



The Royal College of  
**Chiropractors**

Chiropractic Practice Standard  
**Clinical Record Keeping**

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Chiropractic Practice Standard

### **Clinical Record Keeping**

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## About this Chiropractic Practice Standard

The Royal College of Chiropractors' Chiropractic Practice Standards are evidence-based documents designed to help chiropractors meet their obligations in the provision of patient care and/or the governance of their services. For each area of practice, they:

- Highlight relevant elements of the General Chiropractic Council's Code, and relevant legislation, as requirements;
- Provide expected standards of practice informed by the evidence;
- Provide additional helpful guidance; and
- Provide a benchmark for normal practice.

This Chiropractic Practice Standard is concerned with clinical record keeping.

Effective clinical record keeping is vital in the provision of safe, high quality, evidence-based healthcare. The General Chiropractic Council's Code defines a patient's record as:

*Document containing personal information and information relating to the clinical assessment and working diagnosis or rationale for care of a patient. Typically it should include: relevant clinical findings, decisions made, actions agreed, names of those involved in decisions and agreement; information provided to the patient and the name of the person creating the record.*

This Chiropractic Practice Standard focuses on the principles and expected standards of clinical record keeping in a chiropractic care setting and aims to assist chiropractors in achieving those standards.

## 1. Key Aspects of Clinical Record Keeping

### *Requirements*

The records you keep must be an accurate reflection of the clinical encounter and must include any factors relevant to the patient's ongoing care, including their general health (Principle H: The Code, GCC). Furthermore, you must:

- keep information about patients confidential and avoid improper disclosure of their personal information (H1: The Code, GCC),
- only disclose personal information without patient consent if required to do so by law (H2: The Code, GCC),
- ensure your patient records are kept up to date, legible, attributable and truly representative of your interaction with each patient (H3: The Code, GCC),
- ensure the safe storage of patient records so that they remain in good condition and are kept secure. Storage should be for at least a period relevant to the age of the patient as prescribed by law (H4: The Code, GCC),
- make proper arrangements if you close down your practice or move clinics and have appropriate arrangements in place in the event of your death (H5: The Code, GCC),
- make sure that patient records remain your responsibility, even where a patient has moved, unless you have contractually transferred this responsibility to another healthcare professional or organisation (H6: The Code, GCC),
- give patients access to their personal health records as required by law (H7: The Code, GCC), and
- comply with the Data Protection Act 2018<sup>1</sup> and UK GDPR<sup>2</sup>.

### *Expected Standards of Practice*

- Records that contain personal information about patients, colleagues or others must be kept securely, and in line with any data protection law requirements<sup>3,4</sup>.
- Records need to be clear, accurate, attributable and legible. They should be made at the same time as the events you are recording, or as soon as possible afterwards<sup>3</sup>. Records are intended to support patient care and should authentically represent each and every consultation (including by telephone). Clinical records also provide evidence of patient interactions and decision making that can be reviewed by authorised third parties, and referred to in the case of disputes and complaints<sup>4</sup>. Keeping patient's records up to date is important for continuity of care<sup>5,6,7</sup>.
- As health professionals, chiropractors must ensure continued safe storage of clinical records in line with data protection law. If you are operating an independent practice, you will be responsible under regulation and ICO guidance to store and adequately protect records against such events as accidental loss, including corruption, damage or destruction regardless of their format<sup>4,8</sup>.
- Chiropractors must allow appropriate patient access to records.

### *Guidance*

Detailed guidance on relevant areas concerned with these Expected Standard of Practice can be found in the subsections below. Information provided is applicable regardless of the format in which records are kept, for example: digital, handwritten, verbal recordings, or

video recordings. If handwritten notes are being made these should be made in pen, not pencil.

Clinical health records should include:

- relevant clinical findings,
- the decisions made and actions agreed, and who is making the decisions and agreeing the actions,
- the information given to patients,
- any drugs prescribed or other investigation or treatment, and
- who is making the record and when<sup>3</sup>.

