RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

RUHANI COLLEGE · MEDICAL TERMINOLOGY · LECTURE 3

Clinical Note Taking

Documentation Standards, the Client Record, the SOAP Format, and the Legal and Ethical Duties of the Registered Massage Therapist

Full-day session · 6–7 instructional hours · 60 slides

HOW WE WILL SPEND THE DAY

Session Roadmap

Six modules. Each closes with a practice set. Two breaks and one lunch.

I	**Foundations of Clinical Documentation**	*What it is, why it matters, what "good" means*	60 min
II	**The Client Record**	*Required components, consent, retrieval*	60 min
III	**The SOAP Documentation Format**	*Subjective, Objective, Assessment, Plan*	90 min
IV	**Documenting Treatment**	*Techniques, pressure, response, home care*	60 min
V	**Language, Errors, and Quality**	*Objective writing and common failures*	60 min
VI	**Legal and Ethical Responsibilities**	*Records, privacy, corrections, best practice*	60 min

Learning Objectives

By the end of this lecture, students will be able to:

Explain	the importance of clinical documentation.
Identify	required components of client records.
Use	the SOAP documentation format.
Demonstrate	accurate and professional charting.
Understand	legal and ethical documentation responsibilities.

FRAMING

The Only Thing That Survives the Treatment

Your hands, your reasoning, and your care all end when the client leaves the room. The note does not.

Who reads your note

- The next therapist who treats this client — possibly a colleague, possibly you in six months.
- The physician or physiotherapist you refer to, and who refers to you.
- An insurance adjuster deciding whether to pay the claim.
- A College investigator, or a court, years after the fact.

What they can see

- Only what you wrote. Not what you noticed. Not what you intended.
- Not your competence — only the evidence of it that you left behind.
- A vague note reads as an absence of clinical reasoning, whether or not reasoning occurred.
- If a treatment is not documented, it may be considered not performed.

I

MODULE I

Foundations of Clinical Documentation

- What clinical documentation is
- Continuity of care
- Professional accountability
- Clinical, legal, and professional purposes
- The five standards
- Timeliness

What is Clinical Documentation?

Clinical documentation refers to the written record of client care including:

- Client health history
- Assessment findings
- Treatment interventions
- Client responses
- Treatment plans and recommendations

It ensures continuity of care and professional accountability.

Continuity of Care and Professional Accountability

The two phrases that close the definition are not decoration. They are the reason the record exists.

Continuity of care

- Care is delivered across visits, across therapists, and across professions.
- The record is the only mechanism by which a treatment plan survives the person who wrote it.
- Without it, every visit restarts from zero and progress cannot be measured.
- A client should never have to be their own medical record.

Professional accountability

- The record demonstrates that assessment preceded treatment.
- It shows that consent was obtained and that scope of practice was respected.
- It allows a regulator to verify that the standard of care was met.
- It protects the therapist as much as it protects the client.

Why Documentation is Critical

Clinical notes serve several purposes.

- Clinical
  - *Tracks progress and outcomes*
  - *Supports treatment planning*
- Legal
  - *Provides evidence of care*
  - *Protects therapist and client*
- Professional
  - *Supports communication with other healthcare providers*
  - *Demonstrates professional competence*

The Clinical Purpose

Tracking progress and supporting treatment planning. The note is a clinical instrument, not a chore performed after the clinical work is finished.

- A measurement recorded once is a data point. Recorded across visits, it becomes an outcome.
- "AROM cervical rotation left: 45°" tells the next therapist nothing on its own. Compared to last week's 30°, it is proof the plan is working.
- Without a baseline, you cannot demonstrate improvement, plateau, or deterioration — to the client, the physician, or the insurer.
- The plan section is a hypothesis. The next visit's objective findings test it.
- Charting is where clinical reasoning becomes visible. If your reasoning is not on the page, it did not inform anyone's care but your own.

The Legal and Professional Purposes

These two purposes overlap, but they are answerable to different audiences.

Legal — evidence of care

- The chart is the primary evidence of what occurred in a closed treatment room.
- It records that consent was obtained, that contraindications were screened, and that the client was informed.
- It protects the therapist against an allegation, and protects the client against substandard care.
- Memory is not evidence. A contemporaneous note is.

