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Clinical documentation during clinical placements: Perspectives of physiotherapy students and clinical educators

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Abstract

Background: Clinical documentation is a critical form of communication in healthcare settings. As defined by the Physiotherapy Practice Thresholds, clinical documentation that complies with relevant professional and legal obligations is a requirement for all physiotherapists in Australia and New Zealand.

Aims: The aims of this study were to explore the experiences of clinical documentation and perceived support and training needs for physiotherapy students whilst on clinical placement, from the perspective of students and clinical educators.

Method: A qualitative approach was used to investigate physiotherapy student (n=18) and clinical educator (n=17) experiences and perspectives. Interviews from eight focus groups were professionally transcribed, and reflexive thematic analysis was applied to the data to determine common themes.

Results: Four overarching themes were generated; 1) Recognising the value of documentation, 2) Variance of expectations, 3) Challenges in measuring performance, and 4) Clinical placement readiness and requirements.

Conclusion: The main findings from this study identify the unique challenges that students experience to meet documentation requirements on clinical placement. This study highlights the shared responsibility of university education providers and clinical placement facilities to support students to understand the importance of clinical documentation and assist in improving their documentation skills.

I INTRODUCTION

Clinical documentation is a critical form of communication within healthcare settings (Mathioudakis et al., 2016). Quality clinical documentation facilitates effective and timely communication and coordination between members of the clinical team, both internal and external to the organisation, and supports safe and efficient patient care (Hammoud et al., 2012). Despite clinical documentation being an essential professional skill, there are challenges in preparing students for documentation within university settings. It is difficult for university teaching staff to be able to prepare students for the variety of clinical documentation needs and processes they will encounter on clinical placements across multiple different clinical areas in a range of settings. Therefore, as documentation can vary across clinical areas, settings, and educators, clinical education settings are where students tend to learn the most about clinical documentation (Rowlands et al., 2016).

Clinical documentation can be broadly defined as notations made by health professionals in relation to a patient's care (Rowlands et al., 2016). This can include patient assessment and management notes, phone conversations, documenting procedures or outcome measures, family meetings and discharge summaries. Clear and accurate documentation is integral for ethical practice and patient safety and is underpinned by strict medicolegal requirements (Hammoud et al., 2012). Clinical documentation that complies with relevant professional and legal obligations is a requirement for all physiotherapists in Australia and New Zealand as defined by the Physiotherapy Practice Thresholds (Physiotherapy Board of Australia and New Zealand, 2015). It is therefore necessary for students to understand the importance of clear and accurate clinical documentation, and how to execute those skills prior to and during clinical placements (Rowlands et al., 2016).

Clinical education of pre-registration physiotherapy students is essential to the development of a safe and effective workforce. It serves as the forum for students to transform theory into practice (Koontz et al., 2010) while achieving professional socialisation (Rodger et al., 2011; Shields et al., 2013) and relevant clinical competencies. Students participate in different clinical experiences across a range of settings and populations throughout their university training. Initially, students may complete shorter clinical placements that focus on observation of normal clinical practice, before progressing to full-time 5-week clinical placements during which they are supervised by a registered physiotherapist. By the end of their full-time placements, students are expected to be meeting entry level standards in that area of practice (Dalton et al., 2011). Students are assessed using the Assessment of Physiotherapy Practice (APP), which is a standardised and validated assessment tool used across Australian and New Zealand settings for full-time clinical placements. One of twenty criteria within the APP relates to the quality of written clinical documentation. Research by Dalton et al. (2011) has demonstrated that a student's APP score is a reliable indication of their underlying level of professional competence in workplace practice.

Physiotherapy clinical educators perform a critical role in clinical education by sharing their knowledge and expertise for the development of both professional and clinical skills. Specifically, clinical educators facilitate students to gain confidence in their clinical reasoning and application of theoretical knowledge in real-life situations, providing feedback as well as evaluating students' clinical performance and behaviours (Delany & Bragge, 2009). Physiotherapy students regularly report that the attitudes of their clinical educators, amount of direction, and the atmosphere of the learning environment play a

large role in influencing their career goals as well as increasing their professional confidence (Laitinen-Väänänen et al., 2007).

Students find clinical placements challenging as they frequently experience clinical situations that have not been experienced within university settings (Levett-Jones et al., 2015). Research exploring the perspectives of nursing students reveals that managing workloads, clinical reasoning, and a perceived lack of professional knowledge and skills are especially challenging (Sheu et al., 2002). Further studies have recommended strategies such as simulation and clinical skills sessions to improve these aspects of clinical practice (Ricketts, 2011; Park, 2018). Clinical documentation is also an important aspect that health professional students have identified as challenging whilst on clinical placement (Rowlands et al., 2016). Previous research has indicated that clinical documentation has a direct link to clinical reasoning, workload efficiency, and professional skills (McCarty et al., 2005; Schenarts & Schenarts, 2012; Gliatto et al. 2009). This reinforces the need to understand strategies that may improve readiness for clinical documentation during clinical placements, as these findings may assist in improving overall student performance during and following clinical placements. However, no research to date has explored clinical documentation from the perspective of physiotherapy students and educators within clinical education settings.

