ACUPUNCTURE NZ
The Acupuncture and Chinese Medicine Professionals

Guidelines for Clinical Notes

Acupuncture NZ
PO Box 14106
Kilbirnie
Wellington 6241
Tel: 0800 acupuncture
0800 228786
04 387 7672
Fax: 04 387 7685
Email: nzra@acupuncture.org.nz
Website: www.acupuncture.org.nz

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1. Introduction

The guidelines set out the requirements in respect of presentation and storage of clinical notes. Members of the Acupuncture NZ (NZRA) can consult with patients. There are special requirements in the documentation, presentation and storage of the "Clinical Notes" required. The guidelines presented here are a summary of the necessary requirements, to be thoroughly read, understood and adhered to in the treatment of patients.

2. Legal requirements for Practitioners

In addition to the Acupuncture NZ requirements for practice, other Public Acts and Regulations cover practitioners.

Members are reminded of their requirements under the following legislation.

- Health and Disability Commissioners Act 1994
- The code of Health and disability Consumers rights
- Human rights act 1993
- Health Information and privacy code 1994. (Enacted under Privacy act 1993)
- Guardianship act 1968
- Smoke free Environments act 1990.

Foremost the legal requirements for practitioners are that:

(1) Every consumer has the rights of this code
(2) Every provider is subject to the duties of this code
(3) Every provider must act to-
    a) Inform consumers of their rights; and
    b) Enable consumers to exercise their rights

3. Patient Informed Consent

The Health and Disability Commissioner Act 1994 and Health Information Privacy Code Act makes it clear that the Practitioner must communicate with the patient giving explanations of the diagnosis, treatment plans and options so that the patient can understand the procedures and give consent to treatment proceeding.

The clinical appointment should consider time for the discussion with the patient. You may have to explain what you are doing in biomedical as well as in traditional Chinese medical terminology.

Practitioners must take every precaution to ensure that accidents do not happen. E.g. the patient should be informed in the following cases:

- Needling PC-6 *Neiguan* could result in an electric shock type feeling.
- That cupping could leave a circular bruise that may last a few days to a week.
- Dermal Hammering
- Gua Sha
- Thread embedding
- Scarring Moxa
- Bleeding
- Needle retention

Consent forms are located on the Acupuncture NZ Clinical Notes and with Acupuncture NZ Clinical Procedures and Safe Clinical Practise

4. Scopes of Practise

An Acupuncturist provides full health services for patients.

The service provided to a client begins with the taking of a full case history and examination to identify clinical 'patterns of disharmony' within the Traditional Chinese Medicine (TCM) context. This is the basis on which a treatment plan is established.

Subsequent treatment may include any one, or a combination, of the following modalities:

- Acupuncture, including:
  - Traditional manual needle stimulation
  - modern usage of laser and electrical stimulation

- Chinese Herbal Medicine
- Chinese massage / Acu Pressure / Tui Na / Shiatsu
- Dietary and lifestyle advice
- Specific techniques including:
  - -Moxibustion (Scarring Moxa)
  - - cupping
  - - scraping (Gua Sha)
  - - Dermal Hammering
  - - Thread Embedding
  - - Bleeding
  - - Needle retention

- Breathing, movement and meditation / Qi Gong

5. Clinical Notes Information

All information recorded on the file needs to be:

1. **Language All notes must be written in English** (This is a requirement of Acupuncture NZ and ACC)
2. Legible All notes must be readable
3. Accurate It is required to record essential, necessary and accurate information.
4. Up to date Notes should be made for each consultation.
5. Record The date and reason if you were in contact with the referring health providers or ACC.
6. Complete All notes should contain: Date, results/progress, examination, treatment principle, treatment. The first set of notes when a patient presents should also have a full history.
7. Relevant Whatever you feel is relevant to the case should be recorded. For example, a patient with a low back sprain due to bending over and lifting a heavy brick may have been exposed to strong cold winds for some hours before the sprain. You may feel that this was a weakening factor and predisposed him to getting the injury. This should be documented as it is going to be relevant in your treatment and prognosis. That is, treatment will require some dispersing of the wind and cold as well as treating the sprain.
8. Avoid misleading information For example, “patient seems better” is your view. Put patient's words. "The patient said that they felt better" This was seen in the fact the patient was able to lift there are level with their shoulder.

6. Clinical Notes must include:

- date
- Name
- address, telephone numbers
- D.O.B
- Occupation,
- Name of referring doctor, specialist or health provider
- ACC details
- Signs and Symptoms: Presenting with, Onset and Progression, Aggravated By, Relieved By
- Relevant medical history: to include chronic diseases and medications that may affect the acupuncture treatment. Social history: to include the type of work that they do and any recreational/professional sport that they may play and home duties they normally do such as lifting babies, cutting the grass, Family medical history etc
- Physical Examination Notes
- TCM Examination Notes
- TCM Treatment Principle
- Treatment Plan/Objectives including Biomedical and Functional details
- Practitioner Name, Signature and Date: *The Practitioner providing the treatment must always sign at the end of every treatment.* Patients can also sign for every treatment.
- Practitioner Checklist.

- For **subsequent treatments** complete the Acupuncture Treatment Record:
  - Date and signature of Provider
  - Treatment Number
  - Practitioner
  - Results/Progress
  - Functional /TCM Examination
  - Treatment Principle
  - Treatment
- Take out a fuller review every fifth treatment or earlier if the case requires.

7. Clinical Notes and Case History Files

As a member of the Acupuncture NZ you are required to keep on going case history and clinical notes of *all your patients*. ***There are no exceptions.***

1. Each patient should have notes written for every treatment /contact they receive

2. The notes should record a true and correct record documenting the injury, diagnosis, assessment, treatment plan and outcome. Including:
   - Details of patient's address, phone numbers and dates of birth
   - The referring agency
   - Details of referral
   - Type of treatment /points used
   - Relevant patients comments
   - Improvement or otherwise after the acupuncture procedures
   - Notation of any correspondence/ telephone conversation concerning patient. E.g. to whom sent, when it was sent and what was sent

3. Medico-legal purposes.
   - Patients have a right to request their case notes.
   - Patients have a right to change Practitioners.
   - In the event of a legal claim against you, patient files can be requested.

4. To meet Privacy Act requirements the following points should be noted.
   a) The notes are only to be seen by the patient and clinical staff. They are NEVER to be left where other people could see them.
   b) Clinical and financial notes need to be kept separate. In case of an audit by the IRD clinical notes should not be made accessible to them.
   c) Consent forms need to be signed by the patient if details from the clinic notes are to be discussed or shown to other practitioners, Insurance companies, used in research. etc.

Shorthand and Abbreviations

If using short hand or abbreviations. You must maintain record of the “Shorthand and Abbreviation List” in your clinic. An example of a “Shorthand and Abbreviations list” used by many New Zealand health practitioners and (New Zealand) acupuncture colleges is contained in appendix 2.

8. Sign and Symptoms - Cause of Injury:

Even if you already have a referral from the patient’s G.P establishing a diagnosis, you still need to show and document the cause of injury. It does not have to be an elaborate description of the events and the following examples should exemplify;

(a) "When pulling lawnmower cord, sprained the back. Couldn’t bend over to touch toes or walk straight immediately after that".
(b) "Lifting a heavy box above head, whilst turning the head, twisted and sprained the neck. Woke up next day and can’t turn neck".
(c) "Whiplash to neck after being hit in rear by another car. Headaches and blurry vision almost immediately after getting out of car".
(d) "Whilst playing football, tripped by another player and fell sideways straining the knee. Had to stop playing and 2 hours afterwards had huge swelling in knee".

9. Diagnosis of injury

The current standing and policy of ACC is that the referring Health Professional is responsible for the official written diagnosis and/or diagnosis code.

