

Guideline G-004  
Quality Assurance Committee  
Approved by Council: February 8, 2011

*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 patients receive optimum, quality care at all times.

**Quality Care vs. Patient Care**

The importance of quality care versus quantity of patient is a key issue. It is imperative that sufficient time be allotted on each patient visit to allow for appropriate care and the recording of detailed, individualized and personalized notes in the patient health record. The provision of adequate scheduled appointment time not only allows for documentation but more importantly, provides time for the appropriate examination and delivery of a therapeutically necessary intervention.

The frequency and length of visits is determined to a large degree by the health care provider. With proper outcome measures, monitoring and continuous reassessment of progress of the patient the issue of time becomes less significant.

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 concerns. However, it is not expected that all patients will always be able to read and understand their health records.

Patient health records may contain abbreviations and terminology unique to health care professions. In such cases, it is expected that an abbreviation legend/key accompany the patient health record.

CCO does not endorse any particular type, template or style of note taking. Information should be stated concisely. It is acceptable to use sentence fragments or outline form.

Whatever style is used, it is important to be consistent, comprehensive, accurate and legible. Members are advised that a clinical entry is required for every visit and all notes must provide sufficient detail to give a clear picture of the treatment, its effectiveness and overall progress.

The following is an illustration of the pattern of the care being provided:

Macroscopic Version		Microscopic Version		
Initial Visit <i>(as per Record Keeping Standard)</i>		Subsequent Visit		Example
History	→ →	Subjective	→ →	Walks Better
Examination	→ →	Objective	→ →	ROM (range of motion)
Diagnosis	→	Assessment	→ →	↑ T 12 ant, L s/i
Plan of Management		Plan	→ →	1 Week (next visit)

Responsible monitoring of the patient is the key. Once the patient has reached maximum therapeutic benefit, then change in treatment plan or referral may be necessary. Other options may include:

- Supportive care, defined as "treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain this benefit and progressively deteriorate when there are periodic trials of withdrawal of treatment" ; and
- Elective care, defined as therapeutically necessary maintenance, and preventative care that is discretionary.

**Electronic Records**

2 The records must contain the story of the patient. While there is some debate about the preferred format of electronic records (e.g., template-based records vs. voice dictation-based records), an electronic format will be adequate if it can capture all the pertinent personal health information, and allows the user to centralize the essentials of the patient's story on several screens. If the format cannot do this, the chiropractor should consider using an alternative system.

It is recognized that there are some limitations of electronic records at the time of writing this policy. In many cases, the printable version of the electronic record does not readily enable a reviewer to understand the whole patient record and is, therefore, of limited use. Furthermore, some of the systems do not readily allow the chiropractor to capture nuances of the patient encounter. Members using such systems must ensure that each record entry captures the unique aspects of that particular patient encounter. Members are discouraged from using systems that create "template-like" records. These may not be an adequate reflection of an individual patient's story.

CCO is aware that this is a developing area and that there is great potential for electronic record keeping to enhance the practice of chiropractic.

Members have an obligation to provide printed copies of electronic records when asked to do so. To ensure they can be understood, some members 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.

### Frequency and Justification of X-ray Examination

Diagnostic x-ray examination offers many benefits, but also has certain risks. Clinical indication is required for diagnostic x-rays to be performed. The Ontario Provincial Government has guidelines addressing issues of the potentially harmful biologic effects of ionising radiation. The *Healing Arts Radiation Protection Act* also imposes requirements for the ordering, taking and interpreting of x-rays.

This guideline should be read in conjunction with CCO's record keeping standard of practice, which requires the patient health record to contain "reasonable information about every initial examination, assessment and reassessment, all relevant diagnostic tests and all relevant diagnostic imaging (images and accompanying reports included) made by the member." [see paragraph 4(3)]