Standard for Record Keeping

Keeping good records is essential to delivering safe, quality, ethical patient care. Records are evidence of professional judgement. They show that the member is accountable to patients and committed to good practice. Patients have the right to expect that their records are:

- Accurate and easy to understand
- Complete
- Private and secure.

This standard addresses the following principles:

Principle 1: Members must follow basic rules for recording and formatting patient records.

Members must manage patient records in a system that makes finding and retrieving records efficient. Patient records can be either on paper or electronic. They must be clear, legible, comprehensive, and accurate.

Applying the principle to practice

Records must be in English or French. Other languages may be used but must be translated into one of the two official languages in a timely manner.

Members must:

- Create entries as soon as possible after the patient visit and no longer than 24 hours after the visit
- Define all short forms used
- Include a patient identifier and page number on each page of a record
- Maintain pages of a record in chronological order
- Date each entry in a consistent format
- Sign each entry, update, and correction
- Note when another person took part in the care (for instance, another person provided the treatment, made an entry, or translated).

Updating or correcting records

Members must not change the original content of an entry. They can add information to make an update or correction but must never remove information.

Principle 2: Members must maintain required records to support their practice.

Members must maintain required patient records, financial records, and records of the supplies and equipment used in their practice.

Applying the principle to practice

Patient records

Members must maintain a daily appointment record that contains the names of patients and the time and duration of each visit.

Members must maintain an individual record for each patient. The record must contain:

- A patient health summary (including contact information, health history, and current health status)
- All notes and signed documents related to informed consent
- Assessment and diagnosis information
- Treatment information (such as acupuncture points, herbal formulations, modalities)
- Progress and follow-up notes
- Referrals from and to other healthcare professionals
- Copies of reports from other healthcare professionals
- Any information on ending the patient-practitioner relationship.

Financial records

Members must keep a financial record for every patient to whom a fee is charged. This can be stored in the patient's health record, in the member's accounting records, or both.

Members must provide receipts to patients that contain:

- The member's registration information
- Names of others involved in the care such as staff or students
- The clinic name, address, and telephone number
- The patient's full name, address, and telephone number
- The date and duration of service
- An accurate description of the services and products provided
- The type of payment used and amount received
- Any balance on the account
- HST registration number, if applicable.

If the receipt is a duplicate, this must be marked.

If a patient or a third-party payer, such as an insurer, requests it, members must be able to provide an itemized account of fees.

Supplies and equipment

Members must keep:

- an inventory of traditional Chinese medicine herbs, including date of purchase, date of expiry, and supplier information
- An equipment inventory, including date of purchase, supplier information, and equipment maintenance such as inspection and servicing
- Records of infection control procedures, such as cleaning, disinfecting, and sterilizing.

Principle 3: Members must safeguard the privacy of patient records.

Members must comply with the laws that protect the privacy of personal and patient health information. The *Personal Health Information Protection Act* (PHIPA) sets out these duties.

Members have duties as either health information custodians or their agents in the practice where they work. The health information custodian is the person who has custody or control over a patient's record. An agent is a person who has been given responsibility to use a patient's record for the purposes of treatment.

Applying the principle to practice

Each patient record must identify the person in the practice who is the health information custodian. The record should also show who is an agent of the information custodian.

Members must:

- Obtain each patient's informed consent for collecting, using, and sharing personal health information.
- Store and transfer records in a secure way that prevents loss or unauthorized access.
- Respond to a patient requests to access and correct personal health information within a reasonable time.
- Ensure that those involved in taking care of patient records are trained in how to keep them private and safe.
- Have a process to detect and respond to a privacy breach.

Principle 4: Members must retain records for required periods and destroy them safely.

Members must retain patient health and financial records for 10 years from the date of the last patient visit. For patients who are minors, records must be kept for 10 years after they turn 18.

Members must retain traditional Chinese medicine herbs and equipment records for 5 years from the date of the last entry in the record.

Applying the principle to practice

Leaving a group practice

If a member leaves a group practice or the practice dissolves, members must ensure that they can still meet their professional responsibilities for the required periods. This means they must:

- maintain the patient records they are responsible for, **and**
- keep copies of the patient records **or**
- ensure that they still have access to them.

Members must give notice to patients when the health information custodian changes. This could happen, for example, if a practice relocates or changes hands. Patients must have the option to:

- obtain a copy of their file **or**
- consent to the transfer of a copy of their record to another health information custodian.

Members should give each patient notice personally, either during a scheduled appointment or by letter or phone call. In addition to these direct methods, the member should post notices in the clinic, on their website, and in their office voicemail message.

Destroying records

Members must destroy records in a secure manner that prevents the reconstruction of the records.

Succession planning

Members must establish a succession plan in case they are not able to retain records for reasons such as death or illness. This plan should establish who will be responsible for retaining the records until the end of the required period.

Learn more about rules for record keeping:

College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario: Jurisprudence Course Handbook

Professional Misconduct Regulation of the *Traditional Chinese Medicine Act,* 2006

Information and Privacy Commissioner of Ontario: A Guide to the Personal Health Information Protection Act

Information and Privacy Commissioner of Ontario: Frequently Asked Questions: Personal Health Information Protection Act

Information and Privacy Commissioner of Ontario: How to Avoid Abandoned Records: Guidelines on the Treatment of Personal Health Information, in the Event of a Change in Practice

College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario: Written Language Plan Policy