Office of the
Saskatchewan Information
and Privacy Commissioner

INVESTIGATION REPORT 045-2021, 064-2021, 071-2021, 074-2021, 075-2021, 078-2021, 080-2021, 086-2021, 098-2021, 116-2021, 117-2021, 120-2021, 149-2021, 153-2021, 162-2021, 165-2021, 169-2021, 175-2021, 176-2021, 178-2021, 209-2021, 229-2021, 232-2021, 251-2021

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Summary: Over the course of 2021, the Commissioner's office received emails or calls from physicians and one non-profit organization indicating that they had received misdirected faxes containing personal health information. The Commissioner initiated investigations into each of the misdirected faxes. The Commissioner noted that while some of the misdirected faxes involved the use of the traditional fax machine, most of the misdirected faxes resulted from the use of fax features associated with electronic systems. The Commissioner explained that as technology evolves, we must guard against naiveté that eliminating the fax machine will eliminate such privacy breaches. He made recommendations to each responsible trustee regarding each misdirected fax. He also made overarching recommendations including that the Saskatchewan Health Authority (SHA) work towards eliminating the use of the traditional fax machine, that the SHA and other trustees disable the auto-suggest features in electronic systems, that trustees design electronic systems to reduce data-entry errors, that the Minister of Health amend *The Health Information Protection Act* to require trustees complete privacy impact assessments and to require trustees to report to the Commissioner's office any theft, loss, or unauthorized use or disclosure of personal health information.

I BACKGROUND

[1] This Report deals with multiple misdirected faxes reported to my office, most of which were reported by physicians. I have identified a potential conflict with some of the faxes

discussed in this Investigation Report. Therefore, I have taken no part in the investigation. I have delegated the Executive Director of Compliance to make all decisions related to these matters.

[2] In 2010, my office issued the *Report on Systemic Issues with Faxing Personal Health Information* (2010 report) that involved 60 misdirected faxes from 31 trustees. The report was primarily focused on the use of fax machines. What happened was a medical clinic's ownership had dissolved. The medical clinic's fax number was reassigned to a private business 17 months later. The private business began to receive faxes intended for physicians who had worked at the medical clinic from pharmacies, other physicians, regional health authorities and other health care organizations across Saskatchewan. In the meantime, physicians who had practiced medicine together at the clinic had formed a new clinic and was assigned a new fax number. The physicians had made efforts to advertise the change in the new fax number at the new clinic, including informing the Canadian Medical Association, College of Physicians and Surgeons of Saskatchewan (CPSS), and the Saskatchewan Medical Association of the new fax number. My office made a number of recommendations regarding the faxing of personal health information in that report.

[3] In 2014, my office issued Investigation Report H-2014-001 (2014 report) that involved 10 trustees, 20 separate files and approximately 1000 affected patients. With a couple of exceptions, this particular investigation report was focused not on fax machines, but faxing features associated with electronic systems such as the electronic medical records (EMRs) at medical clinics and the provincial electronic health record (eHR) as developed by eHealth Saskatchewan. Misdirected faxes were resulting from a number of different reasons including unverified fax numbers loaded on the Radiology Information System (RIS) and automated features of EMRs, including the 'auto-suggest' feature for searching physicians' names.

[4] Then, I issued Investigation Report 223-2017 on October 2017, Investigation Report 005-2018 on September 4, 2018 and Investigation Report 043-2018 on November 20, 2018 involving the Saskatchewan Health Authority (SHA). These investigations involved privacy breaches resulting from the use of fax machines. A private business, Kelly's

Computer Works, was receiving faxes containing personal health information from the SHA intended for Dr. N.A. Rodriguez (Dr. Rodriguez). Kelly's Computer Works estimated it had been receiving one fax intended for Dr. Rodriguez once every two weeks to a month for a period of 18 months to two years. Dr. Rodriguez's fax number was identical to that of the fax number of Kelly's Computer Works except for one digit. Therefore, these faxing errors were a result of manually inputting the incorrect fax number into a fax machine. In the course of these three investigations, the SHA had informed my office that it was working towards eliminating the faxing of personal health information. In my Investigation Report 043-2018, I had recommended that the SHA establish project timelines to eliminate the faxing of personal health information and to provide those timelines to my office within six months of the issuance of that report. Although the SHA indicated it would comply with my recommendation, the SHA never did provide my office with such timelines. The issue of faxing personal health information continues to this day.

[5] In the meantime, between November 2017 and April 2020, my office issued eight investigation reports where medical reports (such as consult reports or lab reports) were misdirected as a result of Dr. Suzanne Meiers being confused for Dr. Pamela Meiers or vice-versa. In addition, there was a case where Dr. Suzanne Meiers was confused for Dr. Courtney Meier. These misdirected faxes were a result of dictation and transcription errors or selecting of the incorrect physician within electronic systems such as the Laboratory Information System (LIS). In other words, these were misdirected faxes as a result of the use of electronic systems and not fax machines. The similarity in names, and not fax numbers, contributed to these privacy breaches.

[6] As of late 2017, custodians subject to Ontario's *Personal Health Information Protection Act*, 2004 (ON PHIPA) have been required to report health privacy breaches to Ontario's Office of the Information and Privacy Commissioner (ON IPC). According to ON IPC's 2018 Statistical Report, there were 10,253 unauthorized disclosures reported. Of that, 6,381 (or 62.24%) of the unauthorized disclosures were due to misdirected faxes. In 2019, ON IPC indicated in its 2019 Statistical Report that 7,158 of the 11,197 reported unauthorized disclosures (or 63.9%) were a result of misdirected faxes. In 2020, ON IPC indicated in its

2020 Statistical Report that 7,117 of the 12,170 reported unauthorized disclosures (or 58.5%) were a result of misdirected faxes.

[7] Saskatchewan's *The Health Information Protection Act* (HIPA) does not have the same privacy breach reporting requirements as ON PHIPA. Therefore, it is impossible to know precisely how many privacy breaches occur in Saskatchewan's health care system as a result of misdirected faxes. However, based on the history of my office's dealing with misdirected faxes, I imagine that the situation here in Saskatchewan would be similar to that of Ontario relative to our population. Health care providers need to interact and communicate with each other regarding patients. We have seen privacy breaches resulting from the use of the traditional fax machines and from the use of fax features associated with electronic systems. Therefore, the mode in which personal health information is transmitted is irrelevant. What is relevant is that we pay special care in how we are transmitting personal health information to ensure the information is sent securely to the intended recipient. In 2016, the former Information and Privacy Commissioner of Nova Scotia predicted that misdirected faxes would not be going away as we move towards more electronic systems:

> Errors in the faxing of personal health information have vexed health care systems for many years. Information and privacy commissioners across Canada have attempted to reduce these errors by conducting investigations into mis-sent faxes, making recommendations and issuing guidelines. But the errors continue. This investigation reveals that Nova Scotia is not immune to this problem. In fact, the majority of breaches reported to the Office of the Information and Privacy Commissioner by health custodians are either mis-sent faxes that are received at another custodian's office, or they are wrong names selected from a pick-list in an electronic communications tool.
> ...
> The results of this investigation are straightforward. Faxing requires careful attention to detail. The more sensitive the information, the more care is required. In this case it was momentary inattention – essentially human error by three different individuals that resulted in exactly the same error occurring. …
>
> The problem of mis-sent faxes will not go away. Whenever information is sent via email, by using a provider pick-list in a database or by faxing, the sender must take the time to ensure that the correct recipient has been selected. My expectation is that this report will prompt health custodians across Nova Scotia to revisit their faxing practices and ensure that the four best faxing practices outlined in this report become part of their everyday practice.

(Investigation Report IR16-02 at p. 1)

[8] Similar to the former Commissioner of Nova Scotia, I anticipate that the issue of misdirected faxes will not be going away. At paragraph [254] of my office's Investigation Report H-2014-001, my office noted that faxing errors will not cease once traditional fax machines are replaced with electronic systems. In fact, more sophisticated technology may multiply the number of faxes going astray:

> Our observation is that quite apart from any particular technology, privacy risks will continue to exist. Faxing may be a particularly vulnerable and high-risk-to-privacy technology but as this Investigation Report documents, more sophisticated computer technology may well eliminate or at least minimize certain risks but may also create or expand new and other risks. Auto-dialing and stored memory of contact information may mean that instead of one misdirected fax there may be hundreds all sent to the incorrect address because there was a lack of care in inputting data. Many of the misdirected faxes discussed in this Investigation Report reflect inadequacies in policy, procedure, and training. It would be a serious error to expect that inappropriate use or disclosure of personal health information will cease to be a problem for public confidence in our health care system once fax machines are displaced by more sophisticated computer equipment.

[9] The need for healthcare providers to communicate with each other regarding patients will continue. Therefore, privacy risks will continue. Section 16 of HIPA requires that trustees safeguard against reasonably anticipated privacy breaches:

> **16** Subject to the regulations, a trustee that has custody or control of personal health information must establish policies and procedures to maintain administrative, technical and physical safeguards that will:
>
> (a) protect the integrity, accuracy and confidentiality of the information;
>
> **(b) protect against any reasonably anticipated:**
>
> (i) threat or hazard to the security or integrity of the information;
>
> (ii) loss of the information; or
>
> **(iii) unauthorized access to or use, disclosure or modification of the information**; and
>
> (c) otherwise ensure compliance with this Act by its employees.

[Emphasis added]

[10] However, we must continue to work towards solutions that will curb the number of misdirected faxes to not only protect the privacy of patients, but to also ensure timely and effective patient care.

