RECORD KEEPING

Standard of Practice S-002
Quality Assurance Committee
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Note to readers: In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

INTENT

To ensure members maintain accurate, current records of personal health information.

OBJECTIVES

- To ensure patients have access to current, accurate information as reflected in their record of personal health information.
- To ensure continuity of care for patients from successive chiropractors or other treating health professionals.
- To provide members with a framework for organizing clinical notes and other records.
- To maintain confidentiality and prevent unauthorized disclosure of the patient health record and financial record.

DESCRIPTION OF STANDARD

Introduction

The record of personal health information must "tell the story" of the patient, as determined by the member, in the circumstances in which the patient was seen. The record is not just a personal memory aid for the member who creates it, but must allow other health care providers to review and understand the patient's past and current health history as well as future health goals.

Patients present to a member for a variety of reasons. However, patients should expect basic procedures to be followed and recorded which represent the chiropractor's unique role in the collaborative health care framework. The results and observations, based upon the performance of these basic procedures, should be recorded in such a way as to accurately recreate the doctor/patient interaction.

Information in records of personal health information should be stated concisely. It is acceptable to use sentence fragments or outline forms and diagrams.

Records of personal health information may contain abbreviations, acronyms, or short forms ("abbreviations") and terminology unique to health care professions. In such cases, an up-to-date abbreviation legend/key that explains any abbreviation used in the record in a clear and consistent manner, must exist in a printed or electronic format. The legend/key must accompany the records of personal health information upon request. A record of personal health information, if requested, is not complete without an abbreviation legend/key.

CCO does not endorse any particular type, template or style of note taking. Whatever style is used, it is important to be consistent, comprehensive, accurate and legible to give a clear picture of the care being provided.

Types of Records to be Maintained

A member shall keep a daily appointment record, equipment service record, and record of personal health information, which includes a patient health record and financial record. All records shall be accurate, legible and comprehensive.

1. Daily Appointment Record

   The daily appointment record shall set out the surname and initials of each patient the member examines or treats or to whom the member renders any service.

2. Equipment Service Record

   The equipment service record shall set out the servicing of:
   - every x-ray machine in accordance with the *Healing Arts Radiation Protection Act, 1990*, and
   - every other piece of equipment used to emit a form of energy permitted for use by members under section 43(1)(a) of the *Regulated Health Professions Act, 1991*.

   Equipment service records shall be consistent with the manufacturer's recommendations.

3. Record of Personal Health Information

   The record of personal health information includes the patient health record and the financial record

Patient Health Record

(1) The patient health record shall contain:
- demographic information as necessary to identify, assess and treat patients, including but not limited to, a patient's name, address, and birth date;
- dates of each of the patient's visits to the member;
- a reference identifying the patient, and the name/address of the primary treating chiropractor, on each printed page, which may be recorded as a header/footer; and
- name(s) of relevant referring health professionals, if appropriate.

(2) The patient health record shall contain a history of the patient, including:
- patient's chief complaint(s)/concern(s) and supporting data;
- relevant past health history; and
- family and social history when indicated by the presenting complaint(s)/ concerns(s).

(3) The patient health record shall contain reasonable information about every initial examination, all assessments (for further information related to the various assessments that are an essential part of any chiropractic care/plan of care of a patient please refer to Guideline G-013: Chiropractic Assessments), all relevant diagnostic tests and all relevant diagnostic imaging (images and accompanying reports included) made by the member.

(4) The initial examination, as recorded in the patient health record, shall:

(a) be sufficiently comprehensive for the member to document:
- evidence of the patient's current condition;
- diagnosis or clinical impression; and
- plan of care for the patient.

(b) include documented evidence on the performance of the necessary clinically indicated analytical/assessment procedures listed below (not an exhaustive list) in order to demonstrate the need for care:
- activities of daily living questionnaires
- advanced diagnostic imaging (e.g., diagnostic ultrasound, CT Scan, MRI, bone scans)
- analog pain scales
- any questionnaire designed by the member to have the patient compare their current and past health and/or lifestyle ratings
- bilateral weight scales
- blood pressure/pulse testing
- disability questionnaires
- exercise compliance
- leg length checks
- malingerer testing
- muscle function testing
- neurological testing
- orthopedic testing
- palpation/motion palpation

- posture evaluation
- range of motion
- reflexes
- sEMG
- sensory testing
- thermography
- trigger points
- x-ray image.

(5) The patient health record shall contain a record of care of the patient, that includes:

- a copy of the patient's consent to any examination or care or course of care that shall be:
  - fully informed;
  - voluntarily given;
  - related to the patient's condition and circumstances;
  - not obtained through fraud or misrepresentation; and
  - evidenced in a written form signed by the patient or otherwise documented in the patient health record;

- reasonable information about who provided the care and the location of where the care was delivered;

- reasonable information about every subsequent treatment/visit, including level of spine or joint contacted for the purpose of adjusting or mobilizing, and technique(s) used[1];

- reasonable information about all advice given by the member to the patient;

- reasonable information about a procedure that was commenced but not completed, including reasons for non-completion;

- reasonable information about every order made by the member for examinations, including diagnostic images and accompanying reports, tests, consultations or treatments to be performed by any other person;

- reasonable information about when a member advises a patient to consult with another health professional; and

- every written report received by the member with respect to examinations, tests, consultations or treatments performed by other health professionals.

