maker may need to be included in our conversations, as they may be making the decision on behalf of our client. Most often, this includes a family member or carer; however, a family member or carer is not always the person regarded by law as the one who has the power or responsibility to make decisions when our client lacks capacity. Physiotherapists encounter a variety of different carers in different settings, some of whom have absolutely no role to play in this regard.

Thus, we need to be thoughtful in our considerations. We always need to clarify whom, if anyone, is the legally recognised substitute decision-maker and document this in our client's health record.

Consent and non-adult clients

To be able to give consent to treatment, a person needs to have legal competence.

Generally, the law in most jurisdictions in Australia recognises that the competence is reached when our client turns 18 (some jurisdictions set the age for healthcare-related consent a little lower). However, the law also recognises that this is an artificial distinction and that competence does not all of a sudden appear as soon as someone turns 18. Instead, the law recognises that there is a sliding scale of competence, where our client even under the age of 18, may have relevant legal competence to make certain decisions about the healthcare they receive. The Office of the

Australian Information Commission recommends that an assessment of a non-adult client's capacity to consent, is made on a case-by-case basis.

Some jurisdictions have specific laws about consent and non-adults and these are not necessarily consistent across the jurisdictions. Therefore, it is recommended that you refer to your jurisdiction's legislation. For example, in NSW^{40,41}; a young person over the age of 16 can consent to treatment. However, between the age of 14-16, the young person can also consent to treatment without parent/guardian consent.

It is useful to consider the value that involvement of parents/guardians can bring, especially in the case of sensitive or significant health concerns; however, involving parents/guardians can raise challenges with respect to confidentiality and thus we need to consider this at the same time.

It is useful for our notes to reflect the 'conversation' that occurs when discussing consent in these contexts. This will ensure that future interactions with the client, especially if another member of the care team is involved, are informed by the 'conversation'.

For more information on factors for assessing capacity, refer to the Australian Law Reform Commission.⁴²

Valid consent

Because the notion of consent has a number of threads, we bring these together to help our members ensure that they have valid consent.

Valid consent⁴³ is consent that is:

- freely given and without duress
- given by someone who is able (legally capable/competent) to consent
- specific and covers the intervention or procedure to be performed
- informed at least in very general terms⁴⁴

Consent to share client information

There are many occasions throughout our client's journey where we may need to share their information with another health professional, carer or third party.

Information about our client is 'sensitive' by definition. We need to firstly consider our ethical obligations with respect to this information and we remember that it is subject to privacy laws.⁴⁵ Should we need to share information, we are likely to need consent from our client to do so.

It is useful for the gaining of consent to begin with information given prior to the consultation, including how we share information. This can be in both written and verbal form. We may also discuss this information when the appointment is made or commenced.

The written form may be an information sheet that refers our client to the formal privacy policy that we have a legal obligation to maintain. It may be text hosted on our website for clients who use this channel of communication. It is important to consider which pieces of written information explain the secondary uses of any information gathered (eg, the sharing of it with other members of the treating team), as this secondary use is a common occurrence in our care for clients. Our conversation regarding the sharing of information will include disclosure of who the information will be shared with, what information is likely to be shared and why this is being shared.

However, there are some situations in where we can share information about a client with someone else even without the specific consent of the client. The main situation where this can occur lawfully is when this sharing would be recognised as having a directly-related secondary purpose within the 'reasonable expectation' of our client. An example of this is where a physiotherapist sees a client under a GP referral—in this situation, communications back to the GP do not require consent.

It can be useful for us to provide clients with an illustration of the secondary uses (eg, sharing information with their GP and using information for quality-improvement activities within the practice) as a part of the information we give to clients when they first attend our clinic. Although this may be shorter and less formal, it is not a substitute for a formal privacy policy—it is a complement.

If we want to share client information outside of 'reasonable expectation' (for example, sharing highly sensitive information or information for direct marketing), we must obtain consent to share this information with the caveat that our client can retract their consent at any time. For further information, refer to the Australian Information Commission (which regulates Commonwealth privacy laws).

Financial consent

We need to ensure that in addition to consent to be touched and consent to be treated, we obtain informed financial consent, as appropriate.

Often a client's financial consent to pay for physiotherapy services is implied because of their voluntary attendance.

In circumstances where the consultation will be of comparatively high cost (eg, a specialised consultation which is known to be longer) or when we plan an episode of care (eg, rehabilitation program), it may be appropriate to seek informed financial consent to the costs of the episode, rather than each individual occasion of service.

In any case, whether the consent is implied or explicit, whether the consent is for an occasion or an episode of care, it needs to be informed. It needs to involve the disclosure of material risks, benefits, alternatives and consequences of refusal. We need to outline the outcomes of the process of consent in our notes.

PART 7: Clinical notes reflect our reasoning and actions

Key points

Our clinical notes document our clinical reasoning.

They include information about our client that is:

- condition-related
- client-related and
- context-related.

We use familiar algorithms, like:

- SOAP (subjective, objective, assessment, plan)
- iSoBAR (identification, situation and status, observation, background and history,

assessment and actions, recommendation/ plan, responsibilities and risks).

We document and share in the development of SMART (specific, measurable, achievable, relevant and time-limited) goals.

Our notes include clinical outcome measures and client-reported measures that are meaningful (outcome and experience measures).

Our notes reflect our clinical reasoning

Our professional judgements are formed based on our clinical reasoning—a thinking and reflective decision-making process.

In addition to eliciting, understanding and documenting our client's subjective and objective circumstances through interview and examination, we bring to the clinical encounter our own expertise as a physiotherapist.

This combination of the client's viewpoint and a health professional's viewpoint may be called a 'meeting between experts'.⁴⁶

Through dialogue and interaction, we can understand our client's perspective. Assisted by our internal dialogue and the concept of multi-voicedness⁴⁷, we form a clinical impression of what is going on with our client. We base this on our perceptions and varying levels of analysis informed by a range of evidence including research, scholarly discourse and personal experience. Together with our client, we reason through the implications of treatment choice and management strategies.

However, to date, there is little literature with a focus on documentation of clinical reasoning.

We can easily record tangible aspects of client information such as demographic data, objective measures, techniques used and outcomes achieved. Yet some aspects of clinical reasoning remain a challenge to describe.⁴⁸ We may find that we are not certain of some aspects of our client's story. We may find that we are not certain of the way that our client's treatment will unfold or their health

status change. We may find we are not certain of the way that our client thinks their treatment will unfold or their health status will change.

Through a range of cues, clinical patterns and categorisation of these aspects, we formulate tentative hypotheses within these clinical categories. Uncertainty is part of our everyday practice. We work in 'grey scale' space, rather than the 'black and white'. We base our decisions often on imperfect data and, at times, limited knowledge.⁴⁹

As a result, our clinical impression and hypotheses are often dynamic and evolving; and as this occurs, we need continue to understand our client's emerging story through purposeful reflection. Writing notes using a clinical reasoning framework helps demonstrate aspects of our clinical reasoning as well as provide a reminder down the track of our clinical reasoning processes.

Our notes document an appropriate range of client-related factors

Clinical notes aid us in our understanding of our client. In this context, we record information about our client that is:

- condition-related (eg, the nature and severity of health conditions)
- client-related (eg, their personal and social history)
- context-related (eg, their work context, their home circumstances; the other professionals involved in their care).

We use familiar algorithms to support our clinical reasoning

SOAP

SOAP is a clinical reasoning framework commonly used across the physiotherapy profession.

It is not so much the acronym that is important—what is important is ensuring that we include key elements, as clinically appropriate, in our clinical process and our notes. Using a framework such as SOAP to assist us, ensures that our clinical notes play their role in communication and safeguarding.

As a result, there are a number of variations of SOAP (subjective, objective, assessment, plan), which are appropriate and relevant to individual practice settings.

Other variations of SOAP may include but not limited to:

- SOATAP (subjective, objective, assessment, treatment, (re)assessment, plan)

- iSOAP (introduction, subjective, objective, assessment, plan)
- SOAPIER (subjective, objective, assessment, plan, intervention, evaluation, review).

If you provide a unique service to a particular client group, you may wish to adapt the SOAP framework so that it helps you and your team consistently capture the information needed in your practice setting.

As we recount the client interaction through a framework such as SOAP there is also opportunity to demonstrate our duty of care by outlining the safeguards put in place to protect all parties concerned. These safeguards include informed consent, clinical flags, precautions, warnings provided and risk mitigation actions, as appropriate. SOAP may include the data points in Table 1 below.

