EDUCATIONAL MANUAL FOR EVIDENCE-BASED CHIROPRACTIC

Chapter 3
Record Keeping

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RECORD KEEPING

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INTRODUCTION

The importance of keeping complete and accurate records cannot be overemphasized. Documentation of patient care is often as important as the rendition of care itself" [1] Proper record keeping is the documentation of the patient-doctor interaction. This record should be constructed so that it may be understood by others necessary to support a patient's health and reimbursement needs.

As a critical component of our health care delivery system, the accumulation of essential information, known as a patient record, serves many purposes, including:

- It provides a historical accounting of the patient's health concerns and treatments. While the actual record belongs to the provider, the information contained within the record belongs to the patient.[1] [3]

- Record keeping should facilitate and maintain communication between health care professionals. "…clinicians must ensure that their documentation of a patient's health status is understood by others on the health care team." 4 Each health care provider having access to that record has the same duty to record patient information and ensure that it is safeguarded.[1, 2, 4, 5]

- Quality record keeping allows a physician or reader to follow the conditions presented by the patient through the evolution of a diagnosis and treatment plan and the patient's response to the treatment.[5] The quality of the patient record may be considered a reflection of the quality of patient care. [1, 5]

- In the context of medico-legal concerns the record serves as the legal instrument to provide *"substantive evidence on whether care rendered met the legal standard of care."[1]* "… the courts side with whatever the patient has said ... 'If it's not in the chart, from a legal standpoint, either the procedure didn't happen or the comment wasn't made'."[6]

- The patient record documents the services provided allowing the physician to be properly reimbursed.[1, 2, 4, 5] "It is often the quality of the documentation, rather than the condition of the patient, that determines the amount of care deemed medically necessary by the insurance company or auditors." [7]

- The record should include documentation of informed consent. Any limitations as requested by the patient should also be noted.[1]

- Patient records have also been used to evaluate physicians for the purposes of teaching, research, and to provide data for public health needs.[4, 5]

- The information in the record constitutes the foundation for writing accurate reports to health care providers, 3rd-party-payors, attorneys or any other interested parties. [1, 4]

As many health care systems grow, mature, and interrelate on an ever-increasing basis, the health care record becomes more and more important. "Ultimately, good record keeping is a necessity. It is important to everyone: patient, doctor and staff."[2] Each physician has an ethical, as well as legal, duty [1] to construct these records in such a manner as to be accurate, legible, complete and organized. [1, 3, 4, 6] Finding ways and methods that allow for the most complete compilation of this essential data in a simple and easy manner is a frequent challenge.

There are numerous forms and methods of record keeping available, including standard formats and other organizational systems used throughout healthcare fields.[1] Each doctor may standardize files in the way best suited to each particular practice. SOAP format is recommended.[7] "Good decisions are often the result of accurate and complete facts being retrievable from a patient record." [7, 8]

RECORD KEEPING

> "Each patient shall have exclusive records which shall be sufficiently detailed and legible as to allow any other chiropractic physician to understand the nature of that patient's case and to be able to follow up with the care of that patient if necessary."
>
> "It will be considered unprofessional conduct not to keep complete and accurate records on all patients, including but not limited to case histories, examinations, diagnostic and therapeutic services, treatment plan, instructions in home treatment and supplements, work status information and referral recommendations." Oregon Administrative Rule 811-015-0005(1)

INTERNAL DOCUMENTATION

Patient record
Information contained in the patient file is the foundation of the patient's permanent record. Each page in the patient file shall contain the patient's name and/or ID number [1] The following additional information shall also be included in the patient file/s:

- Patient identification/pertinent demographic information [4, 9-11]
- Patient/case history [4, 9-11]
- Examination findings [4, 9, 10]
- Imaging, laboratory and special study findings [4, 9-11]
- Diagnoses [4, 9-11]
- Treatment plan[4, 9, 10]
- Chart notes [4, 9-11]
- Insurance and billing information [4, 9, 10]
- Consent documentation [4, 9, 10]
- Reports and other correspondence[4, 9, 10]
- Referring physicians [4, 9, 10, 12]

Often, the patient record is stored in a folder. The folder itself may also become part of the record if the practitioner writes patient data on the folder, such as personal information, treatment plan, diagnoses, etc.;[4] however, care should be taken to comply with patient privacy laws (e.g. HIPAA). Outdated portions of the patient record may be removed and stored in an archive file. If this is done, a note should be kept in the active file identifying the location of those records. [4, 9, 10]

Doctor/clinic identification

Basic information identifying the practitioner and/or clinic should appear on each page of documentation. [4, 9, 10] This information should include:

- Practitioner's name and professional degree [4, 10]
- Facility name (if different) [4, 10]
- Street address and mailing address (if different) [4, 10]
- Telephone numbers [4, 10]

Patient identification

The record shall clearly identify each patient. [1, 5, 6] This information is often obtained by using preprinted forms that are completed by the patient and ***may*** include the following:

- Name (prior/other names) [4, 10]
- Date of birth, age [4, 10]
- Gender [4, 10]
- Occupation/employer [4, 10]
- Marital status/spouse's name, occupation [4, 10]
- Name(s) of dependents [4, 10]
- Race [4, 10]
- Address, telephone numbers (home and work) [4, 10]
- Social security number [4, 10]
- Case/file number (when applicable) [4, 10]
- Name of consenting parent or guardian (when applicable) [4, 10]
- Letter of guardianship (when applicable) [4, 10]
- Radiograph/lab identification [4, 10]
- Emergency contact name/number [4, 10]
- Photographs

Patient case history

A detailed case history is an important part of the patient record as it is the foundation of the clinical database for that patient. [4, 10] This information should include an adequate description of the patient's perception of their history. [4, 10] History questionnaires, drawings and other information completed by the patient should be included in the patient record. [4, 10]

Elements of the patient history may include the following:

- Presenting or chief complaint [4, 9, 10]
- Date or time of onset of symptoms [4, 9, 10]
- Description of accident or injury (if applicable) [4, 9]
- Past and present health history [4, 9, 10]
- Family and social history [4, 9, 10]
- Systems review (as appropriate) [4, 9, 10]
- Past and present therapeutic and diagnostic procedures [4, 9, 10]

- Signature of person eliciting history [4, 10]

Examination findings

The results of all examination procedures performed, ordered or requisitioned must be recorded and will become part of the permanent patient record. [4, 9, 10] Objective information is obtained by a physical examination/assessment of the area of complaint and related areas and/or systems. Preprinted and formatted examination forms may be used to facilitate the gathering and recording of this information.[4, 10] Documentation should include the date of the examination and the name or initials of the examining practitioner. [4, 10] If abbreviations are used, a legend should be available. [4, 10]

The examination and diagnostic procedures may include the following:

A. Physical examination

- Vital signs [4, 8, 10]
- Heart, lung and abdomen [8]
- EENT [8]
- Integumentary examination [8]
- Chiropractic, orthopedic and neurological tests [4, 8, 10]
- Static and motion palpation of spine and extremities [8]
- Postural analysis [8]
- Muscle testing including dynamic, isokinetic, static and manual [8]
- Functional examination [13]
- Other

B. Diagnostic Imaging

- Plain film radiography [4, 8, 10]
- MRI [4, 10]
- CT [4, 10]
- Diagnostic ultrasound [4, 10]
- Radionuclide bone scan [8]
- Other

Reports with clinical findings should be reviewed, initialed, and dated upon receipt. [4, 9, 10]

> Regarding radiographic examinations, "The operator shall maintain a record on each exposure of each patient containing the patient's name, the date, the operator's name or initials, the type of exposure and the radiation factors of time, mA, kVp and target film distance, including those exposures resulting in the necessity of repeat exposure for better diagnostic information such as patient motion or poor technical factors" [14]

For computerized and automated systems the recording of technique factors is not necessary as long as the equipment is calibrated and maintained. OAR 333-106-0045 requires the facility to determine the typical patient exposure for their most common radiographic examinations (i.e. technique chart).

"Each film shall be properly identified by date of exposure, location of X-ray department, patient's name or number, patient's age, right or left marker and postural position marker." [14]

C. Laboratory

Results of laboratory exams ordered or performed by the physician may include:

- Complete blood count[4]
- Erythrocyte Sedimentation Rate[4]
- Urinalysis[4]
- Chemistry Screen [4]
- Other

Reports with clinical findings should be reviewed, initialed, and dated upon receipt. [4, 9, 10]

D. Special Examinations

Results of special exams ordered or performed by the physician may include:

- Gynecological examination [8]
- Proctological examination [8]
- Obstetrical examination [8]
- Minor surgical examination [8]
- Electrodiagnostic evaluation [8]
- Vascular evaluation [8]
- Psycho-social assessment
- Testicular
- Other

Reports with clinical findings should be reviewed, initialed, and dated upon receipt. [4, 9, 10]

Clinical impression or diagnosis

Upon the completion and assessment of the patient's history, subjective complaints, and examination findings, the physician arrives at a clinical impression or diagnosis. The clinical impression or diagnosis must be recorded within the record. [4, 10, 15] Since they may change with new clinical information, time and treatment, it is important that the clinical impression or diagnosis be dated.[4, 10] It is not necessary to update this category at each visit, but periodic re-examinations should be performed and the results included in the record along with any change in the clinical impression or diagnosis. [8]

Accurate recording of the patient's condition frequently requires more than one diagnosis. Of particular concern to the chiropractic practitioner is identification of the biomechanical lesion (subluxation/segmental dysfunction). Recording this information documents the spinal region involved and is the basis for the adjustment/manipulation that is emphasized in chiropractic practice. In addition, the pathoanatomic diagnosis gives the location and severity of specific structures damaged and helps to formulate the prognosis for the patient's condition. A patient may have only a pathoanatomical lesion or only a biomechanical (functional) lesion. However, the biomechanical lesion is most often linked to a pathoanatomical condition. [16]

Components of the clinical impression/diagnosis may include:

- Phase of lesion [8] (e.g. acute, subacute, chronic, acute recurrent, chronic recurrent)
- Severity [4, 8] (e.g. mild, moderate, severe, Grade I, II, III)
- Mechanism of lesion [8] (e.g. traumatic, postural, overuse, hyperextension, torsional)
- Location [4, 8] (e.g. spinal level, muscle, ligament, neurological structures)
- Type of lesion (e.g. sprain, strain, subluxation, myofascitis, DJD)
- Neurological involvement (e.g. nerve root involvement, distribution, site of nerve root or cord compression/irritation)
- Complicating/associated factors [4, 8] (e.g. neurological involvement, DJD, stenosis)
- Resulting anatomical damage or syndrome (e.g. cervicogenic headache, facet syndrome)
- Concomitant pathological diagnoses [4] (e.g. COPD, neoplasm, CHF, HTN)

Treatment plan

The treatment plan is the portion of the patient record that deals with the proposed action by either the treating physician or the patient.[17] The plan arises from the accumulation of clinical data and the initial clinical impression or diagnosis.[4, 10] The treatment plan must be recorded in the patient file.

The treatment plan should include, when applicable:

- The prescribed therapeutic treatment plan (including modes, frequency and duration of care) [4, 10, 17]
- Additional diagnostic testing recommended or being considered [4, 10]
- Reassessment schedule [4, 10]
- Patient education and self-care plan [4, 10, 17]
- Referrals or consultations [4, 10, 17]
- Goals and outcome measures

Chart/progress notes

"Every page of chart notes will identify the patient by name, and the clinic of origin by name and address. Each entry will be identified by day, month, year, provider of service and author of the record."[3] Oregon Administrative Rule 811-015-0005(1)(b)

Chart notes (often referred to as progress notes) are made in a patient's chart to record the patient's state of health, what transpired during patient visits as well as any significant changes in the clinical picture, assessment or treatment plan.[4, 8, 10] Chart notes should document the patient's response to the physician's management of their case. All record should be made in a systematic and organized manner [4, 8, 10] The record shall be legible and clear enough to allow a peer to assume management of the case after an initial review of the chart notes.[1, 8]

Since the 1970s the classic format has been known as "S.O.A.P." notes.[17] S.O.A.P. is an acronym for Subjective, Objective, Assessment, and Plan or Procedures.[7] This pertinent clinical information can be organized in the SOAP format in a variety of ways. While full S.O.A.P. charting at each visit is strongly recommended, it is not required. Components of the record should include: [8]

Subjective complaints: These should be in the patient's own words when possible, indicating improvement, worsening or no change. [8]

Objective findings: Changes in the clinical signs of a condition should be noted at each visit in the doctor's own words. [8]

Assessment or diagnosis: It is not necessary to update this category at each visit. However, periodic clinical reevaluations should be performed and these results included in the daily entries with any modification of the diagnosis. [18]

Plan of Management: A provisional plan of management should be recorded initially and further entries made as this plan is modified and/or as a patient enters a new phase of treatment. Changes in procedures should be noted. [18] Daily recording of procedures performed should include adjustment/manipulation performed (for example, direction and force of the thrust), soft tissue techniques, modalities used (including time, location and intensity), exercises prescribed, nutritional supplementation or prescribed diet and activity instructions or advice. Any significant adverse response to therapies should be noted. [18]

Financial records

Financial records may be kept in the patient record and may include the following:

- Patient account ledgers (including date and type of services billed, payments received and from which source, account balance) [4, 15]
- Billing statements [4]
- Insurance records (explanation of benefits, proof of payment, etc.) [4]

Internal memoranda regarding patient

Internal memoranda regarding individual patients should be kept in the patient record and may include the following:

- Intra-office staff messages [4]
- Phone messages and/or summaries of phone conversations [4]
- Copies of emails sent/received [4]
- Copies of sign-in sheets [4]

Any correspondence sent out of the treating practitioner's office should contain the doctor and clinic name and address, phone number and current date. [19]

Electronic records

The computerization of the medical record has accelerated rapidly in recent years. The use of electronic or computer-assisted record keeping systems is becoming more common in chiropractic offices. These systems may include computer-assisted writing, voice recognition or other developing technologies. [17] Some systems accept input not only from the computer keyboard, but from touch screens, light pens, scanners and other input devices. [17] If an electronic record-keeping system is used, the provider needs to take reasonable steps to ensure the system is so designed and operated that the record is secure from loss, tampering, interference or unauthorized use or access and complies with all state and federal confidentiality regulations.

