# NORTHWEST TERRITORIES
# INFORMATION AND PRIVACY COMMISSIONER
# Review Report 13-114

File: 12-188-4
January 2, 2013

## THE REQUEST FOR REVIEW

This matter was brought to my attention by an employee of one of the health authorities in the Northwest Territories. He is a clinical counselor, working in a smaller community. The employee raised concerns about the confidentiality of client personal health information as a result of the reporting requirements imposed on him by the health authority he works for.

The Complainant indicated that, on occasion, he is called out after hours to make mental health assessments, calm distressed clients, or attend suicidal clients. In the first years of his employment with the health authority he says there was no requirement to submit call-out forms when called out after hours. Rather, the procedure was that he would attend to the client, enter case notes in the client's file in his office and enter the overtime hours in accordance with government procedures. This changed when the health authority changed the supervisory structure of the group. Since then, the Complainant is required to submit "call-out" forms to his supervisor in another community when called to deal with an incident after hours. This form includes the date, the time, the length of the call-out, and a summary of what happened, as well as the name and address of the client. The Complainant objected to providing the name and address of his clients on the basis that this, when combined with the other information on the form, is sensitive personal health information. As a counselor, the Complainant believes that this is in breach of his obligation to protect the confidentiality of his clients. He is further concerned about the fact that his supervisor is not a counselor but is trained in a different field altogether, which makes the sharing of the names of the clients, with all the other information, even more problematic for him. He feels that the disclosure of names is wrong based

on his experience, beliefs, ethics and principals ingrained in him as a counselor. The Complainant indicated that he has been taught that it is the counselor's duty to protect their client's confidentiality and privacy to the full extent possible. By way of example, he pointed out that counselors do not even use client names when consulting with their clinical supervisors unless absolutely necessary. They do not use client names when consulting on a case during team supervision, or when consulting with a psychologist, psychiatrist, medical doctor or any other professional.

He was advised, however, that if he did not provide the names of the clients, he would not be paid for his overtime. As a result, he has been providing the names and contact information, as required by the health authority, but has asked me to review the procedure from the point of view of whether or not this practice is in compliance with the *Access to Information and Protection of Privacy Act.*

## THE PUBLIC BODY'S POSITION

In replying to the concerns raised by the Complainant, the health authority provided me with a copy of the form which they require to be completed when an employee is called out after hours to deal with medical issue. In addition to the information one would expect (the name and phone number of the person who requested the call out, the name of the employee, the date, the time the call came in and the time the call out ended) the form also has space to provide not only the name, but also the address and phone numbers of the clients, as well as a space to outline the reason for the call out. It requests the employee to outline what the issue was, what the employee did, what the current status of the matter is and what follow up is required.

The health authority indicates that the primary purpose of the form is to document activities related to client intervention, which is a legal charting requirement. They say the form is designed for use when there is a need for an after-hours call out and is used to "concisely and thoroughly document the occurrence of a call out" and the

actions of the staff. The form is placed on a client chart as part of the client's permanent record.

There is a risk management function related to the form as well. The health authority indicates that they must be able to recall the details of services provided and there must be some documentation of this information that survives the incident that resulted in the call out. They say this is the equivalent to the "Emergency Medical Services Report" that is completed when an EMR team is called to the scene of an accident.

Once completed, the original form is placed on the client record and a copy of the form is provided to the supervisor of the employee called out. Part of the supervisor's function is to review the incident, the actions taken by the staff member and the identified follow up. They say that the name of the individuals involved helps to ensure that there is continuity of care for the client. This is to ensure that the matter was managed appropriately and any required follow up occurs in a timely and appropriate manner.

The name of the client is required to identify the individual who is at risk. They say that it is possible that more than one person could have received services during a call out and that "it is imperative that the identities of the individuals receiving services are identified and that it is clear which form is related to which individual".

The form is also used as a tool to ensure accurate compensation for on call service provided by the employee. The supervisor receives a copy of the form which indicates a call out occurred, reviews the length of time the employee was required to devote to the issue and ensures that appropriate compensation is entered into the government employee management system. The supervisor must sign off on all requests for callback compensation. They point out, however, that no client information from the form is entered into the employee management system.

Finally, they say the form is used for program evaluation, to ensure appropriate staffing levels and services provision models are appropriate for each community.

The supervisor's copy of the form is, apparently, destroyed once the supervisor has signed off on all aspects of the information including actions taken, plan of care and time approved.

The health authority points out that all employees of the authority have sworn an oath of confidentiality and are aware of the importance of maintaining client confidentiality. They say that they would consider the supervisor to be within the "circle of care" for the clients in question as they are not only employed within the authority, but within the program area and, as such, would have access to the information on a need to know basis.