Table 1: SOAP data points for documentation

Routine data collection		<ul style="list-style-type: none"> • client identification • emergency contact • privacy policy explained.
Key inclusions		<ul style="list-style-type: none"> • consent and informed consent, clinical flags, precautions, warnings provided & risk mitigation actions, if appropriate.
S	Subjective: <ul style="list-style-type: none"> • we make a preliminary impression of emerging clinical patterns • this informs the choice of objective assessments and risk mitigation required to undertake procedures or actions. 	Interview: <ul style="list-style-type: none"> • history, past/current biopsychosocial factors, physical symptom profile • describe and sketch symptoms on a body chart if appropriate.
O	Objective: <ul style="list-style-type: none"> • we use objective measures. 	Physical examination: <ul style="list-style-type: none"> • informed consent • safeguards in place • description of procedures/techniques • description of findings, normal and varied.
A	Assessment: <ul style="list-style-type: none"> • we make an overall impression through clinical reasoning based on pattern recognition (subjective) and results of measures (objective) • we prioritise the issues • we plan remediation • we action the intervention plan • we measure the response to the intervention. 	Analysis: <ul style="list-style-type: none"> • overall clinical impression/diagnosis and options for remediation • outcome measures outlined (SMART goals, clinical and client-reported measures). Action: <ul style="list-style-type: none"> • intervention plan or action to address goals • treatment: techniques, equipment & accessories, exercise & dosage, functional activity, education, self-management • response to treatment and relevant measures compared to baseline • safeguards in place.
P	Plan: <ul style="list-style-type: none"> • we make future plans and time frames to monitor changes in health status. 	<ul style="list-style-type: none"> • evaluation: evaluate treatment through systematic comparison with previous outcome measures, intervention goals, and reference to standards, as appropriate, including review of risks and precautions • monitor: indicators for monitoring prioritised health issues; timing and frequency of visits, risks to monitor • discharge: information when clinically appropriate.

SOAP is dynamic and fluid

SOAP, as represented above, might appear as a linear approach to clinical reasoning.

In practice, we are often presented with, and manage, a number of health issues within one single occasion of service. SOAP, therefore, needs to be a dynamic and fluid clinical reasoning framework where we move from one issue or clinical domain to another.

We might see this when a female client attends physiotherapy with a shoulder injury. Our client might present with a number of problems or clinical domains such as pain, instability, weakness and functional loss. She might be unemployed and a carer for her elderly mother. Thus, our approach needs to be dynamic and fluid.

At the commencement of our contact with our client (regardless of whether we are co-located with the client or using a digitally-mediated channel to connect with them in another location), we immediately commence the process of clinical reasoning. This may be as early as during our observation of the client's posture while sitting in the waiting room or our observation of the tone of their voice in a phone call.

As we conduct an interview (subjective assessment), we may decide to undertake an examination of one of the presenting domains (of the shoulder injury, in our illustration) before finalising our questioning about other domains. Following the examination of the first domain, we may choose to proceed with treating this domain before returning to further investigate the other domains.

Our decision to continue to investigate, examine and treat one domain over the others may depend on the client's preference, clinical priority and other circumstances. For example, it may make sense that while the client is seated in the consulting area, we investigate, assess and educate on pain management, all before asking the client to move to the treatment couch for assessment of instability and where we may perform special tests.

As the client-physiotherapist interaction unfolds, so does the client narrative. New pieces of information may be revealed which may require concurrent assessment throughout the consultation period or a 'circling back' to reappraise our formative assessment. Thus, small or short assessments (interview and examination), followed by targeted treatments, may occur a number of times within one occasion of service.

Clinical reasoning requiring concurrent and dynamic, fluid SOAP cycles may occur when we manage clients who have more than one condition/injury or more complex presentations and/or a number of biopsychosocial issues. In these circumstances, physiotherapists may find that it is beneficial to correlate their findings, analyses, management plan and treatments to a prioritised list of client issues, goals and clinical domains, reflecting a dynamic, multidimensional SOAP process.

Our notes reflect the interaction of contextual key factors

Although frameworks like SOAP separate elements of an assessment, we understand that this sort of separation is somewhat artificial in the real world of our client and their care.

Thus, we consider the interaction between key factors in our client's context.

For example, if our client comes from a CALD background, we understand that their identity might be 'objective' (eg, they may be of Greek citizenship and they may behave in particular ways that reflect their cultural identification) and that their identity has subjective elements (eg, the way they think about their identity and related cultural norms).

The extent to which we record the recommended data points will vary within and between practice settings and specific areas of physiotherapy, and also between single episodes of care.

iSoBAR

iSoBAR (see Tables 2 and 3) is a commonly used framework for clinical handover and also provides a communication and documentation structure for case conferences. iSoBAR was adapted from a framework used in high-risk environments to improve the safe transfer of critical information. We use iSoBAR as a generic clinical handover tool and it helps us to consolidate our thoughts prior to verbal handover. The framework can be adapted to the clinical context and situational variation. It is the preferred communication framework for clinical handover across healthcare sectors and settings. iSoBAR is also commonly referred to as 'ISBAR'. The Australian Commission on Safety and Quality in Healthcare has developed a change-management framework which may have applicability in improving clinical handover in physiotherapy practice.⁵⁰

Table 2: Descriptors of the clinical handover framework iSoBAR

ISoBAR	Descriptor	
I	Identification	Identify the client through demographic and data collection
S	Situation and status	Most pertinent current clinical or biopsychosocial issues
O	Observation	Indicators and measures which trigger or inform assessment and management
B	Background and history	Presenting problems, past medical history, problem lists, evaluation (assessments) and management to date
A	Assessment and actions	Overall impression, shared understanding and agreed management relative to the situation
R	Recommendation: responsibilities and risks	Course of action, treatment plan and task acceptance within the team

Table 3: ISoBAR. The following is an example of clinical handover notes for an elderly inpatient with a fractured patella.

I	<ul style="list-style-type: none"> Ahmed Polat, DOB: 12/12/1930, MRN: 000111. 86-yo male, # R) patella 1/52 ago. Past Hx PD, L) CVA 6/12 ago, # R) Colles 2015.
S	<ul style="list-style-type: none"> Lives alone and newly diagnosed with dementia. Bed-chair transfers-l; x1 assist all other transfers. Amb 4WW with S/v with ZKS. Underlying weakness in R) leg from L) CVA impacting balance and safety when mobilising. Plan for inpatient rehabilitation prior to assessment for suitability for discharge home.
O	<ul style="list-style-type: none"> P= 4/10 (VAS). Weakness R) hand and R) foot with mild hypertonicity.
B	<ul style="list-style-type: none"> English limited (Turkish), often refuses to have PT. Mx: Bed exercises, leg and arms 2x day. Improved Amb from 2m initially to 10m corridor 2x day with S/v & 4WW.
A	<ul style="list-style-type: none"> Mood is low and progression is slow. Nursing staff to assist with Amb to toilet and part way to sitting room. Daily PT input. Propose to discharge to Mount Thomas rehab for gym access and community activities.
R	<ul style="list-style-type: none"> PT to refer for ACAT assessment for return home and to contact family.

Legend: DOB=date of birth, MRN=medical record number, yo=year old, #=fracture, R)=right, 1/52=one week, Hx=history, PD=Parkinson's disease, L)=left, CVA=cerebrovascular accident, 6/12=six months, l=left, x1 assist=one person assist, Amb=ambulate, 4WW=four-wheel walker, S/v=supervision, ZKS=Zimmer knee splint, P=pain, VAS=Visual Analog Scale, PT=physiotherapy/physiotherapist, Mx=management, 2x=two times, m=metres, ACAT=aged care assessment team.

Management plans are co-designed through shared decisions

In the course of respecting the rights and autonomy of our client, outcome-focused physiotherapy management plans are co-designed through collaborative conversation with our client and/or significant others.

To provide the best opportunity for our client to recover, promote enablement, prevent the regression of chronic conditions or improve quality of life or end-of-life journey, our client may benefit from a meeting where they are joined by family, carers or advocates, as well as relevant team healthcare providers.

Where our client has mental, cognitive or intellectual disability, we and the people responsible for the care of our client (such as families or carers) may need to facilitate supported decision-making. Where we have such 'family meetings', we continue to focus primarily on the duty of care we owe to our client and we also consider the impact of our client's health on people close to them.

Writing good clinical notes means that we document the family meeting, including:

- the reason/s the meeting was called
- details of the people we engaged with
- an outline of the overall narrative and prioritised issues
- decisions there were made and agreed to
- a follow-up plan.

Shared care documentation and communication tools are integral to upholding the safeguarding role of 'co-design' of a management plan. Aspects of clinical notes written in plain English also assist readability if our client or relevant people request the sharing of our notes in appropriate situations.

SMART goals are developed

Essential to good clinical notes practice is the recording of person-centred goals. These goals are client-directed outcomes built on step-wise indicators. In the past, this was often left to the style of the treating physiotherapist. However, the International Classification of Functioning, Disability and Health (ICF) framework is increasingly used as a standardised approach of choice for physiotherapists when guiding clients' goals. Endorsed by the World Health Organization (WHO)⁵¹, impairments in health are considered in terms of five domains: body function and structure, activity, participation, environment and personal factors^{51,52,53}. The ICF framework helps us identify areas for improvement in our client's health status from their own perspective.

It is useful to consider establishing goals around the SMART framework (Tables 4 and 5), within the context of the action plan, multidisciplinary team goals and reporting indicators.

SMART goals are of particular importance to the setting (eg, rehabilitation, the management of chronic conditions or residential aged care).

In the context of our clients' varying personal circumstances, we also guide our client in modifying and establishing good and sustainable health behaviours to achieve their goals.

