AK0400 GUIDELINE 1.3 DISCLOSURE OF HARM
ENDORSEMENT DATE: FEBRUARY 2022

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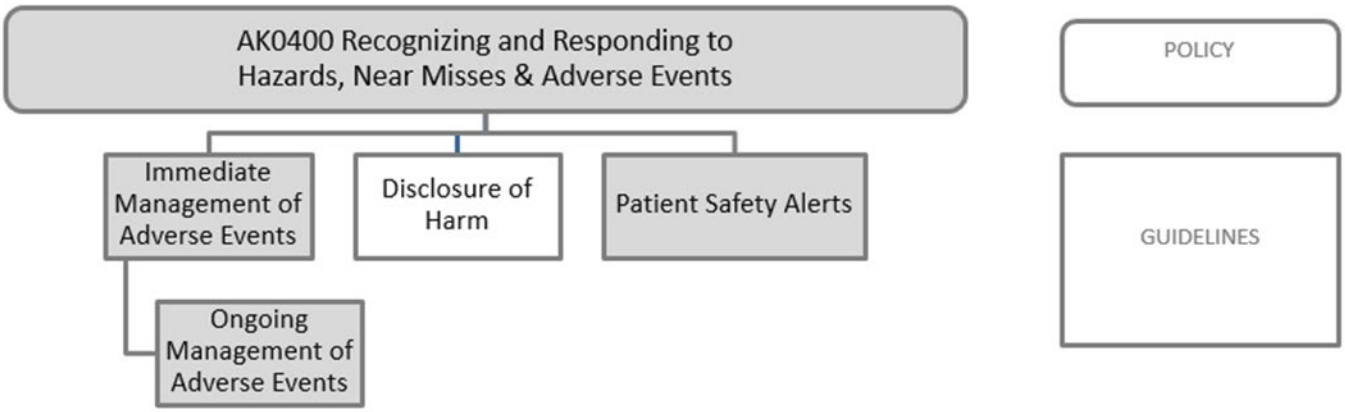
DEFINITIONS

Accountable leader	The individual who has ultimate accountability to ensure the consideration and completion of the listed steps in the AK0400 Guideline 1.2 Ongoing Management of Adverse Events. The accountable leader may delegate responsibility for some or all of the components of management to others, but the accountability remains with the accountable leader.
Adverse event (AE)	An unexpected and undesired event which results in an unintended consequence and is directly associated with the care or services provided to the patient rather than the patient's underlying condition.
Apology	An expression of sympathy or regret, preferably using the words "I'm/we're sorry". An apology is not necessarily an admission of error.
Circle of Care	A group of internal and external healthcare providers supporting a specific person, with whom personal information is shared based on an implied consent model, for the purpose of contributing to their health care plan and meeting the service needs for them and their family.
Clinical leader	The most senior leader immediately available to manage an adverse event. This may be a charge nurse, on-duty supervisor, administrator on call, most responsible practitioner, unit manager, Quality Review Coordinator or other leader as appropriate.
Critical incident	An adverse event that results in severe physical or psychological harm or death.
Decision Review Team	Brought together by the accountable leader with support from Patient Safety and Risk Management, a Decision Review Team includes operational leaders, medical staff and network leaders who review a serious adverse event and collectively make decisions regarding next steps and the need for further review.
Disclosure	The imparting of information to a patient and/or family pertaining to harm.
Family	One or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers. For patients unable to express their wishes, family would include those we can share health information with as per established consent processes.
Handler	The Handler designated in the PSLS report is responsible for ensuring the event is investigated appropriately and that necessary actions are taken. During the Immediate Management phase of an adverse event, the Handler would be the clinical leader. During the Ongoing Management phase of an adverse event, the Handler would be the accountable leader.
Harm	An unexpected and undesired outcome for the patient that negatively affects the patient's physical, psychological (mental or emotional) health and/or quality of life. The PSLS defines degrees of harm as: 1 – No harm 2 – Minor harm 3 – Moderate harm 4 – Severe harm 5 – Death
Hazard	A circumstance, agent or action with the potential to cause harm.
Most Responsible Practitioner (MRP)	The Most Responsible Practitioner is the Physician, Nurse Practitioner, Oral Surgeon or Midwife whose name appears in the patient's chart designated as

