Approved by Council: February 2009

Self-Assessment
Handbook

Improving and Maintaining Clinical Proficiency

College of Chiropractors of Ontario

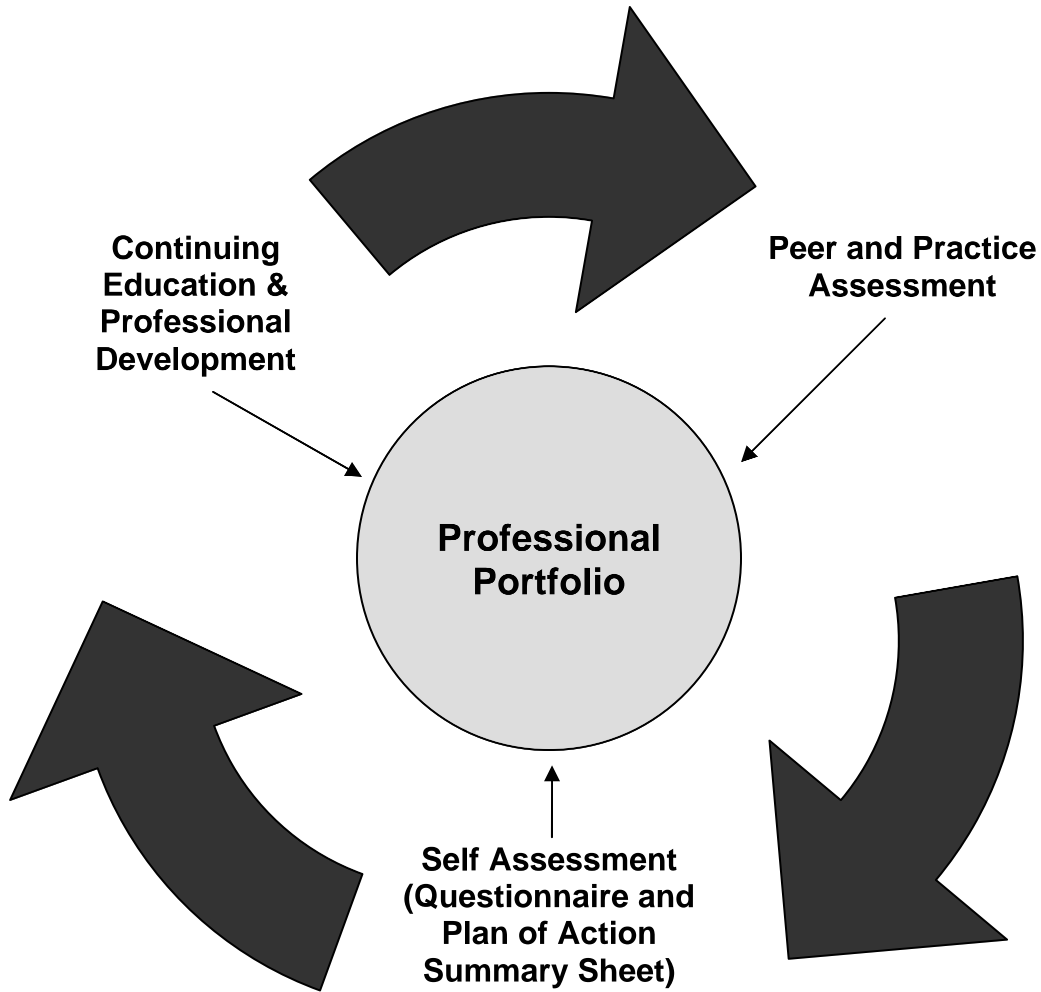
L'Ordre des Chiropraticiens de l'Ontario

130 Bloor St. W.
Suite 902
Toronto, Ontario
M5S 1N5

Tel.: 416-922-6355
Fax: 416-925-9610
E-mail: cco.info@cco.on.ca
www.cco.on.ca

INTEGRATION

The following diagram illustrates the integration of the self assessment and continuing education initiatives of the Quality Assurance Committee.



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BACKGROUND AND LEGISLATIVE CONTEXT

The statutory mandate of the College of Chiropractors of Ontario (CCO) under the *Regulated Health Professions Act, 1991* (*RHPA*) is to regulate chiropractic in the public interest. CCO views continuing education and professional development as an important step in ensuring the people of Ontario receive competent and ethical chiropractic care. In addition, continuing education and self assessment is consistent with the legislative requirements of the *RHPA*.

On becoming registered with CCO, members have the right to call themselves chiropractors and to practise chiropractic within the scope of practice identified in the *Chiropractic Act, 1991*. In assuming the right to practise, members also assume the responsibilities associated with this right, including the responsibility to maintain competence. Members are accountable for their own practice and for implementing professional development activities based on assessed learning needs.

