Guidelines for allied health assistants documenting in health records

Allied Health Professions' Office of Queensland

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An electronic version of this document is available at
www.health.qld.gov.au/ahwac/default.asp

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Introduction

These guidelines have been developed to facilitate the training of allied health assistants (AHAs) in documentation for Queensland Health purposes. It is recommended that you clarify and discuss the content with your supervisor. On completion of this training, AHAs should:

- understand the purpose of documentation
- know what should be documented
- know what to include in health record entries
- be confident about when and how to document
- apply appropriate documentation standards.

Your supervisor or manager will assess your competency in documentation once you have completed both the theoretical and practical elements of the training outlined in Appendix 1a. Once deemed competent, there is no further requirement for the supervising allied health professional to countersign AHA entries.

Please note: Depending on the clinical setting, health records may be synonymously referred to as patient charts, client files, medical records, etc. To ensure consistency, the term health record will be used throughout this document.

Prerequisite information

You will need to complete the following training modules within five days of commencement. They can be accessed online at https://www.health.qld.gov.au/ahwac/html/training-modules.

- clinical documentation
- clinical handover
- informed consent.

Prior to commencing training on documenting in health records, it is essential that you have a clear understanding of the concepts of privacy, confidentiality and consent as they relate to healthcare.

Patient/client information is confidential and the precautions below should be followed to ensure that all documented information remains confidential:

- do not allow anyone to touch or look at a health record unless they are a healthcare provider involved in the care of that patient
- keep all patient records in a safe and secure place
- do not tell anyone about what is in a health record unless they are taking care of the person.

Please note: The obligation to respect the confidentiality and privacy of patient/client information continues after employees have left Queensland Health employment.

Queensland Health is subject to the following privacy and confidentiality legislation, which set the standards for how personal information is handled:

- *Information Privacy Act 2009*
- Information Privacy Regulation 2009
- *Hospital and Health Boards Act 2011*(Part 7)
- Hospital and Health Boards Regulation 2012.

Additional information on health records and privacy is available at: https://www.health.qld.gov.au/system-governance/records-privacy/health-personal.

Queensland Health employees are also required to comply with the standards of confidentiality and privacy as specified in the *Code of Conduct for the Queensland Public Service* available at: https://www.forgov.qld.gov.au/about-code-conduct.

To learn more about consent, please refer to: *Guide to informed decision-making in healthcare* available at: http://www.health.qld.gov.au/consent/.

Why document?

Documentation is essential to maintain safe, high quality care. It is used:

- as a communication tool to facilitate the continuum of patient/client care
- to allow evaluation of the care provided
- for research or epidemiological needs
- to meet statutory requirements
- in case the information is required for medico-legal defense.

What information needs to be documented?

You need to document significant aspects of patient/client care including:

- all direct contact with the patient/client, carers or other related individuals
- other significant activity that relates to patient/client care (including indirect contact), for example, missed or cancelled appointments, information provided/posted to the patient/client.

Principles of documentation

The format of your entries will be guided by Hospital and Health Service (HHS) policy as well as discipline and work unit-specific practices. Regardless of the format, the following principles of documentation apply:

- always document as soon as possible after the intervention (e.g. occasion of service, phone call)
- content should be concise, relevant, appropriate and accurate
- do not diagnose
- use only standard abbreviations and avoid non-standard terminology
  - it is important that your documentation can be understood by anyone reading the health record
  - check with your supervisor regarding which abbreviations you can use
  - if you don't recognise abbreviations you see in other entries, ask your supervisor or another allied health professional to explain these to you
  - refer to Appendix 2 for some commonly used abbreviations
- be objective and factual
  - be specific and avoid general terms
- objective information is what is directly seen, heard, felt, or smelled:
  - seen—for example, recording observations regarding bleeding, deformities, drainage, colour of urine, patient/ client posture and/or attitude
  - heard—for example, the patient/client's comments, moaning, breathing abnormalities, speech sound errors
  - smelled—for example, vomitus odour
  - felt—for example, hot, cold, dry or moist skin, range of movement
- subjective information is your own personal bias, judgement or speculation about the patient
  - subjective statements should be avoided, that is, do not record your own emotional statements or moral judgements
  - if you think it is important to include a subjective statement made by the patient/client or another person you can record this (e.g. 'husband reports improved speech').