	the MRP and who has overall responsibility for directing and coordinating the medical care and management of an individual patient, resident or client.
Near miss	An event with the potential for harm that did not result in harm because it did not reach the patient due to timely intervention or good fortune (sometimes called a close call or good catch).
Never Event	Adverse events that may result in serious patient harm or death and that are preventable using organizational checks and balances.
Patient	Includes all clients, residents, service users and persons in care in Interior Health facilities and programs. In this policy and associated guidelines, references to the patient will include the family if the patient wishes.
Patient Safety Learning System (PSLS)	BC Patient Safety Learning System (PSLS) is a web-based tool used by health-care professionals across B.C. to report and learn from adverse events, near misses and hazards that occur in health care settings.
Person & Family Centered Care	A Person & Family Centered Care approach puts patients at the forefront of their health and care, ensures they retain control over their own choices, helps them make informed decisions and supports a partnership between individuals, families and health care service providers.
Second harm	Negative effects on health and well-being resulting from the impact of being involved, witnessing or affected by an adverse event. Family members of patients, care providers and others may be affected.
Trauma-Informed Practice	A strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma. It emphasizes physical, psychological and emotional safety for everyone, and creates opportunities for survivors to rebuild a sense of control and empowerment.

Overview of AK0400 Recognizing and Responding to Hazards, Near Misses & Adverse Events



1.0 GUIDELINE

1.10 **Why Disclose**

Despite best intentions to provide excellent quality care, harm can occur to people we are caring for – and when it does, patients will have physical, psychological and practical needs. Providing and receiving health care requires a trusting relationship between providers (employees and medical staff) and patients. When trust is lost, it is difficult to recover, often resulting in further negative impacts or harm for patients,

providers and family members.

Failure to provide an apology with an empathic response to harm is a leading driver of complaints and legal action.[1] Effective and timely communication with a harmed patient can restore trust and improve patient outcomes in the future. The disclosure process is a critical part of re-establishing the provider-patient relationship and restoring confidence after harm has occurred.

1.11 When to Disclose

Analysis of an event is an important step in understanding if undesired results have occurred as a result of the natural progression of a medical condition, the inherent risk in the medical investigation or treatment, a failure of the system or provider performance. Gaining an understanding of whether harm has occurred is necessary, as this guides the need to provide disclosure.

Disclosure must occur if:

- The patient has experienced harm,
- There is any potential risk for future harm, or
- If care or monitoring needs to change in order to reduce the impact of future harm.

In the case of a near miss or no harm event, providers should use their clinical, professional and administrative judgment to disclose based on whether the patient is aware of the event and whether they feel the patient would benefit from knowing or would want to know. If they are unsure, disclosure should occur. See Appendix A: Disclosure Process Algorithm.

The first stage of disclosure should take place as soon as possible after an event occurs. Facts that are known can be shared, and a commitment to learning more and following up when more facts are known can be provided. Additional conversations may be required as more is learned about the event and depending on the complexity of the event, severity of harm, the patient's condition and their questions that may arise.

1.12 What to Disclose

Follow the stages of disclosure described below until the patient has been provided with the following:

- An acknowledgement that something has gone wrong and an apology;
- The most accurate factual understanding about what happened, without speculation;
- An understanding of the recommended next steps in clinical care or how their care plan may be effected;
- A genuine expression of concern and regret;
- An understanding of how Interior Health will respond to the event and what next steps will look like; and
- Lessons learned from the event and any actions arising from discussions to improve quality of care.

Disclosure conversations should be truthful, empathic, compassionate, honest and transparent. Language should be adjusted to ensure clarity and understanding, with acronyms avoided and interpreters or translators present if needed. Consideration for cultural needs, time of day and environment (e.g. noise, privacy, comfort, disruptions) should be made. Providers should be mindful of their tone, body language and power imbalances. Use active listening skills during the conversation. Be patient – when in an emotional state, the ability to absorb and interpret information may be slower, and

you may need to answer the same questions more than once.

1.13 Who Should Disclose

The decision about who should disclose and participate in the disclosure process should be based on:

- Who has an existing relationship with the patient,
- Who can provide the best information and clear factual description of the event,
- Who can provide practical/physical/psychological support or information about available support for the patient,
- Who can coordinate ongoing communication and care for the patient, and
- The patient's preference.

The Most Responsible Practitioner (MRP) should lead the disclosure conversation. Other considerations for selection of the lead may include knowledge of the event, strength of existing relationships with the patient and family, status of disclosure training and their understanding of the effect on the patient's medical condition and care plan.

