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Clinical documentation as a construction site: An analysis of stroke rehabilitation records

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Clinical records perform multiple functions. They record interventions, facilitate team communication and meet regulatory requirements. Clinical records also tell stories: stories about patients, illness or injury, therapists, and rehabilitation (Hamilton & Manias, 2006). These stories influence how people perceive the patient and how they understand what has happened-is happening-will happen (Cheek, 1995. Hamilton & Manias, 2006) .This study examined how patient and therapists were constructed in clinical records in stroke rehabilitation.

METHODOLOGY AND METHODS

This study used the Voice Centred Relational Approach (Mauthner & Doucet, 2008; Bright, Kayes, Worrall & McPherson, 2017) to examine the clinical records of four former patients of a community-based stroke rehabilitation service. These included goal-setting documents, records of therapy sessions, meeting minutes, and discharge summaries. The data included records by all allied health rehabilitation disciplines. Data were analysed using the Listening Guide and the three questions detailed below.

FINDINGS

Patients were sometimes constructed as unique individuals, referred to by name, with reference to their experiences, perceptions and emotions. However, they were commonly portrayed as depersonalised, impaired objects of treatment. At times, they were 'missing' as the notes only discussed therapist interventions: "*Pt seen today for PT and SLT with programmes advised by therapists· PTA - HEP for strength and balance· SLTA- HEP with oromotor exercises and dysarthria drills*". There was limited consideration of emotions or psychosocial functioning; such information was often brief or generic, e.g. "*patient looking and stated feeling well*".

Therapists were constructed in different ways. Most commonly, they were presented as experts 'doing to' or 'educating' the patient and as monitors of progress, while sometimes presenting as collaborators 'working with' the patient. There was limited talk of collaboration or interprofessional working within the team.

AN EXAMPLE OF SPEECH-LANGUAGE THERAPY RECORDS

Role + Informed Consent. <pt name> seen at home for communication follow up. <pt name> greeted me at the front door and appeared bright and alert.
O: Discussed progress with dysarthria and problem-solved around his potential return to work in Jan/Feb. <pt name> feels his speech his improved in line with his overall stroke recovery and he only feels his speech is problematic when he is tired. He reports his family inform him when he 'mumbles' and knows to slow down and speak louder. <pt name> has no presentations/courses booked in but expects to have one in February.
O: Oromotor: mild L) facial weakness, with mildly reduced lateralisation but adequate lip seal on pursing and puffing cheeks. Tongue movement NAD. Perceptually G1 R1 B0 A1 S0. <pt name> feels his voice is mildly rough but able to increase volume and alter pitch etc. without difficulty. Mildly imprecise articulation but fully intelligible in conversation.
Problem solving around return to work: <pt name> feels his writing has improved and he will get a whiteboard to practice writing holding a whiteboard marker. He may ask a support person to attend if needed. He will ask for a lapel microphone if available to avoid fatiguing his voice if the presentation is long. He has activities he could provide students to give himself a natural break if needed. Overall, in contrast to my previous visit, <pt name> feels confident with returning to work early next year. He also reported feeling comfortable explaining in advance to the group that he has had a recent stroke and to let him know if anything needs clarifying.
Agreed no further SLT input needed, but <pt name> aware he can self-refer via his GP if he has any further concerns.
A: Mild dysarthria due to L) facial weakness, mostly resolved; 100% intelligible in conversation. <pt name> has strategies available in planning to return to presenting to students when he returns to work
P: No further SLT input required

HOW IS THE PATIENT CONSTRUCTED?
Are they present in the notes? How are they spoken of? What is spoken of? What role do they play (or are assigned)?

HOW IS THE THERAPIST CONSTRUCTED?
Are they present in the notes? How are they spoken of? What is spoken of? How is their work spoken of? What role do they play?

HOW IS THE PATIENT CONSTRUCTED?
Engaged with therapist, recovery, rehabilitation & family. Monitoring progress & problem-solving. Active. Confident. Has future plans.

HOW IS THE THERAPIST CONSTRUCTED?
Blends impairment & functional focus. Expert assessor but collaborating with patient in evaluations.

DISCUSSION AND CLINICAL IMPLICATIONS

Clinical records commonly focused on patient impairments, and on the therapist's disciplinary-based intervention. It was uncommon for such records to "communicate a comprehensive picture of the patient" (Pierre & Sonn, 1999, p.3). The way in which patients and practitioners are constructed can influence how the patient is perceived and how people's practice is understood and what services are offered now or in the future. Some argue that language both reflects and creates a reality (Cheek, 1995), meaning it is important to consider what realities are being created in our documentation; such realities can have significant repercussions for the patient who functions as the subject and object of the records (Cheek, 1995; Hamilton and Manias, 2006; Heartfield, 1996). As such, it is imperative that we think critically about our written documentation. Considering *who* we speak of in our writing, *how* we speak of them and *what* we speak of may support us to critically reflect on our practice and values that underpin or influence our work.

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