At a minimum, the following information must be included in an entry:

When	Date and time of patient/client contact/activity	
Who	Who was involved?	E.g. patient/client, carer, nurse reported stable observations, discussed with physiotherapist
What	What did you observe and do? • Observations/ events relevant to the session • Therapy/ treatment provided	
How	How did you carry out the task?	E.g. with prompting and minimal assistance; walk belt
Why	Why did you perform this task?	E.g. as per the treating therapist's instructions; as per surgical pathway

Documentation standards

- Record in chronological order, that is, in order of date and time.
- Check that you have the correct health record and ensure that the front and back of every page has an identifying label/information attached.
- Black pen only.
- Ensure your writing is legible.
- Avoid spare lines and gaps within and between entries.
- Always time and date entries:
  - try to write the entry as soon as possible after the intervention, if there is a long delay, record when you saw the patient as part of your entry
  - document the time that you write the entry
  - use a 24-hour clock format— 9am as 0900, 1:30pm as 1330
  - do not time or date entries retrospectively (that is, back-date).
- Clearly label your entries:
  - use a discipline sticker, for example, 'Speech Pathology'
  - indicate you are an AHA
  - sign entries and clearly print name and designation (title)
  - once you have been deemed competent by your supervisor, there is no requirement for the allied health professional to countersign entries.
- If errors are made:
  - draw a neat single line through writing. Sign and date this change. If the whole entry is an error, write 'Written in error' or 'Written in wrong chart'
  - do not use white out correction fluid (liquid paper)
  - do not retrospectively amend.

Complete and then discuss the templates in Appendices 3–6 with your supervisor to determine if this is how you should document at your facility.

Alternative documentation formats

SOAP

A number of HHSs have adopted the SOAP system for clinical documentation as follows:

- S = subjective information
- O = observation/objective information
- A = assessment
- P = plan.

Commonly used expansions to SOAP include:

- I = intervention, treatment or care provided
- E = evaluation—the results/impacts of the treatment or care
- R = recommendations/ revisions—what is recommended to happen next or what has changed in the patient/client care.[1]

For additional information on the application of SOAP and some examples, refer to Appendix 6.

SBAR

Other healthcare services have implemented the SBAR as a standardised communication protocol for communicating clinical information:

- S = situation
- B = background
- A = assessment
- R = recommendation.

Electronic health records

Many HHSs in Queensland are now documenting using an integrated electronic medical record (ieMR). The same principles and standards will apply but using a digital document rather than a hand-written document.

Employees should continue to observe Queensland Health legislative and information confidentiality and privacy policies when accessing, viewing, using and transmitting patient/client information electronically.

[1]WA Country Health Service [WACHS], *Assistant training mini-module: Documentation, Government of Western Australia*, Department of Health, 2009. Available at: https://www.cta.qld.edu.au/files/documents/84/wachs_g_aha_trainingmini_module.pdf

Misconduct

Misconduct associated with documentation includes:

- breaches of privacy and/or confidentiality
- failure to keep required records
- inappropriate, intentional destruction of documentation
- falsifying records, for example, documenting care that did not occur, signing a document that is known to contain false or misleading information, and signing for care that was carried out by another person and not documented as such.

Appendix 1a: Assessment of competency

Your competency in documenting in health records will be assessed once you have completed both the theoretical and practical elements of the training outlined below:

Name:			
Learning objectives	**Essential elements**		**Date achieved**
Read and understand theory	Prerequisite information	Clinical handover	
		Documentation	
		Informed consent	
		Privacy and confidentiality	
	Guidelines for AHAs documenting in health records		
	Relevant HHS policy		
	Work unit-specific guidelines, procedures and instructions		
Practice documentation	Example scenarios provided [Appendix 5]		
	Real work situations under supervision [Minimum of three examples]		
Assessment of competency	Satisfactory completion of Knowledge check [Appendix 1b]		
	Satisfactory completion of Health record audit [Appendix 1c]		

Appendix 1b: Knowledge check[1]

Write your answers in the spaces below before discussing with your supervisor.