For more complex or severe harm events that require ongoing management, additional members of the disclosure team may include spiritual care providers, social workers, patient navigators, Elders or others who can support the physical, spiritual and emotional needs of the patient and the accountable leader. Consideration should be made for the patient's wishes and preferences for determining team member attendance at the meetings. In accordance with AR0400-Privacy and Management of Confidential Information, anyone who is not involved in direct care of the patient as part of their job duties will need explicit consent from the patient or legal representative to attend the disclosure meeting. Each member of the disclosure team should be able to clearly articulate their role in the process. All employees and medical staff involved in the disclosure are encouraged to seek guidance for the process from their applicable liability protection association as appropriate.

The patient is welcome to bring additional support people (e.g. family, Elders, friends). Asking them to share the names in advance and to define in what capacity each is attending (e.g. support, interpreter, legal representative) will help to coordinate the logistics and provide clarity for all at the meeting. The patient or appropriate representative must consent to having family or support person(s) present in the room.

1.14 Documenting Disclosure

A complete, accurate and factual account of all disclosure discussions must be recorded in the patient's health record including the following:

- Time and place of disclosure meetings, copies of any disclosure letters provided to the patient and details of phone conversations or other methods of communication;
- Identity of all attendees;
- Consents obtained;
- The facts of the event that are known at the time of the disclosure and who presented them;
- Offer(s) of assistance to the patient and responses to the offer(s) of assistance;
- Care and treatment plans discussed and provided;
- Requests and actions to review the patient's health record;
- Questions raised and the answers given;
- List of any unanswered questions from the patient; and
- Plans for follow-up, including key contact information from the appointed contact person.

1.15 How to Disclose

Stage 1: Immediate Management - Acknowledgement and Apology

When a patient safety event occurs, an acknowledgement and apology should be made as soon as possible after an event occurs. This can be done by any employee or medical staff caring for the patient, by the MRP or sometimes by the clinical leader or accountable leader.

This should include the following components:

- Acknowledgement that an event has occurred and resulted in harm or potential for future harm;
- A sincere apology for what has occurred that includes the words 'I'm/we're sorry' and expresses genuine concern and sympathy for the patient's well-being;
- An explanation for what has happened using known facts and avoiding speculation;
- Exploration and understanding of the patient's questions and needs, with offers of support provided as needed; and
- An explanation of any changes to the patient care plan resulting from the event.

An apology with an admission of responsibility should be provided when review of the event has revealed system failure or provider performance has occurred. Under the *B.C. Apology Act*, an apology does not constitute an expressed or implied admission of fault or liability, does not void liability insurance and is not admissible in court as evidence of the fault or liability of the person apologizing.[2]

For simple adverse events (e.g. resolved during the Immediate Management phase), this will be all that is needed. For adverse events where there is a higher degree of harm, complexity or a need for further adverse event review (e.g. Ongoing Management phase), additional stages of the disclosure process may be required until the patient has received all the components described in section 1.12. If this is the case, an explanation should be provided to the patient about what they can expect for next steps in the process.

Stage 2: Ongoing Management – Planning Disclosure Meetings

Selecting the Venue

Every reasonable effort should be made to ensure disclosure takes place in a face-to-face meeting. If this is not possible, disclosure can occur through a video/telephone call and followed up with a registered letter (or in some cases, if applicable, occur through a registered letter). Consult IH Risk Management prior to sending the letter.

The disclosure meeting should take place at the earliest practical opportunity. An appropriate venue should be selected that is comfortable, allows privacy and is free from disruptions. Consideration should be given to patient preference (e.g. the patient may experience trauma from returning to the same location where the event took place, some patients may prefer the meeting to take place within a setting that feels culturally safe).

Content of the Disclosure Meeting

Components of the disclosure meeting include:

- Acknowledgement that a patient safety event has occurred and resulted in harm or potential for future harm;
- A sincere apology for what has occurred that includes the words 'I'm/We're sorry' and expresses genuine concern and sympathy for the patient's well-being;
- An explanation for what has happened using known facts and avoiding speculation;
- Exploration and understanding of the patient's questions and needs, with offers of support

provided as needed;
- A brief overview of the investigative process that will follow, including approximate timelines and what the patient can be expected to learn through this process;
- Reassurance that appropriate steps are being followed to learn from what happened;
- An explanation of any changes to the patient care plan resulting from the event; and
- Role of the contact person and how the patient can reach them.

