

YUKON HOSPITAL CORPORATION

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| Policy Name:<br><b>Disclosing Unanticipated Outcomes</b> | Policy Number:<br><b>QI/RM - 130</b>                                    |
| Originating Date<br>September 23, 2008 (LI – 60)         | Effective Date of Current Revision/Review:<br><b>September 17, 2010</b> |
| Manual:<br>Corporate                                     | Signature/Approved By:<br>Senior Management Team                        |

**Scope**

The purpose of this policy and procedure is to:

1. Affirm patients and/or families are entitled to be informed of all aspects of their health care including the right to disclosure of harm that may have occurred during the course of receiving health care.
2. Create a standardized mechanism to disclose adverse events without the attribution of blame.
3. Ensure patients and/or families will receive prompt and thorough interventions for any harm suffered or anticipated.
4. Ensure patients and/or families will receive important information about their care in a timely manner.
5. Provide opportunities for practitioners and institutions to learn how to improve the quality of care and improve patient safety through good catches and adverse events.

**Policy**

Patients and/or their Substitute Decision Maker (SDM), and/or their family will be properly informed about their health care. This includes an obligation to inform patients about significant adverse events and unanticipated negative outcomes of care that may affect their well-being.

**Definitions:**

**Adverse Events:** any unintended, undesired, patient outcome as the result of health care treatment and not due to the patient's illness. They are often unanticipated and unexpected outcomes of health care that do, or have the potential to, negatively impact a patient's health and quality of life. They include complications and side effects of treatment as well as errors in the performance of professional practice duties. Adverse medical events are not necessarily markers of substandard care.

**Disclosure:** The acknowledgement and discussion of a negative outcome with the patient and/or his/her substitute decision-maker. The disclosure discussion includes the necessary treatments required to improve the patient's condition and/or prevent further harm.

**Near Miss/Close Call/Good Catch:** An unplanned event or circumstance which has the potential to cause serious physical or psychological injury, unexpected death, or significant property damage; but did not actualize due to chance, corrective action, and/or timely intervention. Examples include articles falling near people, short-circuits on electrical equipment, systems or people problems that could lead to liability-related incidents if not corrected, or any identified potential danger for clients, visitors, or employees.

**Harm:** 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):** The physician who has the primary responsibility and accountability for the medical care of a patient.

**Occurrence/Incident:** An event, accident, or circumstance that resulted in an unintended, undesired outcome for the client, staff, visitor, volunteer, or organization. The incident may result in injury to an individual and/or damage or loss of equipment or property.

## Procedure

### 1. What events ought to be disclosed?

- 1.1. All incidents causing patient harm or having likely potential to do so (see 2.4).
- 1.2. All incidents must be reported internally as outlined in the Yukon Hospital Corporation Incident Reporting and Follow up Policy QI/RM – 110.
- 1.3. If there is a question concerning disclosure, contact the Division Director or Director Quality Improvement and Risk Management.
- 1.4. Where legal action is threatened or anticipated, the Director Quality Improvement or Risk Management or other Senior Management representative must be consulted before disclosure takes place.

### 2. To whom should disclosure be made?

- 2.1. The patient, if the patient is capable of understanding , or
- 2.2. The patient's substitute decision maker(s) (SDM), in accordance with *The Care Consent Act (Yukon 2003)*, if the patient is deemed incapable of understanding a discussion of this nature.

- 2.3. With the patient's consent, family members can also receive information.
- 2.4. There is a "duty to warn" the patient/representative in the event that harm may arise to them as a result of the adverse event.

### 3. Who ought to disclose events to patients?

- 3.1. The patient's Most Responsible Physician (MRP) or delegate, in partnership with the Healthcare Team Member/Manager/Director other designates as appropriate is responsible for disclosing to the patient/SDM.
- 3.2. In some cases the Director Quality Improvement and Risk Management may be contacted to assist with the disclosure process if the MRP/Healthcare Team Member/designate cannot or does not disclose the necessary information to the patient or substitute decision maker(s) in a timely way.
- 3.3. Where legal action is threatened or anticipated, the Director Quality Improvement and Risk Management must be involved in the discussion to determine who is best to disclose.
- 3.4. Two individuals of the healthcare team (or more if appropriate) should be present during the disclosure.

### 4. When should disclosure take place?

- 4.1. The MRP/Healthcare Team Member/Manager/Director/designate should meet with the patient / substitute decision maker as promptly as other duties permit and as appropriate given the patient's clinical condition. The assumption is that most patients/families would want to know what has happened in a timely manner.
- 4.2. Patients have the right to decline disclosure. Prior to any disclosure, ask the patient if he/she wants to receive the information.
- 4.3. Declining receipt of the information should be recorded in the patient's chart.
- 4.4. Adverse events which are discovered after a patient's discharge should also, be disclosed in a timely manner.

### 5. How should the disclosure be made?

- 5.1. Disclosure of an adverse event to the patient/SDM is a process<sup>1</sup> and requires consideration of the patient's personal, social, religious and cultural needs. A detailed guide to the process of disclosure of an adverse event is found in

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<sup>1</sup> The disclosure of a mistake is the giving of bad news. Professionals are advised to use a version of the SPIKES (setting, perception, invitation, knowledge, empathy) or ALEEA (Anticipate, Listen, Empathize, Apologize, Explain) protocol when giving bad news.

**APPENDIX “A”:** Guidelines for Disclosing Unanticipated Outcomes. All staff are encouraged to take a certification course in Disclosure such as the “Institute for Health Care Communication: Disclosing Unanticipated Outcomes” course.

- 5.2. If possible, the disclosure discussion should take place in person and not by telephone.

## 6. What needs to be documented?

- 6.1 As per Yukon Hospital Corporation Incident Reporting and Follow up policy QI/RM - 110, an incident report must be documented in YHC’s electronic incident reporting system.
- 6.2 The disclosure meeting shall consist of the following components:
- A regret that the event occurred and resulted in harm or potential harm to the client;
  - The facts surrounding the healthcare error and what actually happened;
  - The consequences for the client and the steps to be taken to address those consequences, including further communications with the patient/SDM
  - Availability of copies of the health record.
- 6.3 The facts of the disclosure shall be documented, usually in the health record, including:
- Who participated in/attended the disclosure;
  - Where the disclosure took place;
  - The time and date of the disclosure meeting;
  - What information was disclosed;
  - What questions were asked by the client/family;
  - What the staff responses were
  - The patient or SDM refusal to receive information regarding the adverse event.
  - Any discussion regarding a request to transfer to another health professional/institution

\*NOTE: Documentation for more serious events may be kept outside of the health record with a notation in the health record that a disclosure has taken place.

If the individual making the disclosure wishes, they may ask a healthcare team member not involved in the incident to take notes during the disclosure.

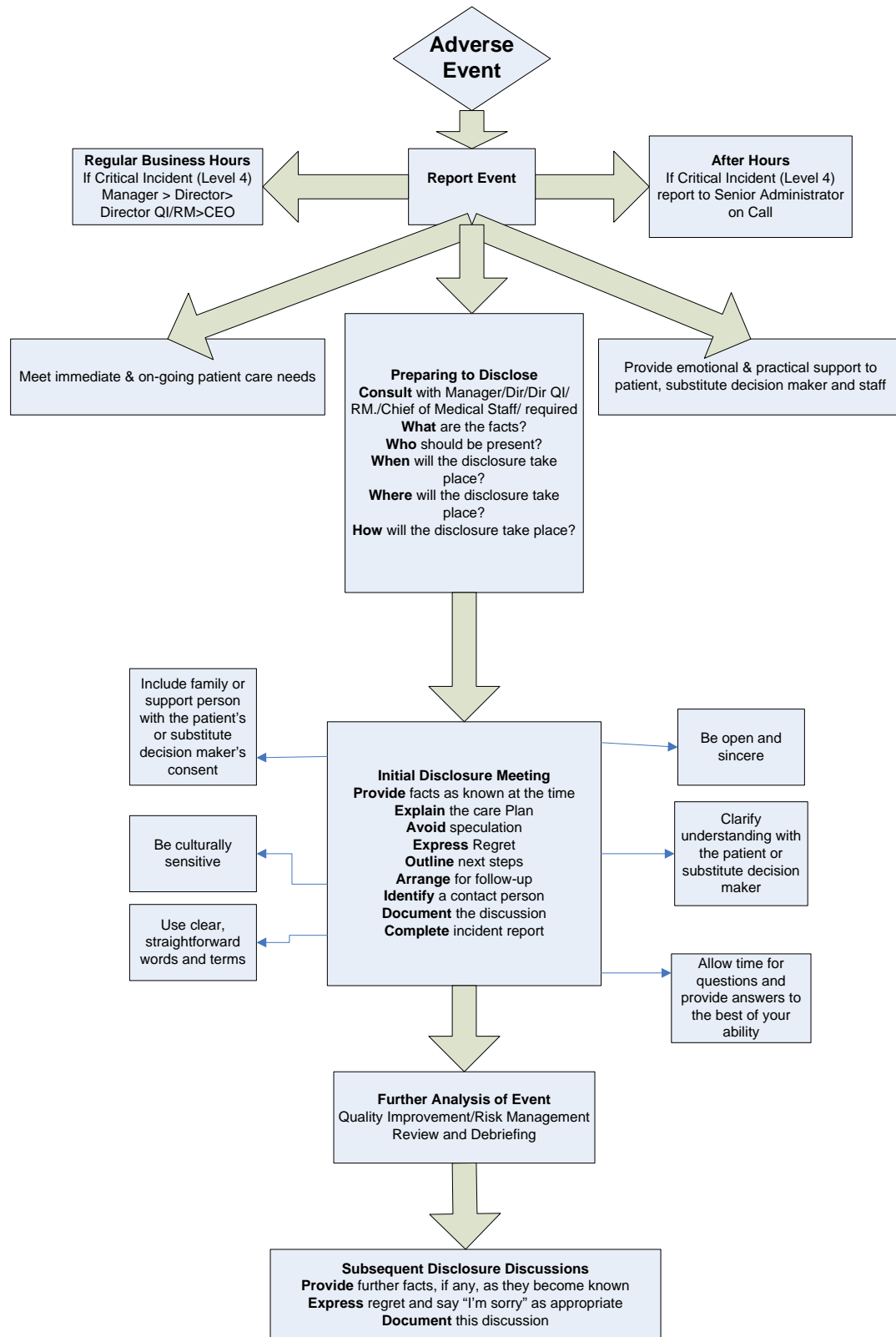
- 6.4 When disclosing incidents where serious harm has been done, individuals making a disclosure may request legal advice from the YHC legal counsel through the Director Quality Improvement and Risk Management or the appropriate Senior Management member. Registered Nurses involved in providing care may wish to contact the Canadian Nurses Protective Society for advice. Physicians who provided clinical care related to a critical clinical incident may wish to obtain advice from the Canadian Medical Protection Association.