Current Cases

[11] At the beginning of 2021, my office began to receive emails or calls from physicians (and one non-profit organization) indicating they had received misdirected reports (such as lab reports) containing personal health information. Overall, 23 misdirected documents were reported to my office. In 19 of the 23 incidents, it appears as though documents were sent through electronic systems as opposed to the traditional fax machine. I have categorized these 23 cases into the following categories:

> **Category 1: Pick-list error (7 cases).** These are cases where an employee used a drop-down menu in a software program to select the intended recipient. The incorrect recipient is selected from the pick-list.
>
> **Category 2: Dictation or transcription errors (5 cases).** These are cases where reports were sent to the incorrect physician due to a physician committing a dictating or transcription error (such as the dictating physician not identifying the first name of an intended recipient).
>
> **Category 3: Reliance on a Google search for a physician's contact information (3 cases).** These are cases where employees conducted a search of physicians' names on Google. The Google search led the employees to my office's website where they erroneously mistook my office's fax number for that of the intended physicians.
>
> **Category 4: Miscommunication (3 cases).** These are cases where a miscommunication occurred between a patient and provider and the miscommunication contributed to the privacy breach. In one case, a language barrier existed between the provider and patient.
>
> **Category 5: Misdialing (1 case).** There was one case where a report containing personal health information was sent to a non-profit organization. The non-profit organization's telephone number was identical to the intended recipient's fax number except for one digit.
>
> **Category 6: Patient-driven (3 cases).** These are cases where reports (such as lab reports) were sent to a physician because the patient identified a particular physician

to be their family physician; however, the physician indicated that the patient is not their patient.

Category 7: Staff not following procedure (1 case). There was one case in which the family physician on a patient's standing requisition order had retired. Instead of having the Ordering Physician update the family physician field on the requisition as instructed by written procedure, the staff member had crossed out the retired family physician's name on the requisition and handwrote "Dr. J.S. McMillan's" name after consulting with the patient. The result was a lab report sent to Dr. J.S. McMillan even though Dr. J.S. McMillan did not recognize this patient as his patient.

[12] Although I outline root causes of each individual investigation below, overwhelmingly, the root cause of these privacy breaches has been identified as human error. Similarly, the former Information and Privacy Commissioner of Nova Scotia characterized the root cause as "momentary inattention" in Investigation Report IR16-02. Prior to the coronavirus disease of 2019 (COVID-19) pandemic, healthcare workers already contended with high volumes of work which inevitably leads to human error. The pandemic has only increased the challenges faced by healthcare workers. Human error will always exist. However, as we have witnessed, technology continues to evolve. All but four cases discussed in this Report involve fax features associated with an electronic system instead of the traditional stand-alone fax machine. Although eliminating the use of the traditional fax machine may help in reducing certain errors, we must guard against the naiveté that eliminating the fax machine will eliminate all errors. Most of the cases discussed in this Report are related to fax features associated with electronic systems. We must leverage technology as a solution to minimizing errors. Systems that rely on its users to be on their best and most alert behaviour at all times will fail. We must design systems to help its users to minimize errors and achieve the intended outcomes. In the context of this Investigation Report, the intended outcome is for faxes to be sent to the intended recipients.

[13] While I provide recommendations for the responsible trustee in each individual investigation my office undertook below, the following are overarching recommendations:

(1) The SHA should work towards eliminating the use of the traditional fax machine

My office's 2010 report outlines the disadvantages of relying on the use of the traditional fax machine, so I will not repeat the disadvantages here. However, the traditional fax machine seems to be on its way out the door in some jurisdictions. In 2018, the National Health Service (NHS) in the United Kingdom announced its plans to phase-out the use of fax machines by April 2020. Similarly, the City of Toronto announced its plan to phase out traditional telephone fax lines by the end of 2021. It is time for our province's largest trustee organization, the SHA, to put together a plan to eliminate the use of the traditional fax machine.

(2) Auto-suggest features should be disabled

In the 2014 report, my office recommended that all auto-suggest features in electronic systems be disabled. The auto-suggest feature had resulted in users selecting the incorrect physician, thus leading to personal health information being sent to the incorrect physician. This recommendation was not heeded.

The issue persists. As discussed in cases in "Category 1" in this Report, privacy breaches are resulting from users selecting physicians with the same or similar name as the intended physician.

(3) Trustees must design electronic systems that reduce data entry errors

Designing software and electronic systems to prompt healthcare workers to enter the required information can help minimize errors. For example, dictation software prompting physicians to spell the full names of intended recipients will ensure transcriptionists have complete information when transcribing physicians' reports. Further, transcription software requiring transcriptionists to enter not only the names of physicians, but their location can assist in differentiating physicians with the same or similar names.

(4) Mandatory privacy impact assessments

As technology evolves, trustees should be conducting privacy impact assessments to identify privacy risks so that trustees can design and implement solutions to mitigate such risks. I recommend that the Minister of Health amend HIPA to require that trustees undertake privacy impact assessments with respect to proposed systems, projects, programs or activities.

(5) Mandatory privacy breach reporting

Requiring trustees to report privacy breaches to my office under HIPA will not only facilitate greater transparency and accountability of how trustees manage patients' personal health information, it will enable my office to provide greater and more comprehensive oversight of trustees. I recommend that the Minister of Health amend HIPA to require trustees to notify my office of a theft, loss, or unauthorized use or disclosure of personal health information.

II DISCUSSION OF THE ISSUES

[14] Given the large number of misdirected faxes, I will analyze the common issues that my office customarily analyzes in each investigation it undertakes, including whether my office has jurisdiction to investigate.

1. Do I have jurisdiction?

a. HIPA

[15] HIPA is engaged when three elements are present: (1) personal health information, (2) a trustee, and (3) the personal health information is in the custody or control of the trustee.

(1) Personal health information

[16] First, personal health information is defined by section 2(m) of HIPA, which provides:

2 In this Act:

> ...
> (m) **"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;
>
> (iv) information that is collected:
>
> (A) in the course of providing health services to the individual; or
>
> (B) incidentally to the provision of health services to the individual; or
>
> (v) registration information;

[17] In each of the misdirected faxes, I found that there was personal health information as defined by section 2(m) of HIPA.

(2) Trustee

[18] Misdirected faxes originated from the SHA, Saskatchewan Cancer Agency (SCA), the "Saskatoon Medical Group" (Dr. Raviqubal Basi), FYidoctors (Dr. Jennifer Guy). I find that these entities each qualify as trustees pursuant to section 2(t) of HIPA as follows:

> **2** In this Act:
> ...
> (t) **"trustee"** means any of the following that have custody or control of personal health information:
> ...
>
> (ii) the provincial health authority or a health care organization;
> ...
> (xi) the Saskatchewan Cancer Foundation;
>
> (xii) a person, other than an employee of a trustee, who is:

> (A) a health professional licensed or registered pursuant to an Act for which the minister is responsible;

[19] Regarding section 2(t)(xi) of HIPA, I note that section 3 of *The Cancer Agency Act* provides:

> **3** The Saskatchewan Cancer Foundation established pursuant to *The Cancer Foundation Act*, as that Act existed before the coming into force of this Act, is continued as a corporation under the name of the Saskatchewan Cancer Agency.

[20] Therefore, the SCA qualifies as a trustee pursuant to section 2(t)(xi) of HIPA.

(3) Custody or control of the personal health information

[21] Since the faxes originated from the trustees, then I find that these trustees have custody or control over the personal health information in question.

[22] Since all three elements are present, I find that HIPA is engaged and that I have jurisdiction to investigate.

[23] I note that in some cases, LifeLabs LP (Lifelabs) and 3sHealth were involved in the misdirected faxes where the SHA was the trustee. An agreement between Lifelabs and the SHA was signed in December of 2017, provides that Lifelabs is an information management service provider (IMSP) for the SHA. An agreement was signed between 3sHealth, the former regional health authorities and Saskatchewan Cancer Agency in 2016 for 3sHEalth to provide a provincial transcription service. Lifelabs and 3sHealth qualify as an IMSPs as defined by section 2(j) of HIPA (Investigation Report 398-2019, 399-2019, 417-2019, 005-2020, 019-2020, 021-2020 at paragraph [39]; Investigation Report 137-2018 at paragraph [9]; Investigation Report 291-2018 at paragraph [9]; Investigation Report 152-2017, 219-2017 at paragraphs [10] to [12]; Investigation Report 151-2017, 208-2017, 233-2017, 235-2017 at paragraphs [12] to [14]).

b. *The Local Authority Freedom of Information and Protection of Privacy Act* (LA FOIP)

[24] In one case (071-2021, 074-2021), a misdirected fax originated from the Department of Pediatrics at the College of Medicine at the University of Saskatchewan (U of S). The U of S is not a trustee under HIPA. However, it is a local authority as defined by section 2(f)(xi) of LA FOIP (Investigation Report 308-2017, 309-2017, 310-2017 at paragraph [16])

[25] Further, I note that section 23(1) of LA FOIP defines "personal information" as follows:

> **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:
>
> ...
>
> (c) information that relates to health care that has been received by the individual or to the health history of the individual;

[26] I note that section 23(1.1) of LA FOIP provides that where a local authority is also a trustee under HIPA, "personal information" does not include information that constitutes personal health information under HIPA. Section 23(1.1) provides:

> **23**(1.1) On and after the coming into force of subsections 4(3) and (6) of *The Health Information Protection Act*, with respect to a local authority that is a trustee as defined in that Act, **"personal information"** does not include information that constitutes personal health information as defined in that Act.

[27] Since the U of S is a local authority, but not a trustee under HIPA, then the information that qualifies as "personal information" pursuant to section 23(1)(c) of LA FOIP remains as personal information. I find that LA FOIP is engaged and that I have jurisdiction to investigate.

2. If a privacy breach occurred, did the responsible trustee respond to the privacy breach appropriately?

[28] A privacy breach occurs when personal information or personal health information is collected, used and/or disclosed in a way that is not authorized by LA FOIP or HIPA.

[29] The term "disclosure" means the sharing of personal information or personal health information with a separate entity that is not a division or a branch of the local authority or trustee organization. Before disclosing personal information or personal health information, a local authority or trustee should ensure it has authority to do so under LA FOIP or HIPA.

[30] Since the circumstances surrounding each misdirected fax case is unique, in Part III of this Investigation Report, I will outline my finding in each case as to whether a privacy breach occurred or not. Of the 23 cases, I found that a privacy breach occurred in 20 of them.

