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-050009-1

A Hospital in a Rural Centre

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-050009-1

INVESTIGATOR: Nancy Ferguson

SUMMARY OF INFORMATION GIVING RISE TO THIS REVIEW:

A hospital was unable to locate the personal health information of a patient relating to his surgical procedure and visits to the emergency department just before the procedure. The hospital reviewed its obligations under the *Personal Health Information Protection Act* (the *Act*) including the notification of the affected patient. The loss was reported to the Information and Privacy Commissioner/Ontario (the IPC).

RESULTS OF REVIEW:

The hospital's "sign-out" book and the "out-guide" in the patient's chart folder indicated that the information about the patient's visits to the emergency department had been signed out to Emergency Department staff. The records showed that the patient's chart folder had been signed out to Operating Room staff.

The patient's chart was returned to the Medical Records department but the documentation relating to the emergency visits and all day surgery documentation was missing. The information was noticed missing from the patient's chart when staff were reviewing the chart to abstract and code information about surgery events at month-end.

Inquiries were made with staff, steps were retraced and searches were undertaken, but the documentation could not be found.

Operating Room staff raised the possibility that the visiting surgeon or the patient himself had inadvertently picked up the documentation that was missing. The visiting surgeon was contacted and indicated he did not keep any original documents from the patient's chart but had made copies of certain documentation for billing purposes. Medical records staff were able to

reconstitute the chart to some extent using these copies and by printing reports that had been dictated and were still available in other formats. Further searches were undertaken but no additional documentation could be found.

When the patient was contacted by phone with a view to providing notification of the loss, the patient indicated he recalled being given a folder of papers and being advised to take these back to the Emergency Department. The patient said he might still have some of these papers but wasn't sure. He agreed he would look for them and return them to the hospital if he was able to find them. The hospital sent a letter to the patient to confirm the information that had been shared during the phone conversation.

To the hospital's relief, the patient did attend at the hospital with documentation that was missing from his file. The hospital indicated that the only document that was not among those provided by the patient was the consent to surgery.

As a result of this incident, the Operating Room staff reviewed and amended their process relating to documentation flow. In particular, changes were made to ensure that chart folders and records of recent surgery are kept securely together and are not held back for workload entry purposes. Further, it was determined that procedures could be changed to ensure missing documentation relating to surgery could be identified more quickly by medical records staff and these changes were implemented. An audit was also planned to check that day surgery records were being received promptly following patients' surgical procedures.

The hospital reported that staff training relating to the *Act* was ongoing. The importance of all staff following procedures relating to patient records was also discussed at a meeting involving surgical services staff.

The hospital regretted that it did not contact the patient earlier in its search and indicated that this lesson would inform their future decisions should a similar incident occur.

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.

October 11, 2005

Ann Cavoukian, Ph.D.
Commissioner