The disclosure should not include the following information:
- Discussions that took place during quality improvement or assurance meetings in keeping with Section 51 of the *Evidence Act*,
- Identity of other patients or information that could lead to the identification of other patients,
- Any disciplinary actions taken involving employees or medical staff, and
- The use of words that express or imply legal responsibility, such as 'negligence', 'fault', or 'failing to meet standard of care'.

The Rehearsal

The words you use and who is saying them will have a deep and lasting impact on the patient and their family. Disclosure should always be rehearsed – preferably one to two days prior to the meeting with the patient. Rehearsal allows for the team to practice saying the words and work out who is best to communicate which information. During rehearsal, it is helpful to discuss whether the team has agreement as to what happened and to walk through a timeline of the event together. If there is uncertainty about aspects of the event, note them so there can be further investigation and so they are not presented as facts.

Create a safe environment where the team can feel open about sharing feedback with each other. Contact a disclosure coach within IH Patient Safety to support the team during rehearsal.

The Conversation

Sit down with the patient – this indicates your attention is undivided and you are listening. Start with introductions – each member of the team should introduce themselves and explain what their role is in the disclosure process. Try to anticipate the questions a patient may have (even better if you can ask them what questions they have ahead of time) and practice answering them. Structure the conversation to give the patient some control, do more listening than talking and allow them to finish speaking before providing answers. Ask open-ended questions (e.g. 'What is your current understanding of what happened?'). Reflect back what you heard to ensure mutual understanding.

Patients will often have three important questions that need to be answered during disclosure meetings: "How did this happen?", "What are you doing about it now?" and "What is the future impact?" During the conversation, listen to what the patient is asking and be prepared to respond to questions as they emerge.

Use empathy – try to comprehend what the patient experienced, and communicate this back to them to validate their experience. Identify their emotion and the cause of that emotion, and respond in a way that lets the patient know you have made that connection. Communicate that you care personally about the patient's well-being.

Ensure the team's responses are not reactionary or defensive – acknowledge different perspectives and understandings. Avoid saying 'it will never happen again' or similar false promises. Instead, explain what you learned from the event and any changes that have been made as a result.

Completing Disclosure

Continue the disclosure discussions as needed until the patient and/or family has received and understands the following components:

- An acknowledgement that something has gone wrong and an apology;
- The most accurate factual understanding about what happened, without speculation;
- An understanding of the recommended next steps in clinical care or how their care plan may be affected;
- A genuine expression of concern and regret;
- An understanding of how Interior Health will respond to the event and what next steps will look like, and
- Lessons learned from the event and any actions arising from discussions to improve quality of care.

Following disclosure, if the patient or family feels their care concerns were not resolved, they can contact the IH Patient Care Quality Office.

2.0 REFERENCES

1. Canadian Medical Protection Agency. *Good Practices Guide: Disclosure – Maintaining Trust*. https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/adverse_events/Disclosure/disclosure-e.html
2. *B.C. Apology Act [SBC 2006] Chapter 19*. Queen's Printer, Victoria B.C. Retrieved from: http://www.bclaws.ca/Recon/document/ID/freeside/00_06019_01. Published 2006.

