



College of Traditional Chinese Medicine
Practitioners and Acupuncturists of Ontario

Ordre des praticiens en médecine traditionnelle
chinoise et des acupuncteurs de l'Ontario

RECORD-KEEPING GUIDELINE

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Introduction

Record keeping is an important part of every member's practice. If colleagues or other health care practitioners are treating a patient, complete records assist in continuity of care. Complete record keeping assists the practitioner in recalling details of the patient's history, condition and treatments received. The patient record also provides a comprehensive record for medical and legal purposes, when the practitioner is asked to prepare a report relating to an injury or injuries treated. Finally, the patient record is important as it provides a record of events for the practitioner, in the event that inquiries are made by insurance companies, or in the process of investigating a complaint received by the College.

Registered practitioners of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario ("CTCMPAO") must maintain accurate, legible and up-to-date records for each of their patients in order to provide proper care and treatment. The guidelines will address the mandatory records that must be maintained by all members, as well as record management and privacy of patients.

In the case of any inconsistency between this guideline and the underlying legislation, the legislation takes priority. For the purposes of this practice-based guideline, members of CTCMPAO will be referred to as "practitioners".

The College would like to thank the members of the Quality Assurance Committee for their ongoing guidance and for providing the necessary vision in which to begin the development of this guideline.



Types of Records to be Maintained

As part of the College's Record Keeping Standard of Practice, it is the practitioner's duty to ensure the following mandatory records are accurate, confidential, and up-to-date:

1. Daily Appointment Log
2. Patient Health Summary
3. Initial Assessment and Treatment Record
4. Follow up Treatment Record
5. Consent to Treatment Form (*Not mandatory but strongly recommended*)
6. Consent to Collect, Use, and Disclose Personal Health Information Form (*Not mandatory but strongly recommended*)
7. Equipment and Supply Records

The following section will explore each of the mandatory records in detail, including the information that must be included in each record. The guideline will explain the mandatory information that must be included and provide an example template to illustrate how it can be used in practice. Standardized templates have been developed by the College and will be used throughout this guideline as an example and for reference. Practitioners have no obligation to copy and use the provided templates, but may find it useful as a starting point for when they develop their own templates and record keeping practices.

1. Daily Appointment Log

A written or electronic daily appointment log must contain the following information:

- ✓ Date in the format of "DD/MM/YY" for consistency of records
- ✓ The surname, first name and/or initials of each patient
- ✓ The time and/or duration of appointment of each patient



2. Patient Health Summary Form

The Patient Health Summary form acts as a cover page of a patient's health record, providing a snapshot of the overall health history of a patient. It lists the essential information of the patient and allows for a quick reference to the patient's overall health. The form is first completed by the patient, and then reviewed and discussed with the practitioner. The practitioner should ensure all pertinent health issues are captured on the form during discussion/counselling with the patient.

A Patient Health Summary form must exist for each patient. Practitioners may use the following sample form to fulfill this requirement, or they may create and use their own form. The information can be recorded in other languages as long as all the information is also recorded in English or French.

A Patient Health Summary form must contain the following information:

- ✓ Patient identification (name, address, phone number)
- ✓ Personal and family data (Date of Birth (DD/MM/YY), Sex, Occupation)
- ✓ Family contact information
- ✓ Emergency contact information
- ✓ Family Doctor (name, address, phone number)
- ✓ Past medical history
- ✓ Risk factors
- ✓ Allergies/drug reactions
- ✓ Ongoing health conditions
- ✓ Long-term treatment
- ✓ Date of last update of the Patient Health Summary – to ensure the patient's health summary form is up to date with the most pertinent health issues.
- ✓ Patient or Substitute Decision-Maker's signature
- ✓ Practitioner's signature



Breakdown of Patient Health Summary Form - Page 1

Patient Health Summary Clinic Name/Practitioner Name/Registration # Clinic Address/Clinic Telephone Number			File Number: _____
Patient Information			
First Name:	Last Name:	Middle Name:	
Telephone (Home/Mobile):	Telephone (Business):	Sex: M / F / Other	
Home/Street Address:		Apt #:	Date of Birth: (DD/MM/YY)
City:	Province:	Postal Code:	
Occupation:	Email:		
Family Contact Information	First name:	Last name:	
Relationship to Patient:	Phone Number:	Mobile Number:	
Emergency Contact information (If different individual from above)	First name:	Last Name:	
Relationship to Patient:	Phone Number:	Mobile Number:	
Family Doctor Name:			
Clinic Address:			
Clinic Phone:	Clinic Email:		
Past Medical History			
<i>Please list any relevant past medical history including any hospitalizations, surgeries, prior injuries, or any past medical conditions etc. Be sure to include any previous family medical conditions or diseases that may be relevant.</i>			
Ongoing Health Conditions/ Allergies/Drug Reactions/ Risk Factors/Long Term Treatment			
<i>Please list any ongoing health conditions, allergies, drug reactions, and long term treatments that may be relevant. If you are currently taking any prescription medications, please include them.</i>			

Practitioners are encouraged to place their practice logo and contact information here. The patient's name and contact information is required. The file number is optional and dependent on the member's record management system.