An understanding of the perspectives of both physiotherapy students and their educators regarding clinical documentation during clinical placements is lacking from the current evidence base. This knowledge will assist in providing recommendations to university education providers and clinical educators. Therefore, this study aimed to explore the experiences of clinical documentation, support, and perceived training needs, for physiotherapy students to meet documentation requirements whilst on clinical placement from the perspective of students and their educators.

II METHOD

A Study Design

A qualitative research design that employed a reflexive thematic analytical approach (Braun & Clarke, 2006) was used to allow for identifying patterns and themes that were shared and different across participant groups (Nowell et al., 2017). Focus groups were used to collect data via open, authentic discussions of the phenomenon, allowing participants to express freely in their own terms (Cohen & Crabtree, 2008).

B Participants

Five clinical education sites were invited to participate in this study. The clinical education sites were a combination of private and public facilities, of varying sizes as well as a range of clinical speciality areas to provide a sample reflective of the clinical education landscape. The clinical education coordinator at each site was emailed with relevant information about the study and invited to participate. Four clinical sites agreed to participate, which consisted of three public hospitals and one university clinic. Two participant groups were involved in this study: (1) physiotherapy students and (2) physiotherapy clinical educators. Physiotherapy students undertaking clinical placements at one of the four participating clinical sites between February and May 2021 were invited to participate. Students were eligible if they were enrolled in an undergraduate or postgraduate entry-level physiotherapy degree at a Queensland university and had completed at least one 5-week clinical placement at the time of recruitment. This criterion

was applied to ensure potential participants had received at least one occurrence of mid-unit and one end-of-unit feedback, and therefore had relevant experience to reflect on clinical documentation experiences and requirements. In addition, limiting the participants to students at Queensland universities optimised the relevance of results to our intended audience (clinical educators in Queensland) and our funder (see Methods, section C), as the vast majority of students who attend clinical placements in Queensland are enrolled in Queensland universities. Clinical educators were invited to participate if they had experience supervising physiotherapy students across at least two periods of 5-week full-time clinical placements at one of the four participating sites. Recruitment and data collection from both groups occurred between February and May 2021. Informed consent was collected from all participants prior to data collection.

Students were introduced to the study during their orientation at each of the participating sites and then followed up by an email invitation to participate sent by the clinical education coordinator or clinical educator at their placement site, who was not a member of the research team. Clinical educators were invited by direct email from the clinical education coordinator at each participating site. The initial invitation, outlining the study topic, inclusion criteria, and consent form, invited participants to contact the lead researcher (author initials removed for blinding) with their availability to participate. Following participants' email reply, a second email was sent to arrange a mutually agreed time for the focus groups.

Thirty-seven students were invited to participate in the study via email. Nineteen students (response rate 51.35%) responded to the initial email and indicated interest. Of these, 18 students met inclusion criteria and provided consent to participate. Ninety-three clinical educators were invited to participate in the study via email. Of these, 18 clinical educators responded to the initial email and indicated interest (response rate 19.35%). Seventeen educator participants indicated availability and provided written consent to participate. All focus groups were completed over a 5-week period (Thursday 1st April, 2021 until Wednesday 5th May, 2021).

C Procedure

This project had a steering committee organised by the funding organisation, Directors of Physiotherapy Services Queensland (DOPSQ) Physiotherapy Clinical Education and Training Initiative (CETI). The steering committee consisted of one Queensland physiotherapy clinical education and training program manager, three Department Directors of physiotherapy, one university based clinical education coordinator and physiotherapy lecturer, one clinical education and new graduate support coordinator, and one recent new graduate (non-research participants), in addition to the research team members. The research team developed draft focus group frameworks following a review of the literature and consultation with the steering committee (see Table 1). Eight focus groups were conducted, one for students and one for educators at each of the four participating sites. All focus groups were performed by one of three members of the research team (L.F, R.F, E.G) who were experienced in focus group interviewing. Focus groups were conducted via videoconferencing (Zoom or Microsoft Teams) and were audio recorded. Focus groups were a mean of 40 minutes in duration.

Table 1
Example Focus Group Questions for Physiotherapy Clinical Educators and Students

Physiotherapy Clinical Educator Focus Group Questions	Physiotherapy Student Focus Group Questions
Can you outline the clinical documentation requirements within the service you work in?	Is clinical documentation important to learn? And why?
What are your experiences with introducing students to the clinical documentation requirements within the service you work in?	What do you understand about the role of clinical documentation when you are a health professional? What purpose does it serve?
How much time and resources are needed to prepare the students specifically for clinical documentation?	What have you found challenging with documentation?
What are students prepared for or not prepared for about clinical documentation?	Did you need any help or training in your first week of placement around documentation?
What are the main challenges around clinical documentation?	What training have you had in documentation before placements?
How do you decide on scoring the APP criterion for documentation? What information do you use?	Did the training that you received prepare you for what you need to do on placement?
What support do you think students need regarding clinical documentation standards prior to placement?	How do you measure your own performance with regard to documentation?
If you believe a student is struggling with documentation what would be your strategies to help them improve?	