1. Why is documentation important?

2. When should you write patient/client notes?

3. How can you make sure your patient/client notes are kept confidential?

4. If you make a mistake when writing in patient/client notes, how do you correct this?

5. What types of things should be included in patient/client notes?

6. What type of abbreviations should be used in a health record?

7. How should you record information provided to you by someone else, rather than what you have observed yourself?

Appendix 1c: Health record audit

Name of candidate	
Assessor name	
Name of workplace/ organisation	
Dates of assessment	
Procedure/activity	**Document client care in the health record**

Did the candidate perform the following skills?	**Comments**	**Yes**	**No**
Demonstrated awareness of where to access health record		☐	☐
Privacy and confidentiality maintained when using health record		☐	☐
Black pen only		☐	☐
Legible writing		☐	☐
Dated		☐	☐
24-hour clock		☐	☐
Signed, printed name, designation and contact details written		☐	☐
Written information clear, concise, objective statements used where possible		☐	☐
Written information accurately reflects the patient/ client presentation and intervention provided		☐	☐
Appropriate language used, abbreviations		☐	☐
Health record appropriately filed at completion		☐	☐

The performance was: **Not competent** ☐ **Competent** ☐

Feedback provided *(if not competent, detail skill development required before reassessment)*

_____

_____

_____

_____

_____

Assessor signature:_____ **Date:** _____

Candidate's signature:_____ **Date:** _____

Appendix 2: Commonly used abbreviations

Documentation format	
S/	Subjective information
O/	Objective information
I/	Intervention
Rx	Treatment
A/	Assessment
P/	Plan
c/o	Complains of
o/e	Objective Examination
//	Outcome of intervention
Mobility aids	
SPS	Single point stick
4PS	Four-point stick
4WW	Four wheeled walker or 'wheelie walker'
FASF / ESF	Forearm support frame or Elbow support frame
W/C	Wheelchair
Indep	Independent
SPS	Single point stick
4PS	Four-point stick
Assistance required	
s/v	Supervision
Min	Minimal
Mod	Moderate
Max	Maximal
1xA	One person assist
2xA	Two person assist

Time descriptors	
mane	In the morning
am	Morning
pm	Afternoon
1/7	One day
1/52	One week
1/12	One month
Therapy-specific	
Mob	Mobilise
ROM	Range of motion
HEP	Home exercise program
ex	Exercise
ADL	Activities of daily living
Activities of daily living (ADL) aids	
OTF	Over toilet frame
HHH	Hand held hose
Other	
Pt	Patient
WNL	Within normal limits
NAD	Nil abnormality detected
Physical status	
BMI	Body mass index
Wt	Weight

Appendix 3: Documentation template examples

This section includes examples of treatment for dietetics, speech pathology (SP), occupational therapy (OT) and physiotherapy (PT). Whilst these examples do not form a comprehensive list, it will give you an idea of format and content.

Example 1: Acute ward AHA

DATE TIME	*[DISCIPLINE]* ALLIED HEALTH ASSISTANT Patient consent obtained. Nurse reports stable vital signs. *[Document relevant comments from patient]* Treatment – Mobilised *X* with *X* aid and *X* assistance as per PT instructions. – Completed *X* exercises as per PT instructions. – Pt and carer provided with and discussed equipment hire handouts for *X* aid as per OT instructions. – Dressing retraining using *X* aid with *X* assistance as per OT instructions. – Performed dysarthria drills as per SP instructions. – Pt and carer provided with information and training in the use of *home feeding pump* as per dietitian instructions. *[Comment on relevant observations}* Plan: Feedback to *PT/OT/SP*, review *X* *[Signature] (Printed Name)* Allied health assistant

Example 2: Community AHA home visit

DATE TIME	*[SERVICE NAME]* ALLIED HEALTH ASSISTANT Home visit conducted on / / at *X time*. Allied health assistant, client and client's spouse present. Home program completed and *X* strategies implemented as per *OT/PT/SP* instructions. Plan: Appointment scheduled with AHA __/__/ for next home visit. Provide feedback to *OT/PT/SP*. *[Signature] (Printed Name)* Allied health assistant

Example 3: Negative response to intervention

DATE TIME	*[DISCIPLINE]* ALLIED HEALTH ASSISTANT Patient consent obtained. Nurse reports stable vital signs. *[Document relevant comments from patient]* Treatment— carried out exercise program as per PT/OT/SP. Pt completed *X* mins/reps/m, *reported/pt became_____(e.g. chest pain, dizziness, pale).* Exercise ceased, pt returned to *chair/bed* and nurse notified immediately. Feedback provided to *PT/OT/SP.* Plan: Await further instruction of *PT/OT/SP* *[Signature] (Printed Name)* Allied health assistant

Appendix 4: Example scenarios

Read all examples as they represent different interactions with patient/clients which may be helpful in guiding your documentation.

