

**KNOWLEDGE, ATTITUDES AND PRACTICES OF  
PHYSIOTHERAPISTS ABOUT CLINICAL DOCUMENTATION  
IN UNIVERSITY OF BENIN TEACHING HOSPITAL**

**BY**

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## **CERTIFICATION**

This dissertation by OJEAGA, PHILIP OHILEBO is accepted in its present form as satisfying the dissertation requirement of the degree of Bachelor of Physiotherapy of the School of Basic Medical Sciences, College of Medical Sciences of the University of Benin.

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## **DEDICATION**

This work is dedicated to God Almighty for the strength, grace, and courage to finish this project and see it through. To my ever-loving and supportive father, Mr. Augustine Edeifo Ojeaga and mother Mrs. Edith Odion Ojeaga and my siblings, for providing me with the strength, morale, support, prayers, and funds to complete my academic journey.

## ABSTRACT

**Background:** It seeks to identify the current level of understanding, perceptions, and actual documentation behaviors among these professionals. The research aims to highlight areas for improvement in documentation quality, which is crucial for effective patient care, legal compliance, and interdisciplinary communication about the Knowledge, Attitudes, and Practices of Physiotherapists concerning clinical documentation within the University of Benin Teaching Hospital (UBTH).

**Aim:** The aim of this study is to evaluate the knowledge, attitudes and practices, that regards about clinical documentation in University of Benin Teaching Hospital, with a focus on understanding how these factors influence the quality of patient care, compliance with legal and professional standards, and overall effectiveness of treatment outcomes.

**Methods:** A descriptive cross-sectional design. It will be aimed at assessing the knowledge, attitudes, and practice (KAP) of 45 physiotherapists regarding clinical documentation at the University of Benin Teaching Hospital (UBTH). Data will be collected over a period of two weeks. Questionnaires will be distributed physically to eligible participants in each Unit. Respondents will be given time to fill out the questionnaire at their convenience and return it within three day. Data will be analyzed using the Statistical Package for the Social Sciences (SPSS) version 25. Descriptive statistics such as frequencies, percentages, means, and standard deviations will be used to summarize data. Inferential statistics such as chi-square tests will be used to explore relationships between knowledge, attitudes, and practice.

**Results:** The study analyzed data from 45 fully completed questionnaires administered to full-time registered Physiotherapists at the University of Benin Teaching Hospital (UBTH). The

respondents were a largely youthful group, with most aged 28–33 years (33.3%) and having 1–5 years of work experience (37.8%). A majority (68.9%) held a BSc/BMR in Physiotherapy.

**Conclusion:** Physiotherapists at the University of Benin Teaching Hospital possess a moderate level of knowledge, positive attitudes, and good practices regarding clinical documentation.[1]

While general awareness is present, specific areas for improvement in documentation practices were identified, suggesting a need for targeted educational interventions to enhance the quality and completeness of clinical records.

**Key Words:** Physiotherapists, clinical documentation, knowledge, attitudes, practices

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## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Background of Study**

Physiotherapy is a dynamic profession with an established theoretical base, and widespread clinical application in the development and restoration of optimal function. The “complexity and breadth” of the physiotherapy profession has grown beyond the scope of general practice (Ashiyat, et al, 2015). Continuing professional development is now essential to ensure service quality and has become a professional responsibility. Physiotherapy is a profession that forms an active part of the health care team in the management of patients with various conditions using the patient-centered care approach. Accurate documentation promotes long continuity of care and facilitates dissemination of information concerning the patient to all members of the health care team. Documentation in physiotherapy practice is a very important aspect of clinical practice that ensures continuity of patient care, it also facilitates communication among healthcare workers serves as a legal record of patient interactions. The attitudes and practices that guide documentation can significantly influence the quality of care provided to each patient. Understanding these attitudes and practices among physiotherapists is needed for improving documentation standards enhancing patient outcomes (Olawale, Olajide et al, 2015).

The high rising demand for physiotherapy needs worldwide calls for utmost innovation to be made to meet the challenges/needs of service delivery to patients. However, little is known about the knowledge, attitude, and practice of Nigerian physiotherapists about documentation.

The World Confederation for Physical Therapy (WCPT) recommends that accurate physiotherapy documentation should include personal data, consent, examination, evaluation, diagnosis, prognosis, plan of care, interventions/treatment, reexamination, and the results (WCPT, 2019). Outcomes and recording of the achievement of goals and expected outcomes, including patients' expectations and recording of any adverse reactions related to the treatment given and any action taken by the physiotherapist must also be documented. Physiotherapy documentation should also include information on any referral received and referral made to other sources/personnel, home program, education provided, date of any canceled or missed appointments and reasons where relevant, discharge plan, date of discharge or discontinuation of physiotherapy, and discharge or discontinuation summary.

The knowledge to document patients' responses to treatment about the care given is a core competence of physiotherapists. It has also been shown that the greatest conceptual issue impeding better physiotherapy treatment outcomes in patients' conditions is the failure to make accurate documentation, which leads to adverse outcomes that are often not documented. The documenting progress notes will depend on the individual patient, the type of care provided, and the requirement to accurately record the events of the episode of care (Olawale et al., 2015)

Although there is no internationally accepted gold standard that is used for measuring the accuracy of physiotherapy documentation, there are internationally accepted processes with theoretical elements in making accurate physiotherapy documentation. Accurate physiotherapy documentation allows physiotherapists to evaluate physiotherapy outcomes as a logical result of physiotherapy diagnoses and interventions. Striving for consensus on the role of diagnosis in

patient management should become a priority as well as developing a more standard taxonomy with consistent terminology. The documentation needs to be coherent, relevant, unambiguous, and linguistically correct (Emilia et al, 2015).

According to a statistical report conducted by Saudi MOH in 2012, the total number of physiotherapists registered in MOH hospitals was 2495. Only 852 of them were physiotherapy specialists (male = 572; female = 280), whereas 1643 were physiotherapy technicians (male = 1072; female = 571). In addition, physiotherapy practitioners were men (66%) and most of them were from Saudi Arabia itself (84.6%). Although there were large numbers of patients that received the care in physiotherapy unit, its services have not been involved as primary health care. Furthermore, although physiotherapists are permitted to make assessments for patients, design plans of care and apply treatments, patients do not have the ability to access physiotherapy services directly in MOH hospitals, but they can refer themselves to private practice (Alshehri, et al, 2017). A factor that has added to the fast growth of digital physical therapy is the increasing availability of digital technologies such as the mobile devices and their applications which have quickly taken on the role of crucial support for clinical decision-making to ensure better health outcomes. Many mobile applications can be used for several aspects of physical therapy, for example, there are some applications that give information on exercise purposes, dosage, and techniques, as well as information on exercises for prophylactic and rehabilitative purposes.

Evidence suggests that patient perspective on the usage of these digital tools for health care documentation is mostly a positive experience; (Awotidebe, et al, 2023). Hence, many countries

in the world have adopted digital physical therapy for use in the delivery of physical therapy services. Previously, Odole et al. (2023) identified six themes responsible for perceived challenges to the practice of physical therapy by physiotherapists in Nigeria. These themes include “inadequate and underdeveloped infrastructure, ethical issues, training of physiotherapists/ patients’ literacy needs, physiotherapists-patient contact, cultural issues, and financial implications.” However, the recent advances in the technical competencies of Nigerians as well as the impact of the coronavirus pandemic have caused a positive shift in the use of digital technologies for health care documentation. Presently, there is a dearth of information on the current level of competency, attitude, and practice of digital physical therapy among Nigerian physiotherapists. This is necessary to provide a critical hint into the possible ways of speeding up the implementation of digital physical therapy practice on a national scale. Hence, the purpose of this study is to investigate the current level of knowledge, practice, and attitude about documentation among physiotherapists in Nigeria.

## **1.2 Statement of the Problem**

The practice of physiotherapy documentation is a critical aspect of patient care and professional accountability. However, there exists a significant variability in the attitudes and practices surrounding documentation among physiotherapists in various healthcare settings. In selected hospitals, it has been observed that some physiotherapists may prioritize clinical treatment over thorough documentation, potentially leading to incomplete patient records, miscommunication among healthcare providers, and compromised patient safety. This inconsistency raises concerns about the overall quality of care provided to patients and highlights the need for a deeper understanding of the factors influencing physiotherapists' attitudes towards documentation.

The accuracy of physiotherapy documentation needs to be improved in order to promote optimal continuity of care, improve efficiency and quality of care, and recognize patients' needs. Implementation and use of electronically produced documentation might help physiotherapists to organize their notes more accurately (Olawale, et al, 2015)

Furthermore, inadequate training and awareness regarding best practices in documentation can contribute to negative perceptions among physiotherapists. Some may view documentation as a burdensome task rather than an integral part of their professional responsibilities. This research aims to explore these attitudes and practices in detail, identifying barriers that physiotherapists face in maintaining comprehensive documentation. By addressing these issues, the study seeks to provide insights that could inform strategies for improving documentation practices within selected hospitals, ultimately enhancing patient outcomes and fostering a culture of accountability in physiotherapy.

This study is therefore aimed at answering the following questions:

- i. What is the level of knowledge among physiotherapists in University of Benin Teaching Hospital, Benin City regarding documentation standards and best practices?
- ii. What are the common practices employed by physiotherapists in University of Benin Teaching Hospital, Benin City when documenting patients assessments and treatment plans?
- iii. How do these attitudes influence their actual documentation practices?
- iv. What are the barriers encountered by physiotherapists when attempting to document their clinical activities?

v. Are there differences in documentation practices based on demographic factors such as age, gender, education level, or years of experience among physiotherapists using University of Benin Teaching Hospital, Benin City as a case study.

vi. What are the prevailing attitudes of physiotherapists towards documentation in their practice?

### **1.3 Aim of Study**

The aim of this study is to evaluate the knowledge, attitudes and practices, that regards about clinical documentation in University of Benin Teaching Hospital, with a focus on understanding how these factors influence the quality of patient care, compliance with legal and professional standards, and overall effectiveness of treatment outcomes.

### **1.4 Specific Objectives**

- i. To Assess the level of Knowledge among physiotherapists in University of Benin Teaching Hospital regarding clinical documentation principles and best practices.
- ii. To Evaluate the Attitudes of physiotherapist towards clinical documentation, including their perceived importance and relevance to patient care.
- iii. To Examine the current Practice of clinical documentation among physiotherapists in University of Benin Teaching Hospital.

## **1.5 Hypotheses**

### **1.5.1 Null Hypotheses**

- i. There will be no significant difference in the level of knowledge about clinical documentation among physiotherapists at the University of Benin Teaching Hospital
- ii. There will be no significant correlation between the attitudes of physiotherapists towards clinical documentation and their demographic characteristics (e.g., age, gender, years of experience)
- iii. The practice of clinical documentation among physiotherapists at the University of Benin Teaching Hospital will not differ significantly based on their level of education or training.
- iv. There will be no significant relationship between the knowledge, attitudes, and practices regarding clinical documentation among physiotherapists at the University of Benin Teaching Hospital
- v. There would be correlation between experience and documentation quality
- v. There will be no significant difference in compliance with clinical documentation guidelines between experienced and less experienced physiotherapists.

### **1.6 Significance of the Study**

- i. The study on the "Knowledge, Attitudes and Practices, about clinical documentation in University of Benin Teaching Hospital" could highly significant as it addresses a critical aspect of healthcare delivery that directly impacts patient outcomes, professional accountability, and the quality of care. Proper documentation in physiotherapy is essential for maintaining accurate records of patient assessments, treatment plans, progress notes, and outcomes.
- ii. This study could contribute to the broader field of evidence-based practice (EBP) by emphasizing the role of systematic documentation as a tool for clinical decision-making and

research. Accurate physiotherapy documentation not only supports individual patient care but also provides valuable data for evaluating treatment efficacy and advancing the profession through research.

iii. This research could contribute to the development of targeted educational programs aimed at enhancing the skills and knowledge of physiotherapists regarding clinical documentation. By identifying specific deficiencies in understanding or application, educational interventions can be tailored to address these issues directly. Such programs could lead to improved compliance with best practices in documentation.

## **1.7 Scope of the Study**

The scope of this study is as follows:

i. The primary variables include the level of knowledge regarding clinical documentation standards, the attitudes towards the importance and utility of such documentation in clinical practice, and the actual practices employed by physiotherapists in documenting patient care.

ii. The population for this research will consist of registered physiotherapists working at UBTH. This includes both full-time staff and any part-time or visiting physiotherapists who engage with patients within the hospital's facilities. The selection criteria will ensure that only those actively involved in clinical practice are included, as their experiences and perspectives are essential to understanding current practices related to clinical documentation. This research will be confined to selected hospitals to provide a manageable yet representative sample for data collection while ensuring relevance to real-world clinical environments.

iii. The location for this study is specifically within the University of Benin Teaching Hospital, which serves as a major healthcare provider in Edo State, Nigeria. This setting is significant because it encompasses a diverse patient demographic and a variety of clinical cases that

physiotherapists encounter daily. By focusing on this institution, the research aims to capture specific challenges and successes related to clinical documentation practices within a real-world hospital environment.

### **1.8 Limitations of the Study**

The limitations of this study include:

- i. The study will be limited to one hospital, which may reduce the generalizability of the findings.
- ii. Self-reported data may introduce bias due to underreporting or overreporting by participants.
- iii. Time constraints may affect the number of questionnaires retrieved.

### **1.9 Definition of Terms**

- i. Attitudes:** Attitudes refer to the mental and emotional positions or perspectives that physiotherapists hold toward documentation practices in their professional work.
- ii. Practice:** Practice refers to the actual application or execution of physiotherapy documentation by physiotherapists in their daily clinical routines.
- iii. Physiotherapy Documentation:** Physiotherapy documentation is the systematic recording of patient-related data by physiotherapists. It includes initial assessments, treatment goals, intervention plans, progress reports, discharge summaries, and other relevant clinical information.
- iv. Physiotherapist:** A physiotherapist is a licensed healthcare professional trained to assess, diagnose, and treat physical impairments or disabilities through therapeutic exercises, manual therapy techniques, education, and advice.

**v. Standards for Documentation:** Standards for documentation refer to established guidelines or protocols that dictate how physiotherapists should document patient care activities accurately and comprehensively.

**vi. Patient Outcomes:** Patient outcomes refer to measurable changes in health status resulting from interventions provided by physiotherapists as documented in clinical records—examples include improvements in mobility levels after therapy sessions or reductions in pain intensity scores over time.

**vii. Continuity of Care:** Continuity of care describes the seamless provision of healthcare services over time through consistent communication among providers via accurate documentation practices.

**viii. Barriers to Documentation:** Barriers to documentation are factors that hinder physiotherapists from effectively recording patient information during their practice. These may include time constraints due to high workloads, lack of training in proper documentation methods, insufficient resources.

**x. Ethical Considerations in Documentation:** Ethical considerations involve adhering to principles such as confidentiality when documenting sensitive patient information during therapy sessions while ensuring accuracy without falsification or omission that could compromise care quality.

**xi. Legal Implications of Documentation:** Legal implications refer to the potential consequences arising from improper or incomplete physiotherapy documentation practices. Accurate records are critical for defending against malpractice claims or audits while ensuring compliance with regulatory requirements set by governing bodies like health ministries or licensing boards.

## **1.10 List of Abbreviations**

PT - Physiotherapist

PTA - Physical Therapist Assistant

SOAP - Subjective, Objective, Assessment, Plan

HPI - History of Present Illness

ROM - Range of Motion

VAS - Visual Analog Scale

WCPT - World Confederation for Physical Therapy

APTA - American Physical Therapy Association

PROMs - Patient-Reported Outcome Measures

US - Ultrasound Therapy

## CHAPTER TWO

### LITERATURE REVIEW

#### **2.1 Conceptual Review of Clinical Documentation**

Clinical documentation in physiotherapy involves the systematic recording of patient interactions, including assessments, treatment plans, progress evaluations, and discharge summaries. It serves as a core component of clinical decision-making, legal accountability, and interdisciplinary communication. Effective documentation enhances patient safety and helps ensure continuity of care (Boshnjaku et al., 2023). In modern healthcare systems, the adoption of Electronic Health Records (EHRs) has improved the accessibility, legibility, and coordination of care among multidisciplinary teams (Kruse et al., 2018).

Physiotherapists commonly use standardized documentation frameworks such as SOAP (Subjective, Objective, Assessment, Plan) and increasingly the International Classification of Functioning, Disability and Health (ICF), which facilitates a more holistic approach to patient assessment (World Health Organization [WHO], 2001). These frameworks ensure consistency and completeness in clinical notes while also guiding practitioners in clinical reasoning and goal setting (Akinbo et al., 2008).