At the same time, the public must feel confident that members, who demonstrated entry-level competencies when they received their initial registration, continue to be competent for as long as they are in practice. Further, the public should reasonably expect some level of consistency of experience, such as a thorough history, pertinent examination, diagnosis/clinical impression, plan of care, and outcome evaluations.

REVISIONS TO THE *RHPA*

The provincial government introduced revisions to the *RHPA* in June 2007, which went into effect on June 4, 2009. Amendments include revisions to the Quality Assurance program of all colleges regulated by the *RHPA*. The Quality Assurance Committee's statutory responsibility is reflected in Section 80 (1) of the *Health Professions Procedural Code* (*Code*), schedule 2 of the *RHPA,* which reads as follows:

80.1 A quality assurance program prescribed under section 80 shall include,

(a) continuing education or professional development designed to,

(i) promote continuing competence and continuing quality improvement among the members,
(ii) address changes in practice environments, and
(iii) incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues in the discretion of the Council;

(b) self, peer and practice assessments; and

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(c) a mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program.

SELF ASSESSMENT

Self assessment consists of two sections – a self-reflective questionnaire and a plan of action summary sheet.

The self-assessment questionnaire is designed to help members reflect on their current professional proficiency, identify areas of strength and areas for improvement, and develop a learning plan that will address those areas that need improvement. Members must complete the self assessment process once every two years, as determined by CCO.

Members will not be required to submit their self-assessment questionnaire to CCO. It is for their personal review only.

Once a member has completed the self-assessment questionnaire and has identified areas that need improvement, the member should transfer the information to the self-assessment plan of action summary sheet. Using this summary sheet, the member will develop a learning plan to guide his/her CE and professional development. The plan of action summary sheet is a component of the member's professional portfolio. It will be reviewed by a peer assessor during the member's peer and practice assessment to monitor his/her compliance with the self-assessment process.

Please review this handbook when completing the self assessment. It will provide you with important information that explains the clinical relevance and professional standards associated with each response.

Please refer to CCO's web site (www.cco.on.ca) for all relevant regulations, standards of practice, policies and guidelines. Government legislation is posted on www.e-laws.gov.on.ca/index.html. In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

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GUIDE TO COMPLETING THE SELF-ASSESSMENT QUESTIONNAIRE

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I Doctor-Patient Interaction

1. History Taking

It is useful to divide the patient interview or history-taking process into two components: those questions that ask about what prompted the patient to attend your office (the 'problem') and general information about the patient (the 'person').

With respect to the 'problem', questions listed should be asked during patient interviews. Each question can provide valuable information. It is also important to ask these questions from a clinical perspective (information gathered to reach a diagnosis/clinical impression in order to develop a reasonable care plan) rather than a purely technical perspective (simply asking each question). It should be remembered that 80 per cent of all relevant information germane to the patient's problem/concern is gathered during the interview.

For example, simply asking the patient: *How often do you experience the problem* (*frequency*) and recording vague responses such as "sometimes" or "a lot" may be insufficient. It is more informative to ascertain specifically what the patient means by "sometimes." For some patients, this may mean monthly. For other patients, this may mean three times a week.

It may also be beneficial to find out *when* or *at what times* does the patient experience the problem. For example, a problem that is identified as "worse in the morning" may be related to the patient's sleeping position, whereas problems that "worsen as the day goes on" may be related to the patient's occupation. Perhaps the problem is seasonal or perhaps the patient only experiences the problem during the week (e.g., only while at school or work) but not during the weekend.

Similarly, *prior occurrence* can be a very important branch point question. For example, if the patient states he/she has had this problem before, it is beneficial to ascertain:

- the etiology was the same in both instances;
- the length of time needed for the patient to recover previously;
- if the patient received a diagnosis/clinical impression from the other health care provider;
- the availability of other potentially relevant sources of information (previously taken x-rays, blood work);
- what therapies were provided; and
- whether the therapies received were beneficial.

Since there are a plethora of technique systems in chiropractic, it is important not to assume that the patient has previously received the same type of therapy you may be planning on providing to the patient at this time.

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The other set of questions ('the person') are also very important and should be asked during each patient interview a chiropractor performs. If a chiropractor should forget to ask a question on the patient's first visit, it is certainly acceptable to ask it on a subsequent visit.

2. Physical Assessment

Unlike some other health care professions, such as dentistry, the physical assessment procedures used by one chiropractor may differ from the physical assessment procedures used by another chiropractor. That said, a prudent clinician avoids relying exclusively on only one or two of the assessment procedures listed.

