QUINTE HEALTHCARE CORPORATION

Corporate – Disclosure Policy

Title: Corporate – Disclosure		**Policy No:**	**2.11.14**
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1. PURPOSE

Quinte Healthcare Corporation (QHC) is committed to and accountable for ensuring patients and their families or their Substitute Decision Maker (SDM) are provided with complete information about their care in order to assist them in making informed decisions about their health care.

Despite dedicated efforts to provide safe care to our patients, patient safety events and unplanned outcomes occur. When a patient safety event occurs, all staff and physicians have an obligation to attend to the immediate needs of the patient and family, communicate openly with patient (s) and their families and commit to the examination of circumstances concerning an unintended outcome and actions in an effort to improve future care for all patients.

This policy provides a documented and coordinated approach to disclosing patient safety events to patients and their families.

2. SCOPE

This policy applies to all employees of Quinte Health Care as well as professional staff, midwives and learners.

3. POLICY

The following principles are adapted from the Canadian Disclosure Guidelines (CPSI 2011) and provide the foundation for these guidelines and the fundamental nature in which disclosure occurs at QHC.

Patient-centered healthcare: An environment of patient-centered care fosters open, honest and ongoing communication between healthcare providers and patients. Healthcare should be respectful, supportive and take into consideration the patient's expectations and needs at all times.

Patient autonomy: Patients have the right to know what has happened to them in order to support their active involvement and decision making regarding their ongoing healthcare.

Healthcare that is safe: Patients have a right to access high quality and safe care. Lessons learned from patient safety events must be used to improve practices, processes and systems of healthcare delivery.

Leadership support: Leaders and decision makers in healthcare must be visible champions of disclosure as a critical component of patient-centered care.

Disclosure is the right thing to do: Individuals involved at all levels of healthcare must ask themselves what they would expect in a similar situation.

Honesty and transparency: When a harmful event occurs, the patient should be told what happened. Disclosure acknowledges and informs the patient, which is critical in maintaining the patient's trust and confidence in the healthcare system.

It is the responsibility of each QHC staff member and physician/provider who observes or discovers a patient safety event to ensure that it is reported through the hospital event reporting system. All learners who are aware of a patient safety event must immediately report the event to their supervisor/preceptor (Refer to Appendix A – Patient Safety Event Nomenclature).

The Most Responsible Physician/Provider (MRP) will be notified in cases where harm has occurred to the patient. The timeliness of informing the MRP is dependent on the need to provide clinical care to the patient.

Disclosure of harm is a documented and coordinated response involving discussion between a patient, and staff and/or medical staff about the events leading to harm and/or a near miss event in the following circumstances:

- The patient has suffered any degree of harm
- There is potential for future harm
- There will be any change in patient care or monitoring as a result of the patient safety event

The disclosure of near miss incidents are generally considered discretionary and do not need to be disclosed unless there is an on-going safety risk or if the patient is aware of the incident and an explanation will address concerns and promote trust.

Disclosure of critical events to the patient; or if the patient is incapable, to their Substitute Decision Maker; or if the patient dies, to their estate will occur as required according to mandatory reporting of critical events under the Public Hospitals Act Regulation 965.

Disclosure of information to patients and their families as per the Quality of Care Information Protection Act (QCIPA, 2016) will include:

- the material facts of what occurred with respect to the critical event;
- what the quality of care committee or health facility identified, if anything, as the cause or causes of the event;
- the consequences of the critical incident to the patient, as they become known;
- the actions taken and recommended to be taken to address the consequences of the critical incident to the patient, including any health care or treatment that is advisable, and
- the systemic steps if any, that a health facility is taking or has taken to avoid or reduce the risk of further similar incidents

The disclosure process identifies who is responsible for guiding and supporting the disclosure process, disclosure communication, when and how to disclose and where to document the disclosure.

Initial disclosure should occur in a face-to-face meeting whenever feasible as soon as is practically possible following the harmful patient safety event. Initial disclosure will include providing facts as they are known; any foreseeable consequences or treatments and what the immediate plan of care involves (refer to Appendix B – Disclosure Process).

Disclosure is an ongoing process and should include an apology for what has occurred, and an explanation of what has happened, without speculation or blame.

The focus on any analysis of a patient safety event will be on identifying systems issues followed by recommendations for improvement that will prevent or reduce the likelihood of future similar events.

