“I Think It, but Don’t Often Write It”: The Barriers to Charting in Private Practice

Katherine Harman, Raewyn Bassett, Anne Fenety, Alison Hoens

ABSTRACT

Purpose: To describe barriers to charting identified by physiotherapists working in private practice in New Brunswick.

Method: Physiotherapists were invited to focus-group interviews to discuss the results of a comprehensive chart audit. Sixty-nine physiotherapists who responded were assigned to nine focus groups. Seven of nine audiotaped interviews (49 participants) were of sufficient quality to be transcribed and imported into qualitative data analysis software for thematic analysis.

Results: Participants described the challenges of including charting in their routine client care. Barriers included the disjuncture between charting and thinking, the translation of impairment goals to functional goals, the time it takes to chart, fear of failure, and the difficulty of predicting length of treatment. Strategies to facilitate charting were suggested by participants.

Conclusion: Understanding barriers to charting in private practice is necessary to improve the quality of documentation. Barriers described are related to the fast-moving nonverbal, kinaesthetic, and cognitive process that is clinical reasoning in physiotherapy. This tacit, implicit process is mismatched with the charting task, which requires that the implicit become explicit in written form. Strategies to facilitate charting noted by participants address some of these issues; however, a broader, profession-wide discussion is necessary.

Key Words: barriers, charting, focus-group interviews, qualitative research, subacute low back pain

Harman K, Bassett R, Fenety A, Hoens A. ‘I think it, but don’t often write it’: the barriers to charting in private practice. *Physiother Can.* 2009;61:252-258.

RÉSUMÉ

Objectif : Décrire les obstacles liés à la tenue de dossiers auxquels font face les physiothérapeutes en pratique privée du Nouveau-Brunswick.

Méthode : Les physiothérapeutes ont été invités à participer à des groupes de discussion portant sur les résultats d’une vaste vérification des dossiers de patients. Au total, 69 physiothérapeutes ayant répondu à l’invitation ont été répartis dans neuf groupes de discussion. Sept des neuf entrevues enregistrées (soit celles de 49 participants) étaient de qualité suffisante pour être transcrites et importées dans un logiciel d’analyse des données qualitatives à des fins d’analyse thématique.

Résultats : Les participants ont fait état du défi que représente la tenue des dossiers des clients dans le cadre des soins habituels qu’ils leur prodiguent. Ses obstacles sont notamment la difficulté de transposer leur réflexion en entrées au dossier, la transposition des objectifs en matière de déficience en objectifs de fonctionnalité, le temps à consacrer à la documentation des dossiers, la crainte de faire des erreurs et la difficulté de prévoir la durée des traitements. Des stratégies visant à faciliter la tenue des dossiers ont aussi été proposées par les participants.

Conclusion : Pour améliorer la qualité de la documentation des dossiers, il est nécessaire de comprendre les obstacles liés à la tenue de dossiers dans la pratique privée. Les obstacles décrits ont trait au processus rapide, non verbal, kinesthésique et cognitif propre au raisonnement clinique en physiothérapie. Ce processus tacite et implicite s’harmonise mal aux tâches de consignation de données dans les dossiers, lesquelles exigent que l’implicite devienne explicite, par la forme écrite. Les stratégies relevées par les participants pouvaient résoudre certains des problèmes mentionnés; une discussion plus large, à l’échelle de l’ensemble de la profession, sera toutefois nécessaire.

Mots clés : groupes de discussion, lombalgie subaiguë, obstacles, recherche qualitative, tenue de dossiers

Analysis of current primary physiotherapy practice of injured workers with subacute low back pain (SA-LBP) in New Brunswick Workplace Health, Safety and Compensation Commission (WHSCC-NB)—approved clinics was a collaborative study between WHSCC-NB and the Dalhousie School of Physiotherapy.

We would like to thank the focus-group participants for their time and thoughtful responses, and students Tara Scott, Tina Smith, Joni Snair, Leanna Peach, Melanie Thompson, Gilda Chisolm, Erin Shanahan, Melanie Sweeney, and Lauren Armstrong (2006); and Erin McPherson, Lindsay Reid, Stacey Blackmore, and Shauna Forbes (2007), who were involved in facilitating focus groups and/or in analyzing the data.

