Addressing Patient Safety Events Summary for Northern Health Leaders

Series A Booklet

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northern health

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Table of Contents

REPORTING PATIENT SAFETY EVENTS: SUMMARY FOR NH LEADERS

This summary is one of a series developed for NH Leaders and should be used in conjunction with the following information provided:

- ✓ *A1 - Reporting Patient Safety Events*
- ✓ A2 - Investigating Patient Safety Events
- ✓ A3 - Reviewing Patient Safety Events
- ✓ A4 - Section 51 Protection for Quality Reviews
- ✓ A5 - Disclosure of Patient Safety Events

What are the different types or classifications of patient safety events?

- The patient safety events are divided into different types in the Patient Safety and Learning System (PSLS).[1]
  - Level 1 – No Harm: An event that could cause harm but is caught before it reaches the patient (an almost event).
  - Level 2 – Minor Harm: An unexpected, undesired event directly associated with care or services reaches the patient resulting in minor harm / injury.
  - Level 3 – Moderate Harm: An unexpected, undesired event directly associated with care or services reaches the patient resulting in moderate harm / injury.
  - Level 4 – Severe Harm: An unexpected, undesired event directly associated with care or services reaches the patient resulting in severe harm / injury.
  - Level 5 – Death: An unexpected, undesired event directly associated with care or services resulting in or significantly contributing to the patient's death.
- Levels 4 and 5 are considered critical events and involve the loss of life, limb or organ.
- Please refer to the examples from PSLS outlined at the end of this document.

When should a patient safety event be reported?

- All patient safety events should be reported.
- When a patient is involved in an event or almost involved in an event.[1]
- An event is something outside of the scope of, or not consistent with, the routine care of a patient.[2]

Who is responsible for reporting a patient safety event?

- Anyone with access to the NH network is responsible for reporting a patient safety event including NH hospital & facility staff, Medical Staff, etc.
- Event reports are completed by the staff involved or those that discovered the event by entering the information into the PSLS.[1]
- Staff should immediately notify their supervisors, managers and/or administration-on-call for critical events and follow the critical events checklist.

What are the reporting requirements in PSLS?[1]

- Certain fields must be completed by the individual reporting an event depending on whether the event actually happened or if it was an 'almost event' (could have happened).
- Those individuals reporting events must indicate: the degree of harm; for almost events only, how the event was caught before it happened & the potential for hard; a category to describe the event, details of the event and ideas for improvement. They also select the place, facility and department/program area most related to the event.
- Drop-down lists are automatically generated for subsequent fields depending on how previous fields have been completed, including a list of appropriate 'handlers' i.e. someone responsible for following-up on the event.
- It is important to complete the PSLS form accurately in order to select an appropriate 'handler'.

What is a 'handler' and why have I been identified as one?[2]

- The term 'handler' is used to describe individuals assigned by their organizations to manage safety event follow-up activities after a reporter submits an event in BC PSLS.
- As a Medical Staff Leader you play a key role in responding to and following up on safety event reports.
- Responding to patient safety events is a learning opportunity. You can help to foster a *culture of safety and learning* by actively promoting open, trusting communication among Medical Staff members and the broader health care team.

What else should be considered when reporting a patient safety event in PSLS?

- NH leaders should ensure their Medical Staff know to report only the facts related to an event.
- Avoid assigning blame and giving opinions about the event when reporting regardless of severity.

Who will receive notification regarding patient safety events?

- The Chief of Staff and the NH Risk Management Office automatically receive a notice from the PSLS system (BCPSLS noreply@bcpsls.ca) when a level 4 or 5 critical event (severe harm or death) occurs in their facility for their information.
- If a Medical Staff Leader (or a Medical Staff Member) is identified by the person reporting the event in PSLS as a 'handler' they will receive an email from the same address (BCPSLS noreply@bcpsls.ca).
- It is up to the designated 'handler' to determine whether it is a 'physician appropriate' issue and to either: 1) reassign it to another appropriate department/program handler or 2) follow- up and investigate the event.
- Refer to the *Investigating Patient Safety Events* summary for more information.

What are the responsibilities of NH leaders regarding patient safety events?

- Generally, NH leaders should work with the PSLS Coordinator and/or Quality leads to generate, monitor and review PSLS reports for quality improvement processes and staff education.[1]
- If they are named as a 'handler'[3] (please also refer to the *Investigating Patient Safety Events* summary), they are responsible:
    - To review the PSLS report for accuracy
    - To investigate and understand the causes that underlie the event reported to them
    - To close the event on PSLS when resolved, and
    - To recommend changes to the organization's systems and processes to reduce the probability of such an event in the future.

