Addressing Patient Safety Events

Training Module for Northern Health Medical Staff Leaders

northern health
the northern way of caring

Overview

Northern Health Medical Affairs has developed a suite of orientation and education resources for Medical Staff Leaders to support them in their administrative positions. This training module booklet is a supplement to the corresponding summary booklet (also titled “Addressing Patient Safety Events”). The training module guides Leaders through key aspects of different policies and processes and tests their knowledge of how to apply what they have learned. The summaries provide more details regarding Medical Staff Leaders’ roles and responsibilities. All of the orientation and education materials for Medical Staff Leaders can be found online at: http://physicians.northernhealth.ca/PhysicianResources/OrientationEducation.aspx.

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1. Reporting Patient Safety Events

1. Reporting Patient Safety Events

What this module covers:

By the end of this module, you will be able to:

- Understand when to report a patient safety event.
- Classify patient safety events according to the degree of harm.
- Know what information to include in a report.
- Understand your reporting responsibilities.

Why do I need to know this?

As physicians, we take pride in our work. But errors happen, and sometimes, those errors have the potential to cause harm to our patients. By reporting and reviewing patient safety events, we can make improvements to our processes and practices, and ensure we provide the highest standard of care possible.

This module will provide you with the information you need to report an event on the Patient Safety and Learning System (PSLS).

What is the PSLS?

The British Columbia Patient Safety and Learning System (BC PSLS) is a web-based tool used by health care providers across BC to report and learn from patient safety concerns such as actual adverse events, good catches (near misses) and hazards.

BC PSLS helps health care providers, leaders, and others to collect and analyze information that is crucial for patient safety and quality improvement. BC PSLS is in use across all BC health authorities in all care settings.

The overarching goal of BC PSLS is to make health care safer for all British Columbians through shared learning and continuous system improvement.

What is a patient safety event?

A patient safety event is an unexpected, undesired event directly associated with care or services provided by the hospital. It results in harm, or potential for harm, to the patient.

When should I report a patient safety event?

Any time a patient has been harmed, or almost harmed, from the care or treatment they received at a Northern Health facility.

1. Reporting Patient Safety Events

What are the different types of patient safety events?

1. Level 1 – No harm to patient
2. Level 2 – Minor Harm to patient
3. Level 3 – Moderate Harm to patient
4. Level 4 – Severe Harm to patient
5. Level 5 – Death

If there was no harm, why do I need to report it?

"No-harm" events sometimes result from a good catch! We can learn from these events. In this case, the question we ask is, "What went right?" Other times, we've just been lucky. We want to capture the no harm events for the same reason we want to capture the other events – to continuously improve our systems and processes.

How do I determine the appropriate level for an incident?

Based on current information, determine the appropriate level by considering two factors:

A. The nature of the intervention
B. The permanence of effect

Level 1 – No Harm

An event occurs that could cause harm to the patient, but no harm results.

Example:

Sally is recovering from surgery. The oximeter reads at 65%, but she has good colour and does not appear to be in distress. The oximeter is swapped for a new one, which indicates sats at 100%.

The faulty oximeter is sent for repairs.

Level 2 – Minor Harm

An event, directly related to the care the patient is receiving, occurs that is unexpected and undesired. It causes minor harm to the patient.

Example:

Sally is recovering from surgery, and gets up to go to the bathroom without assistance after the anesthetic wears off. She falls, which results in some swelling and bruising to one knee. The physician recommends she apply ice and elevate the leg to reduce swelling.

Level 3 – Moderate Harm

An event, directly related to the care the patient is receiving, occurs that is unexpected and undesired. It causes moderate harm to the patient, which results in an extended stay or higher level of care being required.

Example:

Sally is in the hospital for a simple surgery, but due to complications, loses a lot of blood during surgery. Her physician decides to extend her stay in the hospital.

Level 4 – Severe Harm

An event, directly related to the care the patient is receiving, occurs that is unexpected and undesired. It causes severe harm or injury to the patient.

Example:

Sally is in the hospital for a simple surgery, but her IV goes interstitial. Her leg swells and the physician treats her for compartment syndrome, which involves an emergency fasciotomy, IV antibiotics and skin grafts. Sally now has a limp and severe scarring.

Level 5 – Death

An event, directly related to the care the patient is receiving, occurs that results in, or contributes to, the patient's death.

Example:

Sally is prescribed morphine for pain relief, but is inadvertently given hydromorphone instead. This results in a massive overdose; Sally's breathing becomes depressed and she dies.

Critical Events

Level 4 and 5 events are considered "critical events."

- In addition to reporting them on the PSLS, staff must follow the critical events checklist.

1. Reporting Patient Safety Events

What will I see when I look at PSLS?

There are certain fields that must be completed by the person reporting an event. For instance: level of harm; a description category; event details; ideas for improvement.

Sometimes, depending on the nature of the event, the system will ask additional questions.

