Alberta College of
Speech-Language Pathologists
and Audiologists

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Guideline

Clinical Documentation and Record Keeping

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Contents

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***Guideline**: Provides recommendations to regulated members that are deemed to be acceptable practice within regulatory requirements. Regulated members are afforded reasonable use of their professional judgment in the application of a guideline.*

INTRODUCTION

The term "*record"* is defined as: "*information in any form or medium, including notes, images, audiovisual recordings, X-rays, books, documents, maps, drawings, photographs, letters, vouchers and papers and any other information that is written, photographed, recorded or stored in any manner"* (1, 2, 3).

Clear, complete, and accurate records are an essential component in the delivery of speech-language pathology and audiology services.

While there is no specific legislation in Alberta that addresses "record keeping" per se, there are three key pieces of privacy legislation that set rules for how information is to be collected, protected, used, disclosed, and amended:

- The *Health Information Act (HIA)* (1) addresses protection of individually identifying health information.
- The *Personal Information Protection Act (PIPA)* (2) governs personal information, including both health and non-health information, held by private-sector organizations in Alberta. This includes private practices that provide speech-language pathology or audiology services, non-profit organizations and professional regulatory bodies.
- The *Freedom of Information and Protection of Privacy Act (FOIP)* (3) governs public bodies, including school boards and post-secondary institutions. FOIP applies to non-health related personal information (including administrative and financial records).

Additional information regarding privacy legislation and professional obligations may be found in Section F. *Security and Confidentiality of Records.*

A. PURPOSE

This guideline addresses the responsibilities of speech-language pathologists (SLPs) and audiologists in the preparation, maintenance, communication, and disposal of clinical records.

ACSLPA recognizes that variations in practice setting (e.g., public vs. private practice) and types of interventions provided (e.g., assessment, treatment, dispensing of hearing aids, etc.) will impact the type of documentation required. This guideline provides information applicable to all SLPs and audiologists practicing in Alberta. The actual application of each guideline will depend on the clinical context in which professionals find themselves. SLPs and audiologists have a professional responsibility to be aware of and comply with employer and/or agency policies, and

any additional legislation or provincial standards regarding documentation and record keeping, where they exist.

B. TYPES OF RECORDS

Various types of records exist to fulfill the key purposes of record keeping, namely, documentation of daily practice activities, communication with clients, parents, caregivers, referral sources, and professional team members, and overall professional accountability (5). Although the primary focus of this guideline is clinical documentation and record keeping, a full range of record types is outlined below. Depending on the practice setting, context, and legal requirements, the SLP or audiologist will be expected to maintain some or all of these various record formats.

1. Clinical Records

Clinical records contain details related to services provided to the client. They are kept in the client's individual file. Clinical records serve multiple purposes: justifying the need for intervention, delineating the care plan, documenting the effectiveness of intervention, communicating the delivery of professional services, promoting continuity of care, and providing a legal record of events (4, 5).

2. Administration/Support Records

Administration/support records are typically maintained by the employing agency. Dependent on the nature and size of a private practice, an SLP or audiologist may also be required to maintain some or all of these types of records. Administration/support records may include the following (7):

a. Personnel files (including resumes, criminal record checks, reference checks, performance evaluations, disciplinary records, training/continuing education records, records related to leaves, layoff or termination of employment, etc.).
b. Student documents (i.e., for students enrolled in a graduate SLP or audiology program of study, supportive personnel practicum students, etc.).
c. Human resources documents (e.g., employment applications, contracts, employee benefit plans, etc.).
d. Occupational health and safety documents.
e. Legal documents (e.g., professional liability insurance, corporate documents, shareholder documents, etc.).
f. Log books (e.g., mileage and telephone logs).
g. Fixed asset listings/registers.
h. Operational manuals (e.g., employee and quality control manuals).

3. 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 (8). As with all businesses, SLPs and audiologists who work in private practice or non-publicly funded settings should maintain an effective and efficient accounting system.

This system should include the following: cash records, customer records, supplier records, employee records (i.e., salary and deductions, etc.), lender records, owner/shareholder records, and government records.

4. Equipment Service Records

Equipment service records are necessary when the proper functioning of equipment may impact client health and safety, or the accuracy of assessment results (e.g., audiometric testing equipment). Calibration and/or inspection of equipment as per manufacturer's standards (i.e., daily, weekly, monthly, annually as required) should be documented in a record that includes the date, the service provided, and who/where the service was completed in the event that a problem surfaces at a later date (5).