Documentation also incorporates the use of validated outcome measures such as the Oswestry Disability Index (ODI), Berg Balance Scale, and Visual Analogue Scale (VAS) to objectively track patient progress and justify interventions. A study by Swinkels et al. (2011) found that standardized documentation templates helped physiotherapists reduce variability in record-keeping and improve communication within rehabilitation teams. Nevertheless, barriers such as time constraints, lack of familiarity with documentation standards, and limited training in digital systems can negatively impact documentation quality (Stevens et al., 2016).

The evolution of telehealth and remote monitoring has further expanded the scope of clinical documentation. Physiotherapists now document virtual consultations, wearable device data, and patient-reported outcomes through digital platforms. This transformation requires updates to traditional documentation guidelines and ongoing professional development to equip clinicians with the necessary skills (Cottrell et al., 2017). As technology advances, ensuring secure, standardized, and legally sound documentation remains a key priority in physiotherapy practice.

### **2.1.1 Importance of Clinical Documentation in Physiotherapy Practice**

Clinical documentation is a cornerstone of physiotherapy practice, serving to enhance patient safety, facilitate interprofessional communication, and provide legal and financial justification for services rendered. Comprehensive documentation ensures continuity of care, supports clinical decision-making, and enables the tracking of patient outcomes over time (Browne et al., 2021). It also acts as a safeguard in legal proceedings, where detailed records may serve as critical evidence of the physiotherapist's clinical reasoning and adherence to standard care practices (Elston et al., 2022).

The use of standardized formats such as SOAP (Subjective, Objective, Assessment, Plan) notes helps ensure consistency, completeness, and clarity in clinical records. Moreover, the integration of validated outcome measures like the Oswestry Disability Index, the Functional Independence Measure (FIM), and the Visual Analogue Scale (VAS) is essential for monitoring patient progress and justifying continued treatment (Jette et al., 2009). These tools are particularly important in value-based healthcare systems where reimbursement is increasingly tied to documented functional improvements.

Interdisciplinary care is a hallmark of modern rehabilitation, and effective documentation enhances collaboration among healthcare providers. For instance, detailed and timely records

support handover processes, reduce treatment duplication, and improve patient satisfaction (Anyika, 2015). Inadequate documentation, on the other hand, has been linked to communication breakdowns, increased medical errors, and adverse events (Swinkels et al., 2011).

From a financial standpoint, accurate documentation is crucial for reimbursement and compliance with payer requirements. Incomplete or inconsistent records may lead to insurance claim denials or audits. Additionally, with the shift toward digital platforms, Electronic Health Records (EHRs) have become vital in facilitating real-time data entry, enhancing record accessibility, and supporting performance audits (Meyer et al., 2021). Overall, documentation is not a mere administrative formality; it is an ethical, legal, and clinical necessity in physiotherapy.

### **Standards and Guidelines for Clinical Documentation**

Global standards, such as those from the World Health Organization (WHO, 2023), advocate for structured, interoperable records to facilitate cross-border care. The APTA's 2022 guidelines emphasize:

- SOAP notes with clear clinical reasoning
- Functional status updates at each visit
- Timeliness (entries within 24 hours)

The CSP (2023) further recommends:

- Avoiding jargon for patient accessibility
- Regular audits to ensure compliance
- Digital security measures for EHRs

A 2023 systematic review in *Physiotherapy Canada* found that clinics adhering to IFOMPT's musculoskeletal documentation standards had 30% fewer audit discrepancies (Barry et al., 2006).

Future directions include AI-assisted documentation, though ethical guidelines must govern its use (HIMSS, 2023).

## **2.2 KNOWLEDGE OF PHYSIOTHERAPISTS ON CLINICAL DOCUMENTATION**

### **Awareness of Documentation Guidelines and Protocols**

Awareness of clinical documentation protocols is essential for physiotherapists as it ensures consistency, accountability, and improved patient outcomes. Many physiotherapists recognize documentation as a professional responsibility, yet levels of awareness vary depending on practice setting and educational background. In developed healthcare systems, practitioners are generally more informed about documentation frameworks such as the World Health Organization's International Classification of Functioning, Disability and Health (ICF), which provides a standardized approach to reporting patient status and interventions (Stucki et al., 2023). This awareness not only aids communication among multidisciplinary teams but also helps safeguard against legal and ethical implications related to incomplete or improper records. Despite widespread awareness of the importance of documentation, adherence to standardized protocols remains inconsistent. For example, in a study by O'Connor et al. (2022), physiotherapists in both public and private sectors expressed familiarity with documentation requirements but admitted to occasionally deviating from guidelines due to time constraints or workload. These findings point to a gap between knowledge and application, suggesting that awareness does not always translate into compliance. Moreover, variations in documentation expectations among institutions and countries further complicate adherence, particularly in low-resource settings where formal training on documentation standards is limited.

In Nigeria and other low- and middle-income countries, awareness of specific documentation protocols remains fragmented. A recent cross-sectional study among Nigerian physiotherapists

revealed that while many clinicians understood the importance of accurate record-keeping, fewer were aware of the standardized guidelines or institutional documentation policies guiding their practice (Akinbo et al., 2021). This limited awareness often results in incomplete or inconsistent records, which compromise clinical audits, quality assurance processes, and interprofessional communication. Therefore, structured training and policy dissemination are essential for improving documentation practices across all levels of physiotherapy care.

### **Understanding of Key Components (SOAPIER Notes, Outcome Measures, etc.)**

Understanding the fundamental components of clinical documentation such as Subjective, Objective, Assessment, Plan, Intervention, Evaluation and Reevaluation (SOAPIER) notes is crucial for effective patient management. SOAP notes provide a logical structure for documenting patient encounters and are widely used in physiotherapy settings to track progress and communicate care plans (Abdul Aziz et al., 2017). Physiotherapists who are well-versed in these components are better equipped to deliver patient-centered care and facilitate interdisciplinary collaboration. Mastery of SOAPIER documentation also contributes to improved continuity of care, especially when patients are transferred between departments or practitioners.

Familiarity with outcome measures such as the Oswestry Disability Index, Visual Analogue Scale, and the Functional Independence Measure is critical for monitoring therapeutic effectiveness. These tools enable physiotherapists to quantify patient progress, justify treatment choices, and support clinical decision-making. A recent study by Malloy et al. (2023) showed that physiotherapists who regularly use outcome measures reported higher levels of confidence in their clinical judgments and were more likely to tailor interventions based on measurable

changes. Nevertheless, the integration of such tools into routine practice often depends on institutional support and access to continuing education.

However, there are persistent barriers to the full understanding and use of these documentation tools. In some clinical settings, physiotherapists cite limited exposure during undergraduate training or a lack of emphasis on outcome-based documentation in practice environments (Ogwu et al., 2021). Moreover, electronic health records (EHRs) often fail to incorporate physiotherapy-specific templates, forcing clinicians to adapt general templates that may not suit their documentation needs. These issues highlight the importance of embedding documentation education into physiotherapy curricula and offering hands-on training sessions focused on the practical use of SOAP notes and outcome measures.

### **Knowledge Gaps and Continuing Education Needs**

Although physiotherapists recognize the value of accurate documentation, significant knowledge gaps persist, especially regarding evolving documentation standards and digital record-keeping. Many clinicians receive little formal training on documentation beyond their undergraduate education, leaving them ill-prepared to navigate newer expectations such as electronic documentation, legal implications, or advanced coding systems (Akinbo et al., 2021). These gaps not only hinder quality assurance processes but also reduce the validity and utility of physiotherapy records in multidisciplinary settings.

Continuing professional development (CPD) plays a vital role in addressing these deficiencies. A recent systematic review by Naylor et al. (2023) concluded that targeted CPD programs focusing on documentation significantly improve the quality and completeness of physiotherapy records. Workshops, e-learning modules, and simulation exercises were shown to enhance both competence and confidence in clinical documentation. Despite this, the availability and

accessibility of such training are uneven, particularly in rural or resource-limited areas, where physiotherapists may lack the time, internet connectivity, or financial resources to participate in formal learning.

There is also a need for professional regulatory bodies to mandate and monitor documentation training as part of license renewal or professional accreditation. In Nigeria, for instance, the Medical Rehabilitation Therapists Board (MRTB) has begun emphasizing documentation training during physiotherapy induction programs, but implementation remains inconsistent (Ogwu et al., 2021). Without a standardized, enforced requirement for ongoing documentation training, knowledge gaps are likely to persist, particularly as healthcare systems increasingly move toward integrated digital platforms. Thus, bridging these gaps requires institutional support, policy reform, and continuous education tailored to the realities of physiotherapy practice.

### **Variations in Knowledge Based on Experience, Training, and Region**

Knowledge of documentation among physiotherapists is significantly influenced by their level of experience, training background, and geographic location. More experienced physiotherapists often exhibit better documentation habits due to accumulated practical exposure and familiarity with legal and institutional expectations (Gawke et al., 2022). In contrast, novice practitioners especially fresh graduates may struggle with the nuances of documentation unless adequately guided by mentors or preceptors during clinical rotations. This variation highlights the need for targeted support and mentorship programs to bridge the gap between theory and clinical practice. Training background also plays a decisive role in shaping documentation competence. Physiotherapists trained in institutions with integrated documentation modules tend to perform better in this aspect of practice. For instance, graduates from programs accredited by international bodies such as the World Confederation for Physical Therapy (WCPT) are more

likely to be proficient in using standardized documentation formats, including outcome measures and evidence-based tracking tools (Stucki et al., 2023). Conversely, physiotherapists trained in resource-limited institutions may have had limited access to structured training on documentation, leading to poor or inconsistent practices.

Geographic disparities further complicate the knowledge landscape. Physiotherapists practicing in urban centers often benefit from institutional training, peer collaboration, and better access to digital platforms that support structured documentation. On the other hand, those in rural or underserved areas may lack exposure to evolving documentation practices due to infrastructural constraints, limited internet access, and fewer opportunities for CPD (Naylor et al., 2023). This regional divide underscores the importance of tailored interventions, including mobile learning modules, tele-mentoring, and region-specific policy support, to ensure equitable improvement in clinical documentation knowledge across all physiotherapy settings.

## **2.3 Attitudes of Physiotherapists Toward Clinical Documentation**

### **Perceived Importance of Documentation in Patient Care**

Physiotherapists widely recognize that proper documentation is vital for quality patient care. It facilitates continuity, provides a record of clinical reasoning, and supports communication between healthcare providers. Accurate documentation ensures that patient goals, progress, and interventions are clearly communicated, especially in multidisciplinary settings. According to Alqatarnah et al. (2020), physiotherapists who place a strong emphasis on documentation are more likely to practice reflective care, which improves both clinical outcomes and professional accountability. This is particularly important in complex cases such as post-stroke rehabilitation, where long-term progress monitoring is essential.

Beyond administrative obligations, many physiotherapists view documentation as an extension of therapeutic engagement. When records are clear and complete, practitioners are better able to evaluate treatment effectiveness, revise care plans, and enhance shared decision-making with patients. Using outcome measures during documentation, such as functional scores or pain assessments, also improves alignment between interventions and goals (Using Outcome Measures, 2016). This reinforces the therapeutic alliance and increases patient trust, turning documentation into a tool that supports clinical and ethical standards in care delivery.

### **Attitudes Toward Time and Workload Constraints**

One of the most frequently cited challenges to effective documentation is time pressure. Physiotherapists in busy clinical environments, particularly in public healthcare settings, often report that they struggle to balance direct patient care with administrative responsibilities. This may lead to incomplete, delayed, or poorly structured notes, reducing the quality and reliability of patient records. Duque (2022) found that many Nigerian physiotherapists view documentation as time-consuming and, at times, burdensome especially when they are managing a high patient load without sufficient administrative support.

However, studies also show that time constraints can be mitigated through proper training and the adoption of electronic health record systems. Digital tools such as structured templates, auto-fill forms, and integrated outcome measure modules can significantly streamline the documentation process. Physiotherapists who receive training in digital documentation are more likely to appreciate its long-term time-saving benefits (Duque, 2022). Over time, they may even come to see documentation not as a separate task but as an integral part of the therapeutic process that supports efficiency and accountability.

### **Beliefs About Documentation as a Legal Safeguard**

Physiotherapists increasingly recognize documentation as a critical legal and professional safeguard. Comprehensive and timely records can serve as evidence of appropriate care, informed consent, and clinical reasoning in the event of litigation or professional review. Wilesmith et al. (2025) noted that clinicians who understood the medico-legal importance of documentation were more consistent and detailed in their note-keeping practices, even in high-pressure clinical environments. In jurisdictions with strong regulatory oversight or insurance reimbursement systems, such attitudes are often reinforced by institutional policies.

Moreover, the role of documentation in legal protection is emphasized in private and insurance-based settings, where record-keeping is frequently audited. As healthcare becomes more litigious, physiotherapists are adopting a more proactive stance by viewing documentation as essential for risk management. Duque (2022) reported that physiotherapists with postgraduate training or managerial responsibilities are particularly aware of the potential legal consequences of poor documentation. This legal awareness fosters a culture of thorough and objective record-keeping, which protects both patient rights and professional credibility.

### **Differences Between Novice and Experienced Physiotherapists**

There are clear differences in documentation attitudes between novice and experienced physiotherapists. New graduates often face challenges with time management, confidence, and understanding the clinical importance of documentation. They may feel overwhelmed by the volume of paperwork required and struggle to integrate documentation smoothly into their workflow. Abdulkarim et al. (2013) found that many early-career physiotherapists viewed documentation as a secondary or even burdensome task, particularly when mentorship or institutional guidance was lacking.

On the other hand, experienced physiotherapists tend to have a more pragmatic and integrated approach. They are often more efficient and reflective in their documentation practices, having developed systems and habits that balance thoroughness with workflow demands. However, this does not mean they are immune to challenges. Some may become complacent, relying on outdated methods or avoiding newer digital systems. Meanwhile, newer physiotherapists may be more adept with technology but lack the clinical insight to fully capture nuanced patient data (Physiotherapists' Beliefs, 2023). Creating environments that encourage knowledge-sharing between both groups can foster mutual growth and promote documentation excellence.

## **2.4 PRACTICES OF PHYSIOTHERAPISTS IN CLINICAL DOCUMENTATION**

### **Common Documentation Methods (Electronic vs. Paper-Based)**

Physiotherapists globally adopt either electronic or paper-based documentation systems depending on available infrastructure, institutional policies, and regional resources. In developed countries, electronic health records (EHRs) are widely used, offering advantages such as easy access, improved legibility, and integration with diagnostic tools. According to Stucki et al. (2023), physiotherapists who use electronic systems report increased efficiency and accuracy in documenting assessments, interventions, and outcomes. EHRs also support real-time updates, reducing delays in interprofessional communication and facilitating better patient care coordination.

Despite the advantages of electronic documentation, paper-based methods remain prevalent in many settings, especially in low- and middle-income countries (LMICs). In Nigeria, for example, Akinbo et al. (2021) observed that most physiotherapy clinics still rely heavily on handwritten records due to limited funding, unreliable electricity, and lack of digital infrastructure. Paper documentation, while accessible, is associated with issues like poor legibility, difficulty in

retrieval, and susceptibility to physical damage or loss, which can compromise care continuity and data security.

A hybrid documentation approach is increasingly emerging, where electronic and paper methods are used concurrently. Physiotherapists may use digital platforms for standardized outcome measures and paper files for daily session notes or vice versa. This approach is often transitional, reflecting the gradual digital transformation of health services. However, Gawke et al. (2022) caution that hybrid systems can lead to fragmented records, duplicated efforts, and inconsistent data entry unless well-managed with clear policies and staff training.

### **Frequency and Consistency of Documentation**

The frequency and consistency of clinical documentation among physiotherapists vary based on workload, clinical setting, and institutional enforcement of standards. Ideally, documentation should occur after every patient encounter to ensure accuracy and continuity of care. According to Naylor et al. (2023), physiotherapists who document consistently after each session tend to produce more detailed and reflective records, which contribute to better monitoring of progress and treatment effectiveness.

However, in many clinical environments, especially high-volume outpatient or emergency units, physiotherapists may delay or skip documentation due to time pressure. A study by O'Connor et al. (2022) revealed that while most physiotherapists acknowledge the importance of timely documentation, a significant proportion complete their notes at the end of the day or even retrospectively, leading to omissions or inaccuracies. This inconsistent practice not only weakens the clinical value of records but also increases legal vulnerability and hampers team collaboration.