In addition to the Requirements and Expected Standards of Practice above, chiropractors should:

- remain familiar with all relevant GCC guidance,
- share and transfer information appropriately, adhering to regulation.

## 2. Clinical Aspects

### 2.1 Clinical History

#### *Requirements*

- Obtain and document the case history of each patient, using suitable methods to draw out the necessary information (C1: The Code, GCC).
- Ensure your patient records are kept up to date, legible, attributable and truly representative of your interaction with each patient (H3: The Code, GCC).

#### *Expected Standards of Practice*

- Chiropractors should gain and record a detailed clinical history from the patient before performing any examination, or commencing any treatments, investigations or other interventions.
- Case histories should record all aspects of the patient's health, not just those directly related to the patient's musculoskeletal health.
- Clinical records, at an initial consultation and any subsequent interactions, should accurately reflect the patient interaction.
- Clinical records should be made at the time of the interaction, or as soon as possible afterwards, in order to be contemporaneous.
- Any retrospective amendments to clinical records should be made without removing the original entry (inaccurate entries should be struck through rather than deleted) and should include details of why the records have been amended, when they were changed, and by whom<sup>9</sup>.

#### *Guidance*

General Chiropractic Council Guidance on Confidentiality<sup>10</sup>.

Chiropractors should document all the information discussed, including any specific requests or concerns expressed by the patient, any written, visual, or audio information, or any other

support given to the patient<sup>6</sup>.

Chiropractors should record details of any patient triaging along with results of stratifying tools together with baseline scores of any outcome measures.

The documenting of a patient's account not only applies to new patients and first appointments, but also to all subsequent interaction with the patient, after which there is a requirement to update the patient's record and document all relevant and pertinent additional information and discussions<sup>6</sup>.

Consider using templated case history forms to ensure all aspects are fully covered. Any pre-treatment forms should be used as guidance only and should never replace the clinician's interviewing skills. Interviewing the patient is key to ensure information provided on any patient completed form is accurate and full.

The recording of a patient clinical history should be wide-ranging, and might be expected to include:

- a detailed history of the presenting complaint, including its location, onset, duration, timing, progression and functional impact,
- predisposing, aggravating and relieving factors,
- symptom characteristics, including quality, severity, frequency and pattern,
- pertinent negatives in a history, particularly those with relevance to excluding certain diagnoses and pathology (e.g. red flags),
- past history and management of the presenting complaint (including previous episodes, investigations and management),
- relevant psychosocial and contextual factors, such as attitudes, beliefs, behaviours, concerns, expectations, relationships and work or social environments,
- lifestyle and exercise habits, including details of occupation, diet, alcohol consumption, smoking, recreational drug use and physical activity,
- a medical history and systems review, including any history of trauma, hospitalisations and surgery,
- any medications and supplements being taken, and
- an appropriate family history.

Clinical entries need to be decipherable at a later date either by yourself, the patient, clinical colleagues or relevant third parties. Shorthand is often used in clinical notes for speed and accuracy, but the use of abbreviations is best limited to those in common use. Those with more than one meaning should be avoided. Consideration should be given to producing a glossary of frequently used terms/symbols that can be provided alongside the clinical records.

## **2.2 Examination & Investigations**

### *Requirements*

- When carrying out a physical examination of a patient, use diagnostic methods and tools that give due regard to patient health and dignity. You must document the results of the examination in the patient's records and fully explain these to the patient (C2: The Code, GCC).
- Ensure that investigations, if undertaken, are in the patient's best interests and minimise risk to the patient. All investigations must be consented to by the patient.

You must record the rationale for, and outcomes of, all investigations. You must adhere to all regulatory standards applicable to an investigation which you perform (C8: The Code, GCC).

