DISCLOSURE

POLICY

It is the policy of Campbellford Memorial Hospital that patients be treated with openness and honesty at all times, and that the right to know their medical status is respected. In order for patients to be able to make informed decisions concerning their heath care, full disclosure of results, including those that differ from what was anticipated must be presented.

Disclosure to the patient or substitute decision maker should be made by the most appropriate medical staff member and/or manager in a timely fashion (48-72 hours) and documentation of the conversation should be made in the patient's record.

Subsection 2(4) of Regulation 965 of the Public Hospitals Act has been amended to state "that the disclosure of a critical incident is to be made, as soon as is practicable not only to the affected patient, but to the Medical Advisory Committee and the administrator." Sub section 5.1 has been added that provides; "the board shall ensure that the administrator establishes a system for ensuring, following a disclosure of a critical incident, that the incident is analyzed and a plan developed with systemic steps to avoid or reduce the risk of further similar critical incidents."

Disclosure means "the full and frank acknowledgment of and discussion regarding a negative outcome or adverse consequence of medical care."

Harm is defined broadly as "any non-trivial injury, complication, or adverse consequence sustained by a patient in the course of receiving medical care – whether or not such harm was preventable and regardless or cause".

Critical incident is defined in Public Hospitals Act Regulation 423/07 as "any unintended event that occurs when a patient receives treatment in the hospital,

1. that results in death, or serious disability, injury or harm to the patient, and

2. does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing the treatment; ("incident critique")

GUIDELINES FOR DISCLOSURE OF AN ERROR

PRIOR TO DISCLOSURE

1. Do a personal inventory of the events in order to assist your memory and allow you to deal with any emotions associated with the event, prior to speaking with the patients.

2. Remember the importance to be honest, but factual with those involved.

3. Presume good will on behalf of all patients.

4. Notify the Risk Manager of the occurrence. This should be done immediately if it is clear that an injury to the patient is the result of a medical error. If the Risk Manager is not available the Chief Nursing Officer is notified and acts as the Risk Manager.

5. Be mindful of the need to preserve the confidentiality of patient information.

6. Gather all facts. Review the patient chart. Complete the Healthcare Incident/Unusual Occurrence form. Ensure that the severity classification is appropriate for the severity of the injury to the patient.

7. Prepare to review the chart with the patient/family member. It may be of some assistance to prepare a script to assist you to present a concise disclosure. Anticipate possible questions. If it were you or a family member what would you want to know?

8. Determine who is the most appropriate person to present the information to the patient. If it is a nursing error, then the Nursing Program Director is probably the most appropriate person to talk with the patient.

9. Explain the process of disclosure in simple terms but being mindful of the patient's reaction to the information being given.

10. Be cognizant of the patient's culture and consult resources where necessary.

11. These questions will help put the event into perspective and assist the interviewer in being as prepared as possible for the interview with the patient/family/SDM/Estate Trustee.
    - What happened?
    - How did it happen?
    - What is the professional or Hospital going to do to assist the patient/family/SDM/Estate Trustee?
    - What steps have been taken or will be taken to reduce the likelihood of this happening in the future?

DURING DISCLOSURE

1. Arrange to provide the disclosure in a private setting that allows those involved the ability to move about the room if they feel it is necessary. The person(s) delivering the information should remain seated during the conversation.

2. Ensure you <u>always</u> have a 'scribe' with you. This will allow you to give your undivided attention and at the same time have accurate documentation of the dialogue.

3. Begin the session by carrying out the instructions so that everyone knows who is in the room and their relationship to the patient.

4. Ascertain what information that patient may already have, whether factual or perceived.

5. Ascertain how much information the patient wants to receive. They may wish someone else to be the recipient of the information.

6. Convey the information slowly, in simple terms that are understandable to the patient/family/SDM/Estate Trustee. Avoid using medical jargon.

7. Explain what happened, when and where it occurred, any decisions that were made including those in which the patient participated, any repercussions, and recommended corrective action. Do not speculate on any of this information.

8. Identify and offer and support that is available to the patient/family/SDM/Estate Trustee, including a venue for future conversations. Work with the patient in a collaborative manner to devise a follow up treatment plan for him/her to mitigate the effects of any injury. Pay attention to patient preferences and cultural considerations.

9. Let the patient/family/SDM/Estate Trustee know what will be done to follow up, both with regards to preventing this from happening again and how the patient's care will be managed from this point on. This includes an explanation that a full analysis of the events leading to this undesired outcome of care will be conducted.
10. Express appropriate regret for the error and concern for the welfare of the patient/family.

11. Avoid making a direct admission of fault at this point. Only a thorough objective review of facts can give an unbiased determination of fault.

12. Provide periodic pockets of silence, allowing the patient/family time to process the information being given. Leave opportunity for questions and discussion.