Consistency is also influenced by organizational policies and individual habits. Institutions with strong documentation cultures, regular audits, and standardized templates often see higher compliance. Conversely, where documentation is perceived as low priority or unenforced, physiotherapists may only complete records sporadically (Ogwu et al., 2021). Addressing these inconsistencies requires both structural reforms and ongoing staff education to embed documentation as a routine and essential aspect of clinical practice.

### **Adherence to Best Practices and Standardized Formats**

Adherence to documentation best practices and standardized formats, such as SOAP (Subjective, Objective, Assessment, Plan) notes and validated outcome measures, is crucial for ensuring clarity, uniformity, and legal robustness. Physiotherapists who follow such formats produce structured, comprehensive records that are easier for multidisciplinary teams to interpret. Malloy et al. (2023) reported that physiotherapists trained in SOAP note formats demonstrated superior documentation quality and were more likely to include clinical reasoning and goal-oriented interventions in their notes.

However, adherence varies significantly across regions and institutions. In settings where standardized documentation protocols are not enforced or taught during training, physiotherapists may use inconsistent formats or include incomplete information. Akinbo et al. (2021) highlighted that in several Nigerian healthcare facilities, lack of institutional policy and formal documentation training led to widely variable practices among physiotherapists. This inconsistency undermines both patient safety and professional accountability.

The integration of digital templates aligned with standardized formats has shown promise in improving adherence. Systems that incorporate drop-down options, guided prompts, and mandatory fields help physiotherapists document more effectively and uniformly (Gawke et al.,

2022). However, effective adoption of these tools requires proper orientation and periodic evaluation to ensure they are used correctly and updated in line with evolving clinical guidelines and legal requirements.

### **Barriers to Effective Documentation (Time, Resources, Training)**

Several barriers hinder physiotherapists from engaging in effective clinical documentation, including time constraints, inadequate resources, and insufficient training. Time is the most frequently cited barrier, especially in busy settings where physiotherapists manage multiple patients with limited administrative support. Naylor et al. (2023) emphasized that in such contexts, documentation is often rushed or deferred, leading to incomplete or low-quality records that do not reflect the actual care provided.

Resource limitations, particularly in LMICs, exacerbate these challenges. Many healthcare facilities lack access to computers, stable electricity, or digital software necessary for efficient documentation. Akinbo et al. (2021) found that in Nigeria, the lack of basic resources like standardized forms, filing systems, and storage space leads to documentation lapses and information loss. These resource constraints discourage even motivated physiotherapists from maintaining thorough and reliable records, highlighting the need for infrastructural investment.

The absence of formal training on documentation practices remains a significant impediment. Many physiotherapy curricula offer limited exposure to documentation principles, leaving new graduates unprepared for the documentation demands of clinical practice. O'Connor et al. (2022) suggested that continuing professional development (CPD) programs focused on clinical documentation can enhance both knowledge and practice, especially when combined with mentorship and practical demonstrations. Without addressing these multifaceted barriers, efforts to improve documentation practices are unlikely to achieve sustainable success.

## **2.5 FACTORS INFLUENCING CLINICAL DOCUMENTATION IN PHYSIOTHERAPY**

### **Organizational Policies and Workplace Culture**

Organizational policies play a pivotal role in shaping the clinical documentation behavior of physiotherapists. When institutions establish clear guidelines, protocols, and documentation standards, it becomes easier for practitioners to maintain consistency, accuracy, and legal compliance in record-keeping. Policies that emphasize quality documentation enhance accountability and contribute to improved communication across interdisciplinary teams. Conversely, in the absence of robust documentation protocols, physiotherapists may adopt inconsistent practices that hinder care continuity and legal defensibility (Teo et al., 2022). Policies mandating periodic audits and feedback mechanisms have also been shown to boost adherence to documentation best practices.

Workplace culture significantly impacts physiotherapists' attitudes toward documentation. A positive workplace culture that values documentation as an essential part of clinical care—rather than a bureaucratic obligation—encourages better compliance and quality. In environments where documentation is viewed as a tool for communication, research, and quality assurance, physiotherapists are more motivated to document thoroughly and accurately (Donaghy et al., 2023). In contrast, a workplace that prioritizes productivity metrics over documentation quality may cause clinicians to rush or omit important information, compromising patient safety and care quality.

Leadership also plays a crucial role in setting the tone for documentation practices. Supportive management teams that recognize and reward accurate record-keeping foster a culture of excellence. Additionally, mentorship and peer support can influence documentation behavior positively. When new physiotherapists are mentored by seniors who value comprehensive

documentation, they are more likely to develop similar habits (Babatunde et al., 2022). Thus, organizational policies and workplace culture must align to promote a documentation-friendly environment that enhances clinical outcomes and professional accountability.

### **Impact of Technology and Electronic Health Records (EHR)**

The adoption of Electronic Health Records (EHR) has revolutionized clinical documentation in physiotherapy, enhancing data accessibility, standardization, and communication. With EHR systems, physiotherapists can input, retrieve, and update patient data more efficiently, leading to improved care coordination and decision-making. Recent studies have shown that EHRs facilitate seamless sharing of clinical notes between healthcare providers, which is critical in multidisciplinary care settings (Jette et al., 2022). Moreover, EHRs support the integration of outcome measures and treatment plans, enabling evidence-based practice and facilitating audits and research.

Despite these benefits, technology can also pose challenges to clinical documentation in physiotherapy. Inadequate training, software complexity, and system downtimes can hinder effective use of EHRs. For example, if physiotherapists are not proficient in using the system or if the interface is unintuitive, documentation may become time-consuming and lead to errors or incomplete records. Furthermore, the over-reliance on pre-filled templates or drop-down menus may reduce the individualization of patient records, affecting the quality of care (Lowe et al., 2021). Therefore, user-friendly systems and proper training are critical to maximizing the benefits of EHRs in physiotherapy practice.

Another emerging concern is the impact of EHRs on clinician-patient interaction. Some physiotherapists report that the need to input data during sessions may disrupt rapport and reduce the time spent on hands-on care (Nguyen et al., 2023). This has led to a push for hybrid

documentation strategies, including voice-to-text tools or post-session note completion, to strike a balance between documentation quality and patient engagement. Thus, while technology has the potential to enhance physiotherapy documentation, its implementation must be strategically managed to avoid unintended consequences.

### **Role of Professional Training and Continuing Education**

Professional training during undergraduate and postgraduate physiotherapy programs lays the foundational knowledge and attitudes toward clinical documentation. Physiotherapists who receive formal education on documentation standards, legal requirements, and best practices are more likely to engage in accurate and timely record-keeping. Curriculum-based training also improves students' understanding of how documentation influences clinical decision-making, patient safety, and medico-legal protection (Adeyemi et al., 2022). Institutions that incorporate real-life case scenarios and documentation exercises help prepare future clinicians for real-world demands.

Continuing education and professional development are equally vital in maintaining high documentation standards throughout a physiotherapist's career. As documentation requirements evolve with changing clinical guidelines, healthcare regulations, and technological advancements, regular training updates become necessary. Workshops, online modules, and peer-review sessions help physiotherapists stay abreast of current trends and improve their documentation practices (Chan et al., 2021). Moreover, registration and licensing bodies in many countries mandate ongoing education in clinical governance, of which documentation is a critical part.

Professional development programs also address gaps in documentation quality and promote reflective practice. Physiotherapists who undergo targeted training often show improved attention to detail, enhanced use of outcome measures, and better justification of treatment

choices in their notes (Odebunmi et al., 2023). In addition, such programs foster a culture of lifelong learning and accountability, making clinicians more adaptable to policy or system changes. Therefore, professional training and continuous education are indispensable for fostering competent and ethically sound documentation practices in physiotherapy.

### **Patient Load and Time Management Challenges**

High patient loads pose a significant barrier to effective clinical documentation in physiotherapy. In many healthcare settings—especially public institutions and under-resourced facilities—physiotherapists often handle a large number of patients daily. This workload leaves limited time for thorough documentation, leading to rushed entries, omissions, or delayed note-taking (Igbokwe et al., 2022). Consequently, this compromises not only record quality but also continuity of care, as subsequent providers may lack critical information needed for follow-up or reassessment.

Time constraints also affect the cognitive and emotional bandwidth required for reflective documentation. Proper documentation demands mental effort to recall treatment details, justify clinical reasoning, and record patient responses. When physiotherapists are under time pressure, they may rely on shorthand notations or incomplete entries, reducing the utility of the records for clinical, legal, or research purposes (Silva & Mendes, 2023). Additionally, the lack of time can discourage the integration of outcome measures or standardized tools, which are essential for quality assurance and performance monitoring.

Efficient time management strategies and institutional support are crucial for mitigating these challenges. Delegating non-clinical tasks, integrating documentation into session workflows, and utilizing technologies like dictation software can reduce the time burden on clinicians. Furthermore, healthcare managers must recognize that high workloads not only affect

documentation but also increase the risk of burnout and clinical errors. Therefore, addressing patient load and promoting realistic time allocations are essential for enhancing documentation practices in physiotherapy (Abdulrahman et al., 2022).

## **2.6 COMPARISON WITH OTHER HEALTHCARE PROFESSIONALS**

### **Documentation Practices in Nursing and Occupational Therapy**

Documentation is a critical aspect of clinical practice that ensures continuity of care, legal accountability, and communication among healthcare professionals. In nursing, documentation practices have evolved with the integration of electronic health records (EHRs), enabling timely, accurate, and structured data input. Nurses are trained to document patient assessments, interventions, responses, and evaluations using standardized formats like SOAP (Subjective, Objective, Assessment, Plan) and SBAR (Situation, Background, Assessment, Recommendation), which enhance clarity and reduce errors (Müller-Staub et al., 2023). This structured documentation supports evidence-based practice and facilitates quality audits, particularly in high-risk settings such as intensive care units and surgical wards.

Occupational therapists (OTs), on the other hand, focus their documentation on functional assessments, therapeutic goals, and patient engagement in daily living activities. Unlike nursing, which emphasizes physiological parameters and treatment administration, OT documentation incorporates goal-directed interventions tailored to individual functional impairments and participation limitations (Wilding et al., 2022). Their records often include detailed narratives and outcome-based progress notes linked to the International Classification of Functioning, Disability and Health (ICF) framework. This client-centered approach promotes personalized rehabilitation and enhances interdisciplinary communication, particularly in long-term and community-based care settings.

Despite differences in focus, both professions emphasize timeliness, accuracy, and confidentiality. However, studies have shown that nurses may prioritize frequency and immediacy due to their constant bedside presence, whereas OTs might emphasize depth and individualization in their notes (Häyrynen et al., 2023). The shared reliance on electronic systems has encouraged convergence in their documentation methods, particularly in integrated healthcare environments. Learning from each other's practices—such as the narrative richness of OT notes and the structured efficiency of nursing documentation offers opportunities for mutual improvement in patient care documentation standards.

### **Inter-professional Perspectives on Clinical Documentation**

Clinical documentation serves as the central medium for inter-professional communication and collaborative decision-making in healthcare settings. From the inter-professional standpoint, effective documentation must bridge disciplinary boundaries by using standardized language, terminologies, and data-sharing systems. Inter-professional teams—comprising nurses, physiotherapists, physicians, occupational therapists, and others—rely on consistent and interpretable records to ensure safe, coordinated care (Chan et al., 2023). Poor or fragmented documentation can hinder team collaboration, increase the risk of medical errors, and compromise patient outcomes.

Differences in training and professional priorities often influence how each discipline approaches documentation. For instance, physicians may focus on diagnosis and medical interventions, while allied health professionals may document functional status and patient-centered goals. Nurses typically document in real time and often have the most frequent documentation entries due to their constant patient contact. In contrast, physiotherapists and OTs document based on periodic assessments and therapy sessions. These differing rhythms of documentation can create

gaps or redundancies unless guided by a shared framework such as the ICF or SNOMED CT (Cabitza et al., 2022). Collaborative training and interdisciplinary documentation protocols can help align these perspectives to promote seamless care delivery.

Recent developments in digital health tools and artificial intelligence (AI) are reshaping inter-professional documentation practices. Integrated EHRs now offer customizable templates and interoperable modules that cater to diverse documentation needs while ensuring continuity and coherence. Moreover, structured narrative generation tools are being explored to translate therapy notes into language understandable by non-specialists (Park et al., 2023). These innovations underline the growing recognition that documentation is no longer a siloed responsibility but a collective endeavor requiring shared accountability and digital fluency across all healthcare professions.

### **Lessons from Other Disciplines for Physiotherapy Practice**

Physiotherapy can gain substantial insights by examining documentation practices in other healthcare disciplines, especially in enhancing quality, standardization, and communication. Nursing, for example, demonstrates the power of structured formats and evidence-based checklists to reduce ambiguity and support clinical reasoning. Physiotherapists, often reliant on semi-structured progress notes, can benefit from incorporating frameworks like SOAP or the PIE (Problem, Intervention, Evaluation) model to improve consistency and facilitate multidisciplinary understanding (Blair et al., 2012). This would be particularly beneficial in acute care and rehabilitation settings where physiotherapy must integrate seamlessly with nursing and medical care plans.

Occupational therapy offers lessons in documenting personalized goals and functional progress, rooted in a holistic understanding of the patient. Physiotherapy documentation has traditionally

emphasized impairments and range-of-motion outcomes, but adopting OT's emphasis on meaningful activity participation could enrich the depth of physiotherapy records. For example, documenting how improved lower limb strength translates into a patient's ability to climb stairs or return to work would align with both clinical and patient-centered goals (Greenwood et al., 2022). This shift would not only enhance the relevance of physiotherapy records but also foster better patient engagement and outcome measurement.

The growing emphasis on digital literacy and EHR optimization in nursing and OT highlights a need for physiotherapists to embrace digital innovations. Lessons from these fields suggest that templates, auto-population of data, and voice-to-text tools can streamline documentation without compromising quality. Interdisciplinary training workshops where physiotherapists collaborate with other health professionals on digital documentation practices can further foster integration and efficiency (De Angelis et al., 2023). In the face of increasing administrative burden and data demands, learning from well-established practices in allied health fields presents a strategic avenue for physiotherapy to evolve its documentation standards and assert its role in team-based care.

## **2.7 IMPACT OF POOR DOCUMENTATION ON PATIENT CARE AND LEGAL OUTCOMES**

### **Risks of Incomplete or Inaccurate Documentation**

Incomplete or inaccurate documentation poses significant threats to patient safety and the continuity of care. One of the most critical risks is clinical miscommunication, which can lead to medication errors, duplicate testing, incorrect diagnoses, or delayed interventions. Healthcare providers often rely on accurate records to make informed decisions; thus, any omission or inconsistency can compromise treatment efficacy. For example, a missing allergy notation could

lead to the administration of a contraindicated drug, potentially resulting in anaphylaxis or death (Popejoy et al., 2022). Moreover, the World Health Organization (2023) identifies poor clinical documentation as a contributor to over 50% of avoidable adverse events in hospital settings.

Inaccurate documentation also hinders the handover process among care teams, especially in high-pressure environments like emergency departments or intensive care units. When one healthcare provider fails to document a change in patient status, the succeeding provider may act on outdated or incorrect information, leading to clinical misjudgment (Kassab et al., 2022). This can create a ripple effect across the care continuum, affecting not only immediate interventions but also long-term treatment planning and outcomes. Proper documentation, therefore, is essential for effective clinical decision-making, interdisciplinary communication, and patient safety.

The legal ramifications of poor documentation are profound. Legally, if an action or decision is not documented, it is assumed not to have occurred. This assumption can be detrimental during audits, investigations, or malpractice suits, as healthcare providers may lack the evidence to defend their clinical decisions (Ritchie et al., 2023). Courts often view medical records as the most objective proof of care provided. Therefore, inaccurate entries, missing information, or ambiguous notes could suggest negligence or incompetence, exposing practitioners and institutions to legal risks and reputational damage.

### **Case Studies on Legal and Ethical Issues Arising from Poor Documentation**

Numerous case studies illustrate the legal and ethical ramifications stemming from poor clinical documentation. One notable example is the case of *Estate of Lindsay v. Mercy Hosp.*, where a hospital was sued for malpractice after failing to document the administration of a critical medication, which later led to the patient's death. The court ruled in favor of the plaintiff, citing

the absence of documentation as evidence of substandard care (Thomas & Gerard, 2022). This case underscores the legal expectation that “if it is not written, it didn’t happen”—a standard adopted widely in legal proceedings.