The patient and/or family or SDM will be provided with a contact person for further discussion and a commitment to be kept informed as more information becomes available.

Reimbursement by the organization for reasonable expenses related to the disclosure process may include abut are not limited to: travel expenses, parking, meals, accommodation, child care, and medical files pertinent to the event. These should be offered at the time of the disclosure meeting.

Training and support will be available for any member of staff who may be part of the disclosure of harm process.

The disclosure policy is reviewed and updated at a minimum of once per Accreditation cycle, with input and feedback from employees, physicians and patients and/or families.

4. DEFINITIONS

Apology – a genuine expression of sympathy or regret, a statement that one is sorry for what has happened. An apology includes an acknowledgement of responsibility if such responsibility has been determined after analysis of a patient safety incident (CMPA, 2015).

Critical Incident - any unintended event that occurs when a patient receives treatment in the hospital, and (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 inherent risk in providing the treatment (Regulation 965 under the Public Hospitals Act, CPSI, 2011)

Critical Patient Safety Event is further defined by QHC as:

- *Level 1 Death:* an event whereby on the balance of probabilities; death was caused or brought forward in the short term by the event
- *Level 2 Severe:* an event whereby patient requires life-saving or major surgical/medical intervention. Life expectancy is shortened or there is permanent/long-term severe loss of function. *(See Appendix A Patient Safety Event Nomenclature)*

Degree of Harm (patient safety incidents only) - the severity and duration of harm, and any treatment implications that result from a patient safety incident (CPSI, 2011)

Disclosure – the process by which a patient safety incident is communicated to the patient by health care providers (CPSI, 2011).

Error - any unintentional act of omission or commission that occurs in the planning or delivery of patient care or service.

Event - an occurrence that is unexpected and undesirable.

Harm - includes any hurt or injury to a person; an impairment of structure or function of the body and/or any deleterious effect arising there from. Harm includes disease, injury, suffering, disability and death and may include psychological harm (CPSI, 2012).

Harmful Event - a patient safety event that resulted in harm to the patient.

Initial Disclosure – the initial communications with the patient, as soon as reasonably possible, after a harmful incident or an incident where a potential for harm occurred (CPSI, 2011).

Near Miss - an event that has potential for harm is intercepted or corrected prior to reaching the patient.

No Harm Event - a patient safety event that reached a patient but no discernible harm resulted.

Patient – means a recipient of health care.

Patient Safety Event - an event or circumstance that could have resulted, or did result in harm or an unintended outcome for the patient (CPSI, 2012).

Post-analysis Disclosure – subsequent communications with a patient about known facts related to the reasons for the harm after an appropriate analysis of the harm incident (CPSI, 2011).

Quality of Care Committee (QCC) – a body of one or more individuals that performs quality of care functions; that is established, appointed or approved by the Hospital pursuant to the Quality of Care Information Protection Act (QCIPA) whose functions are to carry on activities for the purpose of studying, assessing or evaluating the provision of health care with a view to improving or maintaining the quality of health care, and includes conducting reviews of critical incidents. At QHC this is accomplished through the Leadership Committee.

Quality of Care Functions – means activities carried on for the purpose of studying, assessing or evaluating the provision of health care with a view to improving or maintaining the quality of health care, and includes conducting reviews of critical incidents.

Quality of Care Information – means information that is (a) collected or prepared by or for a quality of care committee for the sole or primary purpose of assisting the committee in carrying out its quality of care functions; OR (b) relates to the discussion and deliberations of a quality of care committee in carrying out its quality of care functions; OR (c) relates solely or primarily to any activity that a quality of care committee carries on as part of the quality of care functions, including information contained in records that a quality of care committee creates or maintains related to its quality of care functions (QCIPA, 2016).

Quality of Care Information Protection Act (QCIPA) – is the legislation that enables health care providers to have protected quality improvement discussions to help improve patient safety while still ensuring that patients and their authorized representatives have access to the facts about a critical incident (Ontario Ministry of Health and Long Term Care, 2017).

Quality of Care Review – is a type of review conducted most often for critical events and may or may not be completed under QCIPA protection and involves the Quality of Care Committee.

Substitute Decision Maker (SDM) – someone whose responsibility is to make decisions for a person who is not able to make his or her own health care decisions (Ontario Ministry of Health and Long Term Care, 2017).

