

1
Introduction

Preamble

The intent of these Educational and Patient Care Protocols is to communicate trends in chiropractic education and patient care as practiced in the Health Centers of the New York Chiropractic College.

Rather than reiterating detailed diagnostic protocols that are widely disseminated through the health care literature, this text portrays a mixture of flowcharts and case management notes designed to divulge basic case management guidelines utilized in the Health Center. This information is designed to:

1. display a rational and orderly progression of assessment and management

2. provide the clinician educator and student interns with a set of guidelines to supplement sound clinical judgement

3. display summaries of key decision points

Basic strategies of patient management presume that a detailed case history was obtained before performing diagnostic examinations or providing health care. The case history forms the basis for the clinical examination and the ordering of specific diagnostic (imaging and laboratory) tests.

The intent of the clinical examination is to assess the patient in an attempt to form a clinical database so that a working diagnosis can be proposed and a management plan designed.

The management plan, which is arrived upon completion of the clinical database and the formulation of the working diagnosis, should include:

1. short and long term goals with rationale

2. reassessment plans

3. mode and frequency of care

4. patient education and self care (home instruction)

5. intradisciplinary or interdisciplinary referral or consultation

Finally, the clinician educator must monitor the patient with the intent of completing care for the identified clinical condition when no further improvement in the patient's condition can be expected. Determining the need for supportive care as needed is, however, an inherent aspect of this responsibility, as is the offering of wellness care.

The goal of patient care is generally to speed and enhance the quality of natural healing to maximize function while minimizing symptoms. At the same time, a clinician educator should seek to improve the patient's health related quality of life through education and chiropractic management protocols.

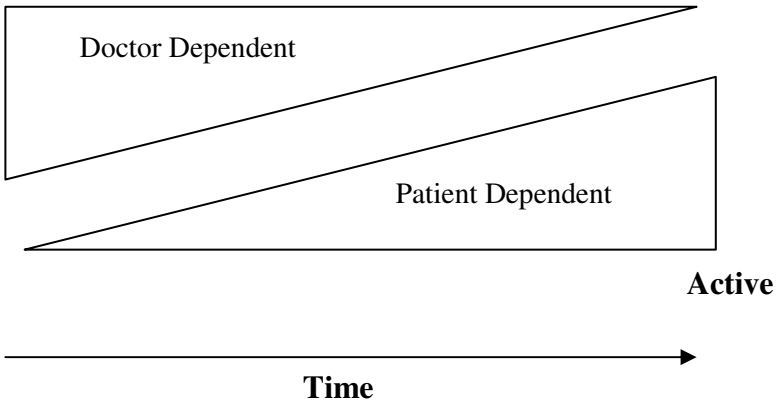
In the process of managing a patient's clinical problem, chiropractors may utilize a wide variety of management strategies. This may increase the speed and quality of healing dramatically including the correction of chiropractic subluxations with the chiropractic adjustment. To maximize this shared goal of improving health related quality of life, both the chiropractor and the patient must be active participants in this process. This concept of shared responsibility in the maintenance of health is referred to as passive and active care and can be defined as:

Passive Care: the application of health management protocols to a patient who passively receives treatment from a provider.

Active Care: progressively increasing the patient's level of responsibility and involvement in his/her health care process (typically this involves a patient's involvement outside of the treatment room and includes self-administered home care).

Levels of Patient/Doctor Responsibility

Passive



It is the responsibility of the Office of Academic Quality Assurance and Support (AQUAS) to observe, document, and report compliance with the Educational and Patient Care Protocols within the Health Center system. Based on information provided by AQUAS, the Office of Academic Affairs will propose modifications to the protocols that will allow for continuous improvement to them. Academic Affairs will recommend changes in the protocols to the Executive Vice President/Provost and the President, who will approve modifications as deemed necessary.

The Need for Educational and Patient Care Protocols

The clinician educator is practicing in a healthcare environment that demands performance as a portal of entry healthcare provider. The College Health Center system must continually evaluate and monitor the degree of success with which it is fulfilling this role. Health Center Educational and Patient Care Protocols are an attempt to define and describe quality chiropractic education and patient care.

1. The clinician educator must be held accountable for the level of care delivered to the health center patient and relate consistent information concerning health care to the chiropractic intern. Educational and patient care protocols cannot be a matter of individual preference or inclination.