EXTERNAL DOCUMENTATION

External documentation includes relevant information received from an outside source and may include correspondence from numerous sources: referring physicians, other previous/concurrent practitioners, attorneys, various pay groups, consultative reports, diagnostic studies, etc. The original of each of those relevant external documents, if available, should be kept in that patient's record. [4, 10, 19]

Any external clinical documents such as reports or diagnostic studies should be initialed, dated and included in the patient's file. This notation provides evidence that the document has been read by the doctor. [1, 3]

CHART/FILE ORGANIZATION

General

Records should be entered in the sequence events took place, and kept in chronological order.[4] Records should be neat, legible, organized and complete, and recorded in dark ink or other permanently retrievable method within 24 hours of occurrence. [1, 4, 9, 20] The record should never be backdated, erased, deleted or altered in any way. [4, 21] If corrections need to be made, a line should be drawn through the error and the change initialed and dated.[4, 15] If records are kept electronically, amendments should be made in such a way that preserves the original record. Records must be complete enough to provide the practitioner with enough information for subsequent care or reporting to outside parties. [4]

Preprinted Forms

Forms may be used based on the practitioner's discretion. Forms provide an orderly means of obtaining the history, noting examination findings and charting progress.[4] If preprinted forms are used, they should include appropriate doctor/clinic identification.[6, 22]If part of a form does not apply to a practitioner's practice, the section should be deleted and the form reprinted.[23]

Abbreviations/Symbols

"Recordable abbreviations and terminology should be internally consistent and a key for these abbreviations must be available." [9] All records sent to a third party should be accompanied by a legend of codes or abbreviations used.[1, 6, 20, 23]

MAINTENANCE OF RECORDS

Oregon Administrative Rules
Records
811-015-0005 (1) It will be considered unprofessional conduct not to keep complete and accurate records on all patients, including but not limited to case histories, examinations, diagnostic and therapeutic services, treatment plan, instructions in home treatment and supplements, work status information and referral recommendations.

811-015-0005 (3) A patient's records shall be kept by the Chiropractic physician a minimum of seven years. If the patient is a minor, the records shall be kept seven years or until the patient is 18 years of age, whichever is longer.[24]

Disclosure of Records
811-015-0006 (1) A Chiropractic physician shall make available within a reasonable time to a patient or a third party upon the patient's written request, copies or summaries of medical records and originals or copies of the patient's X-rays.

(a) The medical records do not necessarily include the personal office notes of the Chiropractic physician or personal communications between a referring and consulting physician relating to the patient.

(b) The Chiropractic physician shall preserve a patient's medical records from disclosure and will release them only on a patient's written consent stating to whom the records are being released or as required by State and Federal law.

(2) The Chiropractic physician may establish a reasonable charge to the patient for the costs incurred in providing the patient with copies of any portion of the medical records. A patient shall not be denied summaries or copies of his/her medical records or X-rays because of inability to pay or financial indebtedness to the Chiropractic physician.[25]

Confidentiality
All patient/doctor communications and interactions are privileged and confidential. This is an ethical responsibility as well as a statutory and/or regulatory one. [4, 10, 15] All information regarding a patient must be kept confidential unless its release is authorized by the patient or is compelled by law.

Assurance of confidentiality is necessary if patients are to be open and forthright with the practitioner. Patients have the right to expect that information regarding their health will remain private and secure from public scrutiny.[4, 10, 26]The unauthorized disclosure of patient records by a physician may create legal liability unless the disclosure is to an authorized source, authorized by law, or justified by a superior public interest.[27] A patient who is injured by disclosure of his or her confidential information may pursue legal remedies against the providers not only for breach of privacy, but also for breach of implied contract of confidentiality, malpractice and/or infliction of emotional distress.[26]

The doctor is responsible for staff actions regarding record keeping. Any employee involved in the preparation, organization, filing, or discussion of records should fully understand professional and legal requirements, including the rules of confidentiality. [4, 10, 28]

Records Retention and Retrieval
Health records should be retained in a way that facilitates retrieval. To the extent possible, they should be kept in a centralized location. In most circumstances, recent records are maintained on premises either as

hard copy or electronically. After a period of time they can be archived, microfilmed or microfiched and placed in storage.[4, 10] While there are administrative rules governing the length of time that records must be kept, from a patient and risk management perspective, it is desirable for all records to be retained indefinitely by the physician. [26],[29]

If a chiropractic office closes or changes ownership, secure retention of the health care record must be ensured. Arrangements should be made through wills or estate plans for the orderly transfer of patient records to another doctor or to a special administrator or caretaker of the records.[22] If health records are to be destroyed, they must be disposed of in a manner protective of patient confidentiality.

Administrative Records

Administrative records are primarily those relating to the non-clinical side of practice, and may include telephone logs, schedules and appointment records, patient personal information, insurance forms and billing documents. These records can be kept separately from the patient file, but they must be maintained in a legible and retrievable form. [4, 10]

Records Transfer

It is mandatory that health care data requested by another provider currently treating a present or former patient be forwarded upon receipt of an appropriate request and patient consent.[4, 9, 10] When responding to a request for patient records, determine whether all or only part of the record is requested. If the nature of the request is not clear, an inquiry to the person making the request will usually clear up what material is required. A subpoena asking for "all medical records pertaining to the care and treatment of 'patient x' between January and June 1995" means that the physician is to produce all medical records for 'patient x' between those dates regardless of the source. A request for "all records documenting your care and treatment of 'patient x' means all records of the physician's own care, not someone else's. [30]

Electronic Records

When records are kept electronically, they must be protected by proper back-up, firewall and confidentiality/security procedures. Increased use of electronic mail, the Internet and remote access creates new opportunities for tampering. This may result in errors of data identification, authentication, availability, and integrity. Availability refers to the ability of an authorized user to access the medical information. Integrity describes the system's capability to prevent outsiders and/or unauthorized insiders from altering data and unauthorized access.

