INTRODUCTION

Purpose/Value Statement

The College of Speech-Language Pathologists and Audiologists of Saskatchewan respects that members of the public are entitled to have their Audiology (Aud) and Speech-Language Pathology (S-LP) records managed in a manner that complies with all appropriate legislation and meets the standards set out in CSASK's Code of Ethics as well as the Canadian Alliance of Audiology and Speech-Language Pathology Regulator's Essential Competencies.

These guidelines are intended to support the practice of CSASK members when working with paper-based and/or electronic records. Speech-Language Pathologists and Audiologist are expected to also adhere to employer or agency policies, when such policies exist.

Legislation

CSASK members need to be aware of three statutes that may affect their record management processes. The *Health Information Protection Act* (*HIPA*) and the *Local Authority Freedom of Information and Protection of Privacy Act* (*LAFOIPPA*) are Saskatchewan statutes governing personal health information and personal information respectively. The *Personal Information Protection and Electronic Documents Act* (*PIPEDA*) is a Canadian statute that governs personal information.

The information provided in this guideline is intended to increase CSASK members' awareness of the legislations and to provide basic overviews of each. The interpretation of the legislation in this guide should not be relied upon as a substitute for the legislation or legal advice. Members obliged to follow HIPA, LAFOIPPA or PIPEDA are expected to familiarize themselves with the appropriate legislation.

HIPA [1]

- "An Act respecting the Collection, Storage, Use and Disclosure of Personal Health Information, Access to Personal Health Information and the Privacy of Individuals with respect to Personal Health Information and making consequential amendments to other Acts"

HIPA directly applies to those S-LPs and Auds that own or operate private clinics as they would be considered the "trustees" of personal health information. A "trustee" is any individual, institution or organization that has custody or control of personal health information. CSASK members employed by a trustee are obligated to follow the rules and regulations of their employer. The definition of personal health information is as follows:

a. "personal health information" means, with respect to an individual, whether living or deceased:
    i. information with respect to the physical or mental health of the individual;
    ii. information with respect to any health service provided to the individual;
    iii. information with respect to the donation by the individual of any body part or any bodily substance of the individual or information derived from the testing or examination of a body part or bodily substance of the individual;
        A. information that is collected:
        in the course of providing health services to the individual; or
        B. incidentally to the provision of health services to the individual; or
    iv. registration information

LAFOIPPA **[2]**

- "An Act respecting a right of access to documents of local authorities and a right of privacy with respect to personal information held by local authorities"

LAFOIPPA governs personal information (versus personal *health* information as governed by *HIPA*) and applies to CSASK members employed by local authorities (e.g., a municipality, college or university). According to *LAFOIPPA*, personal information means:

23(1) Subject to subsections (1.1) and (2) "personal information" means personal information about an identifiable individual that is recorded in any form, and includes:

a) information that relates to the race, creed, religion, colour, sex, sexual orientation, family status or marital status, disability, age, nationality, ancestry, or place of origin of the individual;
   information that relates to the education or the criminal or employment history of the individual or information relating to financial transactions in which the individual has been involved;
b) information that relates to health care that has been received by the individual or to the health history of the individual;
c) any identifying number, symbol or other particular assigned to the individual;
d) the home or business address, home or business telephone number, fingerprints or blood type of the individual;
e) the personal opinions or views of the individual except where they are about another individual;
f) correspondence sent to a local authority by the individual that is implicitly or explicitly of a private or confidential nature, and replies to the correspondence that would reveal the content of the original correspondence, except where the correspondence contains the views or opinions of the individual with respect to another individual;
g) the views or opinions of another individual with respect to the individual;

h) information that was obtained on a tax return or gathered for the purpose of collecting a tax;
i) information that describes an individual's finances, assets, liabilities, net worth, bank balance, financial history or activities or credit worthiness; or
j) the name of the individual where:
    i. it appears with other personal information that relates to the individual; or
    ii. the disclosure of the name itself would reveal personal information about the individual.

PIPEDA [3]

- "An Act to support and promote electronic commerce by protecting personal information that is collected, used or disclosed in certain circumstances, by providing for the use of electronic means to communicate or record information or transactions and by amending the Canada Evidence Act, the Statutory Instruments Act and the Statute Revision Act"

PIPEDA applies to commercial activities and would therefore apply to those S-LPs or Auds owning or operating private clinics.

