GUIDELINE G-004

Documentation of a Chiropractic Visit

Quality Assurance Committee
Approved by Council: February 8, 2011
Amended: September 28, 2012, April 23, 2014
(Revoked: April 24, 2018)

Note to readers: In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

INTENT

To ensure that members maintain accurate and comprehensive records.

DESCRIPTION OF GUIDELINE

The patient health record must "tell the story" of the patient, as determined by the member, in the circumstances in which he/she saw the patient. The components necessary to tell the story are set out in detail in Standard of Practice S-002: Record Keeping. The record is not just a personal memory aid for the member who creates it, but must allow other health care providers to read quickly and understand the patient's past and current health history as well as future health goals.

Patients present to a chiropractor for a variety of reasons. However, patients should expect basic procedures to be followed which represent the chiropractor's unique role in the collaborative health care framework. The results and observations, based upon the performance of these basic procedures, should be recorded in such a way as to accurately recreate the doctor patient interaction.

Chiropractors offer a variety of approaches to care within the scope of practice. CCO regulates the full range of chiropractic approaches and it is expected that members are always practising within the chiropractic scope of practice. As such, patients should expect to experience the following, which is to be clearly and legibly reflected in the patient health record:

- a consultation related to their his/her presenting condition and/or goals;
- an assessment of conditions related to the spine, nervous system and joints; and
- a diagnosis or clinical impression and recommendations for care, including possible referral to an appropriate health care provider if necessary.

On each patient visit, a member should allow sufficient time to:

- provide relevant, safe, supportive and patient-centred quality care within the chiropractic scope of practice, and related to the patient's condition and goals;

- conduct outcome measures, continuous assessment and reassessment of progress related to the patient's condition and goals;
- document accurate and comprehensive care notes which reflect the care provided; and
- ensure patient records are legible, detailed, individualized and personalized.

Information should be stated concisely. It is acceptable to use sentence fragments or outline forms and diagrams. Records of personal health information may contain abbreviations and terminology unique to health care professions. In such cases, an abbreviation legend/key must be available to accompany the records of personal health information.

CCO does not endorse any particular type, template or style of note taking.

Whatever style is used, it is important to be consistent, comprehensive, accurate and legible to give a clear picture of the care being provided.

Electronic Health Records: Special Considerations

An electronic format will be adequate and acceptable if:

- each entry in the record of personal health information is accurate and sufficiently comprehensive to reflect the care provided; and
- each entry is individualized and personalized capturing the unique aspects of that particular patient encounter.

If the electronic format cannot do this, the member should consider using an alternative system. Members are discouraged from using systems that create "template-like" records. These may not be an adequate reflection of an individual patient's story.

Members have an obligation to provide printed copies of electronic records when asked to do so. To ensure the records can be understood, a member may be asked to provide the print-out from the electronic record, together with a dictated summary, to provide an overview of the patient's story.

LEGISLATIVE CONTEXT

Regulation pursuant to the *Chiropractic Act, 1991*. Further, it is an act of professional misconduct under Ontario Regulation 852/93 (Professional Misconduct) to contravene or fail to comply with a standard of practice.

This guideline should be read in conjunction with the following:

- S-001: Scope of Practice
- S-002: Record Keeping
- S-006: Technical and Interpretative Components for X-ray
- S-008: Communicating a Diagnosis
- S-022: Ownership, Storage, Security and Destruction of Records of Personal Information
- Relevant privacy legislation such as the *Personal Health Information Protection Act, 2004*