Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

RNAO response to proposed changes to Regulation 965 under the *Public Hospitals Act, 1990*

Submission to the Ministry of Health and Long-Term Care: Posting 15-HLTC030

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RNAO recommendations to the Ministry of Health and Long-Term Care regarding posting 15-HLTC030: proposed amendments to *Public Hospitals Act* Regulation 965

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP), and nursing students in Ontario. One of RNAO's roles is to advocate for healthy public policy. We welcome this opportunity to provide input to the Ministry of Health and Long-Term Care (MOHLTC) regarding posting 15-HLTC030 under Regulation 965 of the *Public Hospitals Act, 1990.*

RNAO is encouraged by the MOHTLC's efforts to update current legislation/regulation through the *Quality Care Information Protection Act* (QCIPA) Review Committee. Ontarians want and deserve to know the quality of care their hospitals deliver. This must be balanced with appropriate tools that drive the highest standards of care delivery and public safety.

RNAO is supportive of processes that give hospitals the opportunity to review critical incidents so they can improve quality of care.[1] At the same time, it is important that health-care providers speak openly about critical incidents so they learn from past mistakes. RNAO very strongly believes that the need for confidentiality, must be balanced with the need for transparency -- for patients, their families and staff -- all whom have a right to know when errors happened in the course of their hospital stay.

Standardizing the process for reviewing critical incidents

When critical incidents occur, key lessons are learned to prevent similar incidents in the future. Currently, there is no consistent application as to when hospitals invoke QCIPA when reviewing critical incidents. To prevent hospitals from shielding information from patients and families, it is our view that more oversight is required regarding when QCIPA can and should be used. The proposed changes to Regulation 965 should make it clear that, while every critical incident ought to be reviewed by the hospital, not every critical incident can invoke QCIPA. Thus RNAO very strongly favours the proposed amendment to Subsection 2 (6) of the Regulation to strike out "Subject to the Quality of Care Information Protection Act, 2004." Further, RNAO urges for defined parameters that identify the circumstances under which QCIPA may be invoked to ensure that information is not withheld from patients, families or the public in the name of quality improvement.

RNAO supports amendments to Regulation 965 Section 2, which mandate that each hospital board establish a system for ensuring a committee reviews each critical incident in a timely manner. Furthermore, RNAO seeks an amendment that defines the upper limits of "timely," and recommends that it be "no more than four weeks from the beginning of the process to patient and/or family notification of results." RNAO also supports the addition of a patient relations team member on the committee. RNAO believes that the composition of this committee needs to be defined in the regulation. RNAO strongly recommends this committee includes representation from registered nurses, nurse practitioners and other health professionals.

Increased involvement of patients and families in the review process

During the review of critical incidents, it is vital to include, as much as possible, the affected patient and family. RNAO fully supports the proposed amendment under Section 2 of Regulation 965 that indicates that the affected patient or substitute decision-maker be interviewed as part of the review process. In addition to being interviewed, RNAO believes it is critical to keep the patient and family informed about the steps being taken during the review process, as well as the outcomes of the review and what measures will be implemented to prevent such incidents in the future.

Measures to increase transparency and accountability of hospitals in communicating with patients, families and the public

Following a critical incident, it is understandable that patients and families want to know what happened. RNAO is strongly in favour of measures to increase transparency and prevent the unnecessary shielding of information. [2] Thus RNAO supports the proposed addition of a clause to Regulation 965 subsection 2(5) to make it clear that the cause of the critical incident, if known, must be fully disclosed to the patient, their substitute decision-maker, or, in the event of the patient's death, their trustee.

Given that information gained from reviewing critical incidents may help improve the quality of hospital care, and is thus of public value, this information ought to be accessible to the public, while maintaining the confidentiality of persons - both patient, their family and staff -- involved. The proposed amendment to Section 23 of the regulation, indicates that records of reviews of critical incidents shall be provided to the Minister upon request. RNAO believes that, not only should this information be available to the Minister, it ought to be made available more broadly, including other hospitals and members of the public. Although not reflected in the current proposed amendments, RNAO strongly favours the QCIPA committee recommendation to establish a publicly available database with information obtained through the review of critical incidents at Ontario hospitals.[3] RNAO believes that access