Association des chiropraticiens de l'Île-du-Prince-Édouard

Prince Edward Island Chiropractic Association

Record Keeping

Intent

To ensure that members of the Prince Edward Island Chiropractic Association (PEICA) maintain accurate, up-to-date records of personal health information for their patients, supporting high standards of care and compliance with applicable privacy laws.

Objectives

1. To ensure patients have access to current, accurate information as reflected in their record of personal health information.
2. To ensure continuity of care for patients when transitioning between chiropractors or other treating health professionals.
3. To provide members with a framework for organizing clinical notes and other records.
4. To maintain confidentiality and prevent unauthorized disclosure of patient health records and financial records.

Description of Standard

Introduction

The record of personal health information must clearly document the patient's health story, as determined by the chiropractor, in the context of each visit. The record is not merely a personal memory aid but must enable other healthcare providers to review and understand the patient's health history, current condition, and future health goals.

Chiropractors should follow basic procedures that reflect their unique role in the healthcare framework, and these procedures should be recorded in a manner that accurately represents the doctor/patient interaction. Records must be clear, concise, and accurate, with the inclusion of relevant data that can be reviewed and understood by any healthcare provider involved in the patient's care.

Information in Records

Information in records should be stated concisely, and the use of sentence fragments, outline forms, or diagrams is acceptable. Abbreviations, acronyms, or short forms ("abbreviations") and terminology unique to chiropractic care may be used. However, an up-to-date legend/key for these abbreviations must exist in either printed or electronic format and be provided upon request. A record of personal health information is considered incomplete if it does not include this legend/key.

PEICA does not endorse a specific note-taking style, template, or format. However, all notes should be consistent, comprehensive, accurate, and legible to ensure clarity in the care provided.

Types of Records to be Maintained

1. **Daily Appointment Record**
   The daily appointment record should include the surname and initials of each patient examined or treated by the chiropractor.
2. **Equipment Service Record**
   The equipment service record should detail the servicing of:
   - Every x-ray machine in accordance with the PEI Health and Safety Regulations (or relevant local legislation).
   - Other equipment emitting energy types permitted for use by chiropractors.
3. **Record of Personal Health Information**
   The record of personal health information includes both the patient health record and the financial record.

Patient Health Record

(1) The patient health record should contain:

- Demographic information (e.g., name, address, birth date) for identification, assessment, and treatment.
- Dates of each visit.
- The name and address of the primary treating chiropractor.
- Relevant referring healthcare professionals' names (if applicable).

(2) The health record should document the patient's:

- Chief complaint(s) and supporting data.
- Relevant past health history.
- Family and social history when indicated by the presenting complaint(s).

(3) The health record should document every initial examination, assessments, relevant diagnostic tests, and diagnostic imaging results (including images and reports).

(4) The initial examination must:
(a) Be comprehensive, demonstrating:

- Evidence of the patient's current condition.
- Diagnosis or clinical impression.
- Plan of care.
  (b) Include clinically indicated procedures to support the need for care, such as:
- Activities of daily living questionnaires
- Diagnostic imaging (e.g., X-ray, MRI)
- Pain scales
- Blood pressure testing, muscle function testing, neurological testing, and other relevant assessments.

(5) The health record should include:

- Documentation of informed consent for any examinations or treatments, voluntarily given and documented in writing or as part of the patient health record.
- Information about who provided care and where care was delivered.
- Details of treatments and adjustments provided, including the techniques used.

(6) Periodic assessments are mandatory and should be based on clinical judgment, with a comparative assessment when clinically indicated.

(7) Every entry in the patient health record must be dated and clearly identify the person making the entry.

Financial Record

The financial record, part of the patient's personal health information, must include:

- Date of service.
- Services provided.
- Location of service.
- Payment received.
- Account balance.

Electronic Record Keeping

- Members may use an electronic record-keeping system that complies with local data protection laws (e.g., PEI Health Privacy Regulations).
- Electronic records should be secure and protected with appropriate cybersecurity measures to prevent unauthorized access, loss, or tampering.
- A printed copy of an electronic record must be available upon request within 30 days.
- Records should be individualized, comprehensive, and accurate. Systems that use "template-like" records may not adequately reflect individual patient encounters.

Introduction Confidentiality and Access to Records

1. **Access**: A chiropractor shall not disclose personal health information except as required by law or with patient consent.
2. **Security**: Records must be protected from unauthorized access, theft, loss, or disclosure.
3. **Patient Access**: A patient may request access to their personal health records, and the chiropractor must comply within 30 days, barring any exceptional circumstances.
4. **Corrections**: A patient can request corrections to their record, which must be made promptly or a statement of disagreement should be attached to the record.

Introduction Records Retention and Destruction

- Records should be retained for at least seven years after the patient's last visit, or for minors, seven years after the patient turns 18.
- Destruction of records must ensure that they cannot be reproduced or identified.

Member Resignation and Record Transfer

When a chiropractor resigns, they must:

- Ensure that patient records are transferred to another chiropractor, with the patient's consent.
- Notify patients of the resignation and provide an option for obtaining copies of their health records.

- Retain the original record for at least seven years following the patient's last visit.

Use of Artificial Intelligence in Practice

When using AI in clinical practice, members are expected to adhere to the following principles:

- **Transparency/Consent:** Chiropractors using AI in their practice must be transparent about the extent to which they intend to use such tools. They must explain to the patient how the tools work, and their limitations. Informed consent must be obtained from the patient, before using an AI scribe. It is advisable to include written informed consent on intake forms; however, verbal consent must be obtained and documented in every SOAP note.
- **Privacy/Security:** Chiropractors must ensure that all patient data entered into the AI scribe must be securely stored, accessed and transmitted.
- **Accuracy/Reliability:** Chiropractors are responsible for ensuring that responses generated through AI are accurate and reliable. Chiropractors need to review all information summarized by the AI scribe for accuracy and completeness. Chiropractors must document in the patient's file "The information above has been reviewed and found to be complete and accurate."
- **Accountability:** Chiropractors are ultimately accountable for everything that is captured in the patient's medical record. It is their responsibility for ensuring that the above principles are adhered to, and that the AI tool is suited for its intended use.

Legislative Context

This regulation is made pursuant to the **Chiropractic Act** and aligns with PEI's privacy laws and health regulations. Failure to comply with the record-keeping requirements may result in disciplinary actions as per the **Chiropractic Act**, 2009.

As per PEICA By-laws section 37 (1-3) on record keeping, all active members shall complete a record keeping course at a minimum every 5 years and new registrants shall complete a valid record keeping course within the first 6 months of registration.

This Standard of Practice has an effective date of November 25th, 2025.