

Category: BOARD POLICY – ADMINISTRATIVE PARAMETERS	
Title: Disclosure of Adverse Events	Reference Number: AS 140
Approved by: PHSA Board of Directors	Last Approved: June 22, 2011 Last Reviewed: June 22, 2011

*“True professionals admit their errors, seek to understand them and prevent them for recurring, and move on. Candidly disclosing harmful errors to patients simply closes the loop of learning, compassion and trust that is the foundation of the practice of medicine.”*  
 (CMAJ 2001, Philip Hebert, Alex V. Levin, Gerald Robertson, August 7; 165 (3): 271-272.)

## 1. PURPOSE

To assist the Provincial Health Services Authority (“PHSA”) and its health care providers in disclosing adverse events to patients and families.

To ensure that patients are receiving informed, safe and appropriate health care.

To strengthen the lines of communication between patients and their health care providers through encouraging open communication.

To improve the health care provider’s skill and confidence in the disclosure process.

## 2. POLICY

The PHSA is committed to patient safety and ensuring that all personnel understand their individual, ethical and professional responsibility in disclosing adverse events to patients and families. PHSA recognizes its responsibility to disclose to patients and families (Appendix A). The intention is to improve the quality of care a patient receives, ensuring the patient is fully informed and building mutual trust and respect with the patient and their family.

Disclosure of adverse events can only serve to enhance patient safety by reinforcing the values important to a culture of safety – honesty, respect and transparency.

## 3. SCOPE

The standards of behavior set forth in the policy are intended to apply to all personnel within any of the PHSA agency service areas.

## 4. PROCEDURE

a) Ensure immediate measures are taken to stabilize the patient, mitigate any injury and prevent further harm.

b) Ensure immediate action is taken to secure any implicated drugs, equipment, and records.

c) If an adverse event occurs, health care providers and/or staff should immediately inform their appropriate manager.

- d) The adverse event should be reported to the appropriate individuals as per the facility's incident reporting policy.
- e) The appropriate manager and the appropriate health care provider will immediately determine whether disclosure to the patient/substitute decision-maker and family will take place. If unsure, consultation with the Risk Management Department would be appropriate.
- f) If the incident is defined as a near miss, disclosure should be determined on a case by case basis. If a patient has knowledge of the incident disclosure may be appropriate. Discussion should take place with the appropriate manager, appropriate health care provider and the Risk Management Department. The patient's best interests should be considered when deciding whether to disclose.
- g) If it has been determined that the adverse event occurred in another health care setting ("the originating organization") outside the organization currently providing care, the appropriate manager informs the senior administrator who in turn informs the senior administrator of the originating organization of the adverse event in a confidential and sensitive manner. The originating organization is responsible for determining the timing of and process for disclosure of the event to the affected patient, client, family or substitute decision maker.
- h) If the nature of the adverse event necessitates disclosure to more than one patient or family (e.g. events involving large numbers of the public; epidemiologic or communicable diseases events), the appropriate manager informs the senior administrator who will direct coordination with risk management and communications.
- i) After determining disclosure should take place, the team responsible for disclosing should be determined by the appropriate health care provider and the appropriate manager. Consideration should be given to a patient's preferences not to have certain individuals present during the discussion.
- j) Disclosure to the patient should then occur as soon as reasonably possible following the adverse event taking into account the following factors: adequate time for initial assessment of the relevant information, timing regarding normal care practices around the provision of health care information to patients, clinical condition of the patient, and the preference of the patient and family.
- k) If the patient wishes to have a support person present of his/her choice during the disclosure discussion, this request should be respected. An offer should also be made to provide an internal support person such as social work or spiritual services.
- l) Health care providers and staff may also be psychologically and physically impacted following an adverse event. Support should be offered immediately which may include: Employee Assistance Program (EAP), counselling services, etc. Requests should also be granted to health care providers and staff to consult with their indemnifiers or professional associations prior to participating in a disclosure discussion.

**The initial disclosure discussion should include the following:**

**IDENTIFY** - Identify to the patient/substitute all of the individuals who will be present during the discussion. This places the patient/family at ease and creates an open and honest environment.