Related Legislation, Policies and Guidelines

- BC Patient Safety and Learning System (PSLS). (December 2013). *Patient Safety and Learning System Website*.
    - http://www.bcpsls.ca/default.htm.

References

- [1]Northern Health. (August 2013). *Patient Safety and Learning System (PSLS)* – Decision Support Tool; Personal Communication. (August 2013). *Regional Manager, Risk Management, Northern Health*.
    - https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/2-1-3-030.pdf
- [2] BC Patient Safety and Learning System. (October 2013). *Handler Resources Website*.
    - http://www.bcpsls.ca/HandlerResources/default.htm

Examples Related to PSLS Degree of Harm (from PSLS)

No Harm:
- Patient receiving codeine post op - physician discontinues order – order is not flagged for processing - nurse gives codeine instead of switching to tylenol - extra dose - no harm to patient.
- Oximeter malfunctioning - reading is 65% - patient looks pink, in no distress - new machine applied - sats 100% - no harm to patient.
- Patient slipped on wet floor while ambulating without assistance - regained balance without falling but jarred back causing temporary increase in soreness. Recovered quickly without any additional pain medication or intervention. No harm to patient.
- Blood ordered due to low counts. Delay in getting blood from lab due as no porters available. Delay in giving blood but no adverse effects noted. No harm to patient.

Minor Harm:
- Patient's IV goes interstitial, red, swollen, sore. Requires warm compresses and tylenol. OK after a few hours, results in bruise.
- Patient receives total enteral feed in 1 hour instead of 4 hours. Agitated, moaning, vomits. Needs extra bloodwork to check lytes.
- Patient up to bathroom without assistance after epidural wears off. Falls, red area on knee, some bleeding from episiotomy incision. Physician examines, ice applied.

Moderate Harm:
- Patient's IV goes interstitial - on infusion pump - limb is hard, site looks burned, plastic surgery consulted, ointment and dressings applied, some scarring occurs.
- Patient falls out of bed, complains of pain in arm, xrays reveal fracture, patient spends several additional days in hospital due to pain and mobility issues, needs home care set up before discharge can occur.
- Injury or drug variance/reaction that has the potential to: a) significantly alter hospital stay or treatment plan or b) result in admission to hospital or a higher level of care.

Severe Harm:
- Patient's IV goes interstitial during surgical procedure - on infusion pump - leg is grossly swollen, white, hard, pulseless - compartment syndrome diagnosed - requires emergency fasciotomy to release pressure - suffers severe pain, needs IV antibiotics, skin grafts – spends significant extra time in hospital - is left with limp and severe scarring.
- Patient falls out of bed, fractures c-spine, requires surgery to fuse and repair, spends time in halo traction, in hospital for long period of time as a result, left with some permanent neurological deficits.
- Wrong side surgery results in patient's healthy kidney being removed instead of cancerous one. Cancerous kidney subsequently removed, patient on dialysis awaiting transplant.
- Patient receives 10 fold dose of IV morphine, has respiratory arrest, requires resuscitation, is transferred to ICU and ventilated x 1 day, recovers but spends extra 2 days in hospital, family very upset.

Death
- Patient is inadvertently given hydromorphone instead of morphine resulting in a massive overdose, respiratory depression and death.
- Patient's bowel is nicked during abdominal surgery, patient succumbs to massive infection.
- Patient comes to ED seeking treatment for chest pain, but does not speak English. No interpreter is available and patient, who also has flu-like symptoms, is triaged as low priority by ED staff. Several hours later, while sitting in the waiting area, collapses and dies due to massive cardiac event.

INVESTIGATING PATIENT SAFETY EVENTS: SUMMARY FOR NH LEADERS

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- ✓ A1 - Reporting Patient Safety Events
- ✓ *A2 - Investigating Patient Safety Events*
- ✓ A3 - Reviewing Patient Safety Events
- ✓ A4 - Section 51 Protection for Quality Reviews
- ✓ A5 - Disclosure of Patient Safety Events

Why are patient safety events investigated?

- Events are investigated to identify contributing factors and to implement improvements/changes to reduce the likelihood that such an event would reoccur.[1]

Are all patient safety events investigated?

