Disclosure of Patient/Client Safety Events		
For Policy Office Use Only		
Policy Type: Corporate Policy		**Policy Number: 10382**
Approved By: Executive Team (Corporate) **Approval Date: Feb 8, 2022** **Effective Date: Feb 8, 2022**	**Original Date: Mar 30, 2004** **Revised Date(s): Jul 24, 2018** **Next Review Date: Feb 8, 2026**	**Version: 3**
Policy Sponsor: VP – Quality, Strategy and Family Partnership		
Policy Author: Director, Safety & Family Partnerships (Jill Sullivan)		**Dept: Safety & Family Partnership**
Scope/Impact: This policy applies to all staff, medical staff, volunteers, students and contracted service provider organization (SPO) staff.		
Keywords: adverse event, disclosure, patient/client safety event, incident		

See Writing Guidelines in the Policy Toolkit for definitions and tips on how to complete this template

1. Purpose

To provide appropriate and timely disclosure of patient/client safety events (also known as safety or critical incidents, adverse events) to patients/clients, parents and legal guardians at CHEO. (Patient/client safety events will be referred to as safety events this point forward).

2. Policy

2.1. The Public Hospitals Act requires that CHEO establish a system for ensuring the disclosure of harmful incidents, as soon as is practicable, to the affected patient/client or substitute decision maker.

2.2. The Quality of Care Information Protection Act, 2016 requires that CHEO establish a system for ensuring that there be disclosure to the patient/client or family/caregiver of the systemic steps, if any, that the organization is taking or has taken in order to avoid or reduce the risk of further similar critical incidents, and that the content and date of this further disclosure be recorded.

2.3. Accreditation Canada requires that CHEO establish a reporting system for safety events, including appropriate follow-up.

2.4. All safety events must be:

2.4.1. Managed as per the Patient/Client Safety Event Reporting Policy (entered into the Safety Reporting System)

2.4.2. **All safety events that result in harm, or are likely to result in harm, must be disclosed to the patient/legal guardians:**

- The disclosure shall include (a) the material facts of what occurred; (b) the consequences for the patient/client, as they become known; and (c) the actions taken and recommended to be taken to address the consequences to the patient/client of the event, including any health care or treatment that is advisable.

2.4.3. **Safety events that do not result in harm, and do not have the potential to do so, do not require disclosure:**

- However, these events may be disclosed at the discretion of the Most Responsible Physician (MRP).

3. Responsibilities

3.1. CHEO staff is responsible to:

3.1.1. Inform the MRP about the safety event as soon as possible. In circumstances where there is no MRP, notify the individual most responsible for the patient/client's care.

3.1.2. Enter the event in the Safety Reporting System (SRS) if appropriate.

3.2. Most Responsible Physician (MRP) is responsible to:

3.2.1. Discuss with the appropriate Director, Department/Division Chief or Professional Practice Leader as needed.

3.2.2. Consult with the Director of Quality, and Manager of Patient Safety and Clinical Risk, as appropriate

3.2.3. Ensure an SRS event has been entered, or enter one.

3.2.4. Gather information about the event and plan the initial disclosure.

3.2.5. Disclose to the patient/client, parent/legal guardian as per policy.

3.2.6. In situations where there is no MRP, the individual most responsible for the patient/client's care will assume responsibility for disclosure.

4. Procedure

For more details and guidelines refer to Appendix A (Disclosure Roadmap and Guidelines)

4.1. These are the main steps to providing appropriate and timely disclosure of patient/client safety events:

4.1.1. Attend to immediate clinical care. The safety and well-being of the patient/client must be given highest priority when a safety event is discovered.

4.1.2. Plan the initial disclosure. Your approach to disclosure must be planned to meet the patient/client's clinical, information and emotional needs in the specific circumstances.

4.1.3. Conduct the initial disclosure meeting.

4.1.4. Arrange post-analysis disclosure as required. In some cases, a further meeting will be necessary to allow for the exchange of additional information after the event analysis has been completed.

