

# **ONTARIO NURSES' ASSOCIATION**

## **Submission to the Standing Committee on Justice Policy**

**Bill 119, *Health Information Protection Act, 2015***

**March 3, 2016**

Queen's Park



### **ONTARIO NURSES' ASSOCIATION**

85 Grenville Street, Suite 400

Toronto, ON M5S 3A2

Phone: (416) 964-8833

Fax: (416) 964-8864

Web site: [www.ona.org](http://www.ona.org)

The Ontario Nurses' Association (ONA) is the union for Registered Nurses as well as Allied Health Professionals in Ontario and has represented members in the health sector since our formation in 1973.

ONA currently represents 60,000 front-line registered nurses (RNs), nurse practitioners (NPs), registered practical nurses (RPNs) and allied health professionals and more than 14,000 nursing student affiliates across Ontario, providing front-line care in hospitals, long-term care facilities, public health, the home and community, clinics and industry.

Bill 119 will impact all of ONA's members. ONA supports updating both of the Acts covered by Bill 119, but has concerns that we outline below regarding certain of the proposed changes to both the *Personal Health Information Protection Act, 2004* ("PHIPA") and the *Quality of Care Information Protection Act, 2004* ("QCIPA 2004").

### **Quality of Care Information Protection Act, 2015**

With respect to the proposed *QCIPA 2015*, the primary concern to ONA is the need to ensure that the original purpose of QCIPA legislation is not undermined. The stated purpose is as follows.

According to the *QCIPA Review Committee's* report to the Minister, the purpose of *QCIPA* is to create a protected zone of discussion to facilitate learning and systemic change with respect to critical incidents:

QCIPA is designed to encourage health care providers to share information about the provision of health care within their organization in order to improve health care, without fear that the information will be used against them.

The causes of many critical incidents are complex . . . . Understanding a critical incident requires an environment where staff can explore what happened and why. QCIPA is intended to help health care workers identify system and process failures with a view to being able to prevent future incidents. It provides protection for health care providers who share speculation and opinion as part of an investigation of a critical incident. (p. 11) . . .

Without it, there is real concern that in some instances staff will not be as forthcoming as desired with their observations about what might have contributed to a critical incident. (p. 27)

The protections afforded to Quality Care Information (QCI) must be understood in the context of the general statutory framework establishing patients' rights to their personal health information under the *Personal Health Information Protection Act, 2004* and in the context of the obligations of Hospital Boards under Regulation 965 of the *Public Hospitals Act* to disclose prescribed information regarding critical incidents to affected patients or their authorized representatives.

ONA's primary concerns related to the provisions in the proposed *QCIPA 2015* are that:

- they may undermine the purpose of the Act to encourage full and frank discussion; and in particular, the expanded definition of "quality of care information"(s. 2(3)3 ii) and;
- they provide the Minister with sweeping powers to enact regulations "restricting or prohibiting the use of quality of care committees for the purpose of reviewing critical incidents" without public consultation or applicable criteria. These provisions effectively provide the Minister with the power to undermine the stated purpose of *QCIPA 2015* and its protections for quality of care discussions.

### **Personal Health Information Protection Act ("PHIPA")**

ONA's primary concerns with respect to Bill 119's proposed amendments to the *PHIPA* are:

- It creates new reporting obligations to regulatory bodies (e.g. College of Nurses) that are inconsistent with the *Regulated Health Professions Act, 1991*.
- It increases the maximum fine for breaches of the *PHIPA* by natural persons from \$50,000 to \$100,000.
- It removes the existing 6-month limitation period leaving no limitation period. We propose the standard 2-year limitation period.

ONA's detailed analysis and proposed revisions to Bill 119 are set out in the charts in Schedule A (*PHIPA*) and B (*QCIPA 2015*). We have also provided referenced provisions of the *Health Professions Procedural Code* in Appendix A and referenced provisions of Regulation 965 to the *Public Hospitals Act* in Appendix B.

We thank the Standing Committee for this opportunity to present the concerns of frontline registered nurses. We ask the Standing Committee to consider our amendments to ensure the legislation balances the interests of all parties affected.