5. PROCEDURE

5.1 Disclosure following a patient safety event

1. Ensure the immediate needs of the patient have been met (refer to policy 2.22.2 Patient – Patient Safety Event Reporting and Quality Reviews).

2. Provide the patient and/or family with the name and contact number of the Program Manager.

3. Include Spiritual Care Services as necessary or if requested to assist.

4. Determine the degree of harm (refer to policy 2.22.2).

5. For events with no harm or minor harm has occurred, the person(s) discovering the event should disclose the known facts, share what has been or will be done to minimize the impact and provide an apology for what has occurred.

6. Document in the patient care record the initial disclosure including what was disclosed, to whom the information was disclosed, and what interventions or follow-up was or will be provided.

5.2 **Disclosure following a critical patient safety event**

1. Initial disclosure to the patient/ family, and/or Substitute Decision Maker will include providing facts as they are known, any foreseeable consequences or treatments and what the immediate plan of care involves. Please refer to Appendix B - Disclosure Process.

2. The Program Medical and Clinical Directors will be notified of the critical event or the Administrator on Call in the off hours to support the disclosure process when and if necessary.

3. The patient and family and/or SDM will be provided with the contact information for the Clinical Risk Specialist and/or the Patient Experience Specialist.

4. Share with the patient and/or family that further investigation and review will be occurring. Refer to Patient Safety Event reporting and Quality Review policy for time frame for completion.

5. The Clinical Risk Specialist will notify the Chief Executive Officer (CEO), Chief Nursing Executive (CNE) , and Chief of Staff (COS) as soon as possible following the critical event.

5.3 **Arrange to interview patient and/or family**

1. An invitation will be made to the patient and their family, and/or SDM to discuss the incident from their point of view and answer any questions or concerns as possible.

2. The Clinical Risk Specialist and/or Patient Experience Specialist will maintain a record of feedback obtained during the interview and share any suggestions or recommendations with the team as appropriate.

5.4 **Documentation of Disclosure (in the patient record)**

1. **For harmful events** documentation related to the initial disclosure should include:
    - Date, time and location of disclosure
    - Names and roles of those involved in disclosure (e.g. health care organization staff)
    - Names and relationships of family members present
    - Material facts of what occurred or is known
    - Any offers made regarding assistance or support
    - Questions raised and responses provided and by whom
    - Any care and treatment discussed and provided
    - Agreed upon next steps for the patients care and the plans and timelines for follow up
    - Requests to review the patient's health record
    - Name of the designated patient spokesperson
    - Any outstanding questions from the patient

2. **For No Harm events** documentation related to the disclosure should include date, time, facts presented, the response and any questions raised and responses provided.

3. The Most Responsible Physician/Provider (MRP) and other relevant health care providers as appropriate will document the facts of disclosure as provided in the patient care record.

4. Subsequent disclosure(s) will be communicated to the patient and family as information becomes available and will be documented in the Patient Safety review file or the patient relations file.

5.5 **Post Incident Analysis / Quality of Care Review Disclosure Meeting**

1. The Clinical Risk Specialist in consultation with the Program Clinical and Medical Director where the event occurred will determine who needs to be involved in disclosure meetings with patient and/or their families.

2. For critical events the Patient Experience Specialist will be present for post event meetings with the patient and their family. The Patient Experience Specialist will join any family meetings for any level event if requested.

3. The purpose of the meeting will be confirmed with the patient/family to ensure they play a key role in designing the meeting and who should attend.

4. An attempt will be made to ensure appropriate participants are included in the initial meeting however secondary meetings may need to be arranged to accommodate information sharing. A plan will be developed to address any unanswered questions that may arise during initial meeting.

5. Post event meetings for critical events will be arranged to share recommendations and action plans for system improvements taken as a result of the quality of care event review.

6. Hard copies of recommendations and action plans will be shared with patients and their families upon request and as per QCIPA, 2016 regulations regarding release of quality of care information.
7. The Clinical Risk Specialist and Patient Experience Specialist will seek feedback from the patient and their family about their experience with the disclosure process for improvement purposes.

APPENDICES AND REFERENCES

Appendices: Appendix A – Patient Safety Event Nomenclature
Appendix B – Disclosure Procedure

References

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