4.1.5. Document the disclosure in the electronic health record: see Appendix B

4.1.6. Ensure quality improvement and assurance.

5. Cross-References

5.1. Access to and Disclosure of Personal Health Information Policy
5.2. Consent Policy
5.3. Critical Event Management Policy
5.4. Patient/Client Safety Event Reporting No 354
5.5. Reporting an Investigation of Accident/Incident No 320

6. References

- Accreditation Canada. Required Organizational Practices 2018.
- Canadian Patient Safety Institute. Guidelines for Informing the Media after an Adverse Event (2010).
- Canadian Medical Protective Association Communicating with your patient about harm-Disclosure of Adverse Events. Suggestions to help CMPA members meet their patient's clinical, information and emotional needs after an adverse event (2015).
- Canadian Medical Protective Association. Good Practices Guide Safe care — reducing medico-legal risks 2015
- Canadian Patient Safety Institute. Canadian Disclosure Guidelines. Being Open with Patients and Families (2011).
- Capital Health-Nova-Scotia. Disclosure of Adverse Events Policy. 2013
- College of Physicians and Surgeons of Ontario Disclosure of Harm Policy Statement #5-10. Updated May 2010
- National Steering Committee on Patient Safety, Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care, September 2002
- Ministry of Health and Long-Term Care. Guidelines for Critical Incident Reporting, 2010.
- Public Hospitals Act, 1990
- Renfrew Victoria Hospital. Disclosure of Adverse Events and Adverse Outcomes, 2012.
- Sunnybrook Policy: Disclosure of Adverse Medical Events and Unanticipated Outcomes of Care
- Quality of Care Information Protection Act, 2016

7. Appendices

7.1. Appendix A: The Disclosure Road Map and Guidelines

7.2. Appendix B: Documenting Disclosure of Patient/Client Safety Events in EPIC

8. Definitions

- **Capable:** mentally capable, and "capacity" has a corresponding meaning; ("capable", "capacité") (PHIPA)

- **Critical incident:** A "critical incident" is defined in Regulation 965 under the Public Hospitals Act, as any unintended event that occurs when a patient receives treatment in the hospital
  and;
  - 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 treatment.

- **Disclosure:** A process by which harm from healthcare delivery is communicated to the patient/client or their family, or both (CPMA Good Practices Guide). Disclosure is distinct from requirements for reporting to a central reporting body or institution.

- **Initial disclosure:** the first communication with the patient/client, parent/legal guardian. This should occur as soon as reasonably possible after a safety event, focusing on the known facts and the provision of further clinical care and emotional support.

- **Harm:** Defined broadly as an unexpected or normally avoidable outcome that negatively affects the patient's health and/or quality of life, which occurs (or occurred) in the course of health care treatment and is not due directly to the patient's illness.

- **Most Responsible Physician (MRP):** Staff physician (i.e. non-trainee physician) or staff healthcare provider who has the final responsibility and accountability for the medical care of a patient at the time of the patient safety event.

- **Near miss event:** An event with the potential for harm that does not actually reach the patient/client because of a timely intervention or good fortune. Also known as close calls events.

