Information and Privacy Commissioner,
Ontario, Canada

Commissaire à l'information et à la protection de la vie privée,
Ontario, Canada

PHIPA DECISION 85

Complaints HA17-14 and HA17-134

Mackenzie Health

January 30, 2019

Summary: The complainant submitted a correction request under section 55(1) of the *Personal Health Information Protection Act* to Mackenzie Health (the hospital) with respect to information contained in her late mother's medical records. The hospital denied the request for correction, but added a late entry progress note to the medical records. The hospital also denied the complainant's subsequent request for a correction of that progress note. The hospital relied on sections 55(8) and 55(9)(b) in respect of both decisions to deny the correction requests. In this decision, the adjudicator finds that the complainant has not established that the records are incomplete or inaccurate for the purposes for which the hospital uses the information. The hospital is not required to correct the records under section 55(8) of the *Act*, and no order is issued.

Statutes Considered: *Personal Health Information Protection Act, 2004*, sections 55(1), 55(8), 55(9) and 55(11).

Decisions Considered: PHIPA Decisions 36 and 40.

BACKGROUND:

[1] This decision addresses the hospital's denial of requests under section 55(1) of the *Personal Health Information Protection Act* (*PHIPA* or the *Act*) for correction of records of personal health information of the requester's late mother relating to her

hospitalization in May 2016.

[2] After receiving access to the records of personal health information of her mother from the hospital,[1] the daughter requested correction of information on four pages of records identified as Physician Orders, Progress Notes, Medication Administration Record, and Critical Care Response Team Consultation Record.

[3] In its initial decision, the hospital advised the daughter that it was denying her correction request following review of the requested corrections by the identified nurse and a patient care manager.[2] The hospital relied on sections 55(8) and 55(9)(b) of the *Act*, based on its view that the requested corrections concern information consisting of professional opinions or observations made in good faith. The hospital advised the daughter that she had the right to require that the information she provided with the correction request be attached to her mother's records of personal health information as a statement of disagreement, in accordance with section 55(11)(b) of *PHIPA*.

[4] The daughter signed a statement of disagreement and the hospital attached it to the relevant records. However, this did not resolve her concerns and she filed a complaint with the Information and Privacy Commissioner of Ontario (the IPC), thereby becoming the complainant. The IPC opened HA17-14 and assigned it to a mediator to try to effect a mediated resolution of the complaint. The mediator clarified the complainant's concerns, which centre on her belief that her mother's death resulted from the aspiration of an improperly administered medication. The complainant confirmed during mediation that she seeks corrections to her mother's medical records to reflect that her "mother died because she aspirated on an iron capsule. The nurse did not follow Dr.'s orders. She gave the pill whole with water. She did not document this error." The complainant clarified the specific corrections sought by writing the information directly onto copies of the four records. The requested corrections convey substantially the same information – namely, that the patient was given an iron pill whole with water by a named nurse, aspirated the capsule, and suffered a "critical care incident."[3]

[5] The mediator provided these clarified correction requests to the hospital for consideration, but the hospital declined to change its decision to deny them. As a

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[1] Section 23(1)4 of *PHIPA* sets out the authority of a deceased person's estate trustee (or the person who assumed responsibility for the administration of the estate, if there is no estate trustee) to exercise powers with respect to a deceased person's personal health information. These powers include the authority to make a request for access to the personal health information of the deceased person.

[2] The hospital's first decision letter cited no section in *PHIPA* as the reason for refusing the correction request. The hospital remedied this by sending a revised decision to the daughter stating the grounds for refusal on March 3, 2017.

[3] The requested correction to the Medical Administration Record was limited to stating that the iron pill was given whole with water by the named nurse; it did not contain a reference to a critical care incident.

mediated resolution of the complaint was not possible, it was transferred to the adjudication stage of the complaint process.

