OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER
NEWFOUNDLAND AND LABRADOR

Report PH-2019-001

April 24th, 2019

Eastern Health

Summary: The Office of the Information and Privacy Commissioner (OIPC) was made aware of a privacy breach involving the Custodian and initiated a complaint on behalf of the party whose personal health information had been breached. The personal health information of the affected individual was improperly added to another patient's file and then disclosed to that patient in response to an access request. The Commissioner found there had been improper disclosure of personal health information by the Custodian.

Statutes Cited: *Personal Health Information Act*, S.N.L. 2008, c.P-7.01, sections 15, 16, and 36.

File #: 0180-060-18-044

I BACKGROUND

[1] The Office of the Information and Privacy Commissioner (OIPC) was reviewing an Access Complaint under the *Personal Health Information Act* (*PHIA*) involving the Custodian. As part of informal resolution of that complaint, the Custodian agreed to send its Complainant various medical records containing the individual's personal health information (PHI).

[2] When the Complainant received this disclosure it was discovered that included among the Complainant's own PHI was a medical record containing PHI of a Third Party. The Complainant brought this to the attention of this Office, and through the course of discussions with the Custodian, it became clear that a breach of the *PHIA* had occurred: the PHI of the Third Party had been improperly disclosed to the Complainant when, instead of providing the Complainant's own anesthesia report, the Custodian disclosed the Third Party's anesthesia report to the Complainant.

[3] Concern was then raised by the Complainant regarding how the Third Party's medical record could have become intermixed with the Complainant's medical records, and whether this could have occurred through an improper access of the Complainant's medical record by employees of the Custodian.

[4] Given the circumstances, the OIPC initiated a complaint under section 66(3) of the *PHIA* so that the Commissioner could investigate this breach and how it had occurred. The Custodian's investigation, explanation and findings regarding the improper disclosure of the Third Party's medical record were obtained during the investigation. Furthermore, an audit and review of the Complainant's medical file was also sought to ensure no improper access had occurred.

II PUBLIC BODY'S INVESTIGATION

[5] Upon commencement of this investigation, this Office had several discussions with the Custodian and what the OIPC expectations are of custodians in completing privacy breach investigations and responding to privacy complaints. In particular, this Office endeavored to

ensure that the Custodian provided a detailed response including its full investigation process and its investigation conclusions. Simply confirming that the Custodian was satisfied with its own investigation would not satisfy our request. Ultimately, a Custodian must attempt to ascertain the cause of the breach during its investigation, and provide evidence of having done so should an OIPC investigation be commenced. Under the circumstances, an audit of the Complainant's medical file would be a necessary part of the investigation as well.

[6] The Custodian provided an initial submission to this Office after consultation and collaboration with several of its departments, including: Information Security and Privacy ("ISPO"); Release of Information Office ("ROI"); Health Information Services and Informatics ("HISI"), Healthcare Technology and Data Management ("HTDM"), and Surgical Services-Perioperative.

[7] The Custodian's investigation determined that an anesthesia record belonging to the Third Party was located on the Complainant's electronic file in the Meditech system, and this record was then disclosed to the Complainant among his own PHI records. In reviewing the matter, it was found that the Third Party anesthesia report was located in duplicate; on both the Third Party's and Complainant's electronic files in the Meditech system. The Third Party's file accurately contained the anesthesia report, while the Complainant's file incorrectly contained the Third Party's report instead of that of the Complainant. The Custodian's investigation subsequently found that the Complainant's anesthesia report was located in the Centricity Perioperative Anesthesia System (CPA). Once discovered, the correct anesthesia record was scanned into the Complainant's medical file in the Meditech system and a copy disclosed to the Complainant. The duplicate copy of the Third Party's anesthesia record was removed from the Complainant's medical file and the Third Party was notified of the breach.

[8] The Custodian outlined the process followed by the ROI Office in disclosing medical records to the Complainant: five staff comprise the ROI team and it is this team that processes requests for information. A member of this team processed the ROI electronic records search and compiled records involving the Complainant. The Custodian noted that "as per the normal process to ensure accuracy of the responsive records," the ROI team member reviewed each item in the compilation before disclosure to the Complainant by the team manager. The

Custodian noted the team member verified, "the anesthesia record was accounted for in the compilation, however she did not notice the [patient] name being different on the anesthesia record." The Custodian declared this to be "an oversight and unintentional human error." The ROI team member had searched and compiled records from the Complainant's electronic file in the Meditech system, but had overlooked the anesthesia report of the Third Party that had been misfiled to the Complainant's medical file. Instead of the Complainant's anesthesia record, the Third Party's was improperly disclosed.

