PATIENT HEALTH RECORDS

Introduction

This information is from the MTAM Standards of Practice and should be considered in conjunction. It is based on nationally-accepted standards of practice and applies to all MTAM Members. It is reviewed annually and subject to change. Last revised: 10/2016

Details

Patient health records must be dated, accurate, legible and comprehensive and must include the following:

- Personal information including patient name, address, phone number(s), date of birth, source of referral (if any), and name and address of primary care physician.
- Health history information including general health status, primary complaint or area of focus, location and nature of pain or discomfort, contributing factors, current medications use and purpose, allergies or hypersensitivity reactions, timing and nature of injuries, accidents or surgical procedures, limitations on daily life, history of massage therapy, current involvement in treatment with other health care practitioner(s).
- Assessment and reassessment findings based on history, observation, palpation, movement, neurology, referred sensation and special tests as relevant and including acute and chronic conditions or pain, range of motion, evidence of tenderness or tension, potential risks of treatment and consultation with or referral to another health care professional if clinical reasoning or contraindications to massage therapy exist or a more desirable outcome would be achieved through that referral.
- Treatment plan based on clinical findings containing patient goals, all proposed treatment methods and areas of focus, anticipated frequency and duration of treatments, and anticipated patient responses to treatment.
- Records of ongoing treatment based on relevant research and evidence, patient education, recommendations for home care as relevant, treatment outcomes, relevant changes in patient status and all other required elements as listed by the provincial regulatory colleges or provincial association where appropriate.
- Documentation relating to the provision of consent (see MTAM document on informed consent).

Records must be compliant with the requirements for the protection, privacy and security of records as set out in the Personal Information Protection and Electronic Document Act, and the respective provincial health information privacy legislation and all other relevant legal requirements.

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Records must be confidential and safely and securely stored to protect against reasonably anticipated threats or hazards to the security, integrity, loss or unauthorized use, disclosure, modification or unauthorized access to health information.

Records must be stored in Canada and, if in digital format, stored on servers based in Canada.

Records must be maintained and accessible according to the appropriate provincial requirement. Massage therapists must retain personal possession of the records, or have access to those records, or make arrangements for a custodian to assume this responsibility. It is recommended that all health records be kept for 10 years from the last treatment date, or 10 years after the 18th birthday of a minor patient.

Records may only be released if the request to release records has a basis in law or the patient has expressly consented to such release including the full scope of the request.