The form is first completed by the patient. Afterwards, the practitioner should ensure all pertinent health issues are captured on the form during discussion/counseling with the patient.

Date of Last Update of Patient Health Summary:

Breakdown of Patient Health Summary Form - Page 2

Please circle any conditions you are experiencing (past and present):

General Symptoms

Headaches/migraines
Fever
Chills
Sweat
Memory loss
Dizziness/Light headedness
Fainting
Stress/depression
Discoordination
Nervousness
Recent weight loss/gain
Numbness pain in arms, legs

Respiratory

Wheezing
Chronic cough
Spitting up phlegm
Chest pain
Difficulty breathing

Muscle and Joint

Stiff neck
Back ache
Swollen joints
Painful tailbone
Pain in shoulder
Hernia
Spinal curvature
Faulty posture
Arthritis
Foot trouble

Cardiovascular

High or low blood pressure
Previous stroke or TIA
High cholesterol

Swelling of ankles
Poor circulation
Stroke/heart attack
Irregular heart beat
Shortness of breath
Pain over heart

Genitourinary System

Frequent/painful urination
Blood in urine/stool
Mucus in stool
Kidney infection/kidney stone
Bladder infection
Inability to control urine

Ears, Eyes, Nose, Throat

Hearing loss
Vision problems
Glaucoma
Ringing in ear(s)
Crossed eyes
Eye pain
Deafness
Earache
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Hay fever
Asthma

Dental decay
Gum trouble
Frequent colds
Enlarged thyroid

Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands

Skin

Skin conditions/rashes
Itching
Bruise easily
Dryness
Boils
Varicose veins
Sensitive skin
Hives or allergy

Gastrointestinal

Poor appetite
Distress from greasy foods

Excessive hunger/thirst
Belching or gas
Nausea
Vomiting
Burning in stomach
Pain over stomach
Constipation/diarrhea
Colon trouble
Liver trouble/hepatitis
Gall bladder
Ulcers

Colitis
Hemorrhoids
Hypoglycemia
Hiatal hernia

Metallic taste

For Women Only

Cramps/backache
Previous miscarriage
Irregular cycle
Vaginal discharge
Lumps in breast
Menopausal symptoms
Pregnant
Painful menstruation
Excessive flow
Hot flashes
Hysterectomy

Your patient should circle any conditions that they are experiencing (past and present).

Have you had any of the following?

Appendicitis	Malaria	Chicken pox	Alcoholism	Osteoporosis
Diabetes	Venereal infection	Cold sores	Whooping cough	Cancer
Epilepsy	Multiple sclerosis	Anemia	Heart disease	Tuberculosis
Pneumonia	Measles	Goiter	Eczema	Mental illness
Mumps	Influenza	Gout	Polio	Pleurisy
Pneumatic fever	Arthritis	Rubella	Parkinson's	HIV/AIDS

Signature of Patient: _____ **or Substitute Decision-Maker:** _____

Date: _____ **Relationship to Patient:** _____

Date of Last Update of Patient Health Summary:

Remember!
The Patient (or Substitute Decision-Maker) will need to sign and date the form.

3. Initial Assessment and Treatment Record

The Initial Assessment and Treatment Record is the form first used when a practitioner meets with a new patient. This health record will provide the practitioner with a clear understanding of the patient's current and past health conditions, identified health concerns, and the course of treatment to be followed. Accurate, clear and concise documentation facilitates follow-up treatment and prevents error.

The practitioner is expected to first review the Patient Health Summary form with the patient. The practitioner will then discuss the patient's health and any relevant information noted in the Patient Health Summary Form. Any new or important information noted during the discussion will be captured on the Initial Assessment and Treatment Record.

