Part 2 Consultation and Examination

2.1 A chiropractor will keep a ~~patient file~~ clinical record for each patient, showing the patient's name and address, the dates seen, an adequate history and particulars of physical examinations, ~~radiographic examinations~~ the findings from imaging, investigations ordered and the results of same, the diagnosis made, and the treatment prescribed. Clinical records must be accurate, legible and comprehensive. The contents of a good clinical record are reviewed in Appendix "B" to the *Handbook*. For information about preventing and responding to the loss of ~~patient files~~ clinical records see Appendix "C" to the *Handbook*. For requirements and information on documenting findings from imaging see Part 15 and Appendix "L" to the *Handbook*.

2.2 A chiropractor who uses an electronic health record must ensure that the system has additional safeguards to protect the confidentiality and security of information, including but not limited to, ensuring:

(a) An unauthorized person cannot access identifiable health information on electronic devices

(b) Each authorized user can be uniquely identified

(c) Each authorized user has a documented access level based on the individual's role

(d) Appropriate password controls and data encryption are used

(e) Audit logging must always be enabled. The audit trail must clearly capture all access and documentation of alterations made to the record clearly identifying: a. who made the change or addition; and b. the date the change was made.

(f) Where electronic signatures are permitted, the authorized user can be authenticated

(g) Identifiable health information is transmitted or remotely accessed as securely as possible with consideration given to the risks of non-secured structures

(h) Secure backup of data

(i) Data recovery protocols are in place and the regular testing of these protocols

(j) Data integrity is protected such that information is accessible as stipulated in the CCBC Bylaws s. 72(2)

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(k) Practice continuity protocols are in place in the event that information cannot be accessed electronically

(l) When hardware is disposed of that contains identifiable health information, all data is removed and cannot be reconstructed.

2.3 A chiropractor will adequately prepare a patient for both examination and treatment.

2.4 Before commencing examination or treatment, a chiropractor will obtain the patient's informed consent.

2.5 A chiropractor must not exaggerate or minimize the gravity of a patient's condition, and will ensure that the patient, or the person(s) responsible for the patient, has sufficient knowledge of that condition to make decisions regarding the patient's best interests.

2.6 A chiropractor will recommend only those diagnostic procedures deemed necessary to assist in the care of the patient and only that treatment considered essential for the well-being of the patient.

~~2.7 The chiropractor is responsible for making an appropriate referral where they determine that imaging reports they have ordered includes findings or recommendations outside the scope of practice for chiropractic. See Appendix "L" to the *Handbook* for additional information. Standards for x-rays and imaging are set out in PCH Part 15 – Diagnostic Imaging~~

2.~~8~~7 A chiropractor will not guarantee a cure, either verbally or in writing, and at most, will offer only an estimate as to length of time or number of visits required for treatment of the patient's condition.

2.~~9~~8 Before the commencement of treatment, a chiropractor will advise the patient of findings and recommendations in a professional and responsible manner.

2.~~10~~9 Before any chiropractic techniques are used, a chiropractor must conduct a direct physical examination of the patient's area of complaint.

2.1~~1~~0 A chiropractor may examine and treat his or her spouse and other family members so long as, in providing such care, the chiropractor meets all obligations pertaining to examination and the provision of treatment, including obtaining the patient's informed consent and keeping a ~~patient file~~ clinical record in accordance with section 2.1 above.

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