[9] After determining how the Third Party's record was improperly disclosed during the ROI process, the Custodian continued its investigation to determine how it was that a duplicate of this record had been uploaded to the Complainant's electronic medical record to begin with, and why the Complainant's own anesthesia record was not properly uploaded to the Complainant's electronic file. A review of both parties' scanned packages revealed that they were both scanned by the same scanner, on the same date within 25 minutes of each other. A review of the visit history of both parties further uncovered that they both had procedures in the Operating Room at the same Eastern Health facility (St. Clare's Mercy Hospital), with the same surgeon and attending anesthetist on the same date.

[10] The Custodian provided the typical process for the printing of the anesthesia record in a surgical environment for the purpose of scanning to Meditech: in the surgical environment, the anesthesia status has to move from "active" to "ended" in the CPA system for the user to be prompted to print the anesthesia record for scanning. In its review of the CPA system, the Custodian uncovered that the Complainant's anesthesia status was still labelled as active, and therefore the user would not have been prompted to print the anesthesia record. The Custodian then reviewed the print queues (which had been purged in the intervening years), before reviewing all electronic files for patients who had a visit on the same date in the same location as the Complainant to complete a fulsome investigation. The Custodian found no evidence that the Complainant's anesthesia record had been scanned to another patient's chart that was in the same hospital in the same area on the same day, and the transaction logs in the CPA system confirm the Complainant's anesthesia record was never printed. Additionally, a review of the Third Party's record found that it had been printed twice on the date in question, though no determination as to why this happened was offered.

[11] The Custodian reported that scanning errors could occur in a variety of ways, mostly different versions of the patient information being received or grouped together during stages of the process. The Custodian concluded that, "it appears that the misfiling and scanning of information was human error, and it would be near impossible to determine where the misfiling occurred or could have reasonably happened in the physical process."

[12] The Custodian went on to note that it endeavors to maintain accurate health records, and if errors are discovered at any stage of a process they are corrected. The Custodian indicated that "scanning at Eastern Health city sites process over 50,000 pieces of paper per day and the error rate is usually less than 1%." It further noted that "stringent quality control measures were introduced in 2015/2016," along with new scanning software, improved data quality processes, live data quality reviews, mandatory quality control measures, and a HISI training booklet. Additionally, the Custodian provided that, "the ISPO is working with all departments involved in the investigation to ensure that proper procedures are followed and to educate if there are gaps with regards to those proper processes."

[13] An audit was requested to determine if there had been any inappropriate accesses that could shed light on how the Third Party's anesthesia record was placed there. The Custodian initially offered just a brief response regarding the audit. The Custodian confirmed it had executed an audit of the Complainant's Meditech record, along with a subsequent review of that audit. The audit period had included an agreed-upon timeframe stretching from just over two weeks prior to the date both the Complainant and Third Party had undergone medical procedures at the same location involving the same staff, right up to the date the audit was conducted. The Custodian noted that "careful attention [was] paid to the two months after the surgery date." While most accesses were deemed appropriate, the Custodian concluded that accesses by eight individuals could not be easily deemed appropriate but instead required further review. The OIPC agreed to an extension to the Custodian's response to allow for that further review to be concluded.

[14] After that initial discussion, the Custodian responded to this Office to state that no evidence of a breach of the Complainant's electronic health record could be detected. This Office then reminded the Custodian of our initial conversations regarding this matter and the

level of response required by this Office to fully review this privacy breach. More specifically, this Office requested the names, job titles and contact information of the eight individuals requiring review post-audit, as well as the reasons offered for accessing the Complainant's file, details of how the Custodian had subsequently determined those accesses to be valid, and any corroborating evidence, conversations or interviews. The Custodian then provided a more detailed response addressing these matters.

[15] This additional response outlined that an audit is reviewed by comparing the accesses to visit history, appointments, clinical care, screens viewed, etc. Where any accesses are not initially deemed appropriate under those parameters, additional review is then undertaken. In this circumstance it involved identifying eight individuals and consulting with appropriate staff to investigate (in this case that meant following up with 13 additional parties). That follow-up included ISPO managers investigating the accesses through verbal and written discussions with employees and managers until all accesses could be found to be in relation to clinical care, consultations, training, relevant duties, etc. The Custodian's response to this Office further broke that review down so that a detailed description was provided for each named party and the access in question to demonstrate how the conclusion was reached that the accesses by all eight individuals were appropriate.

