



Information and Privacy
Commissioner/Ontario

Commissaire à l'information
et à la protection de la vie privée/Ontario

Personal Health Information Protection Act

REPORT

FILE NO. HI-050052-1/HI-050053-1/HI-050054-1

Three Community Care Access Centres



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INVESTIGATOR:

Gillian Judkins

HEALTH INFORMATION CUSTODIAN:

**Three Community Care Access
Centres**

SUMMARY OF INFORMATION GIVING RISE TO REVIEW:

A member of the public contacted the Office of the Information and Privacy Commissioner/Ontario (the IPC) to advise that he had been receiving misdirected faxes from three Community Care Access Centres (CCACs) at his private fax. The IPC opened three files, one for each CCAC, and contacted each CCAC involved to discuss the faxes. The IPC began to work with the CCACs to ensure they were fulfilling their obligations under the *Personal Health Information Protection Act* (the *Act*).

RESULTS OF REVIEW:

Directors at each of the three CCACs provided the following information.

CCAC A:

The first CCAC (CCAC A) advised the IPC that in December of 2005, they had received a referral for a client for the Victorian Order of Nurses (the VON). As CCAC A does not have a contract with this agency, they contacted the offices of CCAC B to obtain the fax number. They were later contacted by CCAC B to advise that the VON had not received the fax. Upon looking up the fax number for the VON itself, CCAC A realized that they had sent the fax to an incorrect number and immediately re-sent the fax to the correct number.

CCAC A contacted the individual who had received the fax in error. The individual advised them that they were in receipt of three misdirected faxes from three different CCACs and that he had contacted each of the CCACs and the IPC to investigate the matter. The Director of CCAC A contacted the Directors at the other two CCACs involved (*B* and *C*) to advise of the misdirected faxes. All three CCACs began an investigation into the incidents.

The Director of CCAC A advised the IPC that they had looked into their procedures for sending faxes and determined that there had been some inconsistencies in the ways in which staff had sent them out. The Director advised that they implemented a corporate fax policy and re-educated staff on privacy issues to coordinate with the roll out of the new policy. In addition, CCAC A has established a new process for maintaining current listings of fax numbers and have dedicated a section of their quarterly staff newsletter to privacy issues titled, "Privacy Corner".

In order to fulfill its obligations under section 12(2) of the *Act*, CCAC A contacted the client involved by telephone to inform them of the misdirected fax.

CCAC B:

The Director at CCAC B advised the IPC that they had been contacted by the recipient of their misdirected fax. CCAC B made arrangements to have the fax retrieved from the individual. Upon investigation, CCAC B determined that a staff member had manually input the incorrect number into the fax machine instead of using the pre-programmed fax system. The Director advised that as a result of this incident, they have re-instructed the employee regarding the use of the pre-programmed fax system. The Director advised that an e-mail was sent to all staff to remind them to use the pre-programmed numbers when sending out faxes and Privacy Breach Awareness training was delivered to all staff. In addition, all fax machines and network directories have been checked to ensure that they have programmed the correct numbers, and a policy on faxing procedures is being developed.

In order to fulfill its obligations under section 12(2) of the *Act*, CCAC B contacted the client involved by telephone to inform them of the misdirected fax.

CCAC C:

The Director at CCAC C advised the IPC that upon receiving a phone call from the recipient of the misdirected fax, they conducted a review into the matter. Upon investigation, it was determined that a staff member had manually input the incorrect fax number into the machine. The CCAC reviewed its current faxing procedures along with their contact information for all services pre-programmed into their system. Staff were re-educated about the proper faxing procedures and advised that in circumstances where manual input is necessary, numbers must be double checked before sending the fax.

In addition to sending the fax to the incorrect number, the CCAC also realized that some staff had been re-using an old fax cover sheet that contained the names of ten other clients. Staff members had been crossing off the name of the first client and adding the next client's name to

the fax sheet instead of using a new fax cover sheet. In order to prevent staff from sending faxes in this manner, a standard fax cover sheet has been developed and staff have been advised to use a separate cover sheet for each and every outgoing fax.

The Director of CCAC C further advised that they are reviewing their fax policy, training staff on relevant policies and procedures and working with the other CCACs to develop a clear and consistent policy across the organizations, and to share the lessons learned from this privacy breach.

In order to fulfill its obligations under section 12(2) of the *Act*, CCAC C contacted all affected clients by telephone to inform them of the incident.

All three CCACs will report back to the IPC within three months of issuing this report in order to advise of the status of the changes to the above-noted policies and procedures.

On the basis of all of the above, it was determined that further review of this matter was not warranted and the file was closed.

Original signed by: _____
Ann Cavoukian, Ph.D.
Commissioner

September 8, 2006 _____