The system will generate a drop-down list of appropriate "handlers" for the event, based on the information entered by the reporter.

Who enters the report into PSLS?

- Anyone with access to the NH network can report the event, including both NH hospital and facility staff, as well as medical staff.
- The report should be completed by staff involved in the event, or staff that discovered the event.
- Staff should immediately notify their supervisors, managers, and/or administration for critical events, and follow the critical events checklist.

As a "handler" what are my responsibilities?

As the assigned handler, you will:

- Review the PSLS report for accuracy.
- Determine whether you are the appropriate handler.
- If not, reassign it to another appropriate handler.
- Investigate and understand the causes that underlie the event reported to you.
- Close the event on PSLS when resolved.
- Recommend changes to the organization's systems and processes to reduce the probability of such an event in the future.

Fact-Finding, not Blame-Finding

Your organization has assigned you to manage the follow-up activities for events reported in the BC PSLS. This is your opportunity to foster a culture of safety and learning by actively promoting open, trusting communication.

Focus on fact finding, and avoid the temptation to engage in blaming and finger-pointing. Everyone makes mistakes. We want to ensure that processes and systems are improved to reduce the probability that a similar event will take place in the future.

Who else is notified?

- The Chief of Staff and the NH Risk Management Office automatically receive a notice from the PSLS system when a level 4 or 5 critical event (severe harm or death) occurs in their facility.
- Regardless of these notifications, as the handler, it is still your responsibility to follow up on the report.

Quiz Time

Classify the event according to the degree of harm:

Sally is prescribed morphine for pain relief, but the pharmacist reading the order is having difficulty reading it. She thinks the prescription is for hydromorphone, but decides to phone the doctor to confirm before filling the prescription.

- **Level 1: No Harm**
- **Level 2: Minor Harm**
- **Level 3: Moderate Harm**
- **Level 4: Severe Harm**
- **Level 5: Death**

Answer: **Level 1: No Harm**

Sally could have had serious complications if the pharmacist had not called the doctor to check the order.

Hopefully, the pharmacist reached the doctor quickly, and Sally did not experience any delay in receiving pain medication.

Classify the event according to the degree of harm:

Barjinder is in surgery after a workplace accident. During the surgery, his bowel is nicked but the surgical team isn't aware of it.

Eventually, Barjinder succumbs to a massive infection.

- **Level 1: No Harm**
- **Level 2: Minor Harm**
- **Level 3: Moderate Harm**
- **Level 4: Severe Harm**
- **Level 5: Death**

Answer: **Level 5: Death**

Remember that for level 4 and 5 incidents, you must follow the critical events checklist.

Classify the event according to the degree of harm:

Fatima falls out of her bed in the hospital. The attending physician orders x-rays, and learns that she has fractured her wrist. She has to spend a few more days in hospital due to pain and mobility issues.

- **Level 1: No Harm**
- **Level 2: Minor Harm**
- **Level 3: Moderate Harm**
- **Level 4: Severe Harm**
- **Level 5: Death**

Answer: **Level 3: Moderate Harm**

Fatima must stay in the hospital for a few more days, but she will eventually heal from her injury.

Next, lets talk about your reporting role as a Medical Staff Leader.

Classify the event according to the degree of harm:

Mark is 22 years old, in hospital due to a serious car accident. He receives a total enteral feed in one hour instead of four hours. He appears agitated and is moaning, and starts to vomit. You fix the feed and order blood work to check his lytes.

- **Level 1: No Harm**
- **Level 2: Minor Harm**
- **Level 3: Moderate Harm**
- **Level 4: Severe Harm**
- **Level 5: Death**

Answer: **Level 2: Minor Harm**

Mark has definitely been harmed, but not seriously. Fortunately, Mark will not have any long-term consequences.

Classify the event according to the degree of harm:

Jiang was admitted for severe pneumonia. She was moved into a room on the ward this morning; unfortunately, she was hooked up to room air instead of oxygen. When the nurse checked on Jiang half an hour later, she was blue.

She was immediately given oxygen, but now has permanent brain damage.

- **Level 1: No Harm**
- **Level 2: Minor Harm**
- **Level 3: Moderate Harm**
- **Level 4: Severe Harm**
- **Level 5: Death**

Answer: **Level 4: Severe Harm**

This is definitely severe harm. This mistake resulted in permanent harm to the patient.

1. Reporting Patient Safety Events

True or False?

When entering a report into the PSLS, the reporter can choose anyone they want to act as the "handler" for the event.

☐ True
☐ False

Answer: **False**

Organizations designate specific individuals to act as handlers.

When a report is entered into PSLS, Reporters must select a handler from a drop-down menu; the system determines which handlers would be most appropriate for the type of event entered.

True or False?

