NUNAVUT
INFORMATION AND PRIVACY COMMISSIONER
Review Recommendation 15-096
November 6, 2015

Review File: 15-141-5

BACKGROUND

In May of this year I received a letter from the Department of Health pursuant to section 49.9 of the *Access to Information and Protection of Privacy Act*. This section of the Act requires public bodies to inform the Information and Privacy Commissioner when it knows or has reason to believe that a breach of privacy has occurred with respect to personal information under its control if the breach is material. The breach occurred in a small, remote community. On April 29th, one of the Community Health Nurses working at the health centre was seeing a patient for a prenatal visit. She attempted to find the patient's chart for the purposes of the appointment, but it could not be found. The nurse and other staff at the clinic did a thorough search over the next two days to try to find the chart, but to no avail. The search included the health centre itself, staff accommodations and the non-nursing areas of the health centre. On May 1st, the Community Health Nurse in charge of the prenatal program at the Health centre discovered that three more prenatal charts were missing. An incident report was completed and sent to the Director of Health Programs in Rankin Inlet on May 6th. On May 8th, the Department of Health, ADM Operations was notified by telephone about the missing charts and on the same day, the ADM Operations notified both the Deputy Minister and the Director of Policy and Planning. On May 13 the ADM Operations requested the Health Centre to submit a full report including a list of the specific charts missing, a time line of the events, a list of the information what would have been in the charts and recommendations to prevent a similar loss of records in the future. The affected patients were all informed of the loss of their records and the initiatives taken to create and maintain new charts for them. All charts were reconstructed with the exception of documents which could not be replaced, such as nursing and physician documentation.

When staff went back to try to analyse what happened, it appears that the nurse in charge of the prenatal program had been asked to audit four prenatal charts some time in late April. She remembers having reviewed one of the four missing ones so it appears probable that this and the three other files went missing some time during or as a result of the audit process. The audit sheet was also missing.

The breach was reported to me by letter of May 19th, 2015.

In response to a number of questions from my office some additional information came to light.

The four missing charts have never been found.

It is the practice of this clinic to have a "separate" file for pre-natal clients. These files are kept on a shelf of their own and are not filed in the patient's general chart between appointments. At the end of the pregnancy, the records in these charts are integrated into the patient's general chart. Separate charts are kept so that all relevant information regarding a pregnancy, including lab and diagnostics, progress notes, prenatal record notes, MD consultation notes and any travel is in one place for easy reference. A lot of paper is generated with a prenatal patient and it would be difficult to try and follow a client's progress if everything were put on the general file, which is not designed to be able to accommodate this need. These prenatal charts are "sturdy 3 ring binders" that are bulky, which means that it is unlikely that they were accidentally picked up along with other files by a physician or nurse or other worker or that they accidentally ended up in the garbage.

The medical records office in this health centre is secure in that there are doors to the room that lock. The room is behind the reception desk and after regular working hours there is a grate that closes down the reception desk as well. All staff (medical and non-medical) have access to the medical records room. While it might be possible for a member of the public to gain access to the medical records room, they would have to

get through two closed doors to do so and it is unlikely that they could do so without being seen by an employee.

When charts are pulled from the file room in preparation for a patient's appointment, they are normally put on a counter at the front desk, which is accessible to the public.

All medical charts in this health centre are currently paper records so there is no electronic charting at all. There is, however, a policy with respect to taking files out of the records room. Under this protocol, when a chart is removed from the filing system an "OUT-guide" is to be place in the shelf in place of the chart. A sign-out sheet is supposed to be completed and inserted into the "OUT-guide" to identify which staff member signed out the chart and the date. The policy further provides that at the end of the work day, all charts are to be returned to the locked health records room. The policy also clearly says that charts are not to be removed from the health centre clinic except in extenuating circumstances. The department acknowledges that none of these policies were being followed at the time of the loss of the charts in question here. In particular, the "OUT-guide" was not being used and it was not unheard of for staff to bring charts to their apartments when they lived in the health centre. This did not happen when the staff live elsewhere in the community. Physicians staying in the health centre have also been known to "take files home with them" (i.e. to the apartment in the health centre).