The Initial Assessment and Treatment Record form must contain the following information:

Patient History

- ✓ Personal health and medical history (ongoing problems, past illnesses, operations, allergies, drug reactions, prescription medications, herbal supplements, vitamins, over the counter remedies etc.)
- ✓ Family health history
- ✓ Referring professional's diagnosis

Initial Assessment/Diagnosis and Treatment

- ✓ Presenting condition/chief complaint
- ✓ Signs and symptoms
- ✓ TCM diagnosis and treatment (identified TCM disease, TCM differentiation of syndromes)
- ✓ Treatment principles and strategies
- ✓ Treatment plan (modalities; acupuncture, herbal, dietary, manual therapies), frequency and duration.
- ✓ Any advice given to patients

Treatment by Other Health Care Provider

- ✓ Referring healthcare provider (Regulated Health Professional)
- ✓ Name, address and phone number
- ✓ Other relevant care provider (e.g. personal support workers)
- ✓ All communications to and from other healthcare providers

Initial Assessment/Diagnosis and Treatment

- ✓ Signed reports compiled/produced by the treating practitioner
- ✓ Every report requested and received from another healthcare professional
- ✓ Initial and date every report after review

INITIAL ASSESSMENT AND TREATMENT RECORD

*Clinic Name/Practitioner Name/Registration #
Clinic Address/Clinic Telephone Number*

Patient's Name: _____ Date of Treatment: _____ File Number: _____

Chief Complaint	
Current Symptoms	
<p><i>Energy, Sleep, Appetite, Thirst, Sweating, Chills/Fever, Body Pains, Bowels, Urine, Menstruation</i></p>	

General Observations	
----------------------	--

Examinations																	
Tongue	<p>Shape: <i>thin, swollen, teeth mark</i> Colour: <i>pale, red, purple, others</i> Coating: <i>white, yellow, dry, greasy, others</i> Other:</p>																
Pulse	<table border="0" style="width: 100%;"> <tr> <th colspan="4">Right</th> <th colspan="4">Left</th> </tr> <tr> <td>General</td> <td>Cun</td> <td>Guan</td> <td>Chi</td> <td>General</td> <td>Cun</td> <td>Guan</td> <td>Chi</td> </tr> </table>	Right				Left				General	Cun	Guan	Chi	General	Cun	Guan	Chi
	Right				Left												
General	Cun	Guan	Chi	General	Cun	Guan	Chi										
Palpation	<p><i>Floating, Deep, Slow, Rapid, Deficient, Excessive, Slippery, Choppy, Wiry, Weak</i></p>																

Page 1 of 3

The patient's name and date of treatment is required. The file number is optional and dependent on the member's record management system.

The Chief Complaint should be clearly stated and identified. When counselling with the patient, practitioners should list the patient's symptoms here. The "10" questions are provided at the bottom of the box as a reference.

This is a convenient tool designed for practitioners to quickly assess and conduct the appropriate examinations for each patient. Reference terms are provided for your convenience. For "Others", any other diagnostic information should be placed here that was identified from measuring the tongue, pulse and palpation.

Breakdown of Initial Assessment and Treatment Record - Page 2

File number and patient's name continues onto the second page

INITIAL ASSESSMENT AND TREATMENT RECORD (cont'd)

Patient's Name: _____

File Number: _____

Patient Medical History	<i>Previous family health, ongoing problems, past illnesses/operations, prescription drugs, allergies, nutritional supplement, other health care provider's referral and/or treatment plan</i>

Diagnosis and Treatment	
TCM diagnosis/ differentiations	
TCM Treatment Principle	
TCM Treatment Plan/ Advice	
<p>Acupuncture Points Prescribed</p> <p>See Appendix</p>	

TCM Treatment plan to be described here. For example, length and frequency of treatment, and treatment such as acupuncture, herbal prescription

Breakdown of Initial Assessment and Treatment Record - Page 3

Remember to print patients name and file number on each page.

INITIAL ASSESSMENT AND TREATMENT RECORD (cont'd)

Patient's Name: _____

File Number: _____

Herbal Prescription Name of herbs: <i>Chinese Characters (Traditional or Simplified) or Pinyin (required)</i> + <i>Medical Latinate or botanical name</i> Type of herbs: <i>Raw, powder, granular, sachets, packets, liquids, & extracts</i> Quantity of herbs: <i>e.g. 10 g</i> Instructions for preparation and consumption Storage of herbs: <i>e.g. store in cool and dry place</i> Frequency of Treatment	
Adjunct Modalities <i>Cupping, Exercise, Dietary therapy, Tui Na Therapy, Gua Sha</i>	

Practitioner Signature: _____

Date: _____

Page 3 of 3

The name of the prescribed herb has to contain two sets of information:

1. Chinese Characters (simplified or traditional) and/or Pin Yin; AND
2. Medical Latinate or Botanical Name.

The type of herbs, quantity of herbs, how to prepare them, how to store them and frequency of treatment should all be stated clearly.

