

 <p>Winnipeg Regional Health Authority Office régional de la santé de Winnipeg Caring for Health À l'écoute de notre santé</p> <p style="text-align: center;"><b>POLICY</b></p>	<b>REGIONAL</b>		Level:
	Applicable to all WRHA governed sites and facilities (including hospitals and personal care homes), and all funded hospitals and personal care homes. All other funded entities are excluded unless set out within a particular Service Purchase Agreement.		1
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	<b>Reporting and Investigating Privacy Breaches and Complaints</b>	10.40.110	1 of 5
Approval:	Section:		
	GENERAL ADMINISTRATION		
Date:	Supercedes:		
May 2023	January 1, 2022 September 2017		

Language used within this Policy, particularly discretionary language, is reflective of the terms used in *The Personal Health Information Act*.

## 1.0 PURPOSE:

- 1.1 To ensure that all Privacy Breaches and Complaints involving Personal Health Information are reported, recorded and investigated.
- 1.2 To prescribe the process to investigate Privacy Breaches and Complaints.
- 1.3 To establish procedures that implement corrective actions and to minimize the risk of additional Privacy Breaches.

## 2.0 DEFINITIONS:

- 2.1 Complaint: A Complaint made to a Trustee by any person alleging a Privacy Breach.
- 2.2 Individual: means a patient, client or resident receiving or has received health care services within the Shared Health Facility. For the purpose of access, correction, use and disclosure of Personal Health Information Individual includes Persons Permitted to Exercise the Rights of an Individual.

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**DISCLAIMER:** Please be advised that printed versions of any policy, or policies posted on external web pages, may not be the most current version of the policy. Although we make every effort to ensure that all information is accurate and complete, policies are regularly under review and in the process of being amended and we cannot guarantee the accuracy of printed policies or policies on external web pages. At any given time the most current version of any WRHA policy will be deemed to apply. Users should verify that any policy is the most current policy before acting on it. For the most up to date version of any policy please call 204-926-7000 and ask for the Regional Policy Chair's office.

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- 2.3 Personal Health Information: Recorded information about an identifiable Individual that relates to:
- the Individual's health, or health care history, including genetic information about the Individual;
  - the provision of health care to the Individual; or
  - payment for health care provided to the Individual;
- and includes:
- the PHIN (personal health identification number) and any other identification number, symbol or particular assigned to an Individual; and
  - any identifying information about the Individual that is collected in the course of, and is incidental to, the provision of health care or payment for health care;
- and for further clarity includes:
- personal information such as financial position, home conditions, domestic difficulties or any other private matters relating to the Individual which have been disclosed to the Trustee;
- and for the purpose of the Confidentiality policy (See WRHA policy 10.40.020):  
any Personal Health Information exchanged verbally about an identifiable Individual.
- 2.4 Persons Associated with the WRHA health care facility: includes all contracted persons, volunteers, students, researchers, WRHA medical staff, educators, members of the Boards of Directors, Information Managers, employees, or agents of any of the above or other health agencies.
- 2.5 PHIA: *The Personal Health Information Act* (Manitoba).
- 2.6 Privacy Breach: means, in relation to Personal Health Information,
- Theft or loss; or
  - Access. Use, disclosure, destruction or alteration in contravention of *The Personal Health Information Act* .
- 2.7 Privacy Officer: An employee designated by the WRHA or Site whose responsibilities may include dealing with requests from Individuals who wish to examine and copy or to correct Personal Health Information collected and maintained by the Trustee and facilitating the Trustee's compliance with PHIA. The definition is intended to mean the Privacy Officer and/or their delegate.
- 2.8 Record or Recorded Information: A Record of information in any form, and includes information that is written, photographed, Recorded or stored in any manner, on any storage medium or by any means, including by graphic, electronic or mechanical means, but does not include electronic software or any mechanism that produces Records.
- 2.9 Security: The process of protecting the Personal Health Information by assessing threats and risks to information and taking steps to mitigate these threats and risks. The result is the consistent application of standards and controls to protect the integrity and privacy of the information during all aspects of its use, processing, disclosure, transmittal, transport, storage, retention including conversion to a different medium and destruction.
- 2.10 Significant Harm: includes, in relation to an Individual, bodily harm, humiliation, damage to the Individual's reputation or relationships, loss of employment, business or professional

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opportunities, financial loss, identity theft, negative effects on the individual's credit rating or report, and damage to or loss of the Individual's property.

