Documenting Massage Therapy with CARE Notes

When I was a massage student in 1984, we learned little about charting for massage therapy. We were required to write about a certain number of the sessions we gave as students, but the purpose of this was to record details about the techniques we were learning. We also recorded our thoughts and feelings in a manner that was more akin to writing a personal journal.

In the mid-1980s, massage therapists began to work in chiropractors' offices and do work for which they sought reimbursement from insurance companies. This emphasized the need for charting, but most therapists simply submitted written reports, which usually satisfied the needs of the insurance companies. Later in the '80s some massage therapists began to use the SOAP format to document their work. SOAP is an acronym that stands for Subjective information, Objective information, Assessment, and Plan.

SOAP is a format initially used in physical therapy that has been adapted and used widely by massage therapists. Variations of this charting system have become part of the curriculum in a majority of massage schools nationwide.

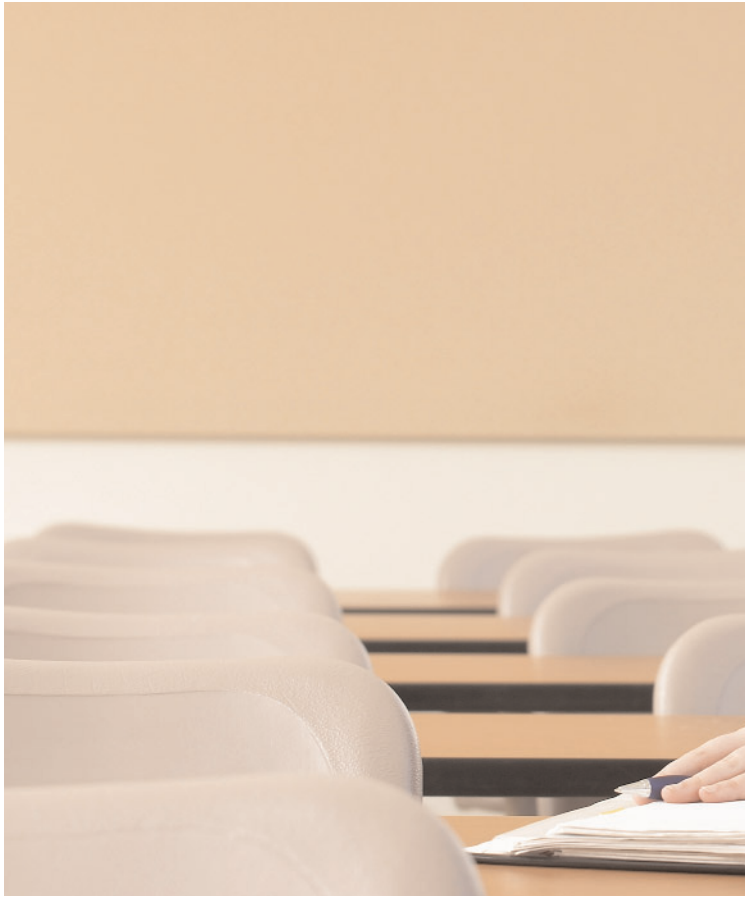
Issues And Concerns

In researching the use of SOAP charting by massage therapists, I discovered a number of concerns with the format. Michelle Bowman, RN, LAc, who is the Integrative Medicine Manager at Longmont United Hospital in Colorado, says, "I don't feel that SOAP charting is appropriate for massage. It is not consistent from one therapist to the next." Bowman supervises a program which employs thirteen massage therapists.

Michele Kolakowski, who is the lead massage therapist on the team, adds, "There is no standardization for charting among massage schools. It is even different now than when I went to school twelve years ago." The meanings and uses of the letters in SOAP vary from textbook to textbook and from teacher to teacher.

Yet, as therapeutic massage becomes more accepted as a valuable treatment in healthcare settings, the need for workable charting systems is imperative. Bowman and her coworkers are working to develop new systems for charting. She says they are also challenged to meet the requirements of the Joint Commission on Accreditation of Healthcare Organizations. This accrediting agency is particularly interested in documentation that can record the status and changes in the levels of pain experienced by the patient before and after receiving massage.

Kolakowski, who has extensive experience in perinatal massage, also acknowledges the importance of charting, emphasizing reliable documentation reflects



on the quality of care for the patient. She emphasizes that good charting promotes continuity of care and facilitates communication among the various healthcare professionals.

