Policy

Policy Title:	Disclosure of Patient Safety Incidents		
Applies To:	All Team Members		
Related Procedure(s):	Disclosure of Patient Safety Incidents - Procedure - NSHA AD-QR-010.01		
Approved:	**Effective:**	**Next Review:**	
July 21, 2022	August 9, 2022	July 21, 2026	
Sponsor:	Senior Director, Quality Improvement and Safety		
Approval Authority:	VP Medicine Executive Leadership Team		
Number: AD-QR-010	**Manual:** Administrative		

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PURPOSE

This policy is part of Nova Scotia Health's system to address Patient Safety Incidents, including the Patient Safety Incident Management Policy and Quality Review Policy. The

Patient Safety Incident Management Policy requires that where Disclosure of a Patient Safety Incident is required, this policy – Disclosure of Patient Safety Incidents – must be followed.

As such, this policy and accompanying procedure provide coordinated processes for Disclosure of Patient Safety Incidents with the goal to make improvements to health care and to limit or prevent the recurrence of Patient Safety Incidents.

DEFINITIONS

Apology	The Nova Scotia Apology Act states that an Apology means an expression of sympathy or regret, a statement that one is sorry or any other words or actions indicating contrition or commiseration, whether the words or actions admit or imply an admission of fault in connection with the matter to which the words or actions relate.
Disclosure	A formal process involving open discussion between a Patient, or where applicable, the Patient's Substitute Decision Maker and Nova Scotia Health about a Patient Safety Incident. Disclosure generally occurs in two broad stages (initial and post-analysis) recognizing that it is an ongoing process in which multiple conversations may occur over time. ○ *Initial Disclosure* is the initial communication with the Patient as soon as reasonably possible after the Patient Safety Incident. ○ *Post-Analysis Disclosure* is the subsequent communication with a Patient about facts which became known after an appropriate analysis of the Patient Safety Incident. ○ *Multi-Patient Disclosure* is the communication about the same Patient Safety Incident with more than one Patient of Nova Scotia Health.
Disclosure Team	Consists of the most responsible Health Care Provider(s), the appropriate Manager/Director (or Delegate), and the Nova Scotia Health Patient Representative (if available).
Health Care Provider	Refers to Team Members who are engaged in providing health care and services.
Manager/Director (or Delegate)	Responsible and accountable for standards of care in the clinical unit or service area in which the Patient Safety Incident occurred or potentially occurred.
Patient(s)	All individuals including clients, residents, and members of the public who receive or have requested health care or services from Nova Scotia Health and its Health Care Providers.
Patient Safety Incident	An event or circumstance which could have resulted or did result in unnecessary harm to a Patient (see Appendix A for severity levels).

Quality Review	The systematic analysis and evaluation of health service structures, practices, and/or results that focus on the entire continuum of care and services; including, but not limited to, • Patient Safety Incidents and individual cases which are reviewed based on predetermined criteria for the purposes of education and/or improvement in and increased safety of health care/service or practice, • Review of team/organization/system data and indicators to proactively improve quality and Patient safety in specific areas of service and the system, • Analysis of health consumer needs with a view to improve performance, quality, safety, and experience.
Safety Improvement & Management System (SIMS)	The Nova Scotia Health province-wide reporting and management information system used to enhance the capability of Health Care Providers to improve safety. The electronic Patient Safety Incident reporting system was developed with processes to report, analyze, recommend actions, and monitor improvements.
Serious Reportable Events (SRE)	A subset of Patient Safety Incidents as identified in the Nova Scotia Health & Wellness Serious Reportable Event Reporting Policy.
Substitute Decision Maker (SDM)	A person who is given the authority to make admission, care, or treatment decisions on behalf of a Patient under the Hospitals Act.
Team Members	Refers to all employees, physicians, learners, volunteers, board members, contractors, contract workers, franchise employees, and those with affiliated appointments and other individuals performing activities within Nova Scotia Health.
Type A Patient Safety Incident	A Patient Safety Incident that affects or potentially affects a particular Patient.
Type B Patient Safety Incident	A Patient Safety Incident which affects or potentially affects one or more of the following: • More than one or a group of Patients – Multi-Patient Disclosure • Is perceived as a public health hazard • Has the potential to undermine public confidence in the health system

