How to use this guide

A major part of the CCOA Practice Visit (self submission practice review) process is having your record keeping reviewed by a Clinical Advisor on the Competence Committee. The patient records you submit will be evaluated based on eight areas: admittance form, case history records, examination records, written (working) diagnosis, progress/SOAP notes, and miscellaneous requirements (equipment-related).

This guide describes what you are required to include in your patient files and shows what criteria the Clinical Advisor will be using to assess the quality of your record keeping and clinical decision making. Complete and accurate record keeping is a critical area of patient care for any practitioner.

The guide also indicates what actions you may need to take if there are comments presented by the Clinical Advisor in your results letter. Any comments provided are intended to help you achieve the minimal level of performance, as per the Standards of Practice, and help you improve as part of your continuing competence. Use the comments to identify where to make improvements combined with the actions noted in each section under "**Applying your practice review results"** to determine how to achieve a consistent level of performance.

1. Admittance Form

An admittance form is designed to elicit basic personal information toward the execution of a full case history. The admittance form does not replace the professional activity of case history taking.

The admittance form **should** include:

- ✓ patient name
- ✓ Alberta Health Care (AHC) number*
- ✓ address
- ✓ primary contact telephone number
- ✓ date of birth
- ✓ gender of patient
- ✓ biological sex of patient
- ✓ occupation
- ✓ provision for identification of a work-related injury
- ✓ provision for emergency contact information

*A record of your patient's AHC number is required should you need to refer a patient to a medical specialist for consultation or imaging. Pending chiropractic integration into Alberta Netcare will require AHC numbers to access patient files.

Other possible items on admittance forms:

- Email address
- If you are collecting patient email addresses, provision of the email address must be presented as an option, i.e., the patient can opt in or out. Reasons for the collection must be provided, such as appointment reminders, birthday emails, etc., as per the requirements of Canada's anti-spam legislation.

2. Case History Records

A professionally elicited case history is a skilled activity that requires the practitioner to properly perform and record the detailed and complete patient information. Note: a comprehensive patient admittance questionnaire is not a replacement for a professionally elicited case history.

To meet the CCOA Standards, case history records **must** include:

- ✓ **presenting complaint**
- ✓ **mode of onset**
- ✓ **frequency**
- ✓ **intensity**
- ✓ **pain radiations**
- ✓ **character**
- ✓ **duration**
- ✓ **aggravating factors**
- ✓ **relieving factors**

Questions and answers on the topics bolded above must be noted in the clinical record, even if the patient had no response, i.e., "patient denies" or "patient disclosed no history".

Case history records **should** include the following:

- ✓ patient name
- ✓ X-ray reports
- ✓ associated symptoms
- ✓ previous incidence
- ✓ previous treatment
- ✓ secondary complaints
- ✓ medical history
- ✓ medications
- ✓ related family history
- ✓ psychosocial history
- ✓ history of injuries
- ✓ a systems review

Note: When there is a patient-completed combined history/intake, there must be evidence that the doctor has reviewed this information with the patient, has elicited additional information where warranted, and documented this elicitation by making notes in the forms.
The admittance form on its own does not meet the CCOA standards for record keeping.

Applying your practice review results: How to improve your case histories

If you received comments in this section of your results letter, use the comments to identify where to make improvements combined with the actions noted here to make a plan to improve your case history competency skills.

- ❑ Reviewing literature on case histories
- ❑ Registering for a course on taking a proper history
- ❑ Evaluating your time management in the clinic to ensure that you leave adequate time to perform an appropriate case history.
- ❑ Ensuring you aways make a complete record of the history obtained.