[31] When I find that a privacy breach has occurred, I will determine if the responsible trustee has responded to the privacy breach appropriately. My office's resources, *Privacy Breach Guidelines for Health Trustees* (updated September 2021) and *Privacy Breach Guidelines for Government Institutions and Local Authorities* (updated September 2021) outlines four steps to be taken when a privacy breach has been discovered:

1. Contain the breach
2. Notification
3. Investigate the breach
4. Prevent future breaches

[32] Here, I will comment on the containment and the notification steps of responding to a privacy breach. In Part III of this Investigation Report, I will summarize the investigation and prevention steps of responding to a privacy breach of each misdirected fax case.

a. Containment

[33] To contain a breach is to ensure that personal information or personal health information is no longer at risk. This may involve:

- stopping the unauthorized practice
- recovering the records
- shutting down the system that was breached

• revoking access to personal information

• correcting weaknesses in physical security

(*Privacy Breach Guidelines for Health Trustees*, p. 3; *Privacy Breach Guidelines for Government Institutions and Local Authorities*, p. 4)

[34] The parties who have reported to my office that they have received misdirected faxes, including physicians who have received misdirected faxes, have confirmed with my office that they had returned, deleted or destroyed the misdirected reports.

[35] There were cases in which my office itself was the recipient of the misdirected fax (discussed in Category 3 below). In those cases, my office notified the responsible trustee of the fax.

b. Notification

[36] Notifying individuals affected by the breach should occur as soon as possible after key facts about the breach have been established. It is best to contact affected individuals directly, such as by telephone, letter or in person. However, there may be circumstances where it is not possible and an indirect method is necessary or more practical. Such situations would include where contact information is unknown or where there are a large number of affected individuals. An indirect method of notification could include a notice on a website, posted notices, media advisories, and advertisements. It is important to ensure the breach is not compounded when using indirect notification. An effective notification should include the following:

- a description of the breach (a general description of what happened)
- a detailed description of the personal information or personal health information involved (e.g. name, credit card numbers, medical records, financial information, etc.)
- a description of possible types of harm that may come to them as a result of the privacy breach
- steps taken and planned to mitigate the harm and to prevent future breaches

- if necessary, advice on actions the individual can take to further mitigate the risk of harm and protect themselves (e.g. how to contact credit reporting agencies, how to change a health services number or driver's license number, etc.)

- contact information of an individual within your organization who can answer questions and provide further information

- a notice that individuals have a right to complain to the my office (provide contact information)

- recognition of the impacts of the breach on affected individuals and, an apology

(*Privacy Breach Guidelines for Health Trustees*, p. 4; *Privacy Breach Guidelines for Government Institutions and Local Authorities*, pp. 5-6)

[37] In Part III of this Investigation Report, I will describe whether the responsible trustee notified the affected individual(s) in each case.

[38] I should note that the SHA was the responsible trustee of many of these misdirected faxes. In these investigations, I observed that it did not have a consistent practice of notifying affected individuals. In some cases, the SHA did send an effective notification directly to the affected individual. However, in other cases, it did not. My office's position has always been for trustees to provide notification to individual(s) affected by a privacy breach, unless there is a compelling reason not to do so. An example of a compelling reason not to notify affected individuals is if the notification would jeopardize a law enforcement investigation. I recommend that the SHA amend its procedures so that it notifies affected individuals of privacy breaches by default unless there is a compelling reason not to.

c. Investigate the breach

[39] Investigating the privacy breach to identify the root cause(s) is key to understanding what happened to prevent similar privacy breaches in the future. Below are some key questions to ask during a privacy breach investigation:

- When and how did your organization learn of the privacy breach?
- What occurred?

- How did the privacy breach occur?
- What is the applicable legislation and what specific sections are engaged?
- What safeguards, policies, and procedures were in place at the time of the privacy breach?
- Was the duty to protect met?
- Who are the affected individuals?

(*Privacy Breach Guidelines for Health Trustees*, p. 5; *Privacy Breach Guidelines for Government Institutions and Local Authorities*, pp. 6-7)

[40] In Part III of this Investigation Report, I will provide a summary of the investigation and the root causes identified that led to each misdirected fax.

d. Prevent future breaches

[41] Prevention is the most important part of responding to a privacy breach. A privacy breach cannot be undone, but a local authority or trustee can learn from one and improve its practices. To avoid future breaches, a local authority or trustee should formulate a prevention plan. Some changes that are needed may have revealed themselves during the investigation phase. For example, deficient policies or procedures, a weakness in the system, a lack of accountability measures or a lack of training.

[42] In Part III of this Investigation Report, I will provide a summary of the prevention plans the responsible trustees have undertaken to prevent similar privacy breaches.

III DISCUSSION OF EACH MISDIRECTED FAX

Category 1 – Pick-List Error (7 cases)

[43] These are cases where an employee, used a drop-down menu (or a pick-list) in a software program to select the intended recipient. The incorrect recipient was selected from the pick-list.

Category 1, Case #1: 080-2021 (SHA)

Summary: A patient was referred to Orthopedic Surgery with the Department of Surgery at the Royal University Hospital on April 9, 2021, by Dr. James MacMillan. Included in the referral were x-rays. The Physician Access Line and bed flow coordination service across the province were consolidated by the SHA into a single Saskatchewan System Flow Coordination Centre (SFCC) to reflect the single provincial system. The SFCC is responsible for coordinating all patient admissions and transfers. From a "pick list", SFCC selected Dr. J.S. McMillan (instead of Dr. James MacMillan) and attached Dr. J.S. McMillan's name to the patient's x-rays. As a result, a dictated and transcribed result was sent to Dr. J.S. McMillan instead of Dr. James MacMillan.

Notification of privacy breach to affected individual: Since the patient is a minor, the SHA notified the patient's parent of the privacy breach by way of a letter dated April 22, 2021.

Investigation of the root cause(s): The root cause was that the SFCC mistakenly selected Dr. J.S. McMillan in the "pick list" instead of Dr. James MacMillan.

Prevention: The SHA indicated that it is working with the SFCC to identify look-alike and sound-alike physician names. It indicated that it created a Work Standard to prevent misdirected faxes in the future. However, when my office sought a copy of the Work Standard, the SHA did not provide a copy of it.

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the SHA has taken the appropriate steps to respond to this privacy breach.

IPC Recommendations:

1	That the SHA provide my office with the Work Standard it created to prevent misdirected faxes within 30 days of the issuance of this Investigation Report.
2	That the SHA continue its efforts to identify look-alike and sound-alike physician names so staff are prompted to double-check that they have selected the correct physician name.

Category 1, Case #2: 149-2021 – SCA

Summary: A physician at the SCA unintentionally and unknowingly clicked on a data field and changed the general practitioner's (GP) name on a patient's file in SCA's electronic medical system, ARIA. The GP's name was changed from the patient's actual GP to Dr. J.S. McMillan. Therefore, the patient's lab test results were sent to Dr. J.S. McMillan instead of the patient's actual GP.

Notification to the affected individual: The patient's physician at the SCA contacted the patient by telephone to notify them of what occurred and apologized for what happened.

Investigation of the root cause(s): The SCA noted that the patient's actual GP has a last name that starts with the same letter as Dr. J.S. McMillan's name. So, when the GP unintentionally and unknowingly clicked on a data field, the data field changed to Dr. J.S. McMillan's name.

Prevention: The SCA followed up with the physician and reminded them that they need to take more care when navigating electronic patient charts. SCA noted that this incident was an isolated incident so it has not made any changes to its policies.

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the SCA has taken the appropriate steps to respond to this privacy breach.

IPC Recommendation:

3	Since misdirected faxes are a reasonably anticipated risk, that the SCA determine if it can make changes to its ARIA system so that if a user makes changes to a patient's electronic chart, a prompt will force the user to confirm the changes. I recommend that the SCA provide quarterly updates to my office until the implementation of solutions is complete.

Category 1, Case #3: 116-2021 – SHA

Summary: A patient registered for and received a test for COVID-19 at the SHA's Saskatoon Thatcher COVID-19 Test Centre. At registration, the patient identified Dr. James MacMillan as their family physician. However, staff at the SHA mistakenly selected Dr. J.S. McMillan as the patient's family physician when filling out the requisition for lab work. As a result, the lab report was sent to Dr. J.S. McMillan instead of Dr. James MacMillan.

Notification to the affected individual: The SHA did not notify the affected individual.

Investigation of the root cause(s): The SHA identified the root cause of this privacy breach to be human error as it is an "easy mistake to accidentally choose the wrong doctor from the drop down list".

Prevention: The SHA indicated that the director of the department from which the error originated have continued to reinforce accurate information entry and process to their staff and they frequently remind staff to pay attention to detail. This is in accordance with its Work Standards for entering data to electronic lab requisitions, which provides that data entered by administrative staff should be reviewed by a "tester".

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the SHA has taken some steps to respond to this privacy breach. However, additional steps are needed as noted in the recommendations below.

IPC Recommendations:

4	That the SHA notify the affected individual within 30 days of the issuance of this Investigation Report.
5	That the SHA design and implement a solution (or solutions) that reduces data entry errors. This may include signs in their systems that prompt staff to double-check the information if a physician is known to have a similar name to another physician, or a prompt that requires staff to double-check the information that is entered if the patient's location does not match that of the selected physician. I recommend that the SHA provide quarterly updates to my office until the implementation of solutions is complete.

Category 1, Case #4: 153-2021 – SHA

Summary: A patient presented at a Lifelabs located in Regina and provided the staff with a requisition that listed the patient's family physician, Dr. J.D. McHattie. The lab requisition also contained the family physician's Laboratory Information System (LIS) code. When entering data into LIS for the lab report, a Lifelabs employee used a physician drop-down name listing instead of using the LIS code to identify the physician. The Lifelabs employee mistakenly selected Dr. J.S. McMillan instead of Dr. J.D. McHattie. Therefore, the lab report was sent to Dr. J.S. McMillan.

Notification to the affected individual: The SHA notified the patient of this privacy breach by way of a letter dated June 7, 2021.