5. Transitory Records

Transitory records are documents of short-term use and are not part of an official record-keeping system. 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, otherwise known as shadow or ghost files), unsolicited materials (e.g., unsolicited resumes), and draft reports (no longer required) that were used in the preparation of formal documents (5). Transitory records do not include any documents that fall into the previously stated record categories.

C. GUIDELINES FOR RECORD KEEPING

1. Professional Obligations

The record-keeping obligations of SLPs and audiologists registered in Alberta are outlined in ACSLPA's *Code of Ethics* and *Standards of Practice* documents. The *Code of Ethics* states "members are expected to prepare and maintain accurate, complete, and timely records of professional services rendered and products dispensed" (6).

In addition to professional obligations outlined above, SLPs and audiologists must comply with any applicable legislation and provincial standards related to privacy or documentation and record keeping. They should also be aware of and comply with employer and/or agency policies where applicable.

2. Practice Guidelines

a. Basic Principles

The following principles of good record keeping should be implemented regardless of whether a paper-based or electronic recording format is used (5, 9, 10). Record entries:

- Include the date, name and professional designation of the person documenting the information (refer to Appendix A, *Using Your Protected Professional Designation the Right Way)*.

- 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.
- Use abbreviations as follows: any term must be written out in full with the abbreviation in brackets the first time it is stated in any continuous document entry (i.e., a formal report would constitute one continuous document entry, as would daily chart notes). Subsequent use of the abbreviation in the continuous document would be acceptable (e.g., "therapy" for the first entry, could be written as "therapy (Tx)" and then just as "Tx" in all following entries). Refer to the *Health Quality Council of Alberta* (HQCA) for information regarding high-risk abbreviations (18).
- 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 audiologist does not chart or sign on behalf of another individual (see exceptions under Section 2.e. *Supervisory Responsibilities*). Record entries (e.g., daily progress notes or chart notes) 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 audiologist. This principle is in keeping with recommendations outlined in ACSLPA's PPGs, *Speech-Language Pathologists' Guidelines for Working with Support Personnel* (2011) (9) and *Audiologists' Guidelines for Working with Support Personnel* (2011) (10).
- 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 (i.e., where specific guidelines requiring co-signature exist).
- 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 audiologist. The supervising SLP or audiologist 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 & reviewed by J.Smith R.SLP/R.Aud").

i) Paper-based Records

In addition to the general principles outlined above, the following are guidelines specific to paper-based records (5, 8):

- 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.
  - Indicate 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.

ii) Electronic Records

Considerations when using electronic recording formats include the following (5):

- 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.

The *Alberta Electronic Health Record Regulation* (AEHRR) (11) defines the Alberta Electronic Health Record (known as Netcare), as the integrated health information system established to provide shared access by authorized custodians (such as Alberta Health Services, the Minister and the Department, and independent health service providers), to prescribed health information in a secure environment. Under the AEHRR, authorized custodians who use prescribed health information through Netcare must keep an electronic log containing specific user information. A detailed listing of this information and additional details regarding the AEHRR may be accessed by visiting the Alberta Queen's Printer website at: http://www.qp.gov.ab.ca/catalogue/.

Please refer to Section F.2. *Protection of Personal Information on Personal Computers, Laptops, or Other Mobile Devices* for additional information regarding the security and confidentiality of electronic information.

b. Clinical Records

SLPs and audiologists should follow employer policies related to the minimum data sets required in their clinical documentation. These will vary based on a number of factors including, but not limited to, the practice setting (e.g., outpatient vs. inpatient, ambulatory care centre vs. community health vs. educational setting vs. private practice, etc.), client age, and the documentation's intended audience. ACSLPA recommends that the following minimum requirements be included in the client chart:

<u>Client Identification</u>

- Client's first and last name on **each page** of the record.

The following information should appear at a designated location within the record:

- For minors, inclusion of the names of parents/guardians and details of custodial rights, if relevant.
- Personal contact information (home and/or business and/or cellphone number, mailing and/or home address, as required).
- Date of birth.
- Client identification number or other identifying numbers, as required by the employer (e.g., school ID number, Alberta Health Care number, etc.).
- Third-party number, as required (e.g., Worker's Compensation Board, Veterans Affairs Canada, etc.).
- Client information should be maintained for individuals who have been screened by an ACSLPA registrant for a speech, language, hearing, and/or feeding concern, and should include content as outlined above. In the case of group screening, the client's name and a reference to the group with whom the client is affiliated is required. In addition, the nature and result of every screening performed should be included, including documentation of any action taken by the member as a result of the screening, and a record of consent provided by the client.

