

Patient Safety In Ontario

An Overview of Critical Incident Review and Disclosure Policies in Selected Ontario Teaching Hospitals



Quality Healthcare Network
Improving Health Care Quality and Safety: Setting the Course of Excellence
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Backgrounder

- Baker & Norton (2004): heightened awareness of patient safety issues, statistics, guidelines
 - A much needed focus on the issue of Patient Safety and a Safety Culture
- Strive to improve the system
- There are no provincial or national best practices/standards to enhance/improve the system
 - Hospitals have implemented individualized approaches to improve patient safety based on their organization's mission, vision, values, culture
 - What do these approaches look like?

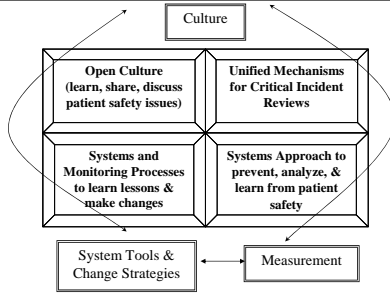


Improving Patient Safety

- ...How can we improve the system?
 - National Patient Safety Agency, UK (2004) "Seven Steps to Patient Safety"
 - Baker, R. & Norton P (2001). "Making Patients Safer"



Improving Patient Safety



Method & Purpose

- **Teaching hospitals:** Outcome of Patient Safety Retreat
 - Inventory of Patient Safety Policies & Processes (Disclosure and Critical Incident Review)
 - CCHSA Patient Safety Goal:
 - *“Need to share regional and national learnings, best practices, and initiatives underway to improve patient safety”*
- **16/22** hospitals submitted information (72% response rate)
- Paper does not reference specific hospitals

Participating Hospitals

1. Bloorview Macmillan Children’s Centre, Toronto, ON
2. Centre for Addiction and Mental Health, Toronto, ON
3. Children’s Hospital of Eastern Ontario, Ottawa, ON
4. London Health Sciences Centre, London, ON
5. Hamilton Health Sciences Centre, Hamilton, ON
6. Hotel Dieu Hospital, Kingston, ON
7. Kingston General Hospital, Kingston, ON
8. Mount Sinai Hospital, Toronto, ON
9. SCO Health Service, Ottawa, ON
10. St. Joseph’s Health Centre, London, ON
11. St. Michael’s Hospital, Toronto, ON
12. Sunnybrook and Women’s College Health Sciences Centre, Toronto, ON
13. The Hospital for Sick Children, Toronto, ON
14. The Ottawa Hospital, Ottawa, ON
15. Thunder Bay Hospital, Thunder Bay, ON
16. University Health Network, Toronto, ON

Agenda

1. Disclosure
2. Critical Incident Review
3. Structural Approaches to Patient Safety

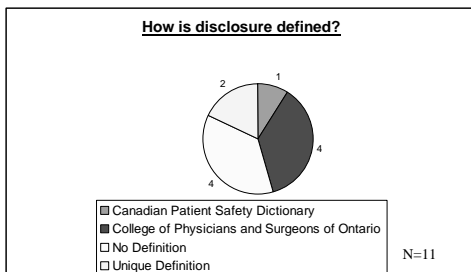
Defining Disclosure

"...the imparting, by health care workers to patients or their significant others, of information pertaining to any health-care event affecting the patient's interest. The obligation to disclose is proportional to the degree of actual harm to the patient arising from an untoward event." (Canadian Patient Safety Dictionary, 2003)

"...the acknowledgement and discussion of a negative outcome with the patient or his/her SDM. It does not mean the reporting of facts of harm to a central reporting body or institution for the purpose of analysis or education." (College of Physicians and Surgeons of Ontario, 2003)

Defining Disclosure

How is disclosure defined?



Observations

#1: Hospitals should refer to and adopt terms from the Canadian Patient Safety Dictionary (2003) when defining patient safety terms in policies and processes.

#2: A consistent definition of disclosure should be applied and this definition should be integrated with the concept of Communication in policies and processes.