**Schedule A: ONA Submissions on Proposed Changes to the *Personal Health Information Protection Act, 2004***

Provision of Bill 119, Schedule 1	Affected Provision of <i>PHIPA</i>	Comments / Issues	ONA's Recommended Amendments
s. 1(8)	New s. 17.1	<ul style="list-style-type: none"> <li>• Of particular note, the health information custodian is required to advise a regulatory health college               <ul style="list-style-type: none"> <li>a) if the custodian “terminates, <b>suspends or disciplines</b> one of the college's members as a result of inappropriate use, disclosure, retention, etc., of personal health information</li> <li>OR</li> <li>b) if the member resigns and if there are reasonable grounds to believe that the resignation is related to an investigation regarding the same.</li> </ul> </li> <li>• This provision has serious implications for ONA members because it expands an employer’s mandatory reporting obligations to include “suspension” and “discipline” in this context. The current reporting obligations of employers are set out in s. 85.5 of the <i>Health Professions Procedural</i></li> </ul>	<p><b>Remove this provision as it is a major change that is inconsistent with the reporting obligations under the <i>Regulated Health Professions Act</i> (see relevant provisions in Appendix A). It creates new reporting obligations for "suspension", "discipline" and "resignation" in addition to "termination" in this context, thereby treating breaches of <i>PHIPA</i> differently from all other forms of professional misconduct.</b></p> <p>At minimum, to ensure consistency with the <i>Regulated Health Professions Act</i> and not create confusion or impose differential reporting standards, this provision should be amended as follows:</p> <p>17.1(2) Subject to any exceptions and additional requirements, if any, that are prescribed, if a health information custodian employs a health care practitioner who is also a member of a College, the health information custodian shall give written notice of any of the following events to the College within 30 days of the event occurring:</p> <ol style="list-style-type: none"> <li>1. The employee is terminated, <del>suspended or subject to disciplinary action</del> as a result of the unauthorized collection, use, disclosure, retention or disposal of personal health information by the employee.</li> <li>2. The employee resigns <del>and the</del> <b>in circumstances in which</b></li> </ol>

Provision of Bill 119, Schedule 1	Affected Provision of <i>PHIPA</i>	Comments / Issues	ONA's Recommended Amendments
		<p><i>Code</i> (see Appendix A) and include a requirement that employers report members who are terminated for professional misconduct or who resign in circumstances where the employer intended to terminate them.</p> <ul style="list-style-type: none"> <li>• In our view, this provision is unnecessary in light of the existing reporting requirements in the <i>Health Professions Procedural Code</i>.</li> <li>• Furthermore, it creates a differential reporting obligation for breaches of the <i>PHIPA</i> by including broader reporting obligations for suspension and discipline for breaches of <i>PHIPA</i> but not other forms of professional misconduct.</li> </ul>	<p><del>the health information custodian has reasonable grounds to believe that the resignation is related to an investigation or other action by the custodian</del> <b>intended to terminate the employment of the employee</b> with respect <b>due</b> to an alleged unauthorized collection, use, disclosure, retention or disposal of personal health information by the employee.</p>

Provision of Bill 119, Schedule 1	Affected Provision of <i>PHIPA</i>	Comments / Issues	ONA's Recommended Amendments
s. 1(25)	s. 72(1)	<ul style="list-style-type: none"> <li>Potential fines are doubled for natural persons from \$50,000 to \$100,000.</li> </ul>	<p><b>ONA recommends maintaining the existing maximum fine of \$50,000 for natural persons.</b> The increased fine of \$100,000 for natural persons is disproportionate given that <i>PHIPA</i> primarily imposes duties and responsibilities on health care organizations and, therefore, any given breach by an individual employee is likely to be linked to a systemic breach by organization in training/supervising its agents. Furthermore, ONA submits that a fine of \$50,000 is a very significant cost for an individual to bear and is a sufficient deterrent without increasing the maximum to \$100,000.</p>
s. 1(26)	s. 72(8)	<ul style="list-style-type: none"> <li>The current six-month limitation period to filing complaints under <i>PHIPA</i> is removed.</li> </ul>	<p><b>ONA submits that 2-year limitation period would be more appropriate,</b> as it would be consistent with the limitation period for civil claims and would promote consistency and finality in the administration of justice.</p>