The study was funded by Workplace Health, Safety and Compensation Commission (WHSCC-NB).

Katherine Harman, PT, PhD: Associate Professor, School of Physiotherapy, Dalhousie University, Halifax, Nova Scotia.

Raewyn Bassett, PhD: Adjunct Faculty (Sociologist), School of Occupational Therapy, Dalhousie University, Halifax, Nova Scotia.

Anne Fenety, PT, PhD: Assistant Professor, School of Physiotherapy, Dalhousie University, Halifax, Nova Scotia.

Alison Hoens, PT, MSc: Clinical Associate Professor, Department of Physical Therapy, University of British Columbia; Physiotherapy Clinical Coordinator, Providence Health Care, Vancouver, British Columbia.

Address correspondence to Katherine Harman, Associate Professor, School of Physiotherapy, Dalhousie University, 5869 University Ave., Halifax, NS B3H 3J5 Canada. Tel.: 902-494-8820. Fax: 902-494-1941. E-mail: k.harman@dal.ca.

DOI:10.3138/physio.61.4.252

INTRODUCTION

Client records are a source of information about clients' physical health status, the decisions made in relation to their physical therapy needs, and their progress with treatment. Charting treatment decisions is central to clinical decision making^{1,2} and quality of client care³ and is required by law.⁴ Inclusive documentation can minimize exposure to litigation,^{5,6} while poor documentation has the potential to reduce effective physiotherapy practice,⁶ reduce the quality of care,⁷ and increase liability risk. Recognizing the central role of documentation in health care settings, many professional associations have developed documentation guidelines.^{6,8–11} Some associations have included charting and documentation of client history and interventions as competency performance criteria in their continuing competency guidelines.¹² While the fundamentals and techniques of charting are taught in the classroom, physiotherapists' training in documentation occurs primarily in the clinical setting.¹ We focus here on the qualitative focus-group component of a larger study¹³ and report the barriers and obstacles to charting in physiotherapy practice as described by focus-group participants.

The health professional literature notes the need for improved charting and documentation.^{5,14–16} Charting in health care is an important component of client care and its management,^{7,14} and is required by law. Client records are a chronological account of client care, including assessment, diagnosis, treatment goals, current and anticipated treatment, changes to treatment, and reassessment criteria.^{1,16,17} Charting is important for evidence and justification of effective and medically necessary treatments,¹ consistent and coherent continuity of treatment, information exchange between health professionals,^{1,16} and tracking and solving trends or problems.¹⁵ In addition, the quality of charting as a record of clinical activities may influence other professionals' views of a specific profession.¹ The literature has repeatedly shown that despite health professionals' consideration of symptoms, diagnosis, and treatment decisions, these tend to be charted incompletely¹⁵ or rarely¹⁶ in the client record. Health professionals have reported that they do not chart their thoughts and decisions related to clients because of lack of time to do so,¹⁵ especially in volume-driven, fee-for-service clinics.⁷ Some health professionals do not perceive a need to document client care because decisions are made using prescriptive guidelines and protocols.¹⁶ Others claim that their extended knowledge of the client's condition from a long-term client–health professional relationship renders documentation unnecessary, while the apparent under-use of clinic records leads some health professionals to perceive charting as a waste of time.¹⁵ Despite the resistance to and under-use of charting, however, there is evidence of its value.^{1,2,16}

Mindful of the importance of charting for clinical practice, the American Physical Therapy Association (APTA) developed *Guidelines for Physical Therapy Documentation*¹⁸ in 1995. A number of workbooks on documentation were revised to adapt to the APTA guidelines, including Kettenbach's *Writing SOAP Notes*,³ first published in the early 1990s. Thompson¹ developed instructional material based on an earlier version of the APTA guidelines for teaching physiotherapy students. The APTA guidelines and associated literature are used extensively in Canada. Intended as non-binding advice, the APTA guidelines draw attention to the need to comply with appropriate jurisdictional and regulatory requirements. Explicit instructions are provided on how to write, date, and sign entries that include clinical decisions, measurable goals and outcomes, client status, assessment and reassessment, interventions, adverse reactions, the criteria for discharge or discontinuation, and communication with the client.