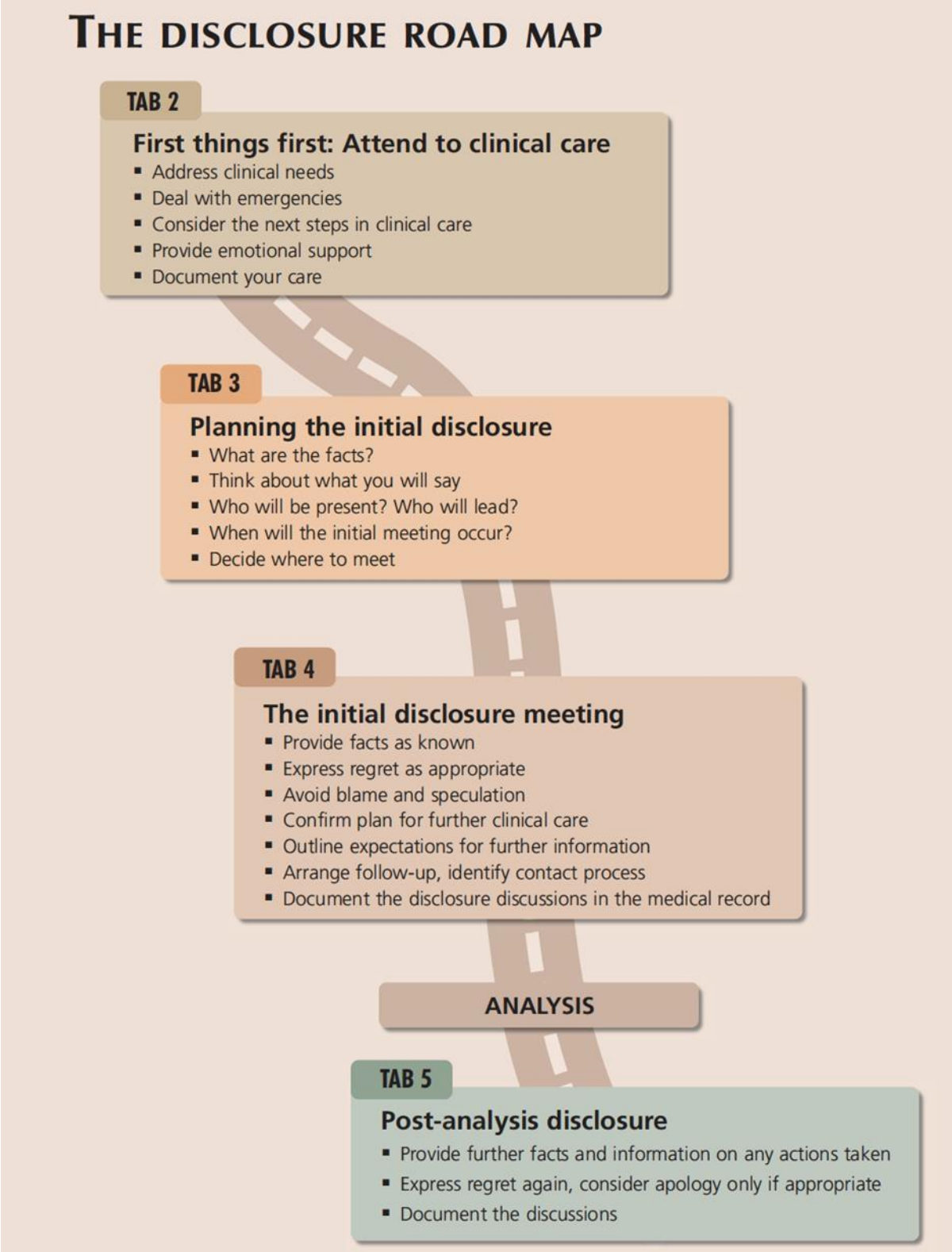
- **Patient/client safety event:** An event or circumstance which could have resulted, or did result, in unnecessary harm to the patient/client. Also known as safety incident or adverse event.

- **Post-analysis disclosure:** Subsequent communications with a patient/client and/or family about known facts related to the harm and the reasons for the harm after an appropriate analysis of the patient safety event.

Version History:

Date	Type of revisions	List of revisions
May 23, 2018	Major Revisions	Harmonization of policies to replace: • OCTC 8.3.3 Disclosure of incidents • CHEO 038 Disclosure of adverse events Updates to reflect current and best practice.
Pick Date	Revisions	

Appendix A: The Disclosure Road Map and Guidelines



Reference: Canadian Medical Protective Association 2015

Guidelines for Disclosure of Patient/Client Safety Events

1. First things first: Attend to clinical care

The safety and well-being of the patient/client must be given highest priority when a safety event is discovered.

The most important steps are:

- Address clinical needs
- Deal with emergencies
- Consider the next steps in clinical care
- Provide emotional support
- Consider transfer care of patient/client to another health care provider

Note: In the event that the patient/client's care team cannot reach consensus as to whether or not a given set of circumstances constitute a safety event, a meeting or teleconference involving Managers, Directors, Division Chiefs or Department Chairs (as appropriate) should be convened.