- Ideally, yes. Events should be reviewed and the level of investigation and degree of intervention depends on the severity of the event.
- As an example, no harm events may not all require individual review. Rather, it would instead be beneficial for NH Leaders to generate monthly PSLS reports for no harm events and examine them as a whole for trends.
- Generating and reviewing monthly PSLS reports is a recommended best practice for NH Leaders for all levels of events, regardless whether a specific, individual investigation or quality review has been or is being conducted.
- For the purposes of this summary we are focusing on the processes and considerations for investigating critical events.

What are the responsibilities of NH Leaders regarding investigating patient safety events?

- If they are named as a 'handler' [1,2]:
  - To review the PSLS report for accuracy,
  - To investigate and understand the causes that underlie the event reported to them,
  - To close the event on PSLS when resolved, and
  - To recommend changes to the organization's systems and processes to reduce the probability of such an event in the future.
- The Patient Safety Learning System guides the handler through the information that they need to provide as part of an investigation.
- A general guideline when investigating an event is to keep in mind: *what happened to the patient?*
- Generally, NH Leaders should work with the PSLS Coordinator and/or Quality leads to generate, monitor and review PSLS reports for quality improvement processes and staff education.[2]
- It is important to share what is learned through the quality reviews and work with hospital co-leads to implement changes.
- NH Leaders are also responsible for leading quality reviews and are delegated to invoke Section 51.

What should be secured and documented for the investigation of an adverse event?[2]

- ❖ As the handler, you may not do this yourself. Instead, you may delegate and oversee some or all of these tasks.
- ❖ Be sure to communicate with Co-Leads to ensure that the appropriate documentation and necessary items have been secured.

- ➢ The scene should be secured immediately.
- ➢ All items relevant to the event must be secured and saved (i.e. medication vials, solutions, syringes, equipment, etc).
- ➢ All documentation relevant to the event should be gathered, secured and saved. This includes assignment sheets, rotations, incident and follow-up reports completed by staff, written standards related to the incident, health records (check for completeness) and any other related materials (notes, etc).
- ➢ Depending on the timing and severity of an event, a patient's health records/chart should be secured. If the patient is deceased, their chart should be secured in health records. If they are still admitted a certified copy of the chart should be made at the time of the event for investigation and review processes.

Related Legislation, Policies and Guidelines

- ➢ Health Care Protection Program. (January 2011). *Section 51 of the Evidence Act: Toolkit for Health Care Agencies.*

References

- ➢ [1]Northern Health. (August 2013). *Patient Safety and Learning System (PSLS)* – Decision Support Tool.
  - o https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/2-1-3-030.pdf
- ➢ [2]Northern Health. (May 2011). *Investigation of Adverse Events* - Decision Support Tool.
  - o https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/4-2-1-050.pdf

REVIEWING ADVERSE EVENTS: SUMMARY FOR NH LEADERS

This summary is one of a series developed for NH Leaders and should be used in conjunction with the following information provided:

- ✓ A1 - Reporting Patient Safety Events
- ✓ A2 - Investigating Patient Safety Events
- ✓ *A3 - Reviewing Patient Safety Events*
- ✓ A4 - Section 51 Protection for Quality Reviews
- ✓ A5 - Disclosure of Patient Safety Events

What should be reviewed?

- Individual events and trends should be reviewed.
- Critical events involving the loss of life, limb or organ (typically level 4 & 5 events) should be reviewed.
  - Please refer to *Reporting Patient Safety Events* for more information.
- If a trend regarding patient safety events is identified, it could be examined further through a quality review.

What are the different types of reviews?

- Administrative Review[2]
  - Examples include reviews to improve housekeeping services or practices.
- Accountability Review[1]
  - This type of review focuses on the conduct or performance of an individual health care provider. This can typically be characterized as a human resources (HR) review.
  - System failures and areas for improvement may be identified through an accountability review.
- Quality Review[1]
  - Quality reviews focus on systems issues. They are designed to identify the causes of adverse events or close calls by looking at the system within which the care was provided.
  - Events and issues that arise in hospitals can be protected by Section 51.

When should reviews be conducted?

- Ideally within days of an event.
- As soon as reasonably practical.[1]

How do I choose the best type of review?[1]

- It is recommended to work with the NH Risk Management office, hospital administration, and quality committees to determine an appropriate review type for each event.
- Generally, two types of reviews are available at the hospital/institutional level: Accountability Reviews and Quality Reviews.
- Refer to *Figure 1* below for step by-step considerations to determine which type of review is most appropriate.

Can there be more than one review of an event?

- One case or event can undergo multiple reviews, even at the same time.
- As an example, one event could involve an accountability (HR) review, be moving through a complaints process (outside of Section 51) and also be subject to a quality review.

What else should be considered regarding a quality review?

- Properly constituted quality committees should conduct these types of reviews. These can be existing committees or committees convened for a specific review.
- There must be a Terms of Reference that outlines the purpose to be related to quality, a reporting structure, scope of activities and a list of membership.[1]
- Effective quality reviews are multi-disciplinary and have a patient-centred approach.
- Members from all health care disciplines should be included on the quality committee.

How does Section 51 apply to a quality review?

- Section 51 is legislation that prohibits the release of and admissibility of evidence or information prepared by a properly constituted quality committee. It is not a type of quality review.
- Refer to *Section 51 Protection for Quality Reviews* summary.

When should Section 51 be initiated?

- Section 51 protection of a quality review should be initiated at the outset.
- It is better to start by protecting all documentation and information and use a properly constituted committee at the beginning of a review. If it is determined that the protection is not needed during the course of the review, Section 51 can be removed.

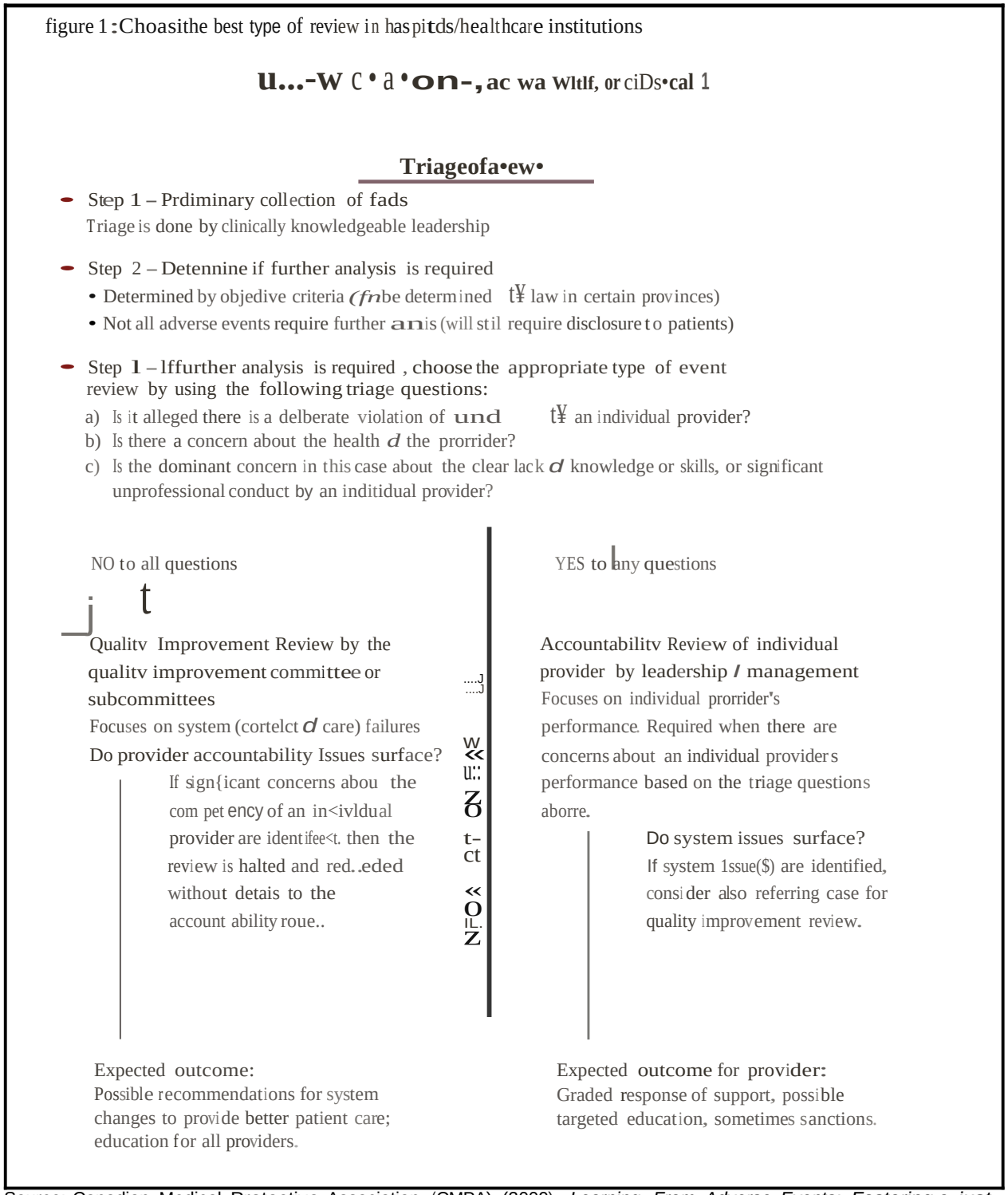
Related Legislation, Policies and Guidelines

