CCOA

Chart Stimulated Recall

COLLEGE OF CHIROPRACTORS OF ALBERTA

Supervisor Name		Date:
Supervisee Name		

The Chart Stimulated Recall is an activity in which the supervisor interviews a supervisee about the care delivered by the supervisee to a patient. The selected patient health record is used to help guide recall about the details.

- The supervisee uses the recall to reflect on and improve their practice.
- The supervisor uses the recall to evaluate the supervisee's clinical decision-making.

Instructions:

- One patient health record is selected by the preceptor to be used for the discussion.
- The patient health record is the source of information that informs the complete discussion.
- The supervisor reviews the chart prior to the interview.
- It is anticipated that the interview will last approximately 45 minutes to one hour.
- The questions in the table below are the basis of the discussion.
    - Every question may not be applicable to every chart.
        - The supervisee must only perform activities that they are authorized and competent to perform.
    - Activities described in the table may be explored in further detail.
    - Activities not specifically addressed on the table may be explored, as appropriate.
- The supervisor and supervisee record their discussion regarding key information in the space provided in the table below.
- Both the supervisor and supervisee may refer to the patient's chart, as needed, during the interview, to assist with recalling details about the case.
- The intended outcome of the Chart Stimulated Recall is:
    - Improved patient care in the future through reflective review of past care.
    - Supervisee self-assessment of competencies to inform student improvement goals.
    - Updates to activities in the supervision plan as agreed to by the supervisee.

Overview – Presenting Complaint and Diagnosis	
Briefly summarize this patient, including: • their presenting complaint and/or • the reason for them seeking chiropractic care.	
Provide the diagnosis for: • their presenting complaint or • the reason that the patient is seeking chiropractic care.	
Consent – Communication to and from the patient for the purpose of assessment and treatment	
How was informed consent obtained from the patient for the provision of care from the student? • Is this reflected in the patient health record?	
How was informed consent obtained from the patient for the patient health history or intake interview?	

• Is this reflected in the patient health record?	
How was informed consent obtained from the patient for examination including signposting for physical touch? • Is this reflected in the patient health record?	
How was informed consent obtained from the patient for the treatments proposed in the treatment plan? • Is this reflected in the patient health record?	
How was informed consent obtained from the patient for the delivery of professional services in the SOAP/Progress notes? • Is this reflected in the patient health record?	
Assessment (History and Examination)	
History You collected subjective information (history/ background) information. Describe why you collected the information you did.	
History Describe the impact of the subjective information collected on the examination performed. • What judgements did you make based on the history/decisions?	
History Upon reflection, is there any information you did not collect in the history, that would have been helpful in the examination of this patient?	
History Describe the impact of the subjective information not collected on the examination performed. What impact would the missing information have had on your judgements/decisions?	
History Describe the screening for Red flags, Orange Flags and Yellow Flags. What impact did identified flags have on your judgements/decisions?	
History Were relevant outcome measures/assessments identified and implemented?	

Were any opportunities missed?	
<u>Examination</u> Please explain/describe the relevance of the examination judgements. What other exams, if any would add to addressing the presenting complaint?	
<u>Examination</u> With consideration of flags identified in the history, were: • All exams relevant/safe/acceptable? • there other exams that would add to identified flags? If so, please identify.	
<u>Examination</u> Were appropriate examinations to rule out other potential conditions or risks completed? Was the examination adequate to determine that care will be safe?	
<u>Examination</u> How did the findings of the exam procedures potentially impact your diagnosis?	
<u>Examination</u> Was the exam adequately documented per the: • Standards of Practice and • The CCOA Record Keeping Requirements Guide	
<u>Examination</u> Is the clinical record a reasonable reflection of the assessment (history and exam) process you undertook with the patient?	
<u>Examination</u> Upon reflection, are there assessments that you would include or delete if given the same scenario?	

Diagnosis	
What is the clinical diagnosis?	
What components of the assessment informed the diagnosis?	
What comorbidities/ or differential diagnosis were identified during assessment that would require further investigation ore referral with another healthcare practitioner? Please describe.	
Is the diagnosis reflective of the Standards of Practice and demonstrate current evidence as informed by the Canadian Chiropractic Guidelines Initiative (CCGI)?	
Goals – What goals/outcomes is the patient hoping for?	
What patient expectations/goals for chiropractic care were identified?	
What judgements/decisions are evident considering the patient goals and the clinical diagnosis?	
Treatment Plan	
<u>Decisions/Judgements</u> Describe the judgments that informed the treatment plan for the patient?	

Decisions/Judgements Describe the risks identified and communicated to the patient and the plan to monitor and assess these risks.	
Education Was the condition education adequate to support the patient's decision making when considering their treatment options?	
Education Was the condition education adequate to support the patient's decision making when considering their treatment options?	
Treatment Plan Describe the risks identified that require a referral to the most appropriate healthcare practitioner.	
Treatment Plan Describe the relevance of the frequency of care? Is the recommended frequency supported by clinical care guidelines (CCGI)?	
Treatment Plan Describe the relevance of duration of care? Is the recommended duration of care supported by clinical care guidelines (CCGI)?	
Treatment Plan Describe the relevance of re-assessment plan including intervals?	

Is the recommended frequency supported by clinical care guidelines (CCGI)?	
<u>Discontinuance of Care/Discharge Plan</u> Describe the discharge plans that support chiropractor and patient decision-making. What criteria inform why patient would be discharged from care, or treatment would be discontinued.	
<u>Scope of Practice</u> Does the treatment plan adequate consider the scope of practice and competence of the chiropractor?	
On reflection of the written treatment plan, what was well documented, and what opportunities for improvement are identified?	
SOAP/Progress Notes	
<u>Re-Assessment</u> How did you determine the impact of treatment on the patient? What assessments did you use to monitor this patient's condition?	
<u>Re-Assessment</u> Were the assessments adequate? What other assessments would support the patient's desired outcomes?	
<u>Patient risk surveillance</u> Was monitoring to assess and identify risks maintained throughout patient care?	

Unexpected Outcomes Describe any unexpected outcomes reported by the patient or identified by the student or regulated chiropractor.	
Unexpected Outcomes What evidence of judgement/decision making is evident if an unexpected outcome occurred?	
Treatment plan modifications Describe how and why you modified/progressed the patient's treatment plan over the course of care. Include changes to modalities, frequency, duration of care and assessments.	
Discontinuance of care/discharge from care Please describe the discharge criteria used to determine why the patient was discharged from care or treatment was discontinued.	
SOAP/Progress Notes Is the record keeping adequate to identify the progress of the patient, including: • Subjective reporting • Objective examination • Assessments • Procedures performed	
SOAP/Progress Notes Would the records meet the Standards of Practice for record keeping as informed by the Record Keeping Requirements Guide?	

Discharge Planning and Execution	
What discharge instructions, recommendations, and self-management approaches were communicated? When and how did you communicate this component of care?	
How did you document this component of care?	
Collaborative Care	
Were other health care professionals involved in the patient's care? Describe how you facilitated a coordinated approach to care.	
Conclusion	
Following review of this patient's treatment file, is there anything you would do differently, in a similar situation, in the future?	
Strengths/positives in this case:	
Areas for improvement in future cases:	