Document Standards and Guidelines for Occupational Therapists

Saskatchewan Society of Occupational Therapists

Revised June 2016

Managing Client Care Records

Best Practices for:

- Collection
- Use
- Disclosure
- Retention
- Destruction

PURPOSE

SSOT Document Standards and Guidelines are prepared to assist occupational therapists in meeting the *Essential Competencies of Practice for Occupational Therapists in Canada* through:

- increasing occupational therapist knowledge of responsibilities
- describing expectations of practice
- defining safe, ethical, competent practice; and
- guiding critical thinking for everyday practice.

Questions regarding the content or application of these guidelines can be made to:

Executive Director
Saskatchewan Society of Occupational Therapists
P.O. Box 9089
Saskatoon, SK
S7K 7E7
Canada
ed@ssot.sk.ca
(306) 956-7768

© Saskatchewan Society of Occupational Therapists (SSOT), 2013; Revised May, 2014; Revised June, 2015

TABLE OF CONTENTS

Introduction 4

Definitions 5

Relevant extracts from *The Essential Competencies of Occupational Therapists in Canada* (2011) 6

General practice principles 7

Collection 8

Use 10

Disclosure 12

Access 13

Retention 14

General 14

Electronic data storage and transmission 14

Destruction of documents 15

Cessation of practice 16

Retention of Financial records 17

APPENDICES

Resources: Applicable statute and links 18

Chart: Core principles of privacy law in Canada 19

Form A: Sample Alternate Trustee Agreement 20

Form B: Sample Notice of Cessation to Current Client 21

INTRODUCTION

These guidelines refer to the client care records and to all records which contain the personal and/or personal health information of a client. Not all aspects of these guidelines may be applicable to all types of practice.

Client records serve a variety of purposes for the occupational therapist and for the client such as:

- Contributing to continuity and adequacy of care.
- Facilitating communication between others.
- Creating an historical document for the client and the professional.
- Providing a means of quality review.

The value of a record depends upon it being meaningful, accurate, timely and clear.

These guidelines are prepared in contemplation of certain privacy laws, current to March 2015, specifically *The Health Information Protection Act* (*HIPA*), *The Local Authority Freedom of Information and Protection of Privacy Act (LAFOIP)*, and *The Personal Information Protection and Electronic Documents Act* (*PIPEDA*). However, legal compliance is not assured by following these guidelines and independent legal advice is recommended whenever legal considerations arise. The central purposes of *HIPA* are the safeguarding of personal health information and defining client right to access it. The purpose of LAFOIP is to set up guidelines for the collection and use of personal information by local authorities, such as a school board. A chart outlining these and other central principles of *HIPA* and contemporary privacy legislation is found at page 24.

These guidelines have been prepared based upon a model used by the College of Occupational Therapists of Manitoba. They have been prepared with the assistance from students from the University of Saskatchewan College Of Law; however, they do not constitute legal advice.

DEFINITIONS

Care protocol: This term is used in this guideline to refer to any care map, clinical pathway or protocol that has been developed and approved for client use.

Client: the person(s) in receipt of the occupational therapy service.

Consent: consent for the collection, use or disclosure of information (a) must explain why the information is required, (b) must be informed, (c) and must be given voluntarily without fraud or coercion. Consent can be limited to a specific period of time, person or purpose. Consent may be express or implied.

Cumulative Record: All information collected by the school division pertaining to a student's cumulative record which is owned by the school division and is kept at the school that the student attends.

Designated trustee: an eligible trustee who is willing to take on the responsibility for care and security of the personal health information of another trustee, in case of cessation of practice.

***Health Information Protection Act* (*HIPA*):** Saskatchewan legislation which deals with the privacy of individuals and the duty of trustees in the collection, use, disclosure, security, retention and destruction of health information.

Local Authority: for the purposes of this document is any board of education or conseil scolaire within the meaning of the Education Act. A local authority is not a trustee for the purposes of HIPA

Local Authority Freedom of Information and Protection of Privacy Act (LAFOIP): Saskatchewan Legislation which deals with access to documents of local authorities and the privacy rights of individuals with respect to the information held by the local authority.

Occupational therapist: is an occupational therapist who is a member of the Society of Saskatchewan Occupational Therapists (SSOT), in accordance with The Occupational Therapist Act.

Personal health information (PHI): means information with respect to the physical or mental health of an individual, or pertaining to services provided, or any information that is collected in the course of providing health services to an individual.

***Personal Information Protection and Electronic Documents Act* (*PIPEDA*):** Canadian legislation which governs the collection, use and disclosure of personal information with a specific focus on electronic communications.