Investigation of the root causes: The SHA noted that the Lifelabs employee relied on using the physician drop-down name listing instead of using the LIS Code. This led the employee to mistakenly select Dr. J.S. McMillan instead of Dr. J.D. McHattie. The SHA also found that the employee did not verify the physician information before issuing the lab report.

Prevention: The SHA identified a relevant Job Aid entitled, "Choose the Correct Healthcare Provider". This Job Aid provided that an employee is to check on the LIS code on the requisition and ensure that it matches the physician and location before accessioning the requisition. The SHA reviewed this matter with the employee and reminded them to double-check the data entry for accuracy.

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the SHA has taken appropriate steps to respond to this privacy breach.

IPC Recommendation:

6	That the SHA explore the possibility of implementing a prompt in LIS that would require employees to double-check the accuracy of the data they have entered. I

	recommend that the SHA provide quarterly updates to my office until the implementation of a prompt is complete.

Category 1, Case #5: 165-2021 – SHA

Summary: A patient was admitted to the Saskatoon City Hospital, a facility of the SHA. A medical imaging requisition form was filled out that listed Dr. James MacMillan as the Ordering Physician. On that same day, Dr. J.S. McMillan of Regina received a medical imaging report from the Saskatoon City Hospital. The medical imaging report listed Dr. J.S. McMillan as the Ordering Physician and Dr. James MacMillan as the Family Physician.

Notification to the affected individual: The SHA did not notify the affected individual.

Investigation into the root cause(s): The SHA identified human error as the reason for the privacy breach.

Prevention: The SHA indicated that management will remind employees of the importance of accuracy and ensuring employees are paying attention to the details.

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the SHA has taken some steps to respond to this privacy breach. However, some additional steps are needed as outlined in the recommendations below.

IPC Recommendations:

7	That the SHA notify the patient of this privacy breach within 30 days of the issuance of this Investigation Report.
8	That the SHA amend its procedure, "Ordering a Medical Imaging Procedure in RIS" so that it requires employees to double-check for accuracy within 30 days of the issuance of this Investigation Report.
9	That the SHA explore the possibility of implementing prompts into the Radiology Information System (RIS) that requires employees to double-check their data entry before proceeding. I recommend that the SHA provide quarterly updates to my office until the implementation of a prompt is complete.
10	That the SHA develop a plan on how to effectively remind employees to make a practice of ensuring accuracy. This may include regular email reminders, signage where employees are reminded to double-check their data entry, and discussing the topic regularly during staff meetings, etc. I recommend that this plan is developed within 30 days of the issuance of this Investigation Report.

Category 1, Case #6: 175-2021 – SHA

Summary: Dr. Rania Ibrahim of Melville Medical Associates filled out a medical consultation request by hand. Staff at the Yorkton Regional Health Centre, a facility

of the SHA, received the medical consultation request and entered the patient's data into the RIS and mistakenly selected Dr. Rizqi Ibrahim of Southwest Medi-Centre located in Swift Current as the Ordering Provider. Once the examination was completed, the medical imaging report was faxed to Dr. Rizqi Ibrahim instead of Dr. Rania Ibrahim.

Notification: The SHA did not notify the affected individual.

Investigation into the root cause(s): The SHA identified the following factors that contributed to the privacy breach: (1) the printed name and signature of the Ordering Provider on the medical consultation request was unclear; (2) similarities between the two physicians' names, (3) the lack of a pop-up flag in RIS to prompt staff to double-check the correct physician name is selected, (4) staff did not confirm the physician's name and location with the patient, neither at registration nor at the completion of the examination, and (5) physicians and locums constantly move between locations within the province.

Prevention: The SHA indicated that its Medical Imaging Team have had preliminary discussions regarding the following: (1) creating a pop-up flag in RIS reminding clerks to confirm the provider's location, (2) crafting a document entitled *Ordering Provider Best Practice Sheet*, (3) modifying the booking form so it reasons as "Ordering Provider (please print legibly): First Name _____ Last Name _____", (4) implementing office requisitions with an electronic signature, (5) creating pre-printed requisition forms, and (6) requesting that written names be replaced with stamps or labels.

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the SHA has taken some steps to respond to this privacy breach. However, some additional steps are needed as outlined in the recommendations below.

IPC Recommendations:

11	That the SHA notify the patient of this privacy breach within 30 days of issuance of this Investigation Report.
12	That the SHA follow through with the suggested actions discussed by its Medical Imaging Team. I recommend that the SHA provide quarterly updates to my office until the suggested actions are completed.

Category 1, Case #7: 176-2021 – SHA

Summary: Multiple lab reports were sent erroneously to Dr. Rizqi Ibrahim of Southwest Medi-Centre in Swift Current by the Yorkton Hospital Regional Health Centre, a facility of the SHA. The lab reports were meant to be sent to Dr. Rania Ibrahim of Melville Medical Associates.

Notification to the affected individuals: The SHA notified the affected individuals by letter.

Investigation into the root cause(s): The SHA determined that the lab requisitions were legible and contained the correct physician address and fax number. However, the SHA noticed that Dr. Rizqi Ibrahim's LIS code was very similar to that of Dr. Rania Ibrahim's LIS code. Dr. Rizqi Ibrahim's LIS code is IBRR1 while Dr. Rania Ibrahim's LIS code is IBRR2. What occurred was that multiple staff members erroneously entered Dr. Rizqi Ibrahim's LIS code into LIS instead of Dr. Rania Ibrahim's LIS code. As a result, the lab reports were mistakenly sent to Dr. Rizqi Ibrahim.

Prevention: The SHA identified the Work Standard, "Choosing the Correct Physician", which explicitly instructs staff to look for the physician's LIS code. The SHA said that the LIS Management team reminded its staff to slow down and verify when choosing the correct LIS codes. Also, the SHA indicated that it would work to remind, "order entry health care providers to practice [two-part] verification beyond same surnames for all persons listed on the requisition." Finally, the SHA said it will work with the Quality Safety and LIS Teams to determine if changes can be made within forms so that the provider can be better identified.

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the SHA has taken appropriate steps to respond to this privacy breach.

IPC Recommendation:

13	That the SHA follow through with its prevention plans. I recommend that the SHA provide an update to my office if it has completed its prevention plans. If it has not completed the prevention plans, I recommend that the SHA provide quarterly updates to my office until the prevention plans are complete.

Category 2 – Dictation/Transcription Error (5 cases)

[44] These are cases where reports were sent to the incorrect physician due to a physician committing a dictating or transcription error (such as the dictating physician not identifying the first name of an intended recipient).

Category 2, Case #1: 045-2021 - SHA

Summary: A patient presented at the Emergency Department at the Regina General Hospital, a facility of the SHA and was seen by an attending physician. The patient was referred for surgery under Dr. Sarah Miller. A resident physician dictated an Operative/Procedure Report, including dictating the name of the

physician, but did not spell the first and last names of the physician. The report was then sent to 3sHealth as part of the shared services agreement between 3sHealth and the SHA where 3sHealth provides provincial transcription services. The transcriptionists typed Dr. Sarah Mueller's name (instead of Dr. Sarah Miller). The transcriptionist then forwarded the Operative/Procedure Report to Quality Assurance asking which physician should be selected. Quality Assurance selected Dr. Sarah Mueller to be the recipient.

Notification of privacy breach to affected individual: SHA did not notify the affected individual.

Investigation for root cause(s): Page 4 of the Saskatchewan Dictation Manual provides that dictating physicians are to spell the first and last names of physicians; however, the dictating physician did not do so. Further, Quality Assurance did not follow the "when in doubt, leave it out" standard, but had arbitrarily selected Dr. S. Mueller to be the recipient of the Operative/Procedure Report.

Prevention: The SHA is requiring all resident physicians mandatory orientation on SHA's requirements, which includes a presentation about dictation; reminders will be issued to transcriptionists and quality assurance members to never copy a physician if the dictation does not include a first and last name spelling or if the first name is not included in the identification; SHA's Academic Health Sciences Department will take steps to remind medical learners about the importance of accuracy in dictation; and SHA's Health Information and Privacy area will work with Practitioner Staff Affairs to establish a program advisement to the area department leads when physicians make dictation errors so that they can make appropriate corrections.

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the SHA has taken some steps to respond to this privacy breach. However, some additional steps are needed as outlined in the recommendations below.

IPC Recommendations:

14	That the SHA follow through with its prevention plans. I recommend that the SHA provide an update to my office if it has completed its prevention plans. If it has not completed the prevention plans, I recommend that the SHA provide quarterly updates to my office until the prevention plans are complete.
15	That the SHA notify the affected individual within 30 days of the issuance of this Investigation Report.
16	If the SHA has not already done so, speak directly to the resident physician, transcriptionist and Quality Assurance member involved in this case about the errors made so they can learn from their errors within 30 days of the issuance of this Investigation Report. If it has already done so, I recommend that the SHA let my office know.

Category 2, Case #2: 071-2021, 074-2021 – SHA and U of S

Summary: A physician at Rosthern Medical Clinic referred a patient to the Department of Pediatrics at the College of Medicine at the U of S. After the patient had a telephone consultation with Dr. R. Huntsman of the Department of Pediatrics, a clerical assistant (a U of S employee) transcribed the report and then mistakenly faxed the report to Dr. J.S. McMillan of Regina instead of Dr. J.A. MacMillan (who was a part of the Rosthern Medical Clinic).

Notification of privacy breach to affected individual: Dr. R. Hunstman at the Department of Pediatrics contacted the patient's parent on May 3, 2021, to notify them of the error.

Investigation for root cause(s): The U of S noted that the following could have contributed to the privacy breach: (1) the dictation may have had incomplete information such as lacking the first name, location or spelling of last name of the intended recipient, (2) searching for the name of the intended recipient in the EMR may not have returned similar results (for example, search for "McMillan" would not return the same results as searching for "MacMillan"), (3) the providers list in the EMR is kept up-to-date by all users so the level of details varies (such as entering the full name versus entering initials), (4) the lack of attention to the search results or the recipient's address (for example, Dr. J.S. McMillan is located in Regina and it was unlikely that the patient would have been seeing a physician in Regina), and (5) the challenge of working from home during the pandemic may have increased pressure on staff and could have led to lapse in attention and judgement.