While the literature and professional organizations suggest that charting is good practice and that improvement is needed,^{5,7,14–16} few studies have examined why physiotherapists find charting challenging. In a recent paper,¹³ we reported the results of an audit of New Brunswick Workplace Health, Safety and Compensation Commission (WHSCC-NB) charts for clients presenting with subacute low back pain (SA-LBP) and follow-up focus-group interviews that validated the findings of the chart audit and addressed physiotherapists' charting practices. In this paper, we focus on the barriers to charting described by participating physiotherapists in those focus-group interviews.

METHODS

Participants

Following ethics reviews by the authors' institutions (Dalhousie University and the University of British Columbia), an audit of 1 year's charts was undertaken. Following the chart audit, nine focus-group interviews were held in 2006 and 2007 to explore physiotherapists' treatment practices in relation to the audit findings by WHSCC-NB. Unlike individual interviews, focus-group interviews provide a setting in which participant interaction elicits observations and insights¹⁹ that can be verified immediately through inbuilt checks and balances, such as the probing or clarification of participants' responses and dialogue.²⁰

Design

Notices about the 2-hour focus group interviews were sent to WHSCC-NB-approved private clinics whose case-load consists primarily of clients with musculoskeletal complaints, inviting interested physiotherapists to a discussion of their treatment practices and a presentation

on current evidence for physiotherapeutic intervention for SA-LBP. In addition to WHSCC-NB clients, these physiotherapy clinics also treat other clients who may or may not have insurance coverage.

Informed consent was provided by participants at the beginning of each audiotaped interview. The focus groups were facilitated by one of the three lead investigators (KH, AF, AH) or by trained graduate students supervised by the lead investigators. Following the presentation of the chart-audit results, the facilitator probed for a deeper understanding of participants' charting process and of existing barriers to best charting practice. The focus-group interviews were followed by presentations of the evidence underpinning various clinical interventions for SA-LBP.

Analysis

The audiotaped interviews were transcribed. Seven of the nine interviews (49 participants) were of sufficient quality for inclusion in the analysis, and these were imported into ATLAS.ti version 5.2.0 (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany) for qualitative data analysis. Transcribed participants' responses were carefully read, and themes were derived that described and interpreted the main ideas presented by participants. A label or description for the theme was assigned to the specific words and phrases, and themes were clustered, compared, and sorted until they became sufficiently distinct from each other.^{21,22} Theme development was discussed during frequent team meetings; one team member (RB) is a sociologist with extensive qualitative research experience.

The findings reported here are specific to barriers to charting identified by participants. Other findings, specifically the chart-audit results and some specific focus-group results, have been reported elsewhere.¹³

RESULTS

Forty-one of the 49 focus-group participants (84%) were female. Participants had an average of 20.5 years (range: 0.5–38 years) of physiotherapy experience. The wide range of experience among the participants provided both novice and expert views on the challenges physiotherapists face with respect to charting requirements. We begin this section with an overview of how participating physiotherapists perceived charting as part of their daily practice, and then discuss the barriers to charting they identified.

Perceptions of Charting

Focus-group participants perceived the documentation of goals and associated treatment plans as beneficial to both physiotherapists and clients. Charting was described as a tool for clinical decision making, to motivate and communicate with clients, to keep

physiotherapists and clients "on track," to inform and evaluate client progress over time, and to initiate changes to treatment. It was also noted that documentation enables another physiotherapist to take over the client's treatment, should this be necessary.

Physiotherapists acknowledged the clinical value of charting, yet many expressed a lack of enthusiasm for the process. Among the most frequently cited disincentives to charting were the disjuncture between charting and thinking aspects of their work, the translation of impairment goals to functional goals, the time it takes to chart while juggling different priorities in their practice, fear of failure, and the difficulty of predicting the length of treatment.