## **7. What support is available for the health care team and the patient/SDM?**

- 7.1. Support for the client/family shall be offered as appropriate and may include:
- Referral to another health care provider;
  - Referral to a social worker/spiritual care provider;
  - Referral to a First Nations Health Programs liaison worker;
  - Regular updates to the client/family contact as information becomes available;
  - A copy of the relevant information in the health record, if requested by the patient or designate, at no cost.
- 7.2. Support for the health care provider(s) shall be offered as appropriate, and may include:
- Meeting with Department Manager or designate;
  - Critical Incident Stress Debriefing;
  - Employee Assistance Program.

## **8. What follow-up is required?**

- 8.1. Disclosure is an ongoing process. The person(s) who discloses to the patient/SDM should maintain close communication with the patient/SDM regarding ongoing plans for treatment and respond to requests for further follow up.



## References

College of Physicians and Surgeons of Ontario. Disclosure of Harm Policy (#1-03).  
May/June 2003.

Hilfiker D. Facing our mistakes. *NEJM* 1984; 310:118-122.

Institute of Medicine. To Err is Human: Building a Safer Health System, IOM Committee  
on Quality of Healthcare in America, Washington, D.C., National Academy of  
Sciences, 1999.

Hébert Philip C., Levin Alex V., Robertson Gerald. Bioethics for clinicians: 23. Disclosure  
of medical error. *CMAJ* Feb 20, 2001 164(4)

Institute for Healthcare Communication. *Disclosing Unanticipated Medical Outcomes*.  
September 2008

Lakeridge Health Corporation, *Disclosure of Unanticipated Outcomes Policy*. Corporate  
Manual 2007

Leape LL. Error in medicine. *JAMA* 1994; 272: 1851-1857.

Wu A, Cavanaugh TA, McPhee SJ, Lo B, Micco GP. To tell the truth: ethical and  
practical issues in disclosing medical mistakes to patients. *Journal of General Internal  
Medicine* 1997; 12: 770-775.

## APPENDIX “A” Guide to Disclosing Unanticipated Outcomes

The SPIKES protocol was developed for the disclosure of unpleasant news to cancer patients. An amended SPIKES protocol can be used to disclose health care errors. The guidelines are divided into three categories: Pre-Disclosure, During Disclosure and Post Disclosure. The process can be catered to the type of incident you are disclosing – a less serious incident will usually be done in an informal manner by the doctor or other health care team member by the patient bedside but should still consider the following principles. Here is an outline of the Pre-Disclosure, During Disclosure steps and Post Disclosure:

### 1) Pre-Disclosure

Prior to disclosing an adverse event those involved should:

**Acknowledge self-deprecating emotions:** Feelings of failure, incompetence, patient betrayal are common. If these feelings are too strong they may adversely effect the disclosure.

**Positive Approach:** While the disclosure of an adverse event is extremely challenging, it is done for good ethical reasons. A positive approach to the disclosure is essential. It is being done for the good of the patient.

