



# BROCKVILLE GENERAL HOSPITAL

<b>MANUAL:</b> General Policy and Procedure	<b>NUMBER:</b> I-56
<b>CATEGORY:</b> Organizational & Administrative Documents	<b>PAGE:</b> 1 of 10
<b>TITLE:</b> Disclosure of Adverse Events	
<b>ISSUED BY:</b> President and CEO	<b>DATE:</b> June 30, 2008
<b>REVIEWED/REVISED:</b>	

## **POLICY STATEMENT:**

At The Brockville General Hospital we believe that there are ethical, professional and legal responsibilities for our physicians and other health practitioners to provide full and frank disclosure of all adverse outcomes and events to patients (or their surrogates) as soon as reasonably possible after they occur. In keeping with the Brockville Hospital's non-blame, non-punitive philosophy, disclosure does not imply assignment or acceptance of fault.

The Brockville General Hospital requires that for all adverse outcomes and events, the disclosure should involve at a minimum a discussion between the attending practitioner and the patient (or their surrogates); and that this discussion should be documented in the health record. Consideration should be given to conducting a second meeting once the patient or their surrogate has had the opportunity to review the information provided as they may have additional questions or a need for clarification.

*This policy does not apply to errors that do not harm patients (i.e., near misses). These particular occurrences may not require disclosure to patients in all cases and should be left to the individual clinical judgment of the attending physician (or designate) and the clinical director/manager.*

Note: If the patient is involved in a research study, notify the principal investigator and the Chair of the Research Ethics Board.

## **DEFINITION:**

An "adverse outcome" is any of the following:

- development of a new temporary or permanent disability during therapy;
- an unanticipated prolongation of hospitalization (where prolongation can refer to an entire admission or a readmission); or
- an unanticipated death.

An "adverse event" is an adverse outcome that is due to health care management as opposed to progression of natural disease.

A "preventable adverse event" is one that is felt to be due to an obvious error in management or a system design flaw.



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A “critical incident”, *for the purposes of this policy*, 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) that does not result primarily from the patient’s underlying medical condition or from a known risk inherent in providing the treatment.

“Disclosure” refers to the communication of information regarding an adverse event, adverse outcome or critical incident.

A patient’s “surrogate” includes any other person(s) as designated by the patient, or appropriate substitute decision-makers for patients who are incapable.

“Substitute decision maker” means a person who is authorized under the *Health Care Consent Act* to give or refuse consent to a treatment on behalf of a person who is incapable with respect to the treatment.

## **PROCEDURE:**

The responsibility for disclosing an adverse event, adverse outcome, or critical incident to a patient (or their surrogate) generally rests with the attending physician. **(refer to Appendix A – Stages of Disclosure)**

There may be situations where the attending physician will not or cannot take the lead role in the disclosure discussions (i.e., physician unavailable, physician refuses to participate in disclosure discussions). In addition, there may be situations where the attending physician is not the appropriate person to participate in the discussions (i.e., physician feels he/she does not have the requisite communication skills; the relationship with the patient is seriously impaired/compromised). In such situations, the attending physician’s designate (another physician) will conduct disclosure and any subsequent communications, if necessary, with the patient and/or their family.

A resident or a medical student is required to disclose to his or her supervising physician any adverse outcome or adverse event. The supervisor must bring the matter to the attention of the attending physician who is responsible for disclosing to the patient (or their) surrogate.

If the adverse event, adverse outcome or critical incident is not related to care provided by a physician, then responsibility for disclosure will rest with the Clinical Director/Department



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Director/designate, or responsible Clinical Manager, in partnership with the attending physician or designate.

Initial disclosure to the patient or family will occur as soon as is reasonably possible after the adverse outcome, adverse event or critical incident has occurred and the patient's immediate needs have been met.

Disclosure discussions should always take place in a location that guarantees privacy and confidentiality.

For a preventable adverse event or critical incident, the health care professional leading the disclosure discussion should ask another health care colleague or the Quality/Risk Manager to be present for the discussions.

