Subject: Consultation Paper: Guidelines – Clinical Record Keeping

Dear Members of the Board,

Thank you for giving me an opportunity to contribute to the revised guidelines on Clinical Record Keeping for Chiropractors.

This guideline does not address the requirements of record keeping for chiropractic special investigations performed by the Chiropractor. For example, practitioners using specialized equipment for diagnostic purposes such as x-ray, myovision scanners, gait analysis, etc.

It may be appropriate to include a paragraph stating the requirement to complete a full report and include it in the clinical notes where special investigations are performed. In many cases, this may be just a print out from the myovision scanner or gait analysis. However, in the case of x-ray, it should be specified that a full written narrative report of the findings and clinical impression are to be included in the patient file. In cases where x-rays are referred out, then this is covered in section 4 (m), however in cases where chiropractors take their own x-rays, they must either be sent out for reporting by an expert, or the report formulated by the practitioner.

Please feel free to contact me for further information or clarification. If you require an example of a narrative radiology report for reference by Chiropractors, I would be happy to provide one.

Example:

Patient Details: Name, address, DOB (in case it gets separated from the patient file);
Clinical details: To ensure justification for x-ray (this is a requirement on external referral forms now);
Images taken: eg. AP and lateral C-Spine. (this identifies which views were interpreted in order to formulate the written report. It ensures that all were viewed, or identifies if some views were missing);
Findings: a narrative report commenting on all relevant findings;
Clinical Impression: Identification of diagnoses and differentials where required;
Recommendations: Include a description of recommendations where required, eg. Further imaging, laboratory investigations, etc. Whilst the report is the best place for this, it could also be included in the patients' file.

Section 2 (j). Seems excessive to suggest adherence with the Code of Conduct produced by the same Board. It may be worthwhile amalgamating the two into either just the Code of Conduct, or simply stating a one line reference to the Guidelines within the Code, rather than partial duplication.

Retention of patient records: It would seem pertinent to have a statement of record retention requirements either under section 1 – responsibilities or Section 2 – general principles. It would be useful to only have to go to one document for referencing all requirements pertaining to clinical record keeping.

Thank you for allowing me to contribute my opinion.

Kindly

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