2. The protocols should describe the scope of practice available to all patients and are the basis for standards of practice applied to diagnosis and management. The Health Center scope of practice is further based upon legislative (statute) and scientific (research/educational) parameters.

3. The protocols will serve as a standard by which Health Center activities may be evaluated. As the college monitors compliance with protocols, patients will benefit by receiving consistent, state-of-the-art quality care. The protocols will serve as a foundation for ongoing quality assurance in the health center setting.

4. The establishment, and ongoing review, of the protocols will also help ensure high quality intern education. Faculty will instruct students using agreed upon standards for clinical care and be able to assess intern outcomes in a more consistent manner. Protocols allow for more accurate and standardized intern assessment.

5. Protocols for chiropractic practice, standards of care, and quality of care are also the responsibility of the profession at large. Objectives for such protocols used at New York Chiropractic College (NYCC) will be continually modified to not only reflect our responsibility but also that of the chiropractic profession as a whole.

Confidentiality Statement

Each patient's clinical record is the property of NYCC. All records must remain in the custody of NYCC at all times (except when subject to subpoena). Photocopies of your records are available to you at your request. As an educational institution, NYCC may utilize information contained in the patient's clinical record for scholarly research and instructional purposes. In such instances, the patient's identity will be protected.

_____

Name Printed

_____ _____

Signature Date

Protocols for Practice in the Health Centers

Establishing the doctor/patient relationship

1. The clinician educator must establish a confidential relationship with the patient and determine (through an initial consultation, case history, and examination) the nature of the patient's health problem.

2. The clinician educator should determine whether to proceed with patient care or make a referral to another health care provider. To meet these objectives the clinician educator must:

   a) accept responsibility for the care of the patient
   b) recognize their own professional capabilities and determine if the patient's condition is within the scope of chiropractic management
   c) employ measures of observation and evaluation to profile the patient's health problem(s)
   d) continue to provide care and/or refer the patient to the approved health care provider(s)
   e) protect the patient's confidentiality by assuring that the clinical records shall be released only upon the patient's authorization

The case history

1. The clinician educator is obligated to obtain a case history to determine if the patient has a health problem that may be responsive to chiropractic care or if referral to or concurrent care with another health care provider is needed.

2. Case history information is to be permanently recorded in the patient's health record.

3. A detailed case history should be obtained before performing diagnostic procedures, providing health care, or referral. The case history is the basis and foundation for the clinical examination and the ordering of specific confirmatory diagnostic (imaging or laboratory) tests.

The examination

The clinician educator must:

   a) perform, interpret and document appropriate clinical examination procedures
   b) when appropriate, order and use specific diagnostic tests based on information obtained in the case history and other clinical examination procedures
   c) arrive at, and record a working diagnosis based on the highest current level of knowledge and understanding of the patient's case

The working diagnosis

1. A working diagnosis must be arrived at and recorded prior to initiating patient care. When determining and documenting the working diagnosis, the clinician educator must:

   a) use and document the results of appropriate diagnostic procedures and techniques
   b) arrive at and record a working diagnosis
   c) recognize and document concomitant conditions and make appropriate referrals and patient care modifications where needed

2. The clinician educator is obliged to obtain medical records and data from other health care providers rather than repeating a diagnostic test at cost to the patient.

Informed consent and the report of findings

The clinician educator is obligated (must) to discuss the following with the patient prior to rendering care. The report of findings will include:

a) the clinical impression/working diagnosis(es)
b) the management/treatment plan
c) risks and/or complications that may be apparent regarding the condition itself, or the treatment that may be given
d) any alternatives for the management of the diagnosed conditions
e) the likely outcome of chiropractic care and management for the diagnosed conditions

After the patient is informed regarding the above items and related questions answered to his/her satisfaction, the clinician must obtain the patient's consent to initiate treatment.

Plan of care

The clinician educator must decide on appropriate chiropractic care taking into account all contraindications to the planned management. The clinician educator must:

a) provide patients with only those treatment methods that fall within the scope of practice and the tenets of the Health Center system
b) identify any contraindications or non-indications to chiropractic care and if necessary refer to an appropriate health care professional
c) apprise the patient in terms that are understandable to him/her of all procedures, including the probable results of care and outcome(s) if no care is delivered
d) record and date all patient interaction in the file

Evaluation of progress

The clinician educator must monitor the patient to assess desired outcomes and to make appropriate changes in management as required. This assumes:

a) instituting appropriate chiropractic management
b) modifying the management plans to the needs of the individual patients
c) using only those chiropractic adjusting techniques in which competency has been achieved and demonstrated
d) using only those modalities of treatment for which competence has been achieved and demonstrated
e) re-evaluating the patient in a set period of time

Discharging the patient

The faculty clinician educator must monitor the patient with the intent of discharging the patient at the end point of management or establishing through Maximum Clinical Improvement (MCI) when no further improvement in the patient's condition can be expected. Follow-up (supportive) care as needed is, however, an inherent aspect of this responsibility, as is providing the opportunity for patients to receive wellness care. Clear documentation of the phase of care/management must be present in the patient's file.