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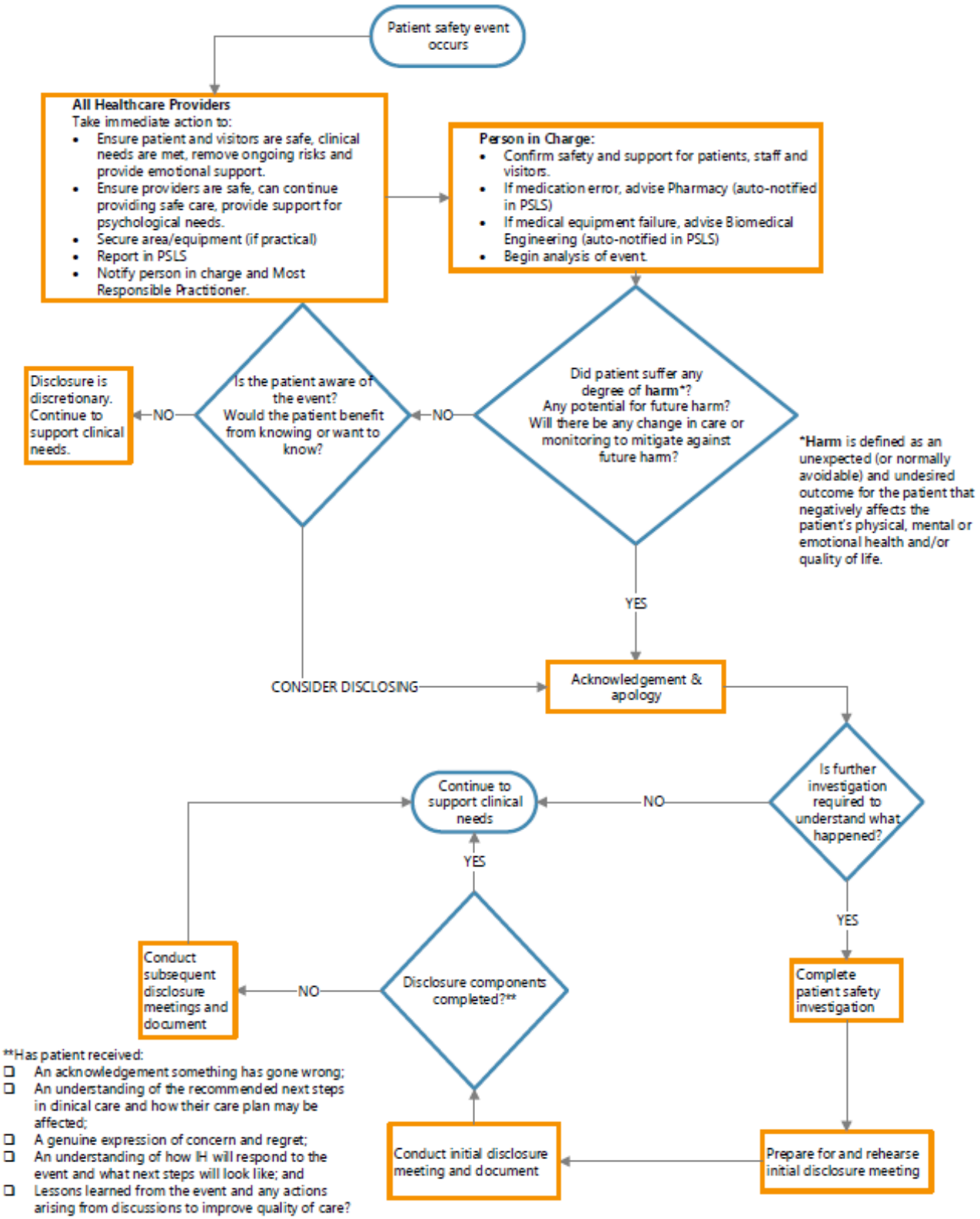
Health Authority Medical Advisory Committee October 2021
Quality Management Committee December 2021
Senior Executive Team February 2022

Please provide a list of keywords to aid in searching for this tool:

Disclosure; adverse event; critical incident; just culture; patient safety; near miss; harm; hazard

Appendix A Disclosure Process Algorithm



Appendix B Disclosure Guidance for Special Circumstances

Disclosure to a Patient with Acute Physical or Mental Illness

Whenever possible, disclosure should occur directly with the patient to the greatest extent possible – however, the disclosure conversation should not be significantly delayed as you wait for the patient's condition to improve. Consider having the patient's temporary substitute decision-maker (TSDM) or other family/support persons present during the disclosure (with the patient's or applicable representative's valid consent). Depending on the patient's mental and physical capacity, the disclosure and/or other information may need to be repeated at a later date as the patient's condition improves.

When disclosing to a patient in a fragile physical or emotional state, consideration should be given to the potential impact of the news, and balance the patient's right/need to know with the potential for additional physical or emotional harm, risk of self-harm or harm to others as a result of the conversation. If unsure, contact the clinical ethics chair in your geographic area for some guidance in your approach to disclosure.

If it is clear that the patient will be unable to receive the disclosure, the accountable leader should work with the substitute decision-maker to determine who is the most appropriate person to disclose to (see *Freedom of Information and Protection of Privacy Regulations* (Section 4)).

Disclosure after a Death

When a patient has died (either as a result of the harm or from other causes), the accountable leader should work with the substitute decision-maker to determine who is the most appropriate person to disclose to (see *Freedom of Information and Protection of Privacy Regulations* (Section 5)).