Code of Ethics

The *CSASK Code of Ethics* [4] sets forth the fundamental values and standards essential to the responsible practice of speech-language pathology and audiology and provides the basis for ethical practice and decision-making. With regard to records, the Code of Ethics states:

Members shall:

a. prepare and maintain adequate records of professional services provided, and products dispensed, in a timely fashion.
b. allow clients to access their own records.
c. allow third-party access to client records when written authorization is obtained from the client or where required to provide access by law.

CAASPR Essential Competencies [5]

CAASPR, along with the Canadian Inter-organizational Steering Group for Audiology and Speech-Language Pathology have created core essential practice competencies for both speech-language pathology and audiology. The competencies are "intended to define the minimum required standard for speech-language pathologists and audiologists in Canada and to ensure that practitioners have the knowledge, skills and attributes to practice safely and effectively in a variety of practice settings". In their role as communicators, Auds and S-LPs are expected to display the following essential documentation skills:

a. Maintain clear, accurate, timely and complete client records.
    a. Comply with regulatory requirements.
    b. Comply with organizational requirements.

b. Ensure timely dissemination of client documentation.

BASIC PRINCIPLES

The value of a record depends upon it being meaningful, accurate, timely and clear. The following are principles of good record keeping and should be implemented regardless of whether a paper-based or electronic recording format is used[6]:

- Include the date, name and professional designation of the person documenting the information
- Document accurate, precise, and objective information supported by facts. Avoid judgmental or derogatory remarks.
- Record clearly and proofread notes to minimize any ambiguity.
- Record concisely. Point form is acceptable.
- Use correct spelling and terminology that is understood by others.
- In a continuous document, abbreviations should be refined by writing the term in full first followed by the abbreviation in brackets, e.g., therapy (Tx), and subsequently the abbreviation can be used.
- Record events in chronological order.
- Complete during or immediately after client contact, and not ahead of time. If a late entry is made, it should include the current date and time, a notation that the entry is late, and the date and time of the events described in the late entry.
- The person who was directly involved in the event completes the record. The SLP or Aud does not chart or sign on behalf of another individual (see Supervisory Responsibility for exception). Record entries should be signed by the person who made the entry including name and credentials or as mandated by the employing agency.
- Formal reports (i.e., assessment reports, intervention summaries, progress reports, discharge summaries, etc.) for clients followed by support personnel should be completed and signed by the supervising SLP or Aud.
- Daily progress notes or chart notes completed by support personnel should be signed by the support person as he/she is the individual who provided the intervention and has first-hand knowledge of the service. Support personnel must clearly indicate their status on any documentation completed. Entries should only be co-signed by the supervisor in accordance with established policies and procedures of the workplace.
- Formal documentation, including reports and letters for clients followed by a clinical practicum student may be written by the student under the supervision of the registered

SLP or Aud. The supervising SLP or Aud should review the report, write or stamp their name, designation and that they have reviewed the report, and sign the report (e.g., "this document has been read and reviewed by J. Smith Reg.SK)

Paper-Based Records

In addition to the general principles above, the following are guidelines specific to paper-based records[6]:

- Write legibly in blue or black ink in order to establish a permanent record and clear transmission through electronic means (e.g., fax or scan).
- Ensure unauthorized alterations are not made to source documents. Where corrections are made, they should be made in line with the appropriate agency/facility policy using the following suggestions for correcting written entries:
    - Draw a single line through the entry so that it is clearly deleted, yet still readable.
    - Indicated the location of the correct entry.
    - Record the correction with the date and time.
    - Initial the correction.
- Do not remove pages from the record. Do not leave blank lines or white space between entries in the record to avoid the risk of additional information being added by another individual.
- Ensure each page is dated and/or numbered to eliminate confusion should pages get mixed up.

Electronic Records

Considerations when using electronic recording formats include the following[7]:

- Where possible, use an electronic medium that is permanent and cannot be altered; all entries made/stored electronically are considered a permanent part of the client record and are governed by the same guidelines as paper records.
- Use the appropriate features of the electronic documentation system to make corrections or late entries. In some situations, this may mean providing an additional entry that is dated for the day the correction is made, indicating which section of the record is being revised and why.
- Ensure that the program used leaves an audit trail that can reveal when each change was made and by whom.
- Ensure the confidentiality of passwords used to access the electronic record. Do not share passwords with colleagues under any circumstances.
- Registrants should follow their employer policies and guidelines with respect to the use of electronic signatures. In private-practice situations, members should ensure that

there is a secure method available only to the member for applying an electronic signature to documents that must be personally signed.

