Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 261

Complaint HA22-00209

Sheridan Villa Long-Term Care Centre

October 21, 2024

Summary: An individual's substitute decision maker asked a care home to remove a progress note from the individual's file, claiming that the progress note is not a record of personal health information and although accurate, implies wrongdoing on the substitute decision-maker's part. The adjudicator finds that the progress note is a record of personal health information. She finds that it is not incomplete or inaccurate for the purposes for which the care home uses the information, and that no duty to correct the record exists under section 55(8) of the *Personal Health Information Protection Act*. No order is issued.

Statutes Considered: *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, sections 4(1) and 55(8).

Decisions Considered: PHIPA Decision 36.

BACKGROUND:

[1] This complaint arises from a refusal by Sheridan Villa Long-Term Care Centre (the custodian or care home) to remove a progress note made in a resident's file. The complainant is the substitute decision maker (SDM) for her husband, the resident.

[2] During a visit at the height of the COVID-19 pandemic, a nurse saw the complainant talking with another visitor. The nurse estimated that the two were not sufficiently physically distant, contrary to requirements for physical distancing in effect at the time. Staff at the care home spoke with the complainant regarding safety protocols,

including physical distancing requirements. The discussion was logged in a progress note that was placed in the complainant's husband's electronic health record (EHR or file).

[3] The complainant made a request under the *Personal Health Information Protection Act* (the *Act* or *PHIPA*) to have the progress note removed from her husband's file. She does not dispute the factual accuracy of the progress note's contents. Rather, she claims that the nurse's underlying estimate of the complainant's distance from the other visitor is wrong, and that the note's inclusion in her husband's file, among other things, implies ignorance of safety protocols and wrongdoing on the complainant's part.

[4] The custodian denied the request, and instead suggested that the complainant submit a statement of disagreement to be attached to her husband's file.[1] The custodian wrote in its decision that:

> …in consultation with the Region of Peel's Privacy and Legal team, it has been ascertained that this particular progress note should remain in [the resident's] health record. The reason for this is that arguably, adherence to IPAC [Infection Prevention and Control] measures could be related to [the resident's] health status and it certainly was not meant as a chastisement of you at all.

[5] The complainant made a complaint to the Information and Privacy Commissioner of Ontario (IPC) about the custodian's denial of her request.

[6] The parties attempted mediation, during which the custodian clarified that it denied the request based on sections 55(8) (duty to correct), 55(9)(b) (exception for professional opinion or observation) and 55(11) (statement of disagreement) of the *Act*. The complainant, meanwhile, challenged the custodian's authority to include a note about her in her husband's record of personal health information.

[7] Mediation was not successful, and the complaint was moved to the adjudication stage of the complaint process, where an adjudicator may conduct a review. An adjudicator conducted a review, during which both parties submitted representations, including in reply and sur-reply to each other's initial representations. The review was transferred to me to complete. After reviewing the parties' representations and the record, I determined that I did not need any further submissions from either party to decide the matter.

[8] For the reasons that follow, I find that the record is a record of personal health information, and that the complainant has not established that the record is incomplete or inaccurate for the purposes for which the custodian uses the information. Accordingly, I find that there is no duty for the custodian to correct the record under section 55(8) by

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[1] In accordance with section 55(11) of *PHIPA*, which allows for a statement of disagreement to be attached to a record of personal health information. There is no dispute that the complainant submitted a statement of disagreement setting out her objections that has been placed in her husband's file.

removing it from the resident's file, and I uphold the custodian's decision to not do so.

RECORDS:

[9] The record is a two-sentence progress note (the progress note or record) contained in the complainant's husband's file. Prepared by a nurse, it documents that a conversation took place between staff and the complainant about infection Information Prevention and Control (IPAC) measures.

ISSUES:

A. Is the progress note a record of "personal health information" as defined in section 4(1) of *PHIPA*?

B. Does Sheridan Villa Long-Term Care Centre have a duty to make the requested correction under section 55(8) of *PHIPA*?

DISCUSSION:

Issue A: Is the progress note a record of "personal health information" as defined in section 4(1)?

[10] First, it is not disputed, and I find that the custodian is a health information custodian as defined in section 3(1) of *PHIPA*. Next, before considering the complainant's request for correction, I must determine whether the record at issue is a record of personal health information. As discussed below, *PHIPA* provides for a right of correction to records of personal health information in certain circumstances and includes as one of its purposes the right to require the correction or amendment of personal health information about oneself subject to limited and specific exceptions set out in the *Act*. If the record is not a record of personal health information, there is no duty on the custodian under *PHIPA* to correct it.

[11] The complainant submits that the progress note is not about her husband and does not contain his personal health information.[2] She says that it simply contains a statement of fact of a conversation about information and instructions given to her, and that, among other things, "[n]othing in the Act allows the practice of recording education giving to caregivers, nor is it the intent of the Act that non health information about third parties be compiled, without their consent, in the [personal health information] file of the patient."

