OWNERSHIP, STORAGE, SECURITY AND DESTRUCTION OF RECORDS OF PERSONAL HEALTH INFORMATION

Standard of Practice S-022
Quality Assurance Committee
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Note to readers: In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

INTENT

Good practices relating to record keeping are essential in providing the best quality patient care, acting in accordance with professional, legal and ethical obligations, and establishing and maintaining trust in the doctor/patient relationship.

This standard of practice advises members of their obligations relating to ownership, storage, security and destruction of records of personal health information, whether in a solo or group practice setting.

All of the items discussed in this document apply equally to paper and electronic records.

DESCRIPTION

The record of personal health information includes the patient health record and the financial record.

Section 4 of the *Personal Health Information Protection Act, 2004 (PHIPA)* defines "personal health information", as subject to certain exceptions, identifying information about an individual in oral or recorded form, if the information,

a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family;
b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual;
c) is a plan of service within the meaning of the *Long-Term Care Act, 1994* for the individual;
d) relates to the payments or eligibility for health care in respect of the individual;
e) relates to the donation by the individual or any body part or bodily substance;
f) identifies an individual's substitute-decision maker.

"Identifying information" mean information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual.

Ownership of the Record of Personal Health Information

The Supreme Court of Canada decision of McInerney v MacDonald held that information in the record of personal health information is owned by the patient.[1] The patient may access and obtain copies of the record of personal health information, including records, diagnostic images and reports prepared by other health care practitioners relevant to the doctor/patient relationship, in accordance with the *Personal Health Information Protection Act, 2004* (*PHIPA*) and standard of practice S-002: Record Keeping. A member owns the physical records or computer hardware on which records are stored, but holds the information in trust and confidence for the patient.

Designation of Health Information Custodian

Under *PHIPA*, a health information custodian is responsible for the record of personal health information. A member must satisfy themselves that for each practice, a health information custodian is designated to be responsible for records and to establish policies consistent with *PHIPA,* this standard and S-002: Record Keeping. A health information custodian may be an individual member, a group of members, a chiropractic health corporation or the facility from where the member practises.

Storage and Security of the Record of Personal Health Information

To safeguard their physical integrity and confidentiality, records of personal health information must be stored in a safe and secure environment. This applies to all records stored at the primary chiropractic facility or any files stored off-site. Members must take reasonable steps to ensure that records are protected from theft, loss, damages and unauthorized use or disclosure, including photocopying, modification or disposal.

What is reasonable depends on the threats, risks and vulnerabilities to which the information is exposed, the sensitivity of the information, and the extent to which it can be linked to the individual. Consideration must be given to each of the following aspects of record protection:

- physical security (e.g., locking file cabinets, restricted office access, alarm systems, protection from damage)
- technological security (e.g., password protection, code encryption, firewalls)
- administrative controls (e.g., security clearances, access restriction, staff training, confidentiality agreements)

[1] McInerney v. MacDonald [1992] 2 S.C.R. 138

A member must take reasonable precautions to protect records of personal health information from damage, especially when records are maintained in an offsite facility or an area that is susceptible to environmental hazards (e.g. flood and fire).

Records of personal health information should be kept in restricted access areas or locked filing cabinets, and measures should be in place to ensure that only those who need access to the records for a legitimate purpose are able to see them. A member needs to consider that non-chiropractic care staff, such as maintenance staff, may have access to records, and must take appropriate steps ensure that access to the records is limited, or that those who have access to the records are bound by an appropriate confidentiality agreement.

Confidentiality of Personal Health Information

A member is required to maintain the privacy and confidentiality in the collection, use and disclosure of the record of personal health information in accordance with *PHIPA* and CCO standards of practice (see sections 36-37 for provisions relating to the collection and use of personal health information www.ontario.ca/laws/statute/04p03#BK47).

A member generally requires express or implied consent before collecting, using or disclosing personal health information. In accordance with *PHIPA*, consent must be:

- of the individual;
- knowledgeable;
- related to the information; and
- not obtained through deception or coercion.

A member may assume that they have the patient's implied consent for providing or assisting in providing health care, unless the patient has expressly withheld or withdrawn consent (except as required by law under *PHIPA*). The patient's express consent is required for providing their personal health information outside the circle of care.

A member may only disclose a patient's personal health information:

- when the member has the patient's or substitute decision-maker's consent and it is necessary for a lawful purpose;
- where it is permitted under legislation, without the patient's or substitute decision-maker's consent; or;
- where it is required by law.

PHIPA allows the disclosure of personal health information without a patient's consent under certain circumstances. A member shall, whenever possible, make every reasonable effort to obtain the patient's consent before disclosing their personal health information. Please see sections 38-50 of *PHIPA* for further information on disclosure of personal health information.

