Resident Safety and Disclosure of Adverse Events

As those who work in long term care know, health care is inherently risky. There are unique issues when dealing with long term care residents, primarily the frail and elderly, but also with regards to individuals with acquired brain injury or other conditions that place them and others at risk. While there has been a significant focus on patient safety initiatives over the past decade, much of this activity has focused on the acute care sector. Recent reports have recognized that improvements in safety in Canadian long term care settings are imperative.[1]

One area of focus is the development of a culture of resident safety, which supports appropriate communication around adverse events. This includes reporting of adverse events within the organization and disclosure of harm to residents and their families. However, an organization can only learn from adverse events with a view to improving resident safety if it is aware of these events in the first place.

Creating a culture of safety

A key component in creating a culture of resident safety is a shift in organizational perspective to a system of shared accountability, both among staff and in the organization itself, which is ultimately responsible for ensuring that appropriate systems are in place. Shared accountability recognizes that people, processes, equipment and systems can fail, and that harm is rarely the result of one individual error. Often, it is the result of a breakdown in one or more systems.

A culture of resident safety promotes open communication—including reporting of safety risks and adverse events as they occur—in a non-punitive environment. Reporting of adverse events, safety risks and near misses provides opportunities for the long term care home to look at improving systems and practices. It also recognizes professional accountability for those involved in the care of the resident.

by Kathryn Frelick

Kathryn Frelick is a partner with the law firm of Miller Thomson LLP, and leads the firm's health regulatory and policy practice in Toronto. She works exclusively with health clients from the public and private sectors. Ms. Frelick can be reached at (416) 595-2979 or kfrelick@millerthomson.com.

Industry/legislative initiatives

Various resident and patient safety initiatives have been developed and endorsed by health care associations, insurers and accreditation agencies across Canada. Many health professional governing bodies have developed policies, guidelines or codes of ethics that support resident and patient safety, including in relation to the disclosure of harm.

Safety initiatives are supported by various types of provincial legislation, including mandatory reporting requirements to external oversight bodies when there has been a death, serious occurrence or reportable or communicable disease. In Ontario, the Ministry of Health and Long-Term Care recently mandated the public reporting of specific patient safety indicators, including hospital-acquired infections and mortality rates. Currently, such reporting is restricted to public hospitals, but these requirements could be extended to long term care.

To encourage quality of care initiatives within the health sector, many provinces have adopted legislation that protects quality of care or peer review information. To promote communication, a number of provinces have also enacted legislation to protect apologies so that they cannot be used against a health care provider as an admission of liability or fault in a legal proceeding. Recent legislation enacted in Ontario makes it mandatory for public hospitals to disclose critical incidents to patients or their substitute decision makers.

Disclosure of adverse events

Common law supports the disclosure of adverse events to residents as part of their right to be informed about all aspects of care. This includes information relating to harm that has resulted from an adverse event. The obligation to disclose is an ethical and professional obligation for a health care professional. It is part of the fiduciary duty that is owed to the resident within the context of the treating relationship. There have been a number of cases where a health professional has been found to be negligent for failing to disclose error when this has resulted in harm to the individual.[2–4]

In March 2008, the Canadian Disclosure Guidelines were released. These were created as national guidelines by the Canadian Patient Safety Institute, and have received widespread acceptance across the health sector.[5] The guidelines provide a useful framework for the disclosure process, and discuss considerations that may be applicable in specific situations. The guidelines focus on harm related to adverse events. The underlying principle is that there is an obligation to disclose harm, regardless of how it occurs.

The guidelines emphasize the importance of a clear, consistent approach to disclosure. However, they are not meant to dictate disclosure policies and procedures created by individual organizations. Organizational disclosure policies should be consistent with applicable provincial legislation, governmental policy and professional obligations.