Practice/Service: these two terms are used interchangeably and refer to the overall organizational and specific goal directed tasks for the provision of service to the client, including direct and indirect client care, research, consultation, education or administration.

Applicable Definition of 'Trustee'
HIPA , s. 2

(t) Trustee means any of the following that have custody and control of personal health information
…
(xii) a person other than an employee of a trustee, who is
(A) a health professional licensed or registered pursuant to an Act for which the minister is responsible; or
(B) a member of a class of persons designated as health professionals in the regulations;

(xiii) a health professional body that regulates members of a health profession pursuant to an Act;

Applicable Definition of 'Trustee'
HIPA , s. 2

(t) Trustee means any of the following that have custody and control of personal health information
…
(xii) a person other than an employee of a trustee, who is
(A) a health professional licensed or registered pursuant to an Act for which the minister is responsible; or
(B) a member of a class of persons designated as health professionals in the regulations;

(xiii) a health professional body that regulates members of a health profession pursuant to an Act;

DEFINITIONS

Record: a record means information, however recorded (e.g. written, audio, video, digital file), generated by the occupational therapist or an individual supervised by the occupational therapist, pertaining to services provided by the occupational therapist. This includes, but is not limited to assessments and evaluations, therapy goals, progress towards goals, attendance and remuneration records. When the record belongs to the occupational therapist it may also include items not generated by the occupational therapist such as, but not limited to, a referral, correspondence, and reports prepared by others.

School Division: includes any public or separate school division in Saskatchewan. A school division is not a trustee under HIPA and therefore all divisions and their employees are subject to LAFOIP regulation.

Sign/Signature: the occupational therapist's signature, including an electronic signature or signature stamp, as long as the occupational therapist takes reasonable steps to ensure that only the occupational therapist can authorize the use of the stamp.

Trustee: An individual or an organization that has custody or control of personal health information; every practicing occupational therapist is a trustee or an agent of a trustee and falls under the same guidelines set out in *HIPA*.

RELEVENT EXTRACTS FROM

The Essential Competencies of Occupational Therapists in Canada (2011) 3rd Edition

Unit 5. Communicates & Collaborates Effectively

Competency 5.2: Communicates using a timely and effective approach

i. Uses a systematic approach to record keeping of occupational therapy services.

ii. Maintains clear, accurate, and appropriate records of client encounters and plans.
Cues: informed consent, results of assessment, interventions, client involvement, written, electronic

iii. Applies the various regulations that are specific to record keeping in occupational therapy.
Cues: provincial and federal regulations, institutional policies

iv. Determines with client the right of others to client's information.
Cues: client right to have access, to clarify, and to comment on or modify the information.

v. Discloses information in accordance with client consent.

Competency 5.3: Maintains confidentiality and security in the sharing, transmission, storage, and management of information

i. Adheres to legislation, regulatory requirements and facility/employer guidelines regarding protection of privacy, security of information.

ii. Establishes and/or adheres to provincial and facility policies and procedures related to the management of information.
Cues: acquiring, documenting, using, transmitting, storing, and disposing of information

iii. Takes action to anticipate and minimize foreseeable risks to privacy and confidentiality of information.
Cues: confidentiality and privacy of conversations, risks of disclosure in public or shared spaces, information technology, encryption, communication devices

Basic actions:

Keep file cabinets locked.

Don't leave client files in your car unsecured.

Password-protect your computer and any programs which provides access to client files.

Set up separate access usernames and passwords for employees with computer access.

In addition to a privacy contact person, it is recommended that occupational therapists have written policies and procedures in place to maintain administrative, technical and physical safeguards that will protect the security of the client care records and all sensitive information in their custody and control.

GENERAL PRINCIPLES

1. Accountability

An occupational therapist is responsible for the content of the client care record related to the occupational therapy services and should understand his or her privacy law obligations and establish best procedures for handling personal information and PHI. Privacy law applies to all documentation, recording, and transmission of personal information and PHI.

2. Client care records

All client care records shall be

(i) legible and understandable;
(ii) in English or another language requested by employer;
(iii) kept in a systematic, professionally acceptable manner;
(iv) an accurate reflection of interaction;
(v) timely; and
(vi) written according to organizational requirements.

3. General security of client care records

All records will be kept respecting reasonable measures of security and the confidential nature of the material. This includes parts of the record not generated by the occupational therapist such as referral, reports from others, materials in support of the referral, etc.

4. General access to client care records

In the case of electronic records, the system must

(i) provide reasonable protection against unauthorized access; and

(ii) have a system which automatically backs up files and allows the recovery of back-up files or otherwise provides reasonable protection against loss of, damage to, and inaccessibility of information.