Table 4: SMART goals framework (modified from Clinical Framework: for the delivery of health services⁵⁴)

S	Specific	States the activity to be measured (eg, walking, work, participation in social activities)
M	Measurable	Measured in units (metres, hours etc.)
A	Achievable	Given everything going on in our client's lives, the likelihood of goal achievement
R	Relevant	The goals are relevant to our client and other key people
T	Time-limited	Time frame within which the goal(s) are expected to be achieved

Table 5: SMART goal sample

An example of a SMART goal for a client with osteoarthritis of the knee might be:

S	Specific	Return to bowls to play one game of one match
M	Measurable	Once per week
A	Achievable	Given that I look after grandchildren one day per week, this is achievable
R	Relevant	It is a hobby that I want to continue with and it is a social outing too
T	Time-limited	I will return to bowls for my first game in six weeks

Another framework that physiotherapists use is the **Goal Attainment Scale (GAS)**. GAS is an individualised outcome measure involving goal selection and goal scaling of outcomes (expected, more than expected or less than expected). GAS is standardised in order to calculate the extent to which a client meets their goals. We often use GAS in rehabilitation plans⁵⁵.

We include outcome measures

Physiotherapy is an evidence-informed health science practice.

We base our physiotherapy interventions on objective and scientific considerations where we evaluate the impact of ongoing repeated assessment using valid and reliable outcome measures. We also base these interventions on our understanding of our client's story and using health outcomes that are important to our clients. This is where the science intersects with the clinical sense of physiotherapy and the two are part of a continuum for validating our practice.

In day-to-day practice, we select the most appropriate clinical objective measures and methods, and we base these on age, cultural background and client values, language and health literacy profile, and presenting clinical status. It is important to choose clinical measures and tools that are both meaningful and valuable to our clients, other clinicians and healthcare funders.

Patient-reported outcome measure (PROMs) and patient-reported experience measures (PREMs) are tools which capture our clients' wellbeing and their experience of their healthcare journey (respectively) from their own perspective.⁵⁶

Client-reported outcome measures are included as appropriate

The routine use of PROMs can support clinical practice and healthcare delivery in a number of ways⁵⁷ Our clients seek our help because they want to improve their health. PROMs can link measurement to a client's health goals so they can gauge their improvement. Patient-reported measures can be a useful complement to clinical metrics. Rather than just using clinical measures, clients see a greater connection to the way that they measure they own goals, using PROMs and PREMs.⁵⁸ Thus client-reported measures that clients understand are imperative for person-centred care.

Client-reported measures are already in use in many clinical settings both across public and private health as well as in specific clinical areas such as joint replacement surgery. Further work is being done to consider their routine use to drive quality improvement,⁵⁹ which will mean that we will need to embrace their value, implement the tools and invest in sufficient resources to support data collection.

The future of healthcare and the accountability required by health funders and commissioners of services will soon see the use of PROMs in everyday practice. The data collected from these tools will be used for benchmarking of healthcare outcomes between health settings, states and countries (after appropriate risk adjustment to account for differences in casemix and other factors).⁶⁰

We can use PROMs to assess a range of health outcomes. A plethora of validated generic and disease specific tools are available to measure symptoms, abilities and unmet needs; some examples include measures to quantify distress/anxiety, quality of life, functional ability, health behaviour, health literacy and health satisfaction.

Client-reported experience measures are included as appropriate

Client-reported experience measures (PREMs) capture our client's experience of their healthcare journey and are particularly useful for monitoring our clients with chronic and complex health needs, and driving improvements in multidisciplinary integrated team care models over time. Examples of PREMS include access to and ability to navigate services, understanding of care plans and pathways, quality of communication, support for self-management for long term conditions and service satisfaction.⁵⁶

As a result, it can be useful to document PREMs in clinical notes.

Clinical measures

We use standardised clinical outcome measures to assess physiotherapy treatment effectiveness and to optimise the quality of client care. They are valuable in helping us assess the pathway of continued treatment for our clients. Clinical outcome measures also provide us with a basis for self-directed learning to drive continuous improvement in delivering physiotherapy services. However, it is proposed that the accuracy of these outcome measures is considered in the context of our client's health status and that outcomes may not be exclusively attributed to the treatment provided.

There is no outcome measure that is perfect for all purposes, and assessment and improvement toward a desired outcome may involve a suite of indicators appropriate for the purpose.⁶⁰

Thus, it is important to make discerning choices about the use of clinical outcome measures and to consider recording these in clinical notes.

Selecting meaningful outcome measures

In order to determine the most important and meaningful outcome measures and tools, consider the following factors.⁶⁰

- Reliability:
 - is the measurement reproducible and stable (test-retest reliability)?
- Validity:
 - does it measure what I want it to measure?
 - has the instrument been tested in populations that you wish to use it in?
 - published population norms may be relevant (if available).
- Clinical relevance: what am I measuring?
 - impairment of body structure and function
 - activity limitations
 - participation restrictions
 - quality of life.
- Responsiveness/sensitive to change:
 - does it detect a change in quality of life?
- Accessibility:
 - copyright issues
 - licensing agreements including fees payable
 - health literacy and readability, availability in languages other than English
 - electronic access and integration with clinical software
 - can it be self-administered?
 - affordability
 - responder burden (length of questionnaire, time taken to complete)
 - scoring considerations (summed score vs more complex scoring algorithm).

PART 8: Clinical notes reflect our commitment to our client's privacy

Key points

Our clinical notes reflect our commitment to our client's privacy.

We understand and adhere to the relevant Commonwealth and state/territory laws that govern the keeping of health records.

We have a written, comprehensive privacy policy which underpins our approach to privacy and thus underpins the way we manage clinical notes.

The privacy of personal health information is ensured

Doing the right thing by our clients means that we do the right thing when it comes to their privacy.

The collection of health information is organised in our client's health record and this includes a recount of what our client says and our professional impression, relevant correspondence, reports, forms and electronic media (videos, audio, photos, emails).

We protect client information

Both federal and state/territory laws regulate the privacy of health information.

As health professionals, we are responsible for collecting, handling, storing and appropriate sharing of health information, such as correspondence with referrers or third parties or via My Health Record and secure messaging platforms. Privacy laws impose a wide range of responsibilities in relation to your management of the 'information life-cycle' of client information. Consequently, we are obliged to 'take reasonable steps to protect personal information it holds from misuse, interference and loss, as well as unauthorised access, modification or disclosure'⁶¹, whatever system (paper or electronic) is the chosen documentation/collection format.

The information provided in these guidelines, intends to provide an overview of privacy and health records. The Australian Privacy Principles set out a range of behaviours in private practice. Some states or territories have their own specific laws. Those laws are similar in spirit (sometimes very similar) to the Australian Privacy Principles but not always in letter of the law.

Commonwealth laws

Health information is regulated by the Commonwealth the [Privacy Act 1988](#) (Privacy Act) which applies to all health service providers in the private sector throughout Australia. A health service provider is a person or entity who provides a health service and holds health information, even if providing a health

service is not their primary activity. Health service providers are covered by the Privacy Act for all activities involving the handling of personal information, not just activities that relate to providing a health service.

The Privacy Act does not apply to state and territory public sector health service providers such as public hospitals.

The Australian Privacy Principles

Many of the states' and territories' systems refer to privacy principles.⁶¹ The Australian Privacy Principles regulate information privacy in the private sector. The office of Australian Information Commissioner provides resources on protecting our client's information.⁶² The state and territory-based Acts or Laws⁶³ regulate information privacy in the public sector.

In addition to referring to your state or territory framework, the Australian Privacy Principles (APPs) provide a useful source of information to understand privacy principles in private practice.

For a summary of the APPs, see the [APP quick reference tool](#).⁶⁴ For more detail, see the [full text of the APPs](#).⁶⁵ Additional information on complying with the APPs can be found in the [APP guidelines](#).⁶⁶ The Office of Australian Information Commissioner (OAIC) also provides a [training webinar on the APPs](#),⁶⁷ aimed at people who are unfamiliar with the Privacy Act. Further guidelines are available on the APA website.⁶⁸

State and territory health privacy

New South Wales (NSW), Victoria and the Australian Capital Territory (ACT) have specific health privacy legislation that covers all health service providers (public and private sector) in those jurisdictions. This means that private sector health service providers operating in NSW, Victoria and the ACT must comply with both Commonwealth and state or territory privacy legislation when handling health information.

Queensland, the Northern Territory (NT) and Tasmania have privacy legislation that applies only to their public sector, including public sector health service providers.

Western Australia and South Australia do not have specific privacy legislation, although South Australia has administrative directions and codes that apply to the public sector, including public sector health service providers. South Australia also has healthcare legislation that contains some privacy related provisions.

For information on privacy regulation of health service providers in the states and territories, please refer to the appropriate links below. You may contact the [OAIC Enquiries line](#) if you have further questions about what aspects of privacy are dealt with by the OAIC.

The OAIC is also the independent privacy regulator for the eHealth record system and Healthcare Identifier service, and has functions and responsibilities under both the [My Health Records Act 2012](#) and the [Healthcare Identifiers Act 2010](#). More information is available on the [eHealth records](#) page.