Records can be in your language of choice, however records must also be transcribed in English or French. In the event of an emergency, the practitioner's health records need to be easily retrieved and understood by all other attending health care professionals.

Remember!
Practitioner's signature is **required**.

From the Safety Program Handbook:

The prescribing practitioner has responsibility for the completeness, accuracy and comprehensiveness of the information that is provided on the prescription. TCM prescriptions should be legible and should contain all necessary information to allow the prescription to be accurately and safely dispensed, used, and tracked. **For the safety of the public**, the information in the prescription must be useful to and understandable by other health professionals, especially in emergency situations.

4. Follow Up Treatment Record

The Follow Up Treatment Record is a simplified form used for subsequent patient visits. The intent of the follow up treatment record form is to document ongoing treatment progress and document any changes in the prescribed treatment (if required).

The Follow Up Treatment form differs from the Initial Assessment and Treatment Record as it is much more simplified. The practitioner can always refer to previously completed forms to provide a context of the patient's ongoing health.

The Follow Up Treatment Form is mainly used to document any changes in the Patient's health and to document any modifications to the patient's treatment if it was required. The record should reflect the ongoing progress of a patient's health.

The Follow Up Treatment Record must contain the following information:

- ✓ Date of visit
- ✓ Progress inquiry
- ✓ TCM differential diagnosis
- ✓ Treatment plan modification
- ✓ Contraindications
- ✓ Herbal medicine prescription
- ✓ Acupuncture prescription
- ✓ Adjunct modalities/treatment or procedures used and specifics
- ✓ Patient's reaction to treatment
- ✓ Document patient refusal to follow recommendation



Breakdown of Follow Up Treatment Record - Page 1

The Follow Up Treatment Record is required for every follow up visit. The practitioner should record the progress of the prescribed treatments and document relevant information regarding the treatment plan.

The practitioner should also record the following information if applicable:

- Treatment plan progress
- Patient's reaction to treatment
- Patient's refusal to follow recommendations
- Contraindications
- Adjunct modalities/treatment procedures used and progress

FOLLOW UP TREATMENT RECORD

File Number: _____

*Clinic Name/Practitioner Name/Registration #
Clinic Address/Clinic Telephone Number*

Patient's Name: _____ Date of Treatment: _____

Patient Progress Inquiry	<i>Treatment plan progress, patient's reaction to treatment, document patient's refusal to follow recommendations, contraindications, adjunct modalities/ treatment or procedures used.</i>

Examinations											
Tongue	Shape: <i>thin, swollen, teeth mark</i> Colour: <i>pale, red, purple, others</i> Coating: <i>white, yellow, dry, greasy, others</i> Other:										
Pulse	RIGHT					LEFT					
	General	Cun	Guan	Chi		General	Cun	Guan	Chi		
	<i>Floating</i>	<i>Deep</i>	<i>Slow</i>	<i>Rapid</i>	<i>Deficient</i>	<i>Excessive</i>	<i>Slippery</i>	<i>Choppy</i>	<i>Wiry</i>	<i>Weak</i>	
Palpation											
General											

Revised Diagnosis and Treatment	
Revised TCM diagnosis/ differentiations	
Revised TCM Treatment Plan/ Advice	

Space provided for any revised diagnosis or treatment (if required)

Breakdown of Follow Up Treatment Record - Page 2

If any previous acupuncture points prescribed need to be revised due to the revision of TCM diagnosis, the record should reflect the change of points here.

<p>Revised Acupuncture Points Prescribed</p> <p>See Appendix</p>	
<p>Revised Herbal Prescription</p> <p><i>Name of herbs: Chinese Characters (Traditional or Simplified) or Pinyin (required) + Medical Latinate or botanical name (required)</i></p> <p><i>Type of herbs: Raw, powder, granular, sachets, packets, liquids, & extracts</i></p> <p><i>Quantity of herbs: e.g. 10 g</i></p> <p><i>Instructions for preparation and consumption</i></p> <p><i>Storage of herbs: e.g. store in cool and dry place</i></p> <p><i>Frequency of Treatment</i></p>	
<p>Adjunct Modalities</p> <p>Cupping Exercise Dietary Therapy Tui Na Therapy Gua Sha</p>	

Practitioner Signature: _____

Date: _____

The name of the prescribed herb has to contain two sets of information. The practitioner must state the following: Chinese Characters (Simplified or traditional) **OR** Pin Yin + Medical Latinate **OR** Botanical Name.