[16] Finally, the Custodian noted that it "does not deny that a breach of personal health information occurred," and that when made aware of the breach, "the organization worked swiftly and efficiently to notify the breached individual, rectify the error, and inform other appropriate parties (OIPC, Department of Health and Community Services, and other departments at Eastern Health)." It went on to state that, while it is unfortunate that this breach occurred, "it was not malicious nor intentional," and "Eastern Health has apologized" to both the Complainant and Third Party for this unfortunate error.

III CONCLUSION

[17] The Custodian eventually provided a very detailed response demonstrating a thorough investigation into all issues arising from this breach. Ultimately, this was good work on behalf of the Custodian that addressed this Office's initial concerns at the start of the investigation.

It is worth noting, however, that this is the level of detail that is expected and required at the outset for privacy breach investigations of this nature when the Custodian's breach investigation comes under scrutiny by this Office. So, while the origins of this complaint may have been unique (the OIPC having been involved with reviewing the access complaint that resulted in the breach), what this Office sought from the Custodian to fulfill its and our legislative mandates should not be seen as unique.

[18] We remind the Custodian that this Office is charged with oversight and review of access and privacy complaints made to it under the *Access to Information and Protection of Privacy Act, 2015* as well as the *PHIA*. To properly and fully complete those tasks this Office must be in a position to review the investigations and responses of public bodies and custodians, particularly where breaches of privacy are alleged or known to have occurred. This Office cannot make a determination that a public body or custodian has discharged its legislative responsibilities and arrived at reasonable and appropriate conclusions without seeing the full investigation and rationale for those conclusions.

[19] Furthermore, while this Office accepts that the breach appears to have arisen out of human error, it is worth noting that this particular circumstance involved multiple breaches and multiple human errors, including:

1. the breach that occurred upon inappropriate disclosure of the Third Party's record to the Complainant;
2. the breach that occurred when the Third Party's medical record was improperly stored within the Complainant's electronic file;
3. the human error by both the ROI team member and manager in overlooking the record retrieved, compiled and ultimately disclosed to the Complainant belonged to that of a Third Party;
4. the human error on the day of the medical procedure by either multiple individuals or several instances by the same individual in not properly printing and scanning the Complainant's anesthesia record to the medical file, printing duplicates of the Third Party's anesthesia report, the two records becoming intermixed with the Complainant's file; and

5. the duplicate being scanned to the Complainant's electronic Meditech file.

[20] Given the above, this Office concludes that the Custodian took reasonable steps as required by sections 15(1) and 16 *PHIA* obligations in relation to ensuring security and accuracy of personal health information in its custody and control; however, a breach still occurred.

[21] We further conclude that the custodian improperly disclosed personal health information in its custody or control pursuant to section 36 of the *PHIA*. Section 36 states:

> *36. (1) A custodian shall not disclose personal health information that is in its custody or control unless*
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> *(a) it has the individual's consent under this Act and the disclosure is necessary for a lawful purpose; or*
>
> *(b) the disclosure is permitted or required by this Act.*

[22] While this Office acknowledges the Custodian's comments regarding its "stringent quality control measures," it must be noted that these controls were in place at the time that the circumstances discussed in this investigation occurred. This Office therefore is left to question whether these measures are being monitored and followed as outlined. This matter involved multiple instances from various departments of breaches and human error occurring without check and causes this Office to question how successfully these quality control and auditing measures were being employed.

IV RECOMMENDATIONS

[23] This Office recommends the Custodian continue its work with all departments involved in the investigation to ensure proper procedures are followed and offer education where gaps in understanding these procedures are identified.

[24] Additionally, this Office recommends a review of quality assurance procedures in the impacted departments and a period of monitoring to ensure these measures are being employed appropriately.

[25] As set out in section 74(1) of the *PHIA*, the Custodian must give written notice of his or her decision with respect to these recommendations to the Commissioner within 15 days of receiving this Report.

[26] Dated at St. John's, in the Province of Newfoundland and Labrador, this 24th day of April 2019.

Victoria Woodworth-Lynas
Information and Privacy Commissioner (A)
Newfoundland and Labrador