Mandatory reporting

As of July 1, 2008, every public hospital in Ontario was required to have a system in place for the mandatory disclosure of critical incidents.[6] Legislative amendments place the obligation squarely on a hospital's board of directors to ensure there is a system for disclosing every critical incident as soon as is practicable after it occurs. While legislative disclosure requirements do not apply to long term care facilities, the provisions do provide insight into different approaches.

The mandatory obligation to disclose is restricted to critical incidents, which are defined as unintended events that occur when a patient receives treatment in a hospital that results in death or serious disability, injury or harm and which do not result primarily from

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the patient's underlying medical condition or from a known risk inherent in providing treatment. These reflect the minimum requirements, and many Ontario hospitals have adopted disclosure of harm policies that encompass more than just critical incidents.

The legislation sets out to whom disclosure must be made, what must be disclosed and the information that must be documented in the health record. Following the disclosure of a critical incident, the hospital is further obligated to advise the individual of the systemic steps, if any, that it is taking or has taken in order to avoid or reduce the risk of similar critical incidents. The content and date of this further disclosure must be recorded in the health record.

Resident safety

Developing a culture of resident safety is multi-levelled, and a systems approach to implementation is necessary. When developing disclosure of harm policies, it is essential that these incorporate—or are linked to—the long term care home's risk, quality and resident safety programs. In developing disclosure of adverse event policies, you may consider the following:

- **Scope of policy.** When developing policies related to disclosure of harm, consider applicable provincial legislative requirements, professional standards or industry best practices. The policy should be organization-wide and set out roles and responsibilities. There is considerable room for determining the scope of the policy in terms of the types of situations that require disclosure and by whom.
- **Reporting.** Key to an effective disclosure policy is the timely reporting of adverse events within the organization. Reporting of adverse events must be linked to existing risk and incident management processes so that the resident's immediate safety needs can be met and the organization can mobilize appropriate resources. It is important to ensure the appropriate persons within the organization are aware of the event and can manage the process. External reporting requirements may also be triggered, for example, to the coroner, police or government.
- **Review and communication.** Effective disclosure involves the right person, saying the right things, in the right setting, at the right time. It may be appropriate to identify both clinical and management spokespersons to address the situation, including treatment options and organizational resources. Communication of harm is a skill and the organization might consider providing training or other supports to ensure effective communication.

When an adverse event occurs, it may take some time to ascertain the facts and to determine whether the process for disclosure has been triggered. Disclosure of harm is a process that unfolds as information becomes known and understood. For example, there may be initial disclosure at the time that the adverse event is discovered to address

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the resident's immediate care needs; as more information becomes available and the situation is analyzed, there may be further disclosure discussions. The later discussions may be led by members of the management team, particularly if systemic issues are identified. In all cases, speculation and attribution of blame must be avoided.

- **Organizational response.** An adverse event can be devastating for the resident, the resident's family and affected staff. Organizations should identify supports for residents, such as spiritual care and social work, as well as supports for staff.

Since resident safety is a systems issue, it requires a systems response. The identification of a serious adverse event may trigger a quality of care review or root cause analysis and the development of recommendations to improve care. Information generated by the review might be protected through legislation or solicitor and client privilege.

There is opportunity for long term care homes to embrace resident safety issues and to shape the response. **LTC**

References

1. *Wagner LM, Rust, TB. Safety in Long-Term Care Settings: Broadening the Patient Safety Agenda to Include Long-Term Care Service. Edmonton, AB: Canadian Patient Safety Institute, 2008.*
2. *Stamos v Davies [1985] Ontario High Court 21 DLR: 507–10.*
3. *Gerula v Flores [1995] 126 DLR:507–30.*
4. *Shobridge v. Thomas, [1999] BCJ. No. 1747 (SC).*
5. *Disclosure Working Group. Canadian Disclosure Guidelines. Edmonton, AB: Canadian Patient Safety Institute.*
6. *Ontario Regulation 423/07 made under the Public Hospitals Act, 2007. Available from: http://www.elaws.gov.on.ca/html/source/regs/english/2007/elaws_src_regs_r07423_e.htm.*