In the case of serious preventable adverse events or Critical Incidents, the Quality/Risk Manager should be contacted as soon as is reasonably possible after gaining knowledge of the adverse event or critical incident.

The disclosure of every critical incident must be made:

- (a) to the affected patient;
- (b) if the affected patient is incapable, to the patient's substitute decision maker; or
- (c) if the affected patient has died,
  - (i) to the substitute decision maker immediately prior to the patient's death, or who would have been so authorized if the patient had been incapable, or
  - (ii) to the patient's estate trustee, or to the person who has assumed responsibility for the administration of the patient's estate, if the estate does not have an estate trustee .

Disclosure discussions concerning preventable adverse events and critical incidents must include

- The material facts of the event,
- Impact and consequences for the patient of the occurrence, as they become known,
- The actions taken and recommended to be taken to address the consequences to the patient of the occurrence, including any health care or treatment that is advisable.



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The above disclosure, including date and time of disclosure, must be documented in the Health Record (in-patient and out-patient record using the documentation of Disclosure Form, including those patients attending solely for diagnostic procedure).

Additional considerations for disclosure and documenting disclosure should include:

- Offers of assistance, including support of Spiritual Care
- Information that is objective and factual, free from speculation or blame, and presented in a caring and compassionate manner
- The cause of the event, if known
- Expression of regret that the adverse event or adverse outcome occurred, including providing an apology and saying “sorry”, as appropriate.
- Plans for a review to identify causal factors and prevent its recurrence
- Names of individuals present at the disclosure meeting and relationship to patient
- Discussion points including: reaction/questions of participants; a statement indicating that the patient (or the surrogates) will be kept informed of new information as it becomes available.
- Whether the patient refuses to receive the disclosure information
- Any request to review the patients’ health record.

Subject to the *Quality of Care Information Protection Act, 2004* (QCIPA - see 3.2.6) at an appropriate time following a disclosure of a critical incident, the physician or responsible Director/designate shall further disclose any systemic steps that the hospital is taking or has taken in order to avoid or reduce the risk of further similar critical incidents. The content and date of this further disclosure shall be recorded in the health record.

If the adverse event has been reviewed under the Critical Incident Review policy, or the review is QCIPA-protected, only the following information may be disclosed:

- Fact that a quality of care review took place (without details)
- Additional facts disclosed by review
- Changes (“systemic steps”) that have been made (without disclosing that quality of care review was reason for them)

After an adverse event, critical incident or serious adverse outcome consideration should be given to waiving charges related to a patient’s care (i.e. room charges), in consultation with Chief Financial Officer.



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If a health care practitioner discovers that a preventable adverse event or critical incident which occurred at the Brockville General Hospital has not been disclosed to a patient (or their surrogate), then the practitioner should inform their responsible Medical Department/Division Head, Professional Health Chief, or Clinical Director/Director/designate, as appropriate. The responsible Medical Department / Division Head, Professional Health Chief, or Clinical Director / Director/designate will look into the matter, as appropriate to the situation.

Consideration should be given by the care givers involved in an adverse event, outcome or critical incident to consulting the Employee Assistance Program, Spiritual Care Services, or professional support services for counselling, crisis intervention and support.

See Checklist (**Appendix B**) regarding Documentation of Disclosure of Preventable Adverse Events or Critical Incidents.

### **RELATED POLICIES AND / OR LEGISLATIONS:**

College of Physicians and Surgeons of Ontario (CPSO) 'Disclosure of Harm' Policy February 2003