PRINCIPLES AND VALUES

Introduction

In the decision-making process about how Patient Safety Incidents are disclosed, it is important to take these principles and values into account, alongside the evidence and data:

1. **People-Centred Care:** As a foundation of Nova Scotia Health, we are working to place the dignity and respect of Patients, families, and communities at the heart of every decision. Through processes such as Disclosure, we seek to build trust-based relationships to achieve more genuine partnerships with those we serve. This policy, in conjunction with others such as NSHA-AD-QR-020 Family Presence demonstrate Nova Scotia Health's commitment to people-centred care.
2. **Just Culture:** The importance of fairly balancing an understanding of system failure with professional accountability. A just culture promotes safe care through a consistent, fair culture of accountability, where Patient Safety Incidents and near misses are freely reported, reviewed, and learned from. In a just culture, the reasons for unexpected clinical outcomes and Patient Safety Incidents are not pre-judged, and the rights of all individuals, including Patients, are protected. All are aware of Patient Safety Incident reporting expectations, and when analyzing Patient Safety Incident reports, professional accountability of Health Service Providers is determined fairly. Without a just culture, individuals would not feel safe to report Patient Safety Incidents and they would go unreported. This would directly impact our ability to prevent Patient Safety Incidents from recurring in the future.
3. **Transparency:** A foundation for creating a supportive environment for Patients and Health Care Providers in which actions flow from a shared belief in openness, honesty, and truth in sharing of information.
4. **Respect for Persons:**
    - 4.1. **Truth Telling:** Involves being honest and open in communications with Patients, families, SDM, and the public. This is a key component of accountability.
    - 4.2. **Trust:** Understood in the health care context as the reliance on and related expectation that health care organizations and those working within them will act to put the interests of Patients first. At a broader level, this refers to earning and maintaining the public's confidence.
    - 4.3. **Individual Autonomy**: Is the Patient's right to know about a Patient Safety Incident that has affected or potentially affected them and to be informed about their future health care and treatment.
5. **Patient Welfare**
    - 5.1. **Beneficence:** The obligation of health care organizations and Health Care Providers to act in ways that provide health benefits to Patients and families.
    - 5.2. **Nonmaleficence:** The obligation to 'first, do not harm' or as little as possible (i.e., the responsibility of health care organizations and Health Care Providers to mitigate/reduce harm to Patients and the public).

6. **Justice**

   6.1. **Formal Justice:** Like individuals and groups should be treated alike unless there is a demonstrable relevant difference between/among them that justifies treating them differently.

   6.2. **Social Justice:** Recognizes that some Patients and social groups are treated unfairly and do not have access to the same opportunities, including health care, as other individuals, and groups. This means that these Patients and social groups may be more vulnerable than others in terms of the outcomes of decision-making processes. As such, it is important to consider the effects of Disclosure of Patient Safety Incidents on vulnerable individuals and social groups. It also means that persons from vulnerable social groups should be included in related decision-making processes.

   6.3. **Procedural Justice**: Ensures that Nova Scotia Health has a fair process for decision making about Disclosure of Patient Safety Incidents.