I interviewed a number of massage therapists, asking them to identify their issues and concerns with charting. Here are some of their comments:

"I am required to write SOAP notes for my clients who are receiving insurance reimbursement. But I hate to write these notes. I like doing the massage, but not writing the reports."

"I'm not always sure what needs to be in a chart, and what might not be necessary."

"When I was in massage school, I learned to chart SOAP notes, but I don't use them in my private practice, so I wouldn't feel confident to use them if I had to."

One massage therapist, with five years of experience as a physical therapy assistant, says the SOAP format makes sense for physical therapy where there are specific treatment goals, but that it didn't seem relevant in her work doing relaxation massage in spa-type settings. Have we been using approaches that feel like hand-me-downs from other systems, not our own?

A Natural Way Of Charting

It is possible to address these concerns and offer a format for documenting massage that is easy for the massage therapist to learn and use, and that meets the requirements of different organizations. The implementation of CARE notes offers a solution that is based on a natural approach to communication. This flexible guide allows for comprehensive detail when it's required. It also offers a simple format for concisely recording a massage session.

The CARE note system is based on the use of the following categories to guide the therapist in recording the session: C=condition of client; A=action taken; R=response of client; E=evaluation. The first three of these elements—C, A and R—provide the critical information about a session. They provide a picture of the recipient of the massage, what kind of work was done and how the individual responded to that work. The fourth element—E—can be optional, but it allows space to record overall observations, recommendations or questions that arise from the session.

CARE notes are completed after the session. We will explore these elements in more detail, but first it is necessary to look at the initial client intake, which is recorded before the session.

Client intake form

An initial session with a client should begin with completion of an intake form. Depending on your setting, these formats vary widely. If you work in a medical setting or massage clinic, they will provide a standard form or one will have already been completed for you to see. Some medical settings do not give the massage therapist access to the patient's chart. Rather, they inform the therapist of specific details: e.g., the patient's diagnosis and current medical condition, contraindications and/or cautions for massage as well as specific areas of concern, or areas needing massage.

The intake form includes the client's name, gender, birthdate and session date. It also has space for: client's contact information, address and phone number; medical history and current health conditions; other therapies and medications currently being used; lifestyle factors, including occupation, exercise and diet; prior experience with massage; and reasons for receiving massage now.

Once an initial intake is completed, the session can begin. Information in the client intake constitutes the first part of the client record. CARE notes are completed at the end of the first session and after every subsequent session. Depending on the complexity of the client's condition, the treatment you give and their response to

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it, CARE notes can be quite simple and concise or they can be more lengthy or extensive.

Information from the client intake or medical record forms the basis for the first part of the CARE notes.

Condition of the client

This section of the chart records the current condition of the client. It should give an accurate picture of the person in the present, and answers the questions, "Who is the client?" and "How is the client now?" This part should include a concise summary of relevant medical information from the client intake form. It will also list current conditions and complaints, areas of discomfort, pain or tension, as well as emotional well-being or state of mind. It records the clients' reasons for wanting massage, and their goals or intentions for the session.

This section can include a notation of physical and/or emotional discomfort or pain before the session. For example, you can ask, "On a scale of one to ten, with ten being the worst, how would you describe the pain you are feeling right now?" After the session, you would ask this question again and record the answer in the response section of the CARE note.

Example. Condition: Clara T, fifty-five-year-old female, with a history of asthma, chronic pain from cervical strain (due to a car accident in 1985), complains of pain in the area of right trapezius, overall tension in back, from shoulder to hip, more notable on right side. Intermittent pain in right sciatic nerve at piriformis, refers down right posterior leg.

She works in sedentary job, commuting forty minutes to and from work daily. Minimal exercise. She has not received massage before. Interested in pain relief and overall relaxation, even though she voiced doubt that massage could be helpful.

Before session: physical pain or discomfort, 7 (0=none; 10=highest level); emotional pain or discomfort, 8 (0=none; 10 =highest level).

Action taken

This section of the chart records the type of massage given, the length of hands-on treatment time and the positions in which the client was situated (prone, supine, seated or side-lying). It includes a summary of techniques used, and the parts of the body massaged.