#### *Expected Standards of Practice*

- Chiropractors must clearly record all examination findings (positive, negative, and equivocal) within the patient's clinical record. This should be completed at the time of the examination, or as soon as possible afterwards, in order to be contemporaneous<sup>6</sup>.
- Results of the examination should be shared with the patient in a format understandable by them.
- The reasons for any investigation being carried out must be recorded together with the patient's consent, the results of the investigation and the relevance of these to the patient.
- The details of any referral for an investigation (e.g. letter or form) should be incorporated into the clinical records.
- Chiropractors using or referring for imaging should be aware of up-to-date regulatory standards, including any additional recording requirements.

#### *Guidance*

Chiropractors should record the sharing of examination findings. This would most commonly form part of the report of findings.

Chiropractors should consider using templated examination routines with space for additional information. This may assist in ensuring examinations are complete and recorded fully.

The GCC has published Diagnostic Imaging Guidance<sup>11</sup> to assist chiropractors in making decision relating to imaging, including references to relevant ionising radiation regulations and relevant record keeping.

### **2.3 Diagnosis & Care Planning**

#### *Requirements*

- Use the results of your clinical assessment of the patient to arrive at a working diagnosis or rationale for care, which you must document. You must keep the patient fully informed (C3: The Code, GCC).
- Develop, apply and document a plan of care in full agreement with the patient (C4: The Code, GCC).
- Obtain and record consent from a patient prior to starting their care and for the plan of care (E2: The Code, GCC).
- Explore care options, risks and benefits with patients, encouraging them to ask questions. You must answer fully and honestly, bearing in mind patients are unlikely to possess clinical knowledge (F1: The Code, GCC).
- Ensure your patient records are kept up-to-date, legible, attributable and truly representative of your interaction with each patient (H3: The Code, GCC).

#### *Expected Standards of Practice*

- Chiropractors must clearly record their working diagnosis, or rationale for care.



- A recorded working diagnosis or rationale for care should be evidence-based and include duration and any possible secondary causes.
- In order to record the discussion and development of a plan of care, the following should be documented in the patient records:
  - a summary of the explanation of your findings given to the patient (report of findings),
  - the patients' concerns, expectations and wishes, and the effect these have on the plan of care,
  - alternative treatment options discussed, including the consequence of providing no care (the natural history of their complaint),
  - the risks and benefits of providing treatment, including any side-effects, adverse reactions and complications. Evidence based/best practice guidance should be used and recorded where possible, and
  - the expected outcome of any care proposed (prognosis).
- The following should be documented in the patient records to confirm an agreed plan of care:
  - agreed aims of care (in terms of symptoms, function and activities of daily living),
  - any proposed further investigations,
  - the proposed management, including details of any package of care (including techniques, management approaches, active care and other self-management strategies, and co-management approaches),
  - proposed frequency and duration of care (treatment schedule), and
  - informed consent to the plan of care.
- To record an expectation of how the plan of care will be evaluated, the following should be documented in the patient records:
  - how progress with the plan of care will be reviewed (e.g. outcome measures),
  - any possible options discussed with regard to additional investigations and/or referrals, and
  - the time when a formal review will be carried out.

### *Guidance*

Chiropractors should document all relevant clinical findings, including associated or causal factors, that lead to a working diagnosis and any differential diagnoses being provided.

The prospect of serious differential diagnoses being likely, together with mitigating actions to monitor this possibility, should be recorded.

Key elements of patient discussion around the working diagnosis and any differential diagnoses should be recorded along with any pertinent questions raised by the patient.

Alternative treatment options to discuss with patients and record (in addition to providing no care) could include the use of variety of different techniques or clinical approaches, self-management, GP referral or referral to another healthcare practitioner.

In considering areas of risk to be discussed and recorded, consideration of the following areas may be appropriate:

- bone health (particularly relating to osteoporosis and fractures),

- serious spinal neurological complications (e.g. cauda equina syndrome and myelopathy),
- inflammatory spondyloarthritis (including ligament calcification), and
- cardiovascular fragility (e.g. coronary artery disease, bleeds, etc).