**Schedule B: ONA Submissions on Proposed *Quality Of Care Information Protection Act, 2015***

Current Provision	Proposed Provision	Comments / Issues	ONA's Recommended Amendments
N/a	Preamble	<ul style="list-style-type: none"> <li>• Bill 119 introduces a Preamble where <i>QCIPA 2004</i> had none.</li> <li>• The Preamble reaffirms the principles and widely recognized purpose of <i>QCIPA 2004</i> but also introduces an emphasis on "openness", "transparency" and "the right of patients . . . to access information about their health care" and "inclusion of patients . . . in the process of reviewing a critical incident"</li> <li>• Introduction of these principles regarding disclosure of information to patients has the potential to create further confusion about the application of <i>QCIPA</i> protections and their relationship to patients' rights to their personal health information and information about critical incidents. It is our view that these principles are adequately supported by the <i>Personal Health Information Act, 2004</i> as a whole and the disclosures required by Hospital Boards to patients or their authorized representatives under s. 2(5) of Regulation 965 to the <i>Public Hospitals Act</i> (see Appendix B).</li> </ul>	<p><b>ONA recommends that the Preamble be removed in its entirety.</b></p> <p><b>In the alternative, ONA recommends amending the Preamble as follows:</b> The people of Ontario and their Government:</p> <p>Believe in patient-centred health care;</p> <p>Remain committed to improving the quality of health care provided by health facilities and maintaining the safety of patients;</p> <p>Believe that quality health care and patient safety is best achieved in a manner that supports openness and transparency to patients and their authorized representatives regarding patient health care <b>while at the same time</b> <del>Recognize</del> <b>recognizing</b> that health care providers and other staff in health facilities sometimes need to hold confidential discussions to identify and analyse errors affecting patients, systemic problems and opportunities for quality improvement in patient health care;</p>

Current Provision	Proposed Provision	Comments / Issues	ONA's Recommended Amendments
			<p>Believe that protections are needed to encourage and enable health care providers and other staff of health facilities to share all available information, provide honest assessment and opinions and participate in discussions to improve patient health care without fear of retaliation;</p> <p>Believe that sharing information <b>within the health care system</b> about critical incidents and quality improvement helps to improve the quality of health care for patients; <b>and</b></p> <p>Are committed to ensuring that measures to facilitate the sharing of information for quality improvement purposes <del>do not interfere</del> <b>are consistent</b> with the right of patients and their authorized representatives to access information about their health care or with the obligations of health facilities to disclose such information to patients and their authorized representatives; <del>and</del></p> <p><del>Affirm that the inclusion of patients and their authorized representatives in the process of reviewing a critical incident helps to improve patient care, and therefore quality of care information protection must be implemented in a manner that supports such inclusion.</del></p>

Current Provision	Proposed Provision	Comments / Issues	ONA's Recommended Amendments
N/a	s. 1, "Purpose"	<ul style="list-style-type: none"> <li>• Bill 119 introduces a Purpose provision where <i>QCIPA 2004</i> had none. The proposed Purpose provision is consistent with the recognized purpose of <i>QCIPA 2004</i> and is in our view a welcome addition to the legislation.</li> <li>• A Purpose provision is useful because it provides an interpretive guide for the statute as a whole. As noted above, however, the focus on disclosure of information to patients set out in the Preamble may undermine the stated purpose of the <i>QCIPA 2015</i> to create a protected zone for quality of care discussion, or otherwise lead to uncertainty or inconsistency of application.</li> </ul>	<p><b>In conjunction with removal of the Preamble, ONA recommends retaining the Purpose clause as drafted.</b></p> <p><b>In the alternative, ONA recommends removal of the Preamble and amendment of the Purpose clause as follows:</b></p> <p>The purpose of this Act is to enable confidential discussions in which information relating to errors, systemic problems and opportunities for quality improvement in health care delivery can be shared within authorized health facilities, in order to improve the quality of health care delivered to patients <b>in a manner that is consistent with the right of patients and their authorized representatives to access information about their health care and the obligations of health facilities to disclose such information to patients and their authorized representatives as set out in the <i>Personal Health Information Protection Act</i> and <i>Public Hospitals Act</i>.</b> [Additional wording taken from the Preamble as drafted in Bill 119]</p>