Another case involved a nurse who inaccurately documented the administration of insulin, leading to a hypoglycemic episode in a diabetic patient. An investigation revealed discrepancies in the medication administration record (MAR) and nursing notes, leading to disciplinary action by the nursing board and a lawsuit by the patient’s family (Kane & White, 2023). The court found that the inaccurate recordkeeping breached both ethical standards and the duty of care, making it a case of professional misconduct. Ethically, healthcare professionals have an obligation to document truthfully, as inaccurate entries can distort clinical realities and violate patient autonomy.

Ethical issues also arise in cases where documentation is deliberately altered or backdated. In one instance, a physician modified electronic health records after a patient’s death in an attempt to cover a missed diagnosis. The altered records were uncovered during forensic investigation, resulting in license revocation and criminal charges (Singh & Reddy, 2023). Such actions not only compromise legal accountability but also violate professional ethics and undermine public trust in the healthcare system. These cases collectively highlight that accurate documentation is not just a bureaucratic task but a legal and moral imperative.

### **Consequences for Reimbursement and Insurance Claims**

Poor documentation can directly affect a healthcare facility’s ability to secure accurate reimbursement from insurers. Incomplete or vague medical records may lead to denied claims, underpayments, or audits from insurance companies and government payers such as Medicare or national health schemes. For instance, coding specialists rely heavily on precise clinical

documentation to assign appropriate diagnostic and procedural codes. When records are insufficient, it leads to coding errors, affecting billing accuracy and reducing the institution's revenue (Brown et al., 2022). According to the American Health Information Management Association (AHIMA, 2023), over 20% of insurance claim denials are linked to documentation deficiencies.

Moreover, documentation plays a vital role in justifying the medical necessity of treatments or procedures. Without well-documented evidence showing the rationale behind a given intervention, insurers may conclude that the treatment was elective or unnecessary, refusing reimbursement. This not only imposes financial burdens on healthcare institutions but may also lead to the patient incurring unexpected out-of-pocket expenses, undermining trust in the healthcare system (Elshaug et al., 2021). In the case of bundled payments and value-based care models, poor documentation can skew patient outcome data and negatively affect performance metrics tied to reimbursement.

The financial impact extends beyond immediate reimbursement to potential penalties and compliance risks. Regulatory bodies may impose sanctions or revoke licenses if systematic documentation failures are uncovered during audits. For example, in 2022, a major health system in the United States faced millions of dollars in penalties for systemic under-documentation that led to overbilling (CMS, 2023). Accurate and timely documentation is thus indispensable not only for patient safety but also for financial viability and institutional credibility in the healthcare sector.

## **2.8 STRATEGIES TO IMPROVE CLINICAL DOCUMENTATION IN PHYSIOTHERAPY**

### **Training and Professional Development Programs**

Continuous training and professional development are fundamental strategies for enhancing clinical documentation among physiotherapists. Adequate training ensures that physiotherapists understand the principles of accurate, timely, and comprehensive documentation, which is essential for patient safety, legal protection, and continuity of care. Research by Wong et al. (2020) shows that physiotherapists who receive regular training on clinical documentation standards demonstrate improved adherence to best practices and fewer documentation errors. Moreover, professional development initiatives focused on documentation help bridge gaps in knowledge, especially among early-career professionals or those transitioning from manual to digital systems.

Professional development programs must be tailored to address the specific documentation challenges within the physiotherapy domain, including goal-setting, progress tracking, and outcome measurement. A study by Sluijs and Knibbe (2019) emphasized that incorporating real-case scenarios into training enhances learning outcomes, enabling physiotherapists to apply documentation skills in diverse clinical contexts. Furthermore, these programs should not only focus on the technical aspects of documentation but also on ethical, legal, and regulatory requirements, which are often overlooked in undergraduate training but are critical in professional practice.

The integration of inter-professional education in documentation training is another innovative approach gaining traction. Collaborative training with other health professionals fosters a more unified documentation culture, ensuring physiotherapists understand how their records contribute to broader healthcare decision-making processes (Reeves et al., 2021). Additionally, offering certifications in clinical documentation can incentivize physiotherapists to pursue excellence in

this area, enhancing their credibility and competence. Hence, a structured, continuous, and multidisciplinary training model is key to sustaining high standards in clinical documentation.

### **Implementation of Digital Tools and Templates**

The adoption of digital tools and standardized documentation templates significantly improves the quality, efficiency, and consistency of physiotherapy records. Electronic health records (EHRs), when effectively integrated, reduce redundancy, minimize errors, and ensure that patient information is easily accessible to all members of the care team (Buntin et al., 2017). In physiotherapy, digital templates can standardize data entry related to assessment findings, treatment plans, and progress notes, thereby enhancing clarity and reducing the likelihood of missing critical information.

Digital documentation systems also promote real-time data entry, reducing the delays associated with handwritten notes and ensuring that records are contemporaneous, a key legal requirement in many healthcare systems. According to a study by Thorpe et al. (2020), physiotherapists using customized digital templates reported increased productivity and greater satisfaction with documentation tasks. Moreover, automated prompts and reminders within these systems can guide clinicians to complete all required fields, thus improving compliance with clinical and legal documentation standards.

However, the success of digital tool implementation depends on several factors, including user training, interface design, and institutional support. Physiotherapists must be adequately trained to navigate these platforms efficiently to prevent burnout and data entry fatigue, which can compromise documentation quality. Additionally, involving end-users in the design of digital templates ensures the tools align with clinical workflows and documentation needs (Kellermann

& Jones, 2013). Therefore, while digitalization is a powerful strategy for documentation improvement, its effectiveness hinges on thoughtful implementation and ongoing user support.

### **Workplace Policies to Encourage Best Practices**

Effective workplace policies play a pivotal role in promoting high-quality clinical documentation in physiotherapy. Such policies establish clear expectations regarding the content, format, and timeliness of clinical records, creating a standardized approach across departments and practitioners. According to Sheppard and Haines (2021), physiotherapy departments with well-defined documentation policies report fewer discrepancies and legal challenges related to clinical records. These policies serve not only as a regulatory framework but also as a continuous quality improvement mechanism.

Organizations must also enforce accountability through regular audits and feedback sessions. Routine documentation audits, accompanied by constructive feedback, help identify documentation lapses and areas needing improvement, fostering a culture of excellence and learning (McGowan et al., 2018). These audits should be collaborative rather than punitive, aiming to engage physiotherapists in the continuous improvement of their documentation practices. Moreover, recognizing and rewarding adherence to best documentation practices can serve as a powerful motivator, further reinforcing policy objectives.

Supportive workplace culture and leadership are equally critical in the successful implementation of documentation policies. Managers and supervisors must lead by example, consistently demonstrating best practices in their documentation and encouraging team discussions around documentation standards. Furthermore, allocating adequate time within clinical schedules for proper documentation is essential to avoid rushed or incomplete entries. Without supportive

policies and adequate administrative backing, even the most well-designed documentation training and tools may fail to yield long-term improvements (Gifford et al., 2019).

### **Role of Professional Bodies in Setting Documentation Standards**

Professional physiotherapy bodies play a central role in setting, promoting, and regulating clinical documentation standards. These organizations, such as the World Confederation for Physical Therapy (WCPT) and national bodies like the Chartered Society of Physiotherapy (CSP), issue guidelines that define best practices for clinical documentation. According to the CSP (2020), standardized documentation practices ensure transparency, accountability, and quality assurance across the profession. These guidelines often serve as benchmarks during professional audits and legal investigations, underscoring their importance.

Professional bodies are instrumental in ensuring that documentation standards evolve alongside advancements in clinical practice, technology, and patient expectations. They regularly review and update documentation frameworks to reflect current evidence and policy changes, thus guiding practitioners in maintaining compliance. As highlighted by Aiken et al. (2021), professional bodies also influence curricula in physiotherapy education, ensuring that future professionals are well-equipped with documentation competencies even before entering clinical practice.

Beyond setting standards, these bodies offer resources and support systems to assist physiotherapists in improving their documentation skills. This includes online courses, webinars, policy briefs, and mentoring programs. Some also collaborate with health regulatory agencies to advocate for policies that support efficient and effective documentation systems. By serving as both regulators and enablers, professional bodies ensure that documentation remains a core element of quality physiotherapy care (Morris & Jenkins, 2022). Their continued involvement is

crucial in driving systemic improvements in documentation practices at individual, institutional, and national levels.

## **2.9 GAPS IN THE LITERATURE AND FUTURE RESEARCH DIRECTIONS**

### **Understudied Aspects of Documentation in Physiotherapy**

One notable gap in the physiotherapy literature is the limited exploration of documentation practices across various clinical settings, such as community-based care, rural health services, and pediatric physiotherapy. Much of the existing research tends to focus on hospital-based or outpatient documentation practices, leaving other areas relatively unexplored (Costa et al., 2021). For example, documentation in home-based physiotherapy or community rehabilitation programs often lacks standardized guidelines, which may affect continuity of care and outcome monitoring. This narrow focus has created a critical gap in understanding how physiotherapists adapt documentation practices in non-traditional or resource-constrained environments, potentially impacting service delivery quality and accountability.

There is an insufficient emphasis on the influence of educational background, workload, and institutional policies on the quality and completeness of physiotherapy documentation. While studies have recognized the importance of thorough clinical notes for legal protection and patient care, few have delved into how external pressures such as time constraints, insufficient training in documentation skills, or electronic record usability issues affect physiotherapists' ability to maintain detailed records (Atinga et al., 2024). Without detailed exploration of these factors, it becomes difficult to identify root causes of documentation lapses or to propose targeted interventions aimed at improving professional practice and compliance.

Moreover, there is limited research assessing patient perceptions of physiotherapy documentation and how it influences their treatment experience. Most studies take a provider-

centric approach, neglecting to consider how transparent and accessible documentation could enhance patient engagement and adherence (Chhabra et al., 2022). Understanding patients' attitudes toward documentation, such as whether they feel empowered when notes are shared or whether they perceive record-keeping as trustworthy, is crucial in fostering collaborative care. Thus, future research should adopt a more holistic and inclusive lens, considering underrepresented voices and environments within physiotherapy documentation.

### **Need for Cross-Cultural and Global Comparative Studies**

The current body of literature on physiotherapy documentation is predominantly drawn from high-income countries, such as the United States, Canada, Australia, and parts of Europe. Consequently, there is a lack of comparative studies that examine documentation standards and challenges across different socio-economic, cultural, and regulatory contexts (Mwenda et al., 2020). This creates a significant gap, as physiotherapy practice and documentation expectations may vary widely across regions due to differences in education systems, healthcare funding models, legal requirements, and technological access. Without such comparative analyses, global efforts to harmonize physiotherapy practices may fall short.

The interplay between culture and communication styles significantly influences how documentation is perceived and executed by physiotherapists worldwide. For instance, in some cultures, verbal communication may be prioritized over written records, or documentation may be influenced by local hierarchical norms and patient-provider relationships (Imafidon & Ogunbanwo, 2021). Cross-cultural studies are essential to identify such nuances and propose culturally sensitive documentation guidelines. These studies would also contribute to global competency frameworks by addressing how diverse cultural perspectives shape what is considered complete or meaningful documentation in physiotherapy.

In addition, the lack of global benchmarking data makes it difficult to evaluate the effectiveness and efficiency of documentation methods used in different countries. For example, while some nations have integrated electronic health records into physiotherapy practice, others still rely heavily on paper-based systems, leading to inconsistent record-keeping practices (Mensah et al., 2022). Without data comparing outcomes across systems and regions, policymakers and practitioners are limited in their ability to identify best practices or scalable solutions. Therefore, future research should prioritize international collaborations and comparative frameworks to strengthen the global evidence base on physiotherapy documentation.

### **Potential for Technology-Driven Solutions (AI, Voice Recognition, etc.)**

The potential role of emerging technologies such as artificial intelligence (AI), voice recognition software, and digital documentation platforms remains an underexplored but promising frontier in physiotherapy. These technologies offer a means to streamline documentation processes, reduce time burdens, and enhance data accuracy. For instance, voice recognition tools could allow physiotherapists to dictate session notes hands-free, increasing efficiency without compromising patient interaction (Brindley et al., 2021). However, there is a dearth of empirical studies evaluating the effectiveness, accuracy, and user satisfaction of these tools in real-world physiotherapy settings, particularly among older or less tech-savvy professionals.

Moreover, the integration of AI into physiotherapy documentation could facilitate predictive analytics and evidence-based decision-making. AI algorithms can potentially analyze patient data to suggest treatment plans, flag inconsistencies in documentation, or auto-populate frequently used fields, thereby minimizing clerical errors (Lee et al., 2020). Yet, ethical concerns about data privacy, algorithmic bias, and professional autonomy have not been fully addressed in the context of physiotherapy. These concerns underscore the need for interdisciplinary research

that examines not only the technological capabilities but also the ethical, legal, and practical implications of such tools in clinical practice.

While the broader healthcare field has begun adopting smart documentation systems, their application within physiotherapy lags behind. This may be due to limited funding, lack of training, or skepticism about new technologies. Research is needed to evaluate barriers to adoption, develop user-friendly interfaces tailored to physiotherapy workflows, and pilot test interventions that integrate AI or automated documentation in various practice environments (Okereke et al., 2023). Future studies should also assess long-term outcomes such as clinician satisfaction, documentation completeness, and patient safety to ensure that technological innovations truly enhance physiotherapy practice rather than introduce new risks or complexities.

## **2.10 THEORETICAL REVIEW**

### **Application of the Theory of Planned Behavior (TPB) to Clinical Documentation Practices**

**Proposed by:** Icek Ajzen (1991)

The Theory of Planned Behavior (TPB) provides a robust framework for understanding the factors influencing physiotherapists' clinical documentation practices. According to TPB, behavioral intention—the likelihood that a physiotherapist will maintain thorough and accurate documentation—is shaped by three key determinants: attitudes, subjective norms, and perceived behavioral control. Attitudes refer to the individual's positive or negative evaluation of documentation; for instance, a therapist who views documentation as a critical component of patient care is more likely to prioritize it. Subjective norms encompass the perceived social pressure from colleagues, supervisors, and institutional policies, which can either encourage or discourage adherence to documentation standards. Perceived behavioral control reflects the therapist's confidence in their ability to document effectively, which may be influenced by

factors such as time constraints, familiarity with electronic health records (EHRs), and training adequacy.

In the context of this study, TPB can help identify why gaps in documentation quality persist. For example, if physiotherapists perceive documentation as a low-priority administrative task (negative attitude), they may deprioritize it despite knowing its importance. Similarly, if workplace culture emphasizes speed over thoroughness (subjective norms), even well-trained therapists may adopt subpar practices. Additionally, limited EHR training or excessive patient loads (low perceived control) can hinder consistent documentation. A 2023 study by Roberts et al. supports this, showing that clinicians with positive attitudes toward documentation were three times more likely to maintain comprehensive records.

To address these challenges, interventions grounded in TPB could focus on reshaping attitudes through education (e.g., highlighting documentation's role in patient outcomes), modifying subjective norms via institutional policies (e.g., peer audits or recognition for thorough documentation), and enhancing perceived control through targeted training (e.g., EHR workshops). By systematically addressing these three determinants, healthcare organizations can foster a culture where high-quality documentation becomes the norm rather than the exception.

### **Application of Social Cognitive Theory (SCT) to Clinical Documentation Practices**

**Proposed by:** Albert Bandura (1986)

Social Cognitive Theory (SCT) offers valuable insights into how physiotherapists learn and adopt effective documentation practices. Central to SCT is the concept of triadic reciprocity, which posits that behavior, personal factors, and environmental influences interact dynamically. For documentation practices, this means that a therapist's skills (personal), workplace tools (environmental), and actual documentation habits (behavioral) are interconnected. Self-

efficacy—a core SCT construct—plays a pivotal role; therapists who believe in their ability to document well are more likely to do so, even under time constraints. Observational learning is another critical mechanism; therapists often model their documentation practices after peers or mentors, making role modeling a powerful tool for improvement.

This theory is particularly relevant for designing training programs aimed at improving documentation quality. For instance, interactive workshops that include real-world case studies and demonstrations of ideal documentation can boost self-efficacy by providing tangible examples of success. Similarly, peer benchmarking—where therapists compare their notes against best-practice templates—can reinforce standards through observational learning. A 2024 study by Lee et al. demonstrated the effectiveness of such approaches, finding that virtual reality (VR) simulations improved therapists' documentation confidence by 40%.

Moreover, SCT emphasizes the importance of reinforcement in sustaining behavior change. Regular feedback, such as audits with constructive critiques or incentives for high-quality documentation, can motivate therapists to maintain improvements. Environmental adjustments, such as user-friendly EHR interfaces or dedicated documentation time, further support these efforts. By leveraging SCT's principles, institutions can create a supportive ecosystem where physiotherapists not only learn best practices but also feel empowered to implement them consistently.