Please refer to **Protection of Personal Information on Personal Computers, Laptops, or other Mobile Devices** for additional information regarding the security and confidentiality of electronic information.

Supervisory Responsibilities [7]

You may have clinical supervisory responsibilities related to support personnel, and students. The clinical supervisor is responsible for documenting any work others have completed and for ensuring that supervisees have documented appropriately. The clinical supervisor may not necessarily be the supervisee's administrative or reporting supervisor. In some instances, supervisees may have more than one clinical supervisor in the course of their training period or in the provision of their services. The clinical supervisor has a responsibility to be familiar not only with the client's case including their individual needs but also with their wishes, risks and goals related to the care. If the author of a report or letter is unavailable to sign the document, the supervisor may sign off and be clear who the report was written by. For example, this report was written by J. Doe, SLP/AUD student and reviewed by J. Smith, Reg.SK.

Referral Documentation [7]

Referrals to other health care providers or service providers should be documented. Client consent is required in order to send or provide client information to any third party. Client refusal for referrals should also be noted.

Amendment of Records [6,7]

Clients have a legal right to request access to personal records that are in the custody or control of a health-care setting (see *HIPA*, Part V), private-sector organization or public body. If clients believe that their personal information contains any errors or omissions, they may request the holder of the information to correct or amend the record. Requests should be made in writing.

You must make every reasonable effort to respond within legislated time frames and assist clients with their requests. If you agree with the change, you should inform the client in writing when the change or amendment has been made. It may be necessary to also inform any third party, who was previously sent the erroneous information, of the corrected information. You should not make a correction or amendment to a professional opinion or observation made by another health care provider or to a record that was not originally created by you. In order to complete a correction or amendment, the original information must be maintained in the original form. The corrected entry or amendment should be inserted into the record, indicating the date, name and designation of the member making the correction or amendment.

TYPES OF RECORDS AND INFORMATION TO BE COLLECTED [6,7]

Clinical Records

Clinical records are a systematic recording of accurate, objective, and relevant information related to speech-language pathology or audiology services provided to the client. They are kept in the client's individual file or chart. Clinical records serve multiple purposes, including justifying the need for the service or intervention, delineating the care plan, documenting effectiveness of service(s), communicating the delivery of the professional services, promoting continuity of care, and providing a legal record of events.

Each employer or agency may follow different protocols for data required in a clinical record. Ensure you follow the guidelines set out by your employer. If no guidelines are available, CSASK recommends the following core components when creating clinical records:

- Client Identification:
    - Client's full name and contact information, date of birth, and unique identifier (if applicable, e.g., Student ID number, Saskatchewan Health Card Number)
    - complete name of client or unique identifier on each page of record
    - identification of parents, legal guardian(s) or decision maker(s)
    - third-party numbers (e.g., Worker's Compensation Board, Treaty)
- Case History Information:
    - All related medical information that influences the care and services provided. Information contained elsewhere in a medical chart does not need to be repeated extensively if the information will be part of the same record. The information can be referenced to avoid duplication and repetition of information.
    - Anecdotal information received from a third party (e.g., parent) should be recorded as such in the case history information.
    - Medical diagnoses pertinent to the care and services to be provided.
    - Significant changes in health status that would positively or negatively affect the client's achievement of their objectives.
- Referrals:
    - Referral source (e.g., physician, self-referral) and reason for referral
    - Referrals to other health care team members, work outsourced to a clinic, lab or agency
    - Client refusals of a referral
- Consent:
    - Data Collection
        - Follow appropriate legislation as set out in the *HIPA* (Part II Sections 5, 6, and 7).
    - Intervention
        - Expressed - consent is clearly and voluntarily given, usually verbally or in writing