Current Provision	Proposed Provision	Comments / Issues	ONA's Recommended Amendments
N/a	s. 2(1), "critical incident"	<ul style="list-style-type: none"> <li>• Bill 119 introduces a definition of "critical incident" where <i>QCIPA 2004</i> had none. The proposed definition of "critical incident" is consistent with the definition contained in Regulation 965 of the <i>Public Hospitals Act</i>, which requires the hospital board to ensure that the administrator disclose critical incidents to the medical advisory committee, the administrator, and the affected patient (see Appendix B).</li> <li>• In light of the lack of consistency and certainty in application of <i>QCIPA 2004</i>, it is useful to add a definition of "critical incident" to <i>QCIPA</i> that is consistent with Regulation 965 to the <i>Public Hospitals Act</i> (Appendix B).</li> <li>• However, in the absence of clear guidance regarding the threshold for triggering <i>QCIPA</i>, uncertainty and inconsistent application of the <i>QCIPA</i> process will likely continue.</li> </ul>	<p><b>ONA recommends an amendment to clarify that reviews of "critical incidents" should all be conducted under the <i>QCIPA</i> framework or otherwise clarify the circumstances which trigger a <i>QCIPA</i> review.</b></p>
s. 1 "quality of care information"	s. 2(3)3i [Quality of Care Information], "What is not included"	<ul style="list-style-type: none"> <li>• Section 2(3) of the proposed <i>QCIPA 2015</i> creates a series of new exceptions to the definition of "quality of care information". These exceptions are largely consistent with the information hospitals are required to disclose to a patient or their authorized representative following a critical incident under the <i>Public Hospitals Act</i> (see Appendix B).</li> </ul>	<p><b>ONA recommends adding the following definition of "facts":</b></p> <p>"facts documented in the health care record and/or incident report and/or other record relating to an incident involving the provision of health care to an individual"</p>

Current Provision	Proposed Provision	Comments / Issues	ONA's Recommended Amendments
		<ul style="list-style-type: none"> <li>• Information falling within these exceptions would not be protected from disclosure outside of a quality of care committee/investigation. This means that it could be disclosed and admissible in legal proceedings arising from a critical incident.</li> <li>• While in our view it is useful to ensure consistency across related legislation, some of the new exceptions to QCI raise concerns.</li> <li>• This section creates the following exception to the definition of "quality of care information" Information relating to a patient in respect of a critical incident that describes <u>facts of what occurred with respect to the incident</u>.</li> <li>• As noted by the <i>QCIPA</i> Review Committee, "It is important to note that the perception and practice about how the "facts" exception is interpreted can be problematic because the definition of "fact" is open to varying interpretations" (p. 13).</li> <li>• We further note that what constitutes a "fact" with respect to a critical incident is often subject to dispute in investigations, legal proceedings and/or other contexts.</li> <li>• In order to promote consistency and certainty with respect to the application of <i>QCIPA 2015</i>, <b>we therefore recommend defining "facts" for the purpose of this exclusion as indicated in the right-hand column.</b></li> </ul>	

Current Provision	Proposed Provision	Comments / Issues	ONA's Recommended Amendments
	s. 2(3)3ii [Quality of Care Information], "What is not included"	<ul style="list-style-type: none"> <li>This section creates the following exception to the definition of "quality of care information" which is  Information relating to a patient in respect of a critical incident that describes . . . <u>what the quality of care committee or health facility has identified, if anything, as the cause or causes of the incident</u></li> </ul>	<b>ONA recommends removing this provision as it is inconsistent with the disclosures required by Regulation 965 to the <i>Public Hospitals Act</i></b> and could be highly prejudicial to parties named in litigation, thereby creating a chilling effect with respect to frank discussion and analysis of critical incidents. This would undermine the stated purpose of the <i>Act</i> .
	s. 2(3)4 [Quality of Care Information], "What is not included"	<ul style="list-style-type: none"> <li>This section amends the current subsection (f) of the definition of "quality of care information" ("QCI") in s. 1 of <i>QCIPA 2004</i> to include the following exception  <u>Information that a regulation specifies</u> is not quality of care information and that a quality of care committee collects or prepares after the day on which that regulation comes into force.</li> </ul>	<b>ONA recommends adding the following criteria for specifying that information is not QCI:</b> <u>Information that a regulation specifies, in a manner consistent with the purpose of this Act and in the public interest,</u> is not quality of care information and that a quality of care committee collects or prepares after the day on which that regulation comes into force.