After recording the official bio-medical diagnosis, the TCM diagnosis should also be recorded. For example: Knee sprain. Local blood stasis with qi obstruction to Liver and Kidney vessels complicated with penetration of damp and cold to local knee area.

10. Subjective Findings

24 hour behaviour. This determines how the injury reacts over a typical 24-hour period, documenting the ebb and flow of the problem.

For example; wakes up very stiff in lower back, but without pain, after hot shower, 30% improvement in mobility, by lunchtime, low back starts to ache, by mid afternoon, pain goes down the back of leg and needs pain killers to get through the day. Needs painkillers to fall asleep.

11. Aggravating and Alleviating Factors

This can help determine whether the client is capable of normal work or light duties. It is also useful for validating the TCM diagnosis.

Examples include: Aggravated if bends over to touch toes

Pain improved with short walks
Pain aggravated with long walks
Severe pain 9/10 if carries any weight

Aggravating factors are important to determine the treatment plan.

12. Objective Findings

Clinical assessment of the injury should include as many of the following as practical.

1. **Range of movement** (ROM) performed by the patient, usually unaided, recorded as e.g. abduction of the arm, Lt. Side 180° Rt. side 90°.

2. **Orthopaedic Testing** applicable in certain cases e.g. tennis elbow test, "Apley's Scratch Test" for the shoulder ROM testing or the Straight Leg Test (SLR) for sciatic nerve tension.

3. **Neurologic evaluation.**

   A. Sensory Deficits. If a sensory nerve root is impinged e.g. with an acute cervical or lumbar disc involvement, where there can be either hypersensitivity but usually experienced by the patient as patches of numbness with loss of feeling and a deficiency in 2 point discrimination. This should be noted on the patient's record and re-evaluate on subsequent visits, recording changes for better or worse.

   B. Tendons Reflexes e.g. Biceps C5 predominately, Triceps C7, Patella L4, Achilles S 1 Tendon reflexes can be recorded as increased, reduced, absent. Compare both sides.
   The Tendon Reflexes help to confirm and build up a symptom picture for a working diagnosis. Tendon reflexes are valuable as inflammation around a disc or disc hernia often resolves or reduces and reflexes along with other symptoms, can mirror this change. Sometimes there is no change, as permanent damage may exist. If in doubt refer them to their patient medical practitioner, specialist or the appropriately qualified person.

   C. Motor Deficiency - Often jointly investigated during Orthopaedic Testing can indicate a neurological impingement.

4. **Muscle strength** - compare both sides. In the case of a disc protrusion for example, loss of power, may indicate a neurologic deficiency,..... but this is not always the only cause. In using a **Muscle-Grading Chart,** movement against resistance should not be overpowering but considered and designed so as not to aggravate the patient's condition - as with all orthopaedic tests you perform.

Table 1 Muscle Grading Chart

Muscle Gradations	Description
5 - Normal	Complete range of motion against gravity with full resistance
4 - Good	Complete range of motion against gravity with some resistance
3 - Fair	Complete range of motion against gravity
2 - Poor	Complete range of motion with gravity eliminated
1 - Trace	Evidence of slight contractility. No joint motion
0 - Zero	No evidence of contractility

D. Pain - Pain is an important symptom. It may be local, referred, follow a dermatome or myotome i.e. into Quadriceps with L4 involvement, L4 predominately supplies the Quadriceps Muscle, or a peripheral nerve. Guarding Muscle spasm is often accompanied with severe disc/spinal pain. Palpate and note areas of tenderness / hypertonicity / spasticity. Compare on subsequent visits.
Pain may also accompany muscle wasting, so be aware of this and refer if the patient's condition is deteriorating.

For objective analysis use a 1-10 pain scale where you ask the patient "How bad is your pain on a 1-10 scale with 10 being the most severe pain?" This is as objective as you can get, as pain is quite subjective. With severe unremitting pain, referral of the patient back to the GP / Specialist or hospital is advised for a review reassessment which may result in change/increase in medication, referral to specialist, more tests such as an MRI as there may be a change in or a confirmation of diagnosis.

