Ontario Nurses' Association

Submission

PROPOSED AMENDMENTS TO REGULATION 965 UNDER THE *PUBLIC HOSPITALS ACT*

MINISTRY OF HEALTH AND LONG TERM CARE

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Background of ONA

The Ontario Nurses' Association is the union that represents 60,000 registered nurses and allied health care professionals working throughout Ontario. This includes nurses and other allied health professionals working in over 150 public hospitals, community care access centres, long-term health care facilities, community health, public health and other clinics. Since it was founded in 1973, the Ontario Nurses' Association has worked collaboratively with the Ministry of Health and Long-Term Care, public hospitals and other institutions as partners to improve the quality of health care in Ontario.

As front-line health care providers, our members regularly participate in QCIPA reviews. As such, ONA is knowledgeable about the *Quality of Care Information Protection Act* (QCIPA) process both in terms of the legislation and how it is implemented in practice across Ontario. We are aware of concerns of front-line health care providers. Our members require a process that gives them assurances they can rely on that the QCIPA process is confidential without fear of anything that they say can be used against them in a potential disciplinary process or in legal proceedings. They often contact ONA to make enquiries on their behalf to ensure that an investigation they have been asked to participate in is a QCIPA process with its protections before they will participate. Without the QCIPA confidentiality assurances, many health care professionals, not just nurses, may be deterred from participating.

Background and Intent of QCIPA and related legislation

Prior to the introduction of QCIPA in 2004, it was widely recognized that a critical element of quality of care investigations is full and frank disclosure by health care practitioners and administrators involved in patient care and following institutional practices. In order to achieve such openness, it has been consistently recognized that the information provided in the course of investigations and reviews to improve the quality of care must be confidential and protected from disclosure in legal proceedings. For example, the *National Steering Committee on Patient Safety* confirmed that the then existing legal and regulatory environment in health care perpetuated a fear of blame and litigation. As a result, disclosure discussions and quality improvement processes often did not involve an open dialogue and a sharing of opinions, questions and concerns. This had a strong negative impact on health care. The Committee recommended the following:

> Review and where applicable, revise *The Evidence Act* and related legislation within all Canadian jurisdictions to ensure that data and opinions associated with patient safety and quality improvement discussions, related documentation and reports are protected from disclosure in legal proceedings. The protection would extend to this information when used internally or shared with others for the sole purpose of improving safety and quality. Wording within the applicable Acts should ensure that all facts related to an adverse incident are recorded on a health record that is accessible to the patient or designated next of kin, and are not considered privileged.[1]

1 *Building a Safer System: A National Strategy for Improving Patient Safety in Canadian Health Care*

Similarly, the QCIPA Review Committee Report submitted December 23, 2014, documents a similar concern, which states the following at page 12:

> Peer reviews and quality assurance are critical and essential components of maintaining quality standards within a health care organization. However, "…without confidentiality assurances, physicians and other health professionals would refuse to participate in or fail to bring candour to such activities".[2]

ONA can assure the Minister and Ministry that it has been repeatedly approached by its members with concerns about participating in reviews and only after being given assurances of the QCIPA confidentiality provisions did they participate in the review. Without such assurances, nurses and other health care professionals may refuse to participate in the process or to bring candour to the process for fear of discipline against themselves and colleagues, either by their employer or by their regulatory College, the College of Nurses of Ontario, or because of fear of litigation.

Recommendations of the QCIPA Committee in their December 23, 2014 report

In principle, ONA agrees with many of principles and recommendations of the Committee but states that all the principles be applied in a purposive approach that is consistent with the reason for the QCIPA legislation in the first place; that is, to improve quality of care by the creation of a protected zone.

1. **Strive for a "Just Culture"**

ONA agrees that the Ontario health care system must strive to achieve a "just culture" with a commitment to quality improvement.

ONA agrees that for health care workers a just culture means a "safe place in which to work, a commitment to participate in quality improvement activities, a presumption of competence, unbiased assessment of performance, support and not to be blamed if things go wrong…" as set out at page 26 of the QCIPA Committee Report.