Scenario 1: PT assistant, medical ward

You are asked to see Mrs. Smith, an 85-year-old female patient who is in hospital following a fall five days ago—with no significant injuries. You are informed by the PT that Mrs. Smith mobilises about 50m with a wheelie walker (4ww) and standby supervision. You are asked to do sit to stand exercises, as tolerated from the patient chair, and take Mrs. Smith for a walk.

You speak to the nurse who reports Mrs. Smith has a sore back but has had pain relief and her vital signs are stable and the nurse is happy for you to carry out the exercise program. When you ask, Mrs. Smith tells you that her back is still sore (no worse/better) and didn't sleep well, but she does agree to go for a short walk. After the walk, Mrs. Smith agrees to a few sit to stand exercises, but after completing five exercises she reports being fatigued. After a rest, Mrs. Smith completes a further three sit to stand exercises. Mrs. Smith required prompting and minimal assistance to carry out the sit to stands.

Example documentation OO3 level

7/10/09 1430	Physiotherapy assistant Patient (pt) agreed to participate. Nurse reports stable vital signs; pt has had analgesia for sore back. Treatment as directed by PT: Mobilised 50m with 4ww and supervision and did sit to stand exercises x8reps with one rest due to reported fatigue. Plan: Feedback to PT, review 1/7. [Signature] (Printed name) Allied health assistant

Scenario 2: PT assistant, rehabilitation unit

You go to see Ben, a 21-year-old who sustained a traumatic brain injury two weeks ago. You have been asked to take Ben for a walk outdoors (with supervision), up and down the stairs holding one railing, heel-toe walking and practice standing on one leg. Yesterday Ben was able to do these activities and he stood on his right leg for four seconds and left leg for two seconds.

When you see Ben, he complains of a headache, but he is keen to do his program. The nurse reports Ben is okay to participate in his rehab program.

You walk Ben to the gym. You practice walking sideways and backwards and then attempt heel-toe walking. You notice that Ben is not performing his walking activities as well as usual. When you start single leg stance (SLS) practice, Ben appears unable to stand for more than one second on either leg, despite encouragement and, what appears to be, sincere attempts. You notice Ben seems frustrated and when you ask, he reports his headache is worsening. You walk Ben back to the ward and immediately inform the nurse of his worsening headache and poorer balance.

Example documentation OO3 level

8/10/09 0955	Physiotherapy assistant Pt reported headache, consented to treatment Treatment as per PT instructions. Walk sideways, backwards, heel-toe, SLS. //Treatment ceased as pt reported headache worse. Returned to ward. Nurse and PT informed. Plan: Await further instruction from PT. [Signature] (Printed name) Allied health assistant

Scenario 3: OT assistant, Geriatric rehabilitation unit

You are asked to see Mavis, an 87-year-old lady, with some memory problems, who sustained a fractured neck of femur and has had a partial hip replacement. Your task is to undertake daily dressing retraining, as per ADL retraining guidelines, with Mavis, ensuring that she adheres to hip precautions.

The OT has done an ADL assessment and recommends that Mavis use a shower stool and dressing stick. In this assessment Mavis required moderate to maximal prompting to ensure she adhered to hip precautions and used the equipment appropriately.

On your third therapy session Mavis was ready with her toiletries, clothes and dressing stick. You observe that she is now able to use the dressing stick correctly but still requires minimal to moderate prompting to stop her bending too much at the hip. Mavis appears to remember all other hip precautions as she avoids these movements during the task.

Example documentation

1/10/09 0830	Occupational therapy assistant—ongoing review Pt agreed to shower this am. Nurse reports no medical concerns. Pt prepared with toiletries, clothes and dressing stick Pt stated 2 of 3 hip precautions, but did not list the precaution not to over-bend at hip - Same observed during retraining. Treatment as per OT plan, dressing retraining using shower stool and dressing stick. //correct use of dressing stick, prompt for hip precaution safety. Plan: Feedback to OT re frequency/progression of further sessions. [Signature] (Printed name) Allied health assistant

Scenario 4: OT assistant, medical ward

You are asked to provide a handout on equipment hire information to a patient and their carer. The OT has completed the patient assessment and this intervention is required for discharge. The equipment to be hired includes an over-toilet frame and shower stool. You complete this task and document in the chart.

Example documentation

5/10/09 1520	Occupational therapy assistant As per OT: Pt and carer provided with and discussed equipment hire handouts for over toilet frame and shower stool. P/ Feedback to OT. [Signature] (Printed name) Allied health assistant

Scenario 5: SP assistant, medical ward

You are asked by the ward SP to perform daily indirect swallowing rehabilitation with Mr. Jay, a 48-year-old male with dysphagia (swallowing difficulties) and aspiration pneumonia, following outpatient radiotherapy to his oropharynx and neck.