D Data Analysis

Focus groups were audio-recorded and transcribed using a strict verbatim process by a professional transcriber. All transcripts were cross-checked with the audio-files to ensure accuracy, and to ensure that no meaning was lost during the transcription process. Analysis occurred concurrently with data collection from Thursday 1st April, 2021 until Wednesday 5th May, 2021.

A reflexive thematic analysis approach (Braun & Clarke, 2012; Braun & Clarke, 2019) was selected to allow for the development of similar and contrasting patterns, codes, and themes across more than one participant group. This process began with the lead researcher (L.F) who immersed themselves in the audio-recordings and transcribed data and became familiar through a process of listening, reading field notes to determine mood, context, and tone of the recorded focus groups and re-read the transcripts to identify initial thematic patterns in the data. After familiarisation of data, the lead researcher assigned codes that reflected meanings to small or large parts of transcribed data. The lead researcher then categorised these codes into preliminary themes before subgrouping into more substantial themes. These were further arranged into four main themes that were able to represent the overall data. Data from the two participant groups were coded simultaneously to allow for the construction of common themes that reflected both participant groups whilst ensuring that competing or contrasting perspectives were acknowledged. Final themes contrasted to determine tensions and similarities, which intended to improve reflexivity. Following this procedure, a second independent researcher (R.F) repeated the same process. Multiple meetings were scheduled for the research team to deliberate and assign coding and final themes.

Several strategies were implemented to enhance rigour and reflexivity. To uphold credibility, two researchers (L.F, R.F) independently completed the process of identifying

codes, subcategories, and themes. Following this process another member of the research team (E.G) reviewed this procedure as well as attended meetings discussing the transcription process. To improve transferability of results, clinical educators and students across four sites were selected as participant groups to represent a variety of perspectives from clinical placement sites. Rigorous qualitative research also requires researcher reflexivity to consider how data interpretation may be influenced by worldviews or perspectives (Mays & Pope, 2000).

The primary researcher (L.F) has worked as a hospital-based physiotherapist for over six years and has educated students for four years. In addition to holding the perspective of an educator, this experience may have allowed a greater understanding of the challenges of clinical documentation requirements. The second researcher (R.F) who repeated all processes independently has worked for 15 years in clinical education within the university setting. The third researcher (E.G) has 13 years' experience working as a physiotherapist within hospital settings and has three years' experience in leading and assisting clinical research. To enhance trustworthiness of the findings, the research team members had no relationship with the students and were not involved in providing or managing student placements.

III RESULTS

A total of 18 students and 17 clinical educators participated in the focus groups. Students were from four higher education institutions and engaged in placements in cardiorespiratory, paediatrics, orthopaedics, musculoskeletal, and neurological rehabilitation. Clinical educators had experience in supervising students across cardiorespiratory, critical care, neurorehabilitation, orthopaedics, paediatrics, women's health, musculoskeletal, acute aged care, and hyper-acute stroke units. More information regarding participants is outlined in Table 2 (students) and Table 3 (educators).

Table 2
Demographic Information Students

Code	Site	Completed Clinical Placements	Current Clinical Placement Area
(1a)	A	2	Cardiorespiratory
(1b)	A	2	Cardiorespiratory
(1c)	A	2	Cardiorespiratory
(1d)	A	2	Paediatrics
(2a)	B	1	Neurorehabilitation
(2b)	B	1	Neurorehabilitation
(2c)	B	1	Neurorehabilitation
(2d)	B	1	Neurorehabilitation
(2e)	B	1	Neurorehabilitation
(3a)	C	5	Neurorehabilitation
(3b)	C	5	Neurorehabilitation
(3c)	C	1	Neurorehabilitation
(3d)	C	1	Cardiorespiratory
(3e)	C	1	Orthopaedics
(3f)	C	1	Orthopaedics
(4a)	D	1	Neurorehabilitation
(4b)	D	1	Orthopaedics
(4c)	D	1	Orthopaedics

Table 3
Demographic Information Clinical Educators

Code	Site	Experience as clinical educator (years)	Clinical Placement Area
(5a)	A	12	Critical Care/ Cardiorespiratory/ Musculoskeletal
(5b)	A	5	Cardiorespiratory
(5c)	A	5	Paediatrics/ Women's Health/ Musculoskeletal
(5d)	A	5	Cardiorespiratory/Outpatient Musculoskeletal
(6a)	B	5	Neurorehabilitation
(6b)	B	6	Musculoskeletal
(6c)	B	13	Musculoskeletal
(6d)	B	6	Musculoskeletal
(7a)	C	8	Musculoskeletal
(7b)	C	5	Cardiorespiratory/Orthopaedics
(7c)	C	8	Cardiorespiratory
(7d)	C	5	Neurorehabilitation
(8a)	D	2	Neurorehabilitation
(8b)	D	5	Neurorehabilitation/Hyper-acute stroke unit
(8c)	D	25	Neurorehabilitation
(8d)	D	2	Acute Aged Care/Hyper-acute stroke unit
(8e)	D	2	Acute Aged Care/Hyper-acute stroke unit

Four overarching themes were generated following analysis: 1. Recognising the value of documentation 2. Variance of expectations 3. Challenges in measuring performance 4. Clinical placement readiness and requirements.

