Disclosure of Harm

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Overview

(1) Disclosure to Patients
(2) Public Hospitals Act amendments
(3) CPSI Guidelines
(4) Recommendations for Organizational Approach
Disclosure to Patients

**Reporting**
- Quality assurance focus
- Internal
- External
- Reduce risk of recurrence

**Disclosure**
- Patient care focus
- To patients, family, estate, etc.
- Facilitate patient autonomy; Treatment; Prevention

**Patient Safety**
Disclosure to Patients (cont’d)

• Patient autonomy

• Ethical/professional obligation of care providers; fiduciary duty
  – Health regulatory College policies and standards

• Systems responsibilities regarding risk management, quality, patient safety
Disclosure to Patients (cont’d)

• Potential liability
  – Case law where not disclosing error that resulted in harm was found to be negligence; breach of fiduciary duty
Disclosure to Patients (cont’d)

• Evolving concept; Varying language (error, adverse event, harm, sentinel event, incident, occurrence, etc.)

• Expectations informed by:
  – Regulation 965 of *Public Hospitals Act* amendments: “critical incidents”
  – Patient safety: “adverse events”; “harm”
  – Professional expectations: “harm”
Disclosure of Critical Incidents

- Amendments to Reg. 965 of *PHA*

- Board responsibility - **Mandatory** disclosure of “critical incidents” to affected patient, SDM, estate

- Disclosure must occur as soon as practicable

- Amendments in force July 1, 2008
Critical Incidents (cont’d)

• Critical incident is an unintended event that:
  – Occurs when patient receives treatment in a hospital;
  – Results in death or serious disability, injury or harm to the patient; and
  – Does not result primarily from underlying medical condition or known risk inherent in providing the treatment
Critical Incidents (cont’d)

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Critical Incidents (cont’d)

• **Must** disclose to patient, SDM, estate:
  – Material facts
  – Consequences for patient
  – Actions taken and recommended for patient
  – Systemic steps – subject to QCIPA

• Documentation in patient record
CPSI Guidelines

- Culture of patient safety supported by growing body of literature
- Reflected in organizational policies, initiatives
- Canadian Patient Safety Institute *Guidelines on Disclosure of Adverse Events*
CPSI Guidelines (cont’d)

• Address “adverse events”

• Where patient suffers harm, “obligation” to communicate to patient harm and event that led to harm
  – “Harm” is an outcome that negatively affects patient’s health or quality of life
CPSI Guidelines (cont’d)

• National in scope

• Guidelines:
  – For when, what, who, documentation
  – Facilitate communication, clear consistent approach
  – Interdisciplinary approach
  – Support learning
CPSI Guidelines (cont’d)
• Recommendations, not legal requirements
• Speak to best practices
• Not attribution of blame, fault
• May inform standard for disclosure
  – Development – Working group, consultation
  – Positive response (OHA, CMPA’s guide “Communicating with your patient about harm”)
Organizational Approach

- Compliance with requirements re: critical incidents
- Management of risk and public perception
- Promote and enhance patient safety
i) Appropriate policies/procedures

- Must reflect critical incident amendments
- Clearly define scope
  - Language
  - May include near misses, close calls in certain circumstances
- Link to risk, quality, incident management programs
- Reflect systems obligations
i) Appropriate policies/procedures (cont’d)

• Best practices for disclosure process

• Identify organizational roles and responsibilities

• Appropriate review of occurrence; Triggers for lookback and notification
ii) Appropriate communication

• The right person saying the right thing(s) in the right setting at the right time
  – Responsibilities of health care provider(s)
  – Organizational roles, responsibilities, involvement

• Ongoing process – Facts, avoid speculation, provide information as it’s known and understood
ii) Appropriate communication (cont’d)

- Constraints on disclosure (QCIPA, privilege)
- Other considerations include PHIPA, by-laws, policies, risk of litigation, legal advice
iii) Appropriate Response

- Systems approach
- Supportive (patient, family, health care provider)
- Reflective of assessment of risks to organization
- Culture of learning, not punishment
- If practice issues – Organizational response, regulatory triggers
Questions?

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THANK YOU!!!