5. Implementation and role of privacy contact person

In all organizations, an occupational therapist should seek to implement, maintain, or identify a privacy contact person to be responsible for coordinating the best practices and compliance with changing privacy standards. The contact person will need to identify the organization's personal health information holdings in client records, current privacy policies, and current privacy practices.

GENERAL PRINCIPLES
For OT'S working in the school division

Legislation:

1. Occupational therapists employed by the Health Region and contracting into the school division are bound by the *HIPA*.
    a. Information gathered by these occupational therapists is owned by the Health Region.
2. Occupational therapists employed by a School Division are subject to the *LAFOIP*.
    a. Information gathered by these occupational therapists is owned by the school division;
    b. These occupational therapists are not bound by *HIPA* and are not "trustees" for the purpose of that legislation.

The occupational therapist's files on the student should be kept in accordance with these guidelines.

Information disclosed to the school division or collected by the school will be kept in the student's cumulative record. This information is owned by the school and is governed by the *LAFOIP*.

Disclosure:
Disclosing student personal health information that was collected for the purpose of enhancing student learning to a school division or a school division employee involved in the education of that student does not breach *HIPA* or *LAFOIP* regulation.

Consent for such disclosure can be obtained expressly from the student's parent or guardian in a consent form signed before the occupational therapist begins working with the student. OR, in the absence of express consent, both *HIPA* and *LAFOIP* state that consent is assumed when the information is disclosed for the purposes that it was collected.

The occupational therapist should still take reasonable security steps as outlined in these guidelines when disclosing information to teachers and other school division employees.

Retention:
School Division retention periods are longer than *HIPA* retention periods as outlined in these guidelines. They require that information be retained for 3 years after the date that the student turns 22. The student's cumulative record is kept in accordance with these guidelines.

Security:
School division guidelines are consistent with the suggestions in these guidelines.

COLLECTION

It is recommended that each occupational therapist maintain a daily appointment and/or work load measurement record to verify the date, duration, and as needed, the time of each client encounter, dependent on work environment.

An occupational therapist has a duty to inform each client about the anticipated uses of the health information collected.

1. General limitation of client consent

The occupational therapist must seek reasonable measures to obtain knowledge and consent of the individual for the collection of personal information. The purposes of collection shall be identified by the occupational therapist at the time of collection. The collection of personal information shall be limited to that which is necessary for the purposes identified. In the case of a student under the age of 18, parental consent is required.

2. Record essentials

An occupational therapist shall make an accurate record for each client containing the following information:

(i) Referral information, including

(a) the name and contact information of any source of referral and relationship to the client, including self-referral, and
(b) the reason for the referral.

(ii) Client identification, including

(a) the client's name, contact information, and address,
(b) the client's date of birth,
(c) the client's personal health number, and
(d) all other relevant numbers (e.g. Treaty #, WCB &/or SGI case #s).

(iii) Client professional encounters, including the date of each interaction with the client, and a record of any cancelled or missed appointment, including reason if available.

(iv) A record of the occupational therapy services including but not limited to:

(a) assessment procedures used,
(b) the results obtained,
(c) the occupational therapist's professional analyses and/or opinions, intervention, and recommendations,
(d) problem formulation or other professional opinion regarding client status,
(e) the occupational therapy intervention plan formulated in collaboration with the client, including the goals of the prescribed intervention,
(f) A summary explanatory note when intervention is completed or was initiated but not completed.

3. Information relied on from third-parties
When client information, relied upon by the occupational therapist, is gathered by another health care provider, the occupational therapist must indicate the relevant issues in the record and confirm that these issues have been reviewed by the occupational therapist with the client.

4. Approved care protocols
Approved care protocols may be implemented when appropriate.

(i) When an approved care protocol has been implemented and the management of client care is within the protocol, an occupational therapist must make reference to the protocol and its date.

(ii) Additional recording is not required respecting the information contained in the protocol.

(iii) Protocols must be dated, archived, and retained for at least 3 years from date of last use.

5. Progress notes
Progress notes must be maintained indicating the outcome of an intervention, and for each change in client condition, problem formulation or intervention plan.

6. Required copies
It is mandatory to keep certain documents on file.

(i) The following are to be kept on file with records:
(a) a copy of every written report sent respecting the client,
(b) a record of client consent including a copy of every written consent, and
(c) a copy of any specific instructions of discharge plans (e.g. written summary of outcomes; a home program; record of referrals).

7. Miscellaneous items
It is good practice to keep certain documents on file.

(i) The following should be kept on file with records:

(a) identification of an individual to whom the occupational therapist has assigned a significant component of the intervention plan, or
(b) specific information related to any referral made by the occupational therapist, or
(c) a copy of every written report received respecting the client.