The federal laws that are most relevant to electronic communications include the Electronic Communications Privacy Act of 1986 (ECPA), 18 U.S.C. 2510 et seq., and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d. HIPAA requires health care providers and health plans to "maintain reasonable and appropriate administrative, technical and physical safeguards (a) to ensure confidentiality of the information, and (b) protect against (i) threats or hazards to the security of the information; and (ii) unauthorized uses or disclosures of this information." [28]

Chiropractic Records Ownership Management and Responsibility

The content of the medical record is owned by the patient; however, the physician has the obligation to maintain the record intact for the use of the patient and to copy it upon request.[30] Upon receipt of a properly executed release of records request, a chiropractic physician shall make available copies or summaries of medical records to the patient or third party within a reasonable time.[25] Although Oregon Law allows release of records under certain circumstances without patient approval,[31] it is strongly recommended prior to release of any records, a properly executed authorization be in place for the full protection of the patient and physician.

When a practice is closed, sold or there is a transfer of ownership, secure retention of the records must be ensured.[4] If a single physician's office is closed, that physician remains responsible for maintenance of records for a minimum period of time, i.e. for adults seven years or for a minor patient, seven years or to the age of 18 whichever is longer.[24] In the case of a group practice closure, the issue of record keeping/maintenance may be dealt with by a contractual agreement.[32] File transfers resulting from the sale/purchase of a practice must follow statute, regulations and policies to ascertain whether a patient authorization is required at the time of the file transfer.[32] If the seller does not keep a copy of the files, the contract/agreement covering the transaction should impose an obligation upon the purchaser to maintain the records and allow access to them by the seller in order to satisfy their professional obligations.[32]

Management of healthcare records in a single physician's office is a relatively straightforward situation where that physician is responsible for all aspects of records management. A more complex set of circumstances occurs when considering records management within the context of a multiple physician/group practice where dissolution, sale, closure or other change is taking place. Many of the potential difficulties with respect to maintenance of records in this type of situation can be avoided with proper contractual arrangements established at the outset of the relationship.[32] Contracts should anticipate the necessity for providing the physician with copies and should establish whose duty it is to provide and pay for duplication.[30] If physicians choose not to retain copies, a release should be obtained from each patient involved guaranteeing access to the records in the future, should the need arise.[30] Keeping a copy of all records after dissolution of a contractual relationship is expensive but vital.[30]

Virtually all state disciplinary actions and malpractice suits turn on the content of the record.[30] The physician who does not maintain custody is at the mercy of the others who may lose, alter or attempt to deny access to records essential to their own defense.[30] Perhaps the best way for the physician to ensure access to the records (e.g. employment contracts, managed care groups, nursing homes, etc.) is to have the patient sign a release (preferably at the initial visit) entitling the physician to obtain complete copies of any medical records containing information related to that physician's care of the patient.[30]

Within the context of a physician leaving a practice, the dissolution of a group practice, or an associate physician arrangement, there are several different scenarios that require further discussion with respect to records management.

- If a patient has been seen by more than one physician, the original file or a copy should be maintained at the clinic.[32]
- If the original file is removed, a signed, dated authorization form should be received from the patient directing that file be provided to a specific practitioner. [32]
- If the patient has been seen only by the remaining physician/s, a copy may be provided to the departing physician with a signed, dated authorization form. [32]
- If the patient has been seen only by the departing physician/s, no consent form is necessary to remove the file unless the file was opened in the name of a group practice or there is a separate agreement stating all records are the property of the clinic. [32] In this case, a copy or the original should be maintained at the clinic and a written authorization for transfer of records out of the facility is required. [32]

- With respect to files where radiographs are involved, due to the costly nature of reproduction, the original films should be kept as part of the original file. [32]

When a practice facility changes status, e.g. purchase/sale, dissolution of a contractual relationship, etc. the most vital concerns with respect to records management are maintenance of privacy/confidentiality and ensuring intact records are readily accessible for the benefit of the patient/s healthcare. In a multi-physician/group practice, an explicit contract defining the responsibilities of all parties involved is a critical component of ensuring proper maintenance of records.

PATIENT CONSENTS

Informed consent must be recorded for evaluation and treatment, treating a minor, obtaining or releasing health records, taking and releasing photos or videos, participation in research or inclusion in publication.[12] The original of any signed written form regarding these consent issues belongs in the patient file.

While legal experts are strong advocates of written consent forms, [4], [10] doctors are reminded that forms may not provide full protection against lawsuits.[33] [17] Whether written or verbal, informed consent for evaluation and treatment should include a discussion with the patient and should be documented as a PARQ conference. For further discussion of informed consent including the PAR/PARQ notation, refer to the Patient/Doctor Relationship Chapter.