In other words, surveys indicated that chiropractors tend to develop their own set of hybridized diagnostic inputs to form a clinical impression or reach a diagnosis/clinical impression. This is based on education (the curriculum of the accredited chiropractic college from which they graduated), their accrual of clinical experience (which tests are found to be useful in clinical practice), mentorship and continuing education activities, such as attending conferences or seminars, or reading current journal articles.

In general, all of the listed physical assessment procedures are permitted for use in Ontario and a chiropractor need not perform all of these procedures. In fact, some chiropractors may choose not to use some of the listed procedures at all. However, the caveat is that it is the chiropractor's responsibility to ensure he/she has performed a sufficiently in-depth assessment to reach a reasonable diagnosis/clinical impression, has identified any *red flags* (absolute contraindications to care) or *yellow flags* (relative contraindications to care) and has gathered sufficient information to determine whether the patient's clinical condition can be managed within the scope of practice of chiropractic in Ontario.

Thus, the physical assessment performed should support the practitioner's decision to exclusively manage the patient; co-manage the patient; or refer the patient to a more appropriate health care provider.

There is no expectation on any chiropractor to possess superhuman diagnostic skills. What is required is that any care plan developed by the chiropractor ought to be clinically defensible based on the physical assessment performed.

Lastly, it is advisable to describe, and have the patient consent, to all the physical assessment procedures you are planning to perform prior to performing them.

3. Technical and Interpretative Components for X-ray

X-ray is an essential diagnostic tool that many chiropractors use as part of their practices. A number of chiropractors own and operate their own x-ray equipment, while others

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order x-rays from other chiropractors and laboratories. All members must be familiar with standard of practice S-006: Technical and Interpretative Components for X-ray. This standard describes what pieces of information are required to be in radiological records, logs and reports. This standard further explains proper record keeping, billing, consent, patient selection and equipment registration protocols for the use of x-ray.

4. Diagnosis/Clinical Impression

There are any number of acceptable formats that can be used to record the diagnosis/clinical impression reached by the chiropractor. In general, however, any discussion about a diagnosis/clinical impression should be able to address all six of the components:

- timeframe (acute, chronic, recurrent);
- intensity (mild, moderate, severe);
- cause (postural, traumatic, lifestyle, genetic, etc.);
- anatomical location/structure;
- pathology (subluxation/joint dysfunction, sprain, strain, etc.); and
- associated symptoms.

For example, acute, moderate, postural (L) sacroiliac joint dysfunction/ subluxation with concomitant hypertonicity of the (L) piriformis muscle. Furthermore, the care plan provided should be reasonably linked to the diagnosis/ clinical impression developed.

5. Report of Findings

The Report of Findings involves providing the patient with his/her diagnosis/clinical impression and the types of therapies the chiropractor plans on providing to the patient. This involves obtaining consent from the patient prior to rendering any type of therapy.

The principle of obtaining consent prior to touching or treating a patient is entrenched in legislation, regulation, and standard of practice S-013: Consent. In general, consent can only be obtained if the patient is provided not only with a description of the risks of the therapy to be provided, but also the purported benefits as well as available alternatives. For additional information regarding consent, please refer to page 12 of this document and standard of practice S-013: Consent.

For consent to be considered valid, the patient must be able to provide it voluntarily, without duress, misrepresentation or fraud. Moreover, the patient must have the mental capacity to provide the consent.

In discussing the effects, material risks and side effects of the proposed examination or treatment and alternative examinations or treatments, members shall disclose improbable risks particularly if the effects are serious. Accordingly, members shall include a

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discussion with patients of the rare but potentially serious risk of stroke associated with cervical adjustments.

Therefore, it falls on the chiropractor to demonstrate that the patient was in a position to provide informed consent (i.e., the patient did not have a diminished mental capacity that would preclude him/her from understanding what he/she was agreeing to).

In the event that a patient has a significant cognitive decline or pathology, such as Alzheimer's disease, informed consent must be obtained from the patient's guardian who has the authority to give it on behalf of the patient. Although it is prudent to obtain written informed consent for all patients, this becomes even more important in cases where the patient's mental capacity may be called into question.

Lastly, it is incumbent on the chiropractor to ensure that the patient (or his/her guardian) is provided with sufficient information in order to decide on the appropriateness of any recommendations, such as scheduling of appointments, exercises, limitations of activities, etc. For more information on the issue of consent, please refer to the *Health Care Consent Act, 1996*, and standard of practice S-013: Consent.

The number of treatments/care/concerns the chiropractor judges to be necessary to resolve the patient's chief complaint is usually discussed at this point (e.g., daily, three times a week, once a month), and a prognosis ought to be provided to the patient as well, if possible.

There are several basic types of patient scheduling that a chiropractor may propose to a patient, which may include (this is not an exhaustive list):

- crisis or acute care (pain or symptoms-based care);
- supportive care (care that when denied, causes deterioration of the patient's condition);
- maintenance care (a schedule of appointments provided irrespective of the presence or absence of patient symptoms); and
- wellness/prevention/health promotion.