Example. Action: I performed a full-body sixty-minute massage. In prone position, using a face cradle,

Tips for Using CARE Notes

Here are some things to think about when charting a massage session:

- **Sign and date the chart.** The massage therapist's name and signature, along with the date of the session, should always be on the chart. The completed chart can then be given to one's supervisor or kept for personal records.
- **Complete the chart as soon as possible after the session.** It's easier to do while the experience is fresh. With practice, it should only take a few minutes to accurately complete all the details necessary.
- **Keep in mind the person(s) who will read the chart.** In the hospice organization where I work, the notes go in the patient's permanent record, but they are also read by several other people, including the nurse, the social worker, the volunteer coordinator and the massage therapy supervisor. In other settings or circumstances your notes could be read by other professionals including physicians, physical therapists, chiropractors, attorneys or insurance claims personnel.
- **Use precise and correct medical terminology.** Avoid vague or imprecise terms. It is best to use correct medical terminology whenever possible. For example, "I massaged her stomach." You probably mean to say, "I massaged her abdominal region." Also, be careful of intangible words like energy or energy work. For a medical record or a chart that will be read by someone working for an insurance company, it is best to use words that describe exact anatomy, physiological responses or specific techniques of bodywork. Of course, much of what happens in a massage therapy session is intangible or difficult to describe. Don't worry about it. Just record what you can, keeping your audience in mind. If you are not sure your notes are adequate or appropriate, ask your supervisor or someone else who reads them.
- **Be aware of legal ramifications.** When charting for insurance purposes, it is important to document levels of physical and emotional pain and suffering. If the client is being reimbursed for massage as part of basic personal injury protection coverages, document these sessions carefully. Record the work you do and changes in the client's condition relevant to the

injury for which they are being compensated. Do not speculate about prior injuries or conditions.

- **These records are confidential.** Notes are to be read only by authorized people who are involved in the patient's care. They should be kept in a safe place where they are protected from anyone else's view.
- **Keep in mind your scope of practice.** Be consistent with your role as a massage therapist. You can make observations of the client, but you can not diagnose a condition. For example "anxiety" is a medical diagnosis. You can report when the client says, "I feel stressed out." If you are trained in other aspects of health education you may draw on that awareness. For example, you might suggest an exercise that can benefit the client, that they can practice to augment the benefit of the massage session.
- **Avoid judgment.** You can present the facts as you see them, but avoid interpretations. As a massage therapist you often receive information that no one else on the client's care team has, so it is important to report those observations.
- **Be careful with abbreviations and use of symbols.** Keep in mind that the point of charting is to record the session and communicate it with others when necessary. The use of abbreviations can be useful to expedite charting, but be sure that everyone reading the chart knows what the abbreviations mean. (One supervisor was alarmed to find the letters S.O.B. in the chart of a frail eighty-five-year-old woman, until she realized that the letters meant "shortness of breath.") Find lists of accepted abbreviations for the facility where you work. You can refer to *Hands Heal* by Diana Thompson or a medical dictionary.
- **You may use sentence fragments.** It is okay to use fragments to save time and space when charting, but make sure they make sense to the reader. The test of an adequate sentence fragment is this: Can the reader easily translate that fragment into a logical sentence that would be consistent with the flow of the information in the chart? For example, "Intermittent pain in right sciatic nerve" can easily be understood as, "The client reports intermittent pain in the right sciatic nerve."

C.A.R.E. NOTES for Massage Therapy

Therapist Name

Client Name **Date** / /

Age

Setting

Condition of Client:
(medical condition, physical discomfort or areas of pain or tension, emotional state, etc.)

Before session: physical pain or discomfort (0 = none 10 = highest level)
emotional pain or discomfort (0 = none 10 = highest level)

Action taken:
(massage strokes performed, parts of body massaged, length of session, etc.)

Response of Client:
(physiological changes noted during and after the session, nonverbal feedback, verbal feedback, etc.)

After session: physical pain or discomfort (0 = none 10 = highest level)
emotional pain or discomfort (0 = none 10 = highest level)

Evaluation:
(expectations or plan for next session, recommendations to client, suggestions to other caregivers, etc.)

- **Write legibly.** A chart that cannot be read is worthless. More people are typing now and plans are underway in various facilities to computerize charting. Nurses and physical therapists are already using new programs for medical charting.
- **Keep a personal journal of your work.** Often you will be the only person to read your CARE notes, particularly if they are notes you keep for your private practice. Even so, they can be a valuable reference from session to session. After an initial session, subsequent sessions can often be recorded very concisely. Along with the elements of a CARE note chart, you may also find it worthwhile to record your personal experience (maybe under the "E" section of the CARE notes). I encourage all of my students to do this. It gives them a place to record questions and concerns and to assess their own level of confidence with the techniques they are learning. Charting can also bring a sense of closure to the massage therapy session.

