CHECKLISTS FOR USE BY CUSTODIANS IN THE EVENT OF A CHANGE IN PROFESSIONAL PRACTICE

On September 1st, 2010, the *Personal Health Information Privacy and Access Act* ("the *Act*") was proclaimed to provide access rights to one's personal health information, to provide rules on the use, collection and disclosure of such private information, and to protect the confidentiality of personal health information and the privacy of the individuals to whom it belongs.

The Office of the Access to Information and Privacy Commissioner has oversight role to ensure compliance with the *Act* in all respects. To provide good guidance, we have devised useful **CHECKLISTS FOR CUSTODIANS**.

The *Act* is reflective of the Province's new approach to providing overall a better public health care system and has resulted in changes for many health care professionals, i.e., custodians, in the way they protect personal health information.

The **CHECKLISTS FOR CUSTODIANS** can be used whenever custodians contemplate a change in their professional practice involving:

A) the TEMPORARY closure of the office (ex. sabbatical leave, illness, etc.); or

B) the PERMANENT closure of the office such as the sale of the practice, the transfer of the practice to another custodian, or when the custodian moves to another location in or outside New Brunswick.

Depending on the change of the professional practice, please refer to CHECKLIST A for the **TEMPORARY CLOSURE** or CHECKLIST B for the **PERMANENT CLOSURE** of the office of the professional practice.

These checklists guide custodians through easy steps which are designed to check that the health care records of patients or clients remain safe in all situations involving a change in their professional practice. Custodians need to be mindful that they continue to be responsible for the records of their patients/clients until those records are passed to another custodian, or until they are passed to another person who is legally authorized to hold them, or until they are destroyed in accordance with the rules found in the *Act*.

Before going through the **CHECKLISTS FOR CUSTODIANS** below, we remind custodians of the obligation to establish a **WRITTEN POLICY** for the retention, secure storage, access, and secure destruction of health care records in their custody. This written policy will serve to protect the personal health information of your patients from being stolen, lost, inadvertently disposed, or disclosed to or accessed by unauthorized individuals.

Checklist A: Temporary Closure of the office/practice

- ❑ STEP 1: Be aware of ALL records in your care and control (including all active and inactive files).

- ❑ STEP 2: Create a list of all records identified in Step 1.

- ❑ STEP 3: Identify the secure location where the records which must be retained will be stored. Remember that as a custodian, you remain responsible for the protection of your patients/client's files even while they are in storage. A secure location means one which has proper security safeguards.

- ❑ STEP 4: Notify all individuals whose records you hold (patients, clients) of the temporary closure of your office or practice, and of the anticipated period of time of the office closure.

  This will permit those who need a copy of their record to request a copy. Notification should include to whom the patient/client can make a written request to access his or her record, and that the record belonging to that individual will be retained until the re-opening of the office or until another notice from your office is issued.

- ❑ STEP 5: Identify which records need to be retained and which can be destroyed. Please verify with your professional Association for the suggested retention schedules (period of time to retain) for the records in your custody.

  For example, College of Physicians and Surgeons Guidelines suggest the following retention schedule:
  - *Files of patients: 10 years after last seen*
  - *Files of minors: 10 years after last seen or until the minor reaches the age of 21, whichever is longer*
  - *Files of deceased patients: 2 years after date of death*

- ❑ STEP 6: Destroy records that need no longer be retained and do so in a secure fashion (ex. secure shredding, disk wiping, etc.). When you proceed to the destruction of records, you must write down the following:

  a) Names of individuals whose records will be destroyed;
  b) Brief summary of the content of each record destroyed;
  c) Time period of each record destroyed;
  d) Method of destruction used (ex. secure shredding or incineration by company X); and
  e) Name of the person who supervised the destruction.

Please use the attached **Appendix – Sample Chart for Records Securely Destroyed** to assist you in keeping track of the information obtained in STEP 6.

Checklist B: Permanent Closure of the office/practice

- ❑ STEP 1: Be aware of ALL records in your care and control (including all active and inactive files).

- ❑ STEP 2: Create a list of all records identified in Step 1.

- ❑ STEP 3: Identify which records need to be retained and which can be destroyed. Please verify with your professional Association for the suggested retention schedules (period of time to retain) for the records in your custody.

  For example, College of Physicians and Surgeons Guidelines suggest the following retention schedule:
  - *Files of patients: 10 years after last seen*
  - *Files of minors: 10 years after last seen or until the minor reaches the age of 21, whichever is longer*
  - *Files of deceased patients: 2 years after date of death*

- ❑ STEP 4: Destroy records that need no longer be retained and do so in a secure fashion (ex. secure shredding, disk wiping, etc.). When you proceed to the destruction of records, you must write down the following:

  a) Names of individuals whose records will be destroyed;
  b) Brief summary of the content of each record destroyed;
  c) Time period of each record destroyed;
  d) Method of destruction used (ex. secure shredding or incineration by company X); and
  e) Name of the person who supervised the destruction.

  Please use the attached **Appendix – Sample Chart for Records Securely Destroyed** to assist you in keeping track of the information obtained in STEP 4.

- ❑ STEP 5: Identify the secure location where the records which must be retained will be stored. Remember that as a custodian, you remain responsible for the protection of your patients/client's files even while they are in storage. A secure location means one which has proper security safeguards.

- ❑ STEP 6: Notify all individuals whose records you hold (patients, clients) of the closure of your office or practice.
  This will permit those who would like to receive a copy of their record to do so.
  Notification to patients/clients should include the name of a contact person, i.e., to whom a patient/client can make a written request to access his or her record. Notification should also indicate the length of time you will retain the file belonging to the individual before it is destroyed (in accordance with your retention schedules).

Appendix – Sample Chart for Records Securely Destroyed

Name of patient or client	Summary of the content in each record	Time period of each record	Method of destruction	Person responsible for the destruction of files	Date of destruction