Healthcare

Massage Therapy Care Documentation

Best Practices, Mitigating Risk

The significance of accurate and complete documentation of massage therapy care cannot be overstated. Not only is documentation integral to the safe delivery of care, but it is an essential risk management tool in any registered massage therapist's (RMT) practice

Thorough, professional documentation may protect the registered massage therapist from liability should an issue arise regarding the massage therapy provided to a particular patient. The patient record frequently is the most important document available in defending against, preventing or determining the outcome of a legal action.

Patient records serve as objective documentation of the delivery of massage therapy to patients. The legal system relies mainly on documentary evidence in a situation where medical negligence is alleged[1] by a patient or her/his relatives. The consequences of altered, incomplete or nonexistent records can be legally and personally catastrophic for an RMT. In a case where there is inadequate or missing documentation, the courts rely on massage therapists to testify that they provided appropriate therapy. A therapist's credibility as a witness is put into question when not backed up by clinical notes. Remember the old adage: "Memory is limited and if it is not written, it did not happen."

Section 1 – Best Practices[2]

Because of documentation's essential role in healthcare, following best practices and regulatory standards is crucial. In British Columbia, a registered massage therapist (RMT) must comply with the College of Massage Therapists of British Columbia's *Standard for Patient Records*[3]. RMTs can use the standard and the following general principles of documentation to evaluate their practices and identify potential gaps in their record keeping:

- Ensure that all entries are written, signed in ink, are legible, and include the date and time of entry.
- Sign all entries with full name, professional designation and title. In the case of electronic signatures, include any required identification number and/or security codes.
- Record notes as soon as possible after the patient encounter (e.g., assessment prior and post-treatment) to ensure accuracy of recall of information.
- Avoid subjective, judgmental comments about the patient. Where applicable, use the patient's own words, e.g. "Patient states she is feeling less back pain."
- Do not leave blank lines between entries or blank spaces on paper records since this leaves the entry open to being altered.

[1]Thomas J. Medical records and issues in negligence. Indian J Urol. 2009;25(3—):384-8.
[2]CNA and HPSO (2017), Adapted from Risk Management Strategies for the Physician Office, and from CNA Physical Therapy Professional Liability Exposure: 2016 Claim Report Update.
[3]College of Massage Therapists of British Columbia (2018), Bylaws of the College of Massage Therapists of British Columbia, Schedule "E" – Standard for Patient Records [Document]. Retrieved from https://www.cmtbc.ca/law-standards/cmtbc-bylaws/

- Document all patient education provided, both spoken and written.
- Identify late entries and make sure they are dated and timed contemporaneously.
- Never alter a record or write a late entry after a claim has been filed or for any reason.
- Never erase, obliterate, or use correction fluid in any portion of the patient record for any reason as this can cast doubt on the truthfulness of the entire record as well as the credibility of the RMT.
- Do not keep personal/anecdotal notes (or diary) in situations that have not gone well. Given their probable subjectivity and potentially damaging consequences, personal notes are discouraged.

Contrary to common belief, personal notes are not private or legally protected and are producible evidence in a legal claim.

Section 2 – Strategies for Effective Documentation

Good notes provide documentation that the therapist is following acceptable standards of care, utilizing appropriate interventions, describing the results of these interventions and documenting the disposition of the case. To improve your documentation, consider the following strategies:

1. Assess your documentation against both best practices (outlined in Section 1 above) and the college's standards, and identify where there are the opportunities for improvement in your documentation.
2. Consider whether adopting a structured method for documentation, if you do not currently use one, would improve your performance.

Structured Documentation Format: Example 1 – SOAP Note Template

A commonly used template for information gathering is SOAP (Subjective, Objective, Assessment and Plan). The outline serves as a template for information gathering. The SOAP note-taking format applies to all types of massage therapy visits; prompts two-way communication, patient participation and informed consent collection; and records the patient's acceptance of responsibility for following through with the self-care plan. The SOAP note-taking process is further outlined below:

S **Subjective** – what the patient says – location/intensity/duration/frequency/onset etc. of symptoms.

O **Objective** – what you find – visual observation, palpable findings etc.

A **Assessment /Application** – what you think is reasonable to support health and well-being – provide treatment options and evidence of informed consent or informed refusal, the treatment used and patient response to treatment.

P **Plan** – what you recommend as treatment options going forward, the patient's self-care plan, and what the patient agrees to.

As a good rule of thumb it is typically better to record SOAP notes if you are completing longer massage sessions on a client you will likely see again for further care. SOAP notes are not appropriate for a 10-minute chair massage .

[4]Sandy. Tips for Writing Better Mental Health SOAP Notes. April 25, 2018 retrieved from https://www.incorporatemassage.com/massage-therapist-resources/tips-for-writing-effective-soap-notes

[5]Teichman, P. Documentation tips for reducing malpractice risk. Fam Pract Manag. 2000 Mar;7(3):29-33.

[6]Butterfield, Kelly, Tips for Effective Massage Therapy Documentation SOAP Notes, April 25, 2018, retrieved from https://www.incorporatemassage.com/massage-therapist-resources/tips-for-writing-effective-soap-notes.

Structured Documentation Format: Example 2 – CARE Note System

Another common format for clinical information gathering is CARE. The CARE[7] note system is based on the use of the following categories to guide the therapist in recording the massage session (Condition of client; Action taken, Response of patient, Evaluation). According to author Mary Rose, the first three of these elements – CA and R – provide the most information about a massage therapy session. The fourth element – E – can be optional, but it allows space to record overall observations, recommendations or questions that arise from the session. The CARE note system is further detailed below:

C Condition of the patient – what the patient states as her/his problem – location of pain (e.g., back, with radiation down both legs), its intensity (7/10 on pain scale) and duration (five months).

A Action taken – what massage technique(s) you used (e.g., full-body massage), the position of the patient (e.g., prone), and length of massage (such as 45-minute session).

R Response of patient – how the patient reacts to the treatment both verbally (e.g., "that really felt relaxing") and non-verbally (e.g., grimacing, tonicity of muscles, facial expressions etc.); patient's goals for treatment (e.g., relief of pain and overall relaxation) record physical pain after the massage session (4/10).

E Evaluation – what is the overall evaluation of the session, such as any plans or expectations for future sessions (e.g., twice weekly for two months then reevaluate), any recommendations made to the patient (e.g., simple exercises to alleviate back pain).

Take Home Message for RMTs

With the regulation of massage therapy, the onus is on the RMT to demonstrate her or his professionalism in documentation practices that meet regulatory, professional and legal obligations. No matter what documentation template a RMT uses, she or he must demonstrate that patient records accurately track a patient's progress, support continuity of care within the healthcare team (where applicable), document proof of service, and protect the RMT from allegations of malpractice.

[7]Rose, Mary Kathleen, (2006) Successful Business Handbook: Documenting Massage Therapy with CARE Notes, Associated Bodywork & Massage Professionals (ABMP).

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