2.11 Site: A health care facility, community health centre,, or community office within the WRHA.

2.12 Trustee: A health professional, health care facility, public body, or health services agency that collects or maintains Personal Health Information. For clarity, the WRHA as a public body is the Trustee of the Personal Health Information collected and maintained within Health Care Facilities and Sites owned and/or operated by the WRHA and includes Community Health Services and Manitoba eHealth. The other hospitals and personal care homes within the region are Trustees of the Personal Health Information collected and maintained at each Individual health care facility.

### 3.0 **POLICY:**

3.1 Any Persons Associated with the WRHA/health care facility, who have received a Complaint, or who have knowledge of a Privacy Breach or reasonable suspicion of a Privacy Breach, shall immediately notify their manager or Privacy Officer at the Site or the WRHA Chief Privacy Officer. The Manager shall notify their Regional Director once a breach is confirmed or as appropriate. The following [Breach Mitigation Process](#) has been established outlining roles and responsibilities of the Privacy Officer or Designate, and of the unit/department/program manager where the breach occurred.

3.2. The manager shall consult with the Privacy Officer at the Site, who will consult with the WRHA Chief Privacy Officer if necessary, to determine whether investigating the Complaint or possible Privacy Breach is required. In determining whether to proceed with an investigation, the Manager and/or Privacy Officer at the Site shall consider:

- if the elapsed time has made the investigation no longer practicable;
- whether the Complaint has been made in good faith; and
- whether the circumstance warrants an investigation.

3.3 Where the initial investigation reveals that a confirmed/unconfirmed Privacy Breach requires additional investigation, the Privacy Officer at the Site and Manager shall determine who will take the lead on the investigation and will consult with Human Resources. The Privacy Officer at the Site shall immediately inform the WRHA Chief Privacy Officer where the confirmed/unconfirmed Privacy Breach involves a large number of Records or heightened sensitivity.

3.4 In accordance with Section 4.6 of this policy, all confirmed Privacy Breaches must be documented in the RL Solutions database by the Privacy Officer conducting the investigation.

### 4.0 **PROCEDURE:**

4.1 The Manager and/or the Privacy Officer at the Site shall conduct the initial investigation, which may include:

- identification of the Persons Associated with the WRHA/health care facility involved;
- identification of the Personal Health Information in question;
- the nature and extent of the alleged Privacy Breach;
- gathering relevant documents;
- consulting with the appropriate resources, including Regional Director,

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Legal, Human Resources and/or the Chief Privacy Officer prior to interviewing staff where there may be potential disciplinary consequences; maintain appropriate documentation.

- 4.2 Based on the findings of the initial investigation, the Manager and/or Privacy Officer at the Site shall determine the status of the event to be one of the following:
- No Privacy Breach;
  - Unconfirmed Privacy Breach; or
  - Confirmed Privacy Breach.

4.3 Where the initial investigation reveals:

4.3.1 No Privacy Breach: If the investigation ensued as a result of a Complaint filed by an Individual, the Manager and/or Privacy Officer at the Site must advise the Individual(s) that the investigation determined no Privacy Breach occurred and they have a right to make a Complaint to the Manitoba Ombudsman.

4.3.2 Unconfirmed Privacy Breach: The Manager and/or Privacy Officer at the Site may, at the discretion of the Privacy Officer at the Site, notify the WRHA Chief Privacy Officer and the Individual(s) affected, provide an explanation and advise that further investigation is underway.

4.3.2.1 If the unconfirmed Privacy Breach is later determined to be a confirmed Privacy Breach, the process in 4.3.3 of this policy must be followed.

4.3.2.2 If it is determined that no Privacy Breach has occurred, the process in 4.3.1 of this policy must be followed.

4.3.3 Confirmed Privacy Breach: The Manager and/or Privacy Officer at the Site, shall notify the WRHA Chief Privacy Officer of the breach and in consultation with the WRHA Chief Privacy Officer, will notify the Individual(s) affected by a breach where there exists a risk of serious harm as a result of the breach, apologize and advise them of their right to make a Complaint to the Manitoba Ombudsman. The Privacy Officer at the Site, and the Shared Health Chief Privacy Officer shall collaborate on notifying the Ombudsman.

4.3.3.1 Take immediate steps to contain the Privacy Breach by stopping the unauthorized practice; recover the Records; revoke access or correct weaknesses in physical Security.

4.3.3.2 The Privacy Officer at the Site shall obtain a copy of the signed PHIA Pledge of Confidentiality for the Person Associated with the WRHA/health care facility or confirm PHIA training via the Learning Management System.