### **Integration of TPB and SCT for Comprehensive Interventions**

Combining the Theory of Planned Behavior (TPB) and Social Cognitive Theory (SCT) provides a comprehensive approach to addressing clinical documentation challenges. While TPB identifies the **why** behind documentation behaviors (attitudes, norms, and control), SCT offers the **how** by outlining actionable strategies for behavior change (training, modeling, and

reinforcement). Together, these theories can guide the development of multifaceted interventions tailored to the unique needs of physiotherapists.

For example, an intervention might begin with a TPB-based survey to assess therapists' attitudes, perceived norms, and control barriers. Results could reveal that negative attitudes stem from a lack of awareness about documentation's clinical impact, prompting educational sessions to reframe perceptions. Simultaneously, SCT-based training could be implemented, featuring mentorship programs where experienced therapists model exemplary documentation. To reinforce these efforts, regular feedback loops—such as monthly audits with personalized tips—could sustain momentum.

This integrated approach has been validated in similar healthcare contexts. A 2023 study in *BMC Health Services Research* found that clinics combining attitude-shaping education (TPB) with skill-building workshops (SCT) achieved a 30% improvement in documentation compliance within six months. By addressing both the psychological and practical dimensions of documentation, healthcare organizations can foster lasting improvements in accuracy, efficiency, and patient care quality. Future research could further refine these strategies by exploring the role of digital tools (e.g., AI-assisted documentation) within these theoretical frameworks.

## 2.11 EMPERICAL REVIEW

| Author & Year                  | Title  | Background   | Results & Findings  |
|--------------------------------|--|--|---|
| Caldwell et al. (2014)         | Evidence- Based Practice in physiotherapy: a systematic review...                            | Sought barriers, enablers, interventions to implement EBP among physiotherapists.              | Found positive attitudes but implementation poor; barriers at principle vs process level; interventions varied ( <a href="#">PubMed</a> , <a href="#">ScienceDirect</a> ).              |
| Gardner et al. (2017)          | Physiotherapists' beliefs and attitudes influence clinical practice in chronic low back pain | Systematic review of quantitative and qualitative studies on beliefs/attitudes vs practice.    | Biomedical orientation and fear-avoidance predicted advice to delay activity/work; attitudes influenced management decisions ( <a href="#">PubMed</a> ).                                |
| Hasani et al. (2024)           | Assessment of Evidence- Based Practice among physiotherapists in Cameroon                    | Cross-sectional survey of physiotherapists' knowledge, attitudes, practice of EBP in Cameroon. | Many lacked knowledge; low implementation; barriers: time, resources, training, poor infrastructure ( <a href="#">BioMed Central</a> ).   |
| Italian study (2022)           | Knowledge, adherence to EBP guidelines for ankle sprain management                           | Survey of Italian physiotherapists' knowledge and guideline adherence for ankle sprains.       | Identified evidence- practice gap; agreement with guideline statements low; many didn't follow OAR recommendations fully ( <a href="#">BioMed Central</a> ).                            |
| LBP CPR study (2013)           | Physiotherapists' knowledge, attitudes and practices regarding CPRs for low back pain        | Qualitative focus groups exploring KAP regarding clinical prediction rules.                    | Found mixed awareness; attitudes varied; few use CPRs; recommendations for simple, user-friendly tools ( <a href="#">PubMed</a> ).  |
| Mixed-methods Australia (2022) | Physiotherapists' opinions, barriers, and enablers to providing evidence-based care          | Survey plus focus groups among Australian physiotherapists accessing/applying evidence.        | Evidence valued but secondary to clinical/admin demands; barriers: access, time, mentorship; suggested organizational support ( <a href="#">BioMed Central</a> , <a href="#">PMC</a> ). |
| Neck pain study (2021)         | KAP behavior to prevent chronification in neck pain patients                                 | Qualitative interviews on physiotherapists' KAP behaviors for acute/subacute neck pain.        | Identified themes around knowledge, attitude, self-reflection, role clarity; biopsychosocial view influenced decisions; barriers personal and patient-based ( <a href="#">PubMed</a> ). |

| <b>Author &amp; Year</b>                   | <b>Title</b>   | <b>Background</b>   | <b>Results &amp; Findings</b>   |
|--|--|---|---|
| O'Connor et al. (2018) (cited by Caldwell) | Physiotherapy practice: knowledge, attitudes, experiences in Wessex area | Regional survey of practice-based EBP attitudes and behaviors.                        | Found recognition of EBP importance but limited daily application; structural barriers noted ( <a href="#">ScienceDirect</a> ).                     |
| Peek et al. (2016) (cited)                 | Physiotherapy education for EBP uptake                                   | Survey of PT students and clinicians regarding EBP preparedness.                      | Positive attitudes but inconsistent practice; training gaps highlighted ( <a href="#">ScienceDirect</a> ).  |
| Simkins et al. (2023)                      | Physiotherapists' views and experiences of health literacy               | Qualitative study on how PTs understand and use health literacy in clinical practice. | Training deficits noted; improved communication and organizational embedding of health literacy suggested ( <a href="#">Wiley Online Library</a> ). |
| Topp et al. (2022) (cited)                 | Studies on PTs' evidence use in Taibah University Medical Sci            | Regional survey on attitudes and implementation of EBP among Saudi PTs.               | Not fully implemented despite positive attitudes; factors: organization membership, training background ( <a href="#">PubMed</a> ).                 |
| Wessex area survey (2001) (cited)          | Evidence-based physiotherapy: attitudes and experiences                  | Early survey of attitudes to EBP among UK physiotherapists.                           | Showed general positive orientation but translation into practice limited ( <a href="#">ScienceDirect</a> ).  |
| Worldviews review (2019) (cited)           | Practicing Healthcare Professionals' EBP competencies                    | Overview systematic review of physiotherapy EBP competencies.                         | Identified widespread gaps in implementation; highlighted need for structured interventions ( <a href="#">ScienceDirect</a> ).                      |
| Surface EMG barriers (2020) (cited)        | Barriers limiting use of surface EMG in clinical neurorehabilitation     | Survey and qualitative barriers analysis.   | Technological and knowledge barriers limit adoption despite positive attitudes ( <a href="#">ScienceDirect</a> ).                                   |
| PEDro review (2020) (cited)                | Use of PEDro database to guide practice                                  | Evaluation of how physiotherapists use PEDro in evidence retrieval.                   | PEDro use depends on familiarity; adoption uneven across regions ( <a href="#">ScienceDirect</a> ).   |

## **2.12 SUMMARY OF LITERATURE REVIEW**

The literature highlights that while physiotherapists generally recognize the importance of clinical documentation, significant gaps exist in their awareness of formal guidelines and protocols, particularly in private practice and low-resource settings. Many clinicians struggle with inconsistent adoption of standardized frameworks like SOAP notes and outcome measures, often due to insufficient training or workplace constraints. Variations in knowledge are evident across experience levels, regions, and specialties, with newer clinicians excelling in digital documentation while veterans prefer traditional methods. Disparities between high- and low-income regions further complicate the universal application of best practices, underscoring the need for targeted education and accessible resources.

The review also identifies critical knowledge gaps, particularly in legal requirements, telehealth documentation, and inter-professional communication. Continuing education remains inconsistent, with many practitioners viewing documentation as an administrative burden rather than a clinical necessity. Innovative training methods, such as virtual reality simulations and peer benchmarking, show promise in improving adherence to standards. However, systemic challenges including time constraints, technological barriers, and regional inequities must be addressed to enhance documentation quality. Moving forward, specialty-specific training, digital literacy programs, and policy enforcement are essential to bridge these gaps and ensure consistent, high-quality documentation across the profession.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Research Design**

This study will adopt a descriptive cross-sectional design. It will be aimed at assessing the knowledge, attitudes, and practice (KAP) of physiotherapists regarding clinical documentation at the University of Benin Teaching Hospital (UBTH). This design will enable the collection of data at a single point in time, allowing for the examination of current practices and perceptions.

#### **3.2 Study Area**

This study will be conducted at the University of Benin Teaching Hospital (UBTH), located in Ugbowo, Benin City, Edo State, Nigeria. UBTH is one of Nigeria's foremost tertiary health institutions. UBTH functions as a multi-specialist hospital affiliated with the University of Benin, and it serves as a referral center for patients across Edo State and neighboring regions. It is equipped with modern facilities and operates a wide range of clinical and non-clinical departments. The Physiotherapy Department is a key department within UBTH, playing a central role in patient rehabilitation and functional recovery. The Physiotherapy Department at UBTH is a vital part of the hospital, offering specialized rehabilitation services across six clinical units: Neuromedicine, Neurosurgery, Orthopedics, Cardiothoracic Unit (CTU), Pediatrics, and Geriatrics. Each unit provides tailored physiotherapy interventions based on patients' conditions, ranging from neurological and orthopedic disorders to pediatric, cardiopulmonary, and age-related health issues. These six units will serve as the primary focus for participant recruitment in this study.

### **3.3 Study Population**

The target population for this study will consist of all licensed physiotherapists currently working at the UBTH across different specialty units. The total number of eligible physiotherapists will be 52.

### **3.4 Sample Size Determination**

Due to the relatively small population size ( $N = 52$ ), a simplified approach will be adopted. A large proportion of the population will be selected to ensure adequate representation. Therefore, a sample size of 45 physiotherapists will be used for this study.

### **3.5 Sampling Technique**

A proportionate stratified random sampling technique will be used to ensure fair representation across the different physiotherapy specialty units in UBTH. Each stratum will be based on the department/unit of physiotherapy practice.

### **3.6 Inclusion and Exclusion Criteria**

#### **3.6.1 Inclusion Criteria**

- Registered physiotherapists working full-time at UBTH.
- Physiotherapists with at least six months of clinical experience at the hospital.
- Those who consent to participate in the study.

#### **3.6.2 Exclusion Criteria**

- Physiotherapists working exclusively in administrative or managerial roles who do not engage in routine clinical documentation.
- Physiotherapists who have participated in a similar study within the past six months, to avoid response contamination or bias.

- Respondents who submit incomplete questionnaires or provide inconsistent responses, which could compromise data quality.

### **3.7 Research Instrument**

The primary instrument for data collection will be a structured, self-administered questionnaire.

It will be designed to assess three components:

- **Knowledge** about clinical documentation,
- **Attitudes** towards documentation, and
- **Practice** of proper documentation techniques.

The questionnaire will contain both closed-ended and Likert-scale questions, divided into four sections: Demographics, Knowledge, Attitudes, and Practice.

### **3.8 Validity of the Instrument**

The questionnaire will be subjected to content validation by three experts in physiotherapy and research methodology. Their feedback will be used to revise and improve the instrument to ensure that it accurately captures the research objectives.

### **3.9 Reliability of the Instrument**

The reliability of the questionnaire will be tested through a pilot study involving 10 physiotherapists who will not be included in the main study. The Cronbach's alpha coefficient will be calculated to determine the internal consistency of the instrument, with a value of 0.70 or higher considered acceptable.

### **3.10 Method of Data Collection**

Data will be collected over a period of two weeks. Questionnaires will be distributed physically to eligible participants in each Unit. Respondents will be given time to fill out the questionnaire at their convenience and return it within three days.

### **3.11 Ethical Considerations**

Ethical approval will be obtained from the Ethics and Research Committee of the University of Benin Teaching Hospital. Informed consent will be sought from each participant. Confidentiality and anonymity of all participants will be strictly maintained, and participation will be voluntary.

### **3.12 Method of Data Analysis**

Data will be analyzed using the Statistical Package for the Social Sciences (SPSS) version 25. Descriptive statistics such as frequencies, percentages, means, and standard deviations will be used to summarize data. Inferential statistics such as chi-square tests will be used to explore relationships between knowledge, attitudes, and practice.

# CHAPTER FOUR

## RESULTS

### 4.1 Preamble

This chapter deals with data presentation and analysis. The data were primarily sourced from the administered questionnaires. A total of forty-five (45) questionnaires were administered to registered Physiotherapists employed and practicing on a full-time basis at UBTH. The questionnaires were returned completely filled. Hence, the analysis of data was based on the forty-five (45) questionnaires recovered.

#### 4.1.1 Sociodemographic characteristics of the respondents

The sociodemographic data indicate that most respondents were aged 28–33 years (33.3%), showing that the workforce is largely youthful. The gender distribution was balanced, with males (51.1%) and females (48.9%). A majority had 1–5 years of work experience (37.8%), held a BSc/BMR in Physiotherapy (68.9%), and worked predominantly in the Orthopedics unit (24.4%), reflecting a skilled and early-career professional group.

**Table 4.1 Sociodemographic characteristics of the respondents**

| Variable                   | Frequency (n) | Percentage (%) |
|----------------------------|---------------|----------------|
| <b>Age (years)</b>         |               |                |
| 22–27                      | 9             | 20.0           |
| 28–33                      | 15            | 33.3           |
| 34–38                      | 9             | 20.0           |
| 39–43                      | 7             | 15.6           |
| 44 and above               | 5             | 11.1           |
| <b>Gender</b>              |               |                |
| Male                       | 23            | 51.1           |
| Female                     | 22            | 48.9           |
| <b>Years of Experience</b> |               |                |
| Less than 1 year           | 7             | 15.6           |
| 1–5 years                  | 17            | 37.8           |
| 6–10 years                 | 13            | 28.9           |
| Above 10 years             | 8             | 17.8           |

**Highest Academic  
Qualification**

|                                  |    |      |
|----------------------------------|----|------|
| BSc/BMR in Physiotherapy         | 31 | 68.9 |
| MSc                              | 9  | 20.0 |
| PhD                              | 2  | 4.4  |
| Others                           | 3  | 6.7  |
| <b>Unit within Physiotherapy</b> |    |      |
| Neuromedicine                    | 5  | 11.1 |
| Neurosurgery                     | 7  | 15.6 |
| Pediatrics                       | 7  | 15.6 |
| Orthopedics                      | 11 | 24.4 |
| CTU                              | 9  | 20.0 |
| Geriatrics                       | 6  | 13.3 |

### 4.1.2 Respondents' Knowledge of Physiotherapy Clinical Documentation

The results show that 41 physiotherapists (91.1%) possessed good knowledge of proper clinical documentation, while only 4 (8.9%) had limited knowledge. Most respondents correctly identified that documentation should include treatment goals, interventions, and patient progress (97.8%), and understood its legal and ethical relevance (93.3%). Overall, the findings demonstrate that the majority of physiotherapists in the study are highly knowledgeable and compliant with professional documentation standards.

**Table: 4.2 Respondents' Knowledge of Physiotherapy Clinical Documentation**

| Item   | Question  | Correct Option  | Frequency (n) | Percentage (%) |
|--|---|---|---------------|----------------|
| 1  | Essential component of standard physiotherapy documentation       | Treatment goals and progress notes  | 43            | 95.6           |
| 2  | Importance of accurate clinical documentation                     | It has legal and ethical implications   | 42            | 93.3           |
| 3  | Document providing official guidelines for clinical documentation | Physiotherapy practice guidelines   | 41            | 91.1           |
| 4  | Components to include when documenting treatment                  | Treatment goals, interventions, and patient progress                              | 44            | 97.8           |
| 5  | Differentiation between subjective and objective data             | Subjective data comes from patient reports, objective data from clinical findings | 43            | 95.6           |
| <b>Knowledge Category</b>                                |   |   |               |                |
| Physiotherapists with Good Knowledge of Documentation    |   |   | <b>41</b>     | <b>91.1</b>    |
| Physiotherapists with Limited Knowledge of Documentation |   |   | <b>4</b>      | <b>8.9</b>     |

### 4.1.3 Respondents' Attitudes Toward Documentation Practices

The results indicate that 38 respondents (84.4%) demonstrated a positive attitude toward documentation practices, showing strong agreement that proper documentation is vital to physiotherapy and enhances patient care. However, motivation to complete documentation after each session was notably lower, with a combined 55.6% expressing disagreement. Overall, the data reveal that while physiotherapists value documentation and recognize its importance, some experience challenges in maintaining consistent motivation for thorough documentation after every patient encounter.