**FACTS** - Stick to the facts during an explanation of the events. The nature of the event, the level of severity and outcomes if known. Do not speculate on any details surrounding the event or begin to attribute blame to any individual.

**APOLOGIZE** - Empathize with the patient/family, “we are so sorry this has happened to you.” However, the discussion should not involve a legal admission of liability.

**TAKE RESPONSIBILITY** – The team should communicate ownership of the event to the patient and family. This is separate and distinct from an assumption of liability. The patient and family must feel confident that the team takes responsibility for determining the causes of the event, ensuring the patient’s care is managed and any future complications are expressed to the patient and family.

**CLARIFY** - If the adverse event was clearly not due to an error (ex. Type 1 or Type 2 unpreventable adverse event), or the cause is unclear, make sure the patient understands that the injury is not the result of a failure of care, but an inherent risk.

**LISTEN** - Allow the patient/family to absorb the information they have just heard. Listen carefully to any questions they may have and clarify their understanding. Respect should be given to a patients’ educational level, cultural background and disabilities.

**FOLLOW-UP** - Let the patient know the steps that are being taken to deal with the adverse event. If there are particular questions or issues which are unable to be dealt with at the time, let the patient know that they will be followed up. Designate a person within the disclosure team that the patient can contact if further questions arise so that there is a central line of communication.

**SUPPORT** - Support in the form of counseling, spiritual services, or other forms should be offered to the patient/family regardless of whether he/she makes the request. Should the patient/family request more detailed long-term support, information must be provided to the patient on how to facilitate this request.

**DOCUMENT** - Record a complete, accurate and factual account of the disclosure discussion in the patient’s medical record including the following: objective details of the event, the patient’s condition immediately before and after the time of the event, medical intervention and patient response, and notification of the physician(s). The individual most involved with the adverse event should be responsible for documentation.

\*For further assistance on disclosure discussion, see guidelines for disclosing located in Appendix B.

m) Following the initial disclosure meeting, further investigation and quality improvement activities will be coordinated through the Quality and Risk Management Department. As a participant in the disclosure process, health care providers and staff may be required to assist in the investigation and identifying process improvements.

n) Ensure follow-up on process improvements continues with patients and families if promised. Delays in follow-up should be communicated promptly and alternative arrangements made.

## **Appendix A: Professional Responsibilities**

### **Canadian Medical Protective Association**

Physicians are encouraged by the CMPA as outlined in their information sheet dated March 2005 and revised May 2008, to disclose to patients the occurrence and nature of adverse outcomes as soon as is reasonable to do so after their occurrence. This is noted as a professional, legal and ethical obligation.

### **Canadian Medical Association, Code of Ethics, 2004**

14. Physicians are required to take all reasonable steps to prevent harm to patients and should harm occur, disclose it to the patient.

21. Provide your patients with information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.

### **Canadian Nurses Association, Code of Ethics, 2008**

#### Safe, Competent and Ethical Care

5. Nurses must admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event. They work with others to reduce the potential for future risks and preventable harms.

### **Canadian Nurses Association, Position Statement – Patient Safety, 2003**

“Patients have the right to know when an adverse event occurred in their care and to have appropriate treatment to address the problem as far as possible. When such an event results in injury, or even a death, there must be open and honest communication with the patient or the family as soon as possible. The implementation of clear agency policies on the reporting of adverse events and near misses, and on disclosure of adverse events to patient and family, are necessary to support good clinical practice and to the overall improvement of patient safety in the system.”

## Appendix B: Guidelines for Disclosing

These guidelines are intended to assist those involved in disclosure with patients and families.