Quality of Care Information Protection Act 2004

*Public Hospitals Act* RSO 1990, Regulation 965

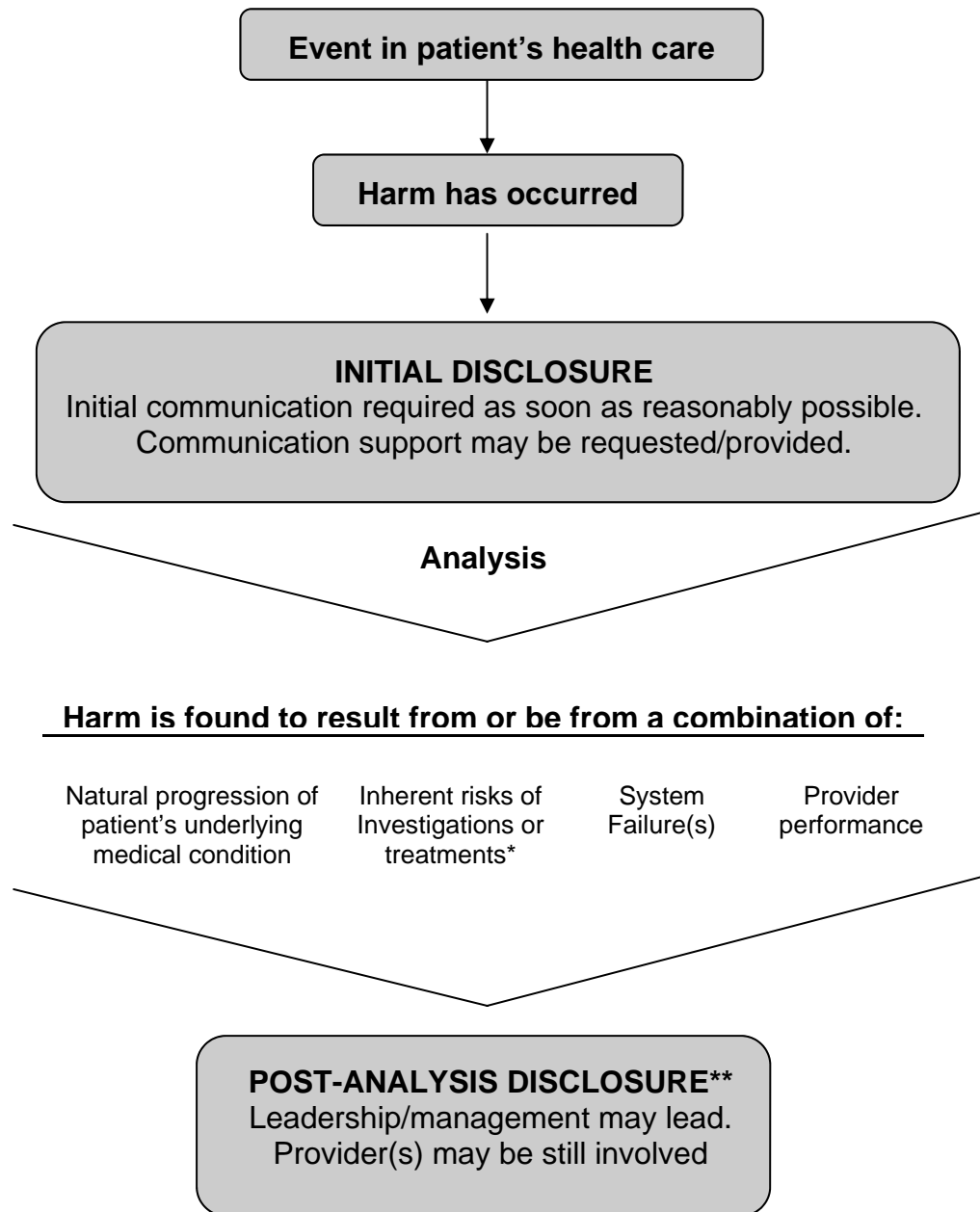
Canadian Patient Safety Dictionary, October 2003