<u>Content Charting Requirements</u>

- SLP's or audiologist's name, signature and properly cited credentials (refer to Appendix A, *Using Your Protected Professional Designation the Right Way*), as well as names and titles of assisting professional service providers, and assisting non-professional support personnel.
- Case history and intake information including referral source (e.g., physician, teacher, other professionals, parents), as appropriate.
- Dates and brief entries related to any communication to or with the client. These may include, but are not limited to, face-to-face or telepractice visits, phone calls, and emails, and should include information regarding missed appointments, treatment breaks, etc.
- Assessment of relevant structure and function, and the impact on activities and participation.
- Description of client strengths and needs relevant to communication, feeding, hearing, and/or balance.
- Relevant supports and services.
- Plan of care outlining intervention goals and strategies.

- Response to interventions and progress toward achieving goals documented in the plan of care.
- Recommendations.
- Transition/discharge plans, including the reason for discharge.
- Referrals to other professionals, reports and correspondence from other professionals, equipment, and other services provided.
- Notation of any change in therapist or chart closure.
- Evidence of consent, whether that be a signed consent form or documentation of a conversation with the client regarding consent, and the resulting outcome.

Standardized intervention protocols and procedures may be developed in situations where a standard or documented program is being followed (e.g., language facilitation/intervention provided in a group or classroom format that addresses specific goals or targets over the duration of a set number of sessions). In this case, the care plan would be included as part of the standard protocol, clearly outlining the goals of the program. The clinician would be expected to document on a "charting by exception" basis, noting client contacts, communications, any deviations from the plan of care, and responses to intervention.

In situations where charting in a client file may be completed by more than one professional (of the same or different disciplines), maintenance of a signature log could be considered. The log lists care providers' signatures/initials and can be very helpful in the event that legal issues arise and it is necessary to identify the maker of an entry. The signature log may be kept as part of individual client records, or may also be part of office records.

c. Financial Records

SLPs and audiologists who work in private practice or non-publicly funded settings must maintain records related to client billing. At a minimum, these billing records should include the following information (4, 5):

- Client name or identifier.
- Date(s) on which the service was provided.
- Nature of the service provided (e.g., assessment, treatment, intervention, etc.).
- Length of time required to provide the service.
- The actual fee charged and method of payment.

According to the Canada Revenue Agency (8), the retention period for records and supporting documents required to determine tax obligations and entitlements is six years. Additional information regarding financial record keeping for individuals and businesses may be accessed from the Canada Revenue Agency (8), *Keeping Records* found at: http://www.cra-arc.gc.ca/tx/bsnss/tpcs/kprc/menu-eng.html

In order for clients to receive reimbursement from third-party insurers for payment of fees to SLPs and audiologists, the name and credentials of the professional involved, including the practice permit number, must appear on the client invoice.

d. Witnessing or Countersigning Documentation

Sound record-keeping practices demonstrate clinical accountability. SLPs, audiologists, support personnel, and SLP and audiology students are responsible for documenting the care that they provide. As a result, the general rule is that documentation should be recorded from first-hand knowledge only (5). Co-signature can blur the lines of accountability, can misrepresent who did what and is therefore generally not recommended.

If two or more people are involved in client care (e.g., a multi-disciplinary team of health-care professionals), individual parties may document and sign for the care given by that individual. Alternatively, one person can indicate in the record that care was provided by the professionals named in the entry. In this instance, the record-keeper should designate specifically what care was provided by which professional. In this situation, co-signature is not required.

e. Supervisory Responsibilities

SLPs and audiologists may have supervisory responsibilities related to support personnel, graduate students completing clinical practica in their respective fields, and/or staff coordination and/or management functions. The act of supervision includes reviewing student and support personnel's work including any documentation they have completed.