[6] I decided to conduct a review of the complaint and began by sending a Notice of Review outlining the issues to the hospital. Just before the hospital's submissions in response to the Notice of Review were due, the hospital contacted this office to advise that it intended to issue a revised decision and "amend the records." Subsequently, the hospital sent a revised decision to the complainant, enclosing a copy of what it referred to as "the amended records." The enclosure was not an amended version of one of the four records, but rather a new record created by the hospital in the form of a late entry Progress Note that provided further detail to that given in the initial Progress Notes.[4]

[7] Upon review of the late entry Progress Note, the complainant advised that the new record did not address her concerns about the four records that were the subject of her original correction request in HA17-14 and that she believed the new record required correction. The complainant submitted a correction request regarding the late entry Progress Note, which was denied by the hospital. Consequently, this office opened HA17-134 to address the denial of the complainant's correction request respecting the new record, and the complaint was moved directly to the adjudication stage, so I could conduct a joint review of it with HA17-14. I sought and received representations on both correction requests from the hospital and the complainant and these were shared in accordance with *Practice Direction Number 3* and the IPC's *Code of Procedure for Complaints under PHIPA*.

[8] In this decision, I find that the complainant has not established that the information that she wishes to have corrected in her mother's records of personal health information is inaccurate or incomplete for the purposes for which it is used under section 55(8) of the *Act*. Consequently, the hospital is not required to make the requested corrections and no order is issued.

RECORDS:

[9] Corrections are requested to the following records of personal health information: Physician Orders (page 37), Progress Notes – All Health Professionals (page 2 of 2), Medication Administration Record – Standard (page 4 of 6), Critical Care Response Team Consultation Record (page 1 of 1) and Progress Notes – All Health Professionals – Late Entry (page 1 of 2).

[4] This late entry Progress Note was dated September 27, 2017 but described the events on May 28, 2016.

DISCUSSION:

[10] There is no dispute that the hospital is a health information custodian under section 3(1) of *PHIPA*. Further, there is no dispute that the records at issue contain personal health information as defined in section 4(1) of *PHIPA* and that the complainant exercised her mother's right of access to her health records under section 52(1) as estate trustee, with reference to section 23(1)4 of *PHIPA*.

[11] The sole issue before me is whether the hospital is required to make corrections to the five records as requested by the complainant.

Does Mackenzie Health have a duty to make the requested corrections under section 55 of *PHIPA*?

[12] Section 55(1) of the *Act* permits an individual who has received access to a record of personal health information to request that a health information custodian, such as the hospital, correct the record "if the individual believes that the record is inaccurate or incomplete for the purposes for which the custodian has collected, uses or has used the information…"

[13] Section 55(8) of *PHIPA* sets out the custodian's duty to correct records of personal health information, as follows:

> The health information custodian shall grant a request for a correction under subsection (1) if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information and gives the custodian the information necessary to enable the custodian to correct the record.

[14] Where a complaint regarding a custodian's refusal to correct records of personal health information is filed with this office, the individual seeking the correction must provide evidence to establish that the "record is incomplete or inaccurate for the purposes for which the custodian uses the information" for the purpose of section 55(8).

[15] If the individual asking for correction provides sufficient evidence to satisfy section 55(8), the question becomes whether or not one of the two exceptions in section 55(9) applies. Under section 55(9), the custodian is not required to correct a record of personal health information if it consists of a professional opinion or observation that a custodian has made in good faith about the individual, or if the record was not originally created by the custodian and the custodian does not have sufficient knowledge, expertise, and authority to correct the record.

[16] Read together, sections 55(8) and 55(9) set out the criteria under which a custodian is required to correct records of personal health information. Section 55(8) requires the individual asking for correction to satisfy two conditions: first, the individual

must demonstrate, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information; and, second, give the custodian the information necessary to enable the custodian to correct the record.

[17] If the conditions of section 55(8) are established, the question becomes whether or not any of the exceptions that are set out in section 55(9) apply. In these complaints, as stated, the hospital relies on sections 55(8) and 55(9)(b) of the *Act*.

[18] Depending on the circumstances of the correction request, the information that the individual is seeking to have corrected and the reasons for the custodian's refusal to correct the records, this office may approach the analysis initially under section 55(8) or under section 55(9) of *PHIPA*. In these complaints, I review the issue of correction under section 55(8). Given my finding under that provision, it is not necessary for me to consider the exception in section 55(9)(b).