13. Treatment Plan

Your clinical notes must include a Treatment Plan. The Treatment Plan is based upon your knowledge, views and experience as well as the general, accepted view of the profession.

This is discussed with the patient. It is important to stick with the Treatment Plan to achieve the goals.

Treatment and results do not always go according to plan. For example, there may be no change after 2 weeks of treatment when you expected there to be. *This needs to be assessed immediately.*

1. Did you make the goal too hard to achieve?
2. Could there be a misdiagnosis?
3. Do you need to consider a different approach to treatment?
4. Do you need more appointments in the time frame that you set?
5. Do you need a second opinion or to refer the patient to the peer reviewer?

In many circumstances the practitioner needs to make a change in the treatment plan. *The change in Treatment Plan needs to be discussed with the patient as well as being documented in the clinical notes and it must be signed.*

For example, “Discussed with the patient the probable reasons for no major change in the back pain. A different treatment strategy is going to be implemented where warm needle techniques will be used. If there is no improvement after 2 weeks with 2 treatments per week, the peer reviewer shall be consulted".

14. Treatment Objectives

You must document the Treatment Objectives you expect to achieve.

These goals must be

1. Specific: For example, "to be able to play tennis as the patient used to do before without pain".
   Or " be able do a full day’s work as they used to before".

2. Measurable: Measurable here means being able to ascertain differences in the progress of treatment by comparing differences in the particular tests that were done in the first consultation.

3. Achievable: Within the scope of normal acupuncture practice, results need to be achievable. In some circumstances, it may not be possible to achieve a result, for example to rejuvenate a shattered disc. It is however possible and achievable to lessen pain associated with a shattered disc.

4. Realistic: The practitioner needs to make the patient aware that treatment and the results are realistic.

5. Timed: This is an important feature of the case history clinical notes. Objectives need to be set between the practitioner and patient as to time frame to achieve the objectives. For example, a sprained ankle will take 7 days to heal in order so that it can be walked on comfortably without pain. However, in a ballet dancer, a sprained ankle may take 3 weeks before they can dance on it again. In the first case, treatment should cease and the patient discharged after 7 days if the goal of walking without pain has been achieved. In the second case, the ballet dancer may be able to walk after a week but still can’t dance so further treatment may be required.

6. Objectives and Client Focus.
   Not only does this set up positive psychological image with the client but also helps the patient stick to the treatment plan. Remember, to achieve the result of eliminating pain in 3 weeks may require treatment 2 times per week and only turning up for an appointment each fortnight will deviate from the treatment plan. Remember that in some cases, the patient may be paid a wage by ACC, as they are unable to go to work. Given appropriate treatment and setting goals can help that person to get back to the workforce

as soon as possible. *Under-treating them and delaying the recovery potential is to be avoided.*

7. Discharge Objectives
   In the treatment plan the practitioner needs to set a specific date of discharge. The discharge must be functional, so that the patient can perform the tasks as they used to do before the injury.

15. Patient Discharge

At the end of the treatment plan or when the patient ceases treatment. The patient's status needs to be recorded whether there has been specific result or not. For example, "Patient can walk freely without pain and can do all home duties as before. There is still back stiffness for l hour when arising in the morning. A summary and discharge has been sent to the referring doctor"

16. ACC Claim Requirements

Treatments for ACC Patients must reflect that our **main modality** is **acupuncture**

17. Numbers of Treatments for ACC Patients.

The numbers of treatments for ACC Patients are set out in "Acupuncture Treatment Profiles" (May 2006)

- **Number of Treatments:** indicates the number of treatments it would be expected to take to sufficiently resolve a injury
- **Trigger Number:** indicates the number of treatments you may provide before seeking approval from ACC for further treatment. (i.e. submit an ACC32) When the trigger number is **less than 16**, an ACC32 should be submitted when that number is reached. When the trigger number is **greater than 16** then an ACC32 should be submitted at the 16th treatment.
- If there is no Treatment Profile for a particular injury, then an ACC32 should be submitted at the 16th treatment.