A Theme 1: Recognising the value of documentation

Students felt that university education had prepared them for the medico-legal aspects of documentation, however clinical placements were considered the real opportunity where they realised the clinical value and utility of documentation. It was during placement that students were able to experience the value of documentation as it was being used by other health professionals, thus they recognised the importance of clear, concise, and accurate records.

“University prepares you for documentation to recall what you do mainly as a medico-legal issue... However clinical placement demonstrated that you are working as a part of a team and a wide array of people read your charts and use your chart entry” (1c).

“Both of my placements have shown me more the importance of documentation. University taught me the layout. Whereas placements showed me how important it is in terms of communication between professions” (4a).

Most students voiced a sense of concern when they realised that other health professionals made use of their documentation on clinical placement; “when a doctor or somebody else reads your charts and you don’t feel confident with what you’ve written, that was the stressful part for me” (1c). One student highlighted that initially their chart entries may not meet an adequate standard however “other healthcare professionals are reading it and don’t know who’s written it, and expect it to be up to standard” (1d). Clinical placement had reinforced the importance of documentation to students as it “isn’t just a personal reminder – it is evidence for everyone to look at and your interpretation of the patient can be used by different people” (3f).

Students reflected on their clinical placement and suggested that not recognising the value of documentation created an increase in their stress levels. At the beginning of placement students felt anxious when clinical educators proofread their chart as they were worried it wouldn't meet documentation standards. Most students were also concerned that initially on clinical placement they spent more time focused on documentation than on patient interactions.

"You spend so much time in the first week unnecessarily worrying and stressing about your charts. You spend so much time, effort and stress making sure your chart is right that it ends up taking up half your day" (3e).

"At the beginning of prac it was a big stressor. The more times you document you start stressing less about documentation and more about the patients themselves. At the start it almost takes away from your time with patients. As the placement progressed it was definitely less stressful and it became pretty routine so it wasn't as concerning anymore" (1c).

Most clinical educators believed there was a clear link for students between understanding the importance of documentation and understanding the "the purpose of why they're writing this piece of documentation" (6a). One clinical educator contrasted this view and highlighted that students "do understand it is important, but they don't get what's important to make clear in documentation" (7c). Most clinical educators recognised that documentation improves over the clinical placement once the students understand "who's going to be reading their documentation" (6c) "what's important to make clear in documentation" (6b), and "the errors that could occur" (7d).

B Theme 2: Variance of Expectations

Most students felt challenged by the differences in expectations from their educators across different clinical placements, even feeling trepidation about the adjustment to the expectations of their next clinical educator on their next 5-week placement. Students tended to try and identify the key aspects of the style of documentation that their clinical educator preferred and would adapt their documentation style to suit their current clinical educator.

"We were taught different things by different educators, which I get it now because in different wards and even with different people, they have different styles of documentation and different requirements" (4a).

"To try and adapt to what each clinical educator wants was a bit challenging for me personally" (2d).

Students felt they were trying to improve their documentation skills on each placement however clinical educators did not acknowledge that they had received different feedback from prior placements: "I think it would be good for them [clinical educators] to understand that documentation for cardiorespiratory at one hospital and cardiorespiratory at another hospital could be completely different" (1a). One student suggested that clinical educator expectations for student documentation are of a higher standard than their other physiotherapy colleagues: "When I documented I was required to write how many sets, how many reps, timeframe; which is different to what's in the system by other physios" (4a). To ensure clinical documentation requirements are clear at each site students felt that specific requirements need to be explicitly explained to students at the beginning of each placement.

Educators also recognised the challenge for students in being presented with different expectations by different clinical educators, and particularly between placement facilities. There were contrasting descriptions from educators about the timing of when students were allowed to write directly into the medical charts. One educator would "let them [the

students] write directly into charts when I'm no longer making significant changes to drafts" (5a). In contrast, another educator admitted to being "conservative" (5b) and not allowing students to write into medical charts until mid-unit feedback.

Clinical educators also recognised that meeting documentation expectations is challenging as clinical placement is "a learning curve" (5d) for students, and that documentation across the placement improved alongside clinical reasoning. Some educators felt that there was a clear link between clinical reasoning and the quality of documentation demonstrated by students: "if they're struggling with the clinical reasoning then documentation usually reflects that and it's usually quite poor" (8c).

Some educators suggested that it takes until mid-unit for students to reach their minimum acceptable standard for documentation. Consequently, clinical educators felt that a lot of their clinical supervision time was used to correct, rewrite, and prepare students documentation to meet their expectation.

"If you had to compare the time it takes to rework someone's clinical note compared to a letter, why it's just- It could take you every bit of an hour to fix letters. And sometimes, if it's a quite important letter, it's maybe not even worth letting the students have a crack, because you're going to have to start pretty much from scratch again" (6a).