With respect to the Complainant's concerns about providing client identifying information to someone not trained as a counselor, the public body points out that it is not the training of the individual which should determine the information to which they should have access, but the job description under which the individual is employed. If the information is necessary for the supervisor to complete his or her duties, then the health authority is entitled to collect the information for that purpose. They point to section 40 (c) (i) of the *Access to Information and Protection of Privacy Act* which provides that personal information can be collected by or for a public body where the information relates directly to and is necessary an existing program or activity of the public body.

## DISCUSSION

The question here is whether the health authority is justified in requiring the complainant (and others in his position) to provide identifying information about clients when reporting to them about after hours call outs. Having reviewed the authority's reasons for requiring the names, I am not convinced that they are. To the contrary, I

am concerned that their insistence having client names and addresses puts the counselor (and others in his position) in the position of having to breach client privacy in order to be compensated for work done.

I agree with the health authority with respect to the Complainant's concerns about providing client identifying information to someone not trained as a counselor. If the information is necessary for the supervisor to complete his or her duties, then the health authority is entitled to use the information for that purpose. The question here is really whether the name/address of the client is necessary for the supervisor to complete his/her job. This is particularly so where the supervisor also has responsibility for other professionals who have other responsibilities (for example, child protection workers) with the potential of wider distribution. This may create additional concerns for a counselor. In my opinion, even where the use of information can be shoe-horned into one of the acceptable uses as set out in the Act, the spirit of the Act requires that personal information be used or disclosed only to the extent necessary to carry out the stated purposes and in a reasonable manner. If the supervisor in this case is able to complete his/her supervisory functions without the names and addresses of the clients seen by the counselors in a call out situation, that information should not be either required or provided.

One of the stated purposes of the *Access to Information and Protection of Privacy Act* is to ensure that the personal information of individuals is protected from unauthorized use or disclosure. When it comes to personal health information, some of the most sensitive personal information that exists, the information must be closely guarded and protected. Even where the use or disclosure of the information might be "authorized" by the Act, the general rule should always be to gather, use or disclose the least amount of information necessary for any particular purpose.

The public body indicates that the primary purposes for requiring the employee to provide the call out form is to document activities related to client intervention, which is a legal charting requirement, as well as for risk management purposes. If the form

were required only for the purpose of documenting the intervention, and were only put on the client's chart, it is information properly collected and properly "used". Clearly, it is necessary to document a call out of this nature in the client's chart. I have no problem with the employee being required to properly document his interaction with the client for the purpose of keeping good client records. It is absolutely proper and necessary for a counselor to prepare a proper report, which includes the client's name and all of the other information requested on the "call out" sheet to be put in the client's chart as part of the client's permanent medical record.

The health authority says that the supervisor also needs the names of the individuals involved to help ensure that there is continuity of care for the client and that any required follow up occurs in a timely and appropriate manner.

All of this, however, applies whether the client is seen during regular business hours or after hours as a result of a 'call out'. There is no suggestion that the counselor is being asked to provide his supervisor with the names and addresses of every client that the counselor sees during the regular work day. If the names and addresses of clients seen during the work day are not necessary for proper supervision, risk management or follow up purposes, I am at a loss as to understand how that information becomes relevant for supervision, risk management, or follow up purposes when the client is seen after hours.

The health authority says that the supervisor requires the name of the client to identify the individual who is at risk. They say that it is possible that more than one person could have received services during a call out and that "it is imperative that the identities of the individuals receiving services are identified and that it is clear which form is related to which individual". Because the supervisor, in a different community, has no direct contact with the client for the purposes of client care, I have to question, once again, the need for names and addresses of clients. Again, it is clearly necessary to document interactions between the counselor and the client on the individual client file. If there is more than one client involved, notes should be kept for

each client and placed on each individual client file. Even if the client requires ongoing counseling, surely that would take place in the community and it is sufficient for the purposes of that counseling that individual client records are kept in the community. For that matter, if the client has to be transferred to a larger community for ongoing services, surely the “client record” would go to the health provider in the larger community, not to the counselor’s supervisor. If the supervisor is the only person responsible for ensuring appropriate follow up, then the name of the individual might be necessary, but only in those circumstances where follow up is indicated. I suspect, however, that the counselor who saw the client in the first instance is primarily responsible for follow up with the client and that in the vast majority of cases, the supervisor’s responsibility would simply be to follow up with the counselor to ensure that the client’s needs had been followed up. I cannot imagine that the supervisor regularly contacts the client directly. In these circumstances I see no reason for the supervisor to know the specific identity of the client.