The type of herbs, quantity of herbs, how to prepare them, how to store them and frequency of treatment should all be stated clearly.

Records can be in your language of choice, however records must also be transcribed in English or French. In the event of an emergency, the practitioner's health records need to be easily retrieved and understood by all other attending health care professionals.

Ensure that you sign off on the patient record!

Relevant Consent Forms

There are two main types of consent forms that Practitioners may use in their practice and which are expected to form part of their records: (1) Consent to Treatment Forms and (2) Consent to Collect, Use, and Disclose Personal Health Information Forms.

5. Consent to Treatment Form

Practitioners are required by law to explain proposed treatments to their patients and to receive their patients' informed consent for the proposed treatment. A patient has the right to receive sufficient information in order to make an informed decision on whether to accept treatment. Practitioners must ensure that their patients know, understand and consent to their assessments or treatments before any treatments begin. Consent must be informed by means of a meaningful dialogue between the practitioner and the patient. If a patient is not capable of providing consent, the Practitioner may receive consent from the patient's substitute decision-maker (in accordance with the **Health Care Consent Act, 1996**).

The following rules are set out in the Health Care Consent Act, 1996:

- ✓ The consent must relate to the treatment;
- ✓ The consent must be informed: this means the Practitioner must inform the patient or substitute decision-maker about the nature of the treatment; the expected benefits of the treatment; the material risks of the treatment; the material side effects of the treatment; alternative courses of action; the likely consequences of not having the treatment;
- ✓ The consent must be given voluntarily; and
- ✓ The consent must not be obtained through misrepresentation or fraud.

The Health Care Consent Act, 1996 does not require Practitioners to use written consent forms. Consent may be obtained in writing or verbally, or it may be implied. However, CTCMPAO strongly recommends written express consent in the form of a signed and documented Consent to Treatment form.

Members must always get expressed consent for treatment that involves contact with sensitive areas. For the initial treatment, the expressed consent must be written.

Regardless of the way in which the Practitioner obtains consent, the Practitioner should document the consent discussion in the patient's chart. The content of the note will depend on the nature of the treatment and the particular circumstances, but should generally include the date of the consent discussion, who participated in the consent discussion, the material risks that were discussed and whether consent was given or refused. The Practitioner should also document if the patient is incapacitated and if there is a substitute decision-maker.

If using a Consent to Treatment Form, the Practitioner must explain each part of the form before asking the patient to sign the form. It is not enough to simply allow the patient to read and sign the Consent to Treatment form. Each of the sections contained within the form must be reviewed and explained by the Practitioner to the patient.

The following details are recommended for the practitioner's Consent to Treatment forms:

- ✓ A voluntary consent to treatment by the patient or substitute decision-maker, with the option to withdraw their consent and halt participation at any time
- ✓ A description and explanation of the services, techniques or procedures that may be used on the patient
- ✓ The expected benefits of the treatment
- ✓ The possible risks, side effects or consequences associated with any potential treatments
- ✓ The alternatives to having the treatment and the likely consequences of not having the treatment
- ✓ A section asking patients to divulge any major past or current health issues to the practitioner, including whether the patient currently has any infectious virus or disease
- ✓ A section outlining that there are no guarantees for the results of TCM Acupuncture treatments
- ✓ A section detailing the fees related to the cost of assessments or treatments
- ✓ Evidence of patient's refusal to consent for treatment
- ✓ An overall acknowledgement of informed consent and agreement of the entire form authorizing the practitioner to begin treating the patient
- ✓ Patient's (or substitute decision-maker's) signature and date
- ✓ Practitioner's signature and date

6. Consent to Collect, Use and Disclose Personal Health Information Form

All regulated health care professionals in Ontario are governed by the **Personal Health Information Protection Act, 2004 ("PHIPA")**, an Ontario statute that defines the roles and the responsibilities of health care professionals with respect to the privacy of health records.

One of the major principles of *PHIPA* is that Practitioners need their patients' consent in order to collect, use or disclose their personal health information. *PHIPA* provides that consent may be either **express** or **implied**:

Implied consent is the assumption that consent is provided by the patient for collection, use or disclosure of personal health information. For example, when a patient answers questions about his or her health history when being counselled by a practitioner - a context where it is implied that the information provided will then be used to assess and treat the patient - the practitioner can infer consent to collect that health information.

Express consent is the formal written or documented agreement for consent from the patient, for example, by using the Consent to Collect, Use, and Disclose Personal Health Information Form. As with the Consent to Treatment Form, the Practitioner must explain each part of the form before asking the patient to sign the form. It is not enough to simply allow the patient to read and sign the Consent to Collect, Use, and Disclose Personal Health Information Form. Each of the sections contained within the form must be reviewed and explained by the Practitioner to the patient.

