CERTIFIED REGISTERED
Massage Therapist Association

CRMTA
Standards of Practice

CERTIFIED REGISTERED Massage Therapist Association Phone: 780.271.7682 Email: admin@crmta.com
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CRMTA STANDARDS OF PRACTICE

1. PATIENT ASSESSMENT

1.1 A member must:

(a) perform a comprehensive patient assessment based on history, observation, palpation, movement, neurology, referred sensation and special tests as relevant;

(b) formulate a treatment plan; and

(c) monitor vital signs as relevant (pulse, blood pressure, respiration rate, temperature).

2. TREATMENT PLANNING AND PATIENT MANAGEMENT

2.1 A member must:

(a) design and implement a management and treatment plan based on clinical findings; and

(b) design and coach a home care program and activities of daily living.

3. INFORMED CONSENT

3.1 A member must

(a) ensure the patient is fully informed regarding assessment and treatment, and provides consent;

(b) discontinue treatment if the patient withdraws consent; and

(c) monitor and work within the patient's pain threshold relative to efficacy of treatment.

4. CONSULTATION AND REFERRAL

4.1 A member must:

(a) consult with other health professionals when this may benefit treatment; and

(b) refer the patient to other health professionals when this may benefit the patient.

5. PATIENT EDUCATION

5.1 A member must:

(a) educate the patient on factors influencing health and wellness; and

(b) educate the patient in self-care.

6. THERAPIST EDUCATION AND TRAINING

6.1 A member:

(a) may practice only those therapeutic methods which the member has sufficient training to perform safely; and

(b) must access peer-reviewed, scientific articles relevant to massage therapy practice, and apply as relevant.

7. NOTICES

7.1 A member must:

(a) visibly display her certificate of CRMTA membership in his or her primary practice location; and

(b) visibly display his or her fee schedule, policies and procedures regarding payment, and fees for missed appointments.

8. SAFETY

8.1 A member must:

(a) apply universal hygiene precautions for infection control and public health;

(b) clean and maintain equipment;

(c) maintain a comfortable and tidy work environment with appropriate room temperature;

(d) ensure adequate space for the safe movement and comfort of the patient and the member; and

(e) ensure unobstructed emergency exits, readily available fire extinguishers, and appropriate training of staff in fire and evacuation procedures.

9. PROFESSIONALISM

9.1 A member must:

(a) maintain personal hygiene and professional appearance;

(b) differentiate between personal and professional beliefs and behaviours;

(c) evaluate strengths and weaknesses as a therapist, and set goals for improvement; and

(d) maintain awareness of, and practice within, the current scope of practice of massage therapy in Alberta.

10. COMMUNICATION AND RELATIONSHIPS

10.1 A member must:

(a) utilize professional oral and written communication;

(b) communicate in manner appropriate to the patient's ability to understand; and

(c) apply conflict resolution strategies as appropriate.

11. PATIENT PRIVACY

11.1 A member must:

(a) recognize and respect differing cultural and personal attitudes toward disrobing;

(b) inform the patient in advance of disrobing and draping options with respect to assessment and treatment, and establish agreement;

(c) respect the patient's right to decline the removal of certain or any clothing;

(d) ensure privacy while the patient disrobes or dresses;

(e) provide non-transparent draping materials, and arrange draping so that only the part of the patient's body that is being assessed or treated is exposed;

(f) instruct the patient on how to cover herself at the commencement of treatment;

(g) discontinue assessment or treatment if, at any time and in any manner, the patient withdraws consent to the agreed draping;

(h) assist the patient to remove or replace clothing if the patient is unable to do so, provided that the patient has consented to assistance; and

(i) in any public setting where massage therapy is to be provided, respect the patient's need for privacy, as the situation permits.

SCHEDULE "E" – HEALTH CARE RECORDS

1. PRIVATE PRACTICE

1.1 A member who is in private practice and is not employed by an organization or another member must, while in private practice:

(a) comply with the *Personal Information Protection Act*, the *Health Information Act* and all other relevant legal requirements; and

(b) develop and follow policies and procedures as required by the *Personal Information Protection Act* or the *Health Information Act*, including a process to respond to complaints concerning the member's application of the *Personal Information Protection Act* or the *Health Information Act.*

2. PRACTICE AS AN EMPLOYEE

2.1 A member who is employed by an organization or another member must, while employed, follow the policies and procedures of the employer as required under the *Freedom of Information and Protection of Privacy Act* or the *Personal Information Protection Act*, whichever applies to the member's employer.

