Best Practices in Clinical Record Keeping: The Basics

Introduction
Since its inception many years ago, The CHP Group (CHP) has engaged panel providers in developing “Best Practices” in clinical record keeping. Clinician advisors from each discipline have contributed their expertise and experience to information gleaned from authoritative sources to develop record keeping policy, procedures and resources to guide and assist CHP providers. High-quality clinical records support high quality patient care.

Why Keep Clinical Records?
The art and science of clinical record keeping deserves, but often does not get, as much attention as the art and science of delivering quality health care to patients. The dictum that “if it didn't get written down, it didn’t occur” is one that all health care providers must respect. CHP is committed to enabling CHP providers to maintain excellent clinical records. There are many reasons why documenting patient care is a critical function in any health care setting.

Professional and Legal Standards
Health care records are both clinical and legal documents. Professional and legal standards routinely include requirements and recommendations about record keeping. Failure to document patient care adequately can be considered evidence of negligence. For example, some statutory practice acts specify the need for complete and accurate clinical records. In Washington State WAC 246-808-560, Documentation of care, states, “The recordkeeping procedures of a chiropractor shall be adequate to provide documentation of the necessity and rationale for examination, diagnostic/analytical procedures, and chiropractic services.” Oregon Administrative Rules Chapter 811-015-0005, Records, specifies that, “It will be considered unprofessional conduct not to keep complete and accurate records on all patients.”

Quality Patient Care
If staying out of hot water with the state licensing board was not reason enough to maintain good records, providing excellent patient care should motivate any practitioner to have excellent clinical records. Good chart notes support good patient care in several ways:

- Memory is not infallible. In a busy practice with diverse patient populations, keeping track of each patient’s unique clinical presentation, treatment plan, progress, precautions and outcomes would be impossible without a systematic and organized written record.
- Clinical decision-making hinges on good documentation. Decisions about how best to help a patient, what works and what doesn’t as treatment proceeds is dependent on a comprehensive record of the patient’s condition (symptoms, signs, examination and lab findings, etc) , what was done, and how the patient responded to the care.
• Continuity of care is enhanced by good clinical records. Whether a patient’s care is shared among different providers in one facility or is transferred from one office to another, sharing legible, understandable and accurate clinical information with other providers reduces unnecessary testing, saves time, and helps patients get the care they need.

• Patient safety can be maximized with consistent documentation and prominent display of warnings and contraindications to treatment.

Malpractice Risk Management
The importance of excellent clinical records is perhaps never appreciated so much as in malpractice actions. While we all strive to produce the best outcomes for our patients, untoward events do occur and patients do sue their health care providers alleging malpractice. In those unfortunate instances complete, thorough and accurate clinical records often make the difference between a successful defense and an unhappy outcome for both the patient and the provider.

Documenting Medical Necessity
CHP has an obligation to payers to provide care that is medically necessary. Generally speaking, medically necessary care is that care which is appropriate for the condition, is being provided for that condition, is within the standards of good care, and is for the benefit of the patient, not the caregiver. Quality clinical documentation can demonstrate all of these elements and assure compliance with requirements of payers including private insurance, workers’ compensation, personal injury and Medicare.