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with small bolsters under each knee, used Swedish massage strokes (effleurage, petrissage, tapotement) and compression on the muscles of the back, gluteal region and legs. Specific compression and acupressure to erector spinae and motor points in piriformis.

In supine position with bolsters under the ankles, massage of neck and shoulders, with specific acupressure to the belly of right trapezius. Massage of arms, including range of motion, effleurage and petrissage with arm extended overhead. General massage of anterior legs. Specific reflexology to feet. Polarity hold of lower abdomen. Gentle rocking, followed by general press of abdominal muscles. General work to head, face and scalp. End with polarity hold of neck and forehead.

Response of client

This section of the chart records the physiological changes noted during and after the session. It includes the verbal feedback of the client, as well as nonverbal responses. You can note changes in breathing, tonicity of muscles, facial expressions or body positioning. This is also the place to record changes on the pain scale if you are using that detail of the chart. It can also be significant if there are no changes. Sometimes the response of the client is not what we desire or anticipate. That is okay. Record it anyway. Sometimes the client's physiological or verbal response will not match your observations. Record both. Remember that human beings are very complex and we don't always fully understand what is happening.

Example. Response: The client was initially very inquisitive about the work, but was quickly receptive to the touch. Throughout commented that it felt good. Her breathing became slower and deeper. The areas of hypertonicity, particularly the shoulder, back and gluteal areas, relaxed notably. Some ticklishness in the feet, but responded positively to more broad pressure there. She commented, "I didn't know massage could feel so good." She said she particularly liked the work on the scalp and face and that she would have liked that to have been longer.

After session: physical pain or discomfort, 2 (0=none; 10=highest level); emotional pain or discomfort, 3 (0=none; 10=highest level).

Evaluation

This section provides a space to record the overall evaluation of the session. It includes plans or expectations for subsequent sessions. It may include any observation not already recorded. It contains any recommendations made to the client. This could include encouragement to breathe more deeply or a suggestion for a simple exercise to alleviate back pain. If the client is being seen by other caregivers, this could include suggestions or relevant information for them.

Example. Evaluation: Follow-up sessions are recommended once a week or every other week. Follow-up on major areas of hypertonicity, allowing more time for scalp and face work. Client has some difficulty breathing in prone position after ten to fifteen minutes. Minimize time in this position next session or try

side-lying position instead. Encouraged client to check posture while driving and while at work to minimize some of her discomfort. Emphasized importance of using phone headset at work. (Possibly make some ergonomic adjustments at work station.)

A Guide To Concise Narrative Summary

The information presented here gives a complete picture of the client's condition, what you did and how they responded. This format tells a story and, while it can be expanded to include more information, sometimes it is necessary to record a more concise summary of the session. Given the CARE note format as a guide, the same session could also be recorded this way:

Clara T, a fifty-five-year-old female, who works at sedentary job, reports pain in her neck, right shoulder, back and buttocks. She experiences significant emotional distress. I gave her a sixty-minute full-body massage, using techniques from Swedish massage, acupressure and polarity, with particular attention to areas of greatest discomfort. Reflexology to the feet. She was very receptive to her first experience of professional massage. She particularly enjoyed the work on her face and scalp. I encourage her to check and correct her posture throughout the day, to minimize pain.

The act of writing CARE notes provides an opportunity to acknowledge individual clients and validate the significance of your work. The notes tell a story about one person's effect upon another through the application of skillful massage therapy. I feel it is a privilege to read the charts I see. When I read the notes of the therapists I supervise or the students I teach, I am also able to identify areas of concern and communicate those issues for the benefit of client and therapist alike.

Attorney Linda M. Herrick underscores the importance of charting, "As an attorney who has worked both as insurance defense counsel and representing plaintiffs who have suffered personal injuries, I believe CARE notes charting offers concise, understandable information that will be useful to all involved. I would like to see CARE notes as the standard for massage therapy charting."

Using CARE notes, we can let the same care and concern that governs our hands-on work also inform the narratives we tell about these people. With a system that is easy to follow, flexible and natural to use, we take our place as healthcare professionals, able to communicate to others this valuable work we do. **SBH**

Mary Kathleen Rose, CMT, has more than twenty-five years of experience in the holistic health field. She is the developer of Comfort Touch, a style of massage appropriate for the elderly and ill. She supervises the massage therapy program at HospiceCare of Boulder and Broomfield Counties in Colorado, and teaches in various massage schools and medical settings. She can be reached at rosevine@comforttouch.com.