Canadian Nurses Protective Society

infoLAW®

Reporting & Disclosure of Adverse Events

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It can be difficult for nurses to know how to do the right thing when a patient is unintentionally harmed by the provision of health care services (i.e. an adverse event or critical incident)[1] rather than their underlying medical condition. Both the patient, or their substitute decision maker,[2] and health care administrators need to know what happened when an adverse event occurs. This *infoLAW* addresses common questions nurses have about their involvement in adverse events.

What is the difference between reporting and disclosure?

Reporting occurs when information is transferred from front line health care providers, either involved in the adverse event or its discovery, to health care administrators. In some provinces, further reporting is done by the health institution to a governmental authority for analysis.[3] Reporting allows health care administrators to respond appropriately to the particular incident as well as to take steps to reduce the risk of a similar event in future. Legally, employers are responsible for what happens on their premises, so their employees, and others who are bound by contract to do so, must adhere to the employer's policy on reporting adverse events. When an adverse event is reported, it will trigger some form of investigation and further action. The response to the adverse event should be proportionate to the nature and severity of the adverse event.

Disclosure of adverse events, on the other hand, is a process of providing information to a patient. The extent of disclosure is variable and dependent upon what occurred. A close call or a simple, minor adverse event with no harm or minimal harm may not require communication to a patient. In more complicated or damaging cases, there may be initial disclosure to the patient as well as later communications as more is learned about the event. Some provinces have enacted legislation requiring disclosure of adverse events to patients.[4] Also, the Canadian Patient Safety Institute has published *Canadian Disclosure Guidelines* to assist health institutions or independent practitioners in developing their own policies on disclosure.

Which comes first, reporting or disclosing?

Both are important. Circumstances will dictate the order of events and a nurse's involvement. Nurses may be more involved in reporting adverse events than disclosing directly to patients, apart from what is required as an adverse event unfolds. It is commonplace for nurses to help patients understand what is happening to them and this must continue. However, legislation and health institution policies typically set out a threshold of seriousness for an incident to be called an adverse event, which triggers an administrative investigation and disclosure, up to and including an apology. When the matter is this serious, it is appropriate for health care administrators to complete their investigation and analysis after an initial disclosure. Post-analysis disclosures may contain information as to how future practices and systems will be improved, if this is possible.

The patient and health care administrators need to know what happened after an adverse event occurred.

Who discloses to the patient and what is disclosed?

Because of the many interests at stake, it may be that nursing and/or other health care administrators are involved in disclosure rather than the nurse involved in the adverse event. Disclosure is a delicate process, with many factors contributing to the decision as to who discloses what information to the patient. Ideally, those who disclose should be trained in the disclosure process and have strong interpersonal skills.

As soon as possible after the adverse event, the patient is to be informed of the facts known at the time and consequences to their care and treatment, offered an expression of sympathy and regret, and given an overview of the investigative process that is underway. A record is to be kept of all of this information. If the investigation makes it clear that a health care provider or organization is responsible for the adverse event, it would be appropriate to acknowledge this by apologizing to the patient as part of a post-analysis disclosure.

If the patient receives an apology, will it prevent a lawsuit?

Not necessarily. Nurses may be subject to one or more investigations, up to and including a lawsuit even if there was proper reporting, prompt disclosure, and an appropriate apology. Several provinces have enacted legislation to prevent an apology from being used as evidence of negligence. Statutory patient safety measures, such as apology legislation, vary across Canada, so nurses should ensure they are in possession of current applicable information when involved in an adverse event. Risk management and quality assurance departments are good resources for nurses. The Canadian Nurses Protective Society supports all nurses in their ongoing efforts to ensure patient safety.

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1. Various phrases, such as adverse event or critical incident, are used to denote the unintended harm patients experience as a result of health care delivery. In this document, definitions for adverse event, close call, harm, disclosure and reporting are taken from the Disclosure Working Group, *Canadian Disclosure Guidelines*, Edmonton, AB: Canadian Patient Safety Institute, 2008.
2. The use of the word “patient” in this document encompasses a substitute decision maker if the patient is no longer capable of consenting to his or her own health treatment.
3. For example, under Manitoba’s *The Regional Health Authorities Act*, C.C.S.M. c. R34, ss. 53.1-53.10, there are criteria for reporting critical incidents to regional health authorities (RHAs). Health corporations and prescribed health care organizations (e.g. land and air ambulances, CancerCare Manitoba) are to have a critical incident review committee investigate incidents and notify the RHA of critical incidents. A written report of their investigation must be submitted to the RHA and ultimately to the Minister of Health. None of these reports are available to the patient.
4. Ibid. Patients must be notified when they suffer serious, undesired consequences of health services, such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay.