POLICIES AND PROCEDURES MANUAL	NUMBER: B-301
POLICY OWNER: Director of Risk Management	EFFECTIVE: Nov 2003
APPROVED BY: Corporate Safety and Risk Management Directors Committee Quality Council Administrative Committee MAC	REVISED: Oct 2015 **Jan 8, 2019**
	REVIEWED: June 2008

DISCLOSING ADVERSE EVENTS

INTENT

The Queensway Carleton Hospital (QCH) affirms that all patients/clients are entitled to be properly informed of all aspects of their treatment and health care. QCH fosters and supports just culture of learning and fair accountability regarding patient safety.

POLICY

The Queensway Carleton Hospital will disclose adverse event(s) that may occur to a patient while in our care or discharged from our care. When an adverse event occurs, the patient and the family or Substitute Decision Maker (SDM) is entitled to a prompt explanation of how the adverse event occurred and if it will have any consequences for the patient's health or care.

The Queensway Carleton Hospital will disclose critical incidents in compliance with Regulation 423/07 under the Public Hospitals Act which requires hospitals to disclose critical incidents to the affected patient or their substitute decision maker or to the estate representative should the patient have died.

This policy will pertain to patients only and not employees, medical staff or visitors.

Patients and/or SDM will receive a truthful and compassionate explanation when:

- outcome of care varies significantly from what was anticipated;
- an adverse event has occurred resulting in clear or potential clinical consequences ("harmful incident");
- an adverse event has occurred that has not resulted in clinical consequences ("no harm incident"), but a reasonable person would want information about the incident because it might assist them in planning future care;
- a near miss has occurred that has reached the patient's awareness (disclose to SDM if patient incapable).

- Diagram A: Relationship Between Terms

In the above circumstances requiring disclosure, QCH's process includes an apology/expression of regret to the patient and/or SDM. The Ontario Apology Act expressly provides that an apology made by or on behalf of a person in connection with any matter does not, in law, constitute an express or implied admission of fault or liability by the person. In addition, the legislation provides that evidence of an apology made by or on behalf of a person in connection with any matter is not admissible in any civil proceeding, administrative proceeding or arbitration as evidence of the fault or liability of any person in connection with that matter.

PROCEDURE FOR DISCLOSURE

1. All incidents involving an adverse event in clinical care must be disclosed. The decision tree in Appendix A provides guidance as to what types of harm should be communicated. Incidents where a patient is significantly harmed and/or where additional interventions were required to rectify the potential harm must be reported by the most responsible physician and/or Director to:
   - Chief of Staff
   - Vice President (V.P.) Patient Care/Chief Nursing Officer
     - The Chief of Staff and/or V.P. Patient Care /Chief Nursing Officer will contact the Director of Risk Management and Chief Executive Officer
   - The Administrator on Call should be notified after normal business hours, between 16:30 and O8:00 weekdays and anytime on weekends or statutory holidays.

2. Occasionally an incident involving an adverse event will occur that involves more than one patient e.g. breach of sterilization standards. In such a case an ad hoc group will be formed to investigate and assess whether disclosure is necessary/advisable and if so how disclosure of the incident should be addressed with patients affected/potentially affected. The ad hoc group will include those with administrative and/or clinical responsibility for the area/department involved such as the manager, director, medical director or chief, etc. All such situations will be reported to the Chief of Staff and the Vice President Patient Care/Chief Nursing Officer.

3. All incidents must be documented in the progress note (or appropriate section of outpatient chart) and an incident report completed. No reference should be made in the patient chart that an incident report was completed. The incident report should not be filed on the patient's chart.

4. Disclosure should occur:
   - As soon as practically possible after the occurrence or after it has been identified, and;
   - When the patient's condition is clinically and emotionally stable and/or s/he is able to comprehend the information or to the SDM if necessary.

   Most often disclosure will take place in at least 2 stages. The initial disclosure discussion is as soon as reasonably possible after the event. A second phase of disclosure, called the post-analysis disclosure, is subsequent communications with the patient about known facts related to the reasons for the harm after an appropriate analysis of the adverse event (Appendix B).

5. The most responsible person for disclosing events to the patient or SDM is:

   - The most responsible physician or his/her designate will handle the disclosure of information and subsequent discussions with the patient or his/her SDM. When the nature of the disclosure is not predominantly physician focused, the most responsible practitioner will undertake the disclosure and the physician will provide support and expert opinion.

   - If the most responsible physician is uncertain how to proceed s/he should discuss it with the Medical Chief of the Department/Service and/or the Director of Risk Management. In the event of a 'compromised' labour delivery, a critical event or one where staff/medical staff suspect future legal action, the Director of Risk Management should be informed of the event BEFORE the disclosure takes place.