POLICY STATEMENTS

1. This policy applies to both Type A and Type B Patient Safety Incidents (see Definitions).
2. All Nova Scotia Health Team Members must report Patient Safety Incidents, including all severity levels (as defined in Appendix A), in accordance with Patient Safety Incident Management - Policy and Procedure - NSHA AD-QR-015
3. Patient Safety Incidents categorized with a severity level of no harm and mild harm incidents (as defined in Appendix A) must be disclosed by the appropriate Health Care Provider, but do not require a Disclosure Team.
4. Patient Safety Incidents categorized with a severity level of Moderate/Severe Harm Incidents or Death (as defined in Appendix A) must be disclosed by the appropriate Health Care Provider and require designation of a Disclosure Team.
5. In general, a Patient Safety Incident categorized as a Near Miss does not need to be disclosed, although there are exceptions. The Patient should be informed about a near miss if there is a similar, ongoing safety risk for that Patient, or where the Disclosure will provide an explanation that will relieve the Patient's concerns.
6. Disclosure of the known factual information regarding a Patient Safety Incident should take place as soon as possible by the most responsible Health Care Provider.
7. Patient Safety Incidents must be Disclosed directly to the Patient, except when the Patient is determined to lack capacity.

   7.1. Team Members disclose to the Substitute Decision-Maker when a Patient is determined to lack capacity.

   7.2. If the Patient regains capacity, the Team Members must disclose directly to the Patient.

8. Patients must receive a timely, respectful, and sincere Apology.

9. Permission of the Patient (or where applicable, the SDM) must be obtained before information that could potentially identify the Patient is released externally, except where the Disclosure is authorized by law.

REFERENCES

Legislative Acts/References

Province of Nova Scotia. (2008). Apology Act. c. 34, s. 1. http://nslegislature.ca/legc/statutes/apology.pdf

Nova Scotia Quality-Improvement Information Protection Act https://nslegislature.ca/sites/default/files/legc/statutes/quality-improvement%20information%20protection.pdf

Province of Nova Scotia. (2013). Personal Directives in Nova Scotia. http://novascotia.ca/just/pda/

Other

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Nova Scotia Department of Health & Wellness. (2005). *Disclosure of Adverse Event Policy.* http://novascotia.ca/dhw/hsq/documents/Disclosure-Adverse-Event-Policy.pdf

Nova Scotia Department of Health & Wellness. (2021). *Serious Reportable Event Reporting Policy*. https://novascotia.ca/dhw/hsq/documents/Serious-Reportable-Event-Interim-Reporting-Policy.pdf

RELATED DOCUMENTS

Policies

NSHA-AD-QR-005 Quality Review

NSHA-AD-QR-015 Patient Safety Incident Management

AD-QR-020 Family Presence

Relevant local policies on access to Personal Health Information

Procedures

Disclosure of Patient Safety Incidents - Procedure - AD-QR-010.01

Brochures

Patient Education Pamphlet NSHA Disclosure Guide for Person Affected

Patient Education Pamphlet NSHA Disclosure Guide for Person Affected: French version

Appendices

Appendix A – Safety Improvement & Management System (SIMS) – Patient Safety Incident Severity Levels

