Ontario
CRITICAL Incident Learning
Improving quality in patient safety

Issue 16
March 2016

Suggested Action Items:

- Refer bulletin to quality/ patient safety leads, risk management and patient relations
- Circulate bulletin to all staff to enhance understanding of the disclosure process including organizational support for practitioners involved in incidents

Distributed to:

- Chief executive officers
- Chiefs of staff
- Board chairs
- Quality/patient safety leads
- Directors of pharmacy
- Directors of nursing

Critical Incidents – Disclosure to Patients and Families

Hospitals across Ontario have widely embraced quality and safety improvement initiatives. Even with system safeguards in place, however, it is recognized that patient safety incidents can continue to occur. The Ontario healthcare system needs to foster a vigilant safety culture, with the capacity and infrastructure to identify and respond effectively and efficiently to patient safety incidents. When a critical incident occurs, healthcare providers are required to disclose the incident to the patient, substitute decision maker, or patient representative.

Beginning in 2008, the Ontario government has taken a number of steps to enhance the Public Hospitals Act to make it mandatory that facilities analyze critical incidents and implement strategies to reduce the risk of event recurrence, in addition to disclosing incidents to patients, to the hospital administrator and the Medical Advisory Committee (MAC).[1,2] Accreditation Canada has made patient safety incident disclosure a Required Organizational Practice within the Safety Culture section of standards to be observed by surveyors during the accreditation process.[3]

Recently, the *Quality of Care Information Protection Act (QCIPA)* Review Committee has identified that some patients and families feel they have not been given full disclosure of the incident.[4] The committee's recommendations include amending the QCIPA to ensure appropriate disclosure to patients and families following a critical incident and informing patients and families about incident investigations, providing them with a voice in the process and keeping them informed throughout the process.

Advice for Hospitals:

- Recognize that the goal of disclosure is honesty and transparency towards patients, families, and healthcare staff when an error occurs, as well as an acknowledgement of the need to investigate and learn from these incidents
- Ensure your facility has a system to support disclosure of critical incidents and harm to patients, the Medical Advisory Committee (MAC), and to the institution's Board of Directors
- Make staff aware of the many resources available for guidance about disclosure of incidents to patients and families
- Value and support the role that patients, families, and caregivers play in investigating and responding to healthcare errors

The act of disclosing a critical incident is not limited to acknowledging that a failure has occurred; rather, it includes an account of the known facts of the incident, a clarification of any consequences to the patient, and an outline of the organization's plan to reduce the risk of recurrence of similar incidents. Disclosure is an ongoing process that requires transparency, sensitivity, diplomacy, and diligence amongst all affected parties and ensures that the patient and family will be included in the process through the

ismp CANADA

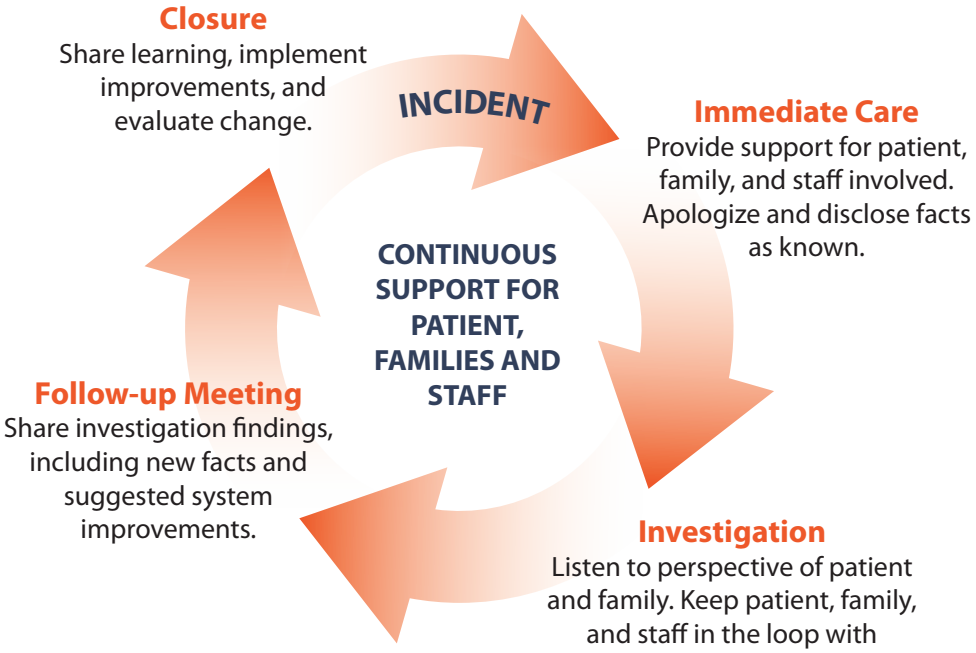
Institute for Safe Medication Practices Canada
www.ismp-canada.org
1-866-544-7672
info@ismp-canada.org

investigation, learning and knowledge transfer.[5] Disclosing and apologizing to the patient assists with the rebuilding of trust and promotes a healing process for the patient, their families and the staff involved in the incident.[6] Figure 1 provides a schematic that illustrates the importance of supporting patients, families, and staff during the disclosure, investigation, and through to closure of the incident.

The Canadian Incident Analysis Framework[7] includes a checklist for effective meetings with patients and families.[8] This checklist, developed by Patients for Patient Safety Canada, is an excellent guide for difficult conversations. As outlined in the checklist for effective meetings with patients and families, key considerations include (i) acknowledging and apologizing immediately (ii) providing ongoing care to the patient, family and staff involved and (iii) ensuring transparency throughout the process with all affected parties participating in the investigation, learning, knowledge translation and evaluation.

Disclosure of a healthcare error is a critical facet of a mature safety culture, and individual practitioners and administrators in Ontario healthcare facilities are encouraged to review their framework for disclosure of incidents to patients, families and staff.

Figure 1: Critical Incident Disclosure – CLOSING THE LOOP



Content reviewed by:

Margaret Doma, MSW, LLM (ADR)
Director, Risk, Legal and Medical Affairs, St. Joseph's Healthcare.

References for this bulletin are available from:
www.ismp-canada.org/download/ocil/ISMPCONCIL2016-16_Disclosure_References.pdf

Collaborating parties of the Ontario Critical Incident Reporting program

Canadian Institute for Health Information / Institut canadien d'information sur la santé
Ontario
Ontario Hospital Association
Institute for Safe Medication Practices Canada
Institut pour la sécurité des médicaments aux patients du Canada
Ontario Health Quality Ontario / Qualité des services de santé Ontario