There are limited situations under PHIPA where Practitioners must obtain written consent, such as to disclose personal health information to someone who is not a health information custodian as defined in PHIPA¹ and to disclose personal health information to another health care provider for purposes other than the provision of health care. In addition, express consent is required for certain fundraising and marketing activities. **Although PHIPA does not require practitioners to use consent forms, CTCMPAO strongly recommends them.** If a patient provides express consent to the collection, use or disclosure of personal health information, the Practitioner is expected to document that consent in the patient's health records. The Practitioner should document whether the patient places any limits on their consent (e.g., if the patient has directed that part of his or her file not be given to another health care provider) or if the patient later withdraws their consent or part of their consent. This is known as a "lock-box" provision. This means a patient is locking all or part of their health information from access by other health care providers. Patients are expressly withholding or withdrawing their consent to the collection, use, or the disclosure of their personal health information or health care.

The following details are recommended for the practitioner's Consent to Collect and Release Information form:

- ✓ A space for the patient or their substitute decision-maker to print his or her name
- ✓ An acknowledgement by the patient for the practitioner/clinic to collect, use or disclose their personal health information for the purpose of receiving traditional Chinese medicine or acupuncture services and for any other relevant purposes set out in the Form (such as to obtain payment for services provided).
- ✓ A description of how the patient's information will be used
- ✓ Information about how the patient can access their personal health information
- ✓ Information about how the patient can request a correction to their personal health information
- ✓ An acknowledgement that the patient understands the form and his/her ability to withdraw consent at anytime
- ✓ A space for the Practitioner or patient to document any restrictions on the patient's consent (e.g., if the patient directs that a part of their file not be shared with other health care providers)
- ✓ Patient signature and date
- ✓ Witness signature and date

¹ "Health information custodian" is defined in PHIPA to include: health care practitioners or persons who operate a group practice of health care practitioners (this includes all those registered under the Regulated Health Professions Act, registered social workers and social service workers, and unregistered health care practitioners); community service providers under the Home Care and Community Services Act, 1994; community care access centres (CCACs); most health facilities including public hospitals, long-term care homes, retirement homes, pharmacies, ambulance services, homes for special care, laboratories and community health centres; an evaluator under the Health Care Consent Act, 1996 or an assessor under the Substitute Decisions Act, 1992; a medical officer of health; and the Minister or Ministry of Health and Long-Term Care.

7. Equipment and Supply Records

All equipment used (including devices such as CPR equipment, scales and slicers) must be maintained according to the standards listed by their manufacturer or supplier. All relevant information should be maintained in a log book.

Additionally, practitioners *must* detail, maintain and keep an inventory of:

- ✓ Every instrument or equipment used for any service to patients
- ✓ Sterilization of equipment if used (such as a cupping instrument and/or other equipment where blood is involved)
- ✓ Other equipment service records as necessary

Equipment Maintenance Log

Name of Equipment:

Manufacturer's contact details:

Manufacturer:

Serial number:

Date of Purchase:

Date:	Maintenance Description	Maintenance performed by:	Notes:
12/1/16	E.g. Sterlization		
	E.g. Repairs		

Management of Records

General

Entries must be made to the patient record at the time of consultation or immediately after. All entries must be dated. The treating member is responsible for the accuracy of the patient's health information, and this responsibility cannot be delegated to another person. In cases where students are entering information into a patient's record, all information must be signed off on by their supervising practitioner. The supervisor must ensure the information entered is correct and complete.

Information on records cannot be deleted or removed. All written communication sent to or received from the patient must be kept in the patient file. Records may be handwritten, typed or in electronic format. If handwritten, it must be clear and legible. Changes to the patient record cannot be erased or whited out. Instead, a line should be drawn through the entry that needs to be changed, or a "strike out" font should be used if done electronically. All changes must be initialed by the person making the change. If the change is made electronically, the name of the individual making the change must be typed next to the change.

Legibility of Records

Records can be handwritten, typed, voice-dictated and transcribed, or electronically kept in computers, as long as the manner of record keeping contains all of the necessary information prescribed in this guideline.

If records are kept electronically, back-up files and restore protocols must be in place. Access to the computer records must be secured via password to avoid tampering. The practitioner is also responsible for the safety and care of the electronic files to avoid privacy breaches. This includes accountability in where the electronic files are stored e.g. location of servers, local back ups, and cloud storage.

