

GUIDELINE

Guideline G-017
Quality Assurance Committee
Approved by Council: February 8, 2011

Ownership, Storage, Security and Destruction of Patient Health Records

Note to Readers: In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

Intent

Good record keeping is part of providing the best quality of patient care.

This policy is intended to advise members of best practices relating to ownership, storage, security and destruction of patient health records. These principles may be used whether in a solo or group practice setting.

All of the principles discussed in this policy apply equally to paper and electronic records.

Description

Ownership of Patient Health Records

Information in patient health records belongs to the patient. The patient may access and obtain copies of patient health records in accordance with the Personal Health Information Protection Act, 2004 (PHIPA) and Standard of Practice S-002: Record Keeping. The member may own the physical records or computer hardware on which records are stored.

Designation of Health Information Custodian

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

Storage and Security of Patient Records

To safeguard their physical integrity and confidentiality, patient records 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, 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)
- Technological security (e.g., password protection, code encryption, firewalls)
- Administrative controls (e.g., security clearances, access restriction, staff training, confidentiality agreements)

Patient records 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. Members need 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.

Electronic Records

There may be some limitations when using electronic record systems to maintain patient health records. In many cases, the printable version of the electronic record does not readily enable a reviewer to understand the whole patient record and is, therefore, of limited use. Furthermore, some of the systems do not readily allow the chiropractor to capture nuances of the patient encounter. Members using such systems must ensure that each record entry captures the unique aspects of that particular patient encounter.

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Members are discouraged from using systems that create generic, repetitive records. These may not be an adequate reflection of an individual patient's story. CCO is aware that this is a developing area and that there is great potential for electronic record keeping to enhance the practice of chiropractic.

Members have an obligation to provide printed copies of all records when asked to do so. To ensure these records can be understood, some members may be asked to provide the print-out from the electronic record, together with a dictated summary, to provide an overview of the patient's story.

Agreements Concerning Patient Health Records

It is in the best interest of members practising in a group setting, such as an association, partnership or corporation, to have a written agreement that establishes responsibility for maintaining and transferring patient health records upon dissolution of the practice. Typically these agreements will address such items as:

- The method for division of patient health records upon termination of the practice arrangement.
- Reasonable access to the content of the patient health record for each member to allow him/her to defend any legal actions or respond to CCO investigations or to appropriately respond to requests from third-party insurance providers.

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

Members who are employees or who work as locums should satisfy themselves that there is an agreement with the employer about access, retention and transfer of patient health records.

Arrangements for Patient Health Records when there is a termination or disruption (temporary or permanent) of practice.

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

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

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

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- A member is given access to his/her patient health records after resigning from practice to fulfil a professional obligation.
- A resigning member keeps his/her patient health records and gives access to the new treating member to fulfil a professional obligation.
- A resigning member takes a copy of the original patient health records with him/her, leaving the originals with the new treating member.

Whichever option is selected will depend on the 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 that he/she can access his/her patient health records after resigning from practice.

Members must give active patients advance notice of any change to their patient health records. 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.

Retention and Destruction of Patient Records

Every patient health record, 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 his/her 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 his/her last visit, patient records should be kept until the patient turns 25.

When considering the destruction of patient records 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.

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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.