The SP assessed the patient and developed and implemented a treatment plan. After receiving training from the SP, you are asked to facilitate the patient to carry out a list of indirect swallowing exercises twice a day.

When you go to see the patient, the nurse reports no concerns and the patient reports he is keen to do his exercises. During the session he complains that he is constipated and also notes that his mouth is very dry. You follow the exercise guideline which states:

Twice daily exercise program for Mr. Jay

Prepare the environment:

- ensure patient alert
- position upright in chair/bed
- minimise distraction and ensure privacy: pull curtains etc.

Exercises:

1. oromotor strengthening and ranging exercises, as per exercise sheet attached
2. head lift exercises, increase repetitions, as able
3. tongue-hold exercises (Masako manoeuvre), as per exercise sheet.

Considerations:

- use water spray to lubricate mouth as required
- use verbal cues and mirror to improve performance.

You complete the exercise program, noting that he:

- appeared to have difficulty performing the tongue ranging exercise on the left side, but this improved when you used the mirror and provided verbal guidance
- did 20 head lift exercises in a row, compared to 15 yesterday
- did 15 tongue exercises, but required the water spray every fifth dry swallow due to c/o mouth dryness.

Example documentation

20/10/09 1150	<u>Speech pathology assistant—swallow rehabilitation session</u> Pt consented to session, complaining of 'dry mouth' and 'constipation'. Nurse reports nil concerns. Pt positioned upright in chair, curtains pulled, minimised distractions. Performed swallow Rehabilitation Tasks as per SP prescribed program. Oromotor strengthening and ranging exercises, observed difficulty performing tongue ranging task to the left side, improved with the use of a mirror and verbal feedback. Head lift exercises performed by patient with verbal direction, increased amount of head lifts tolerated today to 20 consecutive. 15 tongue hold exercises, performed with nil difficulties, required water spray to lubricate mouth after every fifth dry swallow. Plan: AHA to feedback to SP regarding c/o dry mouth AHA to liaise with nurses regarding pt c/o constipation Ongoing daily swallow rehabilitation sessions with patient at bed-side as per SP. [Signature] (Printed name) Allied health assistant

Appendix 5: Practice scenarios

Please complete the relevant entries for the following scenarios, then discuss with your supervisor:

Scenario 1: OT assistant, acute ward

You have been asked to undertake daily Post Traumatic Amnesia Assessment (PTA) on Cooper who is a 23-year-old male. Cooper is now three days post motorbike accident where he lost consciousness at the scene. His PTA score has been 10/12 for the last two days.

When you see Cooper, he is able to name the OT who had seen him, although he reports still being unable to remember the accident. Cooper appears to be distracted when visitors entered the room and requires re-direction to continue. His PTA score today was 11/12 (orientation was 7/7, recall 4/5).

Scenario 2: OT assistant, rehabilitation unit

You are involved in running cooking groups with one of the OTs. Prior to the sessions you discuss with the patients what they want to cook and ensure the necessary ingredients are available. You help bring patients to the group and position them in the room to facilitate their independence.

The therapist asks you to help Bill and Hazel who both have poor endurance for everyday tasks and need regular encouragement to continue with the task.

Over the course of the week, Bill participates in three cooking groups and was able to mobilise around the kitchen independently and safely. He appeared progressively less fatigued over the sessions and required less prompting.

You have been asked to do a weekly health record entry about Bill's progress in the cooking groups.

Scenario 3: PT assistant, outpatients

In the outpatient department, you facilitate patients following ankle sprains to carry out the set of exercises, as determined by the PT and using a written pathway.

Today, Jeremy (a 19-year-old male, four weeks post left ankle sprain) attends and you are to carry out the following exercises, at level 4 on the pathway:

- heel raises, 2 sets of 10
- toe raises, 2 sets of 10, standing on the affected leg
- single leg stance (SLS), 10 reps of as long as possible
- calf stretches, 2 reps of 30 seconds
- balance board for 2 minutes.

Your screening assessment of performance includes:

- calf length— facing the wall with knee bent/touching the wall, measure distance of toe to wall
- time of SLS.