Chiropractors should make themselves aware of the following clinical resources:

- Royal College of Chiropractors' Quality Standards<sup>12</sup>
- National Institute of Clinical Excellence (NICE) Clinical Knowledge Summaries (CKS)<sup>13</sup>

## 2.4 Consent

### *Requirements*

- Obtain and record consent from a patient prior to starting their care and for the plan of care (E2: The Code, GCC).
- Check with the patient that they continue to give their consent to assessments and care (E3: The Code, GCC).
- Obtain and record the express consent (i.e. orally or in writing) from the patient regarding sharing information from their patient record. You must not disclose personal information to third parties unless the patient has given their prior consent for this to happen (E7: The Code, GCC).
- Ensure your patient records are kept up to date, legible, attributable, and truly representative of your interaction with each patient (H3: The Code, GCC).

### *Expected Standards of Practice*

- Informed consent from a patient must be obtained and recorded before commencing any form of treatment or intervention.
- Chiropractors must seek continued consent throughout the care plan, not just prior to starting care. Initial and ongoing consents should be adequately recorded in the patient record.
- Consent is ongoing and may be withdrawn by the patient at any time in the care plan without reason or justification. Chiropractors must clearly record when consent has been withdrawn, with the reason if one is given. If no reason is given, this should also be recorded.
- Key elements of your discussion with the patient must be documented in the patient's clinical record or dedicated consent form which is kept as part of the patient's clinical record<sup>6</sup>.
- Consent forms must document the key discussions held with the patient otherwise they are unlikely to be adequate<sup>6</sup>.
- Chiropractors must understand implied consent and that it is only valid if the patient knows and understands what they are agreeing to. If you are unsure whether you have valid consent, you should seek explicit consent before proceeding<sup>6</sup>. Clear records of implied consent, or the need to clarify consent, must be kept in the patient's clinical record.
- Chiropractors must record if consent is not gained for reasons of:
  - involuntary consent due to pressure from chiropractor, chiropractor's staff, family members or anyone else on the patient,
  - lack of understanding by the patient to make an informed decision,

- lack of capacity for the patient to make an informed decision (this should not be a decision based solely on age),
  - temporary lack of ability by the patient to consent due to illness, fatigue, shock, effects of drugs and/or alcohol, and
  - lack of an appropriate legally consenting adult when treating children, vulnerable adults or anyone else without capacity to make decisions on their care.
- Chiropractors must record when treatment is not provided for reasons of inadequate consent.

### *Guidance*

GCC Guidance on Consent<sup>6</sup>.

The use of a single consent form for all treatments provided by a clinic or chiropractor is unlikely to be adequate. Consent regulation is such that gaining and recording consent must be specific to the patient and especially highlight key discussions had with the patient that may affect consent.

In order to ensure that specific consent is recorded, chiropractors should consider the use of a consent form that is designed to allow individual key points to be recorded, recognising the discussion of individualised needs and considerations prior to gaining adequate consent.

Whilst chiropractors would not be expected to have different consent forms for every management modality offered, they should consider having multiple consent forms to cover distinct forms of management e.g. shockwave therapy, medical acupuncture and imaging.

## **2.5 Management**

### *Requirements*

- Obtain and document the case history of each patient, using suitable methods to draw out the necessary information (C1: The Code, GCC).
- When carrying out a physical examination of a patient, use diagnostic methods and tools that give due regard to patient health and dignity. You must document the results of the examination in the patient's records and fully explain these to the patient (C2: The Code, GCC).
- Check with the patient that they continue to give their consent to assessments and care (E3: The Code, GCC).
- Ensure your patient records are kept up to date, legible, attributable, and truly representative of your interaction with each patient (H3: The Code, GCC).

