CLINIC FILES

A patient waits nervously in the doctor's office.
He's a young man with a big problem – a low back gone very bad with one awkward lift, weeks ago. He's in pain and doesn't get why it's not just going away. He's troubled because it even hurts to put his work boots on.

What does he need? He needs to know what's gone wrong and he needs it to be good again, because he has to get back to his job. What kind of help can he expect at his visit today? It depends on which doctor he's waiting to see – because this will determine the degree to which he'll be 'seen'.

One physician might spend more time looking at the computer screen than at the patient. The young man will mostly see a profile view of the doctor, who is focused on asking questions about his symptoms and entering the answers in to the file. It seems that this doctor is more connected with the process of keeping records than with the process of clearly seeing this young man's body and how he is suffering and how his life's been turned upside down since he loaded that canoe up onto his truck.

A Chiropractic physician will want to know more about what exactly transpired on that fateful day at the lake. Why did it happen? What's gone wrong? How can we help to put things right? Face to face, hand to skin, we use probing questions and curious fingers to figure things out. Our palpation and physical examination skills are what we depend on. They give us the ability to assist this young man in significant ways. Correcting neuromusculoskeletal dysfunction is what we do – and we do it really well.

We know that we can provide the best kind of care for injuries like this, but the only existing proof of our efficacy will be found inside the patient's file. If we don't keep good notes, no one else can know just how good we are at what we do!

WHY KEEP CLINICAL RECORDS?

We must. And, I believe, we should want to. Record keeping is an asset, not a punishment!

WHO BENEFITS?

Everyone. Many parties have an interest in our files.

Third parties (government regulators, insurance companies and lawyers) are the guardians of the public's safety and their money. In a nutshell, third parties assume that the quality of the care you provide is directly reflected by the quality of records you keep. Good notes are the only objective evidence of our competence and our willingness to follow best-practices. As individual practitioners and an entire profession, our record keeping is an opportunity to elevate our status in the eyes of these influential third parties.

Good record keeping is good for our patients. Without it, continuity of care is impossible. When we take seriously the concept of 'accountability', it makes us pay more attention to the details of their case. This is how we keep patients safe.

According to the Public Health Service of Ireland, clinical records do more than support good patient care – they are essential to it.

"*When we have had occasion to examine patient files we have often found them to be unsatisfactory – lacking structure, disorganized, illegible. It is beyond comprehension that caring professions can be so lax in this regard. Such practice could only be described as being akin to a (no doubt unintentional) level of disrespect and disregard for the patient."*
THE IMPORTANCE OF GOOD RECORD KEEPING
The Office of the Ombudsman, Ireland *http://www.ombudsman.gov.ie*

And, good clinical notes are good for us. Keeping them imposes a structure to patient visits, improving consistency and efficiency. Patient records, when they're kept right, are a goldmine of opportunities for personal and professional success. Clinical research is impossible without good notes, and if you pay more attention to your patients' records, they will make you better at what you do!

The challenge for many of us is that we believe record keeping takes too much time and we are not 100% certain how much and what kind of information we should document, particularly when it comes to the least tended-to part of a patient's file – the daily treatment notes.

Imaginethat this young man with the bad back is waiting to see you. If your record keeping habits are really good, you'll start the visit with new, blank forms to document your findings, even if you've seen him before. (A new chief complaint in an 'old' patient should be worked up as though they are a new patient.) If you are using your usual

'ongoing treatment record' paperwork, you will still need to document all of the relevant facts of his case.

WHAT EXACTLY MUST BE DOCUMENTED?

The answers to four key questions.

The Medical Services Plan of British Columbia has a standard for patient records that must be met in order to qualify for payment to the practitioner. Our daily notes must provide clear answers to these four questions:

1. What did the patient say?
2. What did the practitioner find?
3. What's going on with this patient?
4. What's the treatment? What's the plan?

WHERE SHOULD SPECIFIC DETAILS BE RECORDED?

Under the appropriate headings of the SOAP format.

S – Subjective	Take a mini-history using a familiar mnemonic like SOCRATES
O – Objective	Hands-on practitioners will take note of observations, palpation, ranges of motion, special tests and vital signs
A – Assessment	'Mechanical low back pain' or 'Inflamed right lumbosacral junction associated with hypertonic right iliopsoas and quadratus muscles, secondary to subluxations at the thoracolumbar junction and L5'
P – Plan	Treatment provided / recommended follow-up and self-care

HOW CAN YOU TAKE NOTES EFFECTIVELY AND QUICKLY?

Use the right forms.

Whether you make use of electronic records or paper and pen, the 'forms' you use should provide sufficient space for the right information. Make liberal use of ROM charts, body diagrams, headings and checklists for easy entry of details. No one expects you to write a novella!

HOW MUCH TIME DOES IT TAKE TO TAKE NOTES?

Not as much as you might think, but more than you probably do.

With electronic tools we can now collect vast quantities of information, but it's really the quality that matters. If you make use of the right forms, it takes seconds not minutes to jot down brief comments, draw a few lines on a ROM chart and check off some boxes. It should just take another minute to commit to what you believe is going on and decide what's to be done. The better the form you use for ongoing treatment records, the better the information you get on file and the quicker you can accomplish the task.

WHEN SHOULD YOUR CHARTING BE DONE?

Contemporaneously.

Ideally, you should do it right now, during the visit and after the visit, before you start with your next patient. It is acceptable to complete your clinical notes before you go home for the day. They should definitely be done before the file goes back into the drawer for the night.

Attention to clinical record keeping doesn't have to be accomplished at the expense of attention to the whole patient. On the contrary, good record keeping is concrete evidence of our connection to the patient. We can do both - help people who are suffering AND keep good notes to prove it.

WHAT IF….?

What if you were to drop dead next week? Would another practitioner be able to safely and effectively take over the care of this young man and all your other patients?

What if you could begin to appreciate record keeping – not as a burden but a tangible asset and a tool to facilitate practice excellence? Proof of safe, high quality care is the greatest gift you can give your patients.

What if better record keeping became a bigger priority for every Doctor of Chiropractic?

Then we'd all be better at this healthcare detective business – asking the right questions and helping to solve big problems, better able to reassure our young patient with the bad back that he will return to work - and he can look forward to more canoe trips in the future!

"One's accomplishments in life are the cumulative effect of one's attention to detail."
- John Foster Dulles

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