8. Student Information Obtained for School Division:

The Cumulative Record Guidelines state that information included in the student's cumulative record includes:

(i) “The students results of diagnostic tests or other assessments pertinent to program training, including … occupational therapists’ reports, including ***related parental consent forms"; and***
(ii) “Medical information about the student pertinent to program planning that the parent or student provides.”

USE

1. General limitation of use

Personal information and PHI shall not be used for purposes other than for which it was collected, except with the consent of the client. ***This is the same under both HIPA and LAFOIP.***

2. Identification

Every part of the record must have a reference identifying the client and/or the client's health record number and/or any other relevant identification required such as WCB or SGI case #s.

3. Record entry requirements

For each and every entry in the client care record,

(i) Every entry in the record must be dated,

(ii) Every entry in the record must be signed, and

(iii) The identity of the person who made the entry must be evident.

4. Signature requirements

Care must be taken in signing documents.

(i) An occupational therapist must not sign, or permit to be issued in his/her name, any report or similar document without ascertaining or taking reasonable measures to determine the accuracy of its contents. This includes ensuring the report does not contain a statement which the occupational therapist knew or ought to have known was false, misleading or otherwise improper.

(ii) A record originating from more than one contributor where one of the contributors is an occupational therapist requires the signature of the occupational therapist.

(iii) An occupational therapist practising with a restricted license must indicate they are restricted when signing any document e.g. O.T. Res. (SK).

(iv) When more than one occupational therapist contributes to the same record, the signature of each is required.

(v) Copies of a record may be distributed without a signature by the occupational therapist so long as clearly identified as copies, or by stating ‘dictated but not read’.

(vi) ***Electronic Signatures are acceptable.***

Occupational therapists of SSOT whose names are on the Register of Practising Occupational Therapists are entitled to use the designation O.T. Reg. (SK), and/or authorized educational credentials following their name / signature.

5. Revisions to record entries

Care must be taken in revising records so that the original information remains understandable / unchanged.

(i) Revisions to a record for which the occupational therapist is responsible shall be identified and signed or initialed by him or her.

(ii) The original record entry must remain readable; therefore areas requiring revision should be crossed out but not obliterated.

(iii) Modifications made to a document after the document has been distributed can only be accomplished through the use of addendum. Copies of the addendum must be sent to all recipients of the original document.

6. Drafts and raw data

Drafts are not necessary, however if kept, must be retained as part of the record. Raw data should be secured consistent with this guideline.

(i) An occupational therapist is not required to maintain draft documents. However, if such documents are kept on file they are considered part of the record.

(ii) Raw data gathered from standardized evaluation, which is not placed on the record, should be retained separately and consistent with this guideline. Alternatively, if raw data is not maintained due to facility rules then sufficient detail must be documented to support conclusions and/or continuity of service.

7. Student Information

Student information collected by the occupational therapist and given to the school will be kept on the student's cumulative record.

Any information retained by the occupational therapist should be done so in accordance with these guidelines.

DISCLOSURE

1. General limitation of disclosure

Occupational therapists are expected to maintain strict confidentiality of personal information and PHI contained in client care records. Disclosure should be in accordance with the informed consent of the client. Clients have a right to request a copy of their client care record according to organization policy.

Exception to general limitation:

In the absence of express consent, both HIPA and LAFOIP state that valid consent is obtained where personal health information (in the case of HIPA) and personal information (in the case of LAFOIP) is disclosed for the purpose it was collected.

Student information collected for the purpose of enhancing student learning may be disclosed to teachers and staff involved in the student's education if the disclosure is necessary to serve that purpose.

The underlying principle is that security of personal and health related information is a right of the client.

2. Sharing client care records

In all circumstances when an occupational therapist is authorized to share client care records, he or she must share only the minimum amount of information required, i.e. on a need to know basis.

(i) An occupational therapist shall restrict access of a client's care information to health care professionals or interested parties (for example, vendors or funding organizations), with the informed consent of the client, except in some cases to

(a) other health care practitioners or groups of practitioners; or
(b) hospitals, psychiatric facilities, pharmacies and emergency medical services; or
(c) educational professionals involved in the student's education if the original purpose for collecting the information was on behalf of the school division.

on the conditions that

(a) reasonable steps have been taken to verify the identity of the party receiving the information,
(b) the information is necessary to provide health care,
(c) the party receiving the information is made aware not to use or disclose the information for a purpose other than it was originally collected,
(d) informed consent cannot reasonably be obtained prior to disclosure, and
(e) the client has not specifically stated that information should not be disclosed.