- Government of BC. (May 15, 2013). *BC Evidence Act*, S. 51.
  - http://www.bclaws.ca/Recon/document/ID/freeside/00_96124_01
- Canadian Patient Safety Institute. (November 2011). *Canadian Disclosure Guidelines*.
  - http://www.patientsafetyinstitute.ca/english/toolsresources/disclosure/pages/default.aspx
- Northern Health Medical Affairs. (December 2013). *Section 51 Protection for Quality Reviews: Summary for NH Leaders.*

References

- [1]Canadian Medical Protective Association (CMPA). (2009). *Learning From Adverse Events: Fostering a just culture of safety in Canadian hospitals and health care institutions*. Ottawa, ON: CMPA.
  - http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_learning_from_adverse_events-e.cfm.
- [2]Health Care Protection Program. (2011). *Section 51 of the Evidence Act: Toolkit for Health Care Agencies.* British Columbia: HCPP Risk Management Branch.

Figure 1.0: Choosing the Best Type of Review



Source: Canadian Medical Protective Association (CMPA). (2009). *Learning From Adverse Events: Fostering a just culture of safety in Canadian hospitals and health care institutions.* Ottawa, ON: CMPA.

SECTION 51 PROTECTION FOR QUALITY REVIEWS: SUMMARY FOR NH LEADERS

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- ✓ A3 - Reviewing Patient Safety Events
- ✓ *A4 - Section 51 Protection for Quality Reviews*
- ✓ A5 - Disclosure of Patient Safety Events

What is Section 51 of the *BC Evidence Act*?

- It is legislation that prohibits the release of and admissibility of evidence of information prepared by a properly constituted quality committee. [1,2]
- It protects quality information collected in hospitals (as defined in the *Hospitals Act*) and Provincial mental health facilities (as defined in the *Mental Health Act*).[3]
- This means that the activities of these properly constituted QA committees are protected from disclosure in legal proceedings. It also sets out limitations on the dissemination of QA information.[1,2]

Why does it exist? What is its purpose?

- Protecting these quality activities from being used in legal proceedings (inquiries, arbitrations, inquests or civil proceedings) allows for frank and open discussion free from disclosure and blame. It protects efforts to improve patient care and safety by creating a safe environment for an honest appraisal of adverse events.[1,2,3]
- It does not, however, override the obligations to disclose adverse events to patients.[2]

When is Section 51 implemented? What needs to be reviewed?

- The recommendation from the Health Care Protection Program is to implement Section 51 for most incidents.
- HPCC indicates that this includes "all occurrences, events or adverse outcomes that give rise to significant quality of care concerns"[3] and are "reviewed for the purposes of examining the quality of care by health care professionals."[2]

What is the process for implementing Section 51? What do you need to know and do?

- Medical staff (and other front line staff) are to report critical, serious, adverse and other events to a designated individual. In the case of critical or serious events, report them **immediately** before any Section 51 quality review is conducted.[1,3]
- All documents and equipment relating to the incident should be secured.[1]
    - This includes information or evidence that is not routinely kept as part of patient care (for example, rough notes taken by nurse or other practitioner providing care, computer records such as emails, or equipment – for example: a dialysis machine if related to the incident).[3]
- The facility's designated individual (Chief of Staff, Department Head) is responsible for notifying the VP Medicine, Chief Medical Officer (CMO), or delegate of the incident and to discuss whether a Section 51 quality review is to be commissioned.
- They are also responsible for ensuring the Regional Director of Risk Management is aware of the incident and that a Section 51 quality review is being commissioned.
- See the attached diagram for the full notification and implementation process for Medical Staff members.

How is a Section 51 quality review initiated?

- A designated individual will initiate and lead the Section 51 quality review required as a result of the event.[1]

- One individual may initiate a review while another is tasked with leading the review.
- A Section 51 review must be done by a properly constituted quality committee otherwise the information will not be protected under the Act.
- Refer to the information below about designated individuals and properly constituted committees.