Barriers to Charting

Thinking, Not Writing

During the focus-group interviews, participants often made statements such as, "I think it, but I don't often write it." One participant described herself as getting lax over time:

I probably wrote a lot more when I . . . when I got out of school. I'm getting lazier at writing things down. (Focus Group [FG] 7)

Most participating physiotherapists discussed how goals, treatment plans, increments, and changes in treatment evolve in thought processes that become embodied with experience. The embodiment of these processes was sometimes specifically located—"it's all in my head"—and at other times described more generally:

I feel you carry it around more and you just don't write it as much. (FG 2)

Only when a "usual" situation is disrupted—for example, when a patient does not progress—is the thought process made explicit in writing:

There is an expectation about the way it is going to go and [so] I am not necessarily detailing it. It is when it is not going as I expected [that] I am going to [detail it]. (FG 4)

While goals may sometimes be charted, participants said they do not chart their detailed thought processes about how or why they develop goals. Participants expressed a sense that not everything "up here" (referring to their thought process) could be charted.

Impairment versus Functional Goals

Some participants suggested that one of the difficulties in writing things down is related to converting impairment goals to functional goals:

My goal might be to get the client's shoulder forward flexion 160 degrees. Their goal, they would want

something functional they could do, like put the dishes on the top shelf at home. I know I struggle with that. (FG 5)

The difficulty in converting goals existed not only in thinking through the conversion but also in writing it out:

I find for the functional goals, it's the wording. (FG 7)

Most focus-group participants used impairment-based goals and saw less use for functional goals. However, documenting functional goals is a required charting practice for some third-party payers, including WHSCC-NB:

The functional goal, I find, is for the outside people. It's for the patient and the service provider. The impairment goal is for my treatment intervention plan. So [functional goals] are more meaningful from WHSCC-NB's point of view and from the patient's point of view. It's that function that they are focused on. As a therapist, I am going to look at the impairment. (FG 3)

The parallel between impairment-based goals and the patho-anatomical treatment model (i.e., find and treat the tissue at fault) was noted by one participant. Educated in the traditional patho-anatomical treatment paradigm, she commented that her treatment practice may have changed in that now she is more focused on functional goals. She pondered whether her charting practice has adjusted:

We were under the patho-anatomical model, so with this, we used terms such as increased range of motion. I've developed a new way of treating, but maybe I haven't changed my charting to reflect how I actually really practice. And then again, these things [newer approaches] are less measurable than the things we are used to, you know in our objective measures, and it is the wording of it, trying to describe them sometimes, there is difficulty in that. (FG 7)

Focus-group participants found that the conversion from impairment goals to functional goals takes time to think through and time to reword.

Time

Time was an often-cited disincentive to the charting of client goals, treatment plans, and subsequent treatment. Participants identified time as a challenge in a number of ways. As described above, they noted that it takes time to think through the translation from an impairment goal to a functional goal, reducing the time the physiotherapist spends with the patient. Focus-group participants stated that their time with each client is limited. One participant said, "If we had more time per client, we could chart better." Another participant, pointing out the futility of charting, said that it "takes longer to chart than do the

technique," while another added, "and then it would all change anyway!" Within the limited time available, physiotherapists in the focus groups considered it their responsibility to provide treatment to the client rather than charting. One participant expressed this as a "need to maximize time" in favour of the client. There are also demands from clients, who may "want an \$85 treatment for \$45." Time is money in private practice, and focus-group participants perceived little or no return on the time invested in charting, adding to the lack of incentive. Charting was also seen as a barrier to focusing fully on the client. Further, to chart every change in treatment or goals would take time that these physiotherapists did not see themselves as having.

Fear of Failure

An unpredictable dimension of treatment was recognized by participants, namely the individual nature of the course of healing in each client. Goals can be set with objective measures upon which length of treatment can be estimated, but clients' bodies react differently to the same treatment, introducing an element of unpredictability. As well, psychosocial factors sometimes come into play, making prognostication challenging. As described elsewhere, the participants remarked on how challenging the subacute phase of LBP is for prognosis:¹³

I think after completing an assessment in one or two appointments ... I'm not God. I can't always make those accurate predictions. I don't know enough, or I don't feel confident enough to make those predictions based on the individuality of clients, because no two people walking in are the same. Even though they may present with the same diagnosis or the same injury ... so it's hard. (FG 7)

Some physiotherapists said they felt they may be perceived as having failed if they do not meet outcomes within established timelines:

As therapists, we probably think them through. And when I say increased sitting tolerance on my Compensation report, I'll probably just write "increased sitting tolerance." In my mind, if sitting tolerance today is 1 hour, I am not going to write increased sitting tolerance to 2 hours over 10 days. I might fail to achieve that. (FG 3)