"I think my expectation is quite high for the documentation, but if they're doing quite well, I will challenge them and try and get as best as I can. If at mid unit they're really struggling I probably will accept more of a basic documentation so that we can continue on. Because otherwise, I refuse to stay here until six o'clock on a Friday evening" (8c).

C Theme 3: Challenges in measuring performance

Measuring performance in relation to clinical documentation was challenging for both students and clinical educators. Most students felt it was difficult to assess their own performance and development as often information regarding their performance was inconsistent or unclear: "You really don't have much information to go on other than the direct feedback that you're getting all the time" (1b). All students reflected that they had limited awareness of their own performance and relied on "taking the lack of feedback as I must be doing alright" (2e). Students felt they relied on implicit communication and were unable to read between the lines to determine their standard against the APP: "If you've [students] included what they've [educators] been telling you [students], then you might grade yourself up" (2e).

Clinical educators tended to rely on "the amount of corrections, the time it takes, the consistency in the chart writing" (8d) and how much critical feedback was needed to be given to determine assessment of performance: "How many times you have to provide the feedback and are they then implementing strategies on your feedback" (5b). Clinical educators also used medico-legal standards of documentation as a basis to determine students' documentation standards and thus assess their performance.

"If I can read the clinical note and be satisfied that it meets medico-legal standards for what I observed the student did with the client, that's adequate. The quality of what's written in there is probably the difference between meeting standards and exceeding standards, as the baseline is medico-legal standards, because at the end of the day, they're here under our insurance, it's in our name that goes on the clinical audit" (6a).

Students relied heavily on clinical educator feedback to assess performance in documentation. Clinical educators reflected on the feedback they provided and felt they offered general strategies e.g. "I'll show them what corrections and improvements I've made" (8d) regarding documentation and not specific strategies on how to progress from

meeting standards on the APP to exceeding standards: “I’ll call the student over and identify what bits I like and what bits I want them to continue to work on and why” (8b).

Looking towards the future most clinical educators felt a set example of a student chart entry for each APP grade would assist in creating a similar standard for documentation across clinical placements.

“Would be helpful to see clinical educators’ expectations, if you think of those vignettes, they develop, this is a great student, this is an average student, this is a failing one. When I did the APP course, the entire room, except I think three clinical educators failed one student and yet they weren’t great, but they weren’t unsafe. I would probably have passed them. It was just getting that expectation” (5d).

D Theme 4: Clinical Placement Readiness and Requirements

There was a strong perception from students and clinical educators that improving student readiness for documentation on clinical placement is a shared responsibility between the university education provider and their clinical placement facility. Most students recognised that “it’s the uni’s responsibility for us to be at an adequate standard as we start the placement, but then it’s the facility’s job to progress our documentation as we work through the weeks on placement” (2c). This was supported by clinical educators who highlighted that students “can’t come too prepared because it’s different during university than it is in the real world with real people” (5a). Students also highlighted that the “uni has room to improve to ensure we [students] get the idea of why documentation is important” (1b) and improving their “professional language” (3b). However, students also recognised that it was not the university education providers sole responsibility as each placement has site specific “templates that their ward will use and a usual style of documentation” (4c). Clinical educators supported this by recognising that “they [students] all get taught documentation styles at University...And then I will tailor off that to my specific clinical area” (7c).

The need for further exposure to other forms of written documentation prior to placement was recognised by clinical educators and students. Students felt that they needed exposure to “referrals, discharge summaries, and transfer summaries” (3c) to ensure they were aware of typical documentation standards. One student voiced: “We didn’t do a lot of this at uni. I don’t think I even read a referral let alone writing one” (1d). This was reinforced by clinical educators who suggested that “practicing different types of documentation” (8a) at university would assist in understanding the purpose of documentation and “help them prioritise information differently; writing a letter to a doctor is very different to writing a chart” (8a). One clinical educator, however, suggested that students start their placement “somewhat prepared” (5b) for written documentation, but when a student is asked to make a phone call to a doctor or family member, “that’s when I get the deer in the headlights look” (5b).

Students also felt that their clinical placement facility should have introduced other forms of documentation during their orientation: “referrals are challenging, every placement will show you the referral letter and where it is kept but you never get shown how to write one” (1d). Students suggested being shown site specific examples of this documentation on clinical placement is important “at the very start of each placement, it’d be nice to talk through some of them and do one with your educator or see a completed one” (1c). However, this perspective was contrasted by some clinical educators who believe a lot of their time at the beginning of placement is introducing students to documentation.

“What I would do with students on day one, outline their expectations of documentation, set up a template with them, or give them a template to make sure it involves everything that I want it to involve, for our clinical documentation, like accreditation requirements” (7b).

“I found that the pro forma I was giving out they rote learn, but they didn't have the concept. So I start off with a blank piece of paper. And then I'd say, “Okay, so what do we want to know?” And I'll ask open ended question. And then I'll break it down. Their goal is to go home, write out a separate pro forma, and bring it back in and explain the reasoning behind it to me, so I know they grasp the concepts” (7a).