Professional — competence and communication

- A physiotherapist reading "hypertonicity, upper trapezius, B/L" knows exactly what you found.
- Reading "shoulders tight" they learn nothing, and infer that you found nothing.
- Precise terminology demonstrates that you assessed rather than guessed.
- Your chart is the version of your professionalism that other clinicians actually see.

Standards for Clinical Charting

High-quality documentation should be:

- Accurate
- Objective
- Legible
- Complete
- Timely

Chart notes must clearly reflect what occurred during the treatment session.

The Five Standards, Defined

Each standard has a concrete test. Apply the test before you close the chart.

Standard	What it means	The test
Accurate	The note matches what actually happened	Could the client read this and agree it is true?
Objective	Observations, not opinions or assumptions	Did I see, measure, or elicit this — or infer it?
Legible	Readable by someone other than the author	Could a stranger read this under time pressure?
Complete	Nothing material is omitted	Could another therapist continue care from this alone?
Timely	Written at or immediately after the session	Was this written while the session was fresh?

A note may satisfy four standards and still fail. Completeness without accuracy is fabrication; timeliness without legibility is wasted effort.

When to Chart

Timeliness is the standard most often sacrificed, and the one most damaging to lose.

- Chart immediately after treatment, while the session is fresh.
- Memory decays fastest for exactly the details that matter most: pressure tolerated, client response, the precise site of tenderness.
- A note written three days later is a reconstruction. It may be honest and still be wrong.
- Delayed charting is one of the most common documentation errors, and it is visible: the entry date will not match the treatment date.
- If circumstances force a delay, the entry must be identified as a late entry, dated with the date it was written, and reference the date of service.
- Never chart in advance. A note describing a treatment that has not yet occurred is falsification, regardless of intent.

Practice Set 1 — Which Standard Failed?

For each chart entry, name the standard or standards it violates: accurate, objective, legible, complete, or timely.

1. "Client seemed anxious and probably stressed at work."
2. "Massage to back. Client felt better."
3. "Treatment 04 Mar. Note entered 09 Mar."
4. "Rx given as usual."
5. "Hypertonicity noted. Consent obtained." (no site, no technique, no response)
6. "Deep tissue to neck — client tolerated deep pressure well, though I did not actually use deep pressure."

Several entries fail more than one standard. Name every failure you can find.

II

MODULE II

The Client Record

- Required components
- Identification and history
- Informed consent
- Assessment and plan
- Progress notes and home care
- Organization and retrieval

Required Components of Client Records

A complete client record includes:

- Client identification information
- Health history and updates
- Informed consent documentation
- Assessment findings
- Treatment plan
- Treatment provided
- Progress notes
- Home care recommendations

These records must be organized and easily retrievable.

Identification and Health History

The first two components establish who the client is and what you are permitted to do.

Client identification information

- Full legal name, date of birth, and contact information.
- Emergency contact, and physician of record where applicable.
- A unique client file identifier, so no two records can be confused.
- Every subsequent page or entry must be attributable to this client.

Health history and updates

- Presenting complaint, past medical and surgical history, medications.
- Contraindications, allergies, and relevant lifestyle factors.
- History is not taken once. It is updated at every visit, because it changes.
- "Any changes to your health since we last met?" is a clinical question, and its answer belongs in the record.

Informed Consent Documentation

Consent is a process, not a signature. The record must show that the process occurred.

- The client must understand the proposed treatment, its expected benefits, material risks, and reasonable alternatives — including the option of no treatment.
- Consent must be voluntary, informed, and given by a person with capacity to give it.
- Consent is ongoing. It may be withdrawn at any moment, for any reason, without explanation.
- Consent is specific. Consent to treat the lumbar region is not consent to treat the anterior neck.
- Sensitive areas require explicit, separately obtained consent, documented as such.
- Document what was explained, what was agreed to, what was declined, and by whom consent was given.

"Consent obtained" is not documentation of consent. It is an assertion that a conversation happened. Record the conversation.

Assessment, Plan, and Treatment Provided

These three components must be internally consistent. The plan must follow from the assessment, and the treatment provided must follow from the plan.