Who commonly commissions and oversees a Section 51 review?

- Chief Medical Officer
- Medical Directors
- Chiefs of Staff
- Department Heads

Who is ultimately accountable for a Section 51 review?

We:

- Medical Directors
- Chief Medical Officer
- Vice President Medicine
- Northern Health Medical Advisory Committee (MAC) (via the Board of Directors)
- Risk Management
- Chief Executive Officer & Board of Directors

Are all operationally accountable.

- Ultimately, the Board of Directors is accountable via NHMAC.

Which Northern Health Committees are 'properly constituted' to conduct a Section 51 review?

- Generally, committees that report, through any channel, to the Northern Health Board with the purpose of quality improvement specifically outlined in their Terms of Reference (TOR) are properly constituted to conduct a Section 51 review.
- Properly constituted committees can be existing, multi-purpose committees (MACs or related standing/sub-committees) with quality improvement outlined in their TOR, or committees can be convened with the specific purpose of conducting a Section 51 review.[3]
- If you are not sure whether a committee is properly constituted, contact one of the designated individuals in your area.

How is Section 51 protection for a review maintained?

- Reports and recommendations generated through a Section 51 review must flow through Regional MACs to the Northern Health MAC and, if needed, up to the Board.

What is protected under a Section 51 review?

- Any "information, records, summaries, reports or other documentation made or compiled for the purpose of submission to or made at the request of a Section 51 Committee or which arose out of the study, investigation, evaluation or program carried on by a Section 51 Committee"[2] are all protected from disclosure.
- This includes the opinions voiced during the review, as well as conclusions drawn and recommendations made from the review.[3]
- In general, the "what" (the facts) will not be protected but the "why" (the interpretation) is protected.
- As well, recommendations under a Section 51 review may not be disclosed until they have been approved.
- A Section 51 review can be considered a 'cone of silence'. Anyone invited or involved in the review is protected, as well as any documentation generated as part of the review process.
- This includes designated health care professionals under the *BC Health Professions Act* or the *BC Emergency Health Services Act*,[2] as well as staff members and individuals who participate in a Section 51 review.[3]

Are there any exceptions?

- Once approved, the recommendations may be released to individuals within the organization who need to be aware or have the authority to act on the recommendations.[3]

- Information from a Section 51 review may also be disclosed under other limited circumstances related to requests for information and investigations.
- If you are being asked for information, it is important that you to your Medical Director, CMO, VP Medicine or Regional Director of Risk Management for confirmation about release of the protected information.
- If the organization has taken action on recommendations stemming from a Section 51 review, these recommendations may be released to the public.

What is not protected under a Section 51 review?

- Any factual information that is or should be included in the patient's chart.
- Reviews conducted for a purpose other than improving or maintaining quality of care such as a complaint with the intent to disclose to a patient or family or reviews related to care provided in the community (i.e. that cannot be tied to hospital-based care).[2]

What are you allowed to discuss or share?

- All activities, information and discussions relating to a Section 51 review are considered confidential. Details of the review should not be discussed outside of the committee as per the non-disclosure requirements.[3]
- However, originals or copies of medical or hospital records and all clinically factual information that is or should have been included in the patient's chart can be shared under usual patient confidentiality, including facts in an incident report not included in the patient chart and medical facts that were learned during the review[2]
- As well, that a quality of care review was conducted and when it occurred can be shared.

Who do you contact if you aren't sure about the process, need advice, or more information?

- Medical Director
- Chief Medical Officer
- VP Medicine
- Regional Manager of Risk Management