All students recognised the value of learning and practice of documentation at university. One student felt that “at uni it [documentation] wasn't really talked about much at all and I didn't think it was going to have a big role in placement” (2e). All students reflected on the importance of documentation in clinical placement and would have valued having more documentation exposure at university: “it would have been nice to have a class to practice writing a whole chart entry” (1a). However, students felt that documentation activities were only valuable if feedback was received on their work: “in one subject at uni we did a lot of documentation, but we didn't get any feedback before our placement started” (2b).

Students suggested further learning activities would be beneficial to prepare them for clinical placement. The learning activities that were identified were templates, video examples, more documentation exposure in courses, real world clinical relevance, and direct feedback.

“A more specific proforma given to you at uni, just as like a brief outline would be really good that you can then take to each of your placements. You can then modify to suit the specific hospital or clinical educator” (1d).

“It would be good to watch a video of like a physio doing objective treatment and then write your documentation of that” (2e).

“A bit more in uni. I think just doing a little part of it in each course could be useful in terms of gradually building up the skill over time, rather than just getting thrown in the deep end” (4b).

Clinical educators supported this view and felt further learning activities would assist in preparing students for documentation on clinical placement. Clinical educators suggested “role playing” (5d) to improve interview skills, incorporating assessment pieces of “documentation that got marked” (8c) into course structures, and “example chart entries for all different core subjects” (5c). Clinical educators suggested that university education providers should provide the examples given to students on clinical placement to allow clinical placement facilities to understand the structure they have been taught.

IV DISCUSSION

The aims of this study were to explore the experiences of clinical documentation and perceived support and training needs, for physiotherapy students whilst on clinical placement from the perspective of students and clinical educators. The results indicate that university education providers and clinical placement providers have shared responsibilities in facilitating the learning and development of clinical documentation skills. Our findings provide key recommendations for university education providers and clinical placement providers to consider for ensuring students are prepared to meet clinical documentation needs. These key findings have been summarised for the reader in Appendix 1 & 2.

A major theme emerging from the results of this study was the perceived value of clinical documentation. Students were often surprised to learn that other health professionals made use of their chart entries, and clinical placement experiences

highlighted to students the importance of documentation as a communication tool. For some students, the realisation of the importance of documentation was considered a source of stress and led to them spending more than the allocated time writing their clinical documentation entries. The results of our study are supported by Oxentenکو et al. (2010) who also found that students initially spend a large proportion of their clinical time learning to document rather than focused on patient interactions, which can increase experiences of stress during clinical placements. This study supports the perceived value and utility of clinical documentation in healthcare to act as a communication tool and the importance of effective clinical documentation to ensure patient safety from the perspective of students and clinical educators. The findings also highlight the value of clinical placements to offer students an opportunity to integrate their documentation theory into practice and provide students with learning experiences to develop the relevant knowledge, skills, and competence needed for quality clinical documentation (Chan, 2002; Edwards et al., 2004).

Students within the present study felt ill-prepared for documentation when entering clinical placements. There was minimal formal clinical documentation education perceived to be provided in pre-clinical training; most education that was perceived as valuable occurred 'on the job'. This finding is consistent with previous research from Rowlands et al. (2016), who conducted semi-structured interviews with medical students in Australia and found that "formal clinical documentation education using lectures and tutorials was minimal; most education occurred on the job by junior doctors" (p. 99). Additionally, results from the present study demonstrate an acknowledgement by both physiotherapy students and clinical educators of the shared responsibility between university education providers and clinical placement facilities to coach students to learn, refine, and implement clinical documentation skills.

Clinical documentation skills are a requirement for practice. The World Physiotherapy Physiotherapist Education Framework (2021) Domain 3.2 states physiotherapists who meet world physiotherapy expectations are able to "maintain accurate, clear, timely records of assessment, decision-making, interventions, and outcomes and share with other professionals as appropriate" (p. 18). Previous research has reported that university education providers have implemented a number of strategies to support physiotherapy students' clinical skills and theoretical knowledge in preparation for clinical placements. These include simulated learning environments to train clinical skills and competencies (Levett-Jones & Lapkin, 2014), as well as video podcasts to support the acquisition of clinical skills and revision for practical examinations (Hurst, 2016). Clinical educators within the current study described a significant amount of time spent assisting students with understanding the purpose of documentation as well as correcting errors and providing feedback on chart entries as a result of students being underprepared. Students and clinical placement facilities may therefore benefit from students undertaking more university training within pre-clinical courses regarding documentation before beginning placement. Such training may include integrating more sessions dedicated to clinical record keeping, chart audits, virtual simulation, and written documentation standards, perhaps guided by recommendations from clinical facilities (Wong, 2009; Everett-Thomas et al., 2021). Although this previous research relates to the nursing profession, the evidence does suggest that exposing students to documentation before clinical placement results in enhanced readiness and may assist students in becoming more proficient with clinical documentation. This research relates closely to the first theme of the present study, which emphasises that students may not understand the importance of documentation until clinical placement experiences occur. Therefore, integrating

documentation into the pre-clinical curriculum in alignment with the Physiotherapy Practice Thresholds and World Physiotherapy - Physiotherapist Education Framework (Physiotherapy Board of Australia and New Zealand, 2015; World Physiotherapy, 2021) may help to expose students to documentation earlier and assist students in being aware of what is expected when they transition into placement. It is then the responsibility of the clinical educator to not only assess student performance, but provide opportunities to reinforce, progress, and contextualise learnt documentation knowledge during clinical placements.