In the course of billing patients, chiropractors must comply with the business practices section of regulation R-008: Professional Misconduct, and guideline G-008: Business Practices.

Although it depends on the clinical circumstances, a chiropractor may choose to discuss the importance of certain preventive care and healthful lifestyle choices. Preventive and healthful lifestyle choices may include not using tobacco, consuming only moderate amounts of alcohol (if any), wearing seat belts, engaging in safe sex practices and a home safety checklist. If exercises or stretches are to be provided to the patient, current literature suggests that such information be in a prescription format, including such

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features as number of times they should be performed, when in the day, number of repetitions, level of intensity, etc.

6. Treatment/Care

Chiropractors are permitted to use a number of different therapies to render patient care, including modalities, acupuncture, soft tissue therapies, mobilizations, manipulation and other forms of adjusting (e.g., instrumented adjusting, use of padded wedges, etc.) There are also approximately 100 different technique systems in chiropractic. A chiropractor may use a technique system if he/she complies with standard of practice S-010: Techniques, Technologies, Devices or Procedures.

7. Advice Given to Patients

Chiropractors should include a patient's records reasonable information about all advice given to the patient. This is part of the record of therapeutic management (as stated in standard of practice S-002: Record Keeping).

8. Outcome Measures/Re-assessment

The patient's progress (or lack thereof) must be monitored. Patient progress can be monitored subjectively or objectively. Looked at from a different perspective, progress may be monitored using qualitative outcome measures (how the patient feels), quantitative outcome measures (measurable changes in ranges of motion, straight leg raise, x-ray line marking, etc.) or a combination of the two. In general, it is customary for a chiropractor to monitor the patient's progress using the same group of physical assessment procedures used to reach a diagnosis/clinical impression.

A chiropractor should record the progress of the patient at each patient visit. Furthermore, a chiropractor must perform a re-assessment on or before each 24th visit. The re-assessment shall be sufficiently comprehensive for the chiropractor to:

- evaluate the patient's current condition;
- assess the effectiveness of the member's chiropractic care;
- discuss with the patient, the patient's goals and expectations for his/her ongoing care; and
- affirm or revise the patient's diagnosis or clinical impression and plan of management.

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II Professional Responsibilities

1. General Knowledge of Legislation, Regulations, Standards of Practice, Policies and Guidelines

In the course of practising chiropractic in Ontario, it is essential that chiropractors be aware of the relevant legislation, regulations, standards of practice, policies and guidelines that govern the profession.

Chiropractic is a health profession governed under the *RHPA*.

The *RHPA*, including schedule 2, *the Health Professions Procedural Code* (*Code*), gives authority for each regulated health profession to be governed by a college, made up of elected members of the profession and appointed members of the public. The College has several objectives as set out in section 2 of the *Code*, including:

- To regulate the practice of the profession and to govern the members in accordance with the *RHPA,* the *Code* and CCO regulations and by-laws.
- To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.
- To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.
- To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.

The *RHPA* sets out the structure and roles of the statutory committees.

In addition, chiropractic is governed by the *Chiropractic Act, 1991,* which defines the chiropractic scope of practice, restricted titles and authorized acts. The *Act* also sets out the composition of Council.

Chiropractic, as well as all regulated health professions in Ontario, is governed by the *Personal Health Information Protection Act*, *2004* (*PHIPA*). An in-depth piece of legislation, *PHIPA* addresses complex issues concerning the collection, use and disclosure of personal health information by health information custodians. The object of *PHIPA* is to balance the benefits of respecting privacy with the benefits of collecting, using and disclosing personal health information.

The *Health Care Consent Act, 1996,* provides rules with respect to consent to treatment/care, and procedures for:

- individuals who are incapable of consenting to treatment/care;
- communication among health practitioners, patients, and their families; and

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- involvement of the Public Guardian and Trustee.

In addition to the above legislation, the chiropractic profession in Ontario is governed by CCO's regulations, standards of practice, policies and guidelines. Regulations are the details that support the guiding principles of legislation and may only exist pursuant to legislation. For a regulation to come into effect, it is distributed to members for feedback, approved by Council, and submitted to the Ministry of Health and Long-Term Care for review, analysis and approval.

Standards of practice outline the basic requirements chiropractors must meet to demonstrate clinical competence. They outline members' responsibilities in the delivery of health care services and ensure the quality of the profession. Unlike statutes or regulations, standards of practice are easier to implement and quicker to change because they only require approval by Council, following consultation with members. CCO develops standards as issues arise and are identified in the profession.