3. Examination Records

To meet the CCOA Standard, examination records **must** meet the following criteria:

- ✓ **The clinic record must show evidence that the exam tests were actually performed.**
  - Recording **both** positive and negative findings is required when tests are performed.
  - Recording the side (right or left) for which the test was performed, or the side a response was elicited during testing is required.
  - Standard nomenclature and notation are used to record observations and results.
  - The clinical record must demonstrate an appropriate exam for any area that is treated.
- ✓ If you use a form that lists a variety of tests without indicating whether the test was performed is considered an incomplete exam and is unacceptable. If you have not performed a particular exam, it is preferred that you strikeout exams not performed, i.e., [~~insert name of an exam~~]. **The physical exam findings in your clinical record must be sufficient to address the chief (presenting) complaint(s) including appropriate neurological or orthopedic testing.**
  - The tests performed in the physical exam and the test findings must specifically address the issues raised in the chief complaint(s).
  - If patient history or previous exam findings suggest there is either central or peripheral neurological compromise, you are required to use appropriate neurological tests.
  - For peripheral neurological complaints, the minimal assessment includes tendon (DTR), motor, and sensory testing to meet the CCOA standards.

- ✓ **The physical exam findings in your clinical record must support the diagnosis, including appropriate neurological or orthopedic testing.**
    - A diagnosis of a central or peripheral neurological condition requires that appropriate neurological tests occur.
    - For peripheral neurological complaints, the minimal assessment includes tendon (DTR), motor, and sensory testing to meet the CCOA standards.
    - The most common comments/concerns in the evaluation of examination notes are 1) Inadequate examination to address the chief complaints, and 2) Failing to examine an area prior to treatment.

Using specialty techniques in examinations

Regulated Members using specific techniques must be aware that sufficient physical examinations must be performed and recorded to support the determination of a differential diagnosis and elimination of likely pathology, as it is their responsibility as primary contact practitioners. Technique-specific examinations do not demonstrate the requirements of a complete assessment.

Members using specialty techniques should provide some explanation about the unique charting character and notations associated with their technique, as this will facilitate the Clinical Advisors' understanding of your notes and may benefit your review outcome.

Unacceptable examination practices

The following do not meet the CCOA Standards for examinations:

- × **An SEMG/thermoscan is not an acceptable exam to establish a diagnosis.**
- × **A 'Chiropractic Technique' exam without orthopedic or neurological testing is unacceptable to establish a diagnosis or rule out pathology.**
- × **Recording results with 'WNL' is not acceptable.**
- × **Leaving exams blank on a form is not acceptable.**
- × **Treating in an area that you have not examined is unacceptable. For example, treating full spine when you have only examined the low back is not acceptable.**

Applying your practice review results: How to improve your Examinations

If you received comments in this section of your results letter, use the comments to identify where to make improvements combined with the actions noted here to make a plan to improve your physical examination and clinical record competency skills.

If you have received comments in this section of your results letter, you must make a plan to address your physical exam competency. This may include:

- ❑ Reviewing literature on appropriate examinations that lead to a differential diagnosis.
- ❑ Pursuing professional development in core competencies such as orthopedic and neurological testing, including the documentation of this testing will help to strengthen and reinforce your knowledge base.
- ❑ Ensuring you have adequate time to perform and document your examination is essential.

- ❑ Ensuring that you have examined and documented exams in areas that you are treating. If a new complaint arises, always use an exam in the area prior to treatment, or in other words, never treat without an assessment.

4. Written (Working) Diagnosis

To meet the CCOA Standard, written diagnosis **must** meet the following criteria:

- ✓ **There must be a written diagnosis for each patient.**
- ✓ **There must be modifiers, such as anatomical location, or structures effected when using "vertebral subluxation complex" (VSC), "mechanical joint dysfunction", or facet syndrome**
  - To meet the minimum Standard, a diagnosis of "VSC"/ "subluxation"/ "mechanical joint dysfunction (MJD)" must at least identify the spinal region (e.g., cervical VSC/subluxation or thoracic MJD), but more accurately, should additionally specify area of the region (e.g., lower cervical, mid thoracic) and components of the "complex" identified at examination that led to this diagnosis. This diagnosis should address the presenting complaint.
    For example, "Lower cervical VSC/subluxation with C7 trajectory radicular extension" or "lower lumbar MJD with sciatic radiation" would be considered acceptable.
- ✓ **There must be a narrative descriptor when using reported symptoms as a diagnosis**
  - A narrative descriptor is the preferable format of a diagnosis and should be as specific as the clinical analysis allows. A diagnosis must have at least a regional descriptor to meet Standards and should address the presenting complaint.
    For examples, "**mechanical** low back pain," or "**cervicogenic** headache," or "**migraine** headache" are all acceptable.
- ✓ **The diagnosis must be noted after the examination and prior to the treatment plan and initiation of treatment.** The diagnosis should be as robust as possible and written in way that any healthcare provider who reads the diagnosis is presented with the information necessary to understand the patient's condition.
  - Period – acute, subacute, chronic, recurrent, or insidious onset
  - Intensity – mild, moderate, or severe
  - Mechanism of Injury – traumatic, fall, repetitive strain injury, biomechanical, postural, or idiopathic
  - Anatomical Location – upper/lower cervical, upper/middle/lower thoracic, upper/lower lumbar
  - Structures effected – generator of pain, muscles, ligaments, joints, or nerves
  - Pathology of structures effected – joint dysfunction or subluxation, sprain, or strain
  - Concomitant or secondary problem

    Sample diagnosis
    - Chronic, moderate central mechanical, low back pain with associated myofascial strain
    - Acute severe traumatic cervical whiplash with associated sprain-strain complex
    - Chronic L5 disc herniation with a right-sided radiculopathy to the hallux, with demonstrated L5 sensory and motor loss.

The following practices **do not** meet the CCOA standard for diagnosis:

- ✗ Using an exam finding as a diagnosis. A diagnosis must be derived from analysis and assessment of all exam findings to produce a narrative diagnosis.
- ✗ Composing your diagnosis using only ICD-9 codes with a single digit modifier. ICD-9 codes do not meet record keeping standards for a diagnosis. If you choose to use them (it is optional), ICD-10 codes used as the sole diagnosis must have at least a two-digit, post-decimal point descriptor code that identifies segmental level(s) and tissue(s) involved. For example, "S13.11" is minimally acceptable. Care must be taken to make certain that the two-digit modifiers used relate appropriately.

Applying your practice review results: How to Improve your written diagnosis
If you received comments in this section of your results letter, use the comments to identify where to make improvements combined with the actions noted here to make a plan to improve your written diagnosis competency skills.

- ❑ Reviewing the article, "Writing the Working Diagnosis" on the CCOA website.
- ❑ Reviewing other literature on differential diagnosis resulting from examination.

5. Written Treatment Plan

To meet the CCOA Standard, a written treatment plan is required in all patient files and must be congruent with the diagnosis. A written treatment plan **must** include the following:

- ✓ modality of care (i.e., any combination of spinal manipulation therapy (SMT), soft tissue therapies (ART, Graston), laser, ultrasound, electrical stimulation, controlled exercise plan, lifestyle counseling, anti-inflammatory regime, etc.)
- ✓ frequency of care
- ✓ duration of care
- ✓ re-evaluation interval

Applying your practice review results: **how to improve the written treatment plan**
If you received comments in this section of your results letter, use the comments to identify where to make improvements combined with the actions noted here to make a plan to improve your written treatment plan competency skills.

- ❑ Standard notation recognizes the treatment plan as an individual component.
- ❑ The treatment plan should be recorded separately or distinctly, prior to the initiation of treatment.
- ❑ Review the article "The Written Treatment Plan" on the CCOA website.

6. Progress/SOAP Notes

To meet the CCOA Standard, progress/SOAP notes for each event of patient contact **must** include:

- ✓ patient name
- ✓ date of treatment
- ✓ **S**ubjective information of the day
- ✓ **O**bjective information of the day, what observations or test results did the clinician observe or perform.
- ✓ **A**ssessment which is essentially the diagnosis

- ✓ **P**rocedures performed (actual treatment rendered during that patient contact event) and/or change in **P**lan (for follow up)
- ✓ patient name

Applying your practice review results: how to improve your Progress/SOAP notes

If you received comments in this section of your results letter, use the comments to identify where to make improvements combined with the actions noted here to make a plan to improve your Progress/SOAP notes competency skills.