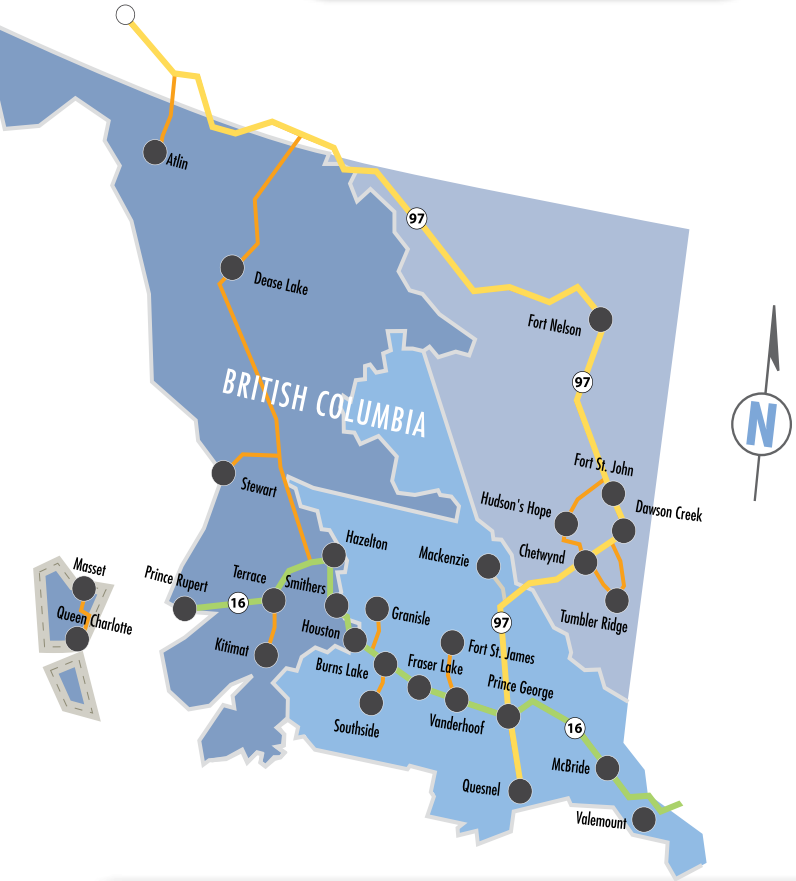
When reviewing events on PSLS, my primary focus as a handler is to determine who made the mistake, and make sure they don't do it again.

☐ True
☐ False

Answer: **False**

Focus on fact-finding, not blame-finding!

Your job is to investigate and understand the causes that underlie the event, and recommend changes to the organization's systems and processes.



Which one of these is not true?

A. As a medical staff leader, I may be assigned as a "handler" for patient safety events.

B. The PSLS is a system designed and used by Northern Health to track patient safety events.

C. As a handler, I must decide whether to investigate the event, or refer it to another handler.

D. The Chief of Staff will automatically be notified if a Level 4 or 5 event is reported.

Answer: **B**

The Patient Safety and Learning System is a provincial system used by all the health authorities in BC.

2. Investigating Patient Safety Events

2. Investigating Patient Safety Events

What this module covers:

By the end of this module, you will be able to:

- Describe the purpose of patient safety event investigations.
- Identify the different roles and responsibilities for investigating a patient safety event.
- Determine what must be secured pending an investigation.

Why do I need to know this?

Events are investigated to implement improvements/changes to reduce the likelihood that such an event would reoccur. We do this by identifying all the contributing factors.

At some point, you will need to either investigate a patient safety event, or secure information pending an investigation. But, an investigation isn't "one size fits all"; your efforts in the investigation must be correlated to the level of harm. It is important that you understand the expectations for a satisfactory investigation.

Do we investigate Level 1 & 2 events?

Yes. But the level of investigation and degree of intervention will depend on the severity of the event.

"No harm" events may not require individual review; however, monthly PSLS reports for no harm events should be examined for trends and patterns.

Generating and reviewing monthly PSLS reports is a recommended best practice for Medial Staff Leaders for all levels of events, regardless of whether an individual investigation or Quality Assurance Review is also conducted.

This module focuses on the processes and considerations for investigating adverse events, which would normally be Level 3 to Level 5.

What are my responsibilities?

As a Medical Staff Leader, you have specific responsibilities when you are the identified "handler" for an event. As we discussed in the Reporting module, these responsibilities are:

- Review the PSLS report for accuracy.
- Investigate and understand the causes that underlie the event reported to them.
- Communicate with Administration and other team members.
- Close the event on PSLS when resolved.
- Recommend changes to the organization's systems and processes to reduce the probability of such an event in the future.

Even when you are not the identified handler, you are responsible for leading Quality Assurance Reviews, and are delegated to invoke Section 51.

What information will I need to gather?

The Patient Safety and Learning System (PSLS) will let you know what information you need to identify at the start of your investigation.

- Where did the event(s) take place?
- When did the event take place?
- Who was involved? Who may have observed?
- What happened?
- What was the result?