What each must contain

- Assessment findings: postural observation, ROM measurements, palpation findings, orthopaedic testing, and the clinical impression drawn from them.
- Treatment plan: goals, proposed techniques, regions to be treated, expected frequency and duration.
- Treatment provided: what was actually done this visit, including any deviation from the plan and why.

The consistency test

- If the assessment names the erector spinae and the treatment names the deltoid, the chart contradicts itself.
- If the plan changed mid-session, the reason must be recorded — new finding, client request, adverse response.
- A regulator reads these three sections together. So does an insurer.
- Consistency is not a formatting rule. It is the evidence that a decision was made.

Progress Notes and Home Care Recommendations

The last two components are what turn a series of appointments into a course of treatment.

Progress notes

- Written for every visit, including visits where nothing changed.
- "No change since last visit" is a clinical finding and must be recorded as one.
- Compare against the baseline. Quantify wherever quantification is possible.
- Record the client's own report of change, in their words, in the Subjective section.

Home care recommendations

- Exactly what was recommended: which exercise, how many repetitions, how often.
- Whether the client was able to demonstrate it correctly before leaving.
- At the next visit: whether they performed it, and what happened.
- Undocumented home care cannot be evaluated, and cannot be defended if it causes harm.

Organized and Easily Retrievable

These records must be organized and easily retrievable. A record that cannot be found is functionally a record that does not exist.

- One client, one file. Entries filed chronologically, most recent accessible first.
- Every entry dated, timed where relevant, and signed or initialled by the therapist who wrote it.
- Paper records: stored securely, indexed, and protected against loss, fire, and water.
- Digital records: backed up, access-logged, and password-protected.
- Retention periods are set by your regulatory College and by legislation. Records for minors are typically retained longer. Confirm your own jurisdiction's requirement.
- Retrievability is tested at the worst possible moment: when someone demands the file on short notice.

Practice Set 2 — Audit the Record

A colleague hands you a client file. Which of the eight required components is missing, and what is the clinical or legal consequence?

1. Intake form with name only; no date of birth.
2. Health history taken at first visit, never updated across eleven visits.
3. A signed consent form dated at intake; no consent recorded for a new anterior neck technique.
4. Assessment findings recorded; no treatment plan.
5. Treatment plan recorded; no record of what was actually performed.
6. Twelve visits, four progress notes.
7. Home care advised verbally at every visit; recorded at none.
8. Paper file stored in an unlocked drawer in a shared room.

For each: name the component, name the standard breached, and name who is harmed.

III

MODULE III

The SOAP Documentation Format

- Subjective
- Objective
- Assessment
- Plan
- A complete example
- Self-audit

SOAP — A Structured Charting Method

SOAP is a structured charting method widely used in healthcare. Four sections, four different kinds of evidence.

S	**Subjective** What the client reports.	*Reported, not verified. The client's words and experience.*
O	**Objective** What you observe or measure.	*Seen, measured, palpated, or elicited by you.*
A	**Assessment** Your clinical interpretation.	*Reasoning drawn from S and O together.*
P	**Plan** Treatment given and future care.	*What you did, and what happens next.*

S — Subjective

Information reported by the client:

- Pain location and intensity
- Symptoms
- Changes since last visit
- Functional limitations
- Example:
  - *Client reports right shoulder pain rated 6/10 when lifting arm overhead.*

Writing a Strong Subjective Entry

The Subjective section is the client's testimony. Record it faithfully, and record it usefully.

- Attribute clearly: "Client reports…", "Client states…". Never assert the client's experience as your own finding.
- Quantify pain with a scale, and name the scale. "6/10" is meaningless without "on a 0–10 numeric rating scale."
- Record what provokes and what relieves. Pain "when lifting arm overhead" is far more useful than pain "in the shoulder."
- Record functional limitations in the client's own terms: cannot reach a seatbelt, cannot sleep on the right side.
- Record changes since the last visit, including no change and including worsening.
- Direct quotation, in quotation marks, is appropriate when the client's exact words matter.

A useful mnemonic for questioning: onset, provocation, quality, radiation, severity, timing.