Disclosure Process

1. Openness & Timeliness of Communication
2. Acknowledgement
3. Expression of Regret
4. Staff Support
5. Integrated Risk Management & Systems Improvement

Openness & timeliness

"...information about a patient safety incident must be given to patients and their carers in a truthful and open manner by an appropriately nominated person." (National Patient Safety Agency, 2004)

Findings

- 11 policies emphasize open & honest disclosure to patients and to hospital staff
- Multidisciplinary team work & communication to facilitate effective patient disclosure

Openness & timeliness

Who Discloses?

- Majority of Policies: **Most Reasonable Physician**
- Other Policies: Level of severity of incident dictates responsibility to disclose

Openness & timeliness

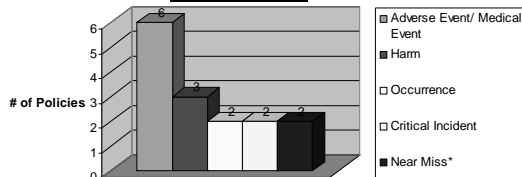
How is information disclosed?

- **9** hospital policies include guidelines for disclosure

- Describe the facts
- Acknowledge that the event occurred
- Ensure all relevant documentation is available
- Avoid speculation, attribution, blame
- Express regret/ sympathy that the adverse event or incident has occurred
- Make recommendations as to what might be done to deal with the situation
- Explain plans for a review to identify causative factors and prevent its recurrence
- Ask for questions or concerns
- Ensure prompt, thorough responses from another staff member who may be in a better position to answer
- Offer assistance from social work, patient relations, religious advisor
- Describe the follow-up/next steps

Openness & timeliness

What is disclosed?

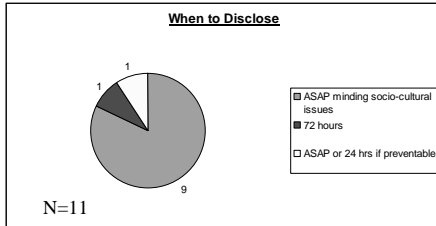


N=11 (duplication)

* Disclosure is at discretion of MRP but is required in 2 policies if it reaches the patient's awareness

Openness & timeliness

- There is no pre-determined timeline for disclosure but patients/families should be provided with information ASAP
- "...disclosure should take place as soon as reasonably possible, taking into account the clinical and emotional state of the patient." (CPSO, 2003)*



Observation

#3: Hospitals should develop a shared and comprehensive understanding of patient safety taxonomy in order to facilitate and coordinate patient safety activities.

#4: Hospitals should consider including a disclosure guide in their policy or procedures. The guide should detail the important features/content within the provider-patient disclosure process to help facilitate an effective communication and information exchange.

Acknowledgement & Expression of Regret

"...all adverse events should be acknowledged to the patient and their support person to initiate the open disclosure process while at the same time, patients should receive an expression of regret and sorrow for the harm that has resulted." (National Patient Safety Agency, 2004 & Australian Council for Safety and Quality in Healthcare, 2003)

"...a timely and empathic expression of sorrow or regret and condolences may be appropriate and should not be construed or taken to be an admission of liability or fault." (CPSO, 2003)

Findings:

- 10 policies include a similar statement on acknowledgement
- 9 include acknowledgement/expression of regret within disclosure guidelines or processes

Staff Support

- Staff should not only be encouraged to report incidents/adverse events but also should feel supported by their colleagues through the process

Findings

- **4 policies** mentioned staff support

"...support, which may include immediate de-briefing sessions, ongoing psychological support and assistance from the EAP, will be offered to members of the team involved with the adverse event...emotional and practical assistance should be offered to all staff, volunteers, and health care practitioners involved."