Australian Capital Territory

The [Health Records \(Privacy and Access\) Act 1997](#) (ACT) regulates the handling of health information by both public and private sector health service providers in the ACT. The [ACT Health Services Commissioner](#) is one of three Commissioners within the ACT Human Rights Commission and handles health record privacy complaints.

The [Information Privacy Act 2014 \(ACT\)](#) (which commenced on 1 September 2014) regulates the handling of personal information by ACT public sector agencies.

The Office of the Australian Information Commissioner is exercising some of the functions of the ACT Information Privacy Commissioner. These responsibilities include handling privacy complaints against, and receiving data breach notifications from, ACT public sector agencies, and conducting assessments of ACT public sector agencies' compliance with the Information Privacy Act. For more detailed information, see [Australian Capital Territory Privacy](#).

New South Wales

The [Health Records and Information Privacy Act 2002](#) (NSW) (HRIP Act) outlines how NSW health service providers and public sector agencies must manage the health information of individuals in NSW. The HRIP Act applies to organisations (public sector agencies or a private sector person) that are health service providers or that collect, hold or use health information. The [NSW Information and Privacy Commission](#) administers the HRIP Act and accept complaints about the handling of health information.

The [NSW Information and Privacy Commission](#) undertakes the privacy functions conferred by the [Privacy and Personal Information Protection](#)

[Act 1998](#) (NSW) and [Health Records and Information Privacy Act 2002](#) (NSW).

Northern Territory

The [Information Act 2003](#) (NT) applies to NT public sector bodies, including to their handling of health information. The [Office of the Information Commissioner](#) for NT is the independent statutory body responsible for overseeing the privacy provisions of the Act and accepts complaints from consumers relating to the privacy of health information. The [Health and Community Services Complaints Commission](#) is also able to accept and resolve complaints about health, disability and aged services in the Northern Territory.

The [Office of the Information Commissioner](#) for the Northern Territory is the independent statutory body responsible for overseeing the privacy provisions of the [Information Act](#) (NT).

Queensland

The [Information Privacy Act 2009](#) (QLD) regulates the handling of personal information, including health information, by the Queensland public sector. [Queensland Health's website](#) has a comprehensive list of privacy and confidentiality contact officers for public hospitals throughout the state. The [Queensland Office of the Information Commissioner](#) receives and conciliates complaints related to the privacy of health information. Queensland's [Health Ombudsman](#) can also receive and investigate complaints about health services and health service providers, including registered and unregistered health practitioners.

The [Queensland Office of the Information Commissioner](#) receives privacy complaints under the [Information Privacy Act 2009](#) (QLD) which covers the Queensland public sector.

South Australia

The state public sector in South Australia does not currently have a legislative privacy regime. However, South Australian government agencies are required to comply with a set of Information Privacy Principles – [PC012 Information Privacy Principles Instruction](#). The [Privacy Committee of South Australia](#) oversees the implementation of these Information Privacy Principles by the South Australian public sector.

In addition, the South Australian Department of Health and Department of Families and Communities have developed a [Code of Fair Information Practice](#) which outlines what the Departments and their service providers should do, and what clients can expect, in protecting personal information. The Code also has its own set of privacy principles which have specific requirements for the handling of health information.

The handling of personal information by public sector employees is also addressed in the [Health Care Act 2008](#) (SA). A public health sector employee can be fined up to \$10,000 if any personal information relating to a client is divulged inappropriately.

The [Health and Community Services Complaints Commissioner](#) also receives complaints about government, private and non-government health and community services.

South Australia has issued an administrative instruction requiring its government agencies to comply, in general, with a set of Information Privacy Principles and has established a [South Australian privacy committee](#) to handle privacy complaints.

Tasmania

The [Personal Information and Protection Act 2004](#) (TAS) covers the Tasmanian public sector including public hospitals. The [Office of the Ombudsman and Health Complaints Commissioner](#) of Tasmania can receive and investigate complaints in relation to complaints under the Act.

The [Tasmanian Ombudsman](#) may receive and investigate complaints in relation to the [Personal Information and Protection Act 2004](#) (TAS). This legislation covers the Tasmanian public sector including the University of Tasmania.

Victoria

The [Health Records Act 2001](#) (VIC) provides for the protection of health information held by the Victorian public and private sectors. The Act is administered by the [Office of the Health Services Commissioner](#), an independent statutory body which conciliates complaints between consumers and healthcare providers.

The [Victorian Commissioner for Privacy and Data Protection](#) is an independent statutory officer established by the [Privacy and Data Protection Act 2014](#) (VIC) (which commenced on 17 September 2014). This legislation covers the handling of all personal information, other than health information, as well as covering protective data security, in the public sector in Victoria.

Western Australia

The state public sector in Western Australia does not currently have a legislative privacy regime. Various confidentiality provisions cover government agencies and some of the privacy principles are provided for in the [Freedom of Information Act 1992](#) (WA) overseen by the [Office of the Information Commissioner](#) (WA). The [Health and Disability Services Complaints](#)

[Office](#) (HaDSCO) is an independent statutory authority that also handles complaints relating to health and disability services in Western Australia.

The state public sector in Western Australia does not currently have a legislative privacy regime. Various confidentiality provisions cover government agencies and some of the privacy principles are provided for in the [Freedom of Information Act 1992](#) (WA) overseen by the [Office of the Information Commissioner](#) (WA).

For more information, refer to the links provided, or to relevant authorities in your state or territory, or to a responsible person in your workplace.

We have a written privacy policy

Physiotherapy services must have a written privacy policy which sets out rules on protecting our client's privacy and information.

We need to ensure that the privacy policy is readily available to our clients.⁶⁹ It is not only important to have this policy in place but it is also important to ensure that the behaviours and the cultures within our practice conform to that policy.

Another benefit of the policy is that when properly worded, it provides our clients with a description of the circumstances in which we propose to share clinical information helping to create a 'reasonable expectation' for sharing information.

Retaining clinical records

We retain our clients' clinical records as required and in accordance with state, territory and Commonwealth legislation. While the management of client information, including both paper-based and electronic formats and electronic media, are governed by laws for the private and public sector, as above, there may be specific statutory requirements in some states and territories.⁷⁰ Because of this variability, it is advisable to check with the relevant legislation.

Some jurisdictions such as ACT, NSW and Victoria have specific legislation relating to the length of time health information must be retained. In ACT, NSW and Victoria, clinical records are retained for a minimum of seven years for clients 18 years of age or older or to at least 25 years of age for clients less than 18 years of age, as from the date when the last entry was made.

The Privacy Act requires health information to be destroyed or permanently de-identified, once it is no longer needed for any authorised use or disclosure. If records are transferred or securely destroyed, a register is kept noting the details of records.

PART 9: We document group-type visits

Key points

Our approach to documenting our client's involvement in groups and classes is systematic, and this facilitates effective use of our time.

We assess or screen for safe client participation in groups and classes respectively.

We document attendance at education and primary prevention activities and make a record of any adverse event that occurs.

Group and class consultations led by physiotherapists

Physiotherapy exercise and education groups and classes are evidence-informed models⁷¹ commonly used in physiotherapy prevention and management programs across a range of health risk factors and health issues (eg, antenatal care, hydrotherapy, cardiopulmonary rehabilitation, chronic disease management programs and fall prevention).

In groups and classes, we see a number of people at once. As a result, the level of personal interaction is limited, compared to one-to-one consultations. The method of delivery of the intervention also shifts more towards client self-directed activities under supervision, with limited 'hands-on' activity by the physiotherapist.

A group or class can be a vehicle for preventive activities, including primary prevention.⁷²

A group or class can also be an effective and safe model of intervention.

Groups

A group consultation⁷² is characterised by participants working concurrently through individualised programs in the same setting (eg, clinic treatment area or pool). This might be the case with post-surgical rehabilitation programs, for example.

Prior to the participation in a group, we conduct an assessment to assess our client's suitability for participation and develop an individualised program. We screen our clients for risks that would otherwise prevent their participation. The assessment and risk screen for group participation is outlined below. The level of assessment and documentation, unless otherwise stated for specific physiotherapy disciplines, is determined by the service descriptor of a group (ie, individualised programs addressing individualised goals identified by individual assessment).

To assess suitability of an individual for participation in a group consultation, the following may occur and clinical notes written accordingly:

- a pre-participation assessment to identify prioritised health issues
- an identification of risks and clinical relevance of these risks to participation in a group consultation
- an agreement on clinical and client goals with the participant
- development of an individual program for the participant to follow
- consideration of the type of group and frequency of attendance
- establishment of clinical review time frames.

The clinical notes written following the participation in a group are likely to include:

- the date of each attendance
- the identification of the treating physiotherapist and their signature for each attendance (the physiotherapist countersigns if documented by allied health assistant for each attendance)
- a brief subjective/interview (narrative) where changes in health status are noted
- a record of the ways in which any identified risks to participation were mitigated (see safety considerations)
- a record of the individual program undertaken (in line with in the initial assessment)
- the response to the activity at each attendance (if an adverse response is reported, the response and action undertaken to remediate the adverse response is noted)
- the review against goals and continued participation in the group (conducted at the discretion of the physiotherapist, based on the clinical trajectory and progress).