DISCLOSURE

3. Disclosing client care records
In limited circumstances, an occupational therapist may disclose client care records containing personal and health information, even without client consent.

> (i) An occupational therapist shall disclose a client's personal and health information to third parties on a need-to-know basis and only with the informed consent of the client, except
>
> > (a) to defend in legal or administrative proceedings with the advice of legal counsel; or
> > (b) to SGI when a client is over the age of 15 and deemed, in his or her professional opinion, to be unable to safely operate a motor vehicle.

Note: ***for the purposes of these guidelines, a school division is not considered a third-party as they are involved in the care of the student.***

ACCESS

1. General client access

Clients have the right to access their personal health information upon request according to organization policy / process. An occupational therapist may refuse the request only if it will endanger the client's health or another person's confidential information, or as permitted by law (legal advice may be prudent).

(i) Any request must be handled in 30 days or less. If a request for information cannot be handled in a reasonable time period, the client must be contacted and the situation explained.
(ii) Any request for student records by the student or their parents should be done through the school.

2. General office access

Access to client care records and all personal and health information must be limited to staff on a need-to-know basis. Such access may be further limited by the scope of the client's consent.

3. Access to physical files

Access to physical records must be reasonably secure and preventative.

(i) Physical files containing personal and health information must be kept in locked and / or supervised areas.
(ii) Access must be limited to staff on a need-to-know basis.

4. Access to computer files

Computer passwords are essential to digital storage of client records.

(i) Computer users should have individual passwords to access client care records.
(ii) When staff leave or change jobs, their access should be immediately terminated.

5. Breach response plan

If an incident occurs where the confidentiality of a client's personal and /or health information is breached, occupational therapists have a duty to respond quickly and effectively.

(i) Upon notice of a breach, occupational therapists should

(a) immediately follow organization's policy /privacy contact person;
(b) notify the client whose personal information has been compromised; and
(c) coordinate the response and assess the incident's severity and scope to identify the best way to address the incident. Legal advice may be required.

If a client requests his or her records, make note of the dates of the request and of any subsequent correspondence.

In exceptional privacy breach situations, the Saskatchewan Society of Occupational Therapists should be notified immediately. A detailed account of the related events should then be prepared and kept safe.

In Saskatchewan, *The Limitations Act* restricts causes of action at 2 years for adults; however debates about when an action is 'discovered' may arise, and notice of a legal action is often not received by a defendant for several months.

RETENTION

General

1. General accountability of retention
There is a duty to protect client care records and all personal information contained within from any reasonably anticipated loss, theft or destruction.

2. Suggested duration of retention of personal information
It is suggested that client care records and any and all documentation containing personal information or PHI be maintained for **a minimum of**

(i) three (3) years after the conclusion of client treatment; or,

(ii) three (3) years after client reaches the age of majority, whichever is longer.

3. School Division Retention Regulations:

The School Board Privacy Commission states that student information is to be kept for at least 3 years after the date the student turns 22. This applies to all students including students with intensive needs and applies to all portions of the record of the student, whether obtained by a third party or not.

The retention period adopted by the school division is longer than what is required by HIPA.

The computer system includes the policies and procedures the occupational therapist and staff use to input, store and access information.

It is important that information can be accessed efficiently, converted in to printed pages and that the person entering information is identifiable.

Electronic data storage and transmission

1. Electronic record-keeping

(i) A computer system can make and maintain client records if it:

(a) has a visual display of the recorded information;
(b) has a means of access to the record of each client;
(c) can print the information promptly;
(d) can visually display and print the recorded information chronologically for each client; and
(e) can maintain an audit trail.

(ii) The computer system can maintain an audit trail when it:

(a) records the date and time of each entry for each client;
(b) indicates the identity of the person who made the entry and who rendered services;
(c) preserves the original content of the recorded information, when the record is changed or updated;
(d) indicates all changes made to the records; and
(e) can separately print each client's record.

For suggested standards of electronic file-keeping, see: International Standards Organization, *Information technology – Security techniques – Information security management systems – Requirements*, ISO 27001:2013.

2. Electronic transmission of records and personal information

Occupational therapists are responsible for taking cautionary measures when transmitting client care records and personal information.

(i) An occupational therapist transmitting records by either facsimile or email should assure that confidentiality and security of the records are maintained during the transmission.
(ii) If emailing records, an occupational therapist should encrypt the email to protect records and prevent document tampering. Alternatively to encrypting, the occupational therapist should de-identify records and /or obtain consent for email communication. Obtaining consent to e-mail communication of student health information eliminates the need to encrypt the email or to de-identify it.
(iii) Fax numbers should be confirmed beforehand. Faxes containing any personal information must include a cover letter identifying the recipient as well as a confidentiality / disclosure statement.
Both HIPA and LAFOIP state that consent for disclosure is obtained either expressly or where the information is disclosed for the purposes that it was collected.