Prevention: The U of S indicated that Dr. R. Huntsman's office implemented a new practice of obtaining a patient's family/referring physician's name and contact information from the patient directly at registration so that the office knows where to send report/discharge summaries. The U of S also noted additional actions that can be taken, including (1) requiring one person from the Department of Pediatrics to maintain the providers list in the electronic medical record (EMR), (2) that the SHA provide increased training and support for the electronic medical record since ownership/management of the EMR is being transitioned from the College of Medicine to the SHA, (3) contact the EMR provider to determine if similar names could be flagged, (4) dictating physicians should include more identifying information of intended recipients, including full name, initials, and spellings of names and location (if possible), and (5) clerical assistants should verify the correct provider is selected when using the providers list in the EMR.

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the U of S has taken appropriate steps to respond to this privacy breach.

IPC Recommendations:

17	That the U of S and the SHA follow through with the additional actions identified by the U of S. I recommend that the U of S and the SHA provide an update to my office if they have completed these actions. If they have not completed these actions, I recommend that the U of S and the SHA provide quarterly updates to my office until the actions are complete.
18	That the SHA ensure physicians and clerical assistants at the Department of Pediatrics are trained on work standards and procedures for dictation and transcription. The training should occur during onboarding of new physicians and clerical assistants and re-occur annually. I recommend that the SHA provide update to my office if it has completed such training. If it has not completed such training, I recommend that the SHA provide quarterly updates until it has done so.
19	Since physicians and clerical assistants are faculty members and U of S employees, then the U of S should support the SHA in the delivery of dictation and transcription training.

Category 2, Case #3: 075-2021 – Dr. Raviqubal Basi

Summary: A patient was seen by physicians from the "Saskatoon Medical Group" (which is also known as the "21st Street Medical Group). The actual legal entity name of this organization is "Matching Priory Holdings Inc." Matching Priory Holdings Inc. is owned by Plumstead Episcopi Holdings Inc., of which Dr. Raviqubal Basi is a shareholder. A report was dictated and then transcribed. However, an error occurred during the transcription when the transcriptionist misheard the dictated name of the intended recipient. As a result, the report was mistakenly sent to Dr. J.S. McMillan. In the course of the investigation, the Commissioner found that Dr. Raviqubal Basi was the trustee with custody or control of the personal health information at issue.

Notification of the affected individual: A physician from Dr. Basi's office who was involved in the patient's care contacted the patient directly by telephone on May 14, 2021.

Investigation of root cause(s): The root cause of the privacy breach was that the transcriptionist misheard the dictated name of the intended recipient.

Prevention: Dr. Basi is working with the Saskatchewan Medical Association (SMA) about templates that would assist in setting up privacy policies and procedures. He is also looking at SMA agreement templates regarding confidentiality, the acceptable use of the EMR, exit agreements (regarding the EMR), and information management service agreements.

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that Dr. Basi has taken appropriate steps to respond to this privacy breach.

IPC Recommendations:

20	That Dr. Basi ensure that physicians within his office are dictating first and last names and the spellings of names of intended recipients of reports. I recommend that Dr. Basi advise my office when he has completed this action.
21	That Dr. Basi explore if there is any capability with his dictation/transcription software as well as his EMR to flag the names of physicians with similar names. This is so that other physicians at his office as well as staff can be cautioned to double-check they have the correct physician(s) when sending reports. I recommend that Dr. Basi provide quarterly updates to my office until this action is completed.
22	That Dr. Basi continue with his efforts to continue to work towards establishing privacy policies and procedures, as well as establishing agreements between himself, the other physicians and his staff. I recommend that Dr. Basi provide quarterly updates to my office until this action is completed.
23	That Dr. Basi ensure that the license and services agreement with QHR Technologies Inc. is amended, so that it specifies that it is Dr. Basi that has custody and/or control of the personal health information, not "21st Street Medical Group". I recommend that Dr. Basi provide quarterly updates to my office until this action is completed.

Category 2, Case #4: 162-2021 – SHA

Summary: A physician at the Kindersley and District Health Centre, a facility of the SHA, dictated an Operative/Procedure report. The physician indicated that "Dr. S. Mueller" was to be copied on the report. The report was then forwarded to 3sHealth for transcription. 3sHealth provides transcription services on behalf of the SHA (Investigation Report 151-2017, 208-2017, 233-2017, 235-2017 at paragraphs [1] and [12]). The transcriptionist mistakenly selected Dr. Sarah Miller to be copied instead of Dr. S. Mueller. Therefore, the report was sent to Dr. S. Miller instead of Dr. S. Mueller.

Notification of the affected individual: The SHA did not notify the affected individual.

Investigation into the root cause(s): The transcriptionist selected the incorrect physician from a "pick list" and did not take steps to verify the information. The SHA indicated that 3sHealth has been providing provincial transcription services since 2017 (Investigation Report 151-2017, 208-2017, 233-2017, 235-2017 at paragraphs [1] and [12]). It explained, "[b]ecause of the support to the entire Authority as a whole, duplication of physician contact information such as first and last names, including look alike [and] sound alikes are common."

Prevention: The SHA indicated that "triggers" have been put into place to alert the transcription team of physicians with look-alike and sound-alike names.

IPC Findings: I find that (1) a privacy breach has occurred, (2) that the SHA has taken some steps to respond to this privacy breach. However, some additional steps are needed as outlined in the recommendations below.

IPC Recommendations:

24	That the SHA notify the affected individual within 30 days of issuance of this Investigation Report.
25	That the SHA require that additional information be used to identify physicians when they are to be sent (or copied) a report, including location and/or address of the physician. I recommend that the SHA provide quarterly updates to my office until this action is completed.
26	If it has not already been done, that the SHA and 3sHealth approach the transcriptionist and any Quality Assurance employee involved to ensure they understand the errors that occurred so they can have an opportunity to learn from this mistake. I recommend that the SHA and 3sHealth provide an update to my office if it has completed such training. If it has not completed such training, I recommend that the SHA and 3sHealth provide quarterly updates until it has done so.

Category 2, Case #5: 169-2021 - SHA

Summary: On July 6, 2021, a patient was seen at the Emergency Department at the Regina General Hospital, a facility of the SHA. On the same day, a resident physician dictated a consult report. The resident physician mistakenly selected Dr. J.S. McMillan to be one of the four recipients of the consult report. The report was then transcribed by 3sHealth and then sent to the four recipients, including Dr. J.S. McMillan. 3sHealth provides transcription services on behalf of the SHA (Investigation Report 151-2017, 208-2017, 233-2017, 235-2017 at paragraphs [1] and [12]).

Notification of the affected individual: The SHA did not notify the affected individual (or next of kin) of the privacy breach.

Investigation of the root cause(s): The SHA and 3sHealth followed up with the resident physician. The resident physician indicated they don't recall why they selected Dr. J.S. McMillan to be a recipient. The resident physician suggested that perhaps they saw the patient's name associated with the Dr. J.S. McMillan in another computer system, Sunrise Clinical Manager (SCM) and therefore, selected Dr. J.S. McMillan to be a recipient.

The SHA noted that the patient's actual family physician was one of the four recipients of the consult report. Therefore, it did not replace the "copy" that was sent to Dr. J.S. McMillan.

Prevention: Even though the SHA and 3sHealth could not definitively determine why the resident physician selected Dr. J.S. McMillan on the consult report, they noted that Dr. J.S. McMillan is often confused for Dr. James MacMillan. Therefore,

3sHealth set an alert in its dictation program to flag the similarities in the names to hopefully prevent confusion.

IPC Findings: I find that (1) a privacy breach has occurred, (2) that the SHA has taken some steps to respond to this privacy breach. However, additional steps are needed as outlined in the recommendations below.

IPC Recommendations:

27	If it has not already done so, that the SHA ensure that the resident physician is dictating reports in accordance with the Dictation Manual. I recommend that the SHA let my office know it has completed this action within 30 days of the issuance of this Investigation Report.

Category 3 – Reliance on a Google search for a physician's contact information (3 cases)

[45] These are cases where employees conducted a search of physicians' names on Google. The Google search led the employees to my office's website where they erroneously mistook my office's fax number for that of the physicians'.

Category 3, Case #1: 229-2021 – SHA

Summary: A Speech Language Pathologist of the Acquired Brain Injury (ABI) Unit at the Wascana Rehabilitation Center, a facility of the SHA, intended to send an intake report to a physician, Dr. Mark Cameron. The Speech Language Pathologist conducted a search on Google to look for Dr. Mark Cameron's phone number. The search results led the Speech Pathologist to my office's website since my office had published a report involving Dr. Mark Cameron. The footer of my office's website contains my office's fax number.

The Speech Language Pathologist mistook my office's website for Dr. Mark Cameron's website and faxed the intake report to my office instead of to Dr. Mark Cameron. On September 14, 2021, my office received a four-page fax from the SHA.

Notification to the affected individual: The SHA notified the affected individual of the privacy breach by way of a letter dated September 17, 2021.

Investigation into the root cause(s): The SHA identified that the root cause was the lack of reliance on the CPSS Physician Listing for the physician's contact information.

Prevention: The SHA has done the following to prevent similar privacy breaches: (1) advised the ABI Unit at the Wascana Rehabilitation Centre of CPSS' Physician Listing and to use it to locate physician contact information, (2) the SHA has addressed the error with the Speech Language Pathologist, (3) staff at the ABI Unit were instructed to use CPSS' Physician Listing during a team huddle in September of 2021, and (4) all faxing will be completed by the Office Assistant within the ABI Unit.

IPC Findings: I find that (1) a privacy breach has occurred, (2) that the SHA has taken appropriate steps to respond to this privacy breach.