In the event of a breach or suspected breach in confidentiality of patient personal health information or damage to records of personal health information, the member shall:

- notify affected patients, CCO and only when there is a suspected breach of confidentiality, the Ontario Office of the Privacy Commissioner
- mitigate consequences that have resulted from this breach or damage; and
- take measures to avoid a similar breach in confidentiality or damage in the future.

Please see the Information and Privacy Commissioner of Ontario's document "Responding to Privacy Breaches" the Privacy section of CCO's website for further information.

Electronic Records

Please see the requirement for maintain electronic record keeping in Standard of Practice S-002: Keeping.

In certain cases, the printable version of the electronic record may not readily enable a reviewer to understand the whole patient record. Some of the systems do not readily allow the chiropractor to capture nuances of the patient encounter. A member using such systems must ensure that each record entry captures the unique aspects of that particular patient encounter. A member is discouraged from using systems that create "template-like" records. These may not be an adequate reflection of an individual patient's story.

A member has an obligation to provide printed copies of electronic records when asked to do so. To ensure they can be understood, a member may be asked to provide a print-out from the electronic record, together with a dictated summary, to allow an overview of the patient's story.

Ownership Agreements Concerning Records of Personal Health Information

It is in the best interest of patients, and a member practising in a group setting, such as an associateship, partnership or corporation, to have a written contract that establishes responsibility for maintaining and transferring records of personal health information upon dissolution of the practice. Typically, these contracts will address such items as:

- the method for division of records upon termination of the practice arrangement; and
- reasonable access to the content of the records for each member to allow the member to defend any legal actions or respond to CCO investigations or to appropriately respond to requests from third-party insurance providers.

Any contract, agreement or arrangement addressing division of records upon dissolution of a practice may not restrict a patient from accessing their record of personal health information or having copies of their records transferred to their treating chiropractor.

If no such ownership contract or agreement exists, a member dissolving a group practice should determine who is the most responsible for each record of personal health information. The patient's best interests will be served by ascertaining from which member the patient wishes to continue receiving care.

A member who is an employee or who works as a locum must satisfy themselves that there is a contract, agreement or written arrangement with the employer about access, retention and transfer of records of personal health information, consistent with *PHIPA*, and CCO standards of practice, policies and guidelines.

There may be circumstances where a member practises in a group setting where the owner of the clinic is not a member of CCO or not a member of an Ontario regulated health profession. CCO reminds members that although the principles of *PHIPA* apply to owners of health care facilities, CCO does not have jurisdiction over individuals who are not members of CCO. Moreover, an owner of a clinic who is not a regulated health professional may not be regulated by any health regulatory college. A member practising in such a group setting must ensure that the member is compliant with privacy legislation and standards of practice, including but not limited to those related to access, retention and transfer of records of personal health information.

Termination or Disruption of Practice

Possible reasons for termination or disruption (temporary or permanent) of practice may include the following:

- dissolution of practice
- leave of absence (maternity, sabbatical)
- incapacity to practise
- retirement
- suspension of registration
- revocation of registration
- death

A member shall make appropriate arrangements for their records of personal health information when there is a termination or disruption from practice. A member may still need to access records. Patients may need to access information from their records for ongoing treatment. As well, a member may need to access information from records to respond to complaints or civil lawsuits. There are several options available to a member:

- a member is given access to their records of personal health information after resigning from practice to fulfil a professional obligation;
- a resigning member keeps their records of personal health information and gives access to the new treating member to fulfil a professional obligation;
- a resigning member takes a copy of the original records of personal health information with them, leaving the originals with the new treating member.

Whichever option is selected will depend on the contract or agreements among the parties, the circumstances, and the preferences of the patients. What is essential is that a resigning member follow a practice to ensure patients can access or obtain a copy of theirs records of personal health information and that the member can access their records after resigning from practice or following a dissolution of a practice.

A member must give active patients advance notice of any change to their records of personal health information, enable them to access or acquire a copy of their records and make secure arrangements for the transfer of records to the patients. This can be accomplished by communicating the information to patients through various methods, such as letters to individual patients, and/or postings in the office, on the member's website or in the local newspaper.

It is important to remember that records must be maintained or be accessible even after a practice has dissolved.

Retention and Destruction of Records of Personal Health Information

Every record of personal health information, including diagnostic images and accompanying reports, and every financial record shall be retained for at least seven years following the patient's last visit, or, if the patient was less than 18 years old at the time of their last visit, the day the patient became or would have become 18 years old. For example, for a patient less than 18 years old at the time of their last visit, patient records should be kept until the patient turns 25.

When considering the destruction of records of personal health information, the following should be taken into consideration:

- match the destruction method to the medium (e.g., paper vs. electronic vs. radiographic records)
- select and engage a destruction service provider with due diligence

Legislative Context

Members are advised to consult the *Personal Health Information Protection Act, 2004*, the website of the Office of the Privacy Commissioner at www.ipc.on.ca, and CCO standard of practice S-002: Record Keeping and guideline G-004: Documentation of a Chiropractic Visit.