ONA is, however, concerned with the Committee's reference to "transparent investigation of adverse events." "Transparency" is a recent popular term but it is so overused that it has lost its meaning. While it may appease the public to use such terms, it is unclear how it is to be applied regarding a process set up to maintain confidentiality without undermining the purpose of the process. The QCIPA process must be consistent with the original intent and purpose of QCIPA as set out above and any amendments cannot undermine its purpose. Mistakes will not be appropriately addressed if health care professionals are not given an environment where they may speak with candour, such that their comments may not be used against themselves or other health care professionals in litigation including disciplinary proceedings.

ONA agrees with the Committee's comments under this recommendation, that QCIPA should be retained as it "provides a protective place" and encourages health care providers and managers to freely share information, including information and speculation without it being used against

2 Taylor KL (2004) Quality Assurance Reviews - An Update: Quality of Care Information Protection Act, 2004 presented at the HIROC-OHA conference held on June 7-8, 2004.

them or another health care provider. It is crucial that health care providers know that this environment is a "protected place" or they will not be able to be forthcoming.

2. **The intent of QCIPA remains valid and QCIPA should be retained, with recommended amendments, as a tool to further the understanding of what caused some critical incidents**

The Committee recognizes that QCIPA set up that protective zone allowing for candour by health care professionals under the Quality of Care Committee (QOC Committee) process. The QCIPA process protects those quality or peer review processes conducted by the QOC Committee for the purpose of evaluating the health care provided in defined critical incidents with a view to improving or maintaining the quality of health care or the level of skill, common knowledge, and confidence of the person providing the health care.

The Ontario Hospital Association, following the introduction of QCIPA, published a resource Guide to assist Hospitals to implement QCIPA and guidelines for creating a QOC Committee.[3] These types of guidelines can assist Hospitals in maintaining a trained QOC Committee, who can then hold competent QOC reviews in a consistent manner. Under the present scheme, terms of references for committees are available to the public, which set out its mandate, its functions, and the recommendations arising out of the review without disclosing admissions, speculation or opinions.

ONA agrees with many of the principles and recommendations of the Committee, such as:

- critical incident investigations should assume good intentions from all parties
- critical incident investigations should be consistent and predictable
- critical incident investigations should entail an obligation to share lessons
- staff need to communicate effectively with patients and families before, during and after critical incident investigations.[4]

The Committee also stated the additional two principles that ONA agrees with generally but finds them unclear:

- critical incident investigations should be patient inclusive
- critical incident investigations should be transparent.

We trust "patient inclusive" does not mean participating in frank discussions of the patient care. Clarity is required so that there is not confusion about what inclusivity means. Similarly we have already expressed our concerns about the use of terms "transparency," which has unfortunately become an overused buzzword. The principles must be interpreted in a way to still ensure the overarching purpose of the QCIPA provisions - that is, to allow the protected space for full and frank discussions among health professionals and hospital administrators

It is important when consulting with patients and their families, and hearing their legitimate concerns, that addressing these concerns do not lead to amendments that undermine the careful balance that went into drafting the original QCIPA and related legislation, which strikes a

3 *Quality of Care Information Protection Act (QCIPA) Toolkit* (Ontario Hospital Association).
4 See page 6 of QCIPA Committee Report.

balance between protecting "quality of care" information and ensuring that the patient's right to access facts of an incident is not compromised.

With respect to information provided at the end of the process, it needs to be kept in mind that there is a distinction between "fact" and opinion and this distinction has to be carefully maintained. It has long been recognized that the opinions and evaluations made by QOC committees are protected. In particular, it should be recognized that there are often challenges of definitively identifying facts or issues such as "cause" of a critical incident" in the delivery of health care. There can be subjective components to what the cause may have been and there are often competing interpretations of the "facts" and causes of the same event. It is ONA's submission that the facts should be charted in patient charts, whereas the opinions of health care providers expressed during frank discussions should be protected inside the zone of a confidential QCIPA review.