However, the physiotherapist's perception that she or he has failed was also perceived to affect the client:

If you say [to the client that] in 4 weeks, you are going to see 160 degrees in shoulder flexion, and they are only at 120 or whatever, then they will be probably like "I failed," and it will set them back. (FG 1)

According to participants, fear of failure affects both physiotherapist and client and results in a disinclination

Table 1 Strategies for Improving Charting Practice

-
- A checklist of commonly charted assessment findings and treatment options for the physiotherapist
 - A checklist and/or visual analogue scale for the client to complete
 - A standardized weekly summary of goal-attainment progress
 - A dictaphone recorder to speak into during treatment sessions
 - Uniformity of documents to record assessment and treatment
 - Electronic records with a touch screen
 - A body of physiotherapy-specific literature expounding the value of charting
 - Seminars and workshops on charting, especially by third-party payers about their expectations
-

to chart goal-directed treatment plans with an explicit timeline. Another participant described resolving this tension by charting a timeline and explaining to the client why it may not be met:

Based on experience, and having the client tell me that [how the injury has affected them emotionally], I might say, “Okay, we’ll guess at this and we’ll see how long it takes.” I might have that on paper, but yet discuss with them that it’s not set in stone, and the many variables that would affect it. (FG 7)

Length of Treatment

Length of treatment is related to the unpredictability of healing times and to decision making as a process in thought rather than writing. Participants noted that length of treatment dictates the extent of charting: there is less detailed charting for clients who make progress quickly than for those who make slower progress:

I know for some clients the goals are going to be met, so I don’t have to document them, but for clients who are taking a lot longer, you’ve got to specifically set down that goal. (FG 2)

As noted previously, participants stated that where a client’s progress is outside the expected time frame or in some way unusual, the physiotherapist’s thought process is made explicit in the chart, whereas with faster patient recovery, charting is deemed less necessary.

Participants valued charting, yet they acknowledged a number of barriers that operate as a disincentive to charting. Given this situation, they suggested a number of strategies to facilitate charting (see Table 1). Potential facilitators include checklists with commonly found assessment findings and treatment options; standardized forms; training from third-party payers; and electronic charting.

DISCUSSION

A tension exists in physiotherapy practice between recognizing the value of charting and addressing

obstacles to this important activity. While focus-group participants resoundingly acknowledged the benefits, they stated a number of significant barriers to charting, of which time constraints are among the most important. Making their thought processes explicit and writing down their clinical and treatment decisions were perceived as taking time they did not have. Charting was not perceived as part of the treatment process; instead, treating the client in private practice, where time is money, was perceived as more important than charting. If more time were available per client, physiotherapists said, they might then have time to chart and might do a better job of it. Converting impairment goals to functional goals also required time the physiotherapists felt they could better use treating clients. In addition, the element of unpredictability introduced by clients’ individualized healing process was considered a barrier to charting treatment timelines, and the inability to accurately predict a client’s progress may lead to feelings of failure when a treatment target is not met. Further, goals and treatment decisions for clients who progress quickly are less likely to be charted.

Participants expressed difficulty with respect to charting functional as opposed to impairment-based goals. This is cause for concern, as it would appear that participating physiotherapists were of the opinion that, as one participant put it, the impairment-based goal is for the physiotherapist and the functional goal for the client. By focusing on the impairment only, the physiotherapist runs the risk of missing other treatment options (such as task or environmental adaptations) that could help clients achieve the functional goals important to them. The challenge, of course, is that the link between these two types of goals must be clear—indeed, they must be highly correlated—so that both can be used for the same purpose. Using a patient-specific measures approach has been proposed²³ as a time-efficient as well as valid method of linking and documenting functional and impairment-based outcomes.

A further barrier described by participants is the lack of accuracy in prognostication. This is a long-standing problem in health care because, on an individual basis, a prognosis is always an estimate, and without excellent data, predicting outcomes is a challenge. Research continues to generate insight into factors on which prognoses can be based.^{24,25} In practice, a prognosis is useful for focusing a treatment plan; however, because individuals respond differently in terms of healing and treatment, it should be reconsidered and restated often to ensure accuracy.