    - Implied - consent which is not expressly granted by a patient/client, but can be inferred from a patient's/client's actions
  - Informed consent
    - Based on the right of each person to determine what will be done to his or her own body. The client has the right to refuse treatment, to consent to treatment and to withdraw consent to treatment.
    - Ensures that each client understands the risks and benefits of each treatment option presented as well as the costs involved. Implied consent may be acceptable if the client comes to the registrant and the services are noninvasive and pose little or no risk to the client. Express consent should be obtained when any treatment or service poses a potential risk to the client, even if the likelihood for complications is low.
    - The standard for client-centered consent is based on what information does the client reasonably need to know, in the client's position. The information provided is client specific and in order to be "informed," the information should include the diagnosis or problem noted, the treatment/intervention alternatives available, the risk and benefits of intervention and the estimated cost of each option (if applicable), the nature and purpose of the treatment and the likely consequences of not having the treatment.
    - You should be certain that the client (or their representative) understands the information and has consented to the intervention or treatment. Oral consent is legally acceptable but where there is significant risk to the client, written confirmation should be secured.
    - There is no age of consent in Saskatchewan (SK). SK follows the "mature minor doctrine," which recognizes that the level of the patient's understanding of the nature and consequences of the treatment have determinants beyond age. This allows physicians to make a determination of capacity to consent for a child just as they would for an adult"[8]. If you are of the opinion that a client is capable of providing his or her own consent, then you can rely on that consent. Consent for payment of the treatment may be a separate issue. A legal guardian or other substitute caregiver must consent to services for incompetent clients or children who are not capable of understanding information that is relevant to making a decision about the treatment and not able to appreciate the reasonable consequences of a decision or lack of a decision.
    - Client consent for research or educational purposes is required unless all identifying information has been removed and the client's anonymity is protected. It is your responsibility to ensure that clients or their representatives have consented to service(s) provided by a support person, trainee or student and that this consent has been documented.

- Screening:
  - The outcome of any screening should be documented including the “go forward plan” for any client who does not pass the screening that was administered (e.g., referral(s) for further investigation, an additional screening, a formal assessment etc.)
- Assessment/Diagnosis:
  - The core components of any assessments and diagnostic testing should be recorded, including the outcomes of such testing, any consultation with client/caregivers that occurred and the specific diagnoses, where applicable. Formal results form part of the assessment and diagnoses.
  - Transitory records should be appropriately destroyed (see **DISPOSAL**) once the formal assessment /diagnosis report is complete.
  - Assessment/diagnostic reports should be recorded as soon as possible following the completion of the session(s).
- Care Plans, Treatment and Interventions:
  - urgency and priority of treatment
  - treatment options and alternatives
  - risks to various treatment options, including those pertaining to no treatment
  - recommendations, instructions, and advice provided, together with pertinent client comments
  - discussion of financial implications and payment options
  - information provided about services that are to be provided or augmented by another registrant or by support personnel
  - client’s decisions with respect to choice of treatment
  - client’s informed consent where applicable (see **Consent**) including consent for services provided by support personnel
  - planned schedule of follow-up, reassessment, or outcome assessment, depending on the treatment plan
  - objectives of treatment and intervention and expected outcomes
  - changes to the care plan and any associated rationale for the change(s)
  - any agreement to assign or delegate services to support personnel must be documented by the registrant in the location that is according to agency policy and where a policy does not exist the registrant must document the agreement in the client record.
- Progress Notes
  - Progress updates should be documented for all service provision.

- Updates should be well organized, legible, and provide a comprehensive description of the care provided.
- Participation and progress should be noted for individual service as well as for services involving a group of clients.
- Support personnel who have been given an assignment or delegation must chart their notes in the clinical record and must sign the entries with their name and title. Counter signature by the registrant is not required.
- Progress notes should include, but are not limited to the:
  - date(s) of intervention
  - registrant's name and designation
  - objective that the treatment /intervention relates to
  - outcome of any testing conducted
  - type and quantity of local anesthetic administered (where applicable)
  - materials used or provided
  - recommendations, instructions, explanations, or advice given to the client
  - changes in client status (positive or negative)
  - complications and adverse events, including who was advised of the incident and what options were available to address it
  - proposed follow-up or next intervention planned If office staff are relied upon to document the registrant's chart entries, the registrant is expected to sign or initial each entry after reviewing it for accuracy and completeness. Entries made by dictation must be initialed by both the registrant and the writer.

Administrative/Support Records

Administrative or business records are typically maintained by the employing agency regarding the day-to-day operations of the business. These records may include but are not limited:

- personnel files (e.g., resumes, reference checks, performance evaluations, disciplinary records)
- human resource files (including applications, contracts, employee benefit plans, layoff information)
- legal documents (e.g., liability insurance, corporate documents, business licenses)
- operational manuals (e.g., emergency procedures).

Financial Records

Financial records ensure effective financial management, controls, reporting and compliance with applicable laws. They are necessary for tax-related purposes as required by the Canada Revenue Agency. As with all businesses, those who work in private practice or non-publicly

funded settings should maintain an effective and efficient accounting system. This system should include cash records, customer records, supplier records, employee records, capital equipment records and office records. The recording of financial transactions must also comply with PIPEDA.

