

Personal Health Information Protection Act 2004

Information Practice Statement – Toronto Long-Term Care Homes and Services October 14, 2004

The City of Toronto's Long-Term Care Homes and Services Division (LTCHS) provides a broad range of health services to residents in the homes for the aged and to clients of LTCHS' community-based service programs. To meet residents' and clients' needs and provide effective care and service, LTCHS needs to collect, use and disclose personal health information. As such, LTCHS is the health information custodian, as defined in the *Personal Health Information Protection Act 2004 (PHIPA)* and is accountable for the protection of residents' and clients' personal health information.

Collection of personal health information

The purpose of collecting personal health information is to provide health services to residents and clients and to promote health, prevent disease and process payment for health-related services. In all but exceptional circumstances, LTCHS uses consent to collect, modify, use and disclose personal health information. In general, the information collected consists of:

- The resident's or client's name, address and Ontario Health Card number
- Facts about health, health care history and the health care that the resident/client has been provided
- Facts about payment for the resident's or client's health care.

Personal information is collected through face-to-face meetings with LTCHS staff, over the telephone, and through written or electronic documents. Information is collected at an initial meeting and/or through initial submission of admission applications, over time as care and service is provided and when follow-up is completed. The documentation of personal health information by LTCHS on paper and in electronic format must comply with stringent internal standards, policies and procedures related to confidentiality, the security of information and professional practice standards.

Personal health information of residents is collected in a number of ways:

- Personal Health Information is received from the Community Care Access Centre for the home to make admission decisions
- Directly from residents, as a component of the admission and ongoing assessment of health status
- From residents and other health care professionals as part of the care planning process, which identifies the goals and the interdisciplinary care team's strategies and interventions for achieving these goals

- Through ongoing documentation and communication in residents' health records
- Through administrative communication in terms of residents' health status (e.g., 24-hour report)
- Through hospital transfer notes regarding the residents' personal health status, e.g., emergency, admission to hospital or attendance at clinic (dental, eye, cardiac, etc.), specialist appointments.

Personal health information of clients of the community-based service programs (Adult Day Programs, Homemaking and Nurses Services and Supportive Housing) is collected in a number of ways:

- From physicians, families and clients as a component of the assessment process for eligibility for programs and services
- As a component of the service plan which identifies the clients' and families' requested service levels and staff interventions
- From the Community Care Access Centre, community agencies and retirement homes where the clients currently reside.

Use of personal health information

The main purpose of using personal health information is to plan, deliver and evaluate care and service for our residents and clients. It is also used to make decisions about the types of services required and to communicate with other service providers involved in that person's care. When necessary, personal health information may be used to investigate and manage potential risks for others who may be affected by a health risk.

Non-identifying information related to residents' and clients' care and service is used for administration, management, strategic planning, decision-making, research, fundraising and allocation of resources within the home to meet legal and regulatory requirements.

Disclosure of personal health information

Personal health information is disclosed to other health care workers involved in the circle of care, based on residents'/clients' implied consent, to provide the health care workers with the information they need to provide appropriate care when a resident or client is referred and care is transferred. Other than to those in the circle of care, personal health information is usually disclosed only when the resident/client gives consent. If a resident or client wishes to refuse consent to disclose information, he/she may do so by notifying the Nurse Manager or Manager of Community Programs. Personal health information will be disclosed without consent in exceptional circumstances. These situations include emergency situations in which consent is not possible and the disclosure of personal health information that is required to meet legal and regulatory requirements [e.g., mandatory reporting requirements of the Ministry of Health and Long-Term Care (MOHLTC) and Public Health, law enforcement requests]. Personal health information is sent to hospitals through Emergency Medical Services or in emergency situations, by phone and fax.

Consent for the collection, use and disclosure of personal health information

Requiring consent means that residents and clients must give specific permission for the collection, use and disclosure of personal health information. Consent is ordinarily required:

- Upon admission to the home for the aged during the signing of the admission agreement
- Upon transfer of a resident to another long-term care home or hospital
- To assess suitability and obtain information about the client's needs for community-based services programs.

When a resident is transferred to another long-term care home or hospital, the personal health information is placed in a sealed envelope marked confidential, and sent with the Emergency Medical Services personnel or family. When residents and clients give consent, they are informed of how their personal health information will be used. Residents and clients may give consent that is limited to certain uses of their personal health information. Residents and clients may also withdraw their consent for LTCHS to use their personal health information for particular purposes. Personal health information is not disclosed without consent unless the sharing of this information is required or permitted by law. In some situations, implied consent may be used by LTCHS, such as in situations in which health care is required but it is not reasonably possible to obtain consent.

Consent to disclose personal health information is also not ordinarily required:

- In situations of imminent harm and risk to the person or others directly affected
- To the Medical Officer of Health for public health protection purposes
- To the Ministry of Health and Long-Term Care (MOHLTC) for monitoring care and payments for health care funded in whole or in part by the Ministry.

Consent is not required for the disclosure of non-identifying information:

- For the purposes of research to be performed in accordance with a research plan approved by a research ethics board
- To a prescribed entity for the purpose of analysis with respect to the management of the health care system
- If the MOHLTC directs a health information custodian to disclose information to a health data institute for the purposes of analysis with respect to the management or evaluation of the health system
- For fundraising purposes.