13. For any critical event, a meeting should be held as soon as possible, even if you can only explain part of what happened. Focus on what is being done for the patient, not what led to the present circumstances. Promise to return when additional facts are known. Explain treatment that may be necessitated by the error. If testing is required, promise to share results as soon as they are known. Provide a general idea as to when that will be and be sure to follow through.

AFTER DISCLOSURE

1. Acknowledge the patient/family/SDM/Estate Trustee's emotions upon hearing the bad news. Validate their reaction appropriately so as not to aggravate the situation.

2. Do not give any impression of insensitivity. Be empathetic and compassionate.

3. If met with anger do not respond in kind. Work hard to avoid defensiveness, rationalizing, or lecturing.

4. If information is requested that you do not have, offer to assist them in getting the information they seek.

5. Provide the patient/family/SDM/Estate Trustee with the name of the contact person if they have any further questions or concerns, and how that person can be reached.

6. If you are asked about what will happen to the responsible person you can say that you don't know, but that it will be followed up by the appropriate manager/physician.

7. Let the patient/family/SDM/Estate Trustee know that the hospital will investigate a systems problem by referral to the Quality of Care Committee.

8. In some instances, follow up meeting should take place within 48 hours after the initial meeting to provide updates about the event to the patient/family.

9. Once the disclosure conversation has concluded, continue facilitating the healing process for the practitioner involved in the error. Refer to the Employee Assistance Program if necessary.

10. Following a disclosure of a critical incident, the incident is analyzed and a plan is developed with systemic steps to avoid or reduce the risk of further similar critical incidents.

DOCUMENTATION OF CRITICAL INCIDENTS

Documentation of a critical incident is as important a part of the disclosure process as the conversation with the patient/family. There are some guidelines to follow when documenting the incident/error.

1. The patient's health record should contain all the information regarding care and treatment of the patient in the appropriate sections of the chart (i.e. progress note, MAR, etc.).

2. The entry must be factual and free of opinion and emotion. Just the facts.

3. Avoid using the pronoun "I" – restate the narrative with the patient as a subject.

4. State only the known facts of what occurred and do not speculate as to the cause(s).

5. Do not include editorial comments. Do not comment on the care provided by others.

6. Avoid terms such as "error" and "inadvertent".

7. Document what did happen, not what you thought should have happened.

8. Record, by name, the medical staff member who was notified.

9. Describe the patient's condition, what was done in response to the error, and what effect the intervention had on the patient.

10. Record any involvement of supportive persons such as clergy, or social work.

11. Document what was told to the patient/family, by whom and when.

12. The health record should not contain any reference to Incident Reports of Risks.
    - Document the analysis of the incident and the action plan including systemic steps to avoid or reduce the risk of further critical incidents.

APPENDIX A: GLOSSARY OF TERMS

Adverse event: An unexpected event in the healthcare delivery system that results in harm and is not attributable to recognized complication.

Critical incident: An event resulting in serious harm (loss of life, limb, or vital organ) to the patient or the significant risk thereof.

Disclosure: The communication of information to the patient, by the healthcare providers, about an adverse event.

Error: The failure to complete a planned action as it was intended, or when an incorrect plan is used in an attempt to achieve a given aim.

Event: A significant occurrence or happening.

Harm: An outcome that negatively affects the patient's health and/or quality of life.

Incident: Defined as including events, processes, practices, or outcomes that are noteworthy by virtue of the hazards they create for, or the harms they cause, patients.

Informing: Providing information about adverse events and the performance of the healthcare system to the public, mainly through the media.

Near Miss: The event did not reach the patient because of timely intervention or good fortune.

Patient Safety: The reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices, shown to lead optimum patient outcome.

Recognized complication: Harm that results from the risks inherent to the investigation or good fortune.
Reporting: The communication of information about an adverse event or near miss by healthcare provides, through appropriate channels inside or outside of the healthcare organizations, for the purpose of reducing the risk of reoccurrence of adverse events in the future.

Root cause analysis (RCA): An analytic tool that can be used to perform a comprehensive, system-based review of critical incidents. It includes the identification of the root and contributory factors, identification of risk reduction strategies, and development of action plans along with measurement strategies, to evaluate the effectiveness of the plans.

Substitute Decision-Maker (SDM): A person, other than the patient, who is legally authorized to make a decision on behalf of the patient. The patient may grant the authority themselves, by a legal document such as an advance directive, by legislation or by the courts.

APPENDIX B: CHECKLIST FOR DISCLOSURE PROCESS

1. The immediate patient care needs are met.
2. Ensure patient, staff and other patients are protected for immediate harm.
3. Any critical event is reported to the Medical Advisory Committee and the Chief Executive Officer.