Classes

A 'class' consultation⁷² is characterised by participants working concurrently through the same activities in the same setting (eg, gym, education or exercise area or pool). A class may be appropriate for ongoing management of osteoarthritis of the knee, for example, especially where the peer support and presence of a physiotherapist assists to enhance attendance for care.⁷³

Prior to the participation in a class, we screen our clients for risks that would otherwise prevent their participation (see *Safety considerations for participation in classes*). This screening for risk may not include an assessment consultation,⁷² as with assessing suitability for group participation. The level of assessment and documentation, unless otherwise stated for specific physiotherapy disciplines, is determined by the service descriptor of a class (ie, all participants follow the same program, which addresses homogenous "class" goals identified by clinically justified participation).

To assess suitability for participation in a class, the following may occur and clinical notes written accordingly:

- screening for risks to the participant's safety and for clinical relevance to participate in a class where a predetermined generic program is to occur (see the next section, *Safety considerations for participation in classes* for an example of discipline-specific pre-participation assessment and risk screen)
- identification of the type of class and frequency of attendance
- establishment of clinical review time frames (as appropriate and conducted at the discretion of the physiotherapist).

The clinical notes written following the participation in a class may include:


- the date of each attendance
- the identification of the treating physiotherapist and their signature for each attendance (the physiotherapist countersigns if documented by allied health assistant for each attendance)
- a brief subjective/interview (narrative) where changes in health status are noted
- a record of the ways in which any identified risks to participation were mitigated (see safety considerations)
- a record of our client's activities undertaken (which are likely to be identical for all class participants)—if an adverse response is reported, the response and action undertaken to remediate the adverse response is noted
- the review for continued participation in program (at the discretion of the physiotherapist, based on the clinical trajectory and progress).

Sample clinical notes

Sample notes for the first exercise session for a participant in a post-op total knee replacement (TKR) exercise group or a knee osteoarthritis (OA) exercise class may include the following detail in Tables 6 and 7 respectively. Clinical notes for subsequent groups and classes may have less information than the first session; however, we write notes if changes in our client's condition occurs.

Table 6: Sample group notes for TKR


(Abbreviations: DOB = date of birth F= female, W√√ = warnings; discussed and provided
 IC√√ = informed consent; discussed and obtained, ROM = range of movement, 2/52 = two weeks, 1/52 = one week)

Ms Helena De Jong DOB: 12/5/47 Gender: F [Client identifiers]	
21/6/17 [Date of data entry]	
Post-op TKR exercise group: 10.30am Wednesday [Group identifier]	
Subjective	No issues with home exercises
Intervention	W√√ IC√√, initial exercises trialed as detailed per exercise program, management advice given
Evaluation	Coped well with introductory exercises
Plan	Continue with additional exercise and progression as able, measure knee ROM 2/52
R/V	1/52
Signature	 Cate Anju (physiotherapist) [Name of facilitating physiotherapist]

Sample notes for first exercise session for a participant in a knee OA exercise class may include the following:

Table 7: Sample class notes for OA knee

(Abbreviations: DOB = date of birth M= male, W√√ = warnings; discussed and provided
 IC√√ = informed consent; discussed and obtained, ROM = range of movement, 1/52 = one week)

Mr Bruce Ng DOB: 1/1/42 Gender: M [Client identifiers]	
22/6/17 [Date of data entry]	
Knee OA exercise class: 11.30am Thursday [Group identifier]	
Subjective	Coping well with knees
Intervention	W√√ IC√√, Class-OA knee focus exercises
Evaluation	No issues, slight discomfort with kneeling exercises-using own pillow
Plan	Weekly class as per plan
R/V	1/52
Signature	 Cate Anju (physiotherapist) [Name of facilitating physiotherapist]

Safety considerations for suitable participation

A characteristic of group and class interventions is that individual physiotherapist-client interactions are more limited, compared to one-to-one consultations. In circumstances like this—where the purpose of the service is educational (for example)—documentation of a clinical reasoning framework such as SOAP may be unnecessary. Despite the application of a clinical reasoning framework being unnecessary, it is important that we assess and record our client's suitability for safe participation.

To assess suitability, physiotherapists undertake a pre-participation assessment of the risks to clients who wish to participate in a group or class. A pre-participation checklist may be beneficial to assist in assessing risks for participation. Assessment of risk does not only consider clinical risk of participation in physical activity; it also considers the following factors based on the Haddon Matrix,⁷⁴ which is a commonly used paradigm in identifying injury prevention:

- client: assess client-specific factors (eg, frailty or fear of water, or existing disability)
- vector: assess factors in the activity (complexity of the activity, number of people involved and risk of being 'bumped', risk inherent in the gym equipment like weights)
- environment: assess the physical and social environment (eg, if there is an emergency, how do we handle this, and are the other clients safe while we deal with an emergency? Is the access way clear? Is the equipment in good order? Are cultural norms, like avoidance or deference, at play?)

Physiotherapy-specific discipline frameworks may also guide the suitable selection of participants for the program. For example, for the participation in hydrotherapy programs, there will be additional clinical considerations to ascertain participant suitability, identifying potential precautions and/or contraindications for immersion in water. For most clients, a land-based assessment is adequate; however, with some clients it will be necessary to assess water safety and the ability to regain safe breathing position. We undertake (in the water) an assessment for water safety for higher-risk clients. *APA Australian guidelines for aquatic physiotherapists working in and/or managing hydrotherapy pools* will assist with the suitability and screening process for hydrotherapy group and class participation.⁷⁵

Similarly, it may be important to write notes about the screening process undertaken before allowing a client to participate in a generic strengthening class, or to assess the need for a personal assistant (for people with a disability).

Documenting terminology in group and class consultations

According to best practice, our physiotherapy group and class programs are evidence-informed. We are aware of correct terminology when describing evidence-informed programs. For example, Pilates is the terminology often used to describe evidence-informed strengthening programs. However, Pilates is an exercise model that may not be delivered in a consistent manner across health and non-health sectors. Therefore, the description of the strengthening program such as 'reformer strengthening' or 'transverse abdominus grade 2' is a more appropriate way of documenting 'core-based' exercise programs.

Clinical handover

We recognise that the physiotherapist who conducts the pre-participation assessment or risk screen and who refers clients into a group or class may not be the same physiotherapist who conducts the group or class. Therefore, clinical handover is integral to the process of referring our clients to a group or class. Physiotherapists facilitating groups and classes who do not conduct the one-to-one assessment have access to a clinical health/physiotherapy summary or tool that has screened for participation-risk, identifying any precautions for participation. The handover will also include the individualised or generic program for the client to follow, for group or class participation respectively.

Prevention and education models

Physiotherapists often conduct primary prevention and education programs. Primary prevention and education models address health risk factors rather than health issues. An example of a primary prevention program is an aqua-aerobics class for people who have no relevant current health conditions. An example of an education program is a sequence of antenatal classes.

A formal pre-participation assessment or a screen-for-risks may not precede a client's participation in primary prevention or education activities. Enrolment in a prevention/education program is often client-directed. In these contexts, it may be prudent to document a client's self-assessment (eg, a client may be asked to make a statement of their water-immersion capabilities for participation in an aquatic exercise 'prevention' program).

However, the responses of participants during and after the activities are monitored and risk mitigation put in place if risks are identified. These risks may be environmental or participant-based. If an adverse event occurs, we record the details of the event in the clinical notes and the ways we mitigated or minimised the risk, or managed the adverse effects to our client.

PART 10: We use clinical notes as part of our site-based quality improvement

Key points

Safe and quality practice is multidimensional, and fundamental to this is a workplace culture of safety.

We recognise that client safety involves having clinical governance systems that safeguard our clients and teams against errors that arise due to human frailty or systems failure.

We take action to address competing priorities.

We use shorthand (abbreviations, terminology, symbols) with caution and keep a log or register of commonly-used shorthand at the workplace. We also 'on-board' team care providers who are audiences of our notes to the definitions and use of our commonly-used shorthand.

A safety culture is fundamental to successful quality assurance and improvement

Safe and quality practice is not just about adhering to the systems—safe and quality practice is multidimensional and fundamental to this is a workplace culture of safety. Safety culture is the behaviours of people, based on trust within the environments in which potential problems are anticipated, detected early and responded to early enough to prevent significant consequences. High-reliability organisations relentlessly prioritise safety over other performance pressures.⁷⁶

While work policies and procedures are standards for practice and strengthen invariance, a safety culture handles emerging discrepancies, disruptions, and variations.⁷⁷ Rules are quick and easy to formulate and pronounce; however, systems include people and we have to understand how people work and behave in systems.⁷⁸ Safety behaviours may be less tangible but they evolve with changing circumstances and the environment.

We are proactive to avoid and minimise harm

Safety is the way we do business, and we demonstrate this through a proactive approach to avoiding and minimising harm in our everyday practice.

One way to we do this is by speaking with our client about risks and side effects and then recording those discussions (ie, informed consent). These discussions need to be ongoing, in line with the client's changing risk profile. This helps to reduce the likelihood that we, or another team member, overlook considerations of risks that we have identified in collaboration with our client.