3. Suggested safeguards for electronic retention

Technical safeguards for electronic document storage include:

External Safety:

(i) Firewalls and adequate anti-virus software program,

(ii) Secure wireless network and encrypted transmissions with Virtual Private Network (VPN) technology,

(iii) Use of private keys to decrypt files and individualized passwords on request for access, and

(iv) Backup of electronic records and disk encryption.

Internal Safety:

Strategies such as the following should be employed:

(i) Establish appropriate-use policies;

(ii) Educate employee on appropriate use and consequences of non-compliance;

(iii) Monitor system for breaches, including regular audits and spot-checks; and

(IV) Enforce consequences for breaches.

Mobile phone use may pose a problem – PHI should not be stored on a mobile device.

Destruction of documents

1. General destruction guidelines

The information contained in client care records and files must be destroyed so as to be completely inaccessible by other parties. Hard drives should be fully destroyed when destroying digital documents and physical files should be shredded.

2.Third-Party destruction

If a third party destroys client care records and files containing personal health information for an occupational therapist, he or she should take all possible steps to ensure that information is destroyed to the standards above. It is recommended that a signed agreement be utilized, outlining the standards expected of a third-party in order to comply with HIPA and PIPEDA.

Cessation of practice

When removing an existing trustee from a cessation plan, take adequate steps to protect the security of the client record and update the contact information for the new trustee with SSOT.

See **Form A** for a sample designated trustee agreement

Temporary cessations of practice include a leave of absence for more than 30 days, with the expectation to return for such events as:
-holiday or vacation from work,
-maternity leave,
-compassionate leave

1. Cessation of practice

A cessation of practice refers to any time period of more than 30 days in which an occupational therapist permanently or temporarily stops working.

2. Cessation plan

Any occupational therapist must have a plan in place for the transfer of records in the event of a cessation of practice.

(i) The cessation plan must include the name, address and telephone number of a designated trustee who can take over the custody of client care records and personal information.

(ii) Contact information for the designated trustee must be provided to SSOT and executor and/or next of kin and be kept up-to-date.

(iii) The cessation plan should also include a notification plan that informs ongoing clients of any transfer of their personal health information.

3. Consent of designated trustee

An occupational therapist must have the consent of their designated trustee before naming him or her.

(i) Ensure that the designated trustee understands his or her duties and responsibilities under *HIPA, LAFOIP* and *PIPEDA* and this guideline.

(ii) Create a record of the informed consent agreement. Give one copy to designated trustee and maintain another with practice records.

(iii) The designated trustee must be able to access the occupational therapy client records and the personal information in an emergency, but access no more information than is necessary in the circumstances.

4. Temporary cessation of practice

An occupational therapist must transfer access of personal information to their designated trustee.

(i) The designated trustee takes temporary responsibility for the protection and confidentiality of the personal information.

(ii) An occupational therapist should notify his or her clients of any transfer of their personal information. A notification plan can include a letter sent to clients, a notice in the newspaper, direct communication with clients, or an automated response via voicemail and /or email.

(iii) Occupational therapists employed by the Health Region contracting in the school division are bound by HIPA and must follow the 'designated trustee' guidelines. A School Division cannot be a trustee.
For third party contractors, such as Health Region-employed occupational therapists, the School Board recommends that the contract should spell out what the contractor must do with the information and records collected in the course of providing the services.

(iv) Occupational therapists employed directly by a School Division are bound by LAFOIP. Information collected by them is owned by the School Board and will remain with the school division in the student's cumulative file. They are not required to obtain a designated trustee.

5. Permanent cessation of practice

An occupational therapist must transfer access to a designated trustee, having notified the clients affected by the transfer of information and whenever possible obtaining their consent. See Form B for a sample client notification letter

(i) The designated trustee takes permanent responsibility for the protection, confidentiality and destruction of the personal information, consistent with these guidelines.

(ii) If the School Division eliminates the occupational therapist position the information gathered by the occupational therapist will remain with the School Division in the student's cumulative record (note: this is not technically a cessation of practice, this would amount to discontinuing work with a client).

(iii) as stated above, occupational therapists employed by the Health Region and contracting into the School Division should agree in advance what will be done with the client care records collected in the course of providing services.

(iv) client care records retained by the occupational therapist following a termination of position in the School Division should be kept in accordance with these guidelines.

Some examples of permanent cessations are:
-retirement from practice,
-a career change
-moving a practice outside of Saskatchewan.

