AT Efficiency

Quality Improvement Documentation Practices for the Athletic Trainer

Patient care documentation is an immensely important task for athletic trainers to complete. However, AT perceptions and barriers tend to overshadow this importance and lead to inconsistencies regarding documentation. Common concerns among athletic trainers and patient care documentation include lack of time to complete detailed documentation, lack of accountability, and confusion regarding procedures. To improve our value and overall place within health care, there must be a moral obligation for athletic trainers to produce quality documentation on a consistent basis. Some helpful tips to get you started include:

1. **Document everything** – This provides a scope of services performed by athletic trainers. Daily tracking logs are important for that reason and will ensure an objective account of individuals seen. From there, daily, weekly, and monthly averages can be broken down providing important data that can assist in justifying the value of AT services. Also, there are legal concerns to consider. Remember, any attorney will tell you that if an interaction was not documented, then it did not occur.

2. **Take detailed injury notes** – The standard S.O.A.P. note format works well and is how EMR's are structured. Take a detailed history, but do not skimp on objective measurements (Goni, MMT, special testing, etc.) Also, include an area for patient reported outcomes. Now more than ever health care is outcomes focused. Utilizing outcome measurements will again demonstrate value for athletic training services.

3. **Carry a note pad with you** – With the scope of work and patient load athletic trainers encounter daily, inputting information on a computer per encounter is impossible. Short hand documentation will help identify key points and increase efficiency when uploading the note. For more information on shorthand, check out: How to Take Faster Handwritten Notes Using Shorthand Techniques. Shred your paper notes once you've input on your EMR.

4. **Utilize your time wisely** – Time management plays a huge role in how effective and consistent your patient care documentation will be. Develop a daily agenda and schedule 30 minutes to an hour and work on your notes. Do not go beyond that time frame and set limits for your patients regarding an appropriate time is to seek your assistance.

5. **Seek further resources** – No mandatory standards for AT patient care documentation exist, but guidelines are available: Documentation and Coding Guidelines for Athletic Trainers. This resource offers a more detailed approach regarding what should be included within your notes. Also, review your state practice act. Specific information pertinent to your state will be helpful as you strive to achieve improving patient care documentation.