Written forms for the release or procurement of health records are required. Written forms for permission to treat a minor are recommended. [17, 34] If a second doctor observes and/or treats the patient, a second consent is necessary. [33]

MALPRACTICE TIPS

Today's practice environment requires careful documentation of patient care. [35] The patient as a plaintiff has the burden of proving that a health care professional has acted negligently.[36] **The most useful factor defending against an accusation of malpractice is the record,**[6] and risk-management is the best line of defense. [6, 36] Patient records allow the professional to show that *proper* rather than negligent care was provided. [36], [23]

The legal definition of malpractice includes four criteria:[6]

1) There must be a duty between the two parties, i.e. a patient/doctor relationship.[3]
2) There must be a breach of that duty, i.e. something wrong has to have occurred between the two parties.[3]
   (Note: Anger toward the doctor is the most frequent instigating factor.[6])
3) Harm or injury must result from that breach of duty. [6]
4) There has to be 'proximate cause', i.e. a relationship in time between the breach and the injury. [6]

If a lawsuit occurs and the patient file (including all billings[6]) cannot be provided or is incomplete, inaccurate or illegible [23], the doctor could be found liable even though not at fault. [6] If documents

are lost and not included or billings are not provided (even though the doctor may have not known they needed to be included), the doctor's credibility may be compromised.)

In the event a potential malpractice situation actually does occur, the chiropractic physician should stay calm and act responsibly. The physician should avoid repeating the procedure, monitor the patient, follow any risk-management procedures as outlined by your insurance company and document the incident. The chiropractic physician should contact legal counsel prior to meeting with the plaintiff(s) and/or their attorneys. [6]

The following is a list of suggestions, habits and/or *risk-management techniques* that create good patient records:

- Stay within licensure boundaries.[22]
  - (See the Chapter 811 Oregon Administrative Rules for those details.)

- Explain procedures and treatments as care proceeds. [6]
  - This treatment narration aids in building rapport with the patient which has been shown to be one of the best defenses against anger and/or malpractice behaviors. [6]

- Make accurate statements about the prognosis. [6]
  - Avoid exaggeration of what may be achieved from the treatment[6]

- Records should not be edited or altered even for the most innocent reason [35], [36], [37]
  - Refuse a request to "change" a record.[22]
  - Deliberately changing or altering a record can be considered a fraudulent action.[35]
  - Most malpractice carriers have a clause which voids coverage in the case of hiding any important information, misleading, attempting to defraud or lying.

- If asked to not make a record, consider the legal obligations.
  - Failure to comply with these obligations may result in severe penalties. [6]
  - Explore the motive behind the request (the wish to not weaken one's battle in court, to avoid stigma for political or other reasons, celebrity status, a concern about possible embarrassment, paranoia, abuse[22]).
  - Suggestions for refuting the request without offending the patient include
    1) acknowledge and gently allay concerns,
    2) explain the need to keep a record,
    3) describe your confidentiality procedures (e.g. the HIPAA protections),
    4) negotiate some acceptable form of recording and/or write only the minimum needed to convey reasonable care has been delivered,
    5) consider refusing the case.[22]

- Correct errors with a line, signature or initials, and date it [1], [23],,[30], [38]
  - Avoid obliteration of any entry [39]
  - Learn to think: "The first draft is the final product"[1]

- Use the SOAP or equivalent format for office notes and progress notes. [1], [6], [23] Have patient's name, chart number (if used), doctor/clinic identification on every page of chart notes. [1], [40], [39]

- Date and sign/initial every entry. [1], [6, 39]
- Write legibly [35],[23],[1] in dark ink; [1],[39]
- Use standard abbreviations; [1], [6], [23] [39]
- Use the patient's own words to describe how they are feeling; [6]
- Make an assessment about the patient's progress; [6]
- Avoid signing/initialing any entry not written by you.[1]
- Have staff sign their own entries, then the chiropractic physician may countersign the entries; [39]
- Make a habit of charting upon occurrence to avoid omissions. [30] Make your entries within 24 hours of contact; [1],[30]
- Chart the procedures and/or treatments that occurred during that date of service, including any recommended home treatments; [6]
- Avoid blank spaces between dates of service; [1], [39]
- Computer-generated and written chart notes must be sufficiently individualized to accurately reflect the clinical findings at each visit;
- Record patient's relevant family, marital, and job stresses;[1],[39]
- Proof read *and initial* dictated records; [6],[23]
- Attempt to document every patient contact [30] such at telephone calls, emails, etc. [6],[23],[39]

- Record a full and complete history and physical examination. [23], [37] Make a diagnosis only after an appropriate physical examination. [6]
  - Record the relevant facts accurately [1], [35], [37]
  - Chart the negative as well as the positive.[39] Avoid exaggeration or making the patient sound worse than he/she is. [39]
  - Use objective, non-judgmental, language. [1], [6], [23], [39]
  - Write an opinion supported by the relevant facts.[35] Include your recommendation for follow-up and [23, 39] include any prescription(s) given [1], [6]

- Avoid recording derogatory, trivial or loose comments about or from patients and/or other health care professionals. [1], [35], [39] Avoid egotistical remarks. [39]

- Document all procedures or treatments recommended by the doctor and refused by the patient, including any non-compliance of treatment recommended by other health care professionals. [1], [23],[37],[39]

