

SAHTU HEALTH & SOCIAL SERVICES AUTHORITY
Policy

ADMINISTRATION POLICY

Reporting of Adverse Events

INDEX:	ADM.110
DATE OF ORIGIN:	May 11, 2009
DATE REVIEWED/APPROVED:	December 14, 2009
DISTRIBUTION:	ALL MANUALS
ORIGINATED BY:	Director, H&SP

POLICY:

The Sahtu Health & Social Services Authority (SHSSA) believes that all health and social services practitioners have an ethical, professional and legal responsibility to provide full and frank disclosure of adverse outcomes and events to patient/clients (or their surrogates) as soon as reasonably possible. Disclosure does not imply assignment of blame or acceptance of fault.

SHSSA requires that for all adverse outcomes and events, disclosure involves **at a minimum** a discussion between the attending practitioner, SHSSA Senior Management, and the patient/client (or surrogate); and that this discussion be documented in the patient/client's record. Consideration should also be given to conducting a second meeting once the patient/client or surrogate has had the opportunity to review the information provided, as there may be additional questions or a need for clarification.

This policy does not apply to incidents that do not harm patient/clients (i.e. near misses). These particular occurrences may not require disclosure to patient/clients in all cases, and should be addressed using the Incident Reporting policy (Adm. 205).

DEFINITIONS:

An "adverse event" is any of the following:

- Injury;
- The development of a new temporary or permanent disability;
- The need to prolong treatment (where prolongation can refer to an entire admission or a readmission); or
- Death;

Where the outcome is directly attributable to health care management as opposed to the natural progression of disease.

SAHTU HEALTH & SOCIAL SERVICES AUTHORITY

Policy

A “preventable adverse event” is one that is felt to be due to an obvious error in management or a system design flaw.

A “critical incident”, *for the purposes of this policy*, means any unintended event that occurs when a patient/client receives treatment from SHSSA:

- (a) that results in death, or serious disability, injury or harm to the patient/client, and
- (b) that does not result primarily from the patient/client’s underlying medical condition or from a known risk inherent in providing the treatment.

“Disclosure” refers to the communication of information regarding an adverse event, adverse outcome or critical incident.

A patient/client’s “surrogate” includes any other person(s) as designated by the patient/client, or appropriate substitute decision-makers for patient/clients who are incapable.

“Substitute decision maker” means a person who is authorized under legislation to give or refuse consent to a treatment on behalf of a person who is incapable or incompetent.

PROCEDURE:

Any employee who becomes aware of an adverse outcome, event, or critical incident as defined by this policy will immediately report the occurrence to his or her supervisor. This is **in addition to the required reporting under the Incident Reporting Policy (Adm 205)**. The supervisor, in collaboration with senior management will conduct an initial investigation, and decide how to proceed.

The responsibility for disclosing an adverse event, adverse outcome, or critical incident to a patient/client (or surrogate) rests with the attending professional **and** senior management.

There may be situations where the attending professional will not, cannot, or should not take a role in the disclosure discussions:

- The professional is unavailable;
- He or she refuses to participate in disclosure discussions;
- The professional does not have the requisite communication skills;
- The professional’s relationship with the patient/client is seriously impaired or compromised).

In such situations, senior management will conduct disclosure, and any subsequent communications with the patient/client or surrogate.

Initial disclosure to the patient/client or surrogate will occur as soon as is reasonably

possible after the adverse outcome, adverse event or critical incident has occurred and the patient/client's immediate needs have been met. **The first priority is to do whatever is necessary to prevent further harm to the patient/client.**

Disclosure discussions must always take place in a location that guarantees privacy and confidentiality. Discussions must always include at least one practitioner and one senior manager, or two senior managers. In no event shall an SHSSA representative meet with the patient, client, or surrogate alone.

In the case of serious preventable adverse events or Critical Incidents, the Risk Management office of the GNWT must be contacted as soon as is reasonably possible after gaining knowledge of the adverse event or critical incident.

The disclosure of every critical incident shall be made:

- (a) To the affected patient/client;
- (b) If the affected patient/client is incapable, to the patient/client's substitute decision maker;
- (c) If the affected patient/client has died,
 - (i) To the person who was the substitute decision maker immediately prior to the patient/client's death, or who would have been so authorized if the patient/client had been incapable, or
 - (ii) To the patient/client's estate trustee (executor), or to the person who has assumed responsibility for the administration of the patient/client's estate, if the estate does not have an estate trustee (executor).

Disclosure discussions concerning adverse outcomes, events and critical incidents shall include:

- The material facts of the event,
- Impact and consequences for the patient/client of the occurrence, as they become known,
- The actions taken and recommended to be taken to address the consequences to the patient/client, including any health care or treatment that is advisable.
- The disclosure, including date and time of disclosure, must be documented in the Health Record using the Documentation of Disclosure form (Appendix 1).

Additional considerations for disclosure and documenting disclosure should include:

- Offers of non-financial assistance, including support for Spiritual Care;

- Information that is objective and factual, free from speculation or blame, and presented in a caring and compassionate manner;
- The cause of the event, if known;
- Expression of regret that the adverse event or adverse outcome occurred, as appropriate. Providing an apology or saying “sorry” are not an admission of guilt nor an acceptance of blame;
- Plans for a review to identify causal factors and prevent its recurrence;
- Names of individuals present at the disclosure meeting and relationship to patient/client;
- Discussion points including: reaction/questions of participants; a statement indicating that the patient/client (or the surrogates) will be kept informed of new information as it becomes available;
- Whether the patient/client refuses to receive the disclosure information;
- Access to the patient/clients’ health record as permitted by ATIPP legislation.

At an appropriate time following a disclosure of an adverse outcome, event or critical incident, the responsible Director/designate shall further disclose any systemic steps that the Authority is taking or has taken in order to avoid or reduce the risk of similar incidents. The content and date of this further disclosure shall be recorded in the health record.

If an employee of the Authority discovers that a preventable adverse event or critical incident has not been disclosed to a patient/client (or surrogate), then the employee must inform his or her supervisor or director as appropriate. The responsible supervisor or director will investigate, and this policy will be followed.

REFERENCES:

1. No byline provided (2007). *Slouching Toward Disclosure*. CMAJ 177(11) 1342-1343.
2. Baker, et al (2004). *The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada*. CMAJ 170(11) 1678-1686.
3. Amori, et al (2003). *Monograph - Disclosure of unanticipated events: the next step in better communication with patients*. American Society for Healthcare Risk Management of the American Hospital Association.
4. Amori, et al (2003). *Monograph - Disclosure of unanticipated events: creating an effective patient communication policy*. American Society for Healthcare Risk Management of the American Hospital Association.
5. Amori, et al (2004). *Monograph - Disclosure: What works now & what can work even better*. American Society for Healthcare Risk Management of the American Hospital Association.
6. Belby & Wallace (2005). *Disclosing adverse events to patients: strengthening*

SAHTU HEALTH & SOCIAL SERVICES AUTHORITY
Policy

the doctor patient relationship. CMPA Information Sheet, March 2005.

7. U.S. Dept. of Veterans' Affairs (2008). *Disclosure of adverse events to patients.* VHA Directive 2008-002.

Approved by:


Chad Fehr, CEO