O — Objective Findings

Therapist's measurable observations:

- Postural assessment
- Range of motion testing
- Palpation findings
- Muscle tone changes
- Swelling or tissue abnormalities
- Example:
  - *Limited shoulder abduction*
  - *Hypertonicity in upper trapezius*
  - *Tenderness at supraspinatus insertion*

Making Objective Findings Measurable

A finding you cannot re-measure next week is not an objective finding. It is an impression.

Category	Weak entry	Measurable entry
Postural assessment	"Poor posture"	"Forward head posture; right shoulder elevated"
Range of motion	"Limited movement"	"AROM shoulder abduction 90°, limited by pain"
Palpation	"Tight muscles"	"Hypertonicity, upper trapezius, bilateral"
Tenderness	"Sore spot"	"Tenderness on palpation at supraspinatus insertion"
Muscle tone	"Feels knotty"	"Trigger point, right levator scapulae, referral to occiput"
Swelling	"Swollen"	"Localised oedema, right lateral ankle; no calor"

The right-hand column uses the terminology of Lectures 1 and 2. That is what the terminology was for.

A — Assessment

Clinical interpretation of findings. This includes:

- Identification of dysfunction
- Clinical reasoning
- Treatment priorities
- Example:
  - *Myofascial restriction in right upper trapezius*
  - *Possible rotator cuff strain*
  - *Reduced shoulder mobility*

Assessment Is Not Diagnosis

The Assessment section is where clinical reasoning becomes visible — and where scope of practice is most easily exceeded.

Within scope

- "Myofascial restriction, right upper trapezius."
- "Findings consistent with rotator cuff strain; recommend physician assessment."
- "Possible rotator cuff strain."
- "Reduced shoulder mobility limiting overhead activity."
- Hedged, tissue-level, and referable.

Beyond scope

- "Client has a torn supraspinatus tendon."
- "Diagnosis: impingement syndrome."
- "Client's pain is caused by a disc herniation."
- "Client does not need to see a doctor."
- Definitive, structural, and diagnostic.

P — Plan

Details of treatment and future care. Includes:

- Techniques used
- Areas treated
- Duration of treatment
- Home care instructions
- Follow-up plan
- Example:
  - *Myofascial release and trigger point therapy to upper trapezius*
  - *Stretching exercises for shoulder mobility*
  - *Recommend follow-up treatment in 1 week*

Example SOAP Note

The complete example from the source material. Read it as a single argument: each section supports the next.

S Client reports low back pain rated 5/10 after prolonged sitting.

O Decreased lumbar flexion. Hypertonicity in erector spinae. Tenderness at L4–L5 region.

A Lumbar muscle tension related to prolonged postural strain.

P Effleurage and petrissage to lumbar region. Myofascial release to erector spinae. Home care: lumbar stretching and posture correction.

Why That Note Works

Each element does a specific job. Remove any one and the note fails a different test.

"S: Client reports low back pain rated 5/10 after prolonged sitting. A: Lumbar muscle tension related to prolonged postural strain."

"Client reports"	→	Attribution. Marks the information as the client's, not the therapist's.
"rated 5/10"	→	Quantified. Re-measurable at the next visit.
"after prolonged sitting"	→	Aggravating factor. Links symptom to mechanism.
"Hypertonicity in erector spinae"	→	Objective, named tissue, standard terminology.
"related to prolonged postural strain"	→	Reasoning. Connects the objective finding to the subjective report.

The Assessment explains the Objective, which explains the Subjective. The Plan then treats the Assessment. That chain is the whole method.

Six Questions to Ask Before You Close the Chart

Run this list on every note until it becomes automatic.

1	Is every statement in S attributed to the client, and every statement in O produced by me?
2	Is every objective finding measurable, so that it can be compared next visit?
3	Does the Assessment follow from the findings, and does it stay within my scope of practice?
4	Does the Plan treat what the Assessment identified, and is the home care specific?
5	Is consent for what I actually did recorded — including any new technique or new region?
6	Could another therapist continue this client's care using only this note?

Practice Set 3 — Write the Note

You are given a scenario. Write a complete SOAP note. Twenty minutes, individually, then exchange and audit a partner's note using the six questions.