DISCLOSURE PROCESS PLAN

1. Gather existing facts.
2. Establish who will be present and who will lead discussion.
3. Set when initial discussion will occur.
4. Formulate what will be said and how the disclosure will be communicated.
5. Locate a private area to hold disclosure meeting, free of interruptions.
6. Be aware of your emotions and seek support if necessary.
7. Anticipate patient's emotions and ensure support is available including who the patient chooses to be part of the discussion such as family, friends, or religious representatives.
8. Contact our support services for disclosure if uncertain how to proceed (Risk Manager, CEO, Chief of Staff, Ethicist).

DISCLOSURE DISCUSSION

1. Introduce the participants to the patient, functions and reasons for attending the meeting.
2. Use language and terminology that is appropriate for the patient.
3. Describe the facts of the adverse event and its outcome known at the time.
4. Describe any actions that are taken as a result of the internal investigations such as system improvements.
5. Describe the steps that were and will be taken in the care of the patient (Changes to care plan as applicable).
6. Avoid speculation or blame.
7. Express sympathy or regret, a statement that one is sorry, as appropriate.

8. Inform the patient of the process for investigating and what the patient can expect to learn from the investigation, with appropriate timelines.

9. Allow time for questions and clarify whether the information is understood.

10. Be sensitive to cultural and language needs.

11. Offer to arrange subsequent meetings along with sharing key contact information.

12. Offer practical and emotional support such as spiritual care services, counseling and social work, as needed.

13. Facilitate further investigation and treatment if required.

14. Plans for follow-up with key contact information for the organization including systemic steps CMH is taking to avoid or reduce the risk or further similar incidents.

15. DOCUMENT the disclosure discussion as per organizational policies and practices and include:

    a) The time, place and date of disclosure discussion.
    b) The names and relationships of all attendees.
    c) The facts presented in the discussion.
    d) Offers of assistance and the response.
    e) Questions raised and the answers given.
    f) Plans for follow-up with key contact information for the organization including systemic steps CMH is taking to avoid or reduce the risk of further similar incidents.

APPENDIX C: RESOURCES

In-House Programs/Resources:

Campbellford Memorial Hospital Ethics committee

Campbellford Palliative Care Program at 705-653-5208

Hicock, Larry, Beware the Grieving Warrior: A Child's Preventable Death A struggle for Truth, Healing and Change. ECW Press, Toronto, 2004 (copies available in-house).

Employee Assistance Program accessible directly through Shepell-FGI at www.shepellfgi.com or 1-800-387-4765.

Foundations Consultants on Ethics and Values, Dr. Robert Butcher. 108 Forward Avenue, London Ontario N6H 1B7

Risk Manager (Extension 2139)

Other Available Resources/Research Literature:

Cantor, MD. Barach, P., Derse Al, Maklan, CQ. Et al. Disclosing Adverse Events to Patients. Joint Commission Journal on Quality and Patient Safety. 2005 January; 31 (1): 5-12.

Duclos, CW, Eicher, M., Taylor, L. et al. Patient perspectives on patient-provider communication after adverse events. Internal Journal for Quality in Health Care; 2005; 17 (6): 479-86

Gallagher, TH., Waterman, AD., Garbutt, JM. Et al. US and Canadian physicians' attitudes and experiences regarding disclosing errors to patients. Archives of Internal Medicine. 2006; 166 (15): 1605-11.

Gallagher, TH., Garbutt, JM., Waterman, AD. Et al. Choosing your words carefully: how physicians would disclose harmful errors to patients. Archives of Internal Medicine. 2006; 166: 1585-93

Lazare A., Apology in Medical Practice: An Emerging Clinical Skill. The Journal of the American Medical Association. 2006 September 20; 296 (11).

*For more literature, visit the Patient Safety Support Service Literature Page at www.oha.com/psss

APPENDIX D: REFERNCES

Baker, R., Norton, P., Flintoft, V., Blais, R., Brown, A., Cox, J, et al. The Canadian Averse Events Study: the incidence of adverse events among hospital patients in Canada, CMAJ.2004; 170(11): 1678-1679.

Marshall M., Vandergrift E., Windwick B, Vallet D, Hoffman C, Dingwell O. Development of national guidelines for the disclosure of adverse events: CPSI background paper. Edmonton, AB: Canadian Patient Safety Institute; 2003.

Canadian Council on Health Services Accreditation. CCHSA Program: Patient Safety Required Organizational Practices (Culture #4), 2006.

Canadian Council on Health Services Accreditation. CCHSA Program: Leadership and Partnership Standards (Criteria 13.), 2007.

Davies JM, Herbert P, Hoffman C. The Canadian Patient Safety Dictionary. 2003

National Steering Committee on Patient Safety, Building a Safer System: A national integrated strategy for improving patient safety in Canadian heath care. Royal College of Physicians and Surgeons of Canada. 2002.

Public Hospitals Act, Regulation 423/07 amending Reg. 965 of R.R.O. 1990.

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