Financial records for clients should include:

- name and registration number of clinician providing services
- client identifying information
- a copy of any agreement with the client or representative
- the date and amount of all fees charged
- the date and amount of all payments made and method of payment
- an itemized list of services and supplies provided
- copies of all claim forms for the client
- any agreement for payment from a third party
- statement of the timeline for which an agreement is in effect

Equipment Service Records

Equipment service records are necessary when the proper functioning of equipment may impact client health and safety or the accuracy of assessments or testing results. For example:

- Calibration, service, maintenance and inspection of equipment as per the manufacturer's standards (i.e., daily, weekly, monthly, annually or as required) should be documented in a record that includes the date, service provider and where the service was completed in case future follow-up is required.

Transitory Records

Transitory records are documents for short-term use, are not part of an official recordkeeping system and do not include any documents that fall into another record category. They may include:

- documents used for a temporary purpose (e.g., phone messages, post-it notes, invitations, etc.),
- copies of main records (e.g., working files or ghost files)
- unsolicited materials
- draft reports that were used in the preparation of formal documents.

DISCLOSURE

General Limitation of Disclosure

Members are expected to maintain strict confidentiality of personal information (PI) and personal health information (PHI) contained in client care records. Disclosure should be in accordance with the informed consent of the client and must occur in accordance with appropriate privacy legislation (e.g., *HIPA* - Section 27).

Transmission [6]

The security and confidentiality of records is at increased risk when records are transmitted from one location to another. You should ensure that all necessary steps are taken to reduce such risk. The following guidelines are helpful in reducing the risks to the security and confidentiality of records during transmission processes.

- Records Being Transmitted Via Mail or Courier
    - Place information a sealed envelope, clearly identified as confidential.
    - As a tracking mechanism, document the date that mail was sent in the client's chart.
- Records Being Transmitted Via Facsimile
    - Use secure and confidential systems.
    - Ensure that the facsimile will be retrieved immediately or stored in a secure area.
    - Verify fax numbers and distribution lists prior to transmitting.
    - Check activity reports to verify successful transmission.
    - Include a confidentiality statement on the cover sheet stating that the information is confidential, to be read by the intended recipients only and a request for verification that facsimiles received in error were destroyed without being read.
- Records Being Transmitted Via Email
    - Use secure and confidential systems.
    - Remove identifying information (e.g., individual identifier numbers, last names) from email messages or electronically transmitted reports; password protection of electronically transmitted files congaing personal information may be considered in situations where one has control over both the sending and receiving ends of the electronic exchange.
    - Verify email addresses of intended recipients prior to transmitting.
    - Request an acknowledgement of receipt.
    - Include a confidentiality statement stating that the information is confidential, to be read by the intended recipients only, and that the email and any attachments are to be deleted if received in error.

RETENTION [6,7]

Clinical Records

CSASK recommends that members observe the record retention policies established by their employers, where applicable.

In Saskatchewan, specific legislation outlining record retention requirements for PHI are "not yet proclaimed" (*HIPA* Section 17(1)). The *Hospital Standards Regulations* (1980) outlines requirements regarding record retention in hospitals.

Where record retention policies do not exist, and for members involved in private practice, the guideline consistent with the *Hospital Standards Regulations*[9] (Section 15 (1)) is that client records should be "…retained … for a minimum period of ten years from the date of last discharge or until age nineteen if the patient is a minor, whichever period is the longer or for such further period as may be deemed necessary …." From a legal protection point of view, the time period within which someone can file a claim or a lawsuit is no more than two years from the time the claim was discovered (*Limitations Act*, *2004*[10] Section 5). Therefore in order to cover the limitation period, it would be prudent to save records for at least an additional 24 months beyond what is stated in the *Hospital Standards Regulations*.

Test protocols are considered to be part of the client record and, as such, should be retained according the guidelines outlined above. Test protocols should be retained with documentation (e.g., progress notes, reports) that provides interpretation of the protocol information. In situations where employer policies do not allow for the storage of test protocols (i.e., raw data) on the client's main health record or cumulative file, it is the SLP or Audiologists responsibility to ensure that all relevant raw data has been included in a written report or progress note to be kept in the client's main record.

Electronic retention of records is acceptable.

Administrative or Business Records

Agency policy and local policy applies to the retention of business-related records that are not directly related to client care and services.

Equipment Service Records

Records should be retained for 6 years from the date of the last entry (*Administrative Records Management System 2014*[11]).

Financial Records

Records should be retained in accordance with applicable laws such as the Canada Revenue Agency. Generally, this is six years from the date of the tax year to which the records apply.