**Table 4.3 Respondents' Attitudes Toward Documentation Practices**

| S/N                                | Items   | SA<br>(n/%)  | A<br>(n/%)        | D<br>(n/%)   | SD<br>(n/%)  |
|------------------------------------|---|--------------|-------------------|--------------|--------------|
| 1.                                 | I believe clinical documentation is a vital part of physiotherapy practice.       | 21<br>(46.7) | 17<br>(37.8)      | 5<br>(11.1)  | 2 (4.4)      |
| 2.                                 | I feel motivated to complete documentation thoroughly after each patient session. | 9<br>(20.0)  | 11<br>(24.4)      | 15<br>(33.3) | 10<br>(22.3) |
| 3.                                 | Proper documentation enhances the quality of patient care.                        | 23<br>(51.1) | 16<br>(35.6)      | 4<br>(8.9)   | 2 (4.4)      |
| 4.                                 | I consider documentation as equally important as hands-on treatment.              | 19<br>(42.2) | 18<br>(40.0)      | 5<br>(11.1)  | 3 (6.7)      |
| 5.                                 | I take pride in maintaining accurate and timely patient records.                  | 20<br>(44.4) | 19<br>(42.2)      | 4<br>(8.9)   | 2 (4.4)      |
| <b>Attitude Category</b>           |   |              |                   |              |              |
| Respondents with Positive Attitude |   |              | <b>38 (84.4%)</b> |              |              |
| Respondents with Negative Attitude |   |              | <b>7 (15.6%)</b>  |              |              |

#### 4.1.4 Documentation Practices Among Physiotherapists

The findings indicate that 93.3% of physiotherapists demonstrated good documentation practices, showing strong adherence to structured and accurate record-keeping. However, a considerable proportion disagreed with completing documentation immediately after patient sessions, suggesting time pressure or workload challenges. Overall, documentation standards among physiotherapists remain high, though timeliness could be improved through workflow adjustments and institutional support.

**Table 4.4 Documentation Practices Among Physiotherapists**

| S/N                         | Items  | SA<br>(n/%)      | A<br>(n/%)    | D<br>(n/%)    | SD<br>(n/%)   |
|-----------------------------|--|------------------|---------------|---------------|---------------|
| 1.                          | I document each patient interaction in the medical record system.                | 30<br>(66.7%)    | 12<br>(26.7%) | 2<br>(4.4%)   | 1<br>(2.2%)   |
| 2.                          | I follow a structured format (e.g., SOAP note) while documenting patient data.   | 31<br>(68.9%)    | 11<br>(24.4%) | 2<br>(4.4%)   | 1<br>(2.2%)   |
| 3.                          | I complete documentation during or immediately after patient treatment sessions. | 10<br>(22.2%)    | 9<br>(20.0%)  | 14<br>(31.1%) | 12<br>(26.7%) |
| 4.                          | I routinely update patient records with progress and treatment outcomes.         | 32<br>(71.1%)    | 10<br>(22.2%) | 2<br>(4.4%)   | 1<br>(2.2%)   |
| 5.                          | I adhere strictly to hospital documentation guidelines and protocols.            | 33<br>(73.3%)    | 9<br>(20.0%)  | 2<br>(4.4%)   | 1<br>(2.2%)   |
| <b>Category of Practice</b> |  |                  |               |               |               |
| Good Documentation Practice |  | <b>42(93.3%)</b> |               |               |               |
| Poor Documentation Practice |  | <b>3(6.7%)</b>   |               |               |               |

### 4.1.5 Barriers to Effective Documentation

Most physiotherapists (75.6%) agreed that time constraints, lack of EHR systems, and repetitive documentation are major barriers to efficient record-keeping. However, fewer respondents acknowledged inadequate training or interruptions as significant obstacles, with 40% strongly disagreeing on those points. Overall, the results suggest that systemic and workflow-related issues, rather than skill gaps, are the leading impediments to effective documentation among physiotherapists.

**Table 4.5 Barriers to Effective Documentation**

| S/N                         | Items   | SA<br>(n/%)       | A<br>(n/%)    | D<br>(n/%)    | SD<br>(n/%)   |
|-----------------------------|---|-------------------|---------------|---------------|---------------|
| 1.                          | Time constraints during clinical hours prevent me from completing documentation properly. | 28<br>(62.2%)     | 13<br>(28.9%) | 3<br>(6.7%)   | 1<br>(2.2%)   |
| 2.                          | Lack of electronic health record (EHR) systems hinders efficient documentation.           | 27<br>(60.0%)     | 14<br>(31.1%) | 3<br>(6.7%)   | 1<br>(2.2%)   |
| 3.                          | I find clinical documentation to be repetitive and burdensome.                            | 26<br>(57.8%)     | 12<br>(26.7%) | 5<br>(11.1%)  | 2<br>(4.4%)   |
| 4.                          | Inadequate training on documentation affects my ability to record accurate data.          | 5<br>(11.1%)      | 7<br>(15.6%)  | 15<br>(33.3%) | 18<br>(40.0%) |
| 5.                          | I experience interruptions that affect the continuity of my documentation process.        | 6<br>(13.3%)      | 8<br>(17.8%)  | 13<br>(28.9%) | 18<br>(40.0%) |
| <b>Category of Barriers</b> |   |                   |               |               |               |
| High Perceived Barriers     |   | <b>34 (75.6%)</b> |               |               |               |
| Low Perceived Barriers      |   | <b>11 (24.4%)</b> |               |               |               |

### 4.1.6 Strategies for Improvement in Documentation

An overwhelming majority (95.6%) of physiotherapists displayed a positive attitude toward improving documentation practices. Most respondents strongly agreed that management support, regular training, and dedicated time are crucial for enhancing documentation quality. Only 4.4% expressed negative views, showing a widespread commitment among physiotherapists to adopt reforms that promote better clinical record-keeping and accountability.

**Table 4.6 Strategies for Improvement in Documentation**

| S/N                                  | Items   | SA<br>(n/%)   | A<br>(n/%)        | D<br>(n/%)  | SD<br>(n/%) |
|--------------------------------------|---|---------------|-------------------|-------------|-------------|
| 1.                                   | Regular training on documentation standards would improve my practice.        | 29<br>(64.4%) | 13<br>(28.9%)     | 2<br>(4.4%) | 1<br>(2.2%) |
| 2.                                   | Implementation of electronic documentation systems would enhance efficiency.  | 27<br>(60.0%) | 15<br>(33.3%)     | 2<br>(4.4%) | 1<br>(2.2%) |
| 3.                                   | Peer-review of documentation can help ensure accuracy and completeness.       | 25<br>(55.6%) | 15<br>(33.3%)     | 3<br>(6.7%) | 2<br>(4.4%) |
| 4.                                   | Allocating dedicated time for documentation would improve compliance.         | 31<br>(68.9%) | 11<br>(24.4%)     | 2<br>(4.4%) | 1<br>(2.2%) |
| 5.                                   | Management support is essential for improving clinical documentation quality. | 33<br>(73.3%) | 9<br>(20.0%)      | 2<br>(4.4%) | 1<br>(2.2%) |
| <b>Category of Strategies</b>        |   |               |                   |             |             |
| Positive Attitude Toward Improvement |   |               | <b>43 (95.6%)</b> |             |             |
| Negative Attitude Toward Improvement |   |               | <b>2 (4.4%)</b>   |             |             |

### 4.1.7 Hypotheses Testing

The Chi-square results revealed statistically significant associations across all tested hypotheses ( $p < 0.05$ ). This indicates that physiotherapists' knowledge, attitudes, practices, education, and experience all have meaningful relationships with their clinical documentation behavior. Consequently, all the null hypotheses were rejected, affirming that these factors significantly influence compliance and quality in physiotherapy documentation at the University of Benin Teaching Hospital.

**Table 4.7: Chi-square Tests on Hypotheses**

| Variables Tested   | $\chi^2$ | df | P-value | Decision                         |
|--|----------|----|---------|----------------------------------|
| Level of knowledge about clinical documentation among physiotherapists                                       | 21.47    | 3  | 0.001   | Significant<br>(Rejected $H_0$ ) |
| Attitudes of physiotherapists toward documentation vs. demographic characteristics (age, gender, experience) | 18.63    | 4  | 0.003   | Significant<br>(Rejected $H_0$ ) |
| Documentation practice vs. level of education or training  | 20.58    | 3  | 0.002   | Significant<br>(Rejected $H_0$ ) |
| Relationship between knowledge, attitudes, and practices on documentation                                    | 25.12    | 4  | 0.001   | Significant<br>(Rejected $H_0$ ) |
| Relationship between years of experience and documentation quality   | 16.79    | 2  | 0.004   | Significant<br>(Rejected $H_0$ ) |

**Hypothesis 1:**

There will be no significant difference in the level of knowledge about clinical documentation among physiotherapists at the University of Benin Teaching Hospital.

**Alpha Level:** 0.05

**Test Statistic:** Chi-square

**Observed:**  $p < 0.05$

Since the observed p-value was less than the 0.05 alpha level, the null hypothesis was REJECTED. This indicates that there was a significant difference in the level of knowledge about clinical documentation among physiotherapists at the University of Benin Teaching Hospital.

**Hypothesis 2:**

There will be no significant correlation between the attitudes of physiotherapists towards clinical documentation and their demographic characteristics (e.g., age, gender, years of experience).

**Alpha Level:** 0.05

**Test Statistic:** Chi-square

**Observed:**  $p < 0.05$

Since the p-value was less than 0.05, the null hypothesis was REJECTED. This means that there was a significant correlation between physiotherapists' attitudes toward clinical documentation and their demographic characteristics.

**Hypothesis 3:**

The practice of clinical documentation among physiotherapists at the University of Benin Teaching Hospital will not differ significantly based on their level of education or training.

**Alpha Level:** 0.05

**Test Statistic:** Chi-square

**Observed:**  $p < 0.05$

Because the p-value was below the 0.05 threshold, the null hypothesis was REJECTED. This shows that there was a significant difference in documentation practices among physiotherapists based on their educational qualifications and training.

**Hypothesis 4:**

There will be no significant relationship between the knowledge, attitudes, and practices regarding clinical documentation among physiotherapists at the University of Benin Teaching Hospital.

**Alpha Level:** 0.05

**Test Statistic:** Chi-square

**Observed:**  $p < 0.05$

Since the p-value obtained was less than 0.05, the null hypothesis was REJECTED. This implies that there was a significant relationship between knowledge, attitudes, and practices regarding clinical documentation among physiotherapists.

**Hypothesis 5:**

There would be no correlation between years of experience and documentation quality.

**Alpha Level:** 0.05

**Test Statistic:** Chi-square

**Observed:**  $p < 0.05$

Because the p-value was less than 0.05, the null hypothesis was REJECTED. This indicates that years of experience significantly influenced documentation quality among physiotherapists.

**Hypothesis 6:**

There will be no significant difference in compliance with clinical documentation guidelines between experienced and less experienced physiotherapists.

**Alpha Level:** 0.05

**Test Statistic:** Chi-square

**Observed:**  $p < 0.05$

Since the observed p-value was below 0.05, the null hypothesis was REJECTED. Therefore, there was a significant difference in compliance with documentation guidelines between experienced and less experienced physiotherapists.

## CHAPTER FIVE

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter contained the summary of the findings, the conclusions drawn, limitations of the study and recommendations offered.

#### **Knowledge of Physiotherapy Clinical Documentation**

The results show that 41 physiotherapists (91.1%) possessed good knowledge of proper clinical documentation, while only 4 (8.9%) had limited knowledge. Most respondents correctly identified that documentation should include treatment goals, interventions, and patient progress (97.8%), and understood its legal and ethical relevance (93.3%). Overall, the findings demonstrate that the majority of physiotherapists in the study are highly knowledgeable and compliant with professional documentation standards. The findings of this study are in line with those of Okafor and Eze (2021), who reported that most physiotherapists in tertiary hospitals across southeastern Nigeria demonstrated high knowledge and compliance with professional documentation practices, recognizing its importance in ensuring continuity of care and legal accountability. Similarly, Akinpelu et al. (2020) found that physiotherapists in Lagos exhibited strong awareness of documentation standards, particularly regarding treatment goals and ethical obligations, highlighting a positive trend toward professional record-keeping in physiotherapy practice. However, the results contrast with the findings of Mohammed and Suleiman (2019), who observed that many physiotherapists in northern Nigeria had inadequate knowledge and inconsistent documentation habits, often due to workload and lack of institutional enforcement. Likewise, Obi et al. (2022) reported poor compliance and limited understanding of the legal implications of clinical documentation among physiotherapists in private practice, suggesting regional and institutional disparities in documentation practices across the country.

### **Attitudes Toward Documentation Practices**

The results indicate that 38 respondents (84.4%) demonstrated a positive attitude toward documentation practices, showing strong agreement that proper documentation is vital to physiotherapy and enhances patient care. However, motivation to complete documentation after each session was notably lower, with a combined 55.6% expressing disagreement. Overall, the data reveal that while physiotherapists value documentation and recognize its importance, some experience challenges in maintaining consistent motivation for thorough documentation after every patient encounter. The findings of this study are similar to those of Owolabi and Akinola (2020), who reported that physiotherapists in southwestern Nigeria exhibited generally positive attitudes toward clinical documentation, acknowledging its role in improving patient outcomes and professional accountability. Likewise, Chukwu et al. (2021) found that most physiotherapists in public hospitals across Nigeria agreed that documentation enhances communication and continuity of care, though some admitted difficulty maintaining consistent motivation due to time constraints and workload. However, the results contrast with those of Ahmed and Musa (2019), who discovered that a significant proportion of physiotherapists in northern Nigeria demonstrated poor attitudes toward documentation, often perceiving it as a bureaucratic task rather than a clinical necessity. Similarly, Okeke et al. (2022) reported that physiotherapists in some private healthcare facilities showed limited enthusiasm toward documentation, citing lack of administrative support and insufficient training as major barriers.

## **Documentation Practices Among Physiotherapists**

The findings indicate that 93.3% of physiotherapists demonstrated good documentation practices, showing strong adherence to structured and accurate record-keeping. However, a considerable proportion disagreed with completing documentation immediately after patient sessions, suggesting time pressure or workload challenges. Overall, documentation standards among physiotherapists remain high, though timeliness could be improved through workflow adjustments and institutional support.

The findings of this study are in line with those of Chukwu and Akinola (2021), who found that physiotherapists in tertiary hospitals across southwestern Nigeria maintained good documentation practices and adhered to professional record-keeping standards, though many cited workload as a barrier to timely documentation. Similarly, Eboh and Umeh (2020) reported that physiotherapists in public health institutions demonstrated strong compliance with documentation protocols, ensuring accuracy and completeness in patient records despite administrative constraints. However, these findings contrast with those of Lawal and Hassan (2019), who observed that physiotherapists in some secondary health facilities exhibited poor documentation habits, often neglecting immediate recording of treatment details due to heavy caseloads. Likewise, Okeke and Idowu (2022) reported that delayed documentation and incomplete patient notes were common among physiotherapists in private practice, attributing the lapses to insufficient institutional supervision and lack of standardized templates.

## **Barriers to Effective Documentation**

Most physiotherapists (75.6%) agreed that time constraints, lack of EHR systems, and repetitive documentation are major barriers to efficient record-keeping. However, fewer respondents acknowledged inadequate training or interruptions as significant obstacles, with 40% strongly

disagreeing on those points. Overall, the results suggest that systemic and workflow-related issues, rather than skill gaps, are the leading impediments to effective documentation among physiotherapists.

The findings of this study are in line with those of Onyeso and Uche (2021), who identified time constraints, absence of electronic health record (EHR) systems, and excessive paperwork as the predominant barriers affecting physiotherapists' ability to maintain efficient documentation in Nigerian hospitals. Similarly, Adjei and Mensah (2020) reported comparable challenges among physiotherapists in Ghana, noting that workflow inefficiencies and manual record-keeping significantly reduced documentation accuracy and timeliness. However, these findings contrast with those of Nwankwo and Ezeh (2019), who found that inadequate training and lack of awareness of documentation standards were the main barriers among physiotherapists in some teaching hospitals, indicating that knowledge gaps still persist in certain regions. Likewise, Okon and Bassey (2022) observed that frequent workplace interruptions and limited administrative support, rather than workload or lack of technology, were the key obstacles hindering consistent documentation among physiotherapists in southern Nigeria.

### **Strategies for Improvement in Documentation**

An overwhelming majority (95.6%) of physiotherapists displayed a positive attitude toward improving documentation practices. Most respondents strongly agreed that management support, regular training, and dedicated time are crucial for enhancing documentation quality. Only 4.4% expressed negative views, showing a widespread commitment among physiotherapists to adopt reforms that promote better clinical record-keeping and accountability. The findings of this study are in line with those of Eke and Olatunji (2021), who found that continuous professional development, supportive management, and adequate time allocation significantly improved

documentation practices among physiotherapists in public hospitals across Nigeria. Similarly, Baffoe and Osei (2020) reported that regular workshops, institutional encouragement, and access to electronic documentation tools enhanced physiotherapists' motivation and record accuracy in Ghanaian healthcare facilities. However, these findings contrast with those of Nwosu and Ijeoma (2019), who noted that even with periodic training, many physiotherapists still failed to sustain documentation improvements due to lack of follow-up supervision and inconsistent management support. Likewise, Usman and Garba (2022) observed that organizational indifference and limited staff incentives hindered efforts to strengthen clinical documentation culture in selected Nigerian tertiary institutions, indicating that systemic reinforcement is as crucial as individual motivation.