Language of Records

While records may initially be recorded in a language other than English or French, members must also translate their records into English or French soon after the original record is made. The College's Standard for Record Keeping states that records must be translated into one of the two official languages in a timely manner.

Members must be aware that requests for records can come at any time (from the College, other health care providers in an emergency, law enforcement, etc.) and it is the member's responsibility to respond to those requests without delay. Failing to respond to a request for records in a timely manner because the records have not been translated, could be considered a breach of the standard of practice. Therefore, members must have a procedure for translating records that allows them to respond to unexpected requests for records.

Security and Storage

The confidentiality and security of all records must be taken seriously. Records must be in paper or electronic files.

All records must be secure from loss, tampering, interference or unauthorized access. If paper records are kept, they must be kept in a secure area, and precautions must be made to ensure the safety of the files.

Sharing and Separation of Records

Practitioners of CTCMPAO must keep separate patient files for each patient regardless of practice setting. Practitioners who work in group settings with other health care professionals in a shared clinic must keep and create their own separate patient files for each patient. Practitioners are expected to have their patients sign their own Consent forms, Patient Health Summary forms and all relevant patient health records.

Practitioners who practice in more than one profession must maintain separate patient records. For instance, a CTCMPAO member who is also registered with the College of Massage Therapists of Ontario must maintain two completely independent patient records, one for TCM/Acupuncture and one for Massage Therapy. Similarly, financial records for each profession must be maintained separately.

Under **Personal Health Information Protection Act, 2004 ("PHIPA")**, patient health records can be shared among health care practitioners in a multi-disciplinary setting under strict circumstances. Please refer to *PHIPA* for these circumstances.

In a multidisciplinary setting, the patient health records from each practitioner, as it pertains to one patient, can be shared for the purposes of providing health care. This is known as a **"circle of care"**. This includes sharing with health care providers who are not caring for the patient, but does not include others such as family, friends, police and so on. It is understandable that some practitioners feel that their colleagues do not have purview to the patient's health information. As stipulated in the legislation, as long as each practitioner has been given consent by the patient (express or implied), it is permissible under *PHIPA*. If one of the practitioners working in the multi-disciplinary clinic has been given consent (express or implied) by the patient to share a patient's personal health information with you, you could make a photocopy of the patient's health summary form and include that with your own patient health file. This will avoid duplication and repetition in the clinic.

Please note that the Patient Health Summary form needs to include specific information outlined by CTCMPAO. It is the Practitioners responsibility that the other health care professional health records meet CTCMPAO's requirement should they be used. This includes the responsibility of practitioners to ensure that the patient health summary form is kept up to date.

Record Retention and Destrutions

According to the **Regulated Health Professions Act, 1991**, patient files must be kept **at least for 10 years** following the patient's last visit. If the patient is a minor, then the patient file must be kept for 10 years following the patient's eighteenth birthday. Destruction of records must be done in a managed and confidential way. This requirement encompasses electronic or paper copies.

All other files related to the practice must also be kept for a period of ten years. These other files include appointment books.

Closure of Practice, Dissolution, Resignation, or Termination of Practice in a **SOLE** Practice

A member must follow the stipulations set out in the *Personal Health Information Protection Act, 2004* ("PHIPA") as well as in the **Professional Misconduct Regulation** (O. Reg. 318/12 made under the **Traditional Chinese Medicine Act, 2006** section 36, when transferring records.

If the member intends to close his or her practice, he/she must take reasonable steps to give appropriate notice of the intended closure to each patient for whom the member has primary responsibility to:

- ✓ Ensure that each patient's records are transferred to the member's successor or to another member, if the patient so requests; or
- ✓ Ensure that each patient's records are retained or disposed in a secure manner

Members who intend to close their practice, resign or leave an existing practice must provide his/her patients with notification of practice closure or restrictions as soon as possible after it becomes apparent that he/she will be leaving or restricting practice, in order to allow patients an opportunity to find another practitioner. They must also assist with the transfer of patient care to another provider. This includes copying the file (at the patients cost) and transferring patient files to another practitioner or simply giving a patient a copy of their file.

Acceptable methods of notification are:

- ✓ In person, at a scheduled appointment;
- ✓ Letter to the patient; and/or
- ✓ Telephone call to the patient.

The member may also wish to use include the following supplementary methods of notification:

- ✓ Printed notice, posted in the office in a place that is accessible even when the office is closed;
- ✓ Newspaper advertisement; and/or
- ✓ Recorded message on the office answering machine

If the member has passed away, his or her estate may elect to store the records and respond individually to patients requests for information or they may choose to transfer the records to another practitioner who will act as a custodian.