- ❑ Avoid highly repetitive computerized notes. Excessive repetition could lead one to question the validity of the chart note entries.
- ❑ Avoid overusing "Same as Above" (SAA) in your notes. This sub-optimal chart note abbreviation appears too frequently. SAA appearance in any of the SOAP categories is reasonable for those infrequent events of patient charting where there has been no change since the latest patient contact. It is not appropriate for a recurrence of a previous condition. Abundant use of the SAA chart entry gives rise to a concern for appropriate case control by presenting the appearance of neglect in the face of a lack of patient progress.
- ❑ Review the article "Soap Notes: The Foundation of Demonstrating Treatment Legitimacy" on the CCOA website.

7. Informed Consent to Treatment Form

The CCPA has released an updated version of the informed consent form, effective September 2015. CCOA members are required to use the most current CCPA form regardless of who their insurer is. The CCPA form is the only form that is evidence based and has been tried in the Canadian legal system. The CCPA forms are considered to provide a complete informed consent inasmuch as they provide a complete risk profile for conversation with the patient. A copy can be obtained on the members' side of the CCOA website and should be used with all new patient files.

To meet the CCOA Standard:

- ✓ An informed consent form is required in all active case files and must address stroke and disc injury if spinal manipulation therapy (SMT) is proposed. It must be current and signed.
- ✓ It is recommended that all informed consent forms are dated and be signed and witnessed with the names clearly printed below the signature. The DC should be the witness.
- ✓ The informed consent form should be a standalone document, as per the recommendations of the CCPA. It should not share a page with other elements of the patient record, including the other side of the page.
- ✓ The CCPA informed consent should not be modified in any way with the exception of replacement of the CCPA logo with your own clinic logo (if desired).
- ✓ Informed consent for acupuncture must be used where the patient is receiving this treatment. Download and use the CCPA's informed consent for acupuncture from the member's side of the CCOA website.

8. Additional Areas of Comment

In addition to commentary about the primary areas of record keeping outlined above, you may also receive recommendations or comments regarding the following areas of review:

- ✓ Clinical documentation should always be **legible** Illegible records do not meet the CCOA's professional conduct standard and may result in a referral to the Complaints Director.
- ✓ It is recommended that a typed sheet of any **charting abbreviations** used should be created and maintained in your clinic in case others are required to read your chart notations, for example, if a locum must fill in for you.
- ✓ It is recommended that the **patient's name** appear at the top of each page of the patient file, in the event the file contents are ever separated.
- ✓ If chiropractors or health professionals other than you provide service to your patients, it is recommended that **each provider** initial or indicate in a clear fashion their own progress/SOAP notes for a particular treatment event.
- ✓ **Sign-in sheets** cannot be used due to privacy legislation. Practitioners concerned with confirmation of patient visits can have patients initial the daily progress note.
- ✓ If you post **patient photos** in your clinic, be aware that a consent form must be obtained for each patient, as per privacy legislation.
- ✓ **Samples of appropriate patient forms** are available on the members' side of theccoa.ca. Review of these templates will also give you a better understanding of appropriate chart notes. You may use these templates as designed or amend them as desired.
- ✓ For guidance in record keeping, we recommend you access the **CCOA Record Keeping Course** on the members' side of the CCOA website. Review this document to fully understand the record keeping standards expected of all CCOA members.

9. Miscellaneous Requirements

In the Diagnostic Equipment list of the Self-Submission Practice Review package, the equipment listed with an asterisk is acknowledged to be required to complete the basic, primary contact health care practitioner examination and diagnosis for which chiropractors in Alberta are responsible. The following equipment is considered minimal diagnostic equipment in practice.

- blood pressure cuff
- gowns
- latex gloves/hand barriers
- oto-ophthalmoscope
- reflex hammer
- stethoscope