Beginning the investigation

Focus on detecting the facts, using open-ended questions:

- What happened to the patient?
- And then what happened?
- And what happened next?

Avoid making assumptions and jumping to conclusions by taking the time to listen. Be curious!

Who will I need to work with?

In addition to the individuals involved in a specific event, you will need to liaise and coordinate your activities with other individuals in your organization.

1. The PSLS Coordinator and/or Quality Leads will generate, monitor and review PSLS reports for quality improvement processes and staff education.
2. Hospital administration and NH Risk Management should be included on your adverse event review team.
3. Share your findings with hospital administration and seek their cooperation with implementing changes.

What information should be secured & documented for adverse events?

1. Secure the scene of the event.
2. Items relevant to the event must be secured and saved.
3. Documentation relevant to the event should be gathered, secured and saved.
4. Depending on the timing and severity of an event, a patient's health records/chart, or a certified copy, should be secured.

As the handler, you may not do this yourself. Your role is similar to a project manager – you may delegate some or all of these tasks. Communicate with administration to ensure that the appropriate items have been secured.

Following up on a Level 1 Event

A faulty oximeter is used, but is detected before there is any harm to the patient. The faulty oximeter is sent for repairs, and the nurse files a report in PSLS.

Is this an isolated incident, or are there any trends or patterns relevant to this event? If so, do we need to review the process for checking and maintaining equipment?

What went right in this incident? How did the nurse catch this, and should this be included in procedures?

Securing information – adverse events

Marta is in labour, and having a tough time. The physician on-call is paged. Time passes and Marta's condition deteriorates. The doctor is paged a 2nd time, but then Marta is rushed for an emergency C-section when the fetal heart rate drops. Marta's baby does not survive.

Dr. Chen is the designated Handler, and immediately ensures that staff secures a certified copy of Marta's chart (as Marta is still in the hospital), phone records and other related documents.

Billy is well known in emergency. He is frequently intoxicated to the point that he stumbles and eventually passes out. He usually uses foul language, shouting and yelling at hospital staff. Tonight, he attends emergency. He appears intoxicated and his speech is slurred. He is told to take a seat in the waiting room. Several hours later a nurse attempts to rouse him, but he is non responsive and dies the next day.

Dr. Flavel is the designated handler. In addition to securing Billy's medical records, he also checks with security to see if there is video footage that could help determine what happened.

Jiang was hooked up to oxygen. When the nurse checked on Jiang half an hour later, she was blue. The nurse realizes that the oxygen is not flowing. Jiang suffers permanent brain damage.

Dr. Cross is the designated handler. In addition to securing a certified copy of Jiang's chart, she also works with Hospital Administration to ensure that the equipment is secured, photos of the scene have been taken, and checks with security to see if there is video footage that could help determine what happened.

Quiz Time

Multiple Choice

Annette is 55 years old, admitted on a Saturday morning due to a serious skin infection. She was prescribed Gentamicin. Annette's kidneys are now shutting down & Annette will be on dialysis for the rest of her life.

What information should be secured?

A. Annette's original health care records.

B. Certified copy of Annette's health records, the Rx lot.

C. Annette's original health care records, the Rx lot.

Answer: **B**

Annette is still being treated, so you will need to get a certified copy of her health records.

Because there are a number of factors that could lead to an overdose of Gentamicin, you will want to ensure the entire lot is secured until you are certain that there was not a quality issue with this drug lot.

Stuart recently visited the hospital for a colonoscopy, and complains that he contracted Hepatitis B as a result of that procedure.

Multiple Choice

Stuart recently visited the hospital for a colonoscopy, and complains that he contracted Hepatitis B as a result of that procedure.

What information should be secured?

A. Stuart's original health records, and the endoscope used in the procedure.

B. A certified copy of Stuart's health care records.

C. A certified copy of Stuart's health care records, and the endoscope used in the procedure.

Answer: **A**

As Stuart is no longer in the hospital, ensure his original health records are secured.

You also want administration to secure the equipment used in the procedure, to verify it is sterile.

Multiple Choice

Barjinder dies from a massive infection, resulting from a nicked bowel during surgery.

What information should be secured?

A. A certified copy of the health care records, video documentation of the surgery.

B. Barjinder's original health care records, video documentation of the surgery, equipment used during the surgery, the operating theatre itself.

C. Barjinder's original health care records, video documentation of the surgery.

Answer: **B**

- Barjinder is no longer a patient, so the original copy of his health care records should be secured.
- The video of the surgery may be informative.
- There may have been an issue with the tools and equipment used in the surgery.
- Lighting or the set-up of the theatre could have been a contributing factor; if the Theatre itself wasn't secured, ask administration to take photos, if they haven't already done so.

True of False

I should review monthly reports on PSLS. If necessary, I should share findings with the Chief Medical Officer.

☐ True
☐ False

Answer: **False**

You should be sharing this information with Quality Leads, the PSLS Coordinator, and/or hospital administration.

3. Reviewing Patient Safety Events

3. Reviewing Patient Safety Events

What this module covers:

By the end of this module, you will be able to:

- Identify and describe three different types of reviews.
- Determine the most appropriate type of review to conduct, in a given circumstance.

Why do I need to know this?

As a Medical Staff Leader involved in investigating and reviewing patient safety events, you will need to determine which type(s) of review is the most appropriate.

The review should start a soon as reasonably practical, ideally within days of an event.

There are three different types of reviews.

What are the 3 types of reviews?

1. Administrative Review
2. Accountability Review
3. Quality Assurance Review

For the most part, you will be conducting Accountability Reviews and Quality Assurance Reviews.

Administrative Reviews

These will normally be conducted by hospital administration, and concern non-medical services or practices.

For example, house-keeping.

Accountability Reviews

These are typically human resources (HR) reviews, and focus on the conduct or performance of an individual health care provider.

Quality Assurance Reviews

These focus on identifying the root causes of adverse events by looking at the systems issues. Events and issues that arise in hospitals can be protected by Section 51. Those protections will be covered in the next module.

Who will I need to work with?

Work with the NH Risk Management office, hospital administration, and quality assurance committees to determine an appropriate review type for each event.

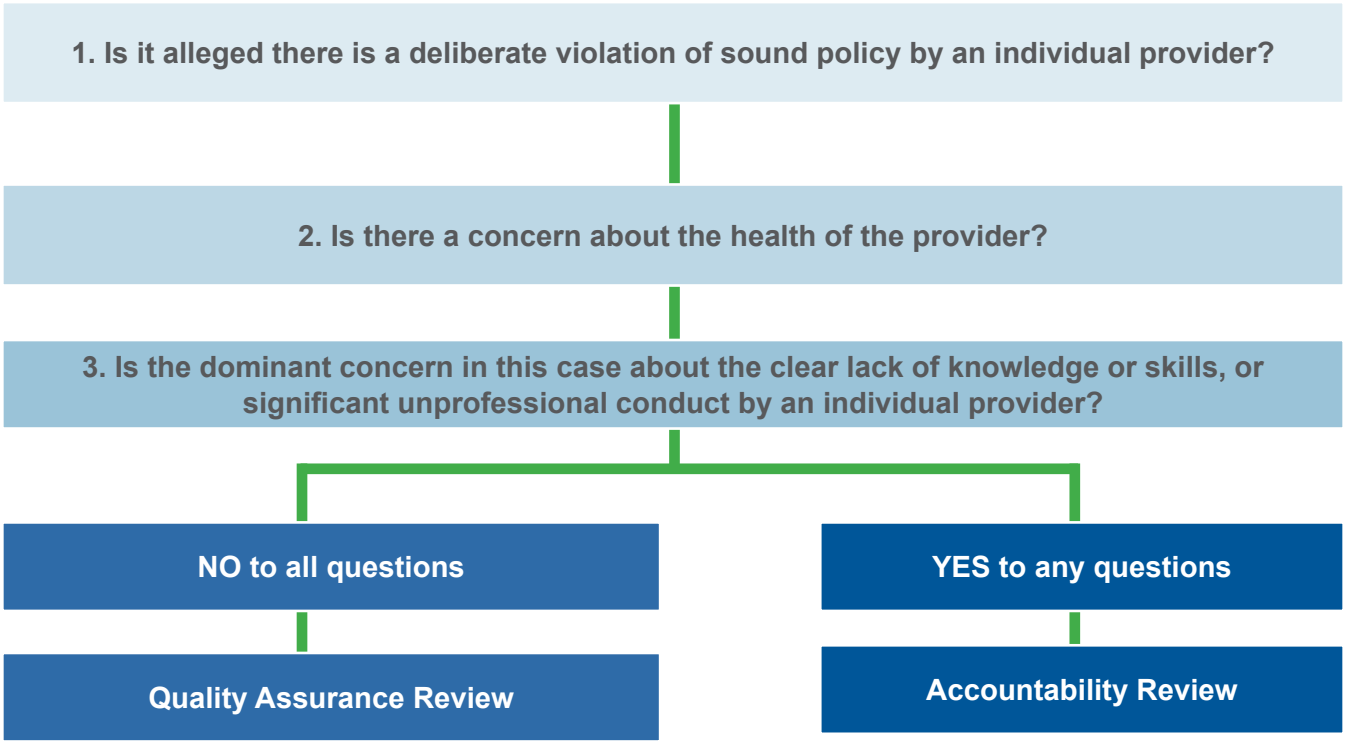
The next section covers how to determine the best type of review.

Choosing the right review type

Sometimes, you will conduct more than one type of review. For instance, one event could involve a Quality Assurance Review, be subject to an Accountability (HR) Review and also be moving through a complaints process (outside of Section 51).

