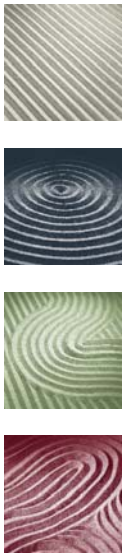

MILLER THOMSON LLP

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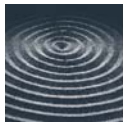
Disclosure of Harm

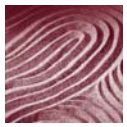
Jesstina McFadden
Miller Thomson LLP

Coffee Talk

June 18, 2008

Overview



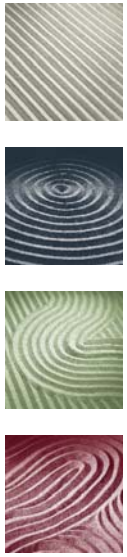
(1) Disclosure to Patients

(2) *Public Hospitals Act* amendments

(3) CPSI Guidelines

(4) Recommendations for Organizational Approach

Disclosure to Patients



Reporting	Disclosure
• Quality assurance focus • Internal • External • Reduce risk of recurrence	• 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

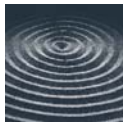
Disclosure to Patients (cont'd)

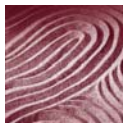
- Evolving concept; Varying language (error, adverse event, harm, sentinel event, incident, occurrence, etc.)

- 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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  - Occurs when patient receives treatment in a hospital;
  - Results in death or serious disability, injury or harm to the patient; and
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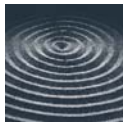
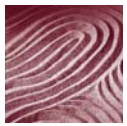
Critical Incidents (cont'd)

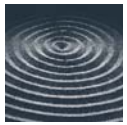
- Must disclose to patient, SDM, estate:
  - Material facts
  - Consequences for patient
  - Actions taken and recommended for patient
  - Systemic steps – subject to *QCIPA*
- Documentation in patient record

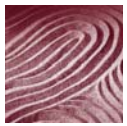
CPSI Guidelines



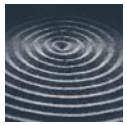
- Culture of patient safety supported by growing body of literature
- Reflected in organizational policies, initiatives
- Canadian Patient Safety Institute *Guidelines on Disclosure of Adverse Events*

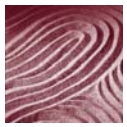





CPSI Guidelines (cont'd)

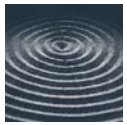
- Address "adverse events"
- Where patient suffers harm, "obligation" to communicate to patient harm and event that led to harm
  - "Harm" is an outcome that negatively affects patient's health or quality of life

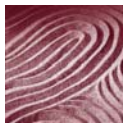





CPSI Guidelines (cont'd)

- National in scope
- Guidelines:
  - For when, what, who, documentation
  - Facilitate communication, clear consistent approach
  - Interdisciplinary approach
  - Support learning

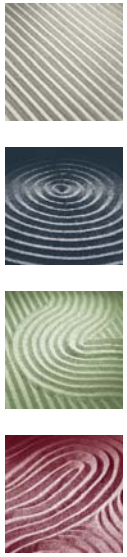





CPSI Guidelines (cont'd)

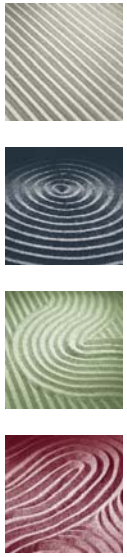
- Recommendations, not legal requirements
- Speak to best practices
- Not attribution of blame, fault
- May inform standard for disclosure
  - Development – Working group, consultation
  - Positive response (OHA, CMPA's guide "Communicating with your patient about harm")

Organizational Approach

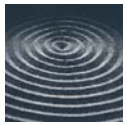


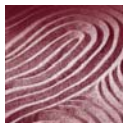
- Compliance with requirements re: critical incidents
- Management of risk and public perception
- Promote and enhance patient safety

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)

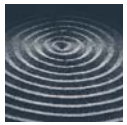
- Best practices for disclosure process
- Identify organizational roles and responsibilities
- Appropriate review of occurrence; Triggers for lookback and notification

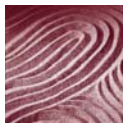
ii) Appropriate communication

- 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)

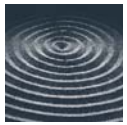
- Constraints on disclosure (*QCIPA*, privilege)
- Other considerations include *PHIPA,* by-laws, policies, risk of litigation, legal advice

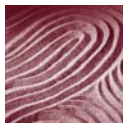





iii) Appropriate Response

- 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!!!

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