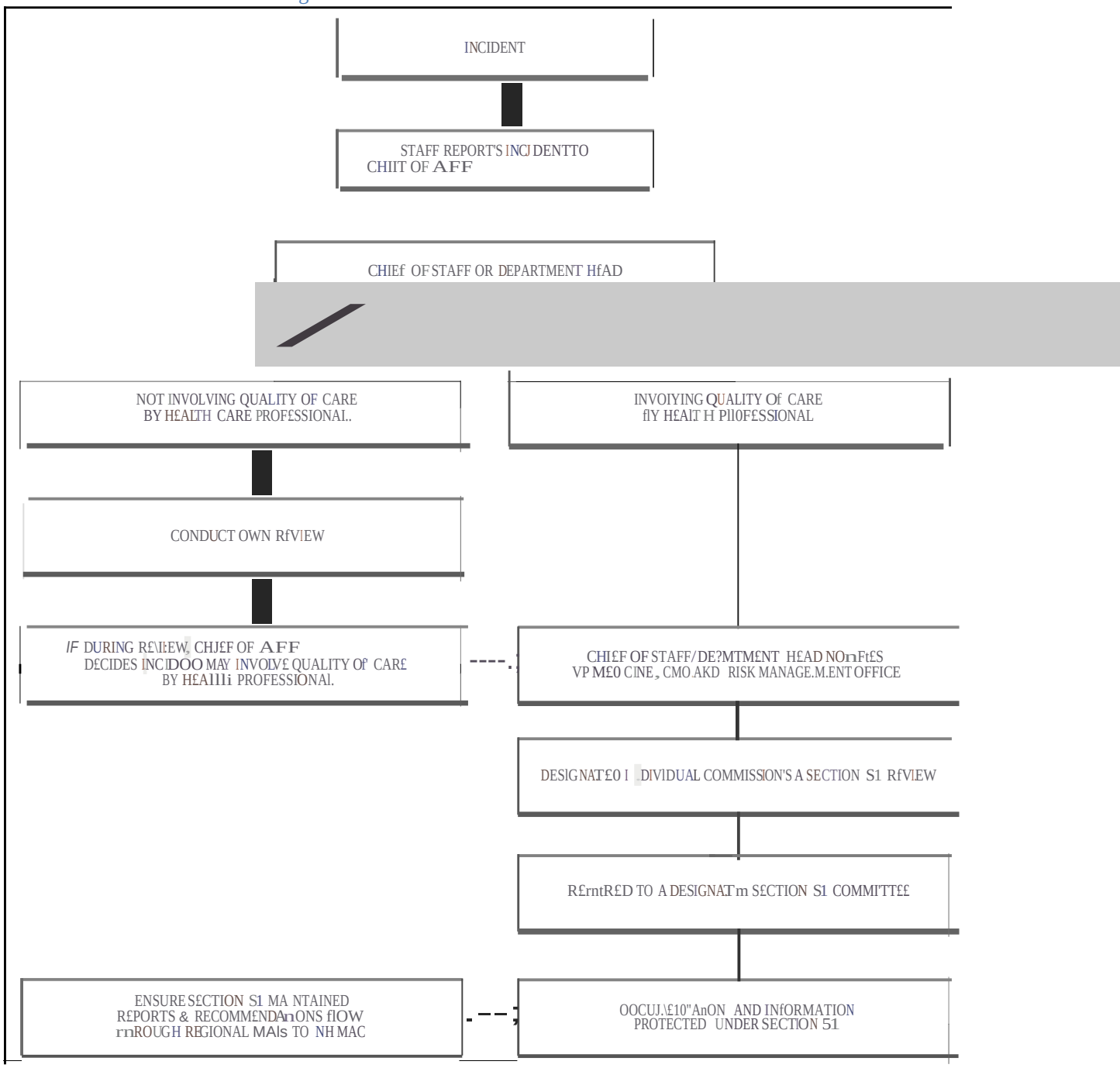
Related Legislation, Policies and Guidelines

- Government of BC. (May 2013). *BC Evidence Act*, S. 51.
  - http://www.bclaws.ca/Recon/document/ID/freeside/00_96124_01
- Government of BC. (February 2014). *BC Health Act.*
  - http://www.bclaws.ca/Recon/document/ID/freeside/00_96179_01
- Government of BC. (February 2014). *BC Health Professions Act*.
  - http://www.bclaws.ca/Recon/document/ID/freeside/00_96183_01
- Government of BC. (February 2014). *BC Emergency Health Services Act.*
  - http://www.bclaws.ca/Recon/document/ID/freeside/00_96182_01
- Government of BC. (February 2014). *Freedom of Information and Protection of Privacy Act*.
  - http://www.bclaws.ca/Recon/document/ID/freeside/96165_00
- Canadian Patient Safety Institute. (November 2011). *Canadian Disclosure Guidelines*.
  - http://www.patientsafetyinstitute.ca/english/toolsresources/disclosure/pages/default.aspx

References

- [1]Northern Health. (November 2011). *BC Evidence Act: Section 51* - Decision Support Tool.
  - https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/4-2-1-010-P.pdf
- [2] Health Care Protection Program. (January 2011). *Section 51 of the Evidence Act: Supplement to the Toolkit for Health Care Agencies.* (Brochure).
- [3] Health Care Protection Program. (January 2011). *Section 51 of the Evidence Act: Toolkit for Health Care Agencies.*

Figure 1.0: Section 51 Process for NH Medical Staff



DISCLOSURE OF PATIENT SAFETY EVENTS: SUMMARY FOR NH LEADERS

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- ✓ A4 - Section 51 Protection for Quality Reviews
- ✓ *A5 - Disclosure of Patient Safety Events*

What are the different types of patient safety events?