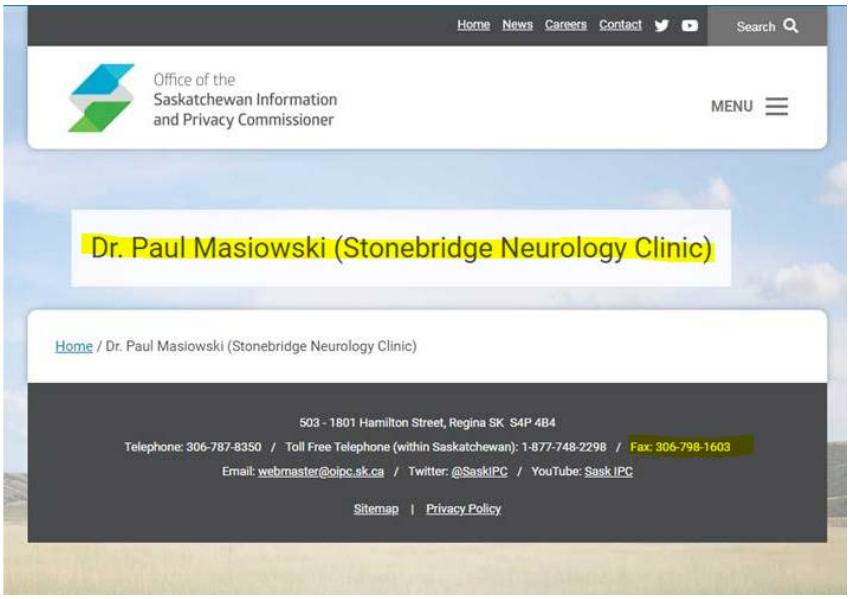
IPC Recommendations:

28	That the SHA take proactive measures to ensure that its employees across the province are relying on the CPSS' Physician Listing as its source of physicians' contact information and that they are cautioned against relying on searching on the Internet for such information. I recommend that the SHA provide quarterly updates to my office until it has completed this action.

29	Since the CPSS' Physician Listing is updated on a monthly basis, that the SHA ensure that all areas of the health authority are updating its telephone/fax address books regularly (at least on a quarterly basis) to ensure accuracy of contact information. I recommend that the SHA provide quarterly updates to my office until it has implemented a strategy to update telephone/fax address books regularly.

Category 3, Case #2: 251-2021 – SHA

Summary: A Speech Language Pathologist at the Therapies Department at Victoria Hospital in Prince Albert (a facility of the SHA) intended to send a fax to Dr. Paul Masiowski at the Stonebridge Neurology Clinic in Saskatoon. A staff member conducted a search on Google to look for Dr. Paul Masiowski's fax number. The search results led the staff member to my office's website since my office had published a report involving Dr. Paul Masiowski.



The footer of my office's website contains my office's fax number. The staff member mistook my office's website fax number for Dr. Paul Masiowski's fax number and faxed a report to my office instead of to Dr. Paul Masiowski. On October 13, 2021, my office received the two-page fax from the SHA.

Notification to the affected individual: The SHA notified by the affected individual by telephone on November 8, 2021, and by way of a letter dated November 9, 2021.

Investigation in to the root cause(s): The SHA noted that a root cause was the lack of relying on "credible sources" such as CPSS' website to search for the most current fax number. It also noted that the staff member did not follow its policy entitled, "Privacy: Faxing of Personal information". I note that this fax policy is very comprehensive and includes instructions on using pre-programmed numbers,

the use of fax cover sheets, and what to do if a fax is misdirected. Specific to this case, the policy provided that "reasonable measures should be taken to verify the identity of the requestor and the appropriateness of sending the fax to that number" and "when faxing personal information, the fax number must be confirmed for accuracy and double checked after entering, prior to sending".

Prevention: The SHA reminded staff within the Therapies Department of the faxing policy and instructed its staff to review the policy.

IPC Findings: I find that (1) a privacy breach has occurred, (2) that the SHA has taken some steps to respond to this privacy breach. However, some additional steps are needed as outlined in the recommendations below.

IPC Recommendations:

30	That the SHA take proactive measures to ensure that its employees across the province are relying on the CPSS' Physician Listing as its source of physicians' contact information and that they are cautioned against relying on searching on the Internet for such information. I recommend that the SHA provide quarterly updates to my office until it has implemented a strategy to complete this action.
31	Since the CPSS' Physician Listing is updated on monthly basis, that the SHA ensures that all areas of the health authority are updating its telephone/fax and address books regularly (at least on a quarterly basis) to ensure accuracy of contact information. I recommend that the SHA provide quarterly updates to my office until it has implemented a strategy to update telephone/fax address books regularly.

Category 3, Case #3: 232-2021 - SHA

Summary: On July 13, 2021, my office received a two-page fax from the SHA. The fax cover sheet indicated that a nurse from Inpatient Mental Health Services at the Regina General Hospital intended to send the fax to a physician, Dr. N. Adams.

Notification to the affected individual: The SHA notified the affected individual of the privacy breach by way of a letter dated September 13, 2021.

Investigation into the root cause(s): In this case, the SHA indicated it was not able to determine from where the fax number was drawn. However, when I consider that the fax was meant for Dr. N. Adams, I note that Dr. N. Adams was involved in the same investigation report by my office involving Dr. Mark Adams. Therefore, it is plausible that a Google search was completed in an effort to search for Dr. N. Adams' fax number, which may have led to confusing my office's website for Dr. N. Adams'.

Prevention: The SHA indicated it has done the following: (1) conducted an audit of all facsimile numbers for both community pharmacies and physician

offices/clinics. Facsimile cover sheets have been updated for accuracy, (2) during a huddle, employees at Inpatient Mental Health Services at the Regina General Hospital were reminded of the importance of verifying contact information prior to sending, (3) updated its Work Standard entitled, "Faxing Depot/Clozapine Clinic" so that Program Nurses are to verify fax information to be accurate. Then, the Unit Clerk will then check the fax information for accuracy and then send the fax. Audits of fax recipients will be conducted on a quarterly basis to ensure accuracy, (4) employees sending facsimiles are to double-check facsimile information prior to sending the information to administrative staff. Administrative staff are to double-check for accuracy prior to sending.

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the SHA has taken some steps to respond to this privacy breach. However, some additional steps are needed as outlined in the recommendations below.

IPC Recommendations:

32	That the SHA take proactive measures to ensure that its employees across the province are relying on the CPSS' Physician Listing as its source of physicians' contact information and that they are cautioned against relying on searching on the Internet for such information. I recommend that the SHA provide quarterly updates to my office until it has implemented a strategy to complete this action.
33	Since the CPSS' Physician Listing is updated on a monthly basis, that the SHA ensures that all areas of the health authority are updating its telephone/fax and address books regularly (at least on a quarterly basis) to ensure accuracy of contact information. I recommend that the SHA provide quarterly updates to my office until it has implemented a strategy to update telephone/fax address books regularly.

Category 4 – Miscommunication (3 cases)

[46] There are two cases where a miscommunication occurred between a patient and provider and the miscommunication contributed to the privacy breach. In one case, a language barrier existed between the provider and patient.

Category 4, Case #1: 086-2021 – SHA

Summary: A Discharge Summary/Transfer Report containing the personal health information of a newborn was disclosed by the Regina General Hospital, a facility of the SHA, to Dr. J.S. McMillan. Dr. J.S. McMillan reported the matter to my office as he had no knowledge of the patient or family. The SHA indicated that Dr. J.S. McMillan was the family physician for the birth mother and that the Discharge/Summary Transfer Report was disclosed pursuant to section 27(2)(b) of

HIPA. The SHA explained that through conversations between the birth mother, a nurse, the attending physician, and representatives from the Ministry of Social Services, Dr. J.S. McMillan was identified as the birth mother's family physician. This was documented in the following four documents: 1) Physician's Orders dated April 12, 2021, 2) Newborn Discharge Care Plan dated April 12, 2021, 3) Discharge Care Plan dated April 12, 2021, and 4) NICU Newborn Referral dated April 12, 2021. As a result, a Discharge Summary/Transfer Report about the patient (the newborn) was sent to Dr. J.S. McMillan. The SHA explained Dr. J.S. McMillan was named as the family physician of the patient, "to create a continuation of care and treatment and was deemed to consent (as a newborn child) via the Social Worker and the birth mother's verbal inclusion at HIPA clause 27(2)(b)". Based on a review of what was provided to my office, it appears that the patient's information was disclosed by the SHA pursuant to section 27(2)(b) of HIPA. However, there is no indication on the fax sent to Dr. J.S. McMillan that would have informed Dr. J.S. McMillan of the reason why he was receiving the Discharge Summary/Transfer Report. There was no information on the fax that would have enabled him to link the patient to the birth mother. Therefore, Dr. J.S. McMillan would not have been able to conclude that he had a need-to-know the personal health information contained within the Discharge Summary/Transfer Report.

IPC Finding: I find there was authority for the disclosure of personal health information. Therefore, I find no privacy breach occurred.

IPC Recommendation:

34	That SHA review its processes to determine a method of communicating clearly to physicians outside of the SHA the reason why personal health information is being disclosed. I recommend that the SHA provide quarterly updates until it has implemented a method.

Category 4, Case #2: 078-2021 - SHA

Summary: In April 2021, an individual contacted the SHA's HealthLine 811 in order to get a referral to be tested for coronavirus disease of 2019 (COVID-19). During the call, with the nurse, the individual indicated that he was "moving physicians" and declined to name the family physician. The nurse created the referral to the SHA's Melfort COVID-19 drive-thru test site. The referral was then routed to the assigned test site. The registration staff booked the individual for an appointment for April 5, 2021. Staff at the test site must complete e-requisitions for the Roy Romanow Provincial Laboratory (RRPL), which includes fields for family physician information (name, city and fax number). At the test site, staff sought information from the patient, which resulted in the patient's molecular diagnostic result being sent to Dr. J.S. McMillan. Dr. J.S. McMillan reported to my office that the patient was not his patient.

Notification to the affected individual: The SHA notified the patient of this privacy breach by way of a letter dated May 17, 2021.