A "new" charting system was implemented about 9 years ago, at which time the Manager for Records Management went to all communities to teach staff (primarily clerk interpreters) about records management. The Department acknowledges that in many of their smaller Community Health Centres there is a constant change-over of staff which can contribute to errors and omissions when it comes to file management and privacy. As a result of this incident, the department has advised me that they had scheduled someone to go into this community in mid-August to teach the staff proper medical record management.

In addition to sending someone to the community to provide staff with a refresher on how to handle medical files, the department has recommended to the health centre that the following steps be taken as a result of this incident:

- re-establish the “OUT-guide” system;
- ensure that the file room doors are always locked after hours;
- charts removed from the records room are to be returned to the file room as soon as they are no longer required for patient care;
- clinic rooms that may have patient charts that the practitioner has not yet completed work on must be closed when no practitioner is present and locked outside of regular work hours;
- charts are not to be placed on the reception counter, but are to remain behind the counter and handed to the practitioner only when the client is to be seen;
- charts must not be left unattended in the lab, the pharmacy or inpatient rooms.

DISCUSSION

The disappearance of four prenatal patient files clearly qualifies as a “material” breach of privacy under the *Access to Information and Protection of Privacy Act*. It is troubling, to say the very least, that four bulky binders have simply disappeared, without a trace. It might be easier to understand how it happened if the missing files were thin, nondescript folders, but they were not. They were bulky, easily identifiable binders, and they have simply disappeared. Despite what I am sure were very thorough searches, these four binders have never been found. Furthermore, they contain significant and sensitive personal health information of the four women the files related to.

On the positive side, as soon as it was discovered that the files were missing, immediate and proper steps were taken by the staff at the clinic to find, report and replace the missing files, to the extent that that was possible. Also on the upside is that, in dealing with this issue, the clinic has recognized that its processes and policies

were not being followed, a failure which lead to this significant breach of privacy, and they have started to take steps to correct some of the deficiencies on their own.

This event highlighted the deficiencies in the file management system at this clinic and how these deficiencies potentially affect the privacy of patients. Quite apart from the missing files, it seems that files were left in unlocked rooms, placed on counters accessible to the public, and sometimes left the clinic with the staff. While ostensibly there is someone in the clinic responsible for file management, that individual was not doing his/her job adequately.It is my guess that this clinic is not alone in terms of its file management problems. It appears that the system for file management in small health centres was developed about 9 years ago. While there was some training done at that time, there has been little ongoing training and no real review of the system since. This is despite the fact that staff turnover in most clinics in small communities in Nunavut is very high. This needs to change.

RECOMMENDATIONS

I make the following recommendations:

1. I **recommend** that over the course of the next 12 to 18 months, compliance audits be conducted at every health facility in Nunavut to ensure that all policies and procedures are being followed with respect to file management;

2. I **recommend** that steps be taken to provide ongoing training in records management for all employees in Nunavut health clinics and medical facilities, such that the staff in every small community receives training at least once each year and those in larger communities have at least two training opportunities a year;

3. I **recommend** that the policies and procedures surrounding file management for all medical facilities in Nunavut be reviewed and strengthened, with specific emphasis on:

- patient charts are not to leave the clinical areas of the facility without authorization from the office manager/nurse in charge, and that authorization is to be given only when necessary for the active medical treatment of the patient;

- charts removed from the records room are to be returned to the records room and properly filed in the system as soon as they are no longer required for patient care and preferably at the end of each work day;

- when a patient chart leaves the records room, the specific protocol which must be followed so as to allow for a measure of tracking of paper files within the clinic itself;

4. I **recommend** that one person in each medical facility be given specific responsibility within their job description for overseeing file management and that this person be held accountable to the department in the event of missing files or records;

5. I **recommend** that steps be taken at the earliest opportunity to transition all health records in Nunavut to electronic format, with necessary privacy controls and audit functions incorporated.

Elaine Keenan Bengts
Information and Privacy Commissioner