- Record entries (e.g., daily progress notes, chart notes) completed by support personnel and clinical practica students should be signed by the individual completing the entry. Students and 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 (i.e., where specific guidelines requiring co-signature exist).
- In keeping with recommendations outlined in ACSLPA's PPGs, *Speech-Language Pathologists' Guidelines for Working with Support Personnel* (2011) (9) and *Audiologists' Guidelines for Working with Support Personnel* (2011) (10), 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 audiologist.
- 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 audiologist. The supervising SLP or audiologist should review the report, write or stamp their name, designation and that they have they have reviewed the report, and sign the report (e.g., "this document has been read & reviewed by J. Smith, R.SLP/R.Aud").
- In the event that a staff SLP or audiologist is unable to sign completed documentation (e.g., clinical reports completed via a dictation system or word-processed reports on a shared computer drive) due to, for example, events such as a sudden medical leave, or needing to sign for a casual employee who is not in the clinic on a regular basis, the disclaimer "dictated/composed but not read by" should be included in the signature block of the report. Should the supervisor choose to

sign off on the completed report, the intent of the signature must be made clear and be indicated in the report (e.g., "this report was written by Jane Smith, R.SLP/R.Aud and has been reviewed by Mary Brown, R.SLP/R.Aud, supervising SLP/Aud").

D. AMENDMENT OF RECORDS

Under the *Health Information Act (HIA)* (1), *Personal Information Protection Act (PIPA)* (2) and *Freedom of Information and Protection of Privacy Act (FOIP)* (3), clients have the legal right to request access to personal records that are in the custody or control of a health-care setting, private-sector organization or public body, respectively.

If a client believes that personal information contains an error or omission, they may request that the *custodian*[1] who has control of that information correct or amend the record. Applicants must make their request to correct or amend their information in writing. Custodians in health-care settings, private-sector organizations and public bodies must make every reasonable effort to respond within legislated time frames and assist applicants with their requests. Custodians are obligated to ensure that information is accurate and complete; the custodian of the record should consult with the individual who made the entry under question prior to taking any action. If a custodian agrees that a change or amendment is required, they must provide the applicant with written notice that the correction or amendment has been made and, where appropriate, send a notice of the correction or amendment to any organization to which the incorrect information had been disclosed. Despite the request of an applicant, custodians under HIA should not make a correction or amendment to a professional opinion or observation made by a health-services provider, or to a record that was not originally created by the custodian (1, Section 13). For individuals who adhere to either *PIPA* or *FOIP*, it is important to note that the equivalent provisions restrict changes to ***any*** opinion, not just those of health-care providers (2 – Section 25, 3 – Section 36).

When a correction or amendment is made, the original entry must be maintained in the original form. The corrected entry or amendment should be inserted into the record, indicating the date and name of the person making the correction or amendment (12).

For further information and details, each piece of legislation may be accessed by visiting the Alberta Queen's Printer website at: http://www.qp.gov.ab.ca/catalogue/.

[1] It is important to note that the term "custodian" is found only within the *HIA*. Although *PIPA* employs the term "organization" and *FOIP* employs the term "head of the public body," for the purposes of this guideline, the term "custodian" will be used to refer to all three situations.

E. MANAGEMENT OF RECORDS

1. Transmission

The security and confidentiality of records is at increased risk when records are transmitted from one location to another. SLPs and audiologists 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 (5).

Records Being Transmitted Via Mail or Courier

- Place information in 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 containing 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.

Disclosure of records containing personal information must occur in accordance with the applicable privacy legislation (refer to Section F.1. *Privacy Legislation and Professional Obligations* of this document).

2. Retention

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

In Alberta, specific legislation outlining record retention requirements for health-care professionals, including registered SLPs and audiologists, does not exist. The *Operation of Approved Hospitals Regulation* under the *Hospitals Act* (1990) outlines requirements regarding record retention in hospitals.

Where record retention policies do not exist, and for registrants involved in private practice, the guideline consistent with the *Hospitals Act* (13-Section 15) is that client records for adults should be retained for a minimum of 10 years following the date of last service. From a legal protection point of view, although the time period within which someone can file a lawsuit is also 10 years, an individual would then have up to 15 months to serve the claim on the defendant. Hence:

- In order to cover the service period, it would be prudent to save adult records for at least 11 years and three months since the date of last service (Jennifer Janz, LLP, personal communication, February 10, 2011).

A "person under disability" is an adult who is under a legal guardianship, or lacks the mental capacity to make judgments about a claim. From a legal perspective, in order to ensure that records are not destroyed before a claim is filed and served:

- It is advisable to retain records for a "person under disability" for three years and three months after the individual's death (Jennifer Janz, LLP, personal communication, February 10, 2011).