- 1.1 **Create an environment of comfort** for patients and their families when disclosing. As a general rule, try to include someone from the disclosure team who is familiar with the patient. Avoid meeting in a room close to where the incident may have taken place. Select an environment that is informal and relaxed for the patient.
- 1.2 **Good communication and interpersonal skills** are essential to the discussion. Speak slowly, clearly as those in stressful situations may require time to digest the information. Don't overwhelm the patient with medical terminology and jargon they are not familiar with.
- 1.3 **Listen** carefully to the patient and their family. Try not to interject until they have concluded their thoughts. Turn off pagers, cell phones and avoid any interruptions. If the discussion is going to require additional time, let the patient know that further time will be set aside.
- 1.4 **Educate** yourself surrounding the needs of the patient and their family. Come to a disclosure discussion prepared and ready to respond to questions and concerns.
- 1.5 **Timing** is critical in any disclosure discussion. Although disclosure should take place as soon as reasonably possible, if the patient and their family is not prepared to enter into a discussion or staff are not available, wait until the next available opportunity may arise
- 1.5 **Limit** the number of health care providers and staff involved in the disclosure discussion to avoid overwhelming the patient and their family.
- 1.7 **Strategize and summarize** the plans for next steps. Ensure that the family and patient clearly understand what is going to happen next. Be careful not to promise unreasonable requests and try to be forthright and clear. Ask if there are any outstanding questions before concluding the discussion.

## Appendix C: Definitions

**Adverse Event: A bad outcome of care.** An injury that was caused by health care management rather than the patient's underlying disease; also called harm, injury, or complication. Bad outcomes of care include disability, death, prolonged hospital stay. Health care management refers to all aspects of the health care system, not just the actions or decisions of physicians or nurses.

**Unpreventable adverse event:** An injury (or complication) that was not due to an error or systems failure and is not always preventable at the current state of scientific knowledge. There are two major categories:

Type 1: Common, well-known hazards of high risk therapy. Patients understand the risks and accept them in order to receive the benefit of the treatment.  
Example: complications of chemotherapy

Type 2: Rare but known risks of ordinary treatments. The patient may or may not have been informed of the risk in advance.  
Example: side-effects of medications; certain wound infections

**Preventable adverse event:** An injury (or complication) that results from an error or systems failure. It is useful to distinguish three categories:

Type 1: Error by the attending physician.  
Example: technical error during performance of a procedure

Type 2: Error by anyone else in the healthcare team  
Examples: a nurse gives wrong medication to patient; a resident makes a technical or decision error; a radiologist misses a lesion.

Type 3: Systems failure with no individual error.  
Examples: IV pump failure that causes drug overdose; Failure of system to communicate abnormal lab results to ordering physician.

**Error:** The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. A medical error that causes harm results in an adverse event. Errors are classified as follows:

Serious Error: An error that has the potential to cause permanent injury or transient but potentially life threatening harm.

Minor Error: An error that does not cause harm or have the potential to do so.

Near Miss: An event or error that could have caused harm but did not reach the patient because it was intercepted.

**Near miss:** An event or error that could have caused harm but did not reach the patient because it was intercepted

**Disclosure:** Imparting by health care workers to patients or their substitute decision-makers, of information pertaining to any health care event affecting (or liable to) affect the patient's interests.

**Appropriate health care provider:** An attending health care provider who is familiar with the patient and has responsibility for providing health care in the treatment domain in which the adverse event occurred or potentially occurred.

**Appropriate manager/director:** The manager/director (or designate) who is responsible and accountable for standards of care in the clinical unit or area in which the adverse event occurred or potentially occurred.

**Substitute Decision - Maker:** An individual who has the legal authorization to consent to treatment.

**Culture of Safety:** An underlying philosophy of the workplace in which a shared and constant commitment to safety permeates the entire organization and is characterized by:

1. An acknowledgement of the high risk, error prone nature of PHSA's health care activities;
2. A blame-free, non-punitive environment where individuals are able to report incidents or near misses without punishment in order to optimize patient care outcomes;
3. The expectation of collaboration across disciplines and sectors to seek solutions to vulnerabilities; and organizational willingness to direct resources to address safety concerns

## Appendix D: References

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Capital District Health Authority, Disclosure of Adverse Events Policy, 2005.

Ombudsman British Columbia, "The Power of an Apology: Removing the Legal Barriers." February 2006.

Patient Safety in Ontario: An Overview of Patient Safety Policies in Select Ontario Academic Hospitals, February 2005, Council of Academic Hospitals of Ontario.

When Things Go Wrong: Responding to Adverse Events, Massachusetts Coalition for the Prevention of Medical Errors, 2006.

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