- Chart important events or adverse reactions conspicuously, rather than burying them in the record. [39]

- Consider including a written informed consent in the file [1, 6, 23]
  - Oregon Administrative Rules do not *require* this document, but many legal sources recommend the use of a form. *(Read 'Informed Consent' in the Patient/Doctor Relationship chapter of this volume.)*
  - Whether a form is used or not, include a notation documenting your consent discussion with the patient.[39]

- Tailor forms to your individual office. [37]

- Respond to each Request for Records, releasing only the information specifically requested. [30]
  - *Before releasing any records, be certain to meet compliance with state and federal privacy guidelines.* [35]

- Retain all original records. [37]

- Records should be kept according OAR 811-015-0005.
  - The rule states " …a minimum of 7 years. If the patient is a minor, the records shall be kept seven years or until the patient is 18, whichever is longer" [24]
  - Protect patient confidentiality (refer to Section III - HIPAA).[35]

Implement a system to ensure that important patient information can be located and is easily accessible. [23]

HIPAA - Health Insurance Portability and Accountability Act of 1996

The following material is a summary of Federal Law.

With the advent and extensive use of electronic media in the health care realm, there is a greater possibility of widespread dissemination and abuse of a patient's Protected Health Information (PHI). "Protected Health Information means individually identifiable health information created, maintained or in the possession of our practice relating to the past, present or future physical or mental health of any individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual." [41] Even if the information provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information. [42]

In August 1996 the Health Insurance Portability and Accountability Act (HIPAA) bill was passed giving the Federal Government the ability to regulate how covered entities (health care plans, providers, and clearing houses) use, store, disclose and transmit Protected Health Information.

Prior to the passage of HIPAA there were no national or industry standards mandating or regulating the privacy and confidentiality of a patient's PHI. Individual states had a variety of rulings related to patient privacy and disclosure of PHI that were very often disjointed and incomplete. HIPAA provides national standards for the protection and security of one's PHI, while improving the efficacy of healthcare provision by providing standards for transmitting patient's financial information to which all covered entities must adhere. The Privacy Rule holds violators accountable by imposing civil and criminal penalties

HIPAA generally encompasses two rules- The Privacy Rule and the Security Standard. The Privacy Rule, (Standards for Privacy of Individually Identifiable Health Information), regulates the use and disclosure of PHI and encompasses three essential purposes. The first purpose is to protect the rights of patients by providing them access to their PHI and the ability to control the use and disclosure of it. The second purpose is to restore public trust in the healthcare delivery system, and the third is to improve the efficiency and effectiveness of healthcare delivery in the US by creating a national framework of healthcare privacy. [43]

The Privacy Rule provides the first national standards for protecting the privacy of health information. It mandates how covered entities (healthcare plans, providers, and clearing houses) use, store, disclose, and transmit PHI. It sets boundaries on the use and disclosure of medical records, by requiring safeguards that most healthcare entities must provide to protect the privacy of health information. It encompasses the practitioner's use of the patients' PHI within their office or health care setting and the disclosure of PHI outside of the office setting. It states that protected health information can only be used and disclosed for treatment, payment, or healthcare operations without a patient authorization. Any other uses require a patient authorization prior to the PHI being released. The rule also generally limits the release of information to the minimum necessary for the purpose of the disclosure so that irrelevant information is not released unnecessarily. This limitation of only releasing the minimum necessary information does not apply when the PHI is disclosed to another practitioner for direct treatment purposes. The rules make allowances with public health responsibilities as well to allow the collection of information used to prevent or control disease, injury, disability, including public health surveillance, investigation and intervention. The HIPAA limitations do not apply to information that is de-identified so that the patient can not be connected with their PHI. The following is a table listing what is considered identifiable information:

Identifiable Information

1. Name
2. Any address specification such as street, city, county, precinct, and zip code
3. All dates except for the year including birthdates, admission date, discharge date, date of death and all ages over 89
4. Telephone number
5. Fax number
6. Electronic mail address
7. Social Security number
8. Medical record number
9. Health plan beneficiary number
10. Account number maintained by the healthcare provider
11. Certificate or license number such as driver's license number
12. Vehicle identifier and serial number including license plate number
13. Medical device identifier and serial number such as pace maker serial number
14. Web site address
15. Internet protocol (IP) address number
16. Biometric identifier including finger and voice prints
17. Full face photographic images and any comparable image, and
18. Any other unique identifying number characteristic or code

Table courtesy of HIPAA Privacy Manual A how-to Guide for Your Medical Practice 2nd Edition. Developed by Gates, Moore & Co. for The American College of Obstetricians and Gynecologists. 2002

Beyond limiting the practitioner's ability to use or disclose PHI without a patient's authorization, the Privacy Rule empowers patients to have more control over their health information. The first step in providing the patient with more control is the mandatory requirement of each health care provider to provide the patient with a copy of the "Notice of Privacy Practices." If the initial contact with a patient is electronic, then an electronic copy of the Notice of Privacy Practices must be provided at that time. The Notice of Privacy Practices outlines the patient's rights to privacy and how personal health information will be routinely used for treatment, payment and healthcare operations within the healthcare setting. The provider must also obtain a written acknowledgment from the patient that a copy of the notice was received. [44]

