Management Patients and Their Records

管理病人及记录
Scope of Practice

• Practitioners of TCM offer an important and unique set of diagnostic and treatment skills to their patients.
• Like all health care professionals, TCM practitioners have a defined scope of practice.
• Unless training and applicable legislation allows, TCM practitioners must not make a medical diagnosis based on non-TCM modality/therapy.
Legal Concepts that are Relevant to the Practitioner-Patient Relationship

• Confidentiality: patients have the right to expect that their personal information will remain confidential
• Informed Consent
Consent

• Consent is the voluntary agreement given by a person to allow something to happen to them, and/or to be done to them, and/or to allow their participation in something.

• It is a fundamental right that every adult with capacity has the absolute right to determine what happens to their own body. This right is protected by law.
Valid consent has to meet the following:

- The patient must have the capacity to give their consent
- The consent must be given voluntarily
- The patient must have been given all the information they ask for in order to make their decision

If any one of the requirements outlined are not met then the consent may not be legally valid.
Can a child consent to treatment without guardian permission?

Yes, according to the BC Infants Act, individuals under 19 years of age may consent to a medical treatment on their own as long as the health care provider is sure that the treatment is in the child’s best interest, and that the child understands the details of the treatment, including risks and benefits. It is up to the health care provider to assess and ensure the child’s understanding of the treatment. (HealthLinkBC)
There is no age in British Columbia when a child is considered capable of giving consent to health care.

- A health care provider can accept consent from a minor provided the health care provider is confident the minor understands the following:
  - the need for treatment
  - what is involved in the treatment
  - and the benefits and risks of having treatment
Treatment records

• TCM practitioners have a legal and ethical responsibility to keep patient information confidential.
• Practitioners must comply with all laws and regulations related to:
  • collection, use, disclosure, disposal and transfer of information;
  • processes that affect the quality and security of the information;
  • procedures that grant access to patient information.
Patient Record Keeping

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Purpose of Record Keeping

- The patient ‘record’ includes all written, scanned, digital, photographic, radiological or other forms of documented.
  - patient health records
  - photographs, images, audio or video tapes
  - lab reports, imaging reports
  - e-mails, records of telephone conversations or text messages
The records can include the following:

- **date and time** of consultation
- **patient’s name, address and contact number**
- **relevant medical and health history** (allergies, prescription and non-prescription medications, past illnesses, pregnancies, etc.)
- **relevant family and social history**
- **other treatments/therapies** being used
- **allergies** with any allergy alerts noted.
- **document adverse reactions to medications**, foods, environmental substances, etc.
• reason(s) for the TCM consultation
• symptoms and signs (identified by the patient and detected and recognized by the practitioner using the four diagnostic methods of Inspection, Auscultation and Olfaction, Inquiry and Palpation)
• assessment findings including tongue and pulse observation/palpation
• TCM diagnosis (with clear evidence of thorough assessment of the patient's condition)
• treatment principles
• detailed treatment plan
• evidence of informed consent by patient. (e.g. a dated and signed “Consent to Treatment” form.)
First visits

- chief complaint and other complaints
- health history
- allergy notation
- medications
- other therapies being utilized
- TCM diagnosis
- treatment principles
- treatment plan
- consent to treatment
- treatment performed
- advice given
• Follow-up visits:
  • progress notes, **significant observations** during appointment, and clinical findings
  • **explanations given to the patient**
  • discussions with the patient
  • **responses to previous treatment(s)**
  • documented **patient's refusal** to follow recommendations
  • document **missed appointments**, cancellations, and late arrivals
  • **correspondence with the patient** and others (e.g., blood tests, e-mail messages)
Records Management

Records must be handled and accessed in compliance with provincial personal information and protection of privacy acts.

- Patient records, or any other patient-related information, should not be sent by email.
- No individual should be permitted to access or use the practice’s computer(s), other than the TCM practitioner and authorised staff.
- If a practitioner leaves a practice, she or he must provide a safe arrangement for the transfer of those records.
What to include in acupuncture treatment records (3-1)

• A copy of the informed written consent form

• Location of the needles using Name or Numbers

• If trigger point needling, the location of the needles should be described using muscle name and depth of needle. A diagram of needle application may sometimes be useful

• Left, right, or bilateral needle placement

• De Qi present or not present for each needle
What to include in acupuncture treatment records:

- Has the needle been removed following treatment
- How the needle was stimulated and how many times
- Was a timer used and set
- The duration of needles
- Was the patient left alone during the acupuncture treatment,
- Any adverse events or comments
What to include in acupuncture treatment records:

• The following can also be included:
  
  • Depth of needle
  • Angle of needle (such as oblique/perpendicular)
  • Anything to reduce risk at risky points.
Retention and Storage

• Patient records have a life cycle, and must be retained for a stated number of years after the records are closed. Currently patient records must be retained for ten (10) years (or longer if the patient is under 18 years of age).

• The storage area for current records should prevent or limit damage to records (e.g., fire, water).

• Storage areas should be secure to restrict unlawful or unauthorized access.
Retention and Storage

• Electronic files are subject to technical failure (power failure, computer break-down). Backup files.

• Paper records may be placed in a secondary storage area (off-site) or scanned and saved electronically if they need to be retained but are no longer required for current use.
Disposal

• Disposal of patient records (following the end of treatment plus the recommended periods of retention) must be conducted in a managed and confidential way.
• Practitioners must comply with all regulations and requirements related to the legal disposal of patient records.
• Records must be destroyed or shredded in a secure environment.
• Keep a register of the records that have been destroyed.
Patient Privacy and Duties to Report

• As a health care provider, practitioners have a legal and professional duty to keep information about their patients private and confidential. However, there is a responsibility and a need to report particular events or conditions to the appropriate government or regulatory agency.
Patient Privacy and Duties to Report

• Requirements for mandatory reporting include, but are not limited to, the following:
  • suspected child abuse and neglect
  • suspected elder abuse
  • certain communicable and reportable diseases (Health Protection and Promotion Act, report to Health Canada or equivalent provincial offices such as British Columbia Centre for Disease Control)
Relevant Regulations

• British Columbia’s Privacy Acts

• The Office of the Information and Privacy Commissioner (http://www.oipc.bc.ca) is independent from government and monitors and enforces British Columbia's Freedom of Information and Protection of Privacy Act (FIPPA) and Personal Information Protection Act (PIPA).
Relevant Regulations

• Freedom of Information and Protection of Privacy Act (FIPPA)
Relevant Regulations

• Personal Information Protection Act (PIPA)
  http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_03063_01
• Personal Health Information Access and Protection of Privacy Act
  http://www.leg.bc.ca/38th4th/3rd_read/gov24-3.htm