Start the process by gathering the facts, and determining if further analysis is required.

Then ask three triage questions:



Quality Assurance Reviews

Ensure you review the module on *Section 51 Protection for Quality Assurance Reviews.*

You **must** initiate Section 51 protection at the outset.

Quiz Time

Multiple Choice

Annette is 55 years old, admitted on a Saturday morning due to a serious skin infection. She was prescribed Gentamicin at a dosage higher than recommended standards. The Pharmacist and a nurse questioned the dose, but he insisted it was “the best way to go” based on something he had read recently. He did not order monitoring. Annette’s kidneys are now shutting down & Annette will be on dialysis for the rest of her life.

A. Quality Assurance Review and Accountability Review

B. Accountability Review

C. Quality Assurance Review

Answer: **A**

Quality Assurance Review and Accountability Review

Usually you won’t know if an accountability review is required until you start investigating the event.

Generally, you would start with a Quality Assurance Review unless there is a blatant practice problem where you can say, “but for that action, this patient would have been fine.”

In this case, the physician did not order monitoring, so you would know that both a Quality Assurance Review and an Accountability Review will be required.

Multiple Choice

Stuart recently visited the hospital for a colonoscopy, and complains that he contracted Hepatitis B as a result of that procedure.

A. Quality Assurance Review

B. Quality Assurance Review and Accountability Review

C. Accountability Review

Answer: **B**

This will start as a Quality Assurance Review.

While it’s possible that a Quality Assurance Review will lead to an Accountability Review, there is currently no information to suggest that any employee deliberately violated a policy, or demonstrated a lack of knowledge or skill. Nor is there a concern about the health of the provider.

Multiple Choice

Barjinder dies from a massive infection, resulting from a nicked bowel during surgery.

A. Quality Assurance Review

B. Quality Assurance Review and Accountability Review

C. Accountability Review

Answer: **A**

This will start as a Quality Assurance Review.

- Start with a Quality Assurance Review. Depending on what you learn, it may lead you to a Accountability Review. A nicked bowel is a known risk for some surgeries and doesn't necessarily imply that an Accountability Review is required.
- The third triage question is, "Is the dominant concern in this case about the clear lack of knowledge or skills?" Generally, this won't become clear until you've started the Quality Assurance Review. Try not to make assumptions about the physician; follow the evidence.

True or False?

I should wait for the Quality Assurance Committee's regular meeting at the end of the month before starting a Quality Assurance Review, to ensure it is protected under Section 51.

☐ True
☐ False

Answer: **False**

Ideally, a Review will begin within a few days of an Event, and as soon as reasonably practical. You should attempt to convene the Quality Assurance Committee, rather than waiting for a regularly scheduled meeting.

4. Section 51 Protection for Quality Assurance Reviews

4. Section 51 Protection for Quality Assurance Reviews

What this module covers:

By the end of this module, you will be able to:

- Explain the purpose of Section 51.
- Determine when to initiate a Section 51 Review.
- Ensure your communication is protected.
- Find additional resources.
- Connect with the people at Northern Health who can answer your questions.

Why do I need to know this?

Your patient just had emergency surgery, and you suspect that the surgery was only needed because someone made a mistake during a routine procedure the day before. You want to talk about your concerns, but you're afraid that if you do, it could be used against someone on your team in a malpractice suit.

How can you ensure that nothing you say will be used against you or your team?

You need to learn about Section 51!

What is Section 51?

It is a section in the *BC Evidence Act* that allows you the freedom to discuss or critique a case or event, without having your thoughts or opinions entered into evidence in any possible legal proceedings.

It is meant to ensure that hospitals and health care professionals can constantly review and improve services and procedures, without fear of reprisals.

But, there is a catch!

What's the catch?

1. Not all communications are protected.
2. You still have an obligation to disclose adverse events to patients.

To be protected under Section 51, you must follow a set process. Your discussions must take place in a Quality Assurance process, within a "properly constituted Quality Assurance committee."

Don't wait to invoke Section 51. Ensure that your communications are protected right from the start.

Quiz Time

4. Section 51 Protection for Quality Assurance Reviews

When should a Section 51 Review be conducted?

The Health Care Protection Program states that reviews under Section 51 should be conducted for "all occurrences, events or adverse outcomes that give rise to significant quality of care concerns"

and

are "reviewed for the purposes of examining the quality of care by health care professionals."

True or False?

I decided that we need to review the case of the patient with an ulcer who fractured her arm on the way to the bathroom. I've started interviewing the nurses who were on staff during the incident.

Are our conversations protected under Section 51?

☐ True
☐ False

Answer: **False**

- You can't just start gathering information, and expect it to be protected under Section 51.
- You must be working with a properly constituted committee on a Quality Assurance Review.

What is a "properly constituted Quality Review committee"?

Committees that report to the Northern Health Board

and

Have a Terms of Reference (ToR) which specifically identifies they have a role in quality assurance.

