

Standard of Practice S-002
Quality Assurance Committee
Approved by Council: May 24, 1996
Amended: November 18, 1999, November 30, 2002, November 26, 2004,
April 22, 2005, November 25, 2005, December 1, 2006, February 23, 2010,
September 22, 2011

Note to Readers: In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

Intent

To facilitate the care and treatment of patients by advising members of their duty to maintain accurate and up-to-date patient records.

Objectives

- To facilitate the care of treatment of patients.
- To ensure patients have access to up-to-date, accurate information about their chiropractic health.
- 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 patient records.

Description of Standard

Types of Records to be Maintained

A member shall keep a daily appointment record, equipment service record, financial record and patient health 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 prescribed under section 43(1)(a) of the *Regulated Health Professions Act, 1991*¹.

3. Financial Record

The financial record shall contain:

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

4. Patient Health Record

(1) The patient health record shall contain:

- patient's name, address, birth date and gender;
- 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 separate page; 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, assessment and reassessment, 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/management 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 his/her current and past health and/or lifestyle ratings
 - bilateral weight scales
 - blood pressure/pulse testing
 - disability questionnaires
 - exercise compliance
 - leg length checks
 - malingering testing
 - muscle function testing
 - neurological tests
 - orthopedic tests
 - palpation/motion palpation
 - posture evaluation
 - range of motion
 - reflexes
 - SEMG
 - sensory testing
 - thermography
 - trigger points
 - x-ray image

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- (5) The patient health record shall contain a record of care/management of the patient, that includes:
- 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;
 - every written report received by the member with respect to examinations, tests, consultations or treatments performed by other health professionals;
 - a copy of the patient's consent to any examination or treatment or course of treatment 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 record.
 - reasonable information about every subsequent treatment, including level of spine or joint contacted for the purpose of adjusting or mobilizing, and technique(s) used;
 - reasonable information about all advice given by the member to the patient;
 - reasonable information about every referral of the patient by the member to another health professional; and
 - reasonable information about a procedure that was commenced but not completed, including reasons for non-completion.
- (6) The re-assessment, as recorded in the patient health record, shall contain reasonable information about every re-assessment that must:
- (a) be conducted when clinically necessary 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 his/her ongoing care; and
 - affirm or revise the patient's diagnosis or clinical impression and plan of care/management.
- (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.

5. Records Retention

Every patient health record, including diagnostic images and accompanying reports, and every financial record shall be retained for at least seven years following the patient's last visit, or, if the patient was less than 18 years old at the time of his/her last visit, the day the patient became or would have become 18 years old.

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

6. Member Resignation

As part of the resignation process, the member shall take reasonable steps to ensure with regard to each patient health record 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 patient health record; and
- if the record transferred is not the original patient health record, 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 his/her last visit, the day the patient became or would have become 18 years old.

7. Confidentiality of and Access to Records

- (1) A member shall not allow any person to examine a patient health record or give any information, copy or thing from a patient health record to any person except as required by law or as required or allowed by this section.
- (2) A member with primary responsibility for a patient health record shall provide, on request, copies of or access to a patient health record 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 lacks capacity to give an authorization, a committee of the patient appointed under the *Mental Incompetency Act*:
 - a person to whom the patient is married and living in a conjugal relationship;
 - a person of the opposite or same sex with whom the patient is living in a conjugal relationship outside marriage if the patient and the person have cohabited for at least one year, are together the parents of a child, or have together entered into a cohabitation agreement under section 53 of the *Family Law Act*;
 - the patient's son or daughter; or
 - the patient's parents.
- (3) 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 health record would likely result in serious harm to the care of the patient or serious physical or emotional harm to the patient or another person.
- (4) Where a member has primary responsibility for a patient health record, 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.
- (5) A member shall give notice of every correction made and statement of disagreement attached to a patient health record to every person and organization to whom the record was disclosed during the 12 months

preceding the day the correction was requested.

- (6) A member shall, upon receiving written authorization from the patient or a duly authorized person as described in section 7(2), provide a copy of the patient health record in a timely manner. The member shall maintain the original patient health record, as outlined in the Records Retention and Destruction section, even if he/she 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 7(2) which shall become part of the patient record. This form should include the following:

- an agreement between the patient or designate listed in section 7(2) 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 7(2) to return the section of the patient record to the member;
 - an acknowledgement of receipt by the patient or designate listed in section 7(2).
- (7) A member may charge a reasonable fee prior to providing copies of a patient health record, including diagnostic images and accompanying reports, to reflect the cost, time and effort required to provide copies of the patient health record. If a member has refused a patient access to his/her patient health record, 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)*.
- (8) A member may provide copies of or access to a patient health record to his/her legal counsel or insurer where the patient health record is relevant to advice being sought by the member or required by the policy of insurance.
- (9) 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 patient health record or give a health professional any information, copy or thing from the record.
- (10) A member may provide information or copies of or access to a patient health record 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.

8. Electronic Equipment

- 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 patient health records:
 - are secure from loss, tampering, interference or unauthorized use or access, and,
 - shall be available as hard copies, as required by CCO.
- A member shall ensure that personal health information of patients that is stored on a mobile device is encrypted.

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.

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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*:

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 his/her records and a health information custodian's obligation to provide information requested. Please consult these sections for further detail, specifically, subsection 54(10-12), which states:

- (10) A health information custodian that makes a record of personal health information or a part of it available to an individual under this Part or provides a copy of it to an individual under clause 1(a) may charge the individual a fee for that purpose if the custodian first gives the individual an estimate of the fee.
- (11) The amount of the fee shall not exceed the prescribed amount or the amount of reasonable cost recovery, if no amount is prescribed.
- (12) A health information custodian mentioned in subsection (10) may waive the payment of all or any part of the fee that an individual is required to pay under that subsection if, in the custodian's opinion, it is fair and equitable to do so.

¹ Currently, chiropractors are not authorized to order or apply prescribed forms of energy. Equipment service records should generally be consistent with the manufacturer's recommendations.

² Every diagnostic or therapeutic procedure must comply with the standard of practice (S-001: Chiropractic Scope of Practice). A legend for every technique, technology, device or procedure must be readily available.

³ Even though records must be kept for seven years, there is no limitation on a patient complaint or civil litigation.