1. A 34-year-old office worker reports neck and shoulder pain, 4/10, worse by the end of the workday, present for two months.
2. On assessment: forward head posture, elevated right shoulder, cervical rotation to the left reduced, upper trapezius hypertonic bilaterally, tenderness at the levator scapulae insertion on the right.
3. You treat with myofascial release and trigger point therapy to the upper trapezius and levator scapulae, moderate pressure, forty minutes.
4. The client reports reduced pain after treatment.
5. You recommend a cervical stretch, three times daily, and a workstation review. You propose review in one week.

Do not add findings you were not given. Charting what you did not observe is the error this exercise is designed to catch.

IV

MODULE IV

Documenting Treatment

- Areas treated
- Techniques used
- Pressure level
- Client response
- Home care
- Naming techniques precisely

Documentation of Treatment Techniques

Clinical notes should include:

- Specific areas treated
- Techniques used
- Pressure level
- Client response
- Example:
  - *Effleurage and petrissage to bilateral lumbar paraspinals*
  - *Moderate pressure tolerated well*
  - *Client reported decreased pain post-treatment*

Naming the Technique Precisely

"Massage" is not a technique. Name what your hands did, using the standard vocabulary.

Technique	What it is	Charted as
Effleurage	Gliding stroke, superficial to deep	"Effleurage to lumbar paraspinals"
Petrissage	Kneading, lifting, wringing of tissue	"Petrissage to upper trapezius, B/L"
Friction	Cross-fibre or circular, applied locally	"Transverse friction, common extensor origin"
Tapotement	Percussive strokes	"Tapotement to posterior thorax"
Myofascial release	Sustained load applied to fascia	"MFR to thoracolumbar fascia"
Trigger point therapy	Sustained ischaemic compression of a TrP	"TrP release, right levator scapulae"
Joint mobilisation	Passive movement within physiological range	Only where within scope; name grade if used

Use only abbreviations approved by your clinic and your College. When in doubt, write the word out in full.

Pressure Level and Client Response

These two elements are what make the note reproducible — and what protect you if the client reports harm.

Pressure level

- Use a consistent scale: light, moderate, deep — or your clinic's numeric scale.
- Record the pressure actually used, not the pressure planned.
- Record any pressure the client requested, and whether you provided it.
- Record any point at which pressure was reduced, and why.

Client response

- During treatment: "Moderate pressure tolerated well." "Client requested lighter pressure over the right scapula."
- After treatment: "Client reported decreased pain post-treatment."
- Adverse responses must always be recorded: pain increase, dizziness, nausea, bruising, autonomic changes.
- An adverse response with no note is the worst combination in this lecture.

Documenting Home Care

Home care recommendations are a treatment intervention. They are documented like one.

- Name the intervention: which stretch, which exercise, which self-care measure.
- Name the dose: how many repetitions, how long the hold, how many times per day.
- Name the instruction given: what to do if it hurts, when to stop, when to call.
- Record whether the client demonstrated it correctly before leaving.
- At the next visit, record adherence and effect. Home care that is never reviewed is home care that was never prescribed.
- Written or printed home care handouts should be noted in the chart, and a copy retained.

"Home care given" documents nothing. "Cervical lateral flexion stretch, 30-second hold, 3× daily; demonstrated correctly" documents a treatment.

Practice Set 4 — Rewrite the Treatment Entry

Each entry is missing at least one of the four required elements: area, technique, pressure, response. Identify what is missing and rewrite the entry.

1. "Massage to back, 45 min."
2. "Deep tissue work. Client did fine."
3. "Effleurage and petrissage. Moderate pressure."
4. "MFR to thoracolumbar fascia; client tolerated well."
5. "Worked on the usual areas."
6. "TrP release to right levator scapulae, deep pressure, client reported sharp pain during treatment."

Item 6 contains all four elements and is still a problem. Say why.

V

MODULE V

Language, Errors, and Quality

- Objective versus subjective language
- Rewriting judgement as observation
- Common documentation errors
- Consequences
- Abbreviations
- Quality control

Objective vs Subjective Language

Documentation must remain objective and professional.

- Wrong:
  - *"Client looked terrible today."*
- Right:
  - *"Client presented with guarded posture and limited cervical ROM."*
- The wrong entry records the therapist's impression of the client. The right entry records the client's presentation.
- Objective documentation increases clinical accuracy and professionalism.