Although we are proactive to avoid and minimise harm, humans are fallible and errors occur in the delivery of health care. Errors are seen as having their origins in upstream systemic factors.⁷⁹ It is important to collect data to ascertain the origin of these factors to inform the needs for improvement

and to demonstrate our accountability in providing the best care for our client following an adverse event.

Thus, organisational policy normally requires documentation of the incident or adverse event, on a purpose-specific form. As well as meeting these organisational obligations, we also document such events and our actions taken in response to the event, in our client health record.

We take action to address competing priorities

While, in theory, these guidelines may be straightforward, constant and continual internal and external drivers challenge our capacity to write adequate and contemporaneous notes. These drivers, such as physiotherapist fatigue, back-to-back time-based appointment scheduling, complex presentations and multidisciplinary models of care, impact the accuracy, completeness and clarity of clinical notes. This occurs despite our professional commitment to do our best to benefit our client within our scope of practice.

The quality of clinical notes is diverse across the profession. Physiotherapists are met with daily competing priorities. Our first priority is our obligation to our client. We spend our limited time dedicated to our client's care and clinical notes often become a second or delayed priority. While many of the pressures in clinical work are similar for all physiotherapists, the circumstances can be very different. However, clinical documentation is not a separate priority to our commitment to our client—it is an integral part of this commitment.

Working out how we can do things better and collaborating with our peers to advocate and drive a consistent quality in our notes will enhance the safeguarding role of our clinical notes. Many physiotherapists value a systems-based approach to help them write consistent and reliable notes for each client interaction.

We have systems in place to ensure the quality of our notes

Clinical documentation is one of our methods of enhancing safe and quality practice. Consequently, we need to know that our notes will in fact do this job.

A systems-based approach to regulating reliable and consistent notes is the preferred method of ensuring that we write good notes.⁵ A systems-based approach focusses on conditions under which the physiotherapist works and the establishment of defences or safeguards to writing poor notes. This approach also encourages a culture of reporting on quality and safety issues rather than direct target of an individual physiotherapist through the person-based approach.⁵

Systems to help regulate reliable and consistent notes can be established within a practitioners' own construct of self-regulation as well as within a work setting of peer regulation.²

Operational-based systems

Work-based systems include operational safeguards such as policies and procedures. A commitment to the audit of adherence to these operational principles and actions is one way of enhancing the quality of notes mitigating risk to our client, our peers and ourselves.

Policies

Policies are statements of purpose, practices and principles dealing with the ongoing management and administration of the practice setting. They describe the actions required to deal with the everyday issues and processes in the workplace. They are usually presented as a set of broad guidelines.⁸⁰ For example, a practice setting may have a policy on safety and quality. One of the practice principles to enhance safety and quality might be to commit to documenting reliable and consistent clinical notes.

Procedures

Procedures explain how to perform tasks and duties to achieve the purpose of the service as well as principles of practice. A procedure may specify who in the organisation is responsible for particular tasks and activities, or how they should carry out their duties.⁸⁰ For example, the practice procedure to achieve the principle of the practice of documenting reliable and consistent clinical notes might be adherence to these guidelines, the use of associated tools, such as SOAP, and/or the participation in a quality audit process.

We have systems in place to ensure the improvement in the quality of our notes

Clinical notes as a whole are tools that can aid the practice setting in establishing, implementing

and developing processes to monitor and improve the quality of our services.

Quality improvement can encompass activities specifically designed to improve clinical care or the health of the entire practice-based population, collect and analyse practice data and make decisions for service changes based on that data.⁸¹

When we seek the consent of our clients to the use of their personal information, we need to explain to them the ways that we will use clinical notes as a part of our site-based quality systems. In doing this, we establish a shared understanding with our client about this secondary use of their information.

Where we want to look across sites at information retained in clinical records, we need to establish the consent of our clients to this process, or ensure that there is no opportunity for clients to be re-identified through the data used in the activity.

The more consistent the approach to entering data into our client's clinical record, the more likely we are to have robust data when we want to analyse the lessons that clinical notes can teach us.

The use of digital health records, which have coded data, will assist to make the use of information in clinical records more accessible and its use more efficient.

Despite this, physiotherapists with paper-based systems can still review records, both individually and collectively, in order to collate data for quality-improvement activities.

Self-reflection is important in maintaining the quality of clinical notes

Our professional judgements are based on our clinical reasoning—a thinking and reflective decision-making process. This happens in real time during our client interaction. While writing clinical notes, we have the opportunity to reflect on and assess our professional judgement and practice.

As a result, reflective thinking and timely documentation used purposively can be described as a physiotherapist-based self-regulation approach to writing good notes. This physiotherapist-based system is anticipatory and therefore allows us to pre-empt risk and mitigate extenuating circumstances.

This is a 'feedforward mechanism'. By being proactive, we can enhance the reliability and consistency of our own notes. We can be proactive in accurately documenting a changing client narrative as the situation unfolds. Through the combined systems of self-reflection and reference to these guidelines, we write our notes recognising the detail necessary to demonstrate safe and quality practice.

Peer review is a system for maintaining and improving the quality of clinical notes

A practice-based system of peer review through a formal audit process is a 'feedback mechanism' used to enhance the reliability of our own notes and our peer's notes. We recognise that one of the most effective ways to sustain excellence in clinical notes is through regular audit and review of practice.⁸²

An objective, reproducible assessment tool is of great benefit in peer review. An audit activity measures our written content against predetermined values often represented in a checklist. Once the most frequent documentation errors are established, we take action to improve our note-writing practice in key areas and we schedule a review of the areas for improvement. Inherent to quality-improvement activities is the ongoing and cyclical nature of review, and this is not exclusive to writing clinical notes.

The feedback mechanism of an audit activity is simpler than a feedforward mechanism as it is consistent across individual practitioners. While the feedback mechanism is reactive in comparison to the more proactive feedforward mechanism, either system cannot stand alone; they are complimentary and additive in the regulation of reliable and consistent notes to enhance safe and quality practice.

Physiotherapists, including those in 'solo' practice, need to turn their minds to the importance of maintaining the professional discipline of writing good notes and need to ensure that they have a structured method of peer-review, such as an audit process. Other opportunities to embed the culture of writing reliable and consistent notes exist in:

- education in a formal setting or informal work based in-service
- peer reviews of clinical case studies and associated notes
- the sharing of notes of an experienced physiotherapist as exemplars for the less-experienced physiotherapist, facilitating an understanding of where to improve practice⁸³
- the development of a performance indicator on the practice of writing notes
- the development of position descriptions with writing reliable and consistent notes as a key responsibility.

We use shorthand with caution

Anecdotally, physiotherapists are extending the amount that they are writing in their notes.

We are responsible for clear communication in all settings and fields of our practice, and the use of shorthand is especially important when we consider clinical handover and team-based care.

The use of shorthand such as abbreviations, specific clinical terminology and symbols are no doubt convenient and time saving methods for documentation of clinical information. However, they can also be responsible for errors and harm and we need to use them with caution.⁸⁴

Shorthand can affect the safeguarding role of clinical documentation and can be:

- ambiguous and stand for more than one thing
- unfamiliar, especially in handover to clinicians who do not practice in the treating specialised field such as a multidisciplinary team⁸⁵
- interpreted as correct even when a mistake was made in the presenting documentation
- evolving, where common shorthand notations change over time and new ones enter documentation processes.

The majority of the literature on communication errors, shorthand and client safety has been written about safety in the use of medicines and abbreviations. However, there is local and international momentum, suggesting that it may be necessary to keep a 'do not use' list of terminology, abbreviations and symbols. The Australian Commission on Safety and Quality in Healthcare has published a list of 'accepted' and 'not accepted' terminology, abbreviations and symbols in the administration of medicines.⁸⁶

A number of physiotherapy settings have taken steps to address the safety risks associated with shorthand:

- most work settings do not permit abbreviations on consent forms and accident/incident forms
- some work settings have ceased the use of shorthand and abbreviations altogether
- some settings require that the complete term is documented at its first use, the abbreviation is written following the first use of the full term, and the abbreviation can only be used following this.

Some sites have generated their own list of commonly-used abbreviations and symbols. An onsite, practice-specific reference list can be important for paper-based notes. Electronic-based documentation may be supported by preprogrammed health information and a 'commonly-accepted' list will most likely be different. An additional, paper-based list of abbreviations, developed by local physiotherapists, might be useful for outlining the agreed abbreviations for free text fields.

Physiotherapists who work particularly in the public health sector may need to adhere to their workplace's health classification or coding system in their documentation.

PART 11: We consider the benefits and risks of the digital domain

We write clinical notes using either an electronic platform or a paper-based system. These guidelines are applicable in both record forms. In saying this, with evolving technology and utility of software, coupled with health system reform and the implementation of innovative healthcare models, we will need to be electronically prepared as we move forward to be part of eHealth.

Risks and limited utility of paper-based systems

Many physiotherapists are using the paper-based system to write clinical notes. The benefits of using paper-based notes such as flexible design and free text are quickly being outweighed by the risks.

