Information and Privacy
Commissioner/Ontario

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

Personal Health Information Protection Act, 2004

REPORT

FILE NO. HI-050001-1

A City Hospital

Tribunal Services Department
2 Bloor Street East
Suite 1400
Toronto, Ontario
Canada M4W 1A8

Services de tribunal administratif
2, rue Bloor Est
Bureau 1400
Toronto (Ontario)
Canada M4W 1A8

Tel: 416-326-3333
1-800-387-0073
Fax/Téléc: 416-325-9188
TTY: 416-325-7539
http://www.ipc.on.ca

Personal Health Information Protection Act, 2004

REPORT

FILE NO. HI-050001-1

INVESTIGATOR: Nancy Ferguson

SUMMARY OF INFORMATION GIVING RISE TO THIS REVIEW:

A hospital was contacted by a local business owner who advised that he had been receiving faxes from the hospital in error. It was discovered that a total of seven documents, each of a similar nature, had been sent to this local business from the hospital over a two week period. The faxed documents were all sent from the hospital's Emergency Department and were meant for the Infection Control Department within the hospital. The faxes contained the personal health information of patients that had been seen in the hospital's Emergency Department.

The hospital was faced with how to fulfill its obligations under the *Personal Health Information Protection Act* (the *Act*) including the notification of the affected patients. The hospital reported the matter to the Information and Privacy Commissioner/Ontario (the IPC).

RESULTS OF REVIEW:

Upon notification by the private business owner, the hospital sent their Privacy Officer to retrieve any of the faxed documents the business owner had retained and to obtain further information about the incident. The location of the fax machine was noted to be in the owner's office and not in a publicly accessible area. The business owner confirmed that the information in the documents had not been shared with anyone. He reported that all but the most recently received document had been put in a bag that was tied shut and sent out with other office waste. The most recent fax was retrieved from the business owner by the hospital. The Privacy Officer confirmed that no copies of any of the faxes had been maintained by the business owner.

Each of the faxed documents constituted a cover sheet and a separate sheet(s) to which "stickers" had been attached, one for each patient seen in the Emergency Department whose visit was being reported to Infection Control staff. The stickers contained varying degrees of information about

the patients including names, addresses, birthdates and health card numbers. In some cases handwritten notes beside the stickers indicated the particular symptoms the patient had reported.

Section 12(2) of the *Act* requires "Health Information Custodians" to notify patients if their personal health information is stolen, lost or accessed by unauthorized persons.

The hospital worked with the IPC to develop a letter to be forwarded to each patient referred to on the seven documents faxed to the private business. The notification provided the patient with details regarding the information that was on the misdirected fax, the purpose of the fax and the fact that it had been sent to a private business owner. The notification also informed patients of the steps the hospital had taken to contain the loss and assured them their hospital chart was complete. It expressed the hospital's deep regret and provided contact information for the hospital's Chief Privacy Officer and the IPC. The hospital has confirmed that the notification letter has been sent to all affected patients.

The hospital's Chief Privacy Officer reviewed the circumstances surrounding the incident with staff to help prevent a similar incident from occurring in the future. Hospital protocol provided for information relating to patients seen in the Emergency Department to be forwarded to the Infection Control Department by phone. For convenience, Emergency Department staff developed a system of faxing the information using a sticker for each patient and making notes in the margins or at the top.

A wrong number had been entered on the first day the mistake occurred, and in reliance on this incorrect fax number, the error was repeated six times.

The hospital had a fax policy in place requiring a cover sheet to be used for every faxed document and this appeared to have been done in each case. The policy also provided for staff to seek confirmation of receipt. This step and other aspects of the policy had not been followed.

The hospital took steps to review the situation with the Emergency Room staff and it was determined that using a fax to convey the information to Infection Control was not necessary. The use of the fax machine for this purpose was discontinued and staff members now deliver the document by hand.

Steps were also taken to ensure that staff generally were made aware of the incident and reminded of the fax policy and its importance. The fax policy was posted at all fax machines and a session was held to discuss the policy and the incident. Staff members were reminded to contact the Chief Privacy Officer should they become aware of a misdirected fax. A form was also developed to be used by evening staff to document releases of personal health information occurring by fax. The form, once completed, is to be left with the Health Records Department.

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

Original Signed by: June 1, 2005

Ann Cavoukian, Ph. D.
Commissioner