Turning Judgement Into Observation

Every judgement conceals an observation. Find the observation and write that instead.

Do not write	The hidden observation	Write instead
"Client looked terrible"	Posture, movement, expression	"Guarded posture; limited cervical ROM"
"Client was difficult"	A request was declined	"Client declined treatment to anterior neck"
"Client is a complainer"	Reported pain level	"Client reports pain 8/10 on palpation"
"Client is lazy"	Adherence to home care	"Client reports not performing home care"
"Probably just stress"	An unverified inference	Omit, or: "Client reports work-related stress"
"Client seemed anxious"	An observable behaviour	"Client declined to lie prone; requested seated Tx"

The client can request their record. Write every entry as though they are reading it — because one day they may be.

Common Documentation Errors

Common mistakes include:

- Vague notes
- Missing treatment details
- Delayed charting
- Illegible handwriting
- Personal opinions or assumptions

Incomplete records can lead to clinical and legal problems.

What Each Error Actually Costs

These are not stylistic faults. Each has a predictable clinical and legal consequence.

Error	Clinical consequence	Legal or professional consequence
Vague notes	No baseline; progress cannot be measured	Reads as absence of assessment; claims denied
Missing treatment details	Next therapist cannot reproduce care	Treatment may be deemed not performed
Delayed charting	Details lost; accuracy degrades	Entry date contradicts service date
Illegible handwriting	Misread finding; wrong region treated	An unreadable record is not a record
Opinions or assumptions	Bias enters clinical reasoning	Damages credibility; may breach conduct standards

Incomplete records can lead to clinical and legal problems. Every row above is one route by which that happens.

Abbreviations — Efficiency Against Clarity

Abbreviations save time. Ambiguous abbreviations have caused documented patient harm. Use only what your clinic and College approve.

Generally safe in RMT charting

- B/L — bilateral · Fx — fracture · Hx — history · Tx — treatment
- ROM, AROM, PROM, RROM — range of motion, active, passive, resisted
- TrP — trigger point · MFR — myofascial release
- c/o — complains of · WNL — within normal limits · PRN — as needed

Avoid entirely

- Any abbreviation invented for your own convenience.
- "U" for unit; "QD"/"QOD" for daily/every other day — mistaken for one another.
- Trailing zeros (1.0 mg) and missing leading zeros (.5 mg) — tenfold dosing errors.
- Eponyms in place of description: write "lateral epicondylitis," not "tennis elbow."

Practice Set 5 — Fix the Note

Rewrite each entry so that it is accurate, objective, complete, and professionally defensible.

1. "Client looked terrible today, gave her the usual."
2. "Massage. 60 min. Good session."
3. "Client probably has a disc problem."
4. "Client refused to cooperate with assessment."
5. "Deep work to the back. Client sore afterwards but that's normal."
6. "Chart completed 5 days later from memory."

For each: name the error, name the standard breached, then write the corrected entry.

VI

MODULE VI

Legal and Ethical Responsibilities

- Chart notes as legal records
- Insurance and audits
- Confidentiality and privacy
- Correcting errors
- Late entries
- Best practices

Legal Importance of Chart Notes

Clinical notes are legal health records. They may be used for:

- Insurance claims
- Workplace injury documentation
- Regulatory audits
- Legal investigations

If a treatment is not documented, it may be considered not performed.

Four Readers, Four Different Tests

The same note is examined by four audiences, each asking a different question of it.

Insurance and workplace injury

- The adjuster asks: is this treatment reasonable, necessary, and related to the claimed injury?
- Answered by: baseline findings, measurable progress, and a plan that follows from the assessment.
- Workplace injury files additionally require mechanism of injury and functional limitation.
- Vague notes are denied claims. The client bears that cost.

Regulatory audit and legal investigation

- The regulator asks: did this therapist meet the standard of practice?
- The court asks: what happened, and can this record be relied upon?
- Both examine consent, scope, contraindication screening, and adverse events.
- Both treat an altered or reconstructed record far more harshly than a deficient one.