3. COMPLIANCE WITH APPLICABLE LAW, POLICIES AND PROCEDURES

3.1 Without limiting the legal requirements with which a member must comply, a member must:

(a) at all times protect and maintain the confidentiality of a patient's Personal Information collected under this Schedule in accordance with the *Personal Information Protection Act* or the *Health Information Act* and all other legal requirements;

(b) upon request, provide patients, or their legal representatives, with access to their Personal Information in accordance with the *Personal Information Protection Act*, or the *Health Information Act* and all other legal requirements; and

(c) ensure that all records from a member's practice containing a patient's Personal Information are safely and securely stored, or disposed of, by making reasonable security arrangements against such risks as unauthorized access, collection, use, disclosure, copying, modification or disposal or similar risks.

4. HEALTH CARE RECORD KEEPING

4.1 A member must:

(a) generate an indelible clinical record for each patient, containing:

(i) the patient's name, address and birth date;

(ii) the name of any referring practitioner;

(iii) the date of each professional visit, and the name of the person who rendered the treatment;

(iv) health history obtained and updated, findings obtained, clinical impressions and relevant information of the patient's condition;

(v) a treatment plan, including objectives, treatments provided, instructions given, periodic reassessment findings and treatment revisions; and

(vi) all written reports received from or sent to other sources with respect to the patient.

(b) ensure that the information in a Health Care Record is current, legible, accurate and complete;

(c) address requests from patients for the correction of Personal Information in a member's custody or control in accordance with the *Personal Information Protection Act* and all other legal requirements;

(d) avoid:

(i) falsifying any part of a patient's Health Care Record, or

(ii) signing or issuing a certificate, report or any document that contains false or misleading statements concerning a patient's Health Care Record, and

(e) maintain possession and control over a patient's Health Care Record until that record can be destroyed or transferred in accordance with section 5 of this Schedule.

5. PRESERVATION AND DISPOSAL OF HEALTH CARE RECORDS

5.1 A member must:

(a) 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;

(b) retain Health Care Records in a safe and secure place for a reasonable period of time after the date of the last treatment entered in a patient's record;

(c) dispose of a Health Care Record, after the applicable retention period referred to in paragraph (b) has elapsed, and the member elects to do so, only by:

(i) effectively destroying a physical Health Care Record by shredding or incinerating it in a controlled environment;

(ii) erasing a Health Care Record information recorded or stored by electronic methods, such as on tapes, disks or cassettes in a manner that ensures all traces of the original information are destroyed and the information cannot be reconstructed;

(iii) returning a Health Care Record to the patient to whom the information pertains; or

(iv) transferring a Health Care Record to another member or a Licensed Practitioner, provided that the patient has given consent for such a transfer; and

(d) 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 practice for any reason and is unable to dispose of the Health Care Records in accordance with paragraph (c).

6. CRMTA ACCESS TO HEALTH CARE RECORDS

6.1 A member must make Health Care Records obtained or created under this Schedule, and any written or electronically, computerized or mechanically recorded documentation relevant to those Health Care Records, available at reasonable hours for inspection by representatives of the CRMTA, including the Registrar and members of the CRMTA Discipline Committee.

7. REMEDYING A BREACH OF SECURITY

7.1 A member must take appropriate measures to remedy any unauthorized access, use, disclosure, copying, modification, or disposal of, or similar risk to a patient's Personal Information as soon as possible after a breach is discovered.

8. LOCUM

8.1 A member must ensure that, if the member enlists the services of a Locum, the Health Care Records, existing and newly-created during the Locum's tenure, remain in the custody and control of the member.

9. PRACTICING WITH NON-MEMBERS

9.1 A member must:

(a) ensure that all patients are informed that the member's practice and professional services are separate and distinct from that of non-members, in the event that the member shares a treatment facility or place of business with non-members;

(b) maintain confidentiality of Personal Information, and disclose relevant Personal Information to non-members only in accordance with the *Personal Information Protection Act* and all other legal requirements; and

(c) avoid providing access to a Health Care Record to any non-member, except as required by law.

10. OWNERSHIP AND CONTROL OF HEALTH CARE RECORDS IN A SHARED FACILITY

10.1 In this section, "shared facility" means any treatment facility, place of business or other premises in which a member associates, co-locates or otherwise occupies and shares the premises with one or more other members or Licensed Practitioners, for the purpose of providing professional services.

10.2 A member who provides professional services in or through a shared facility must:

(a) establish written agreements with each other member or Licensed Practitioner who practices in or through the shared facility, confirming that the member has custody and control over the Health Care Records of the member's patients,

(b) advise each patient, on initial treatment, of the custody and control of the patient's Health Care Record, pursuant to the agreements referred to in paragraph (a), and

(c) maintain custody and control over the Health Care Records of the member's patients at all times.