Policies assist members in their understanding of their professional responsibilities, clarify and interpret regulations, and state CCO's position on a variety of topics. Similarly, guidelines provide advice or recommendations and are intended to "guide" members of the profession.

In the event of any inconsistency, the legislation governs.

2. Scope of Practice

The scope of practice of chiropractic is defined in the *Chiropractic Act, 1991,* as follows:

"3. The practice of chiropractic is the assessment of conditions related to the spine, nervous system and joints and the diagnosis, prevention and treatment, primarily by adjustment, of,

(a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and

(b) dysfunctions or disorders arising from the structures or functions of the joints."

As members of CCO, chiropractors in Ontario have the privilege of performing certain controlled acts authorized to chiropractors under the *RHPA*. These acts are as follows:

1. Communicating a diagnosis identifying, as the cause of a person's symptoms,

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i. a disorder arising from the structures or functions of the spine and their effects on the nervous system, or

ii. a disorder arising from the structures or functions of the joints of the extremities.

2. Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust.

3. Putting a finger beyond the anal verge for the purpose of manipulating the tailbone.

As well, under the *RHPA*, there are a number of controlled acts that are not authorized to chiropractors. Members are expected to familiarize themselves with these controlled acts and have an understanding that they are not authorized to perform any of these acts in Ontario. A listing of the controlled acts can be found at s. 27 of the *RHPA*.

Any diagnostic or treatment procedure performed on a patient that does not involve the performance of a controlled act is considered to be in the public domain, meaning that no profession is legislatively restricted from performing this act. However, members of CCO are reminded that no matter what procedure they are performing, they must always practise within the their scope of practice as defined in the *Chiropractic Act* and in compliance with all CCO standards of practice, policies and guidelines.

CCO has defined certain acts as being outside the scope of practice of chiropractic. These include the following: mobile digital iriscope system, dark field microscopy, vega testing, hyperbaric oxygen therapy, pelvic and prostate examinations.

3. Consent

Consent is an essential obligation in the context of the examination and treatment/care of patients. Chiropractors are required to obtain patient consent prior to any examination, treatment or course of treatments/care. It is essential that in obtaining consent, chiropractors clearly communicate to patients the benefits, risks, side effects and alternatives to examination and treatment/care, and facilitate an environment of discussion and dialogue.

Furthermore, consent must be fully informed, voluntarily given, related to the patient's condition and circumstances, not obtained through fraud or misrepresentation, and evidenced in written form signed by the patient or otherwise documented in the patient record.

Elements of consent, appropriate discussion and legislative sources are addressed in CCO standard of practice S-013: Consent.

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4. Reporting Obligations

All members of Ontario's regulatory health professions, including chiropractors, must make mandatory reports to the appropriate authorities in the following areas – child abuse and neglect, sexual abuse of patients and communicable diseases. Failure to make such reports is grounds for professional misconduct. Chiropractors making any such report must have reasonable grounds to do so and must have obtained the information in the course of conducting their duties.

Child Abuse and Neglect

The obligation to report child abuse and neglect falls under the *Child and Family Services Act, 1990* (*CFSA*). *CFSA* defines child abuse as a child "in need of protection" from physical, sexual and emotional abuse, neglect and risk of harm.

The duty to report is ongoing. If a person has made a previous report about a child, and has additional reasonable grounds to suspect that a child is or may be in need of protection, that person must make a further report to a children's aid society.

The professional's duty to report overrides the provisions of other provincial statutes. The professional must report suspected child abuse even if the information is supposed to be confidential or privileged. However, the professional must base his/her report on "reasonable grounds" and must have obtained the information in the course of conducting his/her duties.

For a complete definition, please refer to the *CFSA*. For more information on the situations that must be reported to a children's aid society, please visit the Ontario Association of Children's Aid Societies web site at www.oacas.org.

Sexual Abuse of Patients

The obligation to report sexual abuse of patients falls under the *RHPA*, which defines sexual abuse of a patient as sexual intercourse or other forms of physical relations with a patient/client, touching a patient/client in a sexual manner, or behaviour or remarks of a sexual nature to a patient/client.

As a chiropractor, you must report sexual abuse when you answer YES to all six of the following questions: (source: Mr. Richard Steinecke, LLB., "Responsibilities of Employers, Managers and Partners under *RHPA*"):

1. Do you know the name of the alleged abuser?
2. Is the alleged abuser registered with one of the colleges of a health profession?
3. Was the other person involved a patient of the alleged sexual abuser?

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4. Did the conduct involve one or more of the following: sexual intercourse or other form of physical sexual relations; touching of a sexual nature; behaviour or remarks of a sexual nature?
5. Was the information of the alleged sexual abuse obtained in the course of practising your profession?
6. Does your information constitute "reasonable grounds"?