Despite some physiotherapists using the paper-based system for years, some of the emerging risks for continuation of this system include:

- clinical information cannot be shared easily across service providers⁸⁷
- quality-improvement activities and evaluation of safety mechanisms are limited with time-consuming and resource-heavy data collection and evaluation
- reduced workforce pool for potential employees, as younger clinicians will be drawn to contemporary practice settings that have systems such as digital technologies
- practice settings will get further behind in fast-evolving health systems and, above all, impact safety, quality and access to their services
- burden to other health providers such as GPs who have to scan paper documents to electronic systems
- standard and unsecured email is not considered suitable for routine communication.

Physiotherapists who currently use paper-based systems will find in the near future that not only will their peers be using digital technologies but that their clients will be expecting digital access to their health records and healthcare solutions.

Physiotherapists who use a mix of paper and electronic forms may find there are potential clinical risks⁸⁸ with this strategy, as significant clinical factors may be overlooked if we do not ensure that clinical notes are duplicated⁸⁹. Hybrid systems also present a risk when more than one physiotherapist is managing a client.

Benefits and risks of digital records are addressed

The benefits of using digital platforms for writing clinical notes are well known in healthcare.

Digital technologies have transformed the way healthcare is delivered and accessed by the community. Some of these benefits include:

- connecting the healthcare network such as through shared care planning tools (eg, CDMNet²⁵, My Health Record²⁶, Health Care Homes⁹⁰ and secure messaging for provider-to-provider communication⁹¹)
- meeting the national standards for electronic transmission of health information
- improving the client experience
- assuring and improving safety, quality and accountability
- a consistent and easy to use framework for writing notes including pre-populated fields
- less human error and less duplication
- reduced overheads (less mail, faxes etc.) and better use of resources
- integration of care between primary, community and tertiary settings
- health data at local sites become part of a data collective
- mobile (remote and offsite), concurrent and immediate access to records
- coded text for aggregating data and easy data extraction for producing reports
- outcome measures such as Client Reported Outcomes and Experience Measures (PROMs and PREMs) are being delivered electronically
- an accessible repository of clinical information for quality improvement, such as client cohorts, health conditions, measureable outcomes and adverse events
- the role of 'big data' in the physiotherapy profession and other healthcare fields where we can build health profiles and better predictive models.⁹²

From the introduction of secure messaging platforms for clinical handover to consumer and provider access to My Health Record and the internet, the way healthcare providers communicate through clinical notes has changed. As of 2018 My Health Record will become an opt-out program,⁹³ so in theory, most of our clients will have an eHealth record. There is now a national priority to move away from paper-based healthcare communication systems towards electronic systems.⁹¹

However, despite the benefits of digital notes and communication, there are risks and barriers to its implementation and sustainable utility. Some of these include:

- significant financial, resource and training investments
- change management and adoption for sustainability
- governance of digital information
- cyber security
- lack of commitment from peak organisations
- poor clinical flow or client narrative when notes are printed.

Physiotherapists who use digital notes and digital technologies have a responsibility to be aware of the risks, evaluate these risks against their practice model and put in place improvement activities to address any concerns. At the time of writing, standards for managing security of digital health information are accessible from the Royal Australian College of General Practice.^{94,95,96}

There is more work to be done in the area of digitising clinical records and healthcare as a whole. Physiotherapists may access current information on this topic through the [Australian Digital Health Agency](#), your local [Primary Health Network](#) or [APA](#).

PART 12: Our clinical notes demonstrate our commitment to accountability

We want to have the ‘real trust’ of our clients and the community

In demonstrating accountability, we need to consider the question: ‘To whom am I accountable?’

One of the hallmarks of a profession is that we seek to gain and maintain the trust of our clients for both intrinsic and instrumental reasons.⁹⁷ This trust is the foundation for our professional and ethical conduct.

If we trust someone, regardless of whether there are penalties for acting otherwise, then the trust applies to the actual person or indeed the institution or profession. This is ‘real trust’. In contrast, regulated trust is a trust in rules where a breach of these rules imposes sanctions or discipline.² As a result, we want to have the ‘real trust’ of our clients.

We recognise there are four cornerstones of gaining trust

We can pursue trust in a number of ways:

- individuals can be accountable for managing their own behaviour (‘As a point of principle I want to demonstrate my safe and effective practice’)
- peers can assist to ensure accountability (‘My peer has an expectation that I will provide a good clinical handover’)
- the market can regulate (‘We are only taking tenders from services that can demonstrate their effectiveness’)
- the state can enforce laws (‘You had better write good notes because if something happens, you will not be able to provide the evidence to defend yourself’).

Using this first pair of cornerstones—individuals and their peers—is a ‘self-regulatory’ model. It is, in a sense, real trust and an ‘internal’ form of regulation.

Because we recognise the limitations of this model (not all members of our profession are influenced by their peers or maintain a sound ‘moral compass’), we understand the need for and role of market and state regulation—in a sense, an external form of regulation.

Clinical notes reflect our adherence to ethical principles

Our clients, key people and organisations trust us because we are professional and accountable for our actions and behaviours. The purpose of writing clinical notes is closely integrated with the behaviours and actions associated with the four ethical principles and five values of the APA Code of Conduct.⁹⁸ The APA Code of Conduct sets out the principles that we believe and hold dear, and how we do things, both as physiotherapists and as members and volunteers with the APA. Good practice in writing clinical notes is just one way we can demonstrate our commitment to high-quality professional and ethical practice.

Table 8 below, describes some examples of how the enduring practice of the APA Code of Conduct is demonstrated through clinical documentation. More information about some of the key ethical principles and values are within the body of this document and can be found on our web resources pages. Members are advised of the importance of seeking the advice of colleagues should they be facing difficult and challenging ethical situations.

Table 8: APA Code of Conduct ethical principles; examples of how we act and what we write in our notes

Principles	Our actions are recorded in our notes: examples
Respect the rights and autonomy of the individual	<p>We undertake shared decisions and establish collaborative goal-setting and management plans</p> <p>We undertake the process of consent to be touched and informed consent to proceed with a given action</p>
Cause no harm	<p>We identify precautions and associated risks of our proposed intervention (we may schedule a reminder to review precautions and risks, if appropriate)</p> <p>A setting-based register of shorthand (eg, abbreviations) is accessible and up-to-date. We ensure that when 'on-boarding' new staff and other healthcare providers who work with our notes that we use shorthand with caution.</p> <p>If in doubt, we expand out our shorthand so there is no ambiguity.</p>
Advance the common good	<p>We use a clinical reasoning framework such as SOAP</p> <p>We select valuable measures and indicate the treatment outcomes against our client's goals, in context to our client's evolving health</p> <p>We demonstrate our client's progress in stages as well as a whole</p> <p>Clinical notes can be read as stand-alone occasions and as a coherent and connected 'story'</p>
Act fairly	<p>We demonstrate our effective communication and outline our client education. We use culturally sensitive and responsive resources to help us communicate with our client.</p> <p>The rationale for and the way in which we have modified our practice to address our client's biopsychosocial and special needs (eg, through the use of an interpreter) is recorded in our notes.</p>

Value	Our actions are recorded in our notes: examples
Respect	<p>The language in our clinical notes is respectful, non-judgmental and we use inclusive language</p>
Build trust	<p>We record our client's goals and associated indicators in our client's own language where possible</p>
Collaborate	<p>We contribute to and record multidisciplinary team discussion and actions</p> <p>We note our client's agreement to the involvement of other team members</p>
Continuously improve	<p>Quality-improvement activities that use the data in clinical notes are evident</p>
Use healthcare resources wisely	<p>Referral details and associated correspondence are noted and filed, and rationale for referral is outlined</p>

Physiotherapy notes and the law

To many health professionals, the law may appear complex, confusing and sometimes even intimidating. This section seeks to outline the legal requirements which we need to consider when writing clinical notes.

The law shapes our documentation approach

Accurate, clear and comprehensive clinical notes play an important clinical role—they are an integral part of good-quality client care.

The law, in regards to our clinical record documentation and management, plays an important foundational role in shaping our approach to creating our clinical notes. It does this by describing and influencing:

- what we **must** do (eg, legislative/contractual compliance)
- what we **should** do (eg, risk reduction and risk management responses to a range of medicolegal risks and responsibilities).

The information in this section is informed by the following approaches and assumptions:

- what is ethically appropriate is also usually legally correct
- what is clinically appropriate usually aligns with sound medicolegal risk management
- but sometimes, the law requires more of us.

Our notes may be scrutinised in various legal/medicolegal settings

A range of courts, tribunals and third-party payers may need to look closely at our clinical records. These include:

Courts and tribunals will often need to look closely at your notes to work out:

- the nature and extent of injuries suffered by a client (eg, industrial accidents)
- the quality of care provided by you (eg, a negligence claim or a disciplinary proceeding against you).

Third-party payers include:

- private health insurers
- state-based workers compensation and transport accident schemes
- Medicare Benefits Schedule (MBS)
- National Disability Insurance Scheme (NDIS)
- Aged Care Funding Instrument (ACFI)
- Department of Veterans' Affairs (DVA).