Disclosure with Pediatric Patients

For patients under the age of 18, disclosure should occur with the patient's legal representative (parent or guardian). Consider repeating the disclosure with the patient (using age-appropriate language) if the legal representative thinks it would be beneficial for them.

Disclosure with Incapable Adults

All adults are presumed capable under the *Adult Guardianship Act*; however, an adult may have been assessed as incapable of understanding and appreciating information regarding a disclosure. If this is the case, they may still have the mental capacity to consent to share information with a person of their choosing. If so, disclosure should occur with that support person present.

If the adult does not have the mental capacity required to provide consent then in accordance with the *Freedom of Information and Protection of Privacy Act Regulations* (Section 4) disclosure can be shared with:

a) A committee appointed under the *Patients Property Act*,
b) A person acting under a power of attorney (provided the disclosure pertains to financial and/or legal matters),
c) A litigation guardian, or
d) A representative acting under a representation agreement, as defined in the *Representation Agreement Act*.

Contact the IH Knowledge Facilitator for Vulnerable and Incapable Adults for support.

Multi-Location Disclosure

IH patients often receive care in multiple locations or across more than one health authority.

Harm may be discovered in a different location from where it took place, or by providers other than the ones involved in the event. Employees, medical staff or leaders who discover the harm should communicate with healthcare providers in other locations involved, and jointly make a decision on which site should lead the disclosure process, with other sites collaborating or participating as needed.

Multi-Patient Disclosure

In some situations there may need to be disclosure to multiple patients about the same event. Privacy and confidentiality remain important. The disclosure should only be with one patient at a time. Disclosure should occur in person if there are higher degrees of harm. If the disclosure cannot occur in person, it should be made first by telephone or registered mail, with opportunities for follow-up made available. In addition, disclosure should be timed to occur with all affected patients in the same time period (where possible) prior to any public informing process, such as media coverage. In the case of multi-jurisdictional disclosure, the health-care team from the organization in which the adverse event occurred should lead the disclosure discussion.

Where the number of patients is known, communication is manageable and the facts of the event are clear, the disclosure team may be able to disclose directly to each patient without the need for broader public notification.

Procedure:

1. As rapidly as possible, identify affected patients and any ongoing risks.
2. Form a multi-patient disclosure team (will include the MRP or Chief of Medical Staff, the accountable leader or senior administrator and other stakeholders as needed (see below).
3. The following stakeholders shall be contacted for multi-patient disclosure guidance and to meet reporting requirements for the Ministry of Health. They may also be included on the disclosure team if required:
    - Director; Patient Safety;
    - Executive Director and/or Executive Medical Director, Quality & Patient Safety;
    - Corporate Director, Privacy, Policy & Risk Management;
    - Medical Health Officer;
    - Appropriate VP and members of the Senior Executive Team; and
    - IH Communications.
4. Develop a group disclosure communication plan (to patients and their primary care providers if applicable) that includes information about the medical treatment plan and contact information. Ensure messaging is consistent for all affected patients. Plan to disclose to all patients as close to the same time as possible.
5. Initiate disclosure, led by the MRP and accountable leader.
6. Follow the same process as individual disclosure. If individual disclosure is not practical initially, follow the public informing process (see below) and then follow-up with individual disclosure.
7. Consider having a toll-free call centre for patient concerns and invite follow-up.
8. Consider offering to pay for transportation and minor expenses if follow-up involves additional medical visits.

Public Informing Process

In some cases, it may be in the public's best interest to inform the public of risk or an event. This may include cases where rapid contact with multiple patients is desired, uncertainty exists about the number or identities of patients affected, misinformation or incorrect facts are circulating within the media or members of the IH Senior Executive Team feel that the public needs reassurance about the quality and safety of care that IH provides pursuant to the "public interest" as defined in Section 25 of the *Freedom of Information and Protection of Privacy Act* (e.g. communicable disease exposure, infected medical devices).

It is important that there is a careful expert assessment (e.g. by the Chief Medical Health Officer) of the risks and benefits to the public and that the appropriate contingency plans of the organization are in place (e.g. help-lines,

testing information) before such public disclosures are made, unless the emergency nature of the circumstances do not permit any delay.

Informing the public does not supersede individual disclosure. Whenever possible, disclosure to individual patients and communication to affected employees/medical staff should take place prior to public informing.

Contact IH Office of the Medical Health Officer, IH Risk Management and IH Communications for support with the public informing process and with media relations.