The importance of aligning teaching and learning expectations between students and clinical educators to achieve learning outcomes (Delany & Bragge, 2009) was supported by this study. Students felt challenged by the differences in documentation expectations from their educators across different clinical placement facilities. These findings are consistent with previous literature from Ernstzen (2013) who emphasised the need for clinical educators to clarify their expectations at the start of clinical placement to manage student and educator expectations. The National Safety and Quality Health Service Standard 7 and Physiotherapy Board of Australia's Code of Conduct (Physiotherapy Board of Australia, 2014; Australian Commission on Safety and Quality in Healthcare, 2019) outline a number of fundamental recommendations to meet medico-legal documentation requirements. Beyond these requirements, though, there is no consensus between university education providers and clinical placement facilities regarding the fundamental principles that must be included. This highlights the importance of clear communication between the university education provider and clinical placement facilities to align expectations on the fundamentals of documentation that can be applied to all professional areas and assist student transition from one placement to the next. To assist in creating a similar standard for documentation across all clinical facilities, clinical educators in the present study suggested an appendix to the APP which has clinical documentation examples for each given APP score awarded. Such a strategy may demonstrate to students the basic consistencies of documentation and align expectations across clinical placements and between students and clinical educators. This is similar to research findings from Simpson et al. (2010), who identified that a written documentation checklist for Speech Pathology students was useful in improving clinical documentation skills. Once the fundamental expectations of documentation have been reinforced, clinical educators may be able to tailor their directions for documentation to meet the expectations of their specific clinical area. This may be achieved by acknowledging previous placement experience, outlining expectations of documentation, establishing templates (Klecza et al., 2018), and providing examples of site-specific documentation at the beginning of each placement.

Educators in the present study felt there was a strong link between clinical reasoning skills and quality of student clinical documentation. This finding is consistent with previous literature, where the development of documentation is considered essential to the ability to document clinical findings and may demonstrate clinical reasoning skills (McCarty et al., 2005; Schenarts & Schenarts, 2012). Gliatto et al. (2009) describes that learning to 'record' provides a framework for assessing skills such as history taking and supports students to clinically reason their own thoughts. This indicates that students may benefit from early pre-clinical courses, providing time and opportunity for self-reflection and practicing documentation, in particular the summarising and assimilation of key findings. Such training may influence clinical reasoning skill development.

Students in the current study tended to rely solely on non-specific feedback to gauge their own performance of clinical documentation across their placement. In contrast,

students received more targeted feedback around their clinical performance and skills which they were able to relate to in their formal APP assessment. Burgess et al. (2020) described feedback within health professional education as “specific information about the comparison between a trainee’s observed performance and a standard, given with the intent to improve the trainee’s performance” (p. 1). Feedback is an integral aspect of learning, especially during clinical placements (Burgess & Mellis, 2015), however it must be constructive and meaningful to assist the student’s performance (Rahimi et al., 2016). This is consistent with the results of the present study where students identified that most of their documentation feedback tended to be non-specific, which they found challenging to link to their formal assessment or their understanding of their performance. Burgess et al. (2020) explained that the feedback process must provide the student with information about the quality of their performance, to lead to improvements in learning strategies. The results of the present study also indicate that when feedback to a student is discontinued, the student may assume that their documentation does not have room for improvement. Therefore, to provide effective feedback it is important for clinical educators to give regular, specific, performance-based feedback in a supportive environment to allow opportunities to improve (Oxentenko et al., 2010; Burgess et al., 2020).

V IMPLICATIONS

The findings of this study indicate that there may be a disconnect between the university education provider and clinical placement facility regarding physiotherapy student clinical documentation preparation and training. Identifying this disconnect shows that university education providers and clinical placement facilities need to communicate effectively to identify what information students need to be taught during classes with the university education providers versus the ‘on the job’ training at the placement facility. The results highlight that university education providers should consider integrating more documentation-related training into pre-clinical courses, perhaps based on recommendations from clinical facilities. They should also consider direct practice of all types of clinical documentation, preferably linked to case-based learning or simulation activities, for example referral letters and transfer summaries (Trommelen et al., 2017; Wright et al., 2018). The study findings also acknowledged that clinical placements inherently highlight the value of documentation as a communication tool to students. Therefore, clinical educators should consider their students’ previous placement experiences, provide documentation to show students facility specific expectations, as well as give regular, specific, performance-based feedback to allow students the opportunity to improve their clinical documentation. There are key staff members already in place in many organisations who may be positioned to facilitate this: clinical education liaison managers within universities, and clinical education coordinators in hospitals. These existing links should be leveraged to enable a consensus to be reached. Further research is warranted to better understand the effect of pre-clinical learning activities on student readiness and performance of clinical documentation on clinical placement. A potential avenue for future research and training is the exploration and development of minimum standards for pre-clinical documentation in each of the core physiotherapy areas. A consensus-based methodology is a potential way of creating documentation minimum standards and assisting in the implementation into university curricula.