[12] The custodian says that the information in the progress note is personal health

[2] If this is true, then there is no duty to correct it in *PHIPA*.

information as defined in section 4(1)(g) of *PHIPA* because it identifies the complainant as her husband's SDM. The custodian says that, in her capacity as her husband's SDM, the complainant is identified as having a role in providing direct care for her husband and that the information in the record, even though it documents a communication to his SDM, affects her husband's continual care and safety.

[13] I find that the progress note contains the complainant's husband's personal health information as that term is defined in paragraph (g) of section 4(1) of *PHIPA* because it identifies his SDM.

[14] Section 4(1) of *PHIPA* defines personal health information. Paragraph (g) of section 4(1) is relevant to this complaint. It states that:

> (1) "personal health information", subject to subsections (3) and (4), means identifying information about an individual in oral or recorded form, if the information,
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> …
>
> (g) identifies an individual's substitute decision-maker.

[15] There is no dispute that the complainant is her husband's SDM or that she is identified in the record. The complainant's designation as SDM inherently connects her identification in the progress note to her husband's care. The complainant's name is noted in the progress note, and her status as the SDM would be evident from other parts of her husband's file, supporting the conclusion that this information – namely, that the SDM is familiar with or was made aware of IPAC protocols – relates to his overall care. I am satisfied that, in these circumstances, the complainant's identification within her husband's medical record constitutes his personal health information under paragraph (g) of section 4(1) of the *Act*, and that the note is therefore a record of his personal health information.

[16] Next, I will consider whether the custodian has a duty to make the requested correction.

Issue B: Does the custodian have a duty to make the requested correction under section 55(8) of *PHIPA*?

[17] The purposes of the *Act* are set out in section 1 and include the right, at paragraph (c), "to provide individuals with a right to require the correction or amendment of personal health information about themselves, subject to limited and specific exceptions" set out in the *Act*.

[18] Section 55(1) permits an individual, in this case the complainant on her husband's behalf as his SDM, to request that a custodian correct a record "if the individual believes that the record is inaccurate or incomplete for the purpose for which the custodian has

collected, uses or has used the information."

[19] Section 55(8) sets out a custodian's duty to correct records of personal health information in certain circumstances. It states that:

> 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.

[20] If a duty to correct a record is established under section 55(8), the question becomes whether any of the exceptions in section 55(9) apply. 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 it.

[21] Read together, sections 55(8) and (9) set out the criteria pursuant to which an individual is entitled to a correction of a record of their own personal health information. Because of my findings under section 55(8), below, I do not need to consider the section 55(9) exceptions in this decision. Although the parties each submitted voluminous representations regarding sections 55(8) and 55(9)(a) (the exception for a good faith professional opinion or observation), I have only summarized those representations relevant to my findings that the complainant has not established that the custodian has a duty to correct the record under section 55(8).

Representations

The custodian's representations

[22] The custodian submits that its staff are trained to document observations necessary for the effective provision of healthcare, including recording information provided to families or essential caregivers for purposes that include record-keeping, potential contact tracing, and resident care. It notes that, in addition to SDM, the complainant is designated as her husband's "essential caregiver,"[3] and that the custodian regularly communicates relevant information to her as part of her husband's care plan and about overall care protocols.

[23] The custodian says that the progress note at issue was written during the third wave of the COVID-19 pandemic, when "extremely strict" public health measures were in place. It says that, during one of the complainant's visits, a nurse observed an alleged failure to comply with physical distancing requirements. A discussion with the complainant

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[3] Defined by the custodian as "an essential visitor and important partner in care who provides direct care to residents, such as helping with feeding, mobility, hygiene, and cognitive stimulation."

followed that was documented in the progress note and placed in the complainant's husband's file as part of the custodian's IPAC[4] obligations, a practice the custodian says is consistent with documentation across all long-term care homes in Peel Region. The custodian says that documenting all such discussions was important to ensure compliance with safety protocols and to support transparency in care delivery. It argues that this documentation was crucial not only for record-keeping purposes, but also to demonstrate that policies had been implemented and were being communicated, in line with public health and policy requirements established or in effect during the pandemic.

[24] The custodian says that it was legally required to have an IPAC program in place to prevent the spread of infection, with all parties, including essential caregivers, expected to follow these measures, and that proper documentation of safety-related discussions is integral to ensuring accountability and protecting the health and wellbeing of residents, staff and anyone visiting the care home. The custodian argues that the progress note does not assess the complainant's knowledge or behaviour and does not imply wrongdoing, but that it merely documents a discussion that IPAC measures were communicated to the complainant that was relevant to the safety and wellbeing of the complainant's husband and others in the facility.

