



Record Keeping Continuing Education Overview, Goals and Outline

Overview

Accurate and complete documentation of the patient-clinician encounter is of paramount importance for the clinician as well as the patient. This is reflected in quality of the clinical record that is produced by the clinician. Documentation of the interaction between the patient and clinician is as important as the actual treatment being provided. This is the living document that provides a record of the patient-clinician encounter in an organized and legible format. Proper record keeping is essential for communication between health care professionals and is required for total patient care. The quality of the patient record may be considered a reflection of the quality of the patient care delivered. Knowing all of the required elements of the clinical record and the preferred methods of documentation is required for good patient care. This is also a requirement to be an effective and respected component of today’s integrated system of health care.

Goals

At the conclusion of the Clinical Record Keeping educational session the attendee will:

- Be familiar with the Record Keeping Compliance Checklist (OBCE document)
- Understand the importance of the clinical record with respect to the patient and the clinician.
- Know all of the required elements of the clinical record and understand the preferred manner of documenting them.
- Understand and properly document informed consent and medical necessity.
- Have a general understanding of the benefits and pitfalls of digital health record systems.

Clinical Record Keeping

Introduction	Importance of clear, accurate, complete, organized, legible clinical record	15 min
Documentation Basics	<ul style="list-style-type: none"> • Clinician and Patient identification. • Identification of date of record (month, day, year). <ul style="list-style-type: none"> ○ Case History/Subjective data – personal and family history, review of systems, chief complaint (location, frequency, onset, provocation, palliation, quality, severity, timing, outcomes assessment tools), preventive health components. ○ Outcomes Assessment Tools (OATS): definitions, examples, documentation, importance for clinical decision making. ○ Preventive Health Components: definitions, examples, documentation, follow up, e.g. smoking cessation. 	15 min

Documentation Basics	<ul style="list-style-type: none"> a) Examination/Objective data – physical examination (initial and subsequent), diagnostic imaging, labs, special examinations. b) Assessment/Diagnosis/Clinical Impression and decision making. c) Treatment Planning – components, duration, frequency, re-assessment (changes/modifications and rationale), goals, expected outcomes/prognosis, complicating factors. d) Record of services performed including provider of service and author of record. e) Other pertinent information regarding patient, e.g. clinical picture, correspondence/communication with patient and/or other providers involved in the care of the patient, referrals, etc. f) Record of charges for services performed and billed to patient, insurance carrier or other individual responsible for payment. 	15 min
Informed Consent and Medical Necessity	<ul style="list-style-type: none"> Process and documentation Documentation consistent with defined criteria 	15 min
Chart/Progress/SOAP/Daily Visit Notes	<ul style="list-style-type: none"> a) Format. b) Components, e.g. where chiropractic adjustment(s) were performed, patients response to treatment. c) Signatures: acceptable methods 	15min
Medicare	<ul style="list-style-type: none"> a) 3 Types of Care: <ul style="list-style-type: none"> g) Acute subluxation h) Chronic subluxation i) Maintenance care b) Documentation requirements, e.g. PART 	15 min
Digital Records and Medico-legal and Ethical Considerations	<ul style="list-style-type: none"> a) Electronic Medical Record (EMR), Electronic Health Record (EHR), Personal Health Record (PHR). b) Options/Systems (cloud vs. in-house). c) Comparison with traditional paper records. d) Pitfalls, e.g. chart note same as last visit ongoing. e) Editing the record, patient requests to “change” the record or “don’t write this down” in the record. 	15 min
Questions and additional discussion.		15 min