Access to personal health information

Residents and clients have the right to request access to their personal health information, subject to the provisions of PHIPA. LTCHS policy states that individual residents/clients or the legally authorized substitute decision-maker may make a request for access to the resident's or client's personal health information. A designated LTCHS staff member will be provided, at a mutually convenient time, to explain and help the resident/client understand medical terminology and LTCHS procedures. However, access to this information may be denied, for specific reasons outlined in the legislation, including situations in which the sharing of the personal health information could reasonably be expected to harm the resident's or client's or

others' mental or physical health and safety. Residents and clients also have the right to ask the LTCHS to correct a record if it is inaccurate and to ask for and receive, with limited exceptions, a copy of their personal health record or portion thereof, as described in PHIPA. Although residents and clients have the right to see their personal health information, this right does not automatically extend to their family members and/or friends. If consent is provided to let a family member or friend see personal health information, then the family member or friend may be allowed access to the part(s) of the personal health record that the resident/client has consented to let them see. If the resident/client is unable to give consent and/or has a legally authorized substitute decision-maker, then this person may be allowed access to the personal health information, in accordance with their legal authority. This person is bound by law to act on the resident's/client's behalf and must make decisions based on their knowledge of what the resident/client would wish done if he/she were able to decide. Questions about access to or correcting personal health information can be directed to a Nurse Manager or Administrator in the home and/or the Director of Resident Services (for community based service programs). However, individuals may also make a written request for access or to correct personal health information under PHIPA, through the City of Toronto Corporate Access and Privacy (CAP) Office at (416) 392-9684.

Family and friends

Personal health information is private. Unless the law authorizes sharing it with others, LTCHS cannot and will not give out any personal health information without consent. However, it is understood that the home is the residents' home and family and friends may inquire about their well-being from time-to-time. Unless the resident objects, the following information will be provided to someone who makes an inquiry about a resident:

- Confirmation that the person is a resident and their room number
- A general statement about the resident's health status, such as "well, stable, satisfactory, fair, poor," etc.

Specific consent is required to authorize LTCHS to disclose any additional information about the resident. During an incoming telephone call, staff may not be able to verify that the person calling is who he/she says he/she is. Therefore, to protect the privacy of the resident's personal health information, only a minimal amount of information will be given over the phone.

Formal requests and complaints

The City of Toronto is committed to resolving all concerns or complaints and encourages individuals to first contact the department involved. Concerns or complaints about access or privacy practices within the home can be directed to the Administrator. For concerns or questions about access or privacy practices in community-based service programs, contact the Director of Resident Services. For general concerns or complaints about privacy practices, individuals are encouraged to contact the Director, Corporate Access and Privacy at 416-392-9684. You can also lodge a complaint regarding access or privacy practices of Toronto Long-Term Care Homes and Services directly with the Office of the Information and

Privacy Commissioner (IPC) at 416-326-3333, or through their Web site at www.ipc.on.ca.

Security

Personal health information is kept securely by LTCHS. All paper files are stored in locked files or restricted areas. All electronic records are password protected. Residents' and clients' personal health information is retained in their active health care record files, which are safely and securely stored to limit access. When the resident or client is discharged or deceased, the inactive health care record is securely stored in a locked area until it is archived. LTCHS staff do not generally transport personal health information. If staff working in the community need immediate access to personal health information to conduct a home visit, provide community-based services or attend a meeting in another office for the purpose of planning and providing authorized service, a copy of the required personal health information will be used. These copies will not be left unsupervised and will be shredded once transportation is complete. New personal health information collected through the home visit or meeting will be secured in the client's file immediately upon return to LTCHS. The personal health information removed from LTCHS for the home visit or meeting will be limited to the information required for the particular meeting.

LTCHS has policies to limit access to personal health information to the following situations:

- With the informed written consent of either the resident/client or the legally authorized substitute decision-maker
- When required by law
- Upon issuance of a subpoena
- When medical reasons require the release of information without the resident's/client's consent
- As required to provide care and service by members of the interdisciplinary care team
- To medical, therapeutic and pharmaceutical consultants, who are included in the circle of care.

The City of Toronto's network security and firewall are in place to protect unwarranted access to the server on which electronic personal health information resides. Access to the application that is used for health care records is governed by a unique user identification and password. User identifications are assigned and controlled based on the job function of the employee and their need to know. Back-up tapes from the application are stored in a safe.

Retention of personal health information

Records containing personal health information are retained according to Ministry of Health and Long-Term Care and City of Toronto policies and professional practice standards. These policies and practices will involve the transfer of the records to the City of Toronto Corporate Records and Archives. LTCHS retention policies are based, in part, on the *Homes for the Aged and Rest Homes Act*, that outlines the following retention schedule:

- Deceased resident documents are retained for seven years
- Discharged resident documents are retained for 20 years.

Deceased resident files are kept under lock in LTCHS for two years. For the remaining five years, the records are transferred to the Toronto Archives and Records Centre. Discharged resident files are managed in the same way, except they are retained in the Toronto Corporate Records Centre for 18 years. Once the records are no longer required to be retained, they are shredded as confidential material.

Privacy matters to us

The mission of Toronto Long-Term Care Homes and Services is to provide residents, clients and their families with the best possible care and service within our resources. We are committed to working to enrich our residents'/clients' lives, and to respecting, supporting and enabling personal decisions and choices. This commitment extends to protecting the privacy of personal health information.