Closure of Practice, Dissolution, Resignation, or Termination of Practice in a **GROUP** Practice

It is in the best interest of patients and practitioners of CTCMPAO practising in a group setting to have a **written agreement** that establishes the responsibility for maintaining and transferring records of personal health information upon the dissolution, resignation or termination of the practice.

The written agreement with the clinic owner, landlord, or other health care professionals cannot restrict a patient from accessing his/her own patient health records or having copies of their patient health records transferred or copied. Patients are the sole owners of their patient records, clinics and health care professionals are entrusted to safe guard their patient records on their behalf.

Clinic owners and practitioners alike are governed by the principles of *Personal Health Information Protection Act, 2004* ("PHIPA"). Therefore, all clinic owners have the same responsibilities as practitioners in ensuring the safeguarding and retention of patient health files.

Usually, patient record agreements will include and address items such as:

- ✓ The method for division of records upon termination/resignation/dissolution of the practice arrangement; and
- ✓ Reasonable access to the content of the records for each member to allow him/her to defend against any legal actions or respond to CTCMPAO investigations or to appropriately respond to any requests from insurance providers.



Disputes of Patient Health Record Ownership

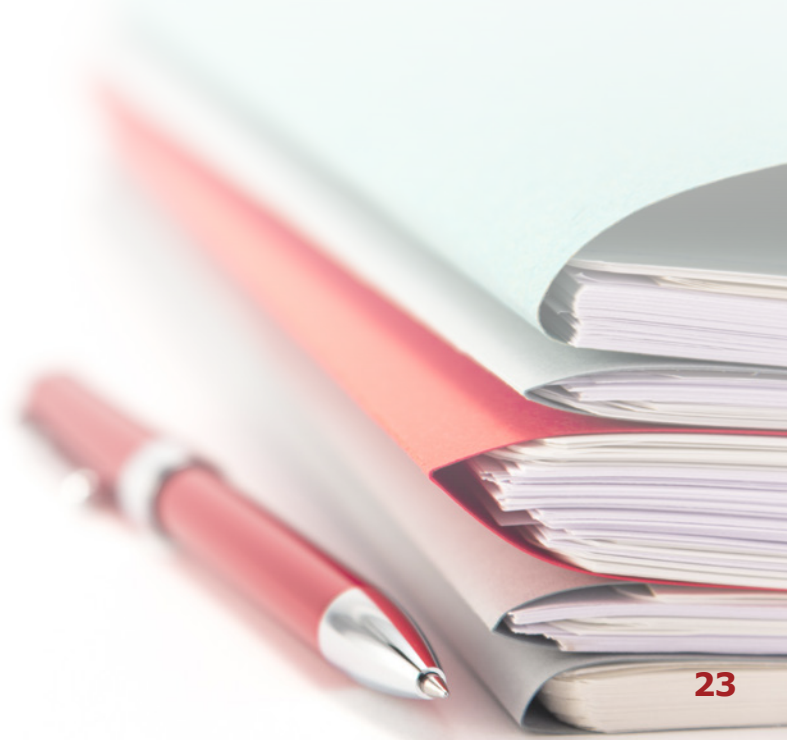
In the event of a dispute during a termination, disruption, or the ongoing backup/storage and retention of patient files, practitioners of CTCMPAO may need access to information from patient health records to respond to complaints or civil lawsuits.

In an event of a dispute between a practitioner with his or her clinic owner, there are several options available to the practitioner:

- A practitioner is given full access to the patient health information records after termination/disruption/closing of practice to fulfill a professional obligation. This may include an in person visit to the practice location;
- A practitioner keeps the patient health information records and gives full access to the previous clinic to fulfil their professional obligations;
- A practitioner creates a copy of the original patient health information records with him/her, leaving the originals with the clinic. This may involve photocopying or creating an electronic copy of the records.

Which option the practitioner or the clinic owners choose will depend on the circumstances, and the preference of the patients. It is important to remember that the patient is entitled to full access to their patient health information and that the member must be able to access the records after resigning, termination or dissolution of practice. A member shall also give patients advance notice of any change in location or ownership of their records should they choose to make an electronic copy of them. This can be accomplished by communicating the information to the patient through a combination of methods that may include letters, posting a notice of the clinic website of the electronic back up of patient records, posting in the local newspaper, or verbally informing patients.

CTCMPAO strongly recommends that all partnerships, agreements, or group practice settings have a written agreement before the practice commences.





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Practitioners and Acupuncturists of Ontario

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