Investigation into the root cause(s): At the test-site, staff must manually enter family physician names on the e-requisition form (there is no drop-down menu or pick-list). Staff may rely on a paper version of CPSS' Physician Directory to locate the physician's contact information. The SHA reported that the error that occurred at the test site that led to the privacy breach could have been one of two things:

- At the test site, the patient may have provided accurate information about a family physician they have seen, but the test-site employee may have searched and manually entered the incorrect family physician's name.

- At the test site, the patient may have provided incomplete or unclear information regarding a family physician they have seen. Then, the test-site employee would have had inaccurate or incomplete information when completing the e-requisition.

Prevention: The SHA has requested that the site manager review Work Standards and protocols regarding COVID-19 testing sites, including the Work Standard entitled, "Booking and Registration of COVID-19 Potential Swabbing Patients – Melfort Hospital".

IPC Findings: I find that (1) a privacy breach has occurred, (2) that the SHA has taken appropriate steps to respond to this privacy breach.

IPC Recommendation:

35	That the SHA require patients to provide information beyond a physician's name to identify physicians. This could include location (such as a city or name of clinic) and/or address of the physician. I recommend that the SHA provide quarterly updates to my office until it has implemented such a requirement.

Category 4, Case #3: 098-2021 – SHA

Summary: A patient was admitted to the Early Pregnancy Assessment Clinic at the Regina General Hospital, a facility of the SHA. During registration, the patient identified that Dr. Sneha Prabha Talukdar as her family physician. Then, during the in-patient consultation, the attending physician asked the patient about her medical history including her current physician. The attending physician understood the patient to have identified "Dr. McMillan". Therefore, a carbon copy of the consult report was sent to Dr. J.S. McMillan. The attending physician indicated that a language barrier existed between them and the patient.

Notification of the affected individual: The SHA has not notified the affected individual of this privacy breach.

Investigation into the root cause(s): The SHA identified the language barrier as the root cause.

Prevention: The SHA's Privacy Office in Regina drafted a Work Standard entitled, "CanTalk Translation Services for Providers". A copy of the Work Standard and supporting documentation has been provided to the Regina-specific Practitioner Staff Affairs, Clinical Standards and Academic Health Services for distribution among its members. Further, the SHA indicated that it is in the preliminary stages of implementing a provincial Language Services program for the entire SHA. Education supports will be issued to all providers, unit clerks and medical office assistants for use in the SHA care sites. Once the provincial Language Services program has been implemented, the CanTalk Live Language Services will be wound down.

IPC Findings: I find that (1) a privacy breach has occurred, (2) that the SHA has taken some steps to respond to this privacy breach. However, some additional steps are needed as outlined in the recommendations below.

IPC Recommendation:

36	That the SHA notify the affected individual of the privacy breach within 30 days of issuance of this Investigation Report. The notification should inform the patient of CanTalk as well as the provincial Language Services program at the SHA to empower her to prompt physicians to use such translation services in the future to overcome the language barrier.

Category 5 – Misdialing (1 case)

[47] This is a case where a report containing personal health information was sent to a non-profit organization. The non-profit organization's telephone number was identical to the intended recipient's fax number except for one digit.

Category 5, Case #1: 209-2021 – SHA

Summary: A non-profit organization received a two-page fax containing a patient's personal health information from the Regina General Hospital, a facility of the SHA. The fax was intended to be sent to Dr. Shawki A. Souf (Dr. Souf). Dr. Souf's fax number is identical to that of the non-profit's telephone number except for one digit. The non-profit's voicemail is software based. Therefore, if it receives a fax, the fax will be sent to the non-profit via email. The non-profit organization returned a physical copy of the fax to the Regina General Hospital and confirmed with my office that it had deleted the fax from its voicemail and computer.

Notification to the affected individual: The SHA notified the affected individual by way of letter dated September 3, 2021.

Investigation of the root cause(s): The SHA noted that the privacy breach occurred due to "human error". The employee manually entered the fax number instead of relying on the pre-programmed fax numbers. The employee failed to verify the fax number that was keyed-in prior to sending the fax.

Prevention: The SHA indicated that "education and reinforcement of preprogramed [sic] fax numbers has been reviewed with the department."

IPC Findings: I find that (1) a privacy breach has occurred, and (2) that the SHA has taken appropriate steps to respond to this privacy breach.

IPC Recommendation:

37	That the SHA eliminate the use of fax machines. I recommend that the SHA provide quarterly updates to my office until it has eliminated the use of fax machines.

Category 6 – Patient-driven (3 cases)

[48] These are cases where reports (such as lab reports) were sent to a physician because the patient identified a particular physician to be their family physician; however, the physician indicated that the patient is not their patient.

Category 6, Case #1: 064-2021 – SHA

Summary: A patient presented at the Emergency Department at the Regina General Hospital, a SHA facility, and was seen by an attending physician. The patient identified Dr. J.S. McMillan as their family physician. As a result, a medical imaging report was sent to Dr. J.S. McMillan. Dr. J.S. McMillan determined that he was not the family physician for this patient.

IPC Finding: Since the patient authorized the disclosure of their personal health information to Dr. J.S. McMillan, then there was authority pursuant to section 27(1) of HIPA for the disclosure. I find no privacy breach occurred.

IPC Recommendation:

38	Take no further action.

Category 6, Case #2: 120-2021 – SHA

Summary: At the registration desk at the Regina General Hospital, a SHA facility, a patient identified Dr. J.S. McMillan as their family physician. As a result, a copy of a medical imaging report was sent to Dr. J.S. McMillan. Dr. J.S. McMillan determined that he was not the family physician for this patient.

IPC Finding: Since the patient authorized the disclosure of their personal health information to Dr. J.S. McMillan, then there was authority pursuant to section 27(1) of HIPA for the disclosure.

IPC Recommendation:

39	Take no further action.

Category 6, Case #3: 178-2021 – Dr. Jennifer Guy

Summary: An agreement between FYI Eye Care Services and Products Inc. and Dr. Jennifer Guy provides that Dr. Jennifer Guy has custody or control over the personal health information at a FYidoctors location in Saskatoon. A referral letter signed by Dr. Jennifer Guy of FYidoctors meant for Dr. James MacMillan was sent to Dr. John McMillan instead. The patient was certain that their family physician's name was "John McMillan" even though no such physician is located in Rosthern. Dr. J.S. (John) McMillan indicated that the patient is not his patient.

Notification to the affected individual: The patient was notified by telephone. Even during the telephone call, the patient indicated that their physician's name is "John McMillan".

Investigation of the root cause(s): The patient mistakenly provided the incorrect name for their family physician. Staff did not seek clarification about location/clinic name of the family physician.

Prevention: Dr. Jennifer Guy has implemented another step so that staff seek not only the name of their family physician, but also the address and/or medical clinic information.

IPC Finding: I find that (1) a privacy breach has occurred, and (2) that Dr. Jennifer Guy has taken appropriate steps to respond to this privacy breach.

IPC Recommendation:

40	Take no further action.

Category 7 – Staff not following procedure (1 case)

[49] This is one case in which the family physician on a patient's standing requisition order had retired. Instead of having the Ordering Physician update the family physician field on the

requisition as required by SHA's written procedure, the staff member at Lifelabs had crossed out the retired family physician's name on the requisition and handwrote "Dr. J. McMillan" after consulting with the patient. The result was a lab report was sent to Dr. J.S. McMillan even though Dr. J.S. McMillan did not recognize this patient as his patient.

Category 7, Case #1: 117-2021 – SHA

Summary: A patient had a standing requisition order that listed the patient's family physician. However, the standing order expired. The ordering physician issued a new standing order; however, the family physician listed on the order had retired in the meantime. The patient indicated to staff at Lifelabs that Dr. J.S. McMillan was their family physician. Therefore, staff crossed out the retired family physician and handwrote Dr. J.S. McMillan on the order as the patient's family physician. Dr. J.S. McMillan received a lab report for the physician. Dr. J.S. McMillan determined that he was not the family physician for this particular patient. In this case, I find that no privacy breach has occurred, because the patient had consented to the release of their personal health information to Dr. J.S. McMillan.

Prevention: Even though no privacy breach occurred, the SHA noted that the procedure for amending the recipient of a lab was not followed. Staff at Lifelabs should not have crossed out the family physician's name and handwritten Dr. J.S. McMillan's name on the order. According to step 7 of a Job Aid entitled, "Choosing the Correct Healthcare Provider", if it is unclear as to which physician needs to be copied, staff at Lifelabs are to put in the canned message, "Unable to forward to 'Copy to doctor' due to insufficient information provided on the requisition. PLEASE FORWARD COPY OF THIS REPORT FROM YOUR CLINIC" and then insert as much information as the staff can about the 'copy to' physician. Therefore, Lifelabs followed up with the particular staff member about this matter to ensure they were clear on the process to be followed. It also sent a memo to its staff on May 27, 2021, reminding staff of the work standard and that patients cannot request to whom a report is copied – only an ordering physician can request a "copy-to".

IPC Finding: Since the patient authorized the disclosure of their personal health information to Dr. J.S. McMillan, then there was authority pursuant to section 27(1) of HIPA for the disclosure.

IPC Recommendation:

41	That the SHA take no further action.

IV FINDINGS

[50] My findings are listed above under each investigation.

V RECOMMENDATIONS

[51] I recommend that the SHA work towards eliminating the use of the traditional fax machine.

[52] I recommend that all trustees, including the SHA, disable the auto-suggest feature in their electronic systems including RIS, LIS, and EMRs.

[53] I recommend that the Minister of Health amend HIPA, so that trustees must complete privacy impact assessments with respect to proposed systems, projects, programs or activities.

[54] I recommend that the Minister of Health amend HIPA, so that trustees must notify my office of theft, loss, or unauthorized use or disclosure of personal health information.

[55] I recommend that the SHA amend its procedures so that it notifies affected individuals of privacy breaches by default unless there is a compelling reason not to.

