

This policy is to establish and define standards of practice to be followed by the Members of the New Brunswick Massotherapy Association.

Training

- A Member shall practice only those therapeutic methods which the Member has sufficient training to perform safely.

Referral from and Recommendation to Another Licensed Practitioner

- If a Member determines:
 - that his/her own expertise or massage therapy is not appropriate to treat that patient for the referred condition, or
 - that the patient's condition warrants further assessment, diagnosis or treatment by a Licensed Practitioner, the Member shall, with the patient's consent, direct that patient back to the referring Licensed Practitioner.
- A Member shall, with the patient's consent, consult with the referring Licensed Practitioner before recommending any alternate and/or complimentary course of treatment.

Treatment Environment

- A Member shall render massage therapy:
 - in a safe environment by doing the following:
 - maintaining clean and tidy treatment and reception areas;
 - maintaining safe and clean hydrotherapy, exercise, and other equipment;
 - maintaining strict infection control procedures in any hydrotherapy facility;
 - providing clean linens or other similar materials;
 - maintaining adequate hand-washing procedures; and
 - providing unobstructed fire exits and readily available fire extinguishers, and by knowing and instructing all staff in fire safety for the facility;
 - in a comfortable environment, by doing the following:
 - providing adequate space for the safe movement of both patient and the Member, so as to minimize inadvertent physical contact between patient and the Member; and
 - maintaining appropriate room temperature.

Notices

- A Member shall:
 - display in a visible location, a notice setting out the Member's policies and procedures concerning a patient's payment for services, and fees for missed appointments;
 - provide to a patient on request, a copy of the Code of Ethical Conduct and Standards of Practice;
 - display the Member's Certificate of Registration in his/her primary practice location.

Patient Consent to Treatment

- Before commencing a treatment, a Member shall:
 - obtain and record all necessary information for a safe and effective treatment, including a case history, a physical assessment and/or a diagnosis, and the reason for any Licensed Practitioner's referral;
 - describe to the patient the proposed treatment, and any risks of the treatment which the Member knows may be of concern to the patient, given his or her history and presenting conditions;
 - answer to the best of the Member's ability any of the patient's questions concerning the proposed treatment; and
 - obtain the patient's consent to provide the proposed treatment.
- A Member shall discontinue the rendering of a treatment if, at any time, the patient withdraws his or her consent to that treatment, whether verbally, in writing or by other means of communication.

Removal of Clothing

- A Member shall recognize differing cultural and personal attitudes towards disrobing.
- A Member shall discontinue the rendering of a treatment if, at any time, the patient withdraws his or her consent to that treatment, whether verbally, in writing or by other means of communication.

- A Member shall respect the right of the patient to decline the removal of certain or any clothing.
- If a patient is unable to remove or replace an item of clothing personally, the Member may assist the patient so long as the patient has consented to that assistance.
- A Member must inform a patient in advance of the option of bringing and wearing a bathing suit during any hydrotherapy treatment.
- In any public setting, where massage therapy is to be provided, a Member shall respect the patient's need for privacy, as the situation permits.

Ensuring Patient Privacy in a Closed Setting

- Before commencing a treatment, and in particular before a patient removes any clothing, a Member shall:
 - ensure patient privacy and dignity by providing suitable apparel for assessment;
 - provide a non-transparent sheet or gown of sufficient length to cover the patient's body from neck to feet during treatment;
 - instruct the patient on how to cover him/herself at the commencement of treatment;
 - provide facilities to ensure physical privacy while a patient disrobes or changes, before and after assessment and treatment; and
 - consider patient privacy with respect to window coverings and mirror location in a treatment room.
- During treatment, a Member shall arrange the draping so that only the part of a patient's body that is being treated is exposed and all other parts are appropriately draped.

Potentially Painful Treatments

- A Member shall not inflict pain as an objective of treatment.
- A Member shall make every effort to minimize pain during treatment.
- In relation to potentially painful treatment and notwithstanding the above a Member shall:

- inform a patient of the possibility of pain;
 - obtain consent to treatment by written or verbal means;
and
 - inform a patient that the treatment can cease or be modified at any time at the patient's request.
- A Member shall promptly cease or modify treatment in response to a patient's request.

Patient Confidentiality

- A Member shall maintain confidentiality of patient information.
- Notwithstanding the preceding paragraph, a Member may disclose relevant patient information verbally or by a copy of the Health Care Record when:
 - the patient has directed the Member, verbally or in writing, to make that disclosure, or
 - required by law.
- A Member shall ensure that all office and support personnel who have access to a patient's Health Care Record permanently undertake to maintain the confidentiality of patient information.