18. More than one injury Site

In the event of a person at the same time received injury to more than one different area of the body e.g. back sprain, shoulder sprain and fractured ribs from a car accident, *the patient will still receive only one ACC number.*

The number of treatments that this type of patient can receive is still dependent on the normal ACC guidelines as set out for one injury site. However, you have excellent grounds for submitting for extra time and treatment numbers if asked why this person's treatment plan is more ambitious.

19. Two different and separate injuries

If there are two separate injuries from two separate accidents, you cannot treat them both on the same day. *This is an ACC rule*. You must treat one injury on one day and the other injury on the other day.

20. New injuries occurring after the initial injury.

For example, a patient has a low back injury in January followed by treatment in January and February. Then discharged, this is regarded as one injury by the ACC. If then 6 months later, the same patient sprained his elbow, this will be regarded as a new injury and a new ACC number will be provided. *You must make a new file, with the new ACC number* and keep his file totally separate from the first and/or other injuries.

21. Pre-existing/non-ACC related conditions

You can only treat injury-related problems through the ACC. You cannot treat any non-related ACC or pre-existing condition through the ACC. For example, if a patient is a chronic migraine sufferer and recently has had a low back sprain you cannot concurrently treat his migraine and back sprain and bill it to the ACC.
If after being discharged from the course of treatment for the ACC the patient wants to have treatment for a pre-existing condition or non-related ACC injury, a new and separate file must be made.
The ACC file is only to have information relevant to the injury and its treatment recorded on it.

22. The Acupuncture NZ Clinical Notes Form

Acupuncture NZ has devised a standard file that can be used for recording clinical notes. The format of this form has been approved by ACC. If you choose to use your own form you must ensure that it includes all the required information. The file itself includes some diagrams so that for example painful areas can be marked to speed up the clinical note taking during the consultation. Other important diagnostic markers have been included to be able to professionally and effectively document clinical notes.

23. ACC Audit of Clinical Notes

In the event of ACC requiring audit of clinical notes, they will be looking at documented evidence as written on the file by you to see that the treatment you gave the patient was in fact:

a) Necessary
   In certain circumstances, it may not have been necessary to treat the patient. For example, in a patient with a suspected broken arm, it may be necessary to refer them for x-ray first to confirm the break before commencing acupuncture treatment to alleviate pain.
b) Appropriate

In review of the treatment given, ACC can establish if what you did was indeed appropriate. For example, in the treatment of an acute sprained ankle, you may be asked why ST-36 *Zusanli* and Ren-12 *Zhongwan* were needled but no traditional ankle and lower leg points were used.

c) Quality

Was the treatment you administered of good quality as required by the ACC and as expected of the professional group, that is the Acupuncture NZ. This can mean, did you use the best possible needle techniques, insertion angles and depths, and other techniques to bring about a rapid recovery?

When a patient signs an ACC 45 declaration it automatically allows the ACC to review any clinical notes related to that person and injury.

In the past with other audits, the ACC has found:

- Clinical records do not meet the professional standard of documentation
- No appropriate clinical reason to justify the visit or ongoing treatment.
- Treatment given not in line with current ACC "Acupuncture Treatment Profiles ".
- The file only had the date plus a tick or "no change recorded"
- Extensive treatment without peer review.
- Treating and claiming ACC for non-related underlying conditions.
- Codependency: Treating and claiming ACC for underlying psychological problems or to treat the person holistically to cover other aspects of health.
- Clinical records being written retrospectively after being requested.
- Practitioner claiming ACC when they have not given the treatment.
- Claims made for treatments not given.

If the file has inappropriate documentation to support necessary and appropriate treatment, the ACC will act to recover payments that have been made to you.

If there is false and misleading documentation the case will be referred to the New Zealand Fraud Unit.