VI LIMITATIONS

There are some limitations to acknowledge regarding the methodology of the current study. Only one of the four participating sites was a university education provider student-

led clinic, which may reduce the generalisability of our findings to similar placement sites. Furthermore, clinical placement sites such as private organisations (private hospitals, community practices, or disability services) were not included, which may further limit generalisability. Participants were volunteers and, therefore, a self-selecting group. Issues may have been missed that related specifically to students and clinical educators who did not volunteer, for example, clinical educators or students who have a particularly negative or positive view of clinical documentation. Participants in the study could only report on learning experiences and clinical educators to whom they were exposed – exposure to different clinical educators may provide different findings. The study took place in Queensland, Australia, which uses a 5-week placement structure. Different models may enable more or less facilitation of clinical documentation on placement. Lastly, the important perspective of the university education provider has not been included within this study which may have provided more insight into students pre-clinical training opportunities and experiences.

VII CONCLUSION

The main findings from this study identify the challenges that students experience to meet documentation requirements on clinical placement. This study highlights the shared responsibility of the university education provider and clinical placement facilities to support students to understand the importance of clinical documentation and assist in improving their clinical documentation skills. Enhancing and providing more documentation-related teaching activities into pre-clinical courses as well as providing clear site-specific expectations may facilitate student learning and provide students with the opportunity to improve clinical documentation skills whilst on clinical placement to support safe and effective patient care.

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Appendix 1

FIVE PRE-CLINICAL TRAINING RECOMMENDATIONS FOR PREPARING PHYSIOTHERAPY STUDENTS FOR CLINICAL DOCUMENTATION

Introduction to clinical documentation best practice	Outline the scope and breadth of clinical documentation used by health professionals early within pre-clinical programs. Refer students to National Safety and Quality Health Service Standard 7 (NSQHS) and APHRA Code of Conduct. Aim for students to understand why quality clinical documentation is critical to health provider communication and safety. Outline the risks of poor clinical documentation.
Modelling of clinical documentation in practice	Provide 'minimal' documentation examples to meet medicolegal requirements. Refer students to NSQHS Standard 7 and AHPRA Code of Conduct. Provide realistic examples of both written and electronic documentation, across clinical settings, that are linked to authentic case studies. Provide opportunities for students to understand the role of clinical documentation from the perspective of health professionals.
Direct practice of clinical documentation skills	Integrate opportunities for direct practice of all types of clinical documentation, preferably linked to case based learning or simulation activities. For example, referral letters, transfer summaries and clinical handover. Provide opportunities for students to problem solve how to prioritise and summarise information effectively for clinical documentation to encourage critical thinking.
Specific learning activities incorporated across the curriculum	Pre-clinical case based learning, problem based learning and simulation are opportunities for students to practice documentation in authentic ways. Consider the use of clinical documentation sharing and examples during interprofessional activities for students to understand language, context, and the role of documentation between professions.
Opportunities for feedback during learning activities	Provide students with clear standards and expectations for clinical documentation to allow for self-reflection and awareness of own performance. Provide specific, performance based feedback to students on their use of clinical documentation. Ensure feedback is linked to clinical documentation standards and healthcare contexts.

Appendix 2

STRATEGIES TO SUPPORT CLINICAL EDUCATORS IN ASSISTING PHYSIOTHERAPY STUDENTS TO MEET CLINICAL DOCUMENTATION STANDARDS ON CLINICAL PLACEMENT

Demonstrate Documentation	Write an example of a chart entry to demonstrate to students your expectations. When students arrive, explain your chart entry and why you have included specific elements.
Establish Templates	Develop templates for charts specific to your facility to allow students to have the structure that you prefer.
Exposure to Site Specific Documentation	Collate handouts and examples of referral templates, discharge summaries, transfer summaries and doctors letters so that students are aware of the expectation for other forms of clinical documentation.
Health Professional Documentation Examples	Gather examples of other health professional chart entries to demonstrate the importance of clear and concise documentation. This will assist in showing students how documentation is used as a communication tool.
Acknowledge Previous Placement Experience	During orientation find out from students what their previous placement required of them regarding documentation so that you are on the same page.
Align Expectations	Outline your expectations of documentations early. Explain the medico-legal requirements to ensure your chart entries comply with National Safety and Quality Health Service Standard 7 and AHPRA Code of Conduct. Also explain your preferred structure, abbreviation use, chart length, and when to document.
Emphasise the 'Context' of Documentation	Help students to understand how to use the chart as a communication tool with other professionals/members of the MDT. Ensure students know who read their chart entry.
Provide Feedback	Provide specific, performance based feedback to allow opportunities to improve. If you stop giving feedback, students may assume that their documentation does not have room for improvement.