The complainant's representations

[25] The complainant submits that she was at all times knowledgeable about and followed all IPAC measures and that the record is wrong to imply that this was not true. She says that:

> The accuracy of the facts in the note are not in question. The events recorded did take place. However, the custodian's assertions about the circumstances leading up to the note are not accurate. The note implies that the complainant's knowledge of IPAC measure[s], specifically around PPE [personal protective equipment] and social distancing, were deficient, and thus she needed the "education." This implication is not accurate.

[26] The complainant submits that the purposes for which the custodian meant to use the record are not clear. She says that "[n]othing in the Act allows the practice of recording education giving to caregivers, nor is it the intent of the Act that non health information about third parties be compiled, without their consent, in the personal health information file of the patient." She disputes that the information needed to be recorded for the purposes of contact tracing and says that the progress note does not itself contain contact information. She argues that information about alleged non-compliance with visitor or IPAC policies should not be kept in a patient's file.

[27] The complainant submits that this "adjudication results from a disagreement as to the estimation of a distance," and not a health or medical issue. She says that the nurse

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[4] Infection Prevention and Control defined above.

was too far from the complainant to have accurately estimated the complainant's distance from the other visitor, which prompted the discussion documented in the progress note. Because I find, below, that the test for correction under section 55(8) is not met, I have not summarized the complainant's representations regarding measurements of distance or that the exception in section 55(9)(b) for professional opinions or observations does not apply to the nurse's estimate of distance.

Analysis and findings

[28] Where a complaint regarding a custodian's refusal to correct records of personal health information is filed with the IPC, the individual seeking the correction has the onus of establishing that the record is "incomplete or inaccurate for the purposes for which the custodian uses the information" under section 55(8).

[29] The complainant argues that the progress note, although accurate, is based on an underlying fallacy that she was not compliant with health and safety protocols for physical distancing and PPE, and that anyone reading the note would be left with the inaccurate assumption that that the complainant needed to be educated about IPAC measures.

[30] *PHIPA* does not require custodians to remove or alter information solely because an individual objects to how it might be perceived. When considering the duty to correct under section 55(8), however, there must be a connection between the information and the purpose for which it is used. In PHIPA Decision 36, Adjudicator Jennifer James set out the approach to be applied when interpreting section 55(8). She found that:

> 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.

[31] Adjudicator James also concluded that not all personal health information contained in records held by a health information custodian needs to be accurate in every respect. She held that, where the custodian is not relying on the information for a purpose relevant to the accuracy of the information, the custodian is not required to correct it. Therefore, if a request is made to correct inconsequential bits of information that have no impact on the purposes for which the custodian uses the information, and the custodian is not relying on the information for a purpose relevant to its accuracy, then the custodian is not required to correct the information.

[32] Following this reasoning, I find that the complainant has not established that the record is incomplete or inaccurate for the purposes for which the custodian uses or used

the information.

[33] The relevant facts of this complaint include that a nurse noted that a discussion took place with the complainant about health and safety measures. The record notes that a conversation occurred about education and compliance, and with whom. Although the record does not contain particulars of the discussion itself, the complainant maintains that the underlying basis for the discussion was the nurse's incorrect estimate of distance, which prompted the discussion that the complainant says she did not need.

[34] On the materials before me, I have no basis to conclude that the record itself is inaccurate, nor do I find that it is inaccurate for the purposes for which the custodian used it.

[35] The progress note documents an interaction regarding IPAC measures that I find is consistent with the custodian's record-keeping practices in adherence to IPAC procedures. I accept the custodian's representations that the purpose of the progress note was to log an interaction relevant to the custodian's public health obligations as they related to the complainant's husband's care as a resident. Additionally, I accept the custodian's submissions that its responsibility, especially during a pandemic, included recording discussions with visitors and caregivers about health and safety protocols for the purposes of infection control and overall resident safety. I find that the progress note was used by the custodian for these purposes, consistent with the custodian's operational needs and its obligations to ensure a safe environment. I therefore find that the progress note (even if the discussion logged in it was based on a misperception of distance, and I make no finding in this regard) is not inaccurate for the purpose of documenting the custodian's compliance with public safety measures and policies that were in place at the time, including where such compliance also involved discussing IPAC measures with visitors or caregivers. For all of these reasons, I find that the requirements in section 55(8) have not been met, and that the custodian does not have a duty to correct the progress note. I uphold the custodian's denial of the complainant's correction request.

[36] The custodian has attached the complainant's statement of disagreement to her husband's file, ensuring that the complainant's objections in this regard are reflected alongside the original note. This fulfills the requirement under section 55(11) of the *Act* to allow a complainant to document their disagreement when a correction is not warranted.

ORDER:

For the foregoing reasons, no order is issued.

Original Signed by: October 21, 2024
Jessica Kowalski
Adjudicator