   - It is strongly recommended that a second staff member or medical staff member be present during the initial conversation with the patient or SDM to be able to validate the disclosure information.

6. For discussions anticipated to be complex or difficult, patients or SDM should be given the option of having another person with them as support during the discussion. The identity of the additional person(s) should be requested before the session. Should a patient or SDM request that a lawyer by present, the Director of Risk Management should be contacted for advice.

7. The Quality of Care Information and Protection Act, 2004 (QCIPA) was enacted to protect from disclosure in legal proceedings information prepared by or for a committee that has been designated as a quality of care committee. Such committees may review an incident for the purpose of improving or maintaining the quality of care provided by the hospital. Should a Quality of Care review of a particular adverse event be conducted under the provisions of QCIPA, only certain information may be disclosed to the patient or SDM as follows:
   - Factual information contained in a record of an incident regarding the provision of health care to the patient
   - Information about the patient's care as recorded in the patient chart
   - Any additional factual information about the patient's care which has been learned in the course of the review but is not noted in the chart
   - That a quality of care review has taken place, without disclosing the details of the review
   - Any steps that have been taken by the hospital after a Quality of Care review without indicating that the review was the reason for the steps

8. During initial and follow-up discussion the following subjects should be discussed, although discussion is not limited to these topics:
   a. The hospital and its staff regret and apologize that an adverse event has occurred.
   b. The nature of the adverse event.

c. The time, place, and circumstances of the adverse event.
d. The cause of the adverse event, if known.
e. The known, definite consequences of the adverse event for the patient and potential consequences if known.
f. Actions taken to treat or ameliorate the consequences of the adverse event.
g. Who will manage ongoing care of the patient.
h. Planned investigation or review of the adverse event.
i. Actions taken to identify systems issues that may have contributed to the adverse event and to prevent the same or similar medical adverse event from re-occurring.
j. The names and phone numbers of individual in the hospital to whom the patient or appropriate guardian or representative may address complaints or concerns about the process around the adverse event.
k. If necessary, plans and dates for subsequent meetings.
l. Emotional support for patients and/or families should be facilitated such as from family, friends, spiritual representatives, etc. It may be necessary to assist patients to access professional support when needed such as social workers or counsellors, and community services such as homecare aid or support groups.

9. The facts and pertinent points of the conversation with the patient and or family (elements 8 b, c, e, and f are required by legislation) will be recorded in the medical health record by the staff/medical staff disclosing the adverse event, including a record of when any disclosure was made. The Director of Risk Management should be updated on all events surrounding the disclosure.

10. In cases when a consensus is not obtained on whether to disclose an adverse event, the Chief of Staff and V.P. of Patient Care/Chief Nursing Officer will provide advice and adjudicate the decision.

CONSULTATION

1. The Canadian Medical Protective Association or the Advisory Services of the College of Physicians and Surgeons of Ontario, the Canadian Nurses Protective Association or other legal services provided for the various college members may be contacted.

2. The Chief of Staff, Director of Risk Management, and the V.P. Patient Care/Chief Nursing Officer can provide guidance to clinicians and hospital staff regarding disclosure by:

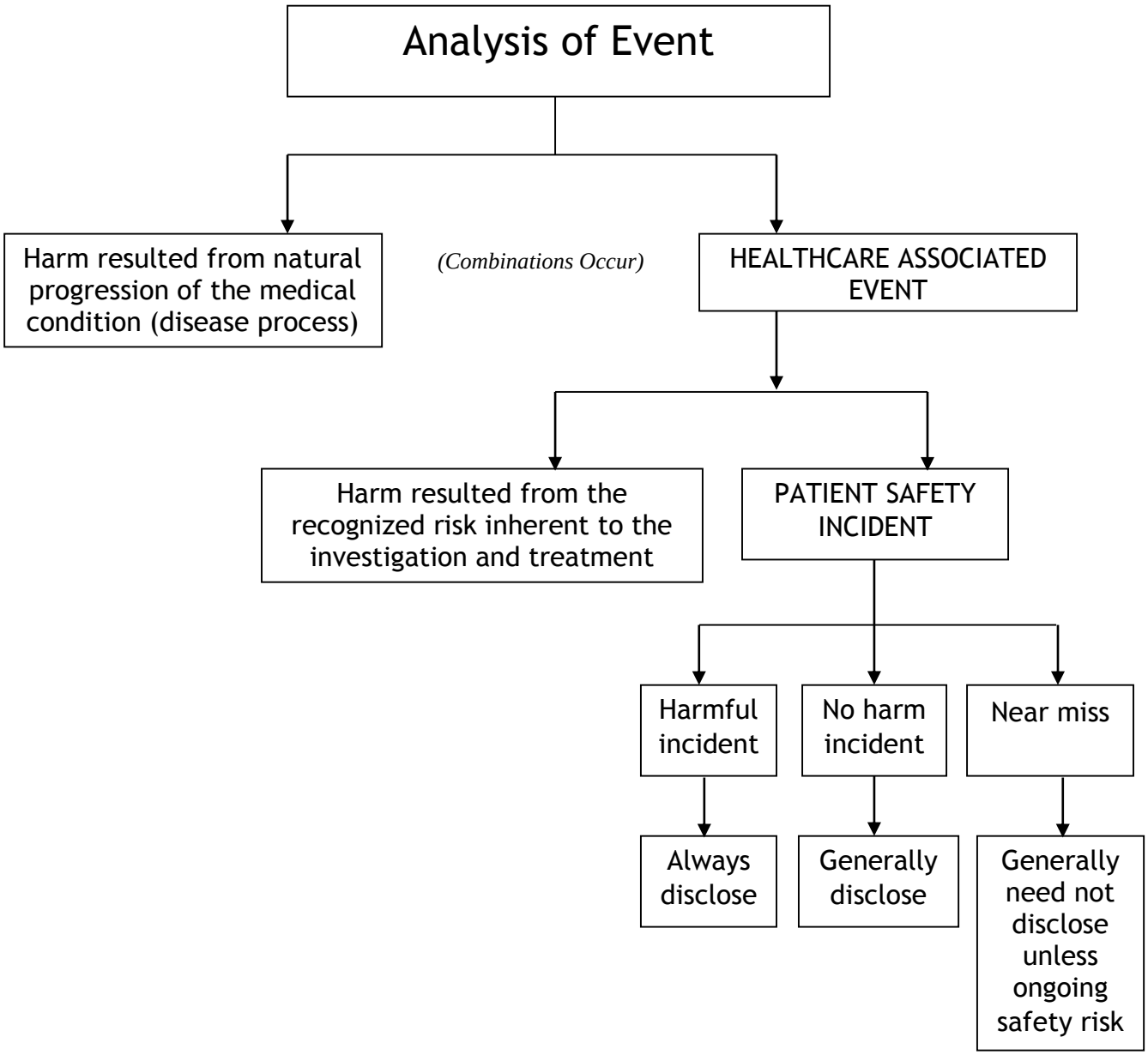
   - consulting with practitioners to guide decisions about disclosure,
   - providing guidance regarding learning opportunities, which will lead to improvements in patient safety and the prevention of an adverse and sentinel event,
   - providing educational support for this policy.

3. The hospital Ethicist can be involved as required.

STAFF SUPPORT

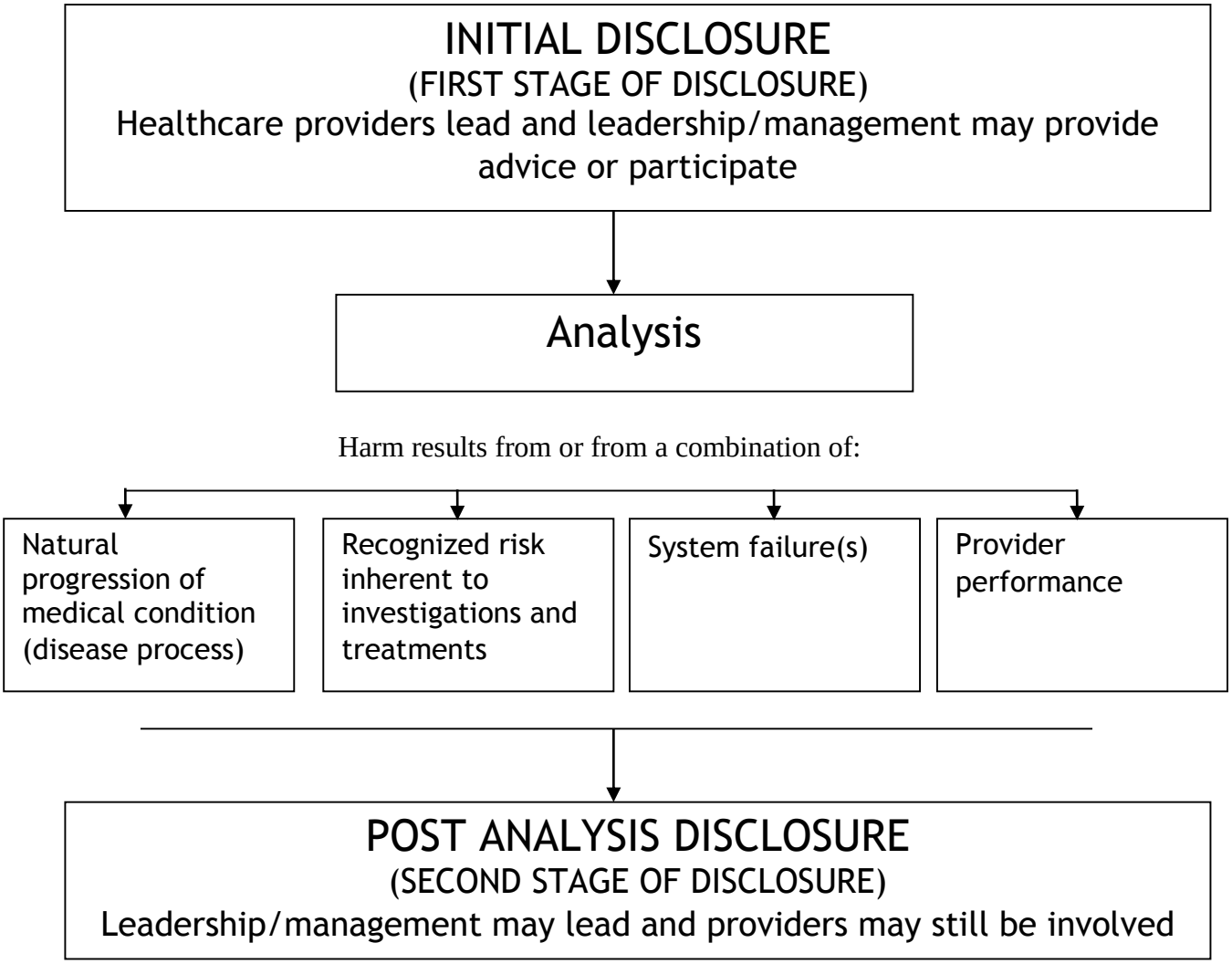
1. In the event employees or medical staff require support, the Hospital policy *'CRITICAL INCIDENT STRESS MANAGEMENT' F-145* should be referenced.

