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-050002-1

A Hospital in a Rural Centre

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INVESTIGATOR: Nancy Ferguson

SUMMARY OF INFORMATION GIVING RISE TO THIS REVIEW:

A hospital advised that a fax containing the "personal health information" of an individual seen in the Emergency Department was mistakenly sent to a private residence. The fax was meant for the police who were being asked to locate and return the individual to the hospital for assessment. The individual was advised before leaving the hospital that the police would be contacted. When the fax was misdirected, the hospital was faced with how to fulfill its obligations under the *Personal Health Information Protection Act* (the *Act*) including the notification of the individual who was now a patient in the hospital. The hospital reported the matter to the Information and Privacy Commissioner/Ontario (the IPC).

RESULTS OF REVIEW:

The hospital conducted its own internal investigation into this matter. The investigation confirmed that the fax had been prepared and sent by Emergency Department staff to provide information the police needed to bring the patient back to the hospital for assessment. The dialing of an incorrect number lead to the fax being directed to a private residence. The fax was sent out late in the night, awakening the homeowners, who contacted the hospital soon after receiving it. The document was faxed back to the hospital and hospital staff were assured that the original had been shredded using a home shredder.

The fax contained the patient's full name, age, address, diagnosis and the doctor's handwritten notes indicating what had been observed in the Emergency Department.

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.

Several days after the incident, two hospital staff went to see the patient who was still in the hospital. The staff members explained that in accordance with the *Act* and hospital policy, they were required to provide notice that a fax containing personal health information was misdirected to a private residence. The patient was told what information had been disclosed and about the steps taken by the hospital to contain the breach. These steps included confirming that the individual who received the fax had shred it and had not maintained any copies. It was noted that while the hospital takes the safeguarding of personal health information seriously, faxing is a required part of their business in certain situations. It was also explained that the incident had given the hospital the opportunity to inspect its processes more closely and implement improved process changes.

The hospital confirmed that in response to this incident and as part of ongoing education relating to the *Act*, they would increase their focus on prevention and detection of misdirected faxes. In particular, the hospital determined that steps would be taken to more clearly set out for staff the requirements when using programmable fax numbers and the importance of independently checking fax numbers entered manually.

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

Original signed by: April 25, 2005

Ann Cavoukian, Ph.D.
Commissioner