Storage of Records

Reasonable measure to guard against unauthorized access to information is required. Hard-copy client records should be stored in a secure location such as a locked filing cabinet or file

room. Registrants employed by an agency should follow the file-management policies of their employer.

Electronic Data Storage (Protection of Information on Personal Computers, Laptops and Mobile Devices)

Members who store personal information regarding clients on personal computers, laptops, or other mobile devices must ensure that the information is protected in the event that the device is lost or stolen. Privacy statutes impose an obligation to take reasonable measures to guard against unauthorized access to information. According to the Office of the Privacy Commissioner of Saskatchewan[12] "trustees should ensure they have three kinds of safeguards in place to protect personal information and/or personal health information":

- Administrative (the following is an incomplete list):
    - Ensuring password-enabled screen locks are engaged
    - Step-by-step procedures for what to do if a device is lost or stolen
    - Enable the ability to remotely wipe a device
    - When using the device, de-identify PI/PHI whenever possible
- Technical (the following is an incomplete list):
    - Use strong passwords
    - Use multi-layer authentication
    - Use encryption
    - Only connect to secure wireless networks
- Physical (the following is an incomplete list):
    - Do not leave your mobile device unattended
    - Securely store mobile devices when not in use
    - Report lost or stolen devices to your Privacy Officer and if appropriate, the police
    - Safely dispose of mobile devices when no longer needed

In the case of an employing organization, the obligation to implement and enforce appropriate policies rests with the employer who would be considered the designated custodian of the information as designated in privacy legislation.

Cessation of practice [13]

A cessation of practice refers to any time period of more than 30 days in which you permanently or temporarily stop working.

- Cessation Plan
    - You must have a plan in place for the transfer of records in the event of a cessation of practice.
    - The Cessation plan <u>must</u> include:

    - Name, address and telephone number of a designated trustee who can take over the custody of client care records and personal information.
    - Contact information for the designated trustee must be provided to CSASK and executor and/or next of kin and be kept up-to-date.
  - The cessation plan <u>should also</u> include:
    - A notification plan that informs ongoing clients of any transfer of their personal health information.
- Designated Trustee
  - Who can be a designated trustee?
    - Any individual who is able and willing to comply with all provincial and national privacy guidelines may be designated as a trustee (for example, a spouse, a colleague or the estate trustee named in a will).
  - You must have the consent of their designated trustee before naming him or her.
  - Ensure that the designated trustee understands his or her duties and responsibilities under *HIPA*, *LAFOIPPA*, *PIPEDA* and this guideline.
  - Create a record of the informed consent agreement. Give one copy to designated trustee and maintain another in practice records.
  - The designated trustee must be able to access the client records and the personal information in an emergency, but access no more information than is necessary in the circumstances.
  - 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 CSASK.
- Temporary Cessation of Practice
  - Temporary cessations of practice include a leave of absence for more than 30 days, with the expectation to return from such events as: holiday or vacation from work, maternity leave, compassionate leave.
  - You must transfer access of personal information to your designated trustee.
  - The designated trustee takes temporary responsibility for the protection and confidentiality of the personal information.
  - You should notify your 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.
- Permanent Cessation of Practice
  - You must transfer access to a designated trustee, having notified the clients affected by the transfer of information and whenever possible obtaining their consent.

    - You must provide your clients the opportunity to choose their new SLP/Aud and transfer all information as needed
    - The designated trustee takes permanent responsibility for the protection, confidentiality and destruction of the personal information, consistent with these guidelines.
- Unforeseen Cessation of Practice
    - The designated trustee takes responsibility for the information from the original trustee.
    - 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.
    - If the unforeseen cessation is permanent, the designated trustee has a duty to:
        - notify all affected clients and the CSASK;
        - retain information for a minimum three years or three years after the client reaches the age of majority, whichever is longer; and
        - destroy such information and PHI in a manner which protects the confidentiality of the individual clients (see **DISPOSAL**).

DISPOSAL [7]

After the appropriate time has elapsed (see **RETENTION**), records should be destroyed. The security and confidentiality of records must be maintained during the disposal process. Generally accepted methods would include shredding, incineration or de-identifying personal and health information on the documents being discarded. A record should be maintained that includes:

- Name of the clients
- File number (if applicable)
- Last date of service
- Date that the record or file was destroyed.

The destruction of electronic records must render them unreadable and eliminate the possible reconstruction of the records in whole or in part.

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