Appendix A
Circumstances When Disclosure Should Take Place



Disclosure must occur if there has been any harm related to a patient safety incident, or if there is a risk of potential future harm. In the case of a near miss, disclosure is discretionary based on whether it is felt that patient would benefit from knowing, for example, if there is a residual safety risk.

Appendix B
Stages of Disclosure



ADDENDUM

Definitions and Notes Related to Patient Safety

PATIENT SAFETY INCIDENT:

An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient.

HARMFUL INCIDENT:

A patient safety incident that resulted I harm to the patient. Replaces “adverse event” and “sentinel event”.

NO HARM INCIDENT:

A patient safety incident which reach a patient but no discernible harm resulted.

NEAR MISS:

A patient safety incident that did not reach the patient. Replaces “close call”.

APOLOGY:

An expression of sympathy or regret, a statement that a person is sorry or any other words or actions indicating contrition or commiseration, whether or not the words or actions admit fault or liability or imply admission of fault or liability in connection with the matter to which the words or actions relate. (Apology Act, 2009)

CRITICAL INCIDENT:

Critical incident means any unintended event that occurs when a patient receives treatment in the hospital:

(a) that results in death, or serious disability, injury or harm to the patient, and

(b) does not result primarily from the patient’s underlying medical condition or from a known risk inherent in providing the treatment *(Ontario Regulation 423/07)*

DISCLOSURE:

The process by which an adverse event is communicated to the patient by healthcare providers. *(CPSI, 2008)*

ERROR:

Failure of a planned action to be completed as intended, or when an incorrect plan is used in an attempt to achieve a given aim. *(Canadian Patient Safety Dictionary, 2003)*

ERROR OF COMMISSION:

An error, which occurs as the result of an action taken. Examples include when a drug is administered at the wrong time, in the wrong dosage, or using the wrong route; surgeries performed on the wrong side of the body; and transfusion errors involving blood cross-matched for another patient. *(JCAHO, 2008)*

ERROR OF OMISSION:

An error which occurs as a result of an action not taken, for example, when a delay in performing an indicated cesarean section results in fetal death, when a nurse omits a dose of a medication that should be administered, or when a patient suicide is associated with a lapse in carrying out frequent patient checks in a psychiatric unit. Errors of omission may or may not lead to adverse outcomes. *(JCAHO, 2008)*

REFERENCES:

- Apology Act, 2009 S.O. 2009, Chapter 3
- Canadian Council on Health Services Accreditation (CCHSA), Reference Guide On Sentinel Events, 2007
- Canadian Disclosure Guidelines, Canadian Patient Safety Institute, 2011
- Canadian Patient Safety Dictionary, National Steering Committee on Patient Safety, October 2003
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Sentinel Event Glossary, 2008
- Ontario Regulation 423/07 made under the Public Hospitals Act, published August 2007, effective July 1, 2008
- Quality of Care Information Protection Act Toolkit, Ontario Hospital Association, 2004