**Gather Information:** Prior to meeting with the patient the health care providers should have all necessary and sufficient information regarding the error. They should also anticipate questions and/or concerns that may be raised by the patient and family. They should have clear, concise, accurate and honest answers prepared.

**How delivered:** Those involved in the disclosure should consider how the unpleasant news is to be disclosed. In fact how information is disclosed is often more important than what is actually said.

**Who should disclose to the patient and/or family?** Each situation will be assessed to determine the most appropriate person to disclose. The individual making the disclosure may be the individual most responsible for the care in issue. The responsibility for disclosure usually, but not always, rests with the client’s attending physician. If the physician is uncertain how to proceed regarding a disclosure, the disclosure should be discussed with the Director of Quality Improvement and Risk Management and/or Chief of Staff or designate.

If the incident is mostly associated with non-physician staff, such as nursing or other healthcare professionals and support staff, disclosure will occur under the direction of the relevant Director/Manager or designate. If this individual is uncertain how to proceed regarding a disclosure, they should discuss it with the Director of Quality Improvement and Risk Management.

## 2) During Disclosure

### **S - SETTING**

Set the scene by ensuring the privacy of your conversation. Select a quiet and private place in which to disclose the adverse event. Greet your patients warmly, with a smile and make eye contact. Ensure there are no physical barriers between you and your patients. Ensure all parties are introduced.

### **P - PERCEPTION**

Assess patients' perceptions of their illnesses by asking open-ended questions. The patient may be suspicious or may have actual knowledge. Remember the vocabulary that the patient uses and repeat their choice of words when you disclose the adverse event. Pay attention to inaccuracies in information. In the following steps you can dispel inaccuracies.

### **I - INVITATION**

Invitation to impart medical information should come from your patients. The vast majority of your patients will want to know the details of their illness/health care errors, but to respect those who don't, be sure to ask their preference. Ascertain how much information the patient wants to receive or if he/she would rather a designee receive the information.

### **K - KNOWLEDGE**

Knowledge should be shared with your patients by replicating their vocabulary. Slowly, give your patient small chunks of information, using appropriate language making sure that they understand the content after each chunk. At the time information is disclosed all information may not be available. Provide factual information but avoid speculation. Periodically, give a silent pause – time to process the information.

#### **What should be disclosed?**

- **The facts** surrounding the incident as they have been established at the time of the initial disclosure, using easy to understand layman's terms. Avoid speculation, and remember that disclosure may be an ongoing process. The patient and/or family may ask questions about the care provided or action taken by another individual other than the one making the disclosure. If this individual has not been involved in the discussion about the disclosure, explain to the client and/or family that these facts and explanations will be provided after the incident has been investigated.
- **The nature, severity, and cause** (only if and when known), presented in a straightforward and non-judgmental fashion. When asked for detailed information about the circumstances, every effort should be undertaken to respond in a timely, accurate, and open manner.

The assumption is that most clients and/or their families want to know what has happened. However, they have the right to decline disclosure. Such refusals for information shall be recorded in the health record.

- **The plan to investigate** including timelines for the investigation and when and how you will be in contact with the patient/SDM/family as more is learned about the incident.
- **The regret** that the incident caused harm to the client. Avoid attributing blame to specific individuals as incidents are rarely caused by the action or inaction of a single individual. An apology or an expression of sorrow is appropriate and not necessarily an admission of fault.
- **Availability of copies of the relevant documentation on the health record**, if requested, to the client and/or family at no cost. All relevant documentation and health record should be available when meeting. Careful documentation of what is said by all parties is essential following such meetings. This should include who was present, and the purpose and content of the meeting. If the individual making the disclosure wishes, they may ask a healthcare team member not involved in the incident to take notes during the disclosure.
- **Further necessary medical attention** as a result of the incident. Describe what can be done clinically, if anything, to correct the consequences that have occurred, and support the client and/or family in their decision.
- **An offer of a second opinion**, the involvement of outside assistance, or the transfer of care to another physician or care provider.

### **E - EMPATHY**

Empathic and exploratory responses should be used when responding to your patients' emotions on hearing the information related to the adverse event. Validate their feelings. Offer support in the form of counseling and future discussions.

### **3) Post Disclosure**

#### **S - STRATEGY AND SUMMARY**

Strategizing and summarizing will give you a chance to reiterate what has just been discussed, and provides the opportunity to raise important issues that should be covered immediately. Ensure that the patient understands the information they have just been provided

Create a strategy so the patient knows what will happen next. Will there be follow-up or future meetings. How will future patient care be handled? Again express appropriate regret for the error and concern for the welfare of the patient/family.