Documentation: What, Why & How

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When you have 400 athletes steadily streaming through your athletic training facility en route to three, four or even five different venues (all of which need medical coverage), paperwork can fall to dead last on the priority list.

But it shouldn't.

Proper documentation is an important way to improve the care you're able to deliver and prove the value of your services.

Why Should You Document?

State statutes, the Board of Certification Standards of Professional Practice, the NATA Code of Ethics and the Athletic Training Educational Competencies insist on proper record-keeping as a key tenant of professional practice.

The BOC's Standards and NATA's Code of Ethics each stipulate the athletic trainer is responsible for maintaining complete written records of all services (see the BOC's Standard 7 and Code 3, and NATA Code of Ethics Principles 2-4).

While documentation is a required part of professional practice, there are many additional reasons to keep good records.

1. Communication

Good medical records are the building blocks of success in health care delivery. Properly recording all the steps of an evaluation or treatment:

- Allows for correct planning and execution of care;
- Eliminates confusion about the diagnosis and prognosis;
- Keeps all the health care professionals involved in a case knowledgeable.

2. Legal Responsibility

There's no escaping the fact that health care is the target of many a lawsuit. Documentation is critical in such cases.

If issues or conflicts arise, all parties involved will scour available medical records, searching for anything to support their cases. If your records are incomplete or poorly kept, your treatments are cast in doubt. And if you performed evaluations or treatments but did not record them, it's as if they never occurred. In most cases, courts rely on medical records to prove what happened.

3. Research

The profession is focused on increasing evidence-based practice. How? By using research to determine if what we're doing is the best we can be doing.

Detailed documentation – precise, accurate record-keeping – helps researchers spot trends and evaluate best practices.

4. ROI

Documenting everything you do can help verify to administration the need for additional staff, improved facilities or other changes in working conditions. It can show the value of athletic training services.

By keeping detailed records, you're also able to illustrate traffic patterns in the athletic training facility, which can help refine your own resource management.

5. Reimbursement

Going hand-in-hand with proving the value of athletic training services, documentation can help reimbursement efforts.

Documentation supporting a patient's interaction with the health care system is required before insurance companies will reimburse.

The Facts About Medical Records

Many facets of athletic training require documentation (budgeting, scheduling, etc.). For now, let's focus on creating and maintaining medical records.

A patient's medical record creates a clear, chronological "story" of the patient's interaction with health care providers. Readers should be able to understand the rationale behind decisions, and the documentation should show the link between services provided and the desired outcome. This helps all providers plan and evaluate treatments and monitor a patient's progress over time.

What is a Medical Record?

In some states, "medical record" is defined by law, and some institutions define it as well. Generally, a medical record contains:

- Medical information (personal medical history, family medical history, orthopedic history, physical examination)
- Evaluation of injuries
- Treatments
- Referrals

Each individual patient record should be labeled with the date and the identify of the provider and should state the reason for the encounter; any relevant history; any physical

exams and findings; any prior test results; diagnosis, assessment and clinical impressions; plan of care. The patient's name and file number should be included on every page.

Other elements to consider in your documentation include general health; social habits; functional status as perceived by the patient; current activity level; medications (OTC and Rx); vitamins/supplements; patient compliance (missed appointments, etc.); prior and concurrent treatment; record of phone calls pertinent to the patient's case (date/time, name of caller, issues discussed, resolution).

With the constant activity and patient turnover in the athletic training room, there are few blocks of time available for documentation. Interruptions are the norm, not the exception. So, if you need to multi-task while inputting information, be sure to secure the patient information in accordance with HIPPA privacy and security rules before moving on to your next task.

How to Maintain Documents

Traditionally, documentation meant literal paperwork, but today's electronic era offers options.

Paper Records

Documentation via paper can take the form of standardized blank forms created by you or your institution; standardized forms developed by insurance carriers or other third parties; "journal-style" briefs of no more than three sentences; journal-style narratives; SOAP notes; carbonless forms; and more. Paper documentation is generally maintained in a folder, or chart.

Computer Records

Storing medical records electronically has become the norm. Several medical record software packages are available, tailored to the needs of athletic trainers. (ATS, Presagia Sports, SimTrak and SportsWare are just a few.) Electronic record-keeping saves space otherwise occupied by file cabinets, but it requires an investment of time when entering data into a record, and it absolutely must be backed up in a secure manner to prevent hacking or loss of files.

Length and Manner of Storage

Whether you choose to store documentation as hard copies or electronically, you must keep security and longevity in mind.

Medical records must remain private and must be maintained through the statute of limitations set by the state. Often this statute of limitations corresponds to the length of time a patient is afforded to file malpractice claims. For minors, however, the statute of limitations might not begin until the patient reaches adulthood.

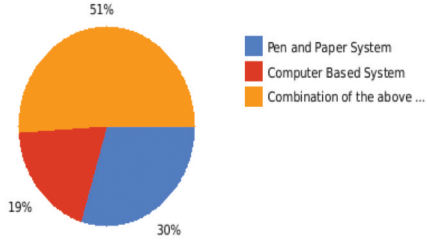
Be sure to check state law before destroying records, as there might be statutes governing the method of destruction as well as the timing.

Survey Results

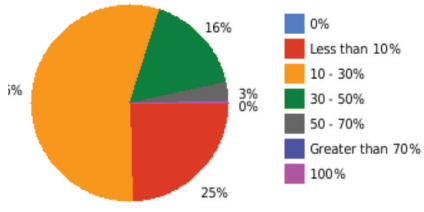
An informal poll of 200 athletic training personnel shed light on how documentation is currently being accomplished.

Each poll participant was asked the same 14 questions and was asked to forward the survey to their own athletic training contacts. Responses were received from 200 people.

What method do you use to document?



Approximately what percentage of your job duties is devoted to documentation?



Summary

A medical record should be complete enough that in two days, two months or two years, you or anyone else can read it and understand the situation.

Most athletic trainers are working with hundreds of athletes, so thorough documentation can be difficult to achieve. Yet ATs are medical professionals required by professional and ethical standards to maintain accurate, thorough records in all settings.

Additional Resources

This article was adapted from a live presentation that has been converted to a CEU course. The course features an expanded look at documentation, along with additional resources, a list of acceptable medical abbreviations and more.

Find it in the NATA Quiz Center at www.nata.org/quiz-center.

Reach Chris Mathewson at chris_mathewson @msn.com.

10 Tips for Documentation

1. Label every page with the patient's name and the date.
2. Indicate the date and time of each entry and sign the entry in ink, complete with your professional title.
3. Use language that is specific, objective, concise and complete.
4. When in doubt, RECORD IT.
5. Stay up-to-date on your documentation. Record entries within 24 hours of patient contact.
6. To correct an inaccurate record, make sure the original entry remains legible and clearly state why it is being changed. NEVER obliterate any part of a record.
7. Document each episode of physical medicine and rehabilitative care and treatment.
8. Maintain permanent records for every case.
9. Keep your files orderly and professional, complete, accurate and legible.
10. Use only standard English and only universally recognized medical abbreviations. If an abbreviation would allow room for confusion, do not use it.