COLLEGE & ASSOCIATION OF
Acupuncturists
OF ALBERTA

PATIENT RECORDS STANDARDS

Introduction

Registered Acupuncturists are expected to keep accurate records of all patient visits and professional services that they provide to a patient. The patient records must be stored in a safe way that ensures integrity and confidentiality.

Patient records are legal documents, evidencing that assessment; consultation and/or treatment of a patient took place on a certain date. It is the registered acupuncturist's legal obligation and responsibility to collect, organize and store all the information that is obtained during each patient consultation and/or treatment in the patient file, and to do so in such a manner that ensures the confidentiality and security of the patients' personal information recorded in patient records. Patient records can be used by the CAAA to resolve questions or concerns about accountability and the provision of care.

Standards on Patient Records

1. Privacy, security and confidentiality of patient records
    a. Registered acupuncturists are expected to keep all patient information confidential. As such registered acupuncturists must adopt measures to ensure the confidentiality and security of patient information recorded in the patient records.
    b. Patient's personal information shall be collected, used or disclosed with the consent of the patient, unless otherwise permitted by applicable privacy legislation.
    c. It is the responsibility of the registered acupuncturists to ensure the privacy of all collected patient information. The safeguarding of patient records can be assigned to an appropriate individual in a clinic but the registered acupuncturist treating the patient is ultimately responsible for the privacy, security, safety and confidentiality of the records.
    d. Patient records shall be stored in a safe way that ensures security and privacy.
    e. Destruction of patient records, if legally permitted, has to be secure. Secure disposal means that no information from the patient record can be retrieved and no copies are available.

2. Patient records must be accurate, complete and legible.
    a. Registered acupuncturists are required to record all patient visits and professional services that they provide to a patient. Patient records must be accurate, complete and legible.

b. The registered acupuncturist is responsible for completing all documentation and is responsible for ensuring the information recorded is accurate to what was provided. Recording of content of the patient records cannot be delegated to another person.

c. Patient records shall be written in a timely manner. The patient records must be documented at the time of the consultation or as soon as possible following the consultation; late entries should be clearly identified by recording the alternate date of entry.

d. All entries must be dated and signed. In case of treatment by a practitioner under direct supervision (e.g. a student), the supervisor is also required to countersign and date the entries.

e. The language used in patient records must be factual, objective and non-judgmental.

f. The information in patient records must be in English, legibly handwritten in permanent ink, or typed in electronic format.

g. All pages of the patient records must clearly and uniquely identify the patient by including the patient's full name (first and last name), preferably at the top of the page. For patient records in electronic format, the patient's full name (first and last name) should appear in the header or footer of the electronic document.

3. Contents of patient records (paper and electronic)

a. Generally, patient records, not including financial records, shall include sufficient detail to allow other registered acupuncturists to continue the care of the patient in case of a transfer of the patient to another registered acupuncturist. In case of a review by the CAAA patient records can be used to assess the member's ability to provide quality care and to identify areas that may need improvements; in case of an investigation, patient records can be used as evidence of decisions, treatments provided, and to verify issues of a complaint.

b. Specifically, patient records shall also include a cumulative patient profile, which contains a summary of information relevant to the treatment, condition, follow-up and identification of the patient and more detailed information gathered during the course of consultations. This cumulative patient profile is commonly collected in an intake form during the first patient visit, and needs to be updated whenever there is a change in data.

Patient records shall include the following information:

- Identification (name, address, phone number, email)
- Name of family physician
- Personal and family information (occupation, relationship status, habits, family medical history, addictions)
- Past medical history (past serious illnesses, operations, accidents)
- Allergies
- Current medication
- Contact person in case of emergencies

