

**ISMP Canada's Guidelines for Sharing Medication Incident Data
in the Era of Ontario's PHIPA and QCIPA**

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The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent, national, non-profit agency established to collect and analyze medication error reports and develop recommendations for the enhancement of patient safety. ISMP Canada is committed to promoting the safe use of medications.

To fulfill this commitment, ISMP Canada collects information regarding preventable adverse drug events from individual healthcare practitioners and institutions on a voluntary basis. The information is received by ISMP Canada via telephone, email, mail, fax, a web-based reporting function, and through "Analyze-ERR", a software documentation tool designed by ISMP Canada to track and analyze medication errors at participating healthcare institutions.

Personal Health Information Protection Act, 2004

In November of 2004, Ontario's *Personal Health Information Protection Act* ("PHIPA") came into force. PHIPA governs how health care practitioners and institutions collect, use and disclose personal health information. The underlying principle of the privacy legislation is that consent is required for the use, collection or disclosure of personal health information. "Personal health information" is defined as any "identifying information about an individual in oral or recorded form" that is related to the provision of health care. The Act defines "identifying information" as being any information that identifies, or could be reasonably foreseen to identify an individual.

In the process of fulfilling its mandate, ISMP Canada requests healthcare practitioners and institutions to provide it with information regarding adverse events involving medication errors. Specifically, ISMP Canada asks for the following information to be shared:

- a description of the incident or preventable adverse drug event
- information about the patient's medical condition
- the outcome of the adverse drug event and the patient's status
- the type of healthcare facility where the incident occurred
- the type and dosage of medication involved
- a description of how the incident was discovered
- any recommendations the practitioner or institution may have as to how the institution intends to prevent similar incidents in the future
- a description of the healthcare practitioners involved in the incident
- information which identifies the institution
- contact information for the person reporting to ISMP Canada

ISMP Canada does not require any information that identifies or may reasonably be foreseen to identify an individual. More specifically, ISMP Canada requests that all identifying information about patients be removed prior to it being shared.

As a way to assist practitioners or institutions in ensuring that personal health information is not disclosed during the collection process, ISMP Canada uses the "Analyze ERR" software that is designed to restrict the collection of non-identifying information.

Despite the above-mentioned precautions, it is possible that, on occasion, information submitted to ISMP Canada may inadvertently include identifying information as defined in PHIPA. ISMP Canada has a privacy policy that covers this type of situation. Accordingly, where identifiable personal information is inadvertently disclosed in an incident report, ISMP Canada has practices and procedures in place to immediately de-identify the information and inform reporters that identifiable information is not required for incident reporting.

Quality of Care Information Protection Act, 2004

Alongside the arrival of PHIPA was the arrival of the *Quality of Care Information Protection Act, 2004* ("QCIPA"). QCIPA mandates the collection, use and disclosure of information in the context of a quality assurance review process conducted by an institution in the wake of an adverse event. "Quality of care information" is defined by the Act as information collected by or prepared for a quality of care committee for the purposes of the committee. These purposes are for the improvement and maintenance of the provision of health care. The Act restricts the disclosure of quality of care information to limited circumstances in order to facilitate open and honest communication during the review process.

Given that QCIPA reviews often follow an adverse event, information that is collected during the review may be a component of the information that a health care provider or hospital wishes to report to ISMP Canada. ISMP Canada does not expect practitioners and institutions to share quality of care information in their reporting of adverse events involving medication errors. The majority of information requested by ISMP Canada (as noted above) is information that QCIPA does not include in its definition of quality of care information. While QCIPA protects opinions and conclusions shared during the review, it does not protect any of the facts uncovered. The Act stipulates that the following information is outside the protection of quality of care information:

- information found in a patient's health record;
- specific facts learned during the course of a QCIPA review; and
- the fact that a quality of care committee met and conducted a review and when it took place

In light of this allowance in the Act, the restrictions under QCIPA should not affect the sharing of information with ISMP Canada. It is important to note that although QCIPA

does not prevent disclosure of this information, PHIPA restrictions will still apply to any information that is personal health information.

The one category of information requested by ISMP Canada that may be restricted under QCIPA is "recommendations as to how the institution intends to prevent similar incidents in the future". If recommendations are arrived at during a quality of care review process, they are protected as quality of care information. However, the Act allows for disclosure of the actual follow-up actions taken by an organization following a QCIPA review as long as the findings or opinions of the quality of care committee that led to the follow-up action being taken are not shared. ISMP Canada would therefore request that any recommendations shared with regard to how the institution intends to prevent similar incidents in the future, be limited to recommendations arrived at outside a QCIPA review process or to ones that have actually been implemented.

Conclusion

ISMP Canada embraces the protections of personal health information mandated by PHIPA and QCIPA and views its commitment to the safe use of medications as working within those protections. This position paper is meant to explain how ISMP Canada works within the legislative structures of PHIPA and QCIPA. It is also our hope that we have provided comfort to health care practitioners and institutions who are sharing important information with us in the wake of an adverse event involving a medication error. The privacy interests of those patients involved in these types of events are of utmost importance to ISMP Canada and will be protected throughout the implementation of our mandate.

This position paper was prepared by ISMP Canada in consultation with Borden Ladner Gervais LLP. Contributors included Sylvia Hyland (Vice President, ISMP Canada), Kristin L. Taylor (Borden Ladner Gervais LLP) and Karen Weisbaum (Privacy Consultant and Policy Advisor to ISMP Canada.)