[1] Diagnostic and therapeutic procedures must comply with Standard of Practice S-001: Chiropractic Scope of Practice.

(6) Periodic and regular comparative assessments are a mandatory component of any care/plan of care and are based on the same clinical judgement components used in all phases of patient care.

Implementation of any evaluation, assessment or treatment is always a clinical judgement call made by the member and based on clinical indications, best evidence, best practices, experience, patient presentation and many other factors.

The timing and reason for each comparative assessment depends on a number of factors including but not limited to:

- patient progress;
- expectations of progress;
- presentation of new conditions; and
- requests from third-party payors such as WSIB, etc.

Therefore, comparative assessments must:

(a) be conducted when clinically indicated and, in any event, no later than each 24th visit.

(b) be sufficiently comprehensive for the member to:
- evaluate the patient's current condition;
- assess the effectiveness of the member's chiropractic care;
- discuss with the patient, the patient's goals and expectations for their ongoing care; and
- affirm or revise the patient's diagnosis or clinical impression and plan of care.

(c) include documented evidence on the performance of three or more of the clinically indicated analytical/assessment procedures listed in 4(4)(b) (not an exhaustive list) in order to demonstrate the need for ongoing care. Members may use additional procedures not listed.

(7) Every entry in a patient health record shall be dated and clearly identify the person who made the entry.

Financial Record

The financial record, which is considered part of the record of patient personal health information, shall contain:

- date of service;
- services billed;
- location of service;
- payment received; and
- balance of account.

Please see Guideline G-008: Business Practices for further information about implementing and recording billing practices.

4. Electronic Record Keeping

- A member may maintain an electronic record keeping system in accordance with this standard.

- A member shall take reasonable steps to ensure the electronic record keeping system is so designed and operated that the electronic record of personal health information:

    - is compliant with the *Personal Health Information Protection Act, 2004 (PHIPA)*
    - has cyber security protections in place to ensure that personal health information is secure from loss, tampering, interference or unauthorized use or access,
    - has protocols in place on steps to take in the event of a privacy breach, and;
    - shall be available as hard copies in a printed form when requested.

- If patient credit card or banking information is stored as part of an electronic financial record, it must be encrypted, secure from loss, tampering, interference and unauthorized use or access, and comply with any applicable financial regulations.

- A member shall ensure that personal health information of patients that is stored on a mobile device is encrypted.

- Each entry in an electronic record shall be:

    - accurate and sufficiently comprehensive to reflect the care provided; and
    - individualized and personalized, capturing the unique aspects of that particular patient encounter.

    If the electronic format cannot do this, the member should consider using an alternative system. Members are discouraged from using systems that create "template-like" records. These may not be an adequate reflection of an individual patient's story.

- When requested to do so and within 30 days, members must provide printed copies of electronic records.

The Privacy section of CCO's website and the Information and Privacy Commissioner of Ontario has several resources available related to electronic health records and responding to privacy breaches:

- "Digital Health under *PHIPA*": Selected Overview
- "Responding to Privacy Breaches"
- Guideline G-010: Mandatory and Permissive Reporting

5. Confidentiality of and Access to Records

(1) A member shall not allow any person to examine a record of personal health information or give any information, copy or thing from a record of personal health information to any person except as required by law (see sections 38-50 of the *Personal Health Information Protection Act, 2004 (PHIPA))* or as required or allowed by this section

(2) A member shall take reasonable steps to ensure that records are protected from theft, loss and unauthorized use or disclosure, including photocopying, modification or disposal.[2]

(3) A member with primary responsibility for a record of personal health information shall provide, on request, copies of or access to a record of personal health information to any of the following persons, or any person authorized by the following persons:

- the patient;
- a personal representative authorized by the patient to obtain copies from or access to the record;
- if the patient is deceased, the patient's legal representative;
- if the patient is determined to be incapable of consenting to the collection, use or disclosure of personal health information:
  - the individual's guardian of the person or guardian of property, if the consent relates to the guardian's authority to make a decision on behalf of the individual;
  - the individual's attorney for personal care or attorney for property, if the consent relates to the attorney's authority to make a decision on behalf of the individual;
  - the individual's representative appointed by the Consent and Capacity Board under section 27, if the representative has authority to give the consent;
  - the individual's spouse or partner;
  - a child or parent of the individual, or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent. This paragraph does not include a parent who has only a right of access to the individual. If a children's aid society or other person is lawfully entitled to consent in the place of the parent, this paragraph does not include the parent;
  - a parent of the individual with only a right of access to the individual;
  - a brother or sister of the individual; and
  - any other relative of the individual.[3]

The above list is in rank order. See s. 26 of *PHIPA* for further details.

(4) A member is not required to provide copies from or access to a patient health record if the member is of the opinion that disclosure of the record of personal health information would likely result in serious harm to the care of the patient or serious physical or emotional harm to the patient or another person.