Some examples of unforeseen cessations are:
- sudden serious illness,
-revocation of license
- fatal injury.

If there is no cessation plan for an unforeseen deceased occupational therapist, the executor is deemed custodian until a trustee with legal authority obtains the records.

6. Unforeseen cessation of practice
The designated trustee takes responsibility for the information from the original trustee.

(i) If the unforeseen cessation appears to be temporary, the designated trustee must have a plan in place in the event the cessation becomes permanent, consistent with these guidelines.

(ii) If the unforeseen cessation is permanent, the designated trustee has a duty to

(a) notify all affected clients and the SSOT; and
(b) retain information for a minimum three years or three years after the client reaches the age of majority, whichever is longer; and
(c) destroy such information and PHI in a manner which protects the confidentiality of the individual clients.

Retention of financial records

1. General retention of financial records
A financial record shall be kept for every client to whom a professional fee is charged by the occupational therapist. The financial record must include:

(i) the item/service sold,

(ii) the cost of the item/service,

(iii) the date the item/service was sold/provided, and

(iv) the date monies were received.

2. Separate from client care record
A financial record must be retained separately and consistent with this guideline, related to Best Practices for Collection, Use, Disclosure, Retention, and Destruction of Client Care records. The recording of financial transactions must also comply with PIPEDA.

Some examples of permanent cessations are:
-retirement from practice,
-a career change
-moving a practice outside of Saskatchewan.

Some examples of unforeseen cessations are:
- sudden serious illness,
-revocation of license
- fatal injury.

If there is no cessation plan for an unforeseen deceased occupational therapist, the executor is deemed custodian until a trustee with legal authority obtains the records.

STATUTE:

The Education Act, SS 1996 c.45.

The Electronic Information and Documents Act, SS 2002 c.18.

The Freedom of Information and Privacy Act, SS 1992 c. 62.

The Health Information Protection Act, SS 2002 c. R-8.2.
http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/H0-021.pdf
http://www.health.gov.sk.ca/hipa Contains additional helpful documents.

The Health Information Protection Regulations, SS 2005 c. H-0.021 Reg 1.
http://www.oipc.sk.ca/Updated%20HIPA%20Regs%20-%20May%2020101%20-%20H0-021r1.pdf

The Limitations Act, SS 2004, c. L-16.1.
http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/L16-1.pdf

The Local Authority Freedom of Information and Protection of Privacy Act, SS 1993 c.55.

The Occupational Therapists Act, SS 1997 c. O1-1.11.
http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/O1-11.pdf

The Occupational Therapists Act Amendments, SS 2003 c. C.
http://www.qp.gov.sk.ca/documents/english/Chapters/2003/Chap-6.pdf

The Personal Information Protection and Electronic Documents Act, SC 2000, c. 5.
http://laws-lois.justice.gc.ca/eng/acts/P%2D8.6/

Saskatchewan Society of Occupational Therapists Bylaws, 2013.
http://ssot.sk.ca/+pub/Resources%20and%20Links/SSOT%20Bylaws%20Nov%202013.pdf

RESOURCES:

Essential Competencies of Practice for Occupational Therapists in Canada, 3rd ed. Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO), 2011.

http://ssot.sk.ca/+pub/Resources%20and%20Links/complete%203rd%20Edition%20essential%20comp%20copper%20seal%20oct%202012.pdf

Walkulowsky, Lydia. Personal Health Information Protection Act: Implementing Best Privacy Practices. 2nd ed. Markham: LexisNexis 2011.

Privacy Laws in a Nutshell. Regina: Saskatchewan Legal Education Society Inc. 2004, looseleaf seminar report

"Mopping up the Privacy Mess" Kaylea Dunn

"Privacy in the Health Sector" Evert Van Olst

Practice Guideline: Collecting, Recording and Protecting Client Information. College of Occupational Therapists of British Columbia, 2006.

http://www.cotbc.org/PDFs/CollectRecordProtectClientinfo.aspx

"Advisory Statement: Providing Clients Access to and Releasing Occupational Therapy Information." College of Occupational Therapists of British Columbia, 2009.

http://www.cotbc.org/PDFs/AdvisoryStatement_AccesstoOTInfo2009.aspx

"Privacy Breach Guidelines." Office of the Information and Privacy Commissioner of Saskatchewan, September 2010.

http://www.oipc.sk.ca/Resources/Privacy%20Breach%20Guidelines1%20(3).pdf

Privacy in Saskatchewan Schools, 2015

http://saskschoolsprivacy.com

The Student Cumulative Record Guidelines, Ministry of Education, 2012.