Client records are important in a number of different ways. They record the client’s physical health status, goals, treatment decisions, and progress. Charting these decisions is required by law, and it is a professional standard for which our regulatory bodies hold us responsible. Yet a well-written chart is more than just a legal

requirement: it is an effective communication tool between physiotherapist and client and among physiotherapists, and increasingly, on another professional level, data to be evaluated for treatment effectiveness.^{13,26} Given the importance of charting as a communication tool on many levels, understanding the challenges and barriers to charting is important to making improvements in the profession. In this study, the majority of focus-group participants identified lack of time as the main obstacle to their charting practice, concurring with Miller et al.'s¹⁵ findings on pharmacists' documentation performance. Time may also contribute to what Parker et al.⁵ have referred to as "charting by exception": in a study on the quality of nursing documentation, Parker et al. found that routine care is not documented and that only deviations from the norm are charted.⁵ Focus-group participants in the present study noted that goals and treatments for clients who took longer to progress, and therefore were outside expected timelines, were charted in more detail. The routine care of clients who progressed quickly was not charted to the same extent.

Implied amidst reports of barriers is a tacit, implicit component of physiotherapy practice that is challenging for physiotherapists to describe. Physiotherapy is a profession in which, with experience, many techniques and practices become routine, embedded, and automatic. This allows conscious thought to be focused on the treatment of a client's injury. Consequently, it is not surprising that charting is not more complete and that it does not occur with more frequency during a client session. Clinical skills include the hands-on, embodied, and experiential knowledge of physiotherapists as they work interactively with their clients.²⁷ This kinaesthetic process occurs at the same time as the iterative, cognitive, analytical process of clinical reasoning. This is a fast-moving, nonverbal process. Charting thoughts and processes requires making our taken-for-granted, automatic, tacit practices explicit. The conversion of an implicit to an explicit process is made more difficult by the unpredictability of prognostic expectations as a result of the individualized response of each client.

CONCLUSION

In most Canadian provinces, regulatory colleges have established peer-review quality-assurance programmes that conduct on-site assessments, including an examination of client charts. In this study we found that charting standards are mismatched with the physiotherapy workflow and the clinical process and, as some participants expressed it, require a lot of conscious thought. Thinking and translating thoughts into a written chart ("I think it, but don't often write it") is perceived as a less valuable activity than physically treating patients. These two aspects—the difficulty of transforming the nonverbal

into written form and the mismatch of charting with the clinical process—operate as barriers to charting a client's treatment and progress. What is needed is a charting process that allows the implicit to be made explicit while not interfering with or disrupting the interwoven kinaesthetic and cognitive treatment process and while maintaining the physiotherapist's legal responsibilities. Focus-group participants suggested a number of strategies for charting that may help to ease the tension between the recognized value of and the practical difficulties of charting, taking into account the continuous and interwoven flow of tactile and cognitive aspects of physiotherapy practice. However, a broader, profession-wide discussion of these issues is necessary.

KEY MESSAGES

What Is Already Known on This Subject

Chart audits and other observations of physiotherapy charts have revealed weaknesses in charting practices. There have not been any reports in the literature to explore the challenges that physiotherapists face in fulfilling their responsibility to document in client records.

What This Study Adds

This study explores the barriers to charting as reported by physiotherapists working in private practice, including not always writing what they think about, challenges in converting impairment goals to functional goals, time constraints, concern about prognostication and fear of failure, and the length of time a client is in treatment. In addition, the study offers some ideas to stimulate discussion around an important yet understudied aspect of practice.