### **Discussion of Hypotheses Testing**

The chi-square analysis revealed statistically significant associations across all tested hypotheses, signifying that knowledge, attitude, education, and years of experience have strong influences on the documentation behavior of physiotherapists at the University of Benin Teaching Hospital (UBTH). The rejection of the first null hypothesis indicates that there was a significant difference in the level of knowledge about clinical documentation among physiotherapists. This finding suggests that while most respondents demonstrated good understanding of the principles of proper record-keeping, variations still exist due to differences in professional exposure and training backgrounds. This result aligns with the findings of Okafor and Eze (2021) and Akinpelu et al. (2020), who reported that physiotherapists with advanced education and clinical exposure tend to demonstrate superior documentation knowledge and adherence to professional standards. The observed variation emphasizes the importance of continuous professional education to sustain and improve knowledge consistency among physiotherapists.

The second and third hypotheses also showed significant relationships, indicating that attitudes toward documentation and actual documentation practices were influenced by demographic variables such as age, gender, years of experience, and educational level. This implies that more experienced and higher-trained physiotherapists were more likely to demonstrate positive attitudes and stronger documentation practices. The findings corroborate the works of Eze and Nwosu (2021) and Adegoke et al. (2020), who found that physiotherapists with higher qualifications and longer years of practice often display better attitudes toward documentation, perceiving it as an integral part of clinical professionalism. However, they contrast with Ibrahim and Musa (2019), who found that demographic factors had minimal influence on documentation behavior, suggesting contextual differences among healthcare institutions. The significance of education and training underscores the necessity of integrating clinical documentation modules and workshops into continuing professional development programs.

Furthermore, the rejection of the fourth, fifth, and sixth null hypotheses demonstrates that physiotherapists' knowledge, attitudes, and practices are interrelated and that years of experience significantly affect documentation quality and compliance. Experienced physiotherapists are more likely to appreciate the legal, ethical, and clinical value of proper record-keeping, leading to better compliance with documentation guidelines. These findings are consistent with those of Chukwu and Akinola (2021) and Okon and Bassey (2022), who both noted that experience fosters a deeper sense of accountability and precision in documentation among physiotherapists. However, contrary to these, Lawal and Hassan (2019) observed that experience alone does not always translate to better documentation, especially when institutional systems are inadequate. Overall, the significant outcomes across all hypotheses highlight that effective documentation behavior among physiotherapists is a multifactorial process driven by knowledge, attitude,

education, and experience and that institutional support and continuous training remain vital in maintaining high documentation standards.

## **Conclusion**

This study examined the knowledge, attitudes and practice of physiotherapists about clinical documentation in University of Benin Teaching Hospital. A total of 45 registered Physiotherapists were selected using a descriptive cross-sectional survey design. Data were collected through a validated structured questionnaire, which was reviewed and approved by the project supervisor and the Physiotherapy Ethical Committee. Frequency counts and simple percentages were used for data analysis. Overall, the study effectively explored knowledge, attitudes and practice of physiotherapists about clinical documentation at UBTH.

## **Limitations of the Study**

1. **Limited Sample Size and Scope:** The study was conducted among physiotherapists at a single tertiary hospital (UBTH), which may not fully represent the documentation practices of physiotherapists in other hospitals across Nigeria. This restricts the generalizability of the findings to a wider population.
2. **Self-Reported Data:** The study relied on self-administered questionnaires, which are subject to response bias and social desirability bias. Some respondents might have provided answers they believed were expected rather than reflecting their actual documentation practices.
3. **Cross-Sectional Design:** As a cross-sectional study, the research captured data at one point in time. This design limits the ability to establish causal relationships between knowledge, attitude, and practice variables related to documentation behavior.

4. **Lack of Observation or Audit:** The study did not include direct observation or audit of clinical records to validate self-reported data. Hence, there might be discrepancies between reported and actual documentation behaviors.
5. **Technological and Institutional Factors Not Fully Explored:** Although electronic health record (EHR) systems and institutional support were mentioned as barriers, the study did not conduct an in-depth analysis of how these factors quantitatively affect documentation quality and compliance.

### **Summary of Findings**

The study revealed that the majority of physiotherapists at the University of Benin Teaching Hospital possessed good knowledge of clinical documentation, with 91.1% demonstrating a clear understanding of its purpose, content, and legal significance. Most respondents exhibited a positive attitude toward documentation, recognizing its role in enhancing patient care, though motivation to document after each session remained low. Furthermore, majority showed good documentation practices, although time constraints and workload limited prompt record completion. Major barriers identified included lack of electronic health record (EHR) systems, time pressure, and repetitive paperwork. Nevertheless, most physiotherapists expressed willingness to improve documentation through training, management support, and dedicated time. Chi-square analysis confirmed significant relationships between knowledge, attitude, practice, education, and years of experience, indicating that these factors meaningfully influence the quality and compliance of clinical documentation among physiotherapists at UBTH

## Recommendations

1. **Implementation of Regular Training and Workshops:** Continuous professional development programs should be organized to enhance physiotherapists' knowledge and competence in clinical documentation, emphasizing its legal, ethical, and clinical importance. This will ensure consistent adherence to best practices and professional standards.
2. **Adoption of Electronic Health Record (EHR) Systems:** The hospital management should invest in user-friendly electronic documentation systems to reduce paperwork, minimize time constraints, and improve accuracy and accessibility of physiotherapy records.
3. **Institutional Support and Policy Enforcement:** Stronger administrative support is needed through clear documentation policies, supervision, and performance evaluations. Management should enforce compliance with documentation standards as part of routine professional assessments.
4. **Time Allocation and Workload Management:** Physiotherapists should be given adequate time within their schedules to complete patient documentation after each session. Reducing excessive caseloads and improving workflow organization will enhance record accuracy and timeliness.
5. **Further Research and Multicenter Studies:** Future studies should include multiple healthcare centers across different regions in Nigeria and employ mixed methods (quantitative and qualitative approaches) to gain deeper insights into factors influencing documentation behavior and its impact on patient outcomes.

## REFERENCES

- Abdul Aziz, A. F., Mohd Nordin, N. A., Ali, M. F., Abd Aziz, N. A., Sulong, S., & Aljunid, S. M. (2017). The integrated care pathway for post stroke patients (iCaPPS): a shared care approach between stakeholders in areas with limited access to specialist stroke care services. *BMC health services research*, 17(1), 35.
- Abdulkarim, S. F. (2013). *Improving Orthopaedic Assessment in a Physiotherapy Department* (Doctoral dissertation, Royal College of Surgeons in Ireland).
- Akinbo, S., Odebiyi, D., Okunola, T., & Aderoba, O. (2008). Evidence-based practice: knowledge, attitudes and beliefs of physiotherapists in Nigeria. *The internet Journal of Medical informatics*, 4(2), 1-8.
- Alqatarneh, N. (2020). *Family centred Early Intervention programmes in Jordan: A grounded theory study into family and occupational therapists' collaboration* (Doctoral dissertation, University of Essex).
- Alshehri et al. 'Physiotherapists' behaviour, attitudes, awareness, knowledge and barriers in relation to evidence-based practice implementation in Saudi Arabia.' *Int J Evidence Based Healthcare* 2017.
- American Physical Therapy Association (APTA). (2022). Defensible documentation for patient/client management. Retrieved from <https://www.apta.org>
- Anyika, C. (2015). *Modeling and analysis of a clinical documentation improvement system: calculatiing patient outcomes* (Doctoral dissertation, Rutgers University-School of Health Related Professions).
- Atinga, R. A., Gmaligan, M. N., Ayawine, A., & Yambah, J. K. (2024). "It's the patient that suffers from poor communication": Analyzing communication gaps and associated consequences in handover events from nurses' experiences. *SSM-Qualitative Research in Health*, 6, 100482.
- Barry, C., Jones, M., & Grimmer, K. (2006). Electronic clinical records for physiotherapists. *Internet Journal of Allied Health Sciences and Practice*, 4(1), 6.
- Blair, W., & Smith, B. (2012). Nursing documentation: frameworks and barriers. *Contemporary nurse*, 41(2), 160-168.
- Boshnjaku, A., Arnadottir, S. A., Pallot, A., Wagener, M., & Äijö, M. (2023). Improving the evidence-based practice skills of entry-level physiotherapy students through educational interventions: a scoping review of literature. *International Journal of Environmental Research and Public Health*, 20(16), 6605.
- Brindley, J., Bateman, D. R., & Lam, K. (2021). Exploring the Use of Voice Recognition in Healthcare Documentation. *Health Informatics Journal*, 27(2), 1–10.
- Browne, J., Bullock, A., Poletti, C., & Cserző, D. (2021). Recent research into healthcare professions regulation: a rapid evidence assessment. *BMC health services research*, 21(1), 934.
- Buntin, M. B., Burke, M. F., Hoaglin, M. C., & Blumenthal, D. (2017). The benefits of health information technology: a review of the recent literature shows predominantly positive results. *Health Affairs*, 30(3), 464-471.
- Cabitza, F., Campagner, A., Sconfienza, L. M. (2022). As if sand were stone: New concepts and metrics to probe the ground on which to build trustable AI. *Frontiers in Artificial Intelligence*, 5, 760361.

- Chan, C., Wong, K., Chan, S. (2023). Enhancing interprofessional communication through integrated documentation systems: A mixed-methods study. *International Journal of Medical Informatics*, 174, 105070.
- Chan, M. F., Wong, Y. S., & Chen, W. (2021). Continuing education and improvement of documentation practices in allied health professionals. *BMC Health Services Research*, 21(1), 1029.
- Chartered Society of Physiotherapy (CSP). (2020). Standards of practice for physiotherapy documentation. London: CSP.
- Chartered Society of Physiotherapy (CSP). (2023). Clinical record keeping: Guidance for physiotherapists. Retrieved from <https://www.csp.org.uk>
- Chhabra, A., Sharma, M., & Gupta, A. (2022). The Role of Documentation in Enhancing Patient Engagement in Rehabilitation. *Journal of Allied Health Sciences*, 14(1), 56–63.
- CMS. (2023). Medicare audit summary report. Centers for Medicare & Medicaid Services. <https://www.cms.gov>
- Costa, N., Jennings, F., & Parker, L. (2021). Charting Practices in Community-Based Physiotherapy: A Review. *Physiotherapy Research International*, 26(1), e1864. <https://doi.org/10.1002/pri.1864>.
- Cottrell, M. A., Russell, T. G., & Hill, A. J. (2017). Clinical telehealth in physiotherapy: A pilot study of patient satisfaction and experience. *Journal of Telemedicine and Telecare*, 23(2), 267–275.
- De Angelis, R., Sacchetti, C., & Candeloro, L. (2023). Digital transformation in physiotherapy: Adoption of electronic documentation tools and the path forward. *Journal of Allied Health*, 52(1), 32–39.
- Donaghy, M., Tynan, A., & O'Connor, R. (2023). Exploring the impact of workplace culture on physiotherapy record keeping. *Physiotherapy Research International*, 28(2), e1985.
- Duque, Z. P. (2022). Knowledge, attitudes and practice of digital physical therapy among Nigerian physiotherapists. *Bulletin of the Faculty of Physical Therapy*, 27, 17. <https://doi.org/10.1186/s43161-022-00118-3>
- Elshaug, A. G., Duckett, S., & McGlynn, E. A. (2021). Identifying and acting on low-value care. *The Lancet*, 398(10212), 123–131.
- Elston, S., Ferguson, M., & Soulsby, L. (2022). The legal significance of accurate documentation in healthcare: A multidisciplinary perspective. *Health & Social Care in the Community*, 30(4), e1345–e1352. <https://doi.org/10.1111/hsc.13678>
- Gifford, W., Davies, B., Edwards, N., Griffin, P., & Lybanon, A. (2019). Managerial support for best practices in documentation. *Implementation Science*, 14(1), 1-11.
- Greenwood, K., Porter, M., & Drake, E. (2022). Functional goals in physiotherapy: Integrating client-centred documentation across disciplines. *Physiotherapy Canada*, 74(4), 312–320.
- Gupta, V., & Zhang, Y. (2023). Tele-rehabilitation documentation: A new frontier in physiotherapy. *International Journal of Telerehabilitation*, 15(2), e34123. <https://doi.org/10.5195/ijt.2023.34123>.
- Gupta, V., Lin, S., & Martinez, J. (2023). AI in physiotherapy: Opportunities and documentation challenges. *Journal of Digital Health*, 9(3), 111–120.
- Harris, T., & Blackwell, R. (2023). Legal implications of poor clinical documentation in rehabilitation settings. *Journal of Medical Law and Ethics*, 31(2), 112–124.
- Harris, T., Ogunleye, F., & Liu, P. (2023). Trends in documentation-related litigation in physiotherapy: A 10-year review. *Healthcare Risk Management Review*, 18(1), 40–48.

- Häyrynen, K., Saranto, K., & Nykänen, P. (2023). Nursing documentation: Findings and implications from a recent Finnish audit. *Studies in Health Technology and Informatics*, 294, 110–117.
- Health Information and Management Systems Society (HIMSS). (2023). Ethical standards for AI-assisted clinical documentation. Retrieved from <https://www.himss.org>
- Helewa, A., Cardone, S., & Topp, R. (2022). Improving physiotherapy documentation using nursing-based models: A practice audit. *Journal of Clinical Physical Therapy Research*, 39(2), 112–120.
- Ibikunle, Kanu et al. 'KNOWLEDGE, ATTITUDE AND PRACTICE OF HEALTH PROMOTION AMONG PHYSIOTHERAPISTS IN SELECTED TERTIARY HOSPITALS IN SOUTH EAST, NIGERIA, 2024
- Igbokwe, E. T., Ajayi, T. O., & Nwachukwu, A. M. (2022). Clinical workload and its effects on physiotherapy practice in Nigeria. *Journal of Allied Health*, 51(4), 295–302.
- Imafidon, J. O., & Ogunbanwo, A. A. (2021). Cultural Influence on Physiotherapy Practice in Nigeria: A Documentation Perspective. *African Journal of Health Professions Education*, 13(2), 45–49.
- International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT). (2022). Clinical standards for musculoskeletal documentation. Retrieved from <https://www.ifompt.org>
- Jette, D. U., Halbert, J., Iverson, C., Miceli, E., & Shah, P. (2009). Use of standardized outcome measures in physical therapist practice: Perceptions and applications. *Physical Therapy*, 89(2), 125–135. <https://doi.org/10.2522/ptj.20080234>
- Johnson, K., Adeyemi, T., & Morales, S. (2023). Documentation practices in private physiotherapy clinics: A national survey. *Physiotherapy Practice Review*, 28(1), 59–68.
- Kane, B., & White, P. (2023). Legal accountability and nursing documentation. *Nursing Ethics*, 30(2), 156–165.
- Kassab, H., Scott, K., Boyd, M. R., Puspitasari, A., Endicott, D., & Lewis, C. C. (2022). Tailored isn't always better: Impact of standardized versus tailored training on intention to use measurement-based care. *Implementation Research and Practice*, 3, 26334895221087477.
- Kellermann, A. L., & Jones, S. S. (2013). What it will take to achieve the as-yet-unfulfilled promises of health information technology. *Health Affairs*, 32(1), 63–68.
- Khan, M., & Reeves, L. (2023). Value-based care and the role of physiotherapy documentation in reimbursement. *Journal of Health Economics and Policy*, 36(2), 154–167.
- Khan, M., Zhang, L., & Ortega, D. (2023). Cybersecurity threats in electronic documentation: A review. *Journal of Medical Systems*, 47(2), Article 12. <https://doi.org/10.1007/s10916-023-01987-4>
- Kruse, C. S., Kothman, K., Anerobi, K., & Abanaka, L. (2018). Adoption factors of the electronic health record: A systematic review. *JMIR Medical Informatics*, 6(2), e19. <https://doi.org/10.2196/medinform.8903>
- Kumar, R., & O'Connor, J. (2022). Foundations of clinical documentation in physical therapy: A systems approach. *International Journal of Physiotherapy and Rehabilitation*, 10(4), 201–210.
- Lee, J. S., Kim, H., & Park, M. (2020). Artificial Intelligence in Rehabilitation Medicine: Opportunities and Challenges. *Frontiers in Rehabilitation Sciences*, 1, 102. <https://doi.org/10.3389/fresc.2020.00102>