*Health Care Consent Act*



# APPENDIX A

## THE STAGES OF DISCLOSURE



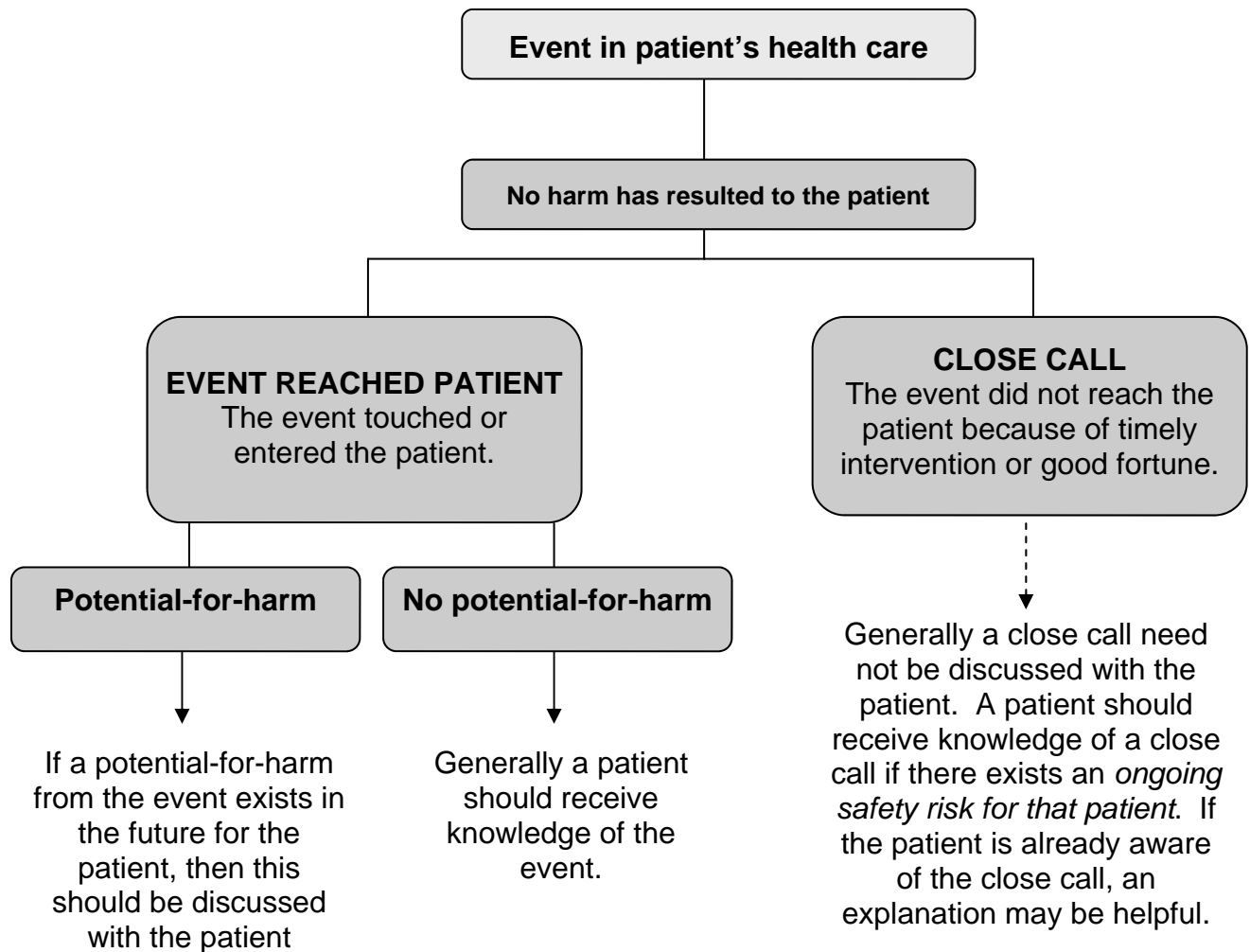
\* Refers to harm known to be associated with the investigation or treatment

\*\* Quality of care information and the recommendations from quality improvement committee investigations are protected by provincial/territorial laws to varying degrees. General access, even to patients, may not be permitted.



## APPENDIX A

### Discussing Potential-for-Harm/no-Harm Events with Patients





## APPENDIX B

# CHECKLIST FOR DISCLOSURE

A checklist summary of the key elements of disclosure for quick reference.

