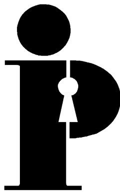

Personal Health Information Protection Act, 2004

REPORT

FILE NO. HR06-62

A Hospital in Rural Setting

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Personal Health Information Protection Act, 2004

REPORT

FILE NO. **HR06-62**

INVESTIGATOR: **Gillian Judkins**

HEALTH INFORMATION CUSTODIAN: **A Hospital in a Rural Setting**

SUMMARY OF INFORMATION GIVING RISE TO REVIEW:

The Vice-President and Chief Information Officer of a health service and prevention organization (the Organization) contacted the Office of the Information and Privacy Commissioner/Ontario (the IPC) to advise of an incident at a Hospital in a Rural Setting (the Hospital) in which data was incorrectly entered into a provincial database, resulting in data of patients from the Hospital being electronically accessible by four staff members at a second facility.

RESULTS OF REVIEW:

The CEO of the Hospital, along with a representative from the Organization provided the following information.

The incident was caused by a technical error when a staff member from the Hospital inputted the incorrect technical identification code into the information system. The Organization advised that the information system was developed for tracking patient information on behalf of the province. The data is used to determine wait times for services in the province.

According to the Organization, when the incorrect identification code was entered into the information system, it identified an incorrect facility as the "sender" of the information. This resulted in information about patients from the Hospital being disclosed to the incorrect facility.

The error was discovered within 24 hours of occurring and the facility's access to the information was immediately removed. An audit was conducted by the Organization to verify that no data had been incorrectly changed. The information that was disclosed included patient names, dates of birth, health card numbers, medical record numbers, gender, procedures, and procedure dates. The Organization advised that the information disclosed would have been viewed by no more than four staff members of the facility.

As a result of this incident, the organization spoke to the employee who incorrectly inputted the data to ensure that they understood the ramifications of the error. In addition, they are changing the documentation that is provided to all staff members responsible for inputting the technical identification code into the information system to ensure that it is made explicit to them that the technical identification codes are unique to each hospital and that there is a privacy risk associated with inputting the incorrect code. The organization also advised that they are changing the testing process to ensure that all staff members inputting the technical identification code do a double check to ensure that the information was sent correctly.

In order to fulfill their obligations under section 12(2) of the *Personal Health Information Protection Act* the Hospital sent letters out to each of the affected patients.

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

Original signed by: May 28, 2007

Brian Beamish
Assistant Commissioner