Release of PHI for purposes other than treatment, payment or healthcare operations requires a signed authorization from the patient. This allows patients to make informed choices about how their individual health information may be used and/or disclosed. The HIPAA privacy rules go beyond requiring an authorization for release of information by requiring tracking what disclosures of PHI have been made. This enables patients to find out how their health information has been used or released. The patient also has the right to obtain a copy of their medical record and can review and correct or amend the PHI. There must be policies and procedures in place for patient review, correction or amendment of their PHI. The provider is not required to change medical records at the request of the patient, but they should be able to link the amended information to the original chart. Corrections or amendments to the health record requested by the patient can only be made with their physician's approval.

To assure that the HIPAA privacy rules are enforced, health care providers are required to designate a privacy officer within the clinic. This person is responsible for implementing the privacy rules. There should also be a designated contact person, who may be the same individual, to receive complaints and provide information to the public related to the privacy policies. The final piece of the privacy rules relates to the need for staff education related to patient privacy and their responsibilities to comply with the HIPAA regulations. There should be documented education with all staff and appropriate policies and procedures in place to demonstrate that the office is doing their due diligence in assuring that the patient's privacy is maintained. The office should also look at their routine operations and make a concerted effort to minimize the chance for inadvertent disclosure of PHI due to processes in place such as leaving patient records in plain sight at the receptionist's desk or having computer screens with PHI easily visible in areas where patients are present.

The other rule HIPAA encompasses is the Security Rule which is composed of two major standards; the security standard and the electronic signature standard [45]

The Security Standard requires a secure electronic environment in which a covered entity would maintain, store, or transmit all PHI. The rule defines and requires a secure electronic environment as; an environment with physical, procedural, technical and administrative procedures, services, and mechanisms.

What is a Secure Electronic Environment? A **Secure Electronic Environment** is an environment that has administrative procedures, physical safeguard and technical security services and mechanisms in place. It also includes the implementation of an electronic signature standard if the practice uses an electronic signature. **Administrative Procedures** are formal, documented practices to protect PHI. This includes the selection and execution of security measures and the management of personnel as it relates to protecting PHI. **Physical Safeguards** are procedures to protect computer systems, buildings and other equipment from fire and other natural and environmental hazards, as well as from intrusion. **Technical Security Services** are processes that are implemented to control and monitor access to PHI such as passwords. **Technical Security Mechanisms** are processes implemented to prevent unauthorized access to data that is transmitted over a communications network (Internet, Intranet, fax machine, etc.)

Table courtesy of HIPAA Privacy Manual A how-to Guide for Your Medical Practice 2nd Edition. Developed by Gates, Moore & Co. for The American College of Obstetricians and Gynecologists. 2002

The Electronic Signature Standard

An electronic signature is a data component that is incorporated into an electronic document for the purpose of uniquely identifying the signer. Practices are not required to use electronic signatures, however if a provider uses electronic signatures, then the Security Standard Rule requires that HIPAA signature standards be used to verify the identity of the message sender, or the signer of a document. [46]

With the implementation of HIPAA regulation, the government has imposed national rules and standards that will greatly improve the security of a patient's protected health information, while giving them more control over where and how it can be used. Securing and standardizing the electronic environment will greatly expedite and secure the transfer of data and Protected Health Information.

STANDARDS

1. The content of the medical record is owned by the patient; however, the physician has the obligation to maintain the record intact for the use of the patient and to copy it upon request.[30]

2. Upon receipt of a properly executed release of records request, a chiropractic physician shall make available copies or summaries of medical records to the patient or third party within a reasonable time.[25]

3. Clinicians must ensure that their documentation of a patient's health status is understandable by others on the health care team. [4]

4. The patient record must include documentation of informed consent.

5. Whether written or verbal, informed consent for evaluation and treatment should include a discussion with the patient and should be documented as a PARQ conference.

6. Recordable abbreviations and terminology should be internally consistent and a key for these abbreviations must be available upon request.[9]

7. The record should never be backdated, erased, deleted or altered in any way.[4,21] If corrections need to be made, a line should be drawn through the error and the change initialed and dated.[4,15] If records are kept electronically, amendments should be made in such a way that preserves the original record.

8. All information regarding a patient must be kept confidential unless its release is authorized by the patient or is compelled by law.

9. The doctor is responsible for staff actions regarding record keeping. Any employee involved in the preparation, organization, filing, or discussion of records should fully understand professional and legal requirements, including the rules of confidentiality.[4,10,28]

10. If a chiropractic office closes or changes ownership, secure retention of the health care record must be ensured.[4]

11. When records are kept electronically, they must be protected by proper back-up, firewall and confidentiality/security procedures.

12. Reports with clinical findings received from external sources should be reviewed, initialed, and dated upon receipt.[4,9,10]

13. The clinical impression or diagnosis must be recorded within the record.[4,10,15] When more than one diagnosis is made (for example, biomechanical assessment and pathoanatomic diagnosis), these must be differentiated and recorded.[14]

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