### FIRST THINGS FIRST. ATTEND TO CLINICAL CARE

- Try to fix or limit any further harm to your patient.
- Make the environment safe (remove any biohazards, malfunctioning equipment, etc.)
- Facilitate any required investigations, treatments and/or consultations.
- Consider whether you are the best individual to provide further care.
- Brief any other health care providers who may be required to provide further care.
- Make sure someone – such as a nurse, social worker or spiritual advisor – is available to comfort you patient as needed.
- Document the clinical condition, recommendations and decisions for further care in a timely fashion.
- For quality improvement investigations:
  - As required, report what has happened (for example to the hospital/institution), or to a coroner/medical examiner in the event of a death).
  - If appropriate, collect any tissue samples or clinical material for future analysis.

### PLANNING THE INITIAL DISCLOSURE

Remember you may only know what has happened, not how or why the adverse event occurred. Therefore, **before you speak** with your patient:

#### **Gather the facts:**

- Begin to gather the facts in an organized manner and review the medical record.
- Consult with the health care providers who were involved to establish a consistent understanding of the facts.
- Avoid speculation and do not blame others.

#### **Consider who should be present at the meeting:**

- Family members (with consent of your patient).
- Other health care providers directly involved with the care.
- Skilled communicators, as necessary.
- Translator if required; generally not a family member.
- Those required to meet any special needs of your patient (e.g. cultural, vision, hearing, spiritual needs).
- Decide who will lead the discussion.

#### **Set the time and place for the meeting:**

- Meet as soon as is reasonably possible.
- Provide sufficient uninterrupted time.
- Choose a setting where you can meet face to face.
- To the extent possible, preserve confidentiality and privacy in a comfortable environment.



## APPENDIX B

### Plan what you will say:

Disclosure cannot be scripted. However, before you meet with your patient, organize your thoughts and consider how you will:

- Manage your own emotions.
- Acknowledge that something unexpected has happened.
- Express your concern and regret.
- Respond to your patient's emotional reactions.
- Respond to questions your patient is likely to ask.
- Explain the process for any analysis of the adverse event.
- Explain if and what additional information about the event may be forthcoming.

### THE INITIAL DISCLOSURE MEETING

#### During the Meeting:

- Introduce the topic for discussion with words such as "something has happened and we need to talk about it".
- Present the existing facts. Don't speculate.
- Describe both the clinical condition as it now exists and any future care requirements.
- Express your regret as appropriate.
- Find out what your patient already knows and is experiencing.
- Be sensitive to how much information is being provided; try not to overload your patient.
- Communicate in a clear, sensitive and empathetic manner.
- Welcome questions.
- Impress on your patient how seriously you are taking the situation.

#### Ending the meeting:

- Confirm the clinical next steps.
- Summarize the discussion and again test for understanding.
- As appropriate, define what the next steps will be to answer any questions about how or why the event occurred.
- Provide contact information about how you or others can be reached.
- Consider arranging a follow-up meeting with your patient.

#### Follow through after the meeting:

- Make other members of the health care team (in particular, the family physician) aware of your patient's clinical condition.
- As appropriate, continue to monitor your patient's condition.

### POST-ANALYSIS DISCLOSURE

*(in a hospital or institution, leadership/management may lead)*

- Continue to provide clinical and emotional support
- If appropriate, convey newly uncovered facts to your patient if any, including what steps have been taken to prevent similar harm to others.
- Provide a further expression of regret that may include an apology with acknowledgement of responsibility for what has happened if this is appropriate.
- Consider arranging appropriate emotional support for all those involved, including yourself.
- Document the clinical care and discussions in a factual way.



## APPENDIX C

### DISCLOSURE FORM

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### Documentation of Disclosure Meeting

Date		
Time		
Place		
Hospital Attendees	Patient/Family Attendees	Relationship to Patient
Brief Factual Description of Preventable Adverse Event/Critical Incident		
Responses & Questions of Attendees		
Request by patient/Substitute Decision Maker/Power of Attorney to Review Chart <input type="checkbox"/> yes <input type="checkbox"/> no		
Clinical Management Options (eg) Transfer of Care to Another Physician		
Services Offered (Social Work, Spiritual Care)		
Responses of Relatives to above offers		
Name of Staff Contact	Date of Contact	Person to be Contacted
Risk Management Signature		
Date:		