2015-16 CLINICAL DECISION MAKING PROCESS

The Clinical Decision Making Process is the process of establishing an appropriate intervention for a client. Key to this process is the utilization of 1) evidence based practice, 2) a client centred practice approach, 3) the International Classification of Functioning, Disability and Health (ICF), and 4) the development of goals that are Specific, Measurable, Achievable, Realistic, and Timed. This Clinical Decision Making Process was designed to be used at the individual or community/group level and to be applicable in preventative and treatment based approaches. Please refer to attached document for definitions.

A. Examination
   History
      Client interview, chart review and/or community health assessment
   Assessment
      Selection of and timing of evaluation including outcome measures.

B. Identification of Issues
   Individual (physical therapy diagnosis) and/or community issues.
   Point of referral for further investigation.

C. Goals
   Development of SMART goals based upon client goals, expected outcomes and prognosis.
   Point of referral for further intervention

D. Strategy for Intervention
   Also known as “Plan of Care”
   Point of referral for further intervention.
   – may include prioritization of issues which will be addressed

E. Intervention

F. Re-examination
   Maximized client autonomy from PT.
   Establish follow-up, maintenance, and client sustainable programs.
Concept descriptions:

**Client**: An individual or group receiving physiotherapy services.

**Client Centred Practice Approach**: Client centred practice is more than goal setting and decision making between the client and physical therapist; the client’s needs are incorporated into the delivery approach of rehabilitation services (Cott, 2004). The rehabilitation process includes the client being actively involved with health providers and the health providers understanding and respecting the needs of each client (Cott, 2004). The concepts of client centred rehabilitation include: client participation in decision-making and goal-setting, client-centred education, evaluation of outcomes from the client’s perspective, family (peer, support group) involvement, emotional support, co-ordination /continuity of care, and physical comfort (Cott, Teare et al., 2006). These concepts can be applied across all aspects of physiotherapy practice.

**Evidence and Best Practice**: Examination methods and interventional approaches will be based upon evidence and best practices (or standards of care). Evidence based practice is the combination of best research evidence with clinical expertise and client values (Sackett et al., 2000).

**ICF**: The International Classification of Functioning, Disability and Health is useful to understand and measure health outcomes. It can be used at the individual, group or population level. The ICF is designed to complement ICD-10 (The International Classification of Diseases and Related Health Problems) (WHO, 2002, 2003). Standardized outcome measures can be chosen to assess levels of impairment (body structure and function), activity/activity limitations, or participation/participation restrictions. The client and the outcome of the client assessment can be described in terms of personal and environmental contextual factors, health condition, impairment level findings, and activity and participation level findings. The results can then be used to design interventional strategies for the levels of impairment, activity limitations or participation restrictions. Client goals can also be described in each of these levels. The ICF works for prevention and treatment approaches.

**Informed consent**: Informed consent should not only occur at the initial outset of the physical therapy encounter, but at the introduction of every new element of intervention. Three factors must be considered in respect of informed consent by clients (Gabard & Martin, 2003).

1. Competence: Clients must be of legal age and sufficiently rational or competent to understand and make health care decisions.
2. Information: Clients must be given the relevant information regarding their condition and treatment at an appropriate level that they can understand and interpret in order to make an informed decision.
3. Voluntariness: Clients should not be coerced or otherwise manipulated.

**Referral**: This is the method by which the client was introduced to the physical therapist (which includes self-referral) or the method by which the client is referred for additional intervention or assessment.

**SMART Goals**: Specific, Measurable, Achievable, Realistic, Timed (Monaghan, Channell et al., 2005). Goals need to be established in consideration of the terms derived from the SMART acronym. These goals are a reflection of the physical therapy diagnosis and prognosis. The physical therapy diagnosis culminates from the physical therapy examination and evaluation (APTA, 2001), where the examination is the process of obtaining data from the client, and the evaluation requires the therapist to make judgements based on the data (Boissonnault, 2005). Whereas the medical diagnosis may be based on pathological origins, the physical therapy diagnosis is based on impairments and functional limitations as assessed by the physical therapist (Boissonnault, 2005).
References