[2] See Standard of Practice S-022: Ownership, Storage, Security and Destruction of Patient Health Records
[3] Section 26(1) of the *Personal Health Information Protection Act, 2004* (*PHIPA*).

(5) Where a member has primary responsibility for a record of personal health information, the member shall, at the request of the patient, cause a correction to be made to the patient's health record or attach a statement of disagreement reflecting the correction requested but not made.

(6) A member shall give notice of every correction made and statement of disagreement attached to a record of personal health information to every person and organization to whom the record was disclosed during the 12 months preceding the day the correction was requested.

(7) A member shall, upon receiving written authorization from the patient or a duly authorized person as described in section 5(3), provide a copy of the record of personal health information as soon as possible in the circumstances, but no later than 30 days after receiving the request, subject to exceptional circumstances (see sections 54(3) and 54(4) of *PHIPA*). The member shall maintain the original record of personal health information, as outlined in the Records Retention and Destruction section and Standard of Practice S-022: Ownership, Storage, Security and Destruction of Patient Health Records, even if the member is no longer providing chiropractic care to that patient.

In cases where a section of the patient record cannot be reasonably copied (e.g., diagnostic images, plain film radiographs), the member shall obtain a written authorization from the patient, or designate listed in section 5(3) which shall become part of the record of personal health information. This form should include the following:

- an agreement between the patient or designate listed in section 5(3) and member to release a section of the original record with recognition that no copies have been retained by the member;
- an agreement by the patient or designate listed in section 5(3) to return the section of the patient record to the member; and
- an acknowledgement of receipt by the patient or designate listed in section 6(3).

(8) A member may charge a reasonable fee prior to providing copies of a record of personal health information, including diagnostic images and accompanying reports, to reflect the cost, time and effort required to provide copies of the record of personal health information. If a member has refused a patient access to the patient's record of personal health information, the patient has the right to challenge the member's decision in Court under subsection of 54(8) of the *Personal Health Information Protection Act, 2004* (*PHIPA*).

(9) A member may provide copies of or access to a record of personal health information to their legal counsel or insurer where the record is relevant to advice being sought by the member or required by the policy of insurance or insurer.

(10)A member may, for the purpose of providing health care or assisting in the provision of health care to a patient, allow a health professional to examine the record of personal health information or give a health professional any information, copy or thing from the record.

(11)A member may provide information or copies of or access to a record of personal health information to a person if:

- the information or copies are to be used for health administration or planning, health research, or epidemiological studies;
- the use of the information or copies is in the public interest as determined by the Minister of Health and Long-Term Care; and
- anything that could identify the patient is removed from the information or copies.

6. Records Retention and Destruction

Every record of personal health information, which includes the patient health record, including diagnostic images and accompanying reports, and every financial record shall be retained in its entirety for at least seven years[4] following the patient's last visit, or, if the patient was less than 18 years old at the time of their last visit, at least seven years following the day the patient became or would have become 18 years old.

Destruction of the record of personal health information shall be done in a secure fashion to ensure that the records cannot be reproduced or identified in any form.

7. Member Resignation

As part of the resignation process, the member shall take reasonable steps to ensure with regard to each record of personal health information for which the member has primary responsibility:

- the record is transferred to another member and reasonable efforts are made to obtain the patient's consent;
- the patient is notified that the member intends to resign and the patient can obtain copies of the record of personal health information; and
- if the record transferred is not the original record of personal health information, the original record is stored in a secure location for seven years following the patient's last visit, or, if the patient was less than 18 years old at the time of their last visit, at least seven years following the day the patient became or would have become 18 years old.

[4] Even though records must be kept for a minimum of seven years, there is no limitation on a patient complaint or civil litigation.

LEGISLATIVE CONTEXT

Regulation pursuant to the *Chiropractic Act, 1991*. Further, it is an act of professional misconduct under *Ontario Regulation 852/93* (Professional Misconduct) to contravene or fail to comply with a standard of practice.

Scope of Practice

3. The practice of chiropractic is the assessment of conditions related to the spine, nervous system and joints and the diagnosis, prevention and treatment, primarily by adjustment, of,

   (a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and

   (b) dysfunctions or disorders arising from the structures or functions of the joints.

Ontario Regulation 852/93

The following are acts of professional misconduct for the purposes of clause 51(1)(c) of the *Health Professions Procedural Code*:

10. Giving information about a patient to a person other than the patient, his or her authorized representative, or the member's legal counsel or insurer, except with the consent of the patient or his or her authorized representative or as required or allowed by law.

11. Breaching an agreement with a patient relating to professional services for the patient or fees for such services.

19. Failing to keep records as required by the regulations.

20. Falsifying a record relating to the member's practice.

21. Failing, without reasonable cause, to provide a report or certificate relating to an examination or treatment performed by the member within a reasonable time after a patient has requested such a report or certificate.

22. Signing or issuing, in the member's professional capacity, a document that the member knows contains a false or misleading statement.

Personal Health Information Protection Act, 2004

Sections 51-54 of the *Personal Health Information Protection Act, 2004,* outline a patient's right of access to their records and a health information custodian's obligation to provide information requested. Please consult these sections for further detail, specifically, section 54.