Submissions of the parties

[19] Mackenzie Health acknowledges that it has a duty to correct records of personal health information under section 55 of *PHIPA* that are inaccurate or incomplete for the purposes for which they use the information, subject to certain exceptions.

[20] The hospital explains that it did not make the requested corrections to the records because the records are not "incomplete," as asserted by the complainant. The hospital explains that it did not amend the Physician Orders, (initial) Progress Notes or Medication Administration Records, because it is not the usual practice to document the information requested by the complainant. Referring specifically to the Medication Administration Record, the hospital explains that in this type of record, "Per Os (PO) by mouth is the route of administration. It is not the usual practice for nurses to document how by mouth a route of administration is provided e.g. whole vs. crushed pills." The hospital maintains that the existing documentation in all four records subject to the complaint in HA17-14 is accurate and complete.

[21] Regarding the late entry Progress Note at issue in HA17-134, the hospital refers to this record as an amendment to the initial Progress Notes. The hospital states that this late entry Progress Note is the nurse's "best recollection of the care that was provided to the patient … which includes her observations of the patient following the administration of the medication." The hospital submits that "with this amendment, the personal health record is complete and the complainant's request has been addressed."

[22] With respect to the correction provisions in the *Act*, the hospital suggests that the complainant has requested correction because "her observation differed from that of the nurse's observation following the administration of medication." Relying on PHIPA Decision 36 and Order H2005-007, a decision of the Alberta Information and Privacy Commissioner, the hospital states that it will not amend the content of the Progress Notes further simply based on the complainant's observation, because the existing

documentation consists of a professional observation that was made in good faith. The hospital also submits that it is no longer relying on the records "for a purpose relevant to the accuracy and/or completeness of the information contained in them as the patient is deceased."

[23] When given an opportunity to respond to the hospital's representations, the complainant expressed renewed concern that the late entry Progress Note is inaccurate as contemplated by section 55(8), because the description of her mother's condition contradicts the observations she made at the time. She notes specifically that the late entry Progress Note describes her mother recovering quickly after coughing and being given nasal tongs for oxygen delivery, while her own observation was that her mother was "coughing a lot … [and was equipped] with the Oxygen Mask in order for her to breathe." The complainant provided a photo she says was taken at this time, after her mother aspirated the pill, and it shows her mother wearing an oxygen mask. The date printed on this photo matches the date recorded on the initial and late entry Progress Notes. In later submissions, the complainant asserts that the use of an oxygen mask should have been documented in the progress notes, because it was used only after her mother was given the pill whole.[5]

[24] In a section addressing whether the information in these records was documented in good faith under section 55(9)(b) of the *Act*, the complainant provides further detail explaining her concerns about the care provided to her late mother by the identified nurse. In support of these submissions, the complainant also attached two journal article abstracts addressing iron pill aspiration. I acknowledge those particular concerns here, although my finding under section 55(8) means that it is not necessary for me to review section 55(9)(b).[6]

[25] In reply, the hospital explains its obligation under the *Public Hospitals Act* to create and maintain medical records in order to document a patient's history, identify problems to help determine the course of care in hospital, and to communicate between health care professionals in that setting. The hospital reiterates that, in this context, the individual's medical records are no longer being relied on for those stated purposes because the individual has passed away.

Analysis and findings

[26] As I noted previously, under section 55(8) of the *Act*, an individual seeking

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[5] With these later submissions, the complainant also submitted a copy of a different record she had received from the hospital – a PRN Medication Record – and she asserted that a correction should be made to a time noted in it. As this particular correction request had not been submitted to the hospital previously, the complainant was advised that it would not be addressed in the decision issued in HA17-14 and HA17-134.

[6] It is also outside the scope of an IPC correction complaint to address care concerns.

correction to records of personal health information must demonstrate, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information. The individual must also give the custodian the information necessary to enable the custodian to correct the record.