While not specifically argued, the health authority suggests that the name and address of clients are necessary in the case of a “call out” for the purposes of supervising the employee’s work. In this case, the supervision of the work done by the counselor is done by someone in a different community from the worker so it makes sense that a report of some description be provided to the supervisor. This said, I am not convinced that, except in very rare circumstances, will it be necessary for the supervisor to know the name and address of the client in order to provide proper supervision of the worker. If, for some reason, the name and address of the client becomes necessary to supervise the employee, the information can be retrieved from the client file on an individual basis as needed.

Finally, the health authority says that the form is used as a tool to ensure accurate compensation for on call service provided by the employee and that the supervisor must sign off on all requests for callback compensation. There is, however, absolutely no need for the names and addresses of the clients to be used in order to ensure proper compensation of the employee. The name of the person who

requested the call out (either the RCMP or the nurse in charge in most cases), the time of the call out and the time the call out ended, the name of the employee and a short description of the intervention is more than sufficient for the supervisor to sign off on the call out. If there is a need to confirm the call out, the supervisor can check with whoever requested the call out. I see no good reason to require a client name for this purpose. Similarly, client name and address information is unnecessary for program evaluation.

In summary, the health authority has provided me with no good explanation why the person who provides supervision to the counselor in a community needs the name and address of clients seen after hours on a call out basis, particularly when that same information is not required for clients seen during the normal work day. While it may be necessary to provide the supervisor with some information about the call out, the name/address is not relevant to the purposes for which the health authority says it is being required. In my opinion, the report provided to the supervisor should be revised so as to omit the need to provide any information that would identify the client for whom counseling was provided.

I would like to comment, as well, on the health authority's reliance on the fact that all employees are required to swear an oath of confidentiality. Confidentiality is not the same a privacy. A patient is entitled to know that his personal health information is not being unnecessarily shared with others, particularly in a place like the Northwest Territories where the population is small and "everyone knows everyone else". Privacy is much more than confidentiality. While the oath of confidentiality is an excellent and necessary starting point for protecting against the inappropriate use and/or disclosure of personal health information, it is far from perfect in terms of end result. Human nature being what it is, it would be folly to rely only on that oath to prevent inappropriate uses or disclosures of personal information. The more information is bandied about, the more likely it is to inadvertently go astray. The less information is used/disclosed within the course of the work done by the department, the less likely that the information will be inadvertently misused or inappropriately disclosed. The

test should always be “Do I truly need this information to complete the job?” If not, it should not be shared.

I would also like to comment on the health authority’s reliance on the concept of “circle of care” to allow the use and exchange of personal health information freely within the “program area”. In this case, the authority argues that the supervisor of the employee is within the “circle of care” for the clients in question because both the counselor and his supervisor are employed not only by the same authority, but within the same program area and, as such, would have access to all client information on a need to know basis. I cannot disagree more strongly with this statement. First of all, while the concept of “circle of care” has been used in legislation in some Canadian jurisdictions to define the allowable scope of disclosure of personal information within the health care sector, the Northwest Territories has not adopted that concept within its privacy legislation. In the Northwest Territories, the use of personal information is limited to the purpose for which it was collected (i.e. treatment) or a use consistent with that purpose. Administration and employee supervision are not necessarily “consistent uses”. Secondly, I emphatically disagree with the suggestion that anyone who works within a particular “program area” should have free access to any client information that is gathered within that program area. Even where the concept of “circle of care” is used, the concept is much more limited and nuanced than that. The “circle of care”, where that concept is within the legislation, refers to those who need information for the purpose of providing direct services to the client/patient. In the case at hand, the circle of care would involve, perhaps, the nurse in charge, the counselor, and any medical personnel that the counselor refers the client to for further medical assistance. It does not include other administrative or personnel supervisory functions. To the extent that any of the health authorities in the Northwest Territories intend to rely on the concept of “circle of care” for the purpose of sharing of information, that concept must be defined to focus on what the patient/client would consider to be the circle of care, not what the public body wishes it to be or thinks it should be, particularly in light of the fact that the policies of the Department of Health and Social Services seem to be erasing the lines between “health” and “social

services". To the extent that the health authority in this case relies on the "circle of care" to justify providing the client name and address to the supervisor for the purposes noted, it is, in my opinion, opening the door to that circle far too widely. The supervisor in this case has nothing to do with the direct provision of treatment or services to clients and will generally have no need for name and address information.

## CONCLUSIONS AND RECOMMENDATIONS

In conclusion, I recommend:

a) that the health authority immediately discontinue the requirement that counselors provide client names and addresses for the purposes of reporting on after hours call outs and that they redraft their reporting forms such as to collect the minimum amount of information necessary for the supervisor to complete her job responsibilities;

b) that the health authority discontinue the use of the term "circle of care" to justify the use and disclosure of personal health information at least until some reasonable definition of the term has been established, based on what a patient would understand to be the medical "circle of care" in any particular situation.

Elaine Keenan Bengts
**Information and Privacy Commissioner**