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MANDATORY DISCLOSURE OF CRITICAL INCIDENTS

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As of July 1, 2008, every public hospital in Ontario will be required by law to have a system in place for the mandatory disclosure of critical incidents.

Regulation 423/07 amends Regulation 965 (Hospital Management) under the *Public Hospitals Act* and defines a critical incident. It sets out the obligation of the Board of Directors to ensure that the administrator of the hospital establishes a system for ensuring that disclosure of every critical incident is made as soon as practicable after the incident occurs.

What is a critical incident?

A critical incident is defined as any unintended event that occurs when a patient receives treatment in a hospital that:

- results in death, or serious disability, injury or harm to the patient; and
- does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing the treatment.

Who is disclosure made to?

Disclosure must be provided to the affected patient or, if the patient is incapable with respect to treatment, the individual's substitute decision-maker. If the patient has died, disclosure must be provided to the individual's estate trustee or the individual who has assumed responsibility for the patient's estate. Alternatively, the disclosure may be provided to the person who is the patient's substitute decision-maker immediately prior to death.

What must be disclosed?

The Regulation mandates what must be included in the disclosure, including:

- the material facts of what occurred with respect to the critical incident
- the consequences for the patient of the critical incident, as they become known
- the actions taken and recommended to be taken to address the consequences to the patient of the critical incident, including any health care or treatment that is advisable

Following the disclosure of a critical incident, there is a further obligation on the hospital to advise the individual of the systemic steps, if any, 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 must be recorded. The one exception to this is in respect of information that is protected from disclosure under the *Quality of Care Information Protection Act, 2004*.

What must be documented?

Reports of any critical incidents with respect to the patient, including the required information above, must be documented in the patient's record of personal health information. Information relating to when disclosure was made is also required.

Implications for Hospitals

It has long been recognized that patients have the right to be informed about all aspects of their care, including information relating to harm that has resulted from a serious adverse event, critical incident or sentinel event (or whatever terminology is adopted). The obligation to disclose is an ethical and professional obligation of the health care professional and is part of the fiduciary duty that is owed to the patient within the context of the treating relationship. There are 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.

Patient safety is a shared responsibility involving each individual health professional and the organization itself, which is responsible for ensuring that there are appropriate systems in place. The College of Physicians and Surgeons of Ontario passed a policy in 2003 requiring mandatory disclosure of harm. Many hospitals have policies in place that encourage or require the reporting and disclosure of harm.

It is essential for hospitals to develop policies to ensure that disclosure of critical events is done effectively and it is linked to the facility's risk, quality and incident management programs. Such policies allow the organization to provide support to its physicians and employed staff in these very difficult situations and to ensure appropriate coordination within the organization.

As of July 1, 2008, these requirements will be law. We would be pleased to assist in the development or review of your disclosure of critical incident/disclosure of harm policies and to provide assistance with your risk management and quality processes.

ABOUT THE AUTHOR

Kathryn Frelick is a lawyer practising in our Health Industry Practice Group and is supervising counsel for the Legal Retainer Program.

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