Committees can be existing, multi-purpose committees, or convened with the specific purpose of conducting a Section 51 review.

True or False?

I need to initiate a Section 51 Review. I am a member of a Physician's Community of Practice. We meet once a month to share information and learn best practices from each other, in order to continuously improve our own practice.

My Community of Practice is a "properly constituted committee" for the purposes of Section 51.

☐ True
☐ False

Answer: **False**

To be "properly constituted", your terms of reference must explicitly state that your committee conducts Quality Assurance Reviews.

4. Section 51 Protection for Quality Assurance Reviews

True or False?

I need to initiate a Section 51 Review. I meet regularly with the other Medical Directors and Chief Medical Health Officer.

This group is a "properly constituted committee" for the purposes of Section 51.

☐ True
☐ False

Answer: **False**

You're involving the right people, but unless your group is a formal committee with a mandate to perform Quality Assurance Reviews in your terms of reference, you're not covered under Section 51.

True or False?

I need to initiate a Section 51 Review. I am a member of the Northern Health Medical Advisory Committee (MAC).

This is a "properly constituted committee" under Section 51.

☐ True
☐ False

Answer: **True**

Regional MACs report to the Northern Health MAC, which in turn reports to the Board; they also have a Terms of Reference that includes a statement about conducting Quality Assurance Reviews.

Who commissions a Section 51 review?

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

Who is ultimately accountable for a Section 51 review?

- Medical Directors
- Chief Medical Officer
- Vice President Medicine
- Northern Health Medical Advisory Committee (NHMAC)
- Regional Manager, Risk Management
- Chief Executive Officer & Board of Directors

What is protected under a Section 51 review?

- Opinions and interpretations of any health care professionals, staff members and individuals who participate in the review are protected.
- All information, records, summaries and documentation arising from the Section 51 Review are protected.

What is not protected under a Section 51 review?

The facts of the case are *not* generally protected.

- Reviews related to care provided in the community (not linked to hospital-based care).
  - **NOTE:** Transportation of patients by BC Emergency Health Services between hospitals is covered.
- Information and opinions gathered by any person or individual who is not working with a "properly constituted committee" to conduct a Quality Assurance Review.

A Note on Recommendations…

- Once approved (for example, by a Medical Advisory Committee), recommendations from a Section 51 review may be released to individuals within the organization who need to be aware of, or have the authority to act on, the recommendations.
- If the organization has taken action on recommendations from a Section 51 review, these recommendations may be released to the public.

Multiple Choice:

Which information would not be protected under a Section 51 Review?

A. My judgement about whether or not the patient should have been discharged.

B. The name and dosage of the medication prescribed.

C. My opinion about the appropriateness of the medication prescribed.

D. My concerns about the personal issues that may have been distracting the attending physician.

Answer: **B**

The name and dosage of the medication prescribed

- The facts of the case are not generally protected, but your thoughts, beliefs and opinions are.

5. Disclosure of Patient Safety Events

5. Disclosure of Patient Safety Events

What this module covers:

By the end of this module, you will be able to:

- Identify who a "client" is, for the purposes of disclosure.
- Describe which patient safety events must be disclosed to the client.
- Assess which information should be included in the disclosure.
- Follow the five recommended disclosure steps.

Why do I need to know this?

Northern Health Clients are entitled to know about the care and treatment they are provided.

Physicians, managers and other medical staff and health care providers are professionally and ethically obligated to be transparent, open and honest with their patients.

Disclosure is one component of this.

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.

There are some exceptions, but a decision not to disclose must be made within a structured process and by more than one individual.

What about "no harm" events?

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.

Broader Northern Health health care teams should be made aware of 'almost events' in order to learn from and prevent future adverse events.

The client may not be the patient

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.

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.

What do we disclose?

Just the facts.

These must come from information already recorded in a Client's hospital record, and/or from those involved in the event itself.

Quality Assurance Review records may not be communicated to a client; for more information, refer to the *Section 51 Protection for Quality Assurance Reviews* module. Opinions and speculation are protected.

When do we disclose?

Disclose as close to the event as possible, after ensuring the client's safety and that the client's care needs are met.

Timing should take into consideration:

- The client's clinical condition.
- The availability of key staff.
- The availability of the client's support person(s).
- The client or family's preference.
- The privacy and comfort of the client.
- The emotional and psychological state of the client.

Quiz Time

5. Disclosure of Patient Safety Events

Multiple Choice:

After an adverse event, I must talk to:

A. The patient or surviving family member

B. The patient or substitute decision maker

C. The patient's support person

D. All of the above

Answer: **D**

Who you talk to will depend on the event. You may not be able to speak with the patient, in which case you will talk to their family / substitute decision maker.

You also want to ensure they have the opportunity to have a friend or family member there to support them.

Yes or No?

