



Documentation in Private Practice



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Opinion

Having been certified for 'Competence of Testing and Calibration Laboratories and Internal Audit as per ISO / IEC 17025: 2005', when I was working at an analytical laboratory few years back, the understanding of jurisdiction and importance of paperwork came to terms with me. The stringent quality it implies to keep document updated at any given time helped my experience of using this when I started my private practice as a Speech Language Pathologist. It also taught me that the precision of your work is only acknowledged when you put it down on a paper. It is only then that piece of paper is entitled to be called as a 'Document', which lead me to maintain 'Good Documentation Practice'.

Juggling between patient appointments to planning therapy sessions to keeping updated with the developments in the field and staying on top of everything else whilst practicing privately, it becomes excruciatingly painstaking to pen down document of entire therapy session in the format of SOAP (Subjective Objective Analysis Plan). Yet, one needs to do this to accomplish the entire circle of therapy. I do not want to stress on how important it is to do documentation in private practice, as much has been said about it before from seniors all over the world. To add to that it is also an ongoing process of improving one's writing skills. What I want to stress instead is that there is a valid point I see why this has been put to practice other than just safeguarding one's skills as a practitioner.

In the beginning, when I started this practice of documenting my session it was more of putting down everything I did in the session with my client. Gradually I realized I was not only putting down my executed work but also looking through my session so much meticulously that I was able to note down on what all have been missed out in the session such as carrying out on a particular exercise or the increment in the number of repetitions or thinking of a particular type of strategy from my big bag of speech path; this eventually gave me insight into how clearer I can become in visualising and planning my future sessions. Today, this practice

of documenting has become a daily mindset practice. Also, to not overstress on time, I give myself specified time limit and schedule per week to channelise my output productively on daily basis as a clinician.

Many a times in private practice setting, where there could be chances of one man's show, it makes it so much easier for a clinician to refer to that document to pick up from where it was left incomplete in cases of relapse or outstation patient when they return after long haul. One big advantage in such circumstances is to have something so handy and not be dependent on subordinates.

'Paperwork', as boring as it sounds is an extension of therapy sessions which entitles the clinician to keep someone else's details, history, progress, etc., as safe and vital information. This information which when needed, it could be shared with another professional or organisation with authorised permission to release it with the concept of becoming "paperless" increasing across the world, comes the need of an hour of using technology. Keeping digital records safe and updated is another challenge faced by many clinicians. Specially in cases where one uses software, clinician need to keep their software updated with definite interval of time frame.

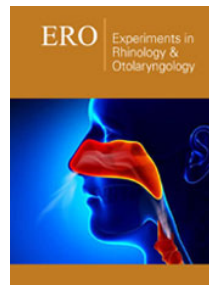
Using a comfortable customised template and format really helps for speedy record keeping. I use these templates for everything possible related to therapy from assessment to daily notes to progress reports to even Home training program and outstation patients' records. Use selected pictures to explain your notes wherein if it has to be given to another professional or laymen who might not understand therapeutic narrative. Be careful of what pictures you might use since, it could be someone else's work. I usually use pictures of my own clients when that client is comfortable to share their pictures with others with of course their prior permission to do so. The key to successful documentation is to embrace it as much as you want to avoid it. After all it is an ongoing anecdote of your client with you and your meaningful work!



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