[27] This office's approach to the interpretation of section 55(8) of *PHIPA* was established by PHIPA Decision 36, in which Adjudicator Jennifer James stated:

> There is no question that the accuracy of records containing personal health information is essential to the effective provision of health care. However, the correction provisions of *PHIPA* are limited by the requirement that the individual requesting the correction demonstrate to the satisfaction of the custodian that the record is incomplete or inaccurate for the purposes for which the custodian uses the information.
>
> The accuracy of the information that is requested to be corrected is therefore connected to the purposes for which the information is used.
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> In interpreting these provisions of the *PHIPA*, I find it helpful to have regard to section 11(1) which requires health information custodians that use [personal health information] about an individual to take reasonable steps to ensure that the information is accurate, complete and up-to-date as is necessary for the purposes for which it uses the information. The duty to use accurate information under section 11(1) can be viewed as the corollary to the duty to correct inaccurate information under section 55(8). In both, the purpose for which the information is used is key to understanding the scope of the duty.

[28] This approach to the issue of correction under *PHIPA* has been adopted in numerous subsequent decisions,[7] and I do so in this decision.

[29] Having reviewed the requested corrections to the five records at issue in Complaints HA17-14 and HA17-134, I agree with the hospital that they consist of the complainant's views of the events on the day in question. I accept that the complainant believes that the additions are required to complete the hospital records documenting her mother's care. However, I am not persuaded by the submissions presented that the five records are "incomplete or inaccurate for the purposes for which the custodian uses the information" as required under section 55(8) of the *Act.*

[30] The hospital's late entry Progress Note was apparently created to provide further information to "complete" the record and satisfy the complainant. I note that this late

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[7] PHIPA Decisions 40, 59, 81 and others.

entry Progress Note record consists of the identified nurse's best recollection of the circumstances surrounding the pill aspiration by the complainant's mother some 16 months after it occurred. The hospital's suggestion that the late entry Progress Note "completes the record" could be seen as contradicting its position that the initial Progress Notes were accurate and complete for the purposes for which the hospital uses them. However, although the creation of a late entry Progress Note as a response to the complainant's correction request may not have had the desired effect of simplifying matters, I do not fault the hospital for trying to address the complainant's documentation concerns.

[31] Returning to the correction issue and whether the records are inaccurate or incomplete for the purposes for which the hospital uses them under section 55(8), I find PHIPA Decision 40 helpful. In that decision, Adjudicator Cathy Hamilton reviewed a correction request made by an individual who was no longer under the care of the doctor involved. The adjudicator observed that:

> While the parties disagree about aspects of the factual basis for the termination of the doctor-patient relationship, the fact remains that the relationship has been terminated. As such, I find that the custodian will not be using the four letters at issue for any purpose, as he is no longer providing care to the complainant and has indicated that he will not be forwarding the first two letters to any of the complainant's future health care providers. In other words, I find that the custodian is not relying on any of the records for a purpose relevant to the accuracy of the information contained in them. Consequently, I find that the custodian does not have a duty to correct the records under section 55(8) of *PHIPA*.

[32] In the complaints before me, the hospital has taken a similar position to the one taken in PHIPA Decision 40, arguing that because the individual is deceased, it is no longer relying on the records for a purpose relevant to the accuracy or completeness of the information contained in them. Essentially, the complainant does not refute the hospital's position; nor has she provided any information to indicate that the hospital continues to use these five records of personal health information for any ongoing purpose, including the provision of health care. Although the complainant continues to disagree with the hospital about the accuracy and completeness of the information in her mother's medical records, the hospital's care relationship with her mother has ended. Therefore, I accept that the hospital is not relying on the records for a purpose relevant to the accuracy or completeness of the information contained within them. Since the complainant has not established the first condition of section 55(8), I find that the hospital is not required to correct the records in the manner she has requested.

[33] As stated, given my finding under section 55(8), it is not necessary for me to consider the exceptions in section 55(9) of *PHIPA.*

[34] The hospital has already added a statement of disagreement to the four records at issue in HA17-14 at the request of the complainant. It remains open to the

complainant to submit a statement of disagreement setting out the correction that has not been made to the late entry Progress Note in HA17-134, which the hospital would be required to attach to it, pursuant to section 55(11)(b) of *PHIPA.*

ORDER:

For the foregoing reasons, no order issued.

Original signed by: January 30, 2019
Daphne Loukidelis
Adjudicator