Appendix B – Nova Scotia Health Quality Oversight Structure

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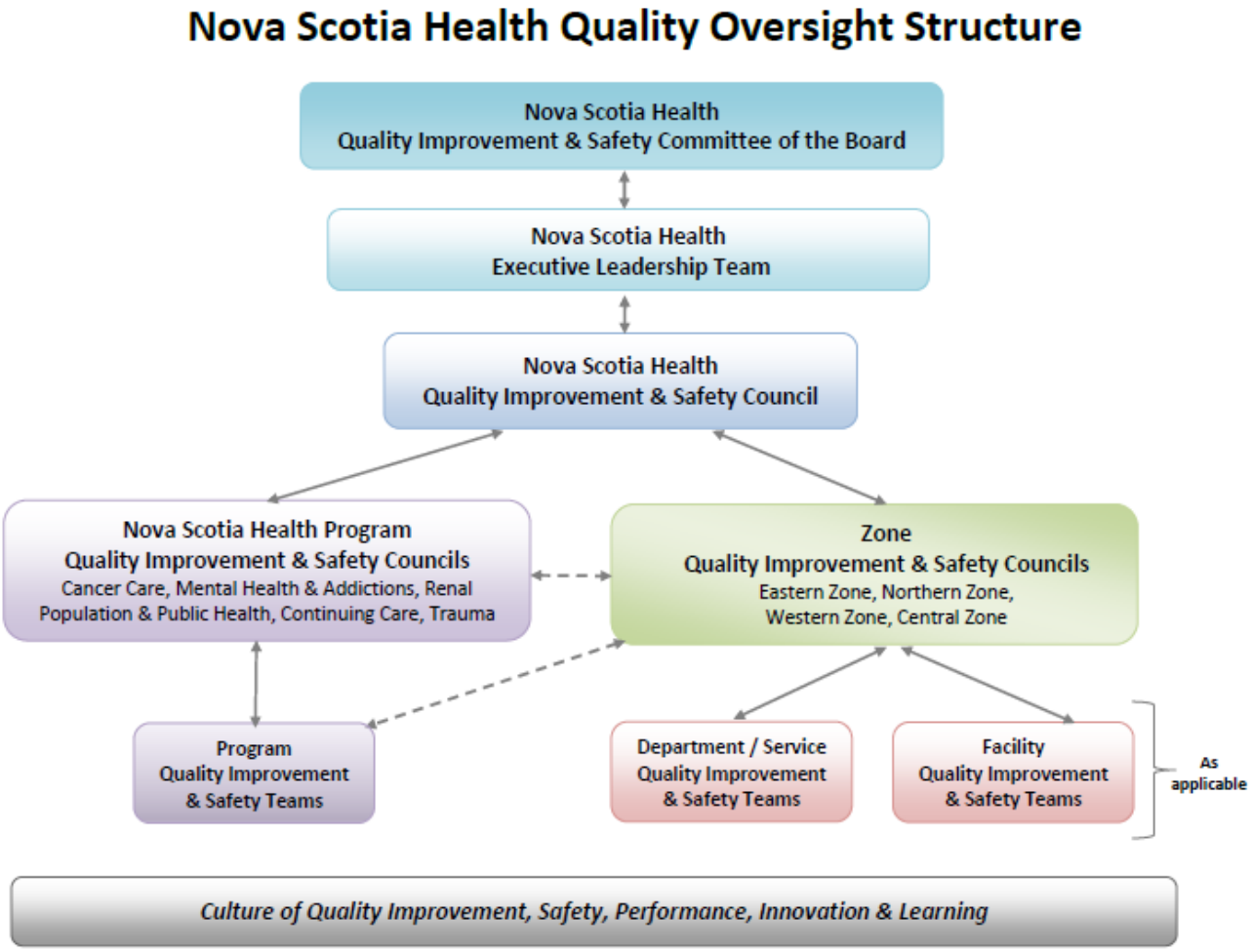
Appendix A: Safety Improvement & Management System (SIMS) - Patient Safety Incident Severity Levels

Severity Level	Definition
Near Miss	An incident that did not reach a person. The incident has potential for harm and is intercepted or corrected prior to reaching a person.
No Harm Incident	An incident that reached a person, but no discernible harm resulted. Outcome is not symptomatic, or no symptoms are detected, and no treatment is required.
Mild Harm Incident	An incident where the outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate, but short term or minimal intervention is required (for example: extra observation, investigation, review, or minor treatment)
Moderate Harm Incident	An incident where the outcome is symptomatic and requires intervention (for example: additional operative procedure, additional therapeutic treatment) or an increased length of stay; or causing minor permanent, long-term harm or loss of function
Severe Harm Incident	An incident where the outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention or shortening life expectancy or causing major permanent, long-term harm or loss of function.
Death	Death which may have occurred in association with a Patient Safety Incident.

Appendix B: Nova Scotia Health Quality Oversight Structure



VERSION HISTORY

Version:	Effective:	Approved by:	What's changed:
Original	2017-07-17	VP, Quality and System Performance Executive Leadership Team (ELT)	N/A
Revised	2022-07-21	VP Medicine ELT	Regular policy review, with additional feedback from Patients and families.