Delegation and Supervision

- A Member is responsible for adequate supervision and direction to all office and support personnel for all interactions with patients and for all billing irregularities.

Health Care Record Keeping

- A Member shall generate an indelible clinical record for each patient containing:
 - the patient's name, address and birth date;
 - the name of any referring practitioner;
 - the date of each professional visit, and the name of the person who rendered the treatment;
 - health history obtained and updated, findings obtained, clinical impressions and relevant information of the patient's condition;

- a treatment plan, including objectives, treatments provided, instructions given, periodic reassessment findings and treatment revisions;
- all written reports received from or sent to other sources with respect to the patient.
- A Member shall ensure that the information in a Health Care Record is current, legible, accurate and complete.
- A Member shall not:
 - falsify any part of a patient's Health Care Record, or
 - sign or issue a certificate, report or any document that contains false or misleading statements concerning a patient's Health Care Record.
- A Member shall maintain possession and control over a patient's Health Care Record, until that Record can be destroyed or transferred in accordance with the "Preservation of Health Care Records" section in this Regulation.

Patient Access to Health Care Record

- For the purposes of this section, "access to" means a patient's opportunity to examine his/her Health Care Record and obtain photocopies.
- A Member who is in possession of a Health Care Record must allow a patient access to that patient's Health Care Record, unless the patient's physician is concerned that disclosure of the Health Care Record may result in significant harm to the safety, or mental or physical health of the patient, in which event, the Member shall provide written reason to the patient for refusal of access.
- A Member shall respond to a patient's request for access to his/her Health Care Record as soon as possible in a medical emergency, otherwise within 30 days of the request by producing producing the original Health Care Record for inspection.
- Where a Member provides access and a patient requests a copy of the Health Care Record, a copy shall be provided to the patient and the Member may charge the cost of photocopying that Health Care Record.

- A Member shall provide access to the Health Care Record of a child under 19 years of age to the persons having guardianship or custody of that child, except where:
 - the child has requested that his/her guardian or the person who has legal custody of the child not be granted such access, and
 - the Member is satisfied the child is of the age and maturity to understand the nature, consequences and anticipated benefits and risks of the massage therapy that is the subject matter of the Health Care Record.

Preservation of Health Care Records

- A Member shall ensure that Health Care Records remain in the Member's treatment facility or place of business until it is necessary to destroy or transfer the records.
- A Member shall retain Health Care Records in a safe and secure place for at least seven years after the date of the last treatment entered in a patient's record except where
 - the Record is of a child under 19 years of age, in which case the seven year period begins the day after that child's 19th birthday, or
 - the Record is of a person over the age of 19 who is mentally incompetent, in which case that Record should be retained for the life of that patient, or, at the end of seven years after the mentally incompetent patient is restored to mental competency.
- A Member may retain all Health Care Records of an indefinite period after the applicable minimum retention period has elapsed.
- After the applicable retention period has elapsed, and a Member elects to dispose of a Health Care Record, he/she may do so by:
 - effectively destroying the physical Record by utilizing a shredder or by complete burning, or
 - erasing information recorded or stored by electronic methods, such as on tapes, disks or cassettes.

- A Member may, with the patient's consent, transfer a Health Care Record to another Member, the patient or a Licensed Practitioner.
- A Member shall make appropriate arrangements by the appointment of another Member as custodian to secure the Health Care Records, in the event that the Member dies or becomes unable to practise for any reason, and Health Care Records must be retained in accordance with this section.

Locum

- A locum means a Member who temporarily replaces another Member.
- When a Member enlists the services of a Locum, the Health Care Records, both existing and newly-created during the Locum's tenure, remain the property of the Member.

Practising with Non-Members

- Where a Member shares a treatment facility or place of business with a non-Member, the Member shall ensure that all patients are informed that the Member's practice and services are separate and distinct from that of the non-Member.
- A Member shall grant access to a Health Care Record only to another Licensed Practitioner or to a Student Intern, with patient consent.
- A Member shall not grant access to a Health Care Record to any other non-Member, except as required by Court Order.

Ownership and Control of Health Care Records in a Shared Facility

- For the purposes of this section, a "Shared Facility" means a business premises occupied by a Member, and one or more other Members or Licensed Practitioners.
- A Member shall provide, by written agreement with each other Member or Licensed Practitioner within the Shared Facility, clarification regarding the ownership of all Health Care Records created by the Member.

- It is the responsibility of a Member in a shared facility to advise each patient on initial treatment of the identity of the owner of the Health Care Record as determined by the written agreement.
- A Member shall maintain possession and control over the Health Care Records of the Member's patients, for so long as the Member occupies the Shared Facility.

Continuing Education

- A member shall comply with the provisions of the Continuing Education Guidelines as approved by the Board.