### *Expected Standards of Practice*

- Clinical records, for all patient interactions, should accurately reflect the patient interaction, including the subjective report of the patient, any assessment carried out, all treatment/interventions delivered, advice given, exercises prescribed, additional material provided and any discussion about ongoing care.
- Details of any psychologically-informed care should be recorded, including behaviour change approaches, goal-orientated techniques and any relevant self-management strategies.
- A copy of any printed advice, instructions or manual should be maintained as part of the clinical record. Details of online resources should also be recorded in the patient's records.

- For any new technique or clinical approach, an explanation and consent should be recorded after the risks and benefits, alternatives and outcomes have been discussed with the patient.

### *Guidance*

Chiropractors should provide enough detail about specific management in the patient's record so that a colleague would be able to understand exactly what had taken place and be able to reproduce the procedures and manage the patient appropriately.

Should another person be present while providing care, whether it be a colleague, student or someone accompanying the patient/acting as a chaperone, ensure that their presence and involvement is documented in the clinical record and consent recorded, as appropriate.

Any conflicts of interest should be recorded in the clinical record.

If something goes wrong with the care of a patient which causes, or has the potential to cause, harm or distress, you should ensure that all discussions and subsequent actions are fully recorded in the clinical record.

## **2.6 Reviews, Modifications to Care Plans, Referrals & Ceasing Care**

### *Requirements*

- Justify and record your reasons for either refusing care or discontinuing care for a patient. You must explain, in a fair and unbiased manner, how they might find out about other healthcare professionals who may be able to offer care (B8: The Code, GCC).
- Develop, apply and document a plan of care in full agreement with the patient. You must check the effectiveness of the care and keep the plan of care under review. A more formal reassessment of the effectiveness of the plan of care must be undertaken at intervals that suit the patient and their needs. All subsequent modifications to the plan of care must be discussed and agreed with the patient and properly documented (C4: The Code, GCC).
- Follow appropriate referral procedures when making a referral or a patient has been referred to you; this must include keeping the healthcare professional making the referral informed. You must obtain consent from the patient to do this (C7: The Code, GCC).

### *Expected Standards of Practice*

- Chiropractors should be able to keep a working diagnosis under review and adapt the care provided as necessary
- When reviewing a plan of care, the following should be documented in the patient records:
  - the date that a formal review was conducted,
  - reflections on the effectiveness of the plan of care and whether the aims of care have been met,
  - details of any conversation with the patient in reviewing their care,
  - the findings of any assessment / examination,
  - results of any outcome tools used, and

- whether any modifications to the plan of care are agreed, or whether care will be discontinued.
- If any modifications to the plan of care are agreed with the patient, an amended plan should be documented, which should include:
  - new agreed aims of care (in terms of symptoms, function and activities of daily living),
  - any proposed additional investigations,
  - the proposed ongoing management, including details of any package of care (including techniques, management approaches, active care and other self-management strategies, and co-management approaches),
  - proposed frequency and duration of ongoing care (treatment schedule), and
  - informed consent to the new plan of care.
- When care is ceased, the reasons should be documented, together with any ongoing advice and/or referral.
- If the patient is co-managed by another healthcare professional(s), details of roles, responsibilities and activities should be documented.
- The reasons for any referral should be documented, together with the consent of the patient.
- Copies of any referral letters should remain part of the patient record. In the case of verbal referrals, a detailed description of any conversation should be recorded.

### *Guidance*

The use of templates can be helpful to ensure that all the necessary information is recorded.

When patient preferences alter the nature of a plan of care, or result in care being ceased, this should be clearly recorded in the patient records.

Any separate outcome measure reports should remain part of the patient's clinical records, and reference should be made to them having been carried out in the chronological treatment notes.

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Reference is also made to the General Chiropractic Council's Code throughout this document: General Chiropractic Council (2016, amended 2019) The Code: Standard of conduct, performance and ethics for chiropractors. <https://www.gcc-uk.org/i-am-a-chiropractor/guidance/the-code> (Accessed 10 April 2023).





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