In the case of minors, the *Hospitals Act* (1990) recommends that records be kept for at least two years past the age of majority or for 10 years, whichever is longer. From the point of view of legal protection, however, a slightly longer retention period is warranted. The limitation period for a minor to file a civil action is two years after he or she turns 18. However, after filing the lawsuit, a plaintiff has up to 15 months to serve it on the defendants. In order to ensure that records are not destroyed prior to receiving service of the claim:

- It is advisable to retain a minor's records for at least three years and three months after his/her 18th birthday (Jennifer Janz, LLP, personal communication, February 10, 2011).

Test protocols are considered to be part of the client record and, as such, should be retained according to the guidelines outlined above. 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 audiologist's responsibility to keep the protocols for the retention period noted above. Test protocols should be retained with documentation (e.g., progress notes, reports) that provides interpretation of the protocol information.

Assessment and intervention service records may be retained either in electronic format or in hard copy taking the appropriate safeguards and precautions to ensure confidentiality and security.

Client records should be retained according to these guidelines even in the event of the death of a client as the estate of the client may require information related to the care and services that were received (12).

Equipment service records should be maintained for 10 years from the date of the last entry.

3. Storage

Privacy statutes impose an obligation to take *reasonable measures* to guard against unauthorized access to information. As such, hard-copy client records should be stored in a secure location, such as a locked filing cabinet or file room.

Guidelines regarding the storage of electronic client files can be found under Section F. *Security and Confidentiality of Records, 2. Protection of Personal Information on Personal Computers, Laptops, or Other Mobile Devices.* SLPs and audiologists employed by an agency should follow the file management policies and procedures as outlined by their employer, where applicable.

Practitioners who work in private-practice settings are responsible for ensuring that professional records are dealt with in an appropriate manner upon closure or transfer of the practice. *The College of Physicians and Surgeons of Alberta* (14) has established guidelines for managing client records upon closure of a medical practice. Based on these guidelines, registered SLPs and audiologists who are in private practice are advised to consider the following in the event that they close their practice:

- Records should be transferred, as necessary, to another registered SLP or audiologist. Clients should be informed of this transfer, and should also be given the option of having their records transferred to an SLP or audiologist of their own choice.
- If the clinician is unable to provide ongoing management or storage of the client records on their own premises, they should be put into commercial storage for custody.

SLPs and audiologists who maintain custody and control of records (or those who are most responsible for records) in a speech-language pathology or audiology practice must ensure that there are plans in place for all aspects of record management and maintenance to ensure that client records are not abandoned.

4. Disposal

After the appropriate time has elapsed (see Section E.2. *Management of Records – Retention*), records should be destroyed. The security and confidentiality of records must be maintained during the disposal process. Generally accepted methods would include shredding or de-identifying personal and health information. In addition, a record of the following should be maintained:

- Name of each client;
- File number (if available);
- Last date of treatment;
- Date that the record or file was destroyed.

The log of destroyed files should be kept indefinitely (Jennifer Janz, LLP, personal communication, February 10, 2011). To help minimize any logistical problems in their maintenance, the logs may be kept as is or transferred to electronic format.

F. SECURITY AND CONFIDENTIALITY OF RECORDS

1. Privacy Legislation and Professional Obligations

SLPs and audiologists need to have access to information in order to provide professional services including assessment and intervention with clients. While clients generally understand that numerous individuals require access to their health information in order to provide quality care and treatment, clients also expect that their privacy will be respected and that their information will be treated confidentially.

Confidentiality requirements are reflected in the section of the ACSLPA *Code of Ethics* (6) which states the following:

> **Confidentiality**
> We respect the confidentiality of client information shared as necessary within the context of professional relationships.

Members:

- ensure any client information is shared only with the client's consent and in adherence with applicable legislation;
- disclose only necessary confidential information when required;
- obtain consent from the client prior to using case material, case records, or audio-visual material in research, education, or media.

Provincially, there are three key pieces of legislation that outline how information should be dealt with in Alberta. Each of these laws sets rules for how information should be collected, protected, used, and disclosed, as well as gives individuals the right to access information and to request a correction of information.

