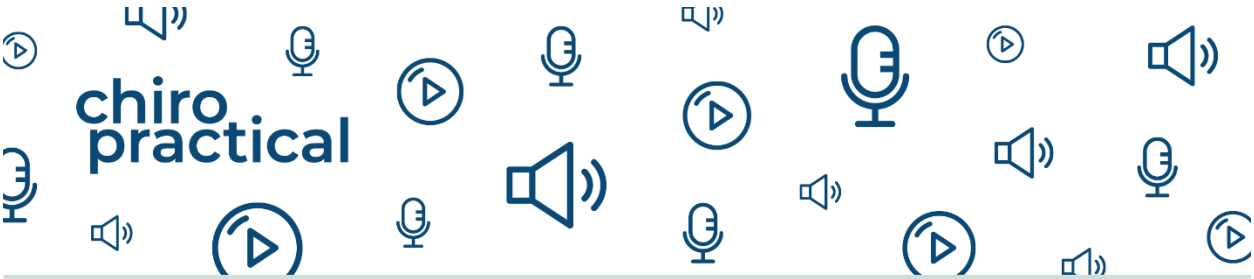
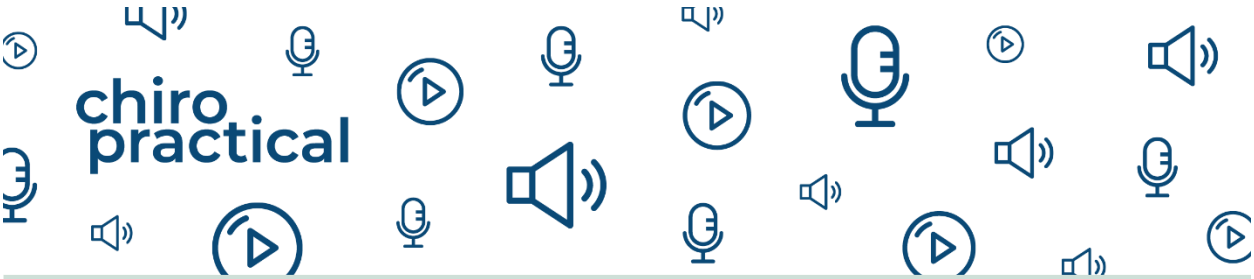


DOCUMENTATION CHECKLIST

You want to provide the best care for your patients while protecting yourself and your practice against allegations of malpractice. Your records can help you do both! Good records help provide the best patient care because it helps you understand their progress and unique issues, enables you to communicate effectively with other healthcare provider, and minimized the risk of oversights and mistakes when treating patients. Your records also provide your first line of defense against a malpractice allegation.

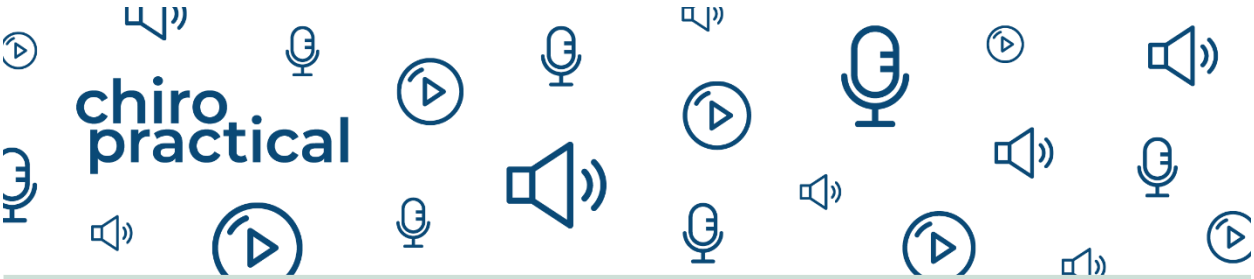
- **Document all conversations**. If you use video, phone, email or text messaging to advise patients about a patient's past or present health concerns, proper nutrition or exercises, use the same standards for documenting clinical advice, continuity of treatment and informed consent discussions you would use in your office. If you are not uniform in which messages you keep and which ones you delete, it could also give rise to an argument that certain messages were intentionally deleted.
- **Treat patients as people, not clinical conditions**. Avoid adverse comments about the patient. View your patient as a unique individual with a distinct set of cultural values, beliefs and attitudes.
- **Don't be judgmental**. **Avoid exaggeration or untruthful comments.** Record patients' statements accurately. Use direct quotes when possible, especially regarding chief complaints.
- **The doctor's observations and treatment**. Include in your documentation what you diagnosed and the levels and type of your adjustment. Essentially, make sure to note what you did and why you did it. In addition, it is vital to include your follow-up plans for the patient.
- **Accuracy**. Properly document and chart the patient's complaints in the SOAP notes. Without a contemporaneously made record, there is no proof of anything—and make no mistake, people remember things differently, which could become an issue if there is a later concern about your care.
- **Timing**. Document the care when it's provided. Be sure to always note the time and date. This is especially important during an emergency.
- **Never alter a patient's records**. Not only is it a criminal act, but altering records also can be especially devastating if done after a lawsuit is filed. Sign and date every entry. There should be no doubt who wrote the note and when.
- **Write what's important**. Your recordkeeping can become your primary defense in a possible lawsuit. When an attorney reviews for consideration of litigation, you don't get to explain them. That makes it important to ensure your notes are clear, concise, precise and legible.