This purpose and intent is in the preamble to QCIPA. It also has long been recognized by the Ministry. The remarks of the then Minister of Health and Long Term Care to the General Standing Committee when Bill 31 was introduced included the following insightful comment:

> This legal protection for quality of care information is available only if the facts of a medical incident are recorded in the patient's file. The information provided to the quality of care committee and the opinions of committee members would be shielded from disclosure in legal proceedings as well as most other disclosures outside the hospital. In this way, we have carefully balanced the need to promote quality care with the need to ensure accountability.[5]

3. **Develop clear guidance on when and how to use QCIPA**

ONA agrees that there is variation among the province's hospitals and how QCIPA is used and the quality of QCIPA investigations by hospitals. Some hospitals have inappropriately used QCIPA processes as disciplinary investigations against health care professionals, which undermines its purpose and leads to lack of credibility and confidence in the QOC Committee's processes.

Appropriate training for QOC Committee Members would be of assistance to ensure the integrity of the process. In 2004 OHA developed a toolkit for hospitals to use to implement QCIPA and it is time for an update now that we have had a decade to observe the variations in implementation and to gather information on best practices. It would be appropriate for Ministry, hospitals and the appropriate stakeholders, which would include OHA, ONA, OMA and others, to develop clear guidance about the circumstances under which QCIPA should be invoked and the best QCIPA processes for clarity and consistency. This would not require amendment to the legislation, but the updating of guidelines and toolkits from appropriate organizations to assist individual Ontario hospitals.

5 *Legislative Assembly of Ontario, Minutes of the Standing Committee on General Government,* January 26, 2004.

4. **QCIPA should be amended to ensure appropriate disclosure to patients and families following a critical incident investigation**

ONA is concerned about this amendment. While ONA agrees that patients and families must be appropriately informed regarding hospital investigations, including QCIPA investigations, the Committee Report states that families should be informed about "what happened, why it happened and what measures (if any) the organization intends to take to prevent future incident."

As stated above, there is a fine line between fact, opinion and speculation and often there is disagreement about what are actually the facts among the health care professionals who are involved. This amendment blurs the line between fact and opinion. Requiring a "cause" of the incident for instance (amendment proposed to subsection 2(5) of the Regulation) requires in many cases the disclosure of what may be disputed speculation and opinion.

"Appropriate disclosure" does not require an amendment to the existing provisions of QCIPA but can be addressed by appropriate training and guidelines for QCIPA committees so that hospitals are consistently abiding by QCIPA and providing appropriate reports in keeping with the QCIPA principles and requirements. This should not create a change in the confidentiality and protections of QCIPA, which are crucial for quality control, for all of the reasons set out in the reports leading to the creation of QCIPA in the first place.

5. **Establish and appeal mechanism for the investigation of critical incidents**

ONA is in agreement with the Committee's report that good communication to patients and their families by the hospital is crucial and that poor communication often leads to unnecessary complaints and litigation. A vast majority of the concerns of patients and families could be addressed by improving communication with them rather than amendments to any of the legislation. ONA would be happy to participate if there were any recommended consultations as suggested by the Committee. The Committee has listed a number of entities including "the regulatory colleges and others." We submit that other entities should include unions or associations representing health care professionals, such as ONA.

6. **Establish a mechanism through which hospitals must share what they have learned from their investigations of critical incidents and their recommendations to prevent future incidents with each other**

ONA agrees that it would be helpful for health care professionals and hospitals to learn from critical incidents not just at their particular hospital or institution but at other institutions as well. Such sharing of information must be appropriately anonymized to ensure confidentiality is protected in a publicly available data base and registry. It is important that, just as the patient information is protected, the individual staff or health care professional's confidentiality is also maintained.

7. **Ensure that critical incidents that occur in organizations other than hospitals are thoroughly investigated and the lessons learned are shared with patients, families and other organizations**

ONA agrees that critical incidents must be thoroughly and appropriately investigated. ONA members at different hospitals are aware that investigations are not all of the same quality and some may be of poor quality. This does not require amendment to the legislation. It does require

training and clarity with hospital administrators and members of the QOC Committee of QCIPA provisions and purposes.