- Written, scanned, digital, photographic, radiological or other forms of chronicled or documented patient information
- Intake forms, documentation of consent[1], procedure explanation, patient comments and responses, observations, diagnostic processes, clinical recommendations, findings, and emails, records of telephone conversations or text messages directly or indirectly related to the patient's condition or treatment with the date and time
- Detailed clinical notes regarding the provided treatments and modalities, recommendations to the patient, patient reactions to treatments (past, present, subjective and objective) and immediate patient response to treatments.
- The use of a numeric rating scale (NRS) or a visual analogue scale (VAS) can be quite useful to document the subjective progress or regress of a patient's condition.
- The SOAP (Subjective data, Objective data, Assessment, Plan) method of documenting patient information is recommended and may assist with completeness of records:
    - Subjective data: Information reported by the patient including elements such as present complaints (pain, nausea, discomfort, changes in health status since last visit etc.).
    - Objective data: Measurable assessment findings obtained by the registered acupuncturist or other health care professionals involved in the patient care; Positive and negative physical findings (Pulse characteristics, tongue presentation, measured range of motion, swelling, vital signs such as blood pressure, lab tests, negative orthopedic test results etc.); Reassessment results of objective findings throughout the treatment process.
    - Assessment: Working Traditional Chinese Medicine (TCM) Diagnosis, differential diagnosis.
    - Plan: Treatment plan (anticipated frequency and duration of the treatment); treatment details (modalities, point selection and treatment method etc.); Recommendations, treatment options and suggestions (herbal supplements, lifestyle and diet changes, exercise etc.); and decisions of the patient not to follow any of the recommendations; referrals to other health care professionals.

c. The information recorded in the patient records must be understandable to other registered acupuncturists, and to other health care professionals except for TCM terminology. Commonly used abbreviations that are generally recognizable by professional peers are allowed. Obscure codes or abbreviations are not. Registered acupuncturists who use a lot of abbreviations should consider including an abbreviation key in the file, clearly explaining their meaning.

d. Acupuncture points used in the treatment need to be identified by the numbering or naming system used in the "WHO (World Health Organization) Standard Acupuncture Point Locations in the Western Pacific Region, WHO (2008)". Extra acupuncture points

[1] For detailed information about informed consent, please refer also to the CAAA Acupuncture Safety Handbook.

that are not mentioned in this document should be documented with a brief literature reference of their name.

e. Financial records regarding compensation for all the services provided by the registered acupuncturist should be kept in a separate file and do not need to be included in the patient records that contain the cumulative patient profile and other data as described above.

4. Modification of entries in the patient records

If entries are modified at a later date, changes and additions have to be dated and initialed, with a brief explanation for the modification. The original entries need to be legibly present and cannot be removed from the file. Corrections also need to be dated and initialed. In this case, the incorrect information shall remain legible, for example, by striking out the incorrect information by a single line.

5. Electronic patient records

A registered acupuncturist who uses electronic patient records must ensure that the confidentiality and security of the entries are protected and that an unauthorized person cannot access identifiable health information on electronic devices. To this end, the following standards are recommended:

a. Electronic patient records must have appropriate password controls and data encryption.

b. Audit logging must always be enabled and meet the requirements of section 6 of the Alberta Electronic Health Record Regulation[2].

c. Electronic patient records should only be accessed remotely if this will not compromise the integrity and confidentiality of the records.

d. Electronically stored patient records should be backed up regularly with the same protection measures in place.

e. Protocols should be in place to ensure effective continuation of treatments in the event that information cannot be accessed electronically.

f. Registered acupuncturists need to ensure that all patient record data are removed and cannot be reconstructed upon disposal or decommissioning of the hardware that contains such information.

6. Patient records retention

Like other professions who are designated custodians under the Health Information Act and to create consistency in record retention policies between different health professions, registered acupuncturists must maintain records for a minimum of 10 years from the date of last entry or, if the patient was less than 18-years-old at the time of the last entry, 10 years from the date the patient became 18.

[2] http://www.qp.alberta.ca/documents/Regs/2010_118.pdf

7. Custodianship of patient records

   The registered acupuncturist is the custodian of the physical patient records, unless otherwise stipulated. The patient or their authorized representative has the right to access their health information.[3] The Health Information Act and the Freedom of Information and Protection of Privacy Act state that the applicant (patient) may ask for a copy of the record or ask to examine the record. This access can be provided in a variety of ways including inspection, provision of a copy, documented explanation or summary of the contents.[4]

[3] A patient's health information belongs to the specific patient; however the medium that stores the information (i.e. the "physical patient record") is the property of the treating registered acupuncturist.

[4] The registered acupuncturist may be legally obligated to grant access to the patient records in the manner that has specifically been requested.