- Refer to *Reporting Patient Safety Events* for definitions.
  - Level 1 – No Harm
  - Level 2 – Minor Harm
  - Level 3 – Moderate Harm
  - Level 4 – Severe Harm (Critical Event)
  - Level 5 – Death (Critical Event)

Which patient safety events need to be disclosed?

- "Any Adverse Event where there is harm, injury or complication due to health care service delivery should be disclosed to the Client[1]."[2]
- Exceptions can occur, but a decision not to disclose must be made within a structured process and by more than one individual (for example, the disclosure team or an ethics review process).[4]

Should 'no harm' events be disclosed?

- If disclosing a 'no harm' or 'almost event' could assist a Client in the future, it should be disclosed. This is a matter of clinical and professional judgement.[4]
- Broader Northern Health health care teams should be made aware of 'almost events' in order to learn from and prevent future Adverse Events.[2]

Who is the Client?

- The Client is someone who receives care or services from a health care agency within Northern Health. These individuals can be patients, residents or clients in acute (hospital facilities), residential or community settings. They may also be their families or, where appropriate, substitute decision makers.[2]

What is disclosure?

- Health care workers sharing information with a patient about a health care event that does or may affect that patient's interest.[2]

Why do we disclose?

- Northern Health Clients are entitled to know about the care and treatment they are provided.[2]
- Physicians, managers and other medical staff and health care providers are professionally and ethically obligated to be transparent, open and honest with their patients.[2]
- Disclosure is one component of this.

[1] The term 'client' in this summary is synonymous with 'patient'.

What do we disclose?

- Facts (the 'what', not necessarily the 'why') about an Adverse Event "must come from the information already recorded in a Client's hospital record and/or from those involved in the event itself and must be factual, not speculative."[2]
- Quality review records may not be communicated to a Client or their representative when disclosing an Adverse Event.[2]
- Refer to *Section 51 Protection for Quality Reviews* for more information on disclosure regarding quality reviews protected by Section 51 of the *BC Evidence Act*.

When do we disclose?

- Disclosure of adverse events should take place as close to the event as possible, after ensuring the client's safety and that the client's care needs are met.[3]
- Timing should take into consideration the client's clinical condition, the availability of key staff and support person(s), the availability of the client's support person(s), the client's/family's preference, the privacy and comfort of the client, and the emotional and psychological state of the client.[2]

How do we disclose?

- Several steps, what to consider at each step, and a checklist are outlined in the Northern Health's *Disclosure of Adverse Events Decision Support Tool Guideline* (link).
- The *Canadian Disclosure Guidelines* is also a helpful resource.

Recommended Disclosure Steps[2]

1. Ensure Patient Safety
2. Identify Key Individuals
    - Health care professionals involved in the adverse event
    - Person(s) responsible for initial disclosure conversation
    - Support person(s) who are available for the patient
3. Initial Disclosure Conversation
    - Should include: an apology, known facts, patient/family questions and concerns, consequences of event and any side effects to look for, discussion of ongoing care, what happens next, arrangement for future meeting(s), contact details.
    - Should be documented (date, time, location; names and roles of those present; facts presented, questions raised and answers given, and reactions in the discussion).
4. Offer Emotional Support
    - To: patient and family members, disclosing health professional, health care professionals involved in the adverse event.
5. Follow-up Discussions/Dialogue

Related Legislation, Policies and Guidelines

- Canadian Patient Safety Institute. (2011). *Canadian Disclosure Guidelines: Being Open with Patients and Families*.

References

- [1]Canadian Patient Safety Institute. (November 2011). *Canadian Disclosure Guidelines: Being Open with Patients and Families*.
    - http://www.patientsafetyinstitute.ca/english/toolsresources/disclosure/pages/default.aspx
- [2]Northern Health. (November 2011). *Disclosure of Adverse Events* - Decision Support Tool; Personal Communication. (August 2013). *Regional Manager, Risk Management, Northern Health.*
    - https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/4-2-3-030.pdf