[56] I recommend that the responsible trustees for each investigation file complies with the recommendations below within the deadline specified or if there is no deadline stated, provide my office with quarterly updates until all are addressed:

Category 1 – Pick list Error	
Category 1, Case #1: 080-2021 (SHA)	
1	That the SHA provide my office with the Work Standard it created to prevent misdirected faxes within 30 days of the issuance of this Investigation Report.
2	That the SHA continue its efforts to identify look-alike and sound-alike physician names, so staff are prompted to double-check that they have selected the correct physician name.
Category 1, Case #2: 149-2021 – SCA	
3	Since misdirected faxes are a reasonably anticipated risk, that the SCA determine if it can make changes to its ARIA system so that if a user makes changes to a patient's electronic chart, a prompt will force the user to confirm the changes. I recommend that the SCA provide quarterly updates to my office until the implementation of solutions is complete.
Category 1, Case #3: 116-2021 – SHA	

4	That the SHA notify the affected individual within 30 days of the issuance of this Investigation Report.
5	That the SHA design and implement a solution (or solutions) that reduces data entry errors. This may include signs in their systems that prompt staff to double-check the information if a physician is known to have a similar name to another physician, or a prompt that requires staff to double-check the information that is entered if the patient's location does not match that of the selected physician. I recommend that the SHA provide quarterly updates to my office until the implementation of solutions is complete.
Category 1, Case #4: 153-2021 – SHA	
6	That the SHA explore the possibility of implementing a prompt in LIS that would require employees to double-check the accuracy of the data they have entered. I recommend that the SHA provide quarterly updates to my office until the implementation of a prompt is complete.
Category 1, Case #5: 165-2021 – SHA	
7	That the SHA notify the patient of this privacy breach within 30 days of the issuance of this Investigation Report.
8	That the SHA amend its procedure "Ordering a Medical Imaging Procedure in RIS" so that it requires employees to double-check for accuracy within 30 days of the issuance of this Investigation Report.
9	That the SHA explore the possibility of implementing prompts into the Radiology Imaging System (RIS) that requires employees to double-check their data entry before proceeding. I recommend that the SHA provide quarterly updates to my office until the implementation of a prompt is complete.
10	That the SHA develop a plan on how to effectively remind employees to make a practice of ensuring accuracy. This may include regular email reminders, signage where employees are reminded to double-check their data entry, and discussing the topic regularly during staff meetings, etc. I recommend that this plan is developed within 30 days of the issuance of this Investigation Report.
Category 1, Case #6: 175-2021 – Saskatchewan Health Authority	
11	That the SHA notify the patient of this privacy breach within 30 days of issuance of this Investigation Report.
12	That the SHA follow through with the suggested actions discussed by its Medical Imaging Team. I recommend that the SHA provide quarterly updates to my office until the suggested actions are completed.
Category 1, Case #7: 176-2021 – SHA	
13	That the SHA follow through with its prevention plans. I recommend that the SHA provide an update to my office if it has completed its prevention plans. If it has not completed the prevention plans, I recommend that the SHA provide quarterly updates to my office until the prevention plans are complete.
Category 2 – Dictation/Transcription Error	
Category 2, Case #1: 045-2021 - SHA	
14	That the SHA follow through with its prevention plans. I recommend that the SHA provide an update to my office if it has completed its prevention plans. If it has not completed the prevention plans, I recommend that the SHA provide quarterly updates to my office until the prevention plans are complete.

15	That the SHA notify the affected individual within 30 days of the issuance of this Investigation Report.
16	If the SHA has not already done so, speak directly to the resident physician, transcriptionist and Quality Assurance member involved in this case about the errors made so they can learn from their errors within 30 days of the issuance of this Investigation Report. If it has already done so, I recommend that the SHA let my office know.
Category 2, Case #2: 071-2021, 074-2021 – SHA and U of S	
17	That the U of S and the SHA follow through with the additional actions identified by the U of S. I recommend that the U of S and the SHA provide an update to my office if they have completed these actions. If they have not completed these actions, I recommend that the U of S and the SHA provide quarterly updates to my office until the actions are complete.
18	That the SHA ensure physicians and clerical assistants at the Department of Pediatrics are trained on work standards and procedures for dictation and transcription. The training should occur during onboarding of new physicians and clerical assistants and re-occur annually. I recommend that the SHA provide update to my office if it has completed such training. If it has not completed such training, I recommend that the SHA provide quarterly updates to my office until it has done so.
19	Since physicians and clerical assistants are faculty members and U of S employees, then the U of S should support the SHA in the delivery of dictation and transcription training.
Category 2, Case #3: 075-2021 – Dr. Raviqubal Basi	
20	That Dr. Basi ensure that physicians within his office are dictating first and last names and the spellings of names of intended recipients of reports. I recommend that Dr. Basi advise my office when he has completed this action.
21	That Dr. Basi explore if there is any capability with his dictation/transcription software as well as his EMR to flag the names of physicians with similar names. This is so that other physicians at his office, as well as staff can be cautioned to double-check they have the correct physician(s) when sending reports. I recommend that Dr. Basi provide quarterly updates to my office until this action is completed.
22	That Dr. Basi continue with his efforts to continue to work towards establishing privacy policies and procedures as well as establishing agreements between himself, the other physicians and his staff. I recommend that Dr. Basi provide quarterly updates to my office until this action is completed.
23	That Dr. Basi ensure that the license and services agreement with QHR Technologies Inc. is amended, so that it specifies that it is Dr. Basi that has custody and/or control of the personal health information, not "21st Street Medical Group". I recommend that Dr. Basi provide quarterly updates to my office until this action is completed.
Category 2, Case #4: 162-2021 – SHA	
24	That the SHA notify the affected individual within 30 days of issuance of this Investigation Report.
25	That the SHA require that additional information be used to identify physicians when they are to be sent (or copied) a report, including location and/or address of the physician. I recommend that the SHA provide quarterly updates to my office until this action is completed.

26	If it has not already been done, that the SHA and 3sHealth approach the transcriptionist and any Quality Assurance employee involved to ensure they understand the errors that occurred so they can have an opportunity to learn from this mistake. I recommend that the SHA and 3sHealth provide an update to my office if it has completed such training. If it has not completed such training, I recommend that the SHA and 3sHealth provide quarterly updates until it has done so.
Category 2, Case #5: 169-2021 - SHA	
27	If it has not already done so, that the SHA ensure that the resident physician is dictating reports in accordance with the Dictation Manual. I recommend that the SHA let my office know it has completed this action within 30 days of the issuance of this Investigation Report.
Category 3 – Reliance on a Google search for a physician's contact information.	
Category 3, Case #1: 229-2021 – SHA	
28	That the SHA take proactive measures to ensure that its employees across the province are relying on the CPSS' Physician Listing as its source of physicians' contact information and that they are cautioned against relying on searching on the Internet for such information. I recommend that the SHA provide quarterly updates to my office until it has completed this action.
29	Since the CPSS' Physician Listing is updated on a monthly basis, that the SHA ensures that all areas of the health authority are updating its telephone/fax address books regularly (at least on a quarterly basis) to ensure accuracy of contact information. I recommend that the SHA provide quarterly updates to my office until it has implemented a strategy to update telephone/fax address books regularly.
Category 3, Case #2: 251-2021 – SHA	
30	That the SHA take proactive measures to ensure that its employees across the province are relying on the CPSS' Physician Listing as its source of physicians' contact information and that they are cautioned against relying on searching on the Internet for such information. I recommend that the SHA provide quarterly updates to my office until it has implemented a strategy to complete this action.
31	Since the CPSS Physician Listing is updated on a monthly basis, that the SHA ensures that all areas of the health authority are updating its telephone/fax and address books regularly (at least on a quarterly basis) to ensure accuracy of contact information. I recommend that the SHA provide quarterly updates to my office until it has implemented a strategy to update telephone/fax address books regularly.
Category 3, Case #3: 232-2021 - SHA	
32	That the SHA take proactive measures to ensure that its employees across the province are relying on the CPSS' Physician Listing as its source of physicians' contact information and that they are cautioned against relying on searching on the Internet for such information. I recommend that the SHA provide quarterly updates to my office until it has implemented a strategy to complete this action.
33	Since the CPSS' Physician Listing is updated on monthly basis, that the SHA ensures that all areas of the health authority are updating its telephone/fax and address books regularly (at least on a quarterly basis) to ensure accuracy of contact information. I recommend that the SHA provide quarterly updates to my office until it has implemented a strategy to update telephone/fax address books regularly.
Category 4 – Miscommunication	

Category 4, Case #2: 086-2021 – SHA	
34	That SHA review its processes to determine a method of communicating clearly to physicians outside of the SHA the reason why personal health information is being disclosed. I recommend that the SHA provide quarterly updates until it has implemented a method.
Category 4, Case #2: 078-2021 – SHA	
35	That the SHA require patients to provide information beyond a physician's name to identify physicians. This could include location (such as a city or name of clinic) and/or address of the physician. I recommend that the SHA provide quarterly updates to my office until it has implemented such a requirement.
Category 4, Case #3: 098-2021 – SHA	
36	That the SHA notify the affected individual of the privacy breach within 30 days of issuance of this Investigation Report. The notification should inform the patient of CanTalk as well as the provincial Language Services program at the SHA to empower her to prompt physicians to use such translation services in the future to overcome the language barrier.
Category 5 – Misdialing	
Category 5, Case #1: 209-2021 – SHA	
37	That the SHA eliminate the use of fax machines. I recommend that the SHA provide quarterly updates to my office until it has eliminated the use of fax machines.
Category 6 – Patient-driven	
Category 6, Case #1: 064-2021 - SHA	
38	Take no further action.
Category 6, Case #2: 120-2021 – SHA	
39	Take no further action.
Category 6, Case #3: 178-2021 – Dr. Jennifer Guy	
40	Take no further action.
Category 7 – Staff not following procedure	
Category 7, Case #1: 117-2021 - SHA	
41	That the SHA take no further action.

Dated at Regina, in the Province of Saskatchewan, this 2nd day of February, 2022.

Ronald J. Kruzeniski, Q.C.
Saskatchewan Information and Privacy Commissioner