2. Plan the initial disclosure

Your approach to disclosure must be planned to meet the patient/client's clinical, information and emotional needs in the specific circumstances. The focus of preparation for the initial disclosure meeting should be on the following:

- What are the facts?
- What is the most effective way to communicate this information?
    - If the patient/client is capable /competent, disclosure of a safety event should be made directly to the patient/client, as well as to the parent/legal guardians unless the patient/client instructs otherwise.
    - If the patient/client is not capable/not competent, disclosure of a safety event should be made to the patient/client's parents/legal guardians as well as the patient/client unless the health care team, in consultation with the parents/legal guardians, thinks that it is inadvisable to do so for medical or psychosocial reasons.
- Who will be present? Who will lead?
    - The MRP will lead the meeting and will be the person to disclose the safety event. In circumstances where there is no MRP, notify the individual most responsible for the patient/client's care.
    - Residents or other trainees may participate in the disclosure process at the discretion of the MRP, but are not expected to disclose safety events on their own.
    - All CHEO regulated health care practitioners are encouraged to participate in the disclosure process, as appropriate.
    - The Patient/Family Representative should be included in the initial disclosure meeting. If disclosures occurs on a weekend, or when the representative is not available, the MRP will contact the representative as soon as possible following the disclosure.
- When will the initial meeting occur?
    - As soon as practically possible after the safety event has been identified.
    - A planning meeting of appropriate staff may be necessary prior to the disclosure meeting.
- What is the best location for the meeting?
    - Disclosure should be made in a private setting, preferably in a face-to-face meeting.

3. Conduct the initial disclosure meeting:

- Provide facts as known
    - The person conducting the disclosure session, where appropriate, will acknowledge the safety event to the patient/client, parents/legal guardians with empathy. The nature, severity and cause (if known) of the event should be presented in a straightforward and non-judgmental fashion.
- Express regret, concern and sympathy as appropriate at every disclosure meeting.
    - "I'm very sorry that this has happened".
- Avoid blame and speculation. Disclosure is an ongoing process. Practitioners should focus on what is known at the time of the discussion. They should answer any questions from the patient/client and/or parents/legal guardians, to the best of their ability. Unanswered questions ought to be noted, and prompt and thorough responses sought.
- Confirm plan for further clinical care
    - The process of disclosure should include outlining the current plan of care, as well as the specific steps that will be taken to monitor and treat any sequelae from the safety event.
- Arrange follow-up and identify contact process for post-analysis disclosure
    - The initial and any subsequent disclosure meetings will be documented in the health record.
    - If not already submitted, an event should be entered into the Safety Reporting System, noting that disclosure has taken place. If an SRS event has already been submitted, it should be updated to indicate disclosure has occurred.
- Offer emotional/psychological and practical assistance to the family involved with the safety event.
- Offer support which may include immediate de-briefing sessions, ongoing psychosocial support and assistance from the Employee and Family Assistance Plan, to members of the team involved with the safety event. Practical clinical assistance, e.g. relief from on call coverage/duties, should be offered (if possible) to all staff, volunteers and health care practitioners involved with the event.

4. Arrange post-analysis disclosure as required

In some cases, a further meeting will be necessary to allow for the exchange of additional information after the event analysis has been completed. The purpose of this meeting is to:

- Update the patient/client and parent/legal guardian on progress made following the initial disclosure meeting.
- Provide further facts and information on any actions taken.
- Express regret again, consider apology only if appropriate.

5. Document: (refer to Documentation Form for Disclosure of Patient/Client Safety Events)

- As soon as possible after the event has occurred or has been recognized, document the safety event in the health record in an objective, factual and narrative way including the circumstances leading up to the event and the consequences for the patient/client.
- Complete the Disclosure of Patient/Client Safety Events Documentation Checklist in EPIC. . Alternatively, the checklist can be used as a template for a written or dictated note.
- Enter the safety event as an SRS event in the Safety Reporting System.