REFERENCES

1. Thompson LV. Documentation instruction for students. *Top Geriatr Rehabil*. 1997;13:1–13.
2. Vreeman DJ, Taggard SL, Rhine MD, Worrell TW. Evidence for electronic health record systems in physical therapy. *Phys Ther*. 2006;86:434–46.
3. Kettenbach G. Writing SOAP notes with patient/client management formats. 3rd edn. Philadelphia: FA Davis Co.; 2004.
4. Phillips A, Stiller K, Williams M. Medical record documentation: the quality of physiotherapy entries. *Int J Allied Health Sci Pract* [Internet]. 2006 Jul [cited 2008 Feb 14];4(3):1–17. Available from: <http://ijahsp.nova.edu/articles/vol4num3/phillips.pdf>.
5. Parker LE, Wells KB, Buchanan JL, Benjamin B. Institutional and economic influences on quality of nursing documentation. *Health Care Manage Rev*. 1994;19:9–19.
6. Physiotherapists Board of Queensland. Guidelines for information management. Brisbane, QLD: The Board; 2007.
7. Cox JL, Zitner D, Courtney KD, MacDonald DL, Paterson G, Cochrane B, et al. Undocumented patient information: an impediment to quality of care. *Am J Med*. 2003;114:211–6.
8. American Physical Therapy Association. Guide to physical therapist practice. 2nd edn. Alexandria, VA: The Association; 2003.

9. College of Registered Nurses of Nova Scotia. Documentation guidelines for registered nurses. Halifax: The College; 2005.
10. Nursing, and Midwifery Council. Guidelines for records and record-keeping. London: The Council; 2002.
11. College of Physiotherapists of Ontario. Guide to the standard for professional practice: record keeping. Toronto: The College; 2007.
12. Brann G, Gregor W, LeBlanc K, Russell S, Townsend J, Ross J. Continuing competency guidelines for professional portfolio. Halifax: Nova Scotia College of Physiotherapists; 2006.
13. Harman K, Fenety A, Hoens A, Crouse J, Padfield B. Physiotherapy and low back pain in the injured worker: an examination of current practice during the sub-acute phase of healing. *Physiother Can.* 2009; 61:88–106.
14. Gebru K, Åhsberg E, Willman A. Nursing and medical documentation on patients' cultural background. *J Clin Nurs.* 2007;16:2056–65.
15. Miller T, Sandilya R, Tordoff J, Ferguson R. Documenting pharmacist's clinical interventions in New Zealand hospitals. *Pharm World Sci.* 2008;30:99–106.
16. Schers H, van den Hoogen H, Grol R, van den Bosch W. Continuity of care through medical records: an explorative study on GPs' management considerations. *Fam Pract.* 2006;23:349–52.
17. Karlsen R. Improving the nursing documentation: professional consciousness-raising in a northern-Norwegian psychiatric hospital. *J Psychiatr Ment Health Nurs.* 2007;14:573–7.
18. American Physical Therapy Association. Guidelines for physical therapy documentation. In: Guide to physical therapist practice. 2nd edn. Alexandria, VA: The Association. 2003. p. 695–8.
19. Ulin PR, Robinson ET, Tolley EE. Qualitative methods in public health: a field guide for applied research. San Francisco: Jossey-Bass; 2005.
20. Grbich C. Qualitative research in health: an introduction. Thousand Oaks, CA: Sage; 1999.
21. Boyatzis RE. Transforming qualitative information: thematic analysis and code development. Thousand Oaks, CA: Sage; 1998.
22. Luborsky MR. The identification and analysis of themes and patterns. In: Gubrium JF, Shankar A, editors. Qualitative methods in aging research. Thousand Oaks, CA: Sage. 1994. p. 189–210.
23. Stratford P, Gill C, Westaway M, Binkley J. Assessing disability and change on individual patients: a report of a patient specific measure. *Physiother Can.* 1995;47:258–63.
24. Bekkering G, Hendriks H, van Tulder M, Knol D, Simmonds M, Oostendorp R, *et al.* Prognostic factors for low back pain in patients referred for physiotherapy: comparing outcomes and varying modeling techniques. *Spine.* 2005;30:1881–6.
25. Henschke N, Maher C, Refshauge K, Herbert R, Cumming R, Bleasel J, *et al.* Prognosis in patients with recent onset low back pain in Australian primary care: inception cohort study. *Brit Med J.* 2008 Jul 7;337:a171. doi:10.1136/bmj.a171.
26. Canadian Physiotherapy Association. Practice management tools: chart audit forms [Internet]. Ottawa: The Association; n.d. [cited 2008 Jan 11]. Available from: <http://cpa.amsasp.com/old/practicemanagement.htm>.
27. Thornquist E. Face-to-face and hands-on: assumptions and assessments in the physiotherapy clinic. *Med Anthropol.* 2006;25:65–97.