Confidentiality and Privacy

Massage therapists must protect client information. Best practices include:

- Secure storage of records
- Password-protected digital files
- Limited access to client charts
- Obtaining consent before sharing information

Confidentiality is essential to professional trust and ethical practice.

Privacy in Practice

Privacy legislation governs health information in every jurisdiction. Confirm which statute and which College standard apply to you.

- Collect only the information you need for the care you are providing.
- Access only the records of clients you are treating. Curiosity is a breach.
- Consent before sharing: name what will be shared, with whom, and for what purpose. Consent to share with a physician is not consent to share with an employer or an insurer.
- Digital: password-protect, encrypt where possible, log access, and never store client data on a personal device without authorisation.
- Physical: lock the cabinet, lock the room, position screens away from public view, and shred rather than discard.
- A breach must be handled according to your legislation and your College's requirements. Know the procedure before you need it.

Confidentiality is essential to professional trust and ethical practice — and it is the duty most easily broken by accident.

Correcting Documentation Errors

If a charting error occurs, the record must show both the error and the correction. Concealment destroys the integrity of the whole file.

Do this

- Draw one line through the incorrect entry.
- Write the correct information.
- Add initials and date.
- The original entry must remain legible beneath the line.

Never do this

- Erase entries.
- Use correction fluid.
- Remove pages from records.
- Backdate, rewrite, or reconstruct an entry after the fact.

Late Entries, Addenda, and Electronic Records

This maintains record integrity. Integrity means the record shows its own history, including its mistakes.

- A late entry is written after the fact. Label it "late entry," date it with the date written, and reference the date of service.
- An addendum adds information to an existing entry. It never replaces it. Date, sign, and reference the original.
- Never insert text into an earlier entry, and never write between the lines of an existing note.
- Electronic records: corrections are made by amendment, and the system's audit trail preserves the original. Do not attempt to defeat the audit trail.
- An amendment made after a complaint, an incident, or a request for records will be scrutinised, and the timestamp will be visible.
- Sign every entry. An unsigned entry cannot be attributed, and an unattributable entry proves nothing.

Documentation Best Practices

To improve documentation quality:

- Chart immediately after treatment
- Use clear medical terminology
- Include assessment findings
- Record client responses
- Document home care advice

Consistent documentation supports high-quality patient care.

REVIEW

The Chart Note Checklist

One page. Run it before you close any file.

Section	Must contain	Common failure
Identification	Client identified on every entry	Loose page, no name
History	Updated at every visit	Taken once, never revisited
Consent	What was explained and agreed	"Consent obtained" alone
Subjective	Attributed, quantified, provoking factors	Therapist's opinion recorded as client's
Objective	Measurable, named tissue, standard terms	"Tight," "sore," "poor posture"
Assessment	Reasoning, within scope	Diagnosis stated as fact
Plan	Area, technique, pressure, response, home care	Technique named, response omitted
Signature	Dated, timed, signed	Unsigned, undated, unattributable

CLOSING

Key Takeaways

Four ideas carry the whole day.

The note is the care	It ensures continuity of care and professional accountability. It is not an administrative task performed after the clinical work.
Objective, not judgemental	Every judgement conceals an observation. Write the observation. The client may read the record.
Complete, or it did not happen	If a treatment is not documented, it may be considered not performed.
Integrity over appearance	One line through an error, initialled and dated. Never erase, never conceal, never reconstruct.

CLOSING

Self-Check Before You Leave

Answer these without notes. If you can, you have met today's objectives.

1. Name the five standards for clinical charting.
2. Name the eight required components of a client record.
3. What distinguishes a Subjective entry from an Objective one?
4. Why does the word "possible" matter in an Assessment entry?
5. Name the four elements every treatment entry must contain.
6. Rewrite "client looked terrible today" as an objective observation.
7. Describe the correct procedure for fixing a charting error.
8. Complete the sentence: "If a treatment is not documented, …"

Bring your answers to the next session. We open Lecture 4 with this list.

END OF LECTURE 3 · RUHANI COLLEGE

Write it as though it will be read.

Because it will be — by the next therapist, by a physician,
by an adjuster, by a regulator, and perhaps by the client themselves.

Accurate. Objective. Legible. Complete. Timely.
Consistent documentation supports high-quality patient care.

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