While the underlying principles outlined in all three pieces of legislation are similar, they differ in terms of the types of information to which they apply (i.e., health information, non-health information) and to which individuals/organizations they are applicable. A summary is provided below:

Health Information Act (HIA)

The *HIA* (1) governs health information by addressing protection of individually identifying health information. The *Act* addresses requirements for the collection, use, disclosure, and protection of health information. It defines individuals and organizations that it applies to as either *custodians* or *affiliates*.

Amendments to *HIA* (September 2010) have expanded the definition of health care *custodian* beyond the publicly funded health system. Custodians are, in effect, gatekeepers who must be vigilant in determining what information will be collected, shared, and with whom it will be shared, in accordance with the legislation. HIA and accompanying regulations define over 20 types of custodians, including provincial health boards (e.g., the Health Quality Council of Alberta), Alberta Health Services, nursing home operators, members of the College of Physicians and Surgeons of Alberta, members of the Alberta College of Pharmacists, licensed pharmacies, and the Minister and Department of Alberta Health and Wellness.
An *affiliate*, by contrast, is a person who:

- is an individual employed by a custodian;
- performs a service for a custodian as an appointee, volunteer or student;
- performs a service for a custodian under a contract or agency relationship with the custodian;
- is exercising the right to admit and treat patients at a hospital as defined in the *Hospitals Act;*
- is an information manager, as defined by HIA; or
- is designated under the regulations to be an affiliate.

The list of custodians has expanded to include regulated members of certain health professions and will continue to expand over time.

Personal Information Protection Act (PIPA)

The *PIPA* (2) governs personal information, including both health and non-health information, held by private-sector organizations in Alberta. *PIPA* is applicable to private businesses (including private practices that provide SLP or audiology services), non-profit organizations and professional regulatory bodies.

As registrants of ACSLPA have not yet been added to the definition of a *custodian* under *HIA*, those registrants who are in private practice continue to be subject to *PIPA*.

Freedom of Information and Protection of Privacy Act (FOIP)

The *FOIP* (3) governs public bodies including the Government of Alberta ministries, boards, agencies and commissions, school boards, post-secondary educational institutions, and municipalities. *FOIP* applies to non-health-related personal information (including administrative and financial records).

Depending on the work environment and employer, an individual registrant may be governed by more than one piece of legislation (e.g., an Alberta Health Services employee who works in the schools would be governed by both the *HIA* and *FOIP* whereas a private practitioner contracting with a school division would be governed by *PIPA* and *FOIP*).

Each piece of legislation may be accessed by visiting the Alberta Queen's Printer website at: http://www.qp.gov.ab.ca/catalogue/.

Helpful resources (15, 16, 17) that provide information on how to understand and use each piece of legislation can be found on the Office of the Information and Privacy Commissioner of Alberta website at: http://www.oipc.ab.ca/about/.

Registrants are encouraged to access these documents directly to obtain the specifics of each piece of legislation.

2. Protection of Personal Information on Personal Computers, Laptops, or Other Mobile Devices

SLPs and audiologists who store personal information regarding clients on personal computers, laptops, or other mobile devices (e.g., BlackBerrys, removable discs) must ensure that the information is protected in the event that their device is lost or stolen. Privacy statutes impose an obligation to take *reasonable measures* to guard against unauthorized access to information.

"Reasonable measures" to guard against unauthorized access to information on a personal computer would include the following:

- Password protection using complex passwords; and
- Anti-virus and anti-malware software.

In the context of storage of personal information on laptops or other mobile devices, the Information and Privacy Commissioner of Alberta has stated that encryption is required in order to meet the standard of "reasonable measures." As such, all personal information stored on these devices should be encrypted. Password protection using complex passwords is also recommended. For mobile devices such as BlackBerrys and iPods, ensure that the device is set to "auto-lock" when not in active use.

In the case of an employing organization, the obligation to implement and enforce appropriate policies rests with the employer, who would be considered the custodian/organization/head of the public body designated in the applicable privacy legislation. ACSLPA registrants employed by an organization would be expected to follow their employer's policies and make use of the technologies designated by the employer.

ACSLPA registrants who are in independent practice are responsible for familiarizing themselves with the appropriate legislation and their corresponding responsibilities (which are outlined above). The rapidly changing nature of technology necessitates maintaining currency as privacy requirements evolve.

APPENDIX A

Advisory Statement:
Using Your Protected Professional Designation the Right Way

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