Something went wrong in surgery. I know I am supposed to disclose as soon as possible, and the patient has just woken up in recovery.

Should I go talk to her now?

☐ Yes
☐ No

Answer: **No**

Timing is important. While it's true that you need to talk to her as soon as possible, in this case it's better to wait until she has fully recovered from the anesthetic, and has a support person with her.

Multiple Choice:

The patient's GP is here.

Do I need to include the family physician in the disclosure meeting?

A. Yes

B. No

C. It depends

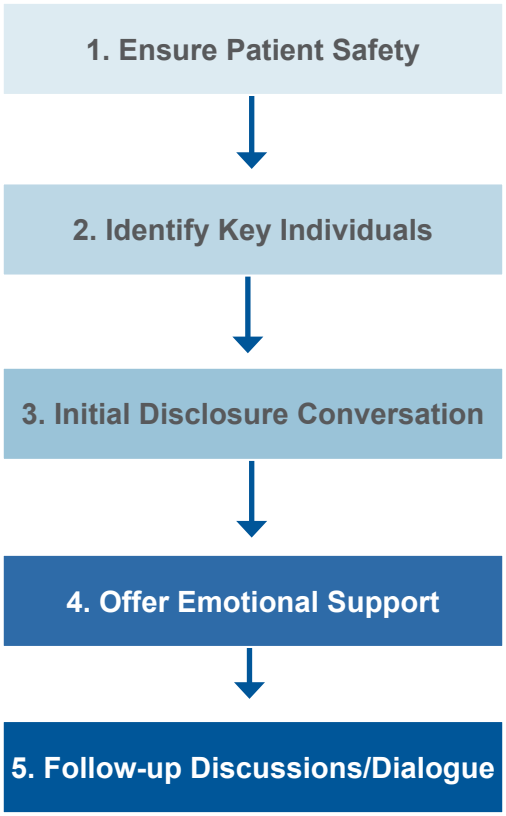
Answer: **C. It depends**

It might be helpful to include the patient's GP, particularly if the GP will be involved in ongoing care or plays the role of support person for the physician.

But, if the physician wasn't involved in the adverse event, his or her participation in the disclosure meeting isn't required.

5. Disclosure of Patient Safety Events

How do we disclose?



Step 1: Ensure Patient Safety

First things first.

- Address clinical needs and deal with emergencies.
- Consider the next steps in clinical care.
- Provide emotional support.
- Document your care.

Disclosure should take place as soon as possible, once this is done.

Step 2: Identify Key Individuals

- Health care professionals involved in the adverse event.
- Administration personnel.
- Person(s) responsible for initial disclosure conversation.
- The patient and/or substitute decision maker.
- Support person(s) who are available for the patient.

Step 3: Initial Disclosure Conversation

Include:

- An apology.
- Known facts.
- Consequences of the event and any side effects to look for.
- Discussion of ongoing care.
- Next steps, including arrangement for future meeting(s), contact details.

Initial Disclosure Conversation (2)

Document the discussion, including:

- Meeting details.
  - Date, time, location; names and roles of those present.
- Facts presented, key questions raised and answers given.
- Emotions and reactions in the discussion
- Plans for follow-up.

Step 4: Offer Emotional Support

Support:

- Patient and family members.
- Disclosing health professional.
- Health care professionals involved in the adverse event.

Step 5: Follow-up Discussions/Dialogue

- Maintain a dialogue with the patient and family.
- Address new concerns.
- Share information as it becomes available.

True or False?

My primary role in the disclosure process is to offer information and support to the patient and/or his family.

☐ True
☐ False

Answer: **True**

Providing information and support to the patient and/or his family is important, but you must also provide support to the health care professionals involved in the adverse event.

This may also be a good time to suggest that physicians inform the CMPA (Canadian Medical Practitioners Association) or their liability insurance provider of the event.

You are also the one who must document the disclosure meeting.

True or False?

A disclosure meeting gives me the opportunity to explain why I did what I did, and give my opinions about the event.

☐ True
☐ False

Answer: **False**

The disclosure meeting is an opportunity to apologize for any harm caused to the patient, provide information, and plan for follow-up.

Avoid providing explanations that defend the actions taken, or including opinions or judgements in your disclosure. Stick to the facts.

Notes

Notes

Where can I find PSLS Training

If you are looking for PSLS – specific training, online training is available through the BC Patient Safety and Learning System:
http://bcpsls.phsa.ca/elearning_2/course/course4032.html

Short training videos on logging on, changing your password, and changing the status of an event:
http://www.bcpsls.ca/HandlerResources/TipsandTroubleshooting/default.htm

You can also contact the Northern Health PSLS Coordinator at:
PSLS.Information@northernhealth.ca

Find more information through Northern Health at:
http://iportal.northernhealth.ca/clinicalresources/QualityofCarePatientSafety/psls/Pages/default.aspx

Thank you for completing these modules.

For more information, contact:

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