Integrated Risk Management & Systems Improvement

- This concept is better addressed within the critical incident review policies

Disclosure and QCIPA

- QCIPA: *Quality of Care Information Protection Act*
 - November 1, 2004 Ontario Legislation
 - Reinforces an open culture by establishing protections around the disclosure of quality of care information to a designated committee
 - Encourages sharing of information open and honest discussions about adverse events within their organization with the intended result being improvement of patient safety
- Distinction between disclosure to patients/families and disclosure to a quality of care committee under QCIPA
- QCIPA will have an impact on the entire process of disclosure and the culture of safety

Critical Incident Review

1. Communication and Notification of all parties
2. Gathering of information to review
3. Obtaining staff feedback to map the events
4. Analyzing the information
5. Developing solutions, recommendations, implementation plan
6. Completing a report and follow-up

Critical Incident Reviews

- A way of reflecting and analyzing the causes and impacts of unusual incidents/occurrences to:
 - Identify how and why they occurred
 - Identify systemic and procedural issues
 - Enable shared learning
 - Incorporate this learning into hospital practice
- An integrated risk management strategy
- Review influences the “**systems approach**” to patient safety

Review Purpose

Findings

- 8 policies with clear purpose statements

“...A systems based analysis and a constructive learning experience to ensure a timely analysis, to ensure that root causes/contributing factors are identified and to produce recommendations and system improvements for change.”

Communication & Notification

Findings

- All policies detail general timelines
- **9 policies:** first step is internal notification
 - Priority: open and honest communication with patients/family
 - Ensure patient needs are addressed
- Specific persons notified varies by hospital

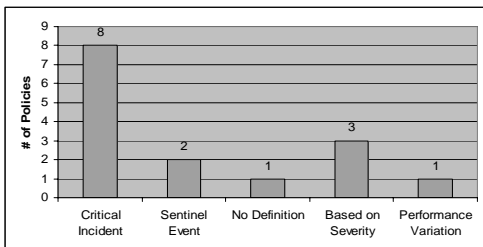
Roles & Responsibilities

Who Conducts the Review?

- **7 hospitals: Review Team** consisting of multidisciplinary staff (administrative and front line)
 - One hospital identifies a specific individual to initiate and lead the review team
- Purpose of Review Team:
 - Investigate & Analyze
 - Gather Information
 - Establish timelines of the event
 - Review documentation/health records
 - Interview relevant individuals
 - Develop & submit recommendations/report

Identifying the incident to investigate

- Important to define and prioritize the incidents to review
- Variation in defining “critical incident”



When to conduct the review

- 8 policies identify timelines (varied):
 1. Within 5 days of occurrence; documentation within 14 days
 2. Team must meet ASAP but no later than 2 weeks after event
 3. Investigation initiated within 48 hours of incident; documentation and report completed within 4 weeks
 4. First review within 24 hours; second review within 72 hours
 5. Within 3 working days of notification; report submitted within 15 days
 6. Notifying senior management within 48 hours
 7. Director must call Review Committee together within 24 hours of receiving incident form
 8. Documentation within 24 hours; no specific investigation timelines
- Is there merit in creating consistency?

Gathering the Information

- Investigation depends on type and amount of information collected
- Important to sort out relevance of sources/materials
 - incident reports/occurrence reports, interview notes, health records, policies/protocols, staff reports, coroner reports, claims review data, meeting minutes
- Important to balance Qualitative and Quantitative information sources

Findings

- Most information from incident reports, health records, interview
- 1 hospital uses Electronic Incident Report Form

Mapping the Events

- Input from staff associated with incident can help piece together chain of events and can be valuable for developing ideas about how to adapt systems to prevent recurrences

Findings

- Staff that is part of the interview is provided with a timeline summary and asked to comment on discrepancies
- 1 hospital uses a facilitator to negotiate tensions and emphasize importance of learning
- 1 hospital adopts a multidisciplinary case review to map events

Analyzing the Information

- Integrated Risk Management
 - Identify, assess, analyze, manage all risks and incidents
- Root Cause Analysis (RCA)
 - Analyze reported incidents and determine the underlying causes and contributing factors
 - Retrospective approach to error analysis

Analyzing the Information

Findings:

- **4 hospitals** specifically mention the use of the RCA
 - 1: details the steps involved to ensure RCA is credible and acceptable
 - 1: developed an RCA database to identify trends and facilitate improvements based on findings
 - 1: extends RCA into "rapid change cycle" to identify where change is required and determine whether the changes will result in improvement
 - Plan-Do-Study-Act
 - RCA coupled with observational studies

Analyzing the Information

- 1 identifies the use of a **System-based analysis** to conduct the review
 - *"an analysis of the processes and issues underlying an occurrence for the purpose of identifying the possible cause and effect relationships, and identifying a risk reduction action plan with pre-determined measurement strategies."*
- 1 uses **Mortality and Morbidity Review**
- Additional Technique excluded from policies is **Failure Modes and Effects Analysis**

Solutions, Recommendations & Implementation Plans

Solutions & Recommendations

- Where a review team exists: develop recommendations and implementation strategies
 - "...identify recommendations to prevent recurrence, assign responsibilities and establish timelines for implementation...submit a report."
 - "...summarize findings in a report that will concisely describe the circumstances that are believed to have led to the actual or potential adverse outcome."
- Where there is no review team:
 - Specific staff members are responsible for developing recommendations, analyzing results and monitoring change

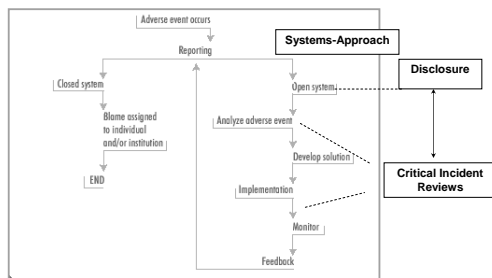
Solutions, Recommendations & Implementation Plans

Evaluation and Implementation Strategies

Findings

- Managers, directors, departments heads are primarily responsible for reviewing recommendations to ensure there is accountability for implementation and to ensure there is tracking
- An action plan is detailed
- Some policies suggest that recommendation and implementation plans be shared with patients and families
- In all but 2 hospitals, policies address the strategy for follow-up and evaluation

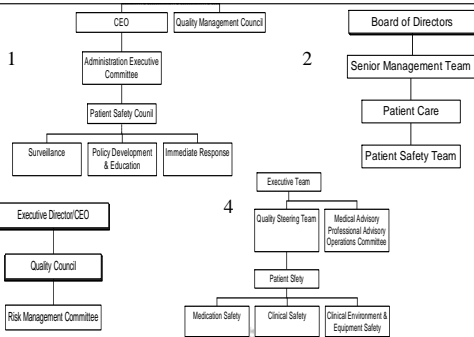
Culture of Safety



Structural Approaches



Structural Approaches



Patient Safety Initiatives

- 3 hospitals: **“Patient Safety Framework”**
 - Details organization’s strategy, approach, communication, pledge to patient safety & action areas
- 1 hospital: **“Patient Safety Specialist”**
 - Leader for development, maintenance, operation of patient safety processes
- 1 hospital: **“Error Management Unit” & “Safety Collaborative” & “Patient Safety Electives for Medical and Nursing Students”**
- Other hospitals (specific policies):
 - **Adult and Paediatric Patient Identification Armband**
 - **Confidentiality**
 - **Security and Access to Hospitals Electronic Data and Information**

Conclusions

- Variation in structural approach
- Structures will have to be reviewed/adapted based on QCIPA guidelines
- Challenge to agree on standards for structure but should there be some universal principles for the creation/establishment of committees?
 - Enhance timely review and analysis of incidents and near misses
 - Support the implementation of recommendations to improve hospital processes and enhance patient safety and quality care
 - Be empowered by senior management and receive ongoing commitment
 - Promote collaboration and information sharing with all hospital staff on issues of patient safety/quality care

Next Steps...

- Implementation Challenges
- What is the legislative impact (Quality of Care Information Protection Act)?
- CCHSA patient safety goals
- System level observations