Current Provision	Proposed Provision	Comments / Issues	ONA's Recommended Amendments
N/a	s. 15(2)(b) Minister's regulations and s. 6 Restrictions on use of committee	<ul style="list-style-type: none"> <li>• Minister may make regulations "restricting or prohibiting the use of quality of care committees for the purpose of reviewing critical incidents               <ul style="list-style-type: none"> <li>○ No public consultation required and no criteria</li> </ul> </li> <li>• "Where a regulation has been made restricting or prohibiting the use of a quality of care committee for the purpose of reviewing critical incidents, every quality of care committee and health facility shall comply with that regulation.</li> <li>• <b>These sections are very problematic and effectively provide the Minister with unfettered discretion to undermine the stated purpose of QCIPA 2015 and gut its protections for quality of care discussions.</b></li> </ul>	<p><b>ONA recommends removing these sections as they have the potential to undermine the purpose of the Act.</b></p> <p>At minimum, this provision should include criteria to be met by the Minister in restricting or prohibiting the use of Quality of Care Committees for reviewing critical incidents, e.g. "consistent with the purpose of this Act and in the public interest"</p>

## APPENDIX A

### Referenced Provisions of the *Health Professions Procedural Code*

#### Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c 18

##### Reporting by employers, etc.

**85.5 (1) A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges of a member** or who dissolves a partnership, a health profession corporation or association with a member **for reasons of professional misconduct**, incompetence or incapacity shall file with the Registrar within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons. 1993, c. 37, s. 23; 2000, c. 42, Sched., s. 36.

##### Same

**(2) If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct**, incompetence or incapacity **but the person did not do so because the member resigned or voluntarily relinquished his or her privileges**, the person shall file with the Registrar within thirty days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act. 1993, c. 37, s. 23.

##### Application

**(3) This section applies to every person, other than a patient, who employs or offers privileges to a member or associates in partnership or otherwise with a member for the purpose of offering health services.** 1993, c. 37, s. 23.

(emphasis added)

## APPENDIX B

### Referenced Provisions of Regulation 965 to the *Public Hospitals Act*, RSO 1990, c P.40

#### R.R.O. 1990, REGULATION 965

#### HOSPITAL MANAGEMENT

##### INTERPRETATION

1. (1) In this Regulation,

“critical incident” means any unintended event that occurs when a patient receives treatment in the hospital,

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

...

##### BOARD

2. ...

(4) The board shall ensure that the administrator establishes a system for ensuring the disclosure of every critical incident, as soon as is practicable after the critical incident occurs, to the medical advisory committee and the administrator and,

- (a) to the affected patient;
- (b) if the affected patient is incapable, to a person lawfully authorized to make treatment decisions on behalf of the patient; or
- (c) if the affected patient has died,
  - (i) to the patient’s estate trustee, or to the person who has assumed responsibility for the administration of the patient’s estate, if the estate does not have an estate trustee, or
  - (ii) to a person who was lawfully authorized to make treatment decisions on behalf of the patient immediately prior to the patient’s death, or who would have been so authorized if the patient had been incapable. O. Reg. 423/07, s. 2; O. Reg. 156/10, s. 1 (2).

(5) The disclosure referred to in subsection (4) shall include,

- (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.  
O. Reg. 423/07, s. 2.

(5.1) The board shall ensure that the administrator establishes a system for ensuring, following a disclosure of a critical incident under subsection (4), that the incident is analyzed and a plan developed with systemic steps to avoid or reduce the risk of further similar critical incidents. O. Reg. 156/10, s. 1 (3).

(5.2) The board shall ensure that the administrator provides aggregated critical incident data related to critical incidents occurring at the hospital to the hospital's quality committee established under [subsection 3 \(1\)](#) of the [Excellent Care for All Act, 2010](#) at least two times per year. O. Reg. 448/10, s. 1 (2).

(5.3) The aggregated data shall include data about all critical incidents occurring at the hospital since the previous aggregated data was provided to the quality committee. O. Reg. 448/10, s. 1 (2).

**(6) Subject to the [Quality of Care Information Protection Act, 2004](#), the board shall ensure that the administrator establishes a system for ensuring that at an appropriate time following a disclosure of a critical incident under subsection (4), there be a disclosure to the person referred to in clauses (a) to (c) of subsection (4) of the systemic steps, if any, that the hospital is taking or has taken in order to avoid or reduce the risk of further similar critical incidents, and that the content and date of this further disclosure be recorded.** O. Reg. 423/07, s. 2.

(emphasis added)