While our primary legal responsibilities are to our client, third-party funders will also have in place a range of accountability mechanisms to ensure they are paying for clinically indicated, properly performed and delivered services in line with expected clinical practice.

For example, private health insurers may conduct audits of our clinical notes when they have reason to believe that a service type was not delivered as stated by the service claim (ie, whether physiotherapy services claimed under 'group' item number were delivered according to the group or a class service descriptor. A 'group' service is where, following an initial assessment, participants identify their goals and undertake individually designed activities concurrently in the same setting. In comparison, a 'class' service is where, following a risk assessment, participants undertake a generic program of activities concurrently in the same setting. Our clinical notes written for our clients' attendances in these services need to reflect this difference (Part 9).

Some of these third-party funders' mechanisms also impose responsibilities on us to create a range of documents, including, for example, referral letters, plans, reports etc. Other mechanisms more directly touch on the content and quality of the clinical notes we create about our clients.

The documents we create, or fail to create, may often have a critical bearing on our capacity to satisfactorily demonstrate we have acted professionally and in line with our various responsibilities.

Statute law and common law are relevant to our record-keeping responsibilities

The laws most relevant to our record keeping responsibilities come from two main sources: statute law and common law.

Statute law

Statute Law comes from legislation created by Parliament. This legislation is created both by Federal Parliament as well as by parliaments of individual states and territories (eg, Privacy Act, Aged Care Act 1997, Medicare scheme).

Medicare scheme

The Medicare scheme is a good example of how statute law requires us to create adequate and contemporaneous records.

Physiotherapists who are entitled to bill Medicare can only do so in line with Medicare's rules. Critically, Medicare is empowered to investigate whether a practitioner's conduct in connection with rendering or

initiating services was 'inappropriate practice'. Medicare may investigate (among other things), whether the physiotherapist kept adequate and contemporaneous records (Health Insurance Act 1973, Section 81)

This expression 'adequate and contemporaneous records' is clarified in relevant regulations such as the Health Insurance-Professional Services Review-Regulations 1999.⁹⁹

To be 'adequate':

- the record must clearly identify the name of the client
- the record must contain a separate entry for each attendance by the client for a service and the date on which the service was rendered or initiated
- each entry must provide clinical information adequate to explain the type of service rendered or initiated
- each entry must be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the client's ongoing care.

To be 'contemporaneous', the record must be created:

- at the time the practitioner rendered or initiated the service, or
- as soon as practicable.

In short, the Medicare authorities require our records to:

- clearly identify the name of our client
- have a separate entry each time our client has attended a service
- include the date the service was provided or initiated
- contain enough information to explain the type of service provided
- be clear enough so another practitioner, relying on the record, could effectively undertake the client's ongoing care
- be up to date, making sure it's completed at the time the service was provided or as soon as possible afterwards
- be in either paper or electronic form.

The potential consequences of non-compliance can be very serious. If we are audited and found to be non-compliant, the following punitive action may apply;

- repayment of the full amount of the incorrect Medicare benefit that was paid
- payment an administrative penalty.

The common law

The common law is also known as judge-made law or the system of 'precedent'. It is the case law made as a result of court decisions in the various jurisdictions. The common law will cover areas not covered by legislation but will also extend to interpreting the meaning of legislative language.

In regards to clinical records, the key legal areas explored by the courts often relate to:

Law of negligence

Our legal duty to exercise reasonable care when treating our clients, as imposed upon us by the law of negligence—a claim based on an alleged failure to exercise reasonable care in the way we manage our client. The way we manage our client is in connection with any, or all parts, of our legal duty to exercise care in the way we:

- diagnose
- treat
- communicate with our clients about risk.

Courts will look at these records to help determine whom did what to whom and why, and whom said what to whom and why. For example, a client developed a deep vein thrombosis (DVT) and subsequent pulmonary embolus following compression bandaging around his swollen, arthritic knee. The client has a high risk of DVT including vessel disease and compromised vessel function (eg, poor pedal pulses). Another example is when a client participating in rehabilitation from a moderate stroke falls off a gym exercise ball during unsupervised exercise and hits their head, resulting in chronic headaches and inability to work.

Contract law

The law of contract imposes upon us certain record-keeping responsibilities. The contract can exist as a result of an agreement in the following circumstances.

A third-party payer agreement

Sometimes the clinical note requirements of a third-party payer do no more than reinforce and emphasise the importance of clear and comprehensive record-keeping. For example, the Department of Veterans' Affairs, in its *Notes for Allied health providers*,¹⁰⁰ includes a requirement that:

'..the healthcare provider must create and maintain adequate and appropriate records related to all administrative and clinical aspects of the provision of treatment to an entitled person. The care plan and/or clinical notes must be updated in a timely manner in relation to healthcare services provided on a specific date of service.'

However, in other circumstances, a third-party payer may require more of the physiotherapist and impose a range of documentation responsibilities relating to the administration of our notes rather than to the content of clinical notes. For example, under the National Disability Insurance Scheme,¹⁰¹ a physiotherapist may need to document part of the 'evidence for access' to that scheme and Department of Veterans' Affairs.

Employment agreement

A contract of employment may contain a provision that requires us to comply with:

- our employer's policies and procedures (eg, policies and procedures on record keeping and responsibilities)
- the rules and laws which our employer must comply with, including laws and rules relating to records, or rules imposed by a jurisdictional health department.

Our professional indemnity insurer

An insurance policy is a contract between a physiotherapist and the insurer. This contract imposes terms, conditions and responsibilities on both parties. If we fail to comply with a condition in the contract, then our entitlement to indemnity cover may be at risk. Common conditions in insurance policies require a policyholder (the physiotherapist) to:

- maintain accurate descriptive records of all professional services and equipment used in medical, clinical or therapeutic consultation, treatments or procedures (these records must be available for inspection and used by the insurer in the investigation and/or defence of any claim to which they relate)
- retain all such records for at least seven years from the date of consultation, treatment or procedure, and, in the case of a minor, for a period of at least seven years after that minor attains majority¹⁰²(see Part 8).

In private practice, we tend not to have a written contract between ourselves and our client. However, as a matter of law there is an implied contractual relationship and, therefore, a range of implied contractual duties will exist, in addition to the legal duties under the law of negligence. One of these implied contractual duties is to exercise reasonable care in providing the service. This arguably extends to the quality of our clinical records, both in terms of the treatment provided and future ongoing care plans and communication between key people.

The Physiotherapy Board of Australia: Code of Conduct

The Physiotherapy Board of Australia (PhysioBA) developed and approved a Code of Conduct for Registered Health Practitioners (the Code).¹⁰³ It came into effect on 1 July 2010.

The Code contains the following key provisions concerning clinical notes:

- maintaining clear and accurate health records is essential for the continuing care of clients
- keeping accurate, up-to-date, factual, objective and legible records that report relevant details of clinical history, clinical findings, investigations, information given to clients or clients, medication and other management in a form that can be understood by other health practitioners
- ensuring that records are held securely and are not subject to unauthorised access, regardless of whether they are held electronically and/or in hard copy
- ensuring that records show respect for clients and do not include demeaning or derogatory remarks
- ensuring that records are sufficient to facilitate continuity of care
- making records at the time of the events or as soon as possible afterwards
- recognising the right of clients or clients to access information contained in the health records and facilitating that access
- promptly facilitating the transfer of health information when requested by clients or clients.

The medicolegal significance of the Code

The Code provisions will be considered by courts and by tribunals when seeking to assess the quality, competence and professionalism of the care delivered. These provisions are therefore considered both in relation to:

- court proceedings where there is a compensation claim against you eg, a negligence claim and,
- disciplinary proceedings against you ie, the code provisions are admissible in proceedings against a physiotherapist as evidence of what constitutes appropriate professional conduct or practice.

Disciplinary consequences

PhysioBA has a broad range of options available as a result of the powers given to it under the National Law. If we have a reasonable defence, then the PhysioBA may decide to do nothing. At other times, it may decide to formally reprimand or require a physiotherapist to undergo a period of additional training, or both.

Sometimes, and if the evidence justifies it, the PhysioBA findings could be more serious.

Quality of clinical notes: quality of defence

'Good records, good defence; bad records, bad defence; no records, no defence'.

This is often a saying of defence lawyers and liability insurers and contains many truths, but it does not tell the whole story.

Often our ability to successfully defend a negligence claim or disciplinary complaint will depend on the quality, content and reliability of our contemporaneous clinical entries.

If we fail to document something, this does not mean it did not happen. However, it will mean that it will be much harder to prove that it happened. The client is sure to profess that they have a detailed and wholly accurate recollection of the event. Therefore, writing our notes at the time of consultation or as soon as practicably possible, when our memory is fresh, will mitigate the risk of relying solely on our memory later on and will often be critical to our defence.

Amending clinical records

We never attempt to erase or alter the clinical notes we make. Sometimes, however, we may need to make corrections to our usual clinical entries. To do this we add a contemporaneously-dated handwritten or electronic note. We do not delete the original text (even if it is wrong or inaccurate) but instead run a line across the mistaken entry and initial the correction, including the date on which we made it.

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