Updates

Message from the Board of Directors

Greetings everyone and welcome to the July 2014 issue of Kinnected. The summer is typically a quiet time in the business community and this is reflected in the size of the current BCAK newsletter. We are attempting to keep you informed on the issues pertinent to the profession of kinesiology.

The office has been receiving an increasing number of inquiries lately regarding the professional standards of our members. We suspect this is primarily in response to the regulation of kinesiology in Ontario and increased public awareness created by the spin-off effect. One of the topics that has recurred recently is when and how to maintain client records (or charting). There can often be a fine line between the practice areas of personal/athletic training and rehabilitation. The question of "When does a *training* client become a *rehabilitation* client?" can be difficult to determine, not to mention what frequency and depth of charting should be maintained for rehabilitation clientele. In this issue you will find an informative article by David Wallin –LL.B. on treatment charting that we hope will provide additional insight into the purposes and values of maintaining high quality chart notes.

We hope you enjoy this issue, and have a wonderful summer.

CASL - Canadian Anti-Spam Legislation

Most of you may have noticed a flurry of emails during the past couple of weeks from various groups or organizations that you have done or currently do business with requesting your permission to continue to send you marketing materials. This new legislation is an attempt by the government to reduce the volume of unsolicited emails (Commercial Electronic Messages or 'CEMs') being sent to you, along with restrictions on other actions for all forms of electronic messaging.

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Kinnected: Summer 2014

The Kinesiologist's Treatment Records: A Legal Perspective

David J. Wallin
Barrister & Solicitor
Director of Whitelaw Twining Law Corporation
www.WTinjury.com

I wrote an earlier article that appeared in the March 2013 edition of Kinnected titled "The Importance of Treatment Records". Since writing the article, I have been asked a number of excellent questions in relation to this important topic, which clearly indicates that this is an area of considerable interest among kinesiologists as well as other treating professionals. The purpose of this article is to discuss this important topic from a bodily injury lawyer's perspective.

It is well accepted that the purpose of any clinical treatment record is principally to assist in providing the patient with quality care and treatment continuity of such care. This is generally the case for all treatment professionals.

As I discussed in my earlier article on this subject, in addition to the more standard quality and continuity of care function served by thorough and accurate clinical records of the treatment professional, these records are often used and relied upon for many other important purposes.

Clinical History – How Much is 'Enough'?

As a bodily injury lawyer, I review a large volume of treatment records of patients involved in bodily injury claims. The variability of the approach amongst treating professionals is considerable. Often times, the clinical records are so cursory or illegible, they provide no assistance in gaining an understanding of the nature and extent of the patient's symptoms, treatment and progress.

Accordingly, a common question that arises relates to how much detail is appropriate to chart and what information is truly relevant or necessary to chart.

The above question is difficult to answer in absolute terms. The context of the reason to seek treatment and the overall nature and extent of the patient's symptoms will have considerable influence on what is, for practical purposes, necessary or required in the circumstances. However, when first meeting with a new patient to consider a treatment plan, it is, in my view, critical to first obtain a thorough and accurate history of the patient before commencing treatment or providing advice.

As a good practical starting point, best practices would suggest that the kinesiologist should be mindful of obtaining a thorough clinical history in relation to the following general areas:

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- **Immediate Symptom History** – The history of onset of symptoms or patient complaints for which the patient is seeking treatment.
- **Prior Symptom History and Treatment** – The prior history or experience of the patient with similar symptoms or complaints in their past, and the prior treatment of such symptoms or complaints.
- **Symptom Onset** – The description of the course of onset of the symptoms or complaints. Did the symptoms or complaints begin suddenly with some form of traumatic incident (ie a car accident; a workplace injury; a fall; an assault, etc), or a more gradual or insidious onset with no apparent or obvious temporally connected event?
- **Medical Conditions –** Are there any underlying medical conditions that may be relevant to the patient's presentation or possible course of treatment?
- **Medication Use** – Is the patient taking any prescription or non-prescription medication that may be relevant to both the patient's presentation and treatment?
- **Other Treatment Modalities** – What other forms of treatment or therapy has the patient recently undertaken or is currently receiving? (eg massage therapy; chiropractic; physiotherapy; acupuncture; naturopathy; etc).

The above list is not intended to be exhaustive, but instead is intended to summarize a few key areas that will both form a good basis to gain an understanding of the patient's presenting symptoms and history which, as will be discussed below, can serve several practical purposes.

The "SOAP" Model – When is 'Enough' Enough?

Once the thorough history has been obtained and patient is now in a treatment plan with the kinesiologist, the next question that can arise is "What do I really need to chart with respect to treatment?".

All kinesiologists are generally familiar with the "SOAP" model or protocol of clinical charting. This useful model is utilized in a clinical context by many treating professionals as a guide to consistently address the pertinent matters of a clinical consultation.

A clinician that consistently and routinely follows the SOAP model will create a useful and consistent clinical picture of the patient. In addition to principally assisting with the patient's quality and continuity of care, such clinical records will also greatly assist the patient in the event that such records are ever reviewed and considered by third parties outside the treating context as well.

Appropriate care should be taken by the kinesiologist to prompt the patient for a thorough detailing of the patient's complaints, signs and symptoms. All patients are different. Some patients can readily provide or articulate a full and complete listing of their complaints with little prompting. Others require more direct questioning, prompting and direct queries by the kinesiologist. Such a thorough history taking requires the kinesiologist's skill and discretion, as well as good clinical judgment and experience.

Once again, as with clinical history, the treatment context will mostly be determinative of the level of detail that is likely required in the circumstances. However, as I discussed in my earlier article, if your patient is seeking treatment through an ICBC or WorkSafe BC claim, this should automatically alert you to the fact that your clinical records will need to be a thorough, accurate, legible, comprehensive record of your patient's history, treatment and progress.

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As discussed in my earlier article, such clinical records will often be reviewed and considered by third parties (once the appropriate patient authorization has been provided) in relation to accessing treatment funding and benefits that may be available to the patient. If such records are not a true or accurate reflection of the patient's history, treatment and progress, it may have a significant impact on both their access to treatment funding and their legal claim to compensation from the individual responsible for their injuries and disability.

Such thorough, legible and consistent treatment records will also have the collateral benefit to the kinesiologist if they are ever called upon to explain their course of treatment in either a clinical audit, regulatory proceedings, or in the context of litigation involving their patient. Regardless of the purpose or context, the benefit of such a thorough and complete clinical record is highly beneficial to the clinician and patient alike. Kinesiologists should be encouraged to consider such matters during the course of patient treatment.

A treating professional who diligently (and legibly) records the patient's complains at various stages of their treatment and rehabilitation (and documents both subjective complaints as well as objective limitations in their patient), cannot only assist the treating practitioner, but such records will also greatly assist the patient. Such clinical records can be utilized in relation to both successfully prosecuting the patient's potential legal claim, but will also support the patient's need for further rehabilitative treatment.

Conclusion

The keeping of thorough, accurate and complete patient clinical records is important for best practices in relation to quality and consistency of patient care. However, kinesiologists should also remain mindful of the collateral benefits of thorough, accurate, detailed and legible clinical records in a context outside the realm of quality of treatment and patient care. The keeping of high quality and consistent patient records can be of significant benefit to both the patient and clinician alike.

By: David J. Wallin, Director

Whitelaw Twining Law Corporation
2400 – 200 Granville Street
Vancouver, British Columbia, V6C 1S4
Internet: www.WTinjury.com
Direct Phone: (604) 891-7211
E-mail Address: DWallin@wt.ca