http://www.education.gov.sk.ca/Cumulative-Record-Guidelines

Office of the Saskatchewan Information and Privacy Commissioner, "Best Practices: Mobile Device Security", March 21, 2011.

http://www.oipc.sk.ca/Resources/Helpful%20Tips%20-%20Best%20Practices%20-%20Mobile%20Device%20Security%20-%20March%202011.pdf

CHART: CORE PRINCIPLES OF PRIVACY LAW IN CANADA

TEN PRIVACY LAW PRINCIPLES	Practice
ACCOUNTABILITY	An organization is responsible for personal information under its control and shall designate a person who is accountable for compliance with the following principles
IDENTIFYING PURPOSES	The purpose for which personal information is collected shall be identified by the organization at or before the time the information is collected
CONSENT	The knowledge and consent of the individual are required for the collection, use or disclosure of personal information except where inappropriate
LIMITING COLLECTION	The collection of personal information shall be limited to that which is necessary for the purposes identified by the organization. Information shall be collected by fair and lawful means
LIMITING USE AND DISCLOSURE	Personal information shall not be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual or as required by law. Personal information shall be retained only as long as necessary for the fulfillment of those purposes
ACCURACY	Personal information shall be as accurate, complete and up to date as is necessary for the purposes for which it is to be used
SAFEGUARDS	Personal information shall be protected with security safeguards appropriate to the sensitivity of the information
OPENNESS	An organization shall make readily available to individuals specific information about its policies and practices relating to its handling of personal information
INDIVIDUAL ACCESS	Upon request, an individual shall be informed of the existence, use and disclosure of personal information about the individual and shall be given access to that information. An individual shall be able to challenge the accuracy and completeness of the informationa and have it amended as appropriate
CHALLENGING COMPLIANCE	An individual shall be able to challenge compliance with the above principles with the person who is accountable within the organization

Adapted from the Office of the Information and Privacy Commissioner of Saskatchewan, *2002-2003 Annual Report.*

FORM A: SAMPLE DESIGNATED TRUSTEE AGREEMENT

Saskatchewan Society of Occupational Therapists

Sample Designated Trustee Agreement and Consent Form

I, ___________, agree to be the designated trustee of the confidential personal information records of ________________, Occupational Therapist, in case of a cessation of practice.

I have read the SSOT's guidelines regarding the protection of personal information. I understand and accept my legal obligations to protect the security and confidentiality of the personal information under *HIPA* and *PIPEDA*. I also understand that clients have a right to access their records and I agree that I will provide them with copies of their personal health information in compliance with *HIPA*.

I understand that I have a duty to retain the records in the event of a civil claim or complaint against the primary occupational therapist. I understand that I must notify the transferring occupational therapist if I move the records to a different location or to a different occupational therapist's custody.

We both agree and know that:

The location of the records is here:	
The replacement trustee will be able to access the records in the following manner:	
The patients have a right of access to the records	
The records will be maintained for a minumum of 3 years, according to the SSOT Document Standards and Guidelines:	
The destruction of the records will be done in the following manner:	

Signed this _____ of _______________, 20__.

	Occupational Therapist	Designated Trustee
Name		
Signature		
Address		
Phone Number		

FORM B: SAMPLE NOTICE OF CESSATION TO CURRENT CLIENT

Saskatchewan Society of Occupational Therapists

Sample Notification Letter to Clients for a Transfer of Custody of Personal Information

Ms. O. Therapist
Retiring OT's address
Saskatchewan

February 1, 2013

Dear Ms. Smith,

This letter is to inform you of upcoming changes to my practice. As you may be aware, I am retiring from my occupational therapy practice as of (date).

Some of my records contain your personal information. When I retire, I will transfer the custody of these confidential records to Mr. James Jones, another occupational therapist here in Saskatoon. You have no obligation to visit Mr. Jones as your occupational therapist. However, if you do not want Mr. Jones to have access to your records you may request that the records are sent elsewhere or be destroyed.

You may request a copy of any existing records be sent to you or to any other occupational therapist in Saskatchewan if you wish to change your occupational therapist. We will make every effort to ensure that your records will remain available to you until you find another occupational therapist.

If you do not elect to have your records destroyed or sent elsewhere, Mr. Jones will hold and protect these records for 3 years, after which they will be destroyed to protect your confidentiality.

If you have any questions about my retirement or the transfer of records, or if you have any concerns, please phone my office at (phone number) or Mr. Jones' office after (date) at (phone number).

Sincerely Yours,

O. Therapist

Saskatchewan Society of
Occupational Therapists
P.O. Box 9089
Saskatoon, SK
S7K 7E7
Canada
www.ssot.sk.ca
(306) 956-7768