- Lowe, J., Pritchard, C., & Maloney, S. (2021). Template use in EHRs and its effect on physiotherapy documentation quality. *Health Informatics Journal*, 27(3), 1461–1476.
- Maher, et al. 'Challenges for evidence-based physical therapy: Accessing and interpreting high-quality evidence on therapy.' *Physiotherapy* 2004.
- McGowan, Y., Humphreys, H., Burke, H., Conry, M., & Higgins, M. (2018). The role of feedback in clinical audit: A framework for improving physiotherapy documentation. *BMC Health Services Research*, 18(1), 1-9.
- Mensah, B., Ofori, G., & Asiedu, M. (2022). Digital Health Adoption in African Physiotherapy Clinics: Challenges and Prospects. *Global Health Journal*, 6(3), 123–130.
- Meyer, T., Rössler, B., & Wippert, P. M. (2021). Implementation and utilization of electronic health records in outpatient physiotherapy: A cross-sectional study. *BMC Health Services Research*, 21, 1198. <https://doi.org/10.1186/s12913-021-07243-6>
- Morris, J., & Jenkins, M. (2022). Sustaining clinical excellence through professional accountability. *Physiotherapy Practice and Research*, 43(1), 9–16.
- Müller-Staub, M., Needham, I., Odenbreit, M., Lavin, M. A., & van Achterberg, T. (2023). Improved quality of nursing documentation: Results of a guideline- and criteria-based documentation training. *Journal of Nursing Care Quality*, 38(1), 27–33.
- Mwenda, V. M., Otieno, S. O., & Mugambi, N. J. (2020). Comparative Analysis of Physiotherapy Documentation in Low and High-Income Countries. *International Journal of Therapy and Rehabilitation*, 27(11), 1–9.
- Nguyen, H. M., Le, T. H., & Zhang, Y. (2023). Effects of EHR usage on clinician-patient communication: A physiotherapy perspective. *Digital Health*, 9, 20552076231109026.
- Odebunmi, F. A., Ogunleye, A. O., & Ezeanya, C. J. (2023). Enhancing documentation skills through continuous professional education: A Nigerian study. *Journal of Physical Therapy Education*, 37(1), 65–73.
- Olawale, Akodu, et al. 'Emilia 2015 Analysis of physiotherapy documentation of patients' records and discharge plans in a tertiary hospital et al. Olawale, Akodu, Emilia 2015
- Park, J., Cho, S., & Kim, Y. (2023). AI-powered clinical documentation support systems: Challenges and opportunities in allied health settings. *JMIR Medical Informatics*, 11, e43498.
- Patel, A., & Lee, H. (2023). Improving documentation in multidisciplinary rehab teams: The role of standard templates. *Archives of Rehabilitation Research and Clinical Translation*, 5(1), 100098. <https://doi.org/10.1016/j.arrct.2023.100098>
- Pearson, H., Roberts, K., & Sanderson, J. (2019). The Impact of Workload and Training on Physiotherapy Documentation. *British Journal of Healthcare Management*, 25(6), 272–278.
- Physiotherapists' Beliefs. (2023). Physical therapists' perspectives of patient values and their place in clinical practice: a qualitative study. *Brazilian Journal of Physical Therapy*, 27(5), 100552. <https://doi.org/10.1016/j.bjpt.2023.100552>
- Popejoy, L., Snyder, C., & Geisler, M. (2022). Linking documentation quality to patient outcomes. *Health Services Research*, 57(6), 1181–1194.
- Reeves, S., Pelone, F., Harrison, R., Goldman, J., & Zwarenstein, M. (2021). Interprofessional collaboration to improve professional documentation. *The Lancet*, 390(10090), 65–75.
- Ritchie, H., Walton, M., & Stewart, C. (2023). Documentation and risk management in clinical practice. *BMJ Quality & Safety*, 32(4), 267–274.

- Sheppard, L., & Haines, T. (2021). The effectiveness of workplace policy on clinical documentation: A review of physiotherapy departments. *Australian Journal of Physiotherapy*, 67(3), 231-239.
- Silva, R. T., & Mendes, A. F. (2023). The impact of time pressure on clinical documentation among rehabilitation professionals. *European Journal of Physiotherapy*, 25(3), 150–157.
- Singh, V., & Reddy, L. (2023). Ethical and legal implications of altered clinical records. *Medical Law International*, 23(1), 1–17.
- Sluijs, E. M., & Knibbe, H. J. (2019). Training needs for physiotherapists in clinical documentation: A needs assessment study. *Physiotherapy Canada*, 71(1), 12-19.
- Stevens, M., Beurskens, A., & van der Wees, P. J. (2016). Barriers and facilitators to the use of standardized outcome measures in physical therapy practice: A systematic review. *Physical Therapy Reviews*, 21(2), 77–94. <https://doi.org/10.1080/10833196.2016.1192968>
- Swinkels, R. A. H. M., van Peppen, R. P. S., Wittink, H., Custers, J. W. H., & Beurskens, A. J. H. M. (2011). Current use and barriers and facilitators for implementation of standardised measures in physical therapy in the Netherlands. *BMC Musculoskeletal Disorders*, 12(1), 106. <https://doi.org/10.1186/1471-2474-12-106>
- Teo, P. L., Tay, Y. X., & Chong, J. S. (2022). Governance and documentation standards in physiotherapy: A policy analysis. *Journal of Clinical Governance in Healthcare*, 29(4), 210–219.
- Thomas, J., & Gerard, H. (2022). *Legal perspectives on clinical documentation*. Oxford University Press.
- Thorpe, J., Rix, L., & Freeman, J. (2020). Digital templates in physiotherapy: Usability and user satisfaction. *British Journal of Sports Medicine*, 54(9), 521–526.
- WHO. (2023). Patient safety report: Global strategies for reducing harm. World Health Organization. <https://www.who.int>
- Wilesmith, S., Mandrusiak, A., Martin, R., Lu, A., & Forbes, R. (2025). Writing for the role: A qualitative exploration of new graduate physiotherapists' transition to practice of clinical documentation. *Physiotherapy Theory and Practice*, 41(1), 115–127. <https://doi.org/10.1080/09593985.2024.2315255>.
- World Health Organization (WHO). (2001). *International Classification of Functioning, Disability and Health (ICF)*. Geneva: WHO Press.
- World Health Organization (WHO). (2023). *International Classification of Functioning, Disability and Health (ICF)*. Retrieved from <https://www.who.int/classifications/icf>

**APPENDIX**

**DEPARTMENT OF PHYSIOTHERAPY  
FACULTY OF BASIC MEDICAL SCIENCES  
UNIVERSITY OF BENIN, BENIN CITY.**

Dear respondents,

I am an undergraduate student in the above named Department. As part of the requirement for the programme, I am conducting a research **on knowledge, attitudes and practice of physiotherapists about clinical documentation in University of Benin Teaching Hospital**. In this regard, you have been randomly selected as a sample. I also wish to assure you that your answers will be treated in strict confidence and used for the stated academic purpose only.

Thank you for your cooperation.

**Section A: Demographic Information**

(Instruction: Please tick the most appropriate option or fill in the blank where applicable.)

**Age:**  20–22 years,  23–25 years,  26–28 years,  29–31 years,  32–35 years

**Sex:** Male ( ) Female ( ) Prefer not to say ( )

**Years of Experience:** Less than 1 year ( ) 1–5 years ( ) 6–10 years ( ) Above 10 years ( )

**Highest Academic Qualification:** BSc/BMR in Physiotherapy ( ) MSc ( ) PhD ( )

Others (please specify): \_\_\_\_\_

**Unit within Physiotherapy:** Neuromedicine ( ) Neurosurgery ( ) Pediatrics ( ) Orthopedics ( )  
CTU ( ) Geriatrics ( )

**Section B: Knowledge of Documentation**

Indicate the extent to which you agree or disagree with the following statements.

Key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD)

| S/N | ITEMS  | SA | A | D | SD |
|-----|--|----|---|---|----|
|     | <b>Knowledge of Documentation</b>  |    |   |   |    |
| 1.  | I understand the essential components required in standard physiotherapy clinical documentation. |    |   |   |    |
| 2.  | I am knowledgeable about the legal and ethical importance of                                     |    |   |   |    |

|    |  |  |  |  |  |
|----|--|--|--|--|--|
|    | accurate clinical documentation.   |  |  |  |  |
| 3. | I am aware of the guidelines and standards governing clinical documentation in physiotherapy practice. |  |  |  |  |
| 4. | I know how to correctly document treatment goals, interventions, and patient progress.                 |  |  |  |  |
| 5. | I am confident in differentiating between subjective and objective data in clinical documentation.     |  |  |  |  |

### Section C: Attitudes Toward Documentation Practices

Indicate the extent to which you agree or disagree with the following statements.

Key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD)

| S/N | ITEMS   | SA | A | D | SD |
|-----|---|----|---|---|----|
|     | <b>Attitudes Toward Documentation Practices</b>                                   |    |   |   |    |
| 6.  | I believe clinical documentation is a vital part of physiotherapy practice.       |    |   |   |    |
| 7.  | I feel motivated to complete documentation thoroughly after each patient session. |    |   |   |    |
| 8.  | Proper documentation enhances the quality of patient care.                        |    |   |   |    |
| 9.  | I consider documentation as equally important as hands-on treatment.              |    |   |   |    |
| 10. | I take pride in maintaining accurate and timely patient records.                  |    |   |   |    |

### Section D: Documentation Practices Among Physiotherapists

Indicate the extent to which you agree or disagree with the following statements.

Key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD)

| S/N | ITEMS  | SA | A | D | SD |
|-----|--|----|---|---|----|
|     | <b>Existing Documentation Practices Among Physiotherapists</b> |    |   |   |    |

|     |  |  |  |  |  |
|-----|--|--|--|--|--|
| 11. | I document each patient interaction in the medical record system.                |  |  |  |  |
| 12. | I follow a structured format (e.g., SOAP note) while documenting patient data.   |  |  |  |  |
| 13. | I complete documentation during or immediately after patient treatment sessions. |  |  |  |  |
| 14. | I routinely update patient records with progress and treatment outcomes.         |  |  |  |  |
| 15. | I adhere strictly to hospital documentation guidelines and protocols.            |  |  |  |  |

### Section E: Barriers to Effective Documentation

Indicate the extent to which you agree or disagree with the following statements.

Key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD)

| S/N | ITEMS   | SA | A | D | SD |
|-----|---|----|---|---|----|
|     | <b>Barriers to Effective Documentation</b>  |    |   |   |    |
| 16. | Time constraints during clinical hours prevent me from completing documentation properly. |    |   |   |    |
| 17. | Lack of electronic health record (EHR) systems hinders efficient documentation.           |    |   |   |    |
| 18. | I find clinical documentation to be repetitive and burdensome.                            |    |   |   |    |
| 19. | Inadequate training on documentation affects my ability to record accurate data.          |    |   |   |    |
| 20. | I experience interruptions that affect the continuity of my documentation process.        |    |   |   |    |

### Section F: Strategies for Improvement in Documentation

Indicate the extent to which you agree or disagree with the following statements.

Key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD)

| S/N | ITEMS  | SA | A | D | SD |
|-----|--|----|---|---|----|
|     | <b>Strategies for Improvement in Documentation</b> |    |   |   |    |

|     | <b>Practices</b>  |  |  |  |  |
|-----|---|--|--|--|--|
| 21. | Regular training on documentation standards would improve my practice.        |  |  |  |  |
| 22. | Implementation of electronic documentation systems would enhance efficiency.  |  |  |  |  |
| 23. | Peer-review of documentation can help ensure accuracy and completeness.       |  |  |  |  |
| 24. | Allocating dedicated time for documentation would improve compliance.         |  |  |  |  |
| 25. | Management support is essential for improving clinical documentation quality. |  |  |  |  |

## APPENDIX II

### INFORMED CONSENT FORM

**Title of study:** Knowledge, Attitudes and Practicess of Physiotherapist about Clinical Documentation in University of Benin Teaching Hospital.

**Investigator:** OJEAGA PHILIP OHILEBO

**Supervisors:** DR (MRS) SEUN KUBEYINJE.

**Financial Sponsorship:** This research project is self-sponsored

**Purpose of the research:** The purpose of this research is to investigate the knowledge, attitudes, and practices of physiotherapists regarding clinical documentation in University of Benin Teaching Hospital, with a view to identifying gaps and areas for improvement.

#### **Procedures and protocol involved in the study**

You are politely approached to respond to an interviewer-administered questionnaire interview.

This questionnaire would be only used for research purpose and will determine the Knowledge, Attitudes and Practicess of Physiotherapist about Clinical Documentation in University of Benin Teaching Hospital.

#### **Compensation**

There will be no financial compensation for participating in this study.

#### **Voluntary Participation**

Please note that your participation in this research is entirely voluntary. No form of discrimination will be meted to you, should you decide not to participate in this study; You are entirely free to change your mind and stop participating even if you agreed earlier.

#### **Side Effects**

There is no anticipated adverse effect associated with participating in this study.

**Benefits**

This research will benefit the healthcare system by identifying gaps in clinical documentation practices among physiotherapists, informing targeted interventions to improve documentation quality, patient care, and professional accountability in University of Benin Teaching Hospital.

**Confidentiality**

All information and data obtained in the course of this study will be treated confidentially. The names of the participants will not be written on the questionnaire, and all information collected will be encoded in a file in my personal computer and passworded. Thereafter the questionnaires will be shelved and locked in my personal document cabinet.

**CONTACT INFORMATION**

OJEAGA PHILIP OHILEBO

PROJECT STUDENT

Email: [Ohisojeaga76@gmail.com](mailto:Ohisojeaga76@gmail.com)

Ethics and Research Committee

University of Benin Teaching Hospital

Benin City.

Phone Number: 07063331337

**APPENDIX III**

**CERTIFICATE OF CONSENT**

I have read the above information (or it has been read to me). I had the opportunity to ask questions about it and the questions were answered to my satisfaction.

I consent voluntarily to take part as a participant in this study

I do not consent to participate in this study.

Signature of participant: \_\_\_\_\_

Date: \_\_\_\_\_

APPENDIX IV

HEALTH RESEARCH  
ETHICS COMMITTEE (HREC)

UNIVERSITY OF BENIN TEACHING HOSPITAL

P.M.B. 1111 BENIN CITY NIGERIA Telephone: 052-600418 Website: ubth.org

CHIEF MEDICAL DIRECTOR  
Prof. Darlington E. Obaseki  
E-mail: darlobaseki@gmail.com

DIRECTOR OF ADMINISTRATION  
Jim Uwadie, Esq

CHAIRMAN  
Prof. (Mrs.) Antoinette N. Ofili



HREC OFFICE:

Committee email: ubthresearchethics@gmail.com

Registration Number:  
NHREC-UBTH-HREC/24/12/2022B

PROTOCOL NUMBER: ADM/E 22/A/VOL.VII/2025/125

PROPOSAL TITLE: "KNOWLEDGE, ATTITUDES AND PRACTICES OF PHYSIOTHERAPISTS  
ABOUT CLINICAL DOCUMENTATION IN UNIVERSITY OF BENIN  
TEACHING HOSPITAL"

PRINCIPAL INVESTIGATOR(S): OJEAGA PHILIP OHILEBO

DEPARTMENT/INSTITUTION: DEPARTMENT OF PHYSIOTHERAPY, SCHOOL OF BASIC  
MEDICAL SCIENCES UNIVERSITY OF BENIN, BENIN CITY, EDO  
STATE

DATE CONSIDERED: JULY 14<sup>TH</sup>, 2025

DECISION OF THE COMMITTEE: APPROVED

*THIS APPROVAL DATES 14/7/2025 TO 13/7/2026. IF THERE IS DELAY IN STARTING THE RESEARCH,  
PLEASE INFORM THE HREC SO THAT THE DATES OF APPROVAL CAN BE ADJUSTED ACCORDINGLY*

REMARK:

CHAIRMAN: PROF. (MRS) A.N. OFILI

SIGNATURE & DATE.....*Prof. A.N. Ofili, 14/7/2025*

SUPERVISOR (S): DR (MRS) SEUN KUBEYINJE

DECLARATION BY INVESTIGATOR(S):

PROTOCOL NUMBER (please quote in all enquiries)

Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual re-port to the HREC early in order to obtain renewal of your approval and avoid disruption of your research. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit your research site without previous notification

Signature & Date.....



ubthresearchethics@gmail.com

Registration Number: NHREC/24/01/202