6. Ensure quality improvement and assurance:

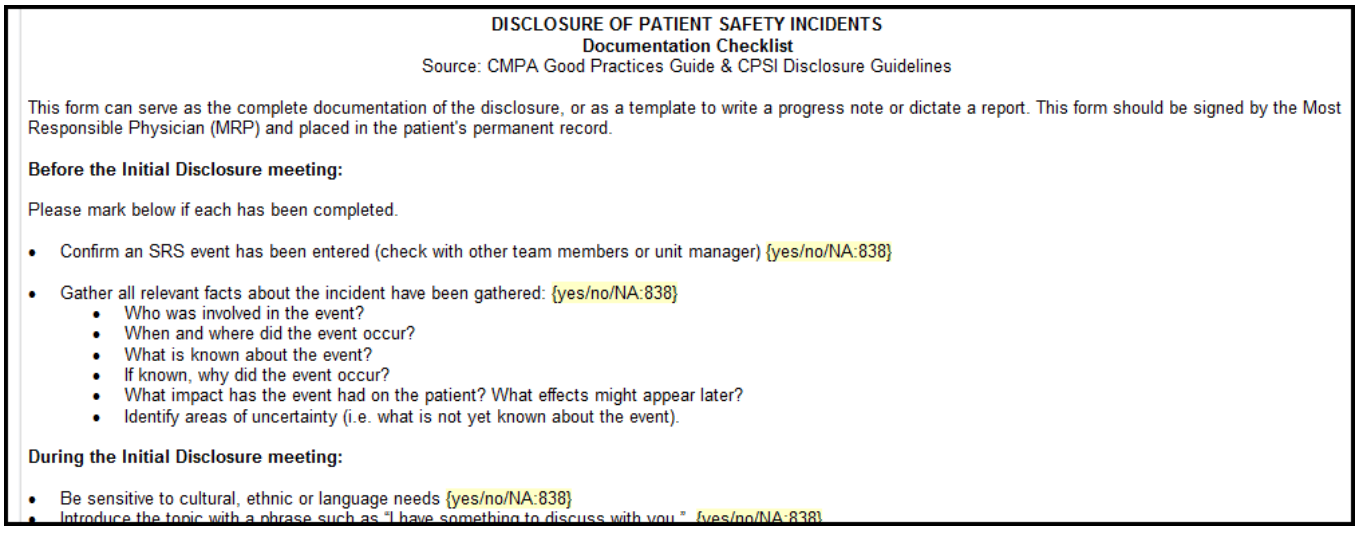
The CHEO Patient Safety & Quality team will monitor the completeness and accuracy of patient safety event documentation and report to the Quality of Care Committee. Feedback will be provided to healthcare providers as appropriate.

Appendix B: Documenting Disclosure of Patient/Client Safety Events in EPIC

1. In any note type in the Insert SmartText field type disclosure:

2. Choose the note template **CHEO IP DISCLOSURE CHECKLIST**

The Documentation checklist will appear:



DISCLOSURE OF PATIENT SAFETY INCIDENTS
Documentation Checklist
Source: CMPA Good Practices Guide & CPSI Disclosure Guidelines

This form can serve as the complete documentation of the disclosure, or as a template to write a progress note or dictate a report. This form should be signed by the Most Responsible Physician (MRP) and placed in the patient's permanent record.

Before the Initial Disclosure meeting:

Please mark below if each has been completed.

- Confirm an SRS event has been entered (check with other team members or unit manager) {yes/no/NA:838}
- Gather all relevant facts about the incident have been gathered: {yes/no/NA:838}
  - Who was involved in the event?
  - When and where did the event occur?
  - What is known about the event?
  - If known, why did the event occur?
  - What impact has the event had on the patient? What effects might appear later?
  - Identify areas of uncertainty (i.e. what is not yet known about the event).

During the Initial Disclosure meeting:

- Be sensitive to cultural, ethnic or language needs {yes/no/NA:838}
- Introduce the topic with a phrase such as "I have something to discuss with you." {yes/no/NA:838}