ONA also agrees with the Committee that errors can be created when a patient is transitioned between two hospitals or organizations and that these transitions occur frequently. These incidents, however, if reviewed by well trained QOC Committee members under the present provisions of QCIPA could result in recommendations to address these problems.

8. **Reinforce the role of the Quality of Care Committee of the hospital Board to provide oversight to critical incident related processes and the recommendations of this report**

As indicated above, ONA is in agreement that the Boards of Hospitals and their QOC Committees must ensure that critical incidents are appropriate investigated in a non-disciplinary way. Further, recommendations that come out of the QOC Committee review are shared with staff, patients and families and are appropriately implemented.

9. **Patients and families must be informed of the process that will be used to investigate their critical incident, they must be kept informed of the progress of the investigation, and their voice must be represented throughout the review process**

ONA is in agreement that an individual in the hospital should be identified and assure appropriate communication with family and patients. Often appropriate communication can prevent unnecessary litigation and complaints. This, however, does not require an amendment to any of the legislation.

10. **Patients and families must be interviewed as part of the process of investigating the critical incident and be fully informed of the results**

ONA agrees that the patients of families must be involved in the investigative process. This should be separate from discussions amongst health care practitioners. This should also not impact on the protected zone for health care professionals. Again, this does not require an amendment to QCIPA or the *Public Hospitals Act*.

11. **Establish a provincial program to train and support highly skilled staff to investigate critical incidents and communicate with and support patients and families**

ONA is in agreement that hospitals should ensure that their staff has appropriate training and skills to fulfil their roles in identifying critical incidents, reporting them, or investigating them. This does not require any amendments to the legislation but ONA can confirm that presently, not all Hospitals are equal with respect to skill level of those persons appointed at the hospital to conduct investigations.

12. **Support hospital staff involved in critical incidents**

ONA is fully supportive of this recommendation. Nurses, and other allied health care professionals represented by ONA, are often traumatized when a critical incident occurs. This is whether or not they are actually responsible in any way for the critical incident. They should have support throughout the quality assurance investigation and following the investigation.

The training of QOC Committee members of hospital staff involved in QCIPA should include training in how to support staff and other health professionals who are involved in a critical incident. This process should not be considered or used as a disciplinary process; it is to meet its goals of being a safe, protective process for health care professionals to come forward and speak with candour in order to improve quality care for Ontarians.

ONA's recommendations regarding the specific Amendment to Regulation 965 of the Public Hospitals Act

With respect to the specific provisions proposed, ONA submits as follows:

i) Proposed amendment to section 2(5)

It is proposed to add to subsection 2(5) to add to mandatory disclosure a description of the cause or cause of the critical incident. This is problematic as a "cause" or "causes" can often requires disclosure of speculation or opinion. Moreover, it should be kept in mind that the remainder of the provision in the existing subsections of the provision presently provides for fulsome disclosure which includes:

(a) the material facts of what occurred with respect to the critical incident;

(b) the consequences for the patient of the critical incident, as they become known; and

(c) the actions taken and recommended to be taken to address the consequences to the patient of the critical incident, including any health care or treatment that is advisable[6]

ii) Proposed amendment to subsection 2(6)

It is proposed that the phrase " Subject to the *Quality of Care Information Protection Act, 2004"* be struck out in subsection (6). Subsection 6 refers to the duties of the board around disclosure. It is submitted that this phrase should not be struck out as it ensures that the Hospital's systems for disclosure following the critical incident review is consistent with the whole provisions of the Act. Without this key phrase, the integrity of the QCIPA process and particularly the confidentiality assurances that the health care professionals rely on when expressing full and frank comments in the process could be undermined.

Thank you for the opportunity to provide our submissions on the proposed amendments to Regulation 965. We would be pleased to meet with the Ministry for further dialogue regarding our position on these proposed amendments.

6 Regulation 965 subsection 2 (5)