- **Patient's history**. A doctor's documentation should focus extensively on the patient's history—not just what the patient wrote on the form. If something is new, record the reasons the patient is there. Identify the patient's chief complaint and follow up with questions about who, what, where, why and when. For example, "Where did this neck pain start? Were you skiing? Were you on a black diamond run? Had you been skiing for two to three hours? Were you sitting on the couch watching television?" All of these details are very helpful for defense attorneys who may be looking at the chart two years (or more) later in an effort to defend you.
- **Patient's actions**. Make sure to document what the patient has done to treat the issue, whether they've seen another healthcare provider, and if they have had X-rays or other tests for the same problem or a problem related to the patient's chief complaint and concern.
- **Be mindful after a gap in care**. As a result of COVID-19 restrictions, many of your regular patients may be returning after a gap in care. Consider that things may have changed with the patient's health, medications or other areas. Depending on how long it has been since you last saw the patient, it may be advisable to follow the protocols you would use with a new patient with any patients you see after a gap in care.
- **Informed consent**. This should include the nature of the treatment to be rendered, the material risks associated with the treatment and the possibility that those risks will occur, alternative treatments available and their associated risks, and the risks of not being treated.
- **Include a follow-up plan**. State what's important for the patient to do once they leave your office. If consultation or referral is needed, that should be indicated. And be sure to make all appropriate referrals and document them.

Being sued is startling or perhaps even frightening, and many doctors will want to correct any inadequate or inaccurate documentation in the patient's chart. No matter how innocent the intention, any change, if not done properly, can be viewed as a self-serving attempt to cover up a misdeed.

- **Electronic Records**. With electronic records, a forensic computer analyst may review the procedures for making computer entries to determine when the entries were made—during or after the office visit. The analyst can often detect any changes to the records, including any reformatting of and deletions to a patient's record.
- **Handwritten Records**. Experts can point out variations in handwriting, chemical content of inks, types of pens or types of forms. Document examiners can scrutinize handwriting to determine who wrote the entry, and they can evaluate folds, creases, and staple and punch holes to determine if pages were inserted or removed or if the document sequence was altered.
- **More Ways Alterations Are Detected**. Plaintiffs' attorneys will try to determine if the records you provided during litigation are different from earlier records. They want to find out if you altered the records after the claim was made. To do this, the plaintiff will often compare the records you



supplied to providers or to patients during the course of treatment with those you supplied after being notified of litigation. The plaintiff's attorney will look for new entries, pages missing from the first set of records and pages added to the first set of records.

- **The Penalty for Altering Records**. Improperly changing clinical documents can invite a world of trouble, in addition to jeopardizing a malpractice defense. In some states, you could face criminal charges for fraud and perjury, or you could lose your license. Authorities/state boards may consider an alteration serious professional misconduct.

Things that may help the plaintiff's case against you:

- **A complete history was not taken**. One of the problems with treating friends or relatives is that they may not want to reveal private clinical information they would share with a doctor with whom they do not have a personal relationship.
- **A complete chiropractic exam was not performed**. The environment or social setting is generally not conducive to what D.C.s can do in their office.
- **A formal, definitive diagnosis was not rendered, which, in any event, is not recorded**.
- **Informed consent was not obtained**. When adjusting a friend or relative, the D.C. may neglect to discuss risks or potential adverse outcomes.
- **A treatment plan was not determined**. The "quick adjustment" is invariably a one-time thing, with no thought given to follow-up.
- **There are no SOAP notes.** Without charting, a D.C. could very well have examined the patient, asked about his or her history, and discussed risks. However, without a contemporaneously made record, there is no proof of anything—and make no mistake, people remember things differently.