4.3.3.3 Any known or suspected breaches of this Policy involving medical staff shall be forwarded to the Shared Health Chief Privacy Office for review and investigation in accordance with the established Privacy Breach Management Process for Medical Staff of Manitoba Health Authorities. Should a medical staff member be found to be in breach of this Policy, appropriate disposition shall occur in consultation with the Shared Health Facility Chief Medical Officer (CMO). This disposition does not prevent the simultaneous referral of the issue by the CMO as a "complaint" pursuant to Section 8 of the Medical Staff By-law. The Regional CMO may determine the appropriate disposition of the complaint, in accordance with the Medical Staff By-law, and whether the physician's privileges should be affected. Medical staff privileges can only be affected through the By-law processes in the Medical Staff

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By-law.

4.3.3.4 The Manager and Privacy Officer at the Site shall inform Human Resources of the Privacy Breach and discuss further investigation options.

4.3.3.5 The Manager and Human Resources will expand the investigation to include employee interviews and determine if the Privacy Breach is a willful or non-willful Privacy Breach or a systemic breach.

[Employee/User Interview Questions – Suspected Willful Privacy Breach Investigation](#)

4.3.3.6 The Privacy Officer at the Site and/or the WRHA Chief Privacy Officer will be responsible for communication with contracted persons, volunteers, students, researchers, WRHA medical staff, educators, members of the Boards of Directors, Information Managers or agents of any of the above or other health services agencies regarding the findings of the investigation.

- 4.4 Where a confirmed Privacy Breach is determined to be willful:
- 4.4.1 The Privacy Officer at the Site in consultation with Human Resources will determine the severity of the Privacy Breach.
  - 4.4.2 The Manager in consultation with Human Resources will determine the disciplinary action to be taken.
  - 4.4.3 The Manager and/or Privacy Officer at the Site in consultation with the WRHA Chief Privacy Officer will send a final letter to Individual(s) affected by the breach in accordance with this policy.
  - 4.4.4 Where a Privacy Breach involves a physician, the process outlined in 4.4.1 – 4.4.3 will be conducted by the CMO and Chief Privacy Officer.
- 4.5 Where a confirmed Privacy Breach is determined to be a non-willful or systemic Privacy Breach; the Privacy Officer at the Site shall ensure the issue is rectified and/or make recommendations to the Department/Unit/Manager.
- 4.6 For willful and non-willful or systemic Privacy Breaches, the Privacy Officer at the Site shall document the details of the Privacy Breach, the subsequent investigation and the corrective actions taken in the RL Solutions database.
- 4.7 All Privacy Officers at the Sites may, upon request, prepare an annual Privacy Breach summary report for their Senior Management with a copy also provided to the WRHA Chief Privacy Officer.
- 4.8 The WRHA Chief Privacy Officer may, upon request, on an annual basis, prepare a regional Privacy Breach summary report for the WRHA Chief Executive Officer.
- 4.9 An Individual must be notified of a privacy breach when it could be reasonably expected to create a real risk of Significant Harm to the Individual.
- 4.9.1 Where a Privacy Breach involves Significant Harm the Privacy Officer/Chief Privacy Officer shall notify the individual about a Privacy Breach relating to the information if, after considering the relevant factors prescribed in the *Regulations*, the breach could reasonably be expected to create a real risk of Significant Harm to the Individual. Relevant factors to be considered are included in the Guidelines for Notification of Breaches, as required by the *Regulations*.
  - 4.9.2 Notice to the individual must:

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- Be given as soon as practicable after the Privacy Breach becomes known to the Trustee;
- Be given in a form and manner, and include the information, required by the *Regulations*; and
- Be given directly to the Individual except in circumstances set out in the *Regulations*, in which case it may be given indirectly in the form and manner required by the *Regulations*.

When notifying an individual about a Privacy Breach with Significant Harm, the Trustee must also notify the Provincial Ombudsman at the time and in the form and manner that the Provincial Ombudsman requires.

- 4.10 For timely disclosure of PHI without consent when necessary to lessen the risk of serious harm to an Individual and/or public safety please refer to [WRHA Policy Personal Health Information Disclosure Due to Risk Of Serious Harm](#) (10.40.150)

## 5.0 **REFERENCE:**

- 5.1 *The Personal Health Information Act*  
5.2 *The Personal Health Information Act Regulations*  
5.3 [Privacy Breach Investigation Process for Privacy Officers – Effective Nov. 2022](#)  
5.4 Discipline and Discharge Policy, #20.80.010  
5.5 [Guidelines for Notification of Privacy Breaches - May 2023](#)  
5.6 [Personal Health Information Disclosure Due to Risk of Serious Harm 10.40.150](#)  
5.7 [Guidelines for Notification of Privacy Breaches - May 2023](#)  
5.8 [Breach Mitigation Process Nov. 2022](#)  
5.9 [Employee/User Interview Questions – Suspected Willful/Privacy Breach Investigation Nov. 2022](#)

**Policy Contact:** WRHA Chief Privacy Officer