Record keeping and documentation

1. Record keeping and documentation is to be within the guidelines established by the Council on Chiropractic Education (CCE) and other state and federal law regulations:

   a) it is essential for the clinician educator to maintain adequate legible and intelligible patient progress notes. The notes contain the patient's statements of reactions to care, improvement, lack of improvement, and any notes pertinent to the patient's management
   b) the clinician educator must monitor and record the patient's progress and upgrade the working diagnosis and prognosis if necessary
   c) the patient's progress must be evaluated at each visit

2. The patient file should include:

   a) base history
   b) date of history
   c) present complaint/chief complaint
   d) description of accident/injurious event or other etiology
   e) past history, family history, social history
   f) review of systems
   g) past and present chiropractic/other medical professional care and attempts at self treatment
   h) all appropriate patient examinations/databases, SOAP notes and daily records
   i) doctor's signature/intern's signature on all patient interactions

3. Examination findings should include:

   a) vital signs
   b) physical examination

c) neuromuscular examination, inclusive of orthopedic and neurological examinations
d) instrumentation
e) functional observations
f) other chiropractic examination procedures

4. Documentation of diagnostic tests should include:

a) diagnostic imaging
b) laboratory tests
c) information from other institutions, clinics, and health care professionals

5. Assessment and outcome instruments should include:

a) visual analog scale
b) pain diagrams
c) general health status measures
d) pain questionnaires and pain disability instruments (Oswestry, Neck Disability Index)
e) patient satisfaction indices

6. Clinical impression:

a) is obtained after completion of the subjective and objective data base
b) may be preliminary
c) may comprise more than one diagnosis
d) must be dated
e) must include primary, secondary and tertiary elements of the diagnosis
f) must include appropriate diagnostic coding

7. Management plan arrived upon completion of the clinical database and the formulation of the initial clinical impression and should include:

a) short and long term goals with rationale
b) reassessment plan
c) mode and frequency of care
d) patient education and self care plan (home care)
e) intradisciplinary or interdisciplinary referral or consultation

8. Progress notes must document every encounter with the patient and should include the following under the subjective notations:

a) the patient's chief complaint or reason for the patient encounter, documenting the patient's qualitative and/or quantitative symptoms
b) qualitative data may include pain descriptions (onset, palliative/provocative, quality, radiation, severity, temporal [OPQRST]), functional status (how symptoms are affecting function)

c) quantitative data may include visual analogue pain scale (VAS), pain diagrams, and numerical pain scales
d) the history dictates which examination procedures are necessary

9. Subsequent patient encounter assessment related to the initial complaints of the patient with objective documentation of findings should include:

a) inspection
b) palpation
c) range of motion
d) provocative testing (orthopedic)
e) neurological tests (muscle stretch reflex, sensory, motor evaluation)

10. Specific treatment/management plans should include:

a) the type and area of adjustment
b) therapeutic exercise (keep copies in chart of any material given to patient)
c) rehabilitation
d) the type, location and parameters of adjunctive therapy
e) home instructions (keep copies in chart of any material given to patient)
f) response to management
g) signed and dated entry

11. Signed and dated documentation of patient communications should include:

a) internal patient memoranda
b) phone conversations and other conversations with patients regarding their health care

12. External documentation and all records arising from outside the health center dealing with the patient's health record must be documented, copied, and placed in the file. Such documentation includes:

a) correspondence to and from other health care providers
b) correspondence to and from attorneys
c) correspondence to and from the patient
d) correspondence to and from payor groups
e) health records
f) consultation reports
g) imaging and lab reports

13. General requirements for record keeping and documentation should include:

a) dating all file entries
b) ensuring all file entries are legible and entered in black ink
c) dating and signing any changes in file entries
d) making sure that all signatures are legible (or displays printed name) and are in ink

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