The pathway states that when the patient can carry out 10 sec SLS on the affected side, they are then to be referred to the PT to commence quarter squats in SLS. He completes all exercises and manages 11 seconds SLS on the left side. The toe to wall distance is 3cm. You ask the PT to review the patient to progress the exercise, as per the pathway. The PT checks Jeremy's technique in doing the new exercise and then leaves you to complete two sets of 10 quarter squats in SLS, with the direction that if the Jeremy completes that with no concerns, then the new exercise is to replace SLS in his home exercise program (HEP).

Jeremy reports discomfort at the front of the ankle during the calf stretches and balance board activities, but he completes the new exercises with no concerns. His next appointment is in one week and he is to continue his HEP 3 times daily.

Scenario 4: Community Allied Health Assistant, community rehabilitation

Mrs. Singh is a 72-year-old female who had a mild stroke resulting in mildly slurred speech. She was discharged from hospital earlier this week. She lives independently at home and appears highly motivated to improve her clarity of speech. Her stated goal is to feel comfortable with her speech when interacting socially with her friends.

After the SP reviews Mrs. Singh, she asks you to carry out speech drills focusing on multi-syllabic words, as per the handouts the SP provides. Mrs. Singh reports compliance with her home exercise program and her husband notes that her speech had already improved.

During the session you work with Mrs. Singh through two pages of speech drills focussing on increasing complexity in multi-syllabic words. She participates well, however you note she has difficulties when the words contain four syllables or more. Mrs. Singh reports being aware of this.

Mrs. Singh is booked in for her next review in three days and the SP has asked you to reinforce that she do her home exercise program twice daily.

Appendix 6: SOAP format

Component	Description	Examples
S	• states the point of view of the patient/client • includes symptomatic data • includes history, home situation, emotions or attitudes, goals, complaints, response to treatment • note verbal consent.	• *c/o painful left knee* • *slept poorly* • *consent obtained* • *lives with husband in lowset home, with 1 step to enter (no rail)* • *nurse reports obs stable* • *nurse happy for patient to participate in exercises*
O	• physical findings (physical signs) • the results or outcomes of treatment that can be clearly measured and does not contain value statements • list current problems in chronological order not priority or severity • each problem numbered for ease of reference.	• *sitting in chair* • *alert and cooperative* • *walked 40m with 4ww and supervision* • *speech appeared slurred* • *appears to be ignoring left side*
A	• patient/client's reaction to treatment • outcome of intervention • '//' may also be used to indicate response to individual treatment activities.	• *participated in Rx* • *increased number of sit-stand from 5 yesterday to 2x5 today* • *reported fatigue after intervention* • *pt reports headache following Rx*
P	• plans for ongoing treatment • description of action and change in treatment plan.	• *to complete ex. program 2 times this pm* • *review in 2/7* • *refer to nurse regarding reported headache*

Example Scenario 1: Documentation using SOAP format

7/10/09 1430	PT assistant S/ c/o sore back ISQ, consent obtained. Nurse reports stable vital signs. Has had medication for back pain. O/ sit to stand with minimal assist and prompts Mobile with 4ww and close supervision Rx as directed by PT Mob 50m as above Sit to stand as above 5 reps, rest, 3 reps. A/ c/o fatigue during treatment. P/ Encouraged to mob twice this pm with nurse. d/w Nurse ✓ Review 1/7, discuss with PT re ongoing back pain. [Signature] (Printed name) PT Assistant

Example Scenario 2: Documentation using SOAP format

8/10/09 0955	PT assistant S/ c/o headache, stated keen to participate Nurse agrees to pt participation in rehab program O/ Mob indoors independent SLS (R)< 1 sec, (L)< 1 sec Rx as per PT instructions Mob to gym Sideways, backwards walking, each x6 lengths of bars Heel- toe walking approx. 20m SLS alternate legs// pt appeared frustrated and c/o worse headache, Rx ceased, returned to ward with pt, nurse informed and nurse contacting Dr for review. A/ Balance appears worse today, SLS reduced from 4sec to 1 sec on R leg. Pt appeared frustrated with performance and c/o worsening headache. P/ refer to PT to review pt [Signature] (Printed name) PT Assistant

Glossary

Privacy	The protection of personal information in accordance with the *Information Privacy Act (2009)*. Privacy applies only to personal information.
Confidentiality	A legislative or contractual mechanism designed to protect information in a particular context. Confidentiality can apply to both personal and non-personal information.
Consent	The concept of consent as it relates to the handling of personal information does not encompass a person's consent to treatment. Consent may be express or implied and may relate to handling of patient or staff personal information, or personal information of a member of the community who has dealings with Queensland Health.