Send the report to the named health professional's college, usually within 30 days. If a member has reasonable grounds to believe the named practitioner will continue to sexually abuse patient(s), he/she must file the report immediately. If a member is obligated to file a report, he/she must advise the patient of the requirement to do so.

Communicable Diseases

The obligation to report specified diseases to the local medical officers of health is outlined in the *Health Protection and Promotion Act, 1990* (*HPPA*), and standard of practice S-004: Reporting of Diseases.

The duty to report diseases also includes the duty to report identifying information (e.g., the patient's name), notwithstanding the duty of confidentiality owed to the patient.

Chiropractors who fail to comply are liable, on conviction, to a fine of not more than $5,000 for every day or part of a day on which the offence occurs or continues. Chiropractors are protected from liability for making a report in good faith.

CCO is aware of the contradiction in chiropractors having the obligation to report diseases but not having access to laboratory services. The contradiction does not relieve members of their obligations under the *HPPA*.

5. Interprofessional Obligations

Chiropractors should foster collaborative inter- and intra-professional relationships with colleagues and other health care professionals. Collaboration includes considering and respecting the opinions of colleagues and other health care professionals, and ensures patients' benefits. Collaboration also includes referring patients, if and when required.

According to regulation R-008: Professional Misconduct, it is an act of professional misconduct for failing to advise a patient to consult with another health professional when the member knows or ought to know that,

- the patient's condition is beyond the scope of practice and competence for the member,
- the patient requires the care of another health professional, or
- the patient would be most appropriately treated by another health professional.

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6. Acupuncture

Acupuncture is regulated under the *Traditional Chinese Medicine Act, 2006.*

The use of acupuncture requires a high degree of skill and is not without risk. Ontario chiropractors may use acupuncture as an adjunctive therapy for their patients provided they comply with S-017: Acupuncture, which describes the educational requirements, safety issues and insurance requirements associated with acupuncture. For more information, please review standard of practice S-017: Acupuncture.

7. Dual Registrants

Chiropractors may also be members of other regulated health professions, including medicine, physiotherapy and naturopathy. These dual registrants have additional obligations to the public to inform them in which capacity they are practising so as to reduce confusion and misunderstanding by the public. For more information, please review standard of practice S-011: Dual Registrants.

8. Chiropractic Care of Animals

Chiropractors may provide chiropractic care to animals. CCO reminds members that the primary responsibility for the health care of animals is with members of the College of Veterinarians of Ontario, and it is the veterinarians who are responsible for appropriate history taking, comprehensive examination, including clinical pathology, and other imaging, and the overall treatment/management of animals.

Members who provide chiropractic care to animals must have appropriate training in animal chiropractic, such as successful completion of a program in animal chiropractic of a minimum of 200 hours of formal training that includes, but is not limited to, studies in the following subject areas: anatomy, neurology, biomechanics, animal adjustment technique, diagnosis, pathology, chiropractic philosophy, and ethics and legalities;

For more information regarding record keeping and office practice, please refer to standard of practice S-009: Chiropractic Care of Animals.

9. Orthotics

Chiropractors may use orthotics as a part of patient care for the management of pedal pathologies and neuromusculoskeletal symptomatology, and to alleviate pain and discomfort from abnormal foot function. Members who manufacture, sell or dispense orthotics are required to have appropriate training, skill and competence, as well as adhere to a set of protocols addressing assessment and examination, informed consent, treatment, billing and conflict of interest. These obligations are further described in standard of practice S-012: Orthotics.

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10. Best Practices

Chiropractors are encouraged to integrate best practices based on research and clinical expertise into their own practices to provide optimum patient care. Chiropractors should base care plans on best practices and evidence that reflect realistic and therapeutically necessary care as opposed to care that is practice management or financially driven. Chiropractors are also encouraged to participate in ongoing learning and research activities, to the extent feasible, and apply research findings and expert opinions to improve their practice.

III Communications

Communicating effectively is a key component in any successful relationship. Whether communicating with patients, colleagues, other health care professionals or CCO, chiropractors are encouraged to engage in proper communication skills that include active listening and proper discourse techniques. This is especially true when communicating with patients.

A chiropractor must ensure that his/her message has been clearly understood by the patient. Using the appropriate words to convey the message may not be sufficient. The chiropractor should also use the appropriate paralinguistic skills (e.g., gestures, facial expressions, body language).

While chiropractors cannot be responsible for the opinions their patients eventually conclude, doctors should be sensitive that their verbal, non-verbal, written and other types of communication will reflect on them and their practice.

Chiropractors are reminded that they may only use titles that are legislated to them under the *RHPA* and the *Chiropractic Act.* These titles include “chiropractor” and “doctor of chiropractic.”

Chiropractors cannot use the following titles because they are restricted to other regulated professions (this is not an exhaustive list):

- “chiropractic physician” – “physician” is a protected title under the *Medicine Act, 1991*;
- “osteopath” – osteopath is a protected title under the *Medicine Act*;
- “acupuncturist” and “Traditional Chinese Medicine practitioner” – both titles are protected titles under the *Traditional Chinese Medicine Act*.

Chiropractors may use the above titles if they are members of those regulatory colleges. Chiropractors may use the specialist designations as outlined in policy P-029: Chiropractic Specialties.

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IV Office Policies

1. Record Keeping

All patient interaction must be recorded. It is not sufficient to simply perform the clinical tasks as outlined in the "Doctor Patient Interaction" sections 1 through 6. Once the doctor has completed the clinical skills, he/she is required to record the information in the patient's file. Records should be made contemporaneously with the interaction and should be thorough enough that, should the doctor be unable to attend the next patient visit, another qualified chiropractor should be able to step in and pick up where the primary doctor left off.

The patient record should read like a story book of the patient's time in the doctor's care. The consultation, initial examination, diagnosis/clinical impression and plan of management may be thought of as the opening chapter. Each following chapter would outline the treatments/care between re-evaluations, and conclude by revisiting the diagnosis/clinical impression and plan of management.

The importance of record keeping cannot be stressed enough. The record is helpful for many reasons, the most important is ensuring that patient care can proceed in an effective, efficient and uninterrupted manner. Other important reasons to have complete and accurate records include defending the member in any potential complaint or disciplinary matter and justifying the need for care to any third-party payor.

2. Management and Financial Policies

It is essential that patients understand for which chiropractic services they are being billed. Misunderstandings may lead to a complaint filed against the member with CCO. Members charging block fees and/or payment plans should especially be familiar with the Business Practices section of regulation R-008: Professional Misconduct and guideline G-008: Business Practices.

3. Advertising

To ensure their advertisements comply with the standard of practice S-016: Advertising, CCO encourages all members to submit their proposed advertisements to the Advertising Committee for review. Turnaround time for a response is 10 business days.

Members interested in conducting public display/health screening should review the policy P-016: Public Display Protocol (posted on www.cco.on.ca).

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V Continuing Education and Professional Development

All chiropractors are required to participate in continuing education and professional development, which includes maintaining an up-to-date professional portfolio and completing the self-assessment questionnaire and plan of action summary sheet.[1]

1. Professional Portfolio

The QA Committee developed the professional portfolio, posted on www.cco.on.ca, to help members document their continuing education and professional development activities. In addition, members should maintain the following items in their portfolios:

- Self-Assessment Plan of Action Summary Sheet;
- Continuing Education and Professional Development Log;
- materials gathered while fulfilling CE requirements (e.g., course outlines, brochures from conventions/conferences, etc.);
- samples of recent advertisements; and
- the disposition report following the peer and practice assessment.

Peer assessors will review members' professional portfolio when selected to be peer assessed. In addition, the QA Committee may ask members to submit their professional portfolios for review.

Members must maintain CE materials for a minimum of two CE cycles (or four years); that is, the current cycle and the immediate preceding cycle, or until they have been peer assessed.

2. Self Assessment

The purpose of self assessment is to help members maintain their clinical acumen and help them provide the best care possible to their patients.

Self assessment consists of two sections – a self-reflective questionnaire and a plan of action summary sheet.

The self-assessment questionnaire is designed to help members reflect on their current professional proficiency, identify areas of strength and areas for improvement, and develop a learning plan that will address those areas that need improvement. Members must complete the self assessment process once every two years, as determined by CCO.

Members will not be required to submit their self assessment questionnaires to CCO. It is for their personal review only.

[1] To be completed every two years.

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Once a member has completed the self assessment questionnaire and has identified areas that need improvement, the member should transfer the information to the self assessment plan of action summary sheet and use it to develop a learning plan that will guide his/her CE and professional development.

The plan of action summary sheet is a component of the member's professional portfolio. It will be reviewed by a peer assessor during the peer and practice assessment to monitor the member's compliance with the self-assessment process.

The Learning Objectives section should summarize the areas identified in the statement "Based on what I learned in this section, I will…" that appears after each section of the Self Assessment questionnaire.

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VII Plan of Action Summary Sheet – Example of a Correctly Completed Summary Sheet

Please complete this section based on the "Learning Objectives (based on what I learned in this section, I will…)" sections.

[☑ = *I need improvement in…*]

	Areas for Improvement *(I need improvement in…)*	Learning Objectives *(I will…)*	Activities Planned *(I will use/participate in…)*	Target Date
I	Doctor-Patient Relationship			
☐	1. History Taking			
☑	A) Patient's Main Concern (the Problem)	• *how to use pain scales and other questionnaires*	• *CMCC rehab course* • *talk to Dr. Asterisk, who is a rehab specialist*	*next month*
☐	B) General Information about the Patient (the Person)			
☑	2. Physical Assessment	• *what "testing for non-organic signs" means*	• *call Dr. Asterisk*	*tomorrow*
☑	3. Diagnosis/Clinical Impression	• *to write it in every file*	• *create a "box" in my paperwork called "Diagnosis"*	*tomorrow*
☐	4. Report of Findings			

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	Areas for Improvement *(I need improvement in…)*	Learning Objectives *(I will…)*	Activities Planned *(I will use/participate in…)*	Target Date
☑	5. Treatment/Care	• *remember to write down all stretching advice*	• *just do it!*	*today*
☑	6. Advice Given to Patients	• *see above*	• *see above*	*today*
☑	7. Outcome Measures/Re-assessment	• *write down any new changes to my treatment plan*	• *specific short forms notes from the CCO record keeping workshop*	*today*
II	**Professional Responsibilities**			
☑	1. General Knowledge of Legislation, Regulations, Standards of Practice, Policies and Guidelines	• *to visit CCO website – www.cco.on.ca*	• *CCO website review*	*1x/month*
☐	2. Scope of Practice			
☑	3. Consent	• *to get consent before any examination*	• *create a new "exam" consent form*	*today*
☐	4. Reporting Obligations			
☐	5. Interprofessional Obligations			
☐	6. Acupuncture			
☐	7. Dual Registrants			

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	Areas for Improvement *(I need improvement in…)*	Learning Objectives *(I will…)*	Activities Planned *(I will use/participate in…)*	Target Date
☐	8. Chiropractic Care of Animals			
☑	9. Orthotics	• *get a separate consent for orthotics*	• *review S-013: consent and obtain separate consent for orthotics*	*end of this month*
☐	10. Best Practices			
III	**Communications**			
☑	Communications	• *improve my handwriting legibility*	• *explore going to "paperless" office that uses more standardized forms*	*next Parker seminar*
IV	**Office Policies**			
☑	1. Record Keeping	• *legibility – see above*	• *see above*	
☑	2. Management and Financial Policies	• *to disclose my fee schedule*	• *make fee schedule part of patient take-home paperwork*	*next staff meeting*
☐	3. Advertising			
V	**Continuing Education and Professional Development**			
☑	Continuing Education and Professional Development	• *to learn more in a diversity of areas*	• *take radiology course at CMCC*	*next year*

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VII Plan of Action Summary Sheet – Example of a Poorly Completed Summary Sheet

Please complete this section based on the "Learning Objectives (based on what I learned in this section, I will…)" sections.

[☑ = *I need improvement in…*]

	Areas for Improvement *(I need improvement in…)*	Learning Objectives *(I will…)*	Activities Planned *(I will use/participate in…)*	Target Date
I	Doctor-Patient Relationship			
☐	1. History Taking			
☐	A) Patient's Main Concern (the Problem)			
☐	B) General Information about the Patient (the Person)			
☑	2. Physical Assessment	• *write it all down*	• *just do it now*	
☐	3. Diagnosis/Clinical Impression			
☐	4. Report of Findings			
☑	5. Treatment/Care	• *3x/week – doing SMT re-evaluate*		
☐	6. Advice Given to Patients			

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	Areas for Improvement *(I need improvement in…)*	Learning Objectives *(I will…)*	Activities Planned *(I will use/participate in…)*	Target Date
☑	7. Outcome Measures/Re-assessment	• *do them*	• *attending record keeping workshop*	*on/before 24th visit*
II	Professional Responsibilities			
☐	1. General Knowledge of Legislation, Regulations, Standards of Practice, Policies and Guidelines			
☐	2. Scope of Practice			
☑	3. Consent	• *make new form*	• *get staff to do it*	*next week*
☐	4. Reporting Obligations			
☐	5. Interprofessional Obligations			
☐	6. Acupuncture			
☐	7. Dual Registrants			
☑	8. Chiropractic Care of Animals	• *take a course to get a certificate*	• *call Dr. Asterisk, who did the course*	*today*
☑	9. Orthotics	• *follow up with patients*		*always*
☐	10. Best Practices			

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Areas for Improvement *(I need improvement in…)*		Learning Objectives *(I will…)*	Activities Planned *(I will use/participate in…)*	Target Date
III	**Communications**			
☐	Communications			
IV	**Office Policies**			
☑	1. Record Keeping	• *write down diagnosis*		
☐	2. Management and Financial Policies			
☐	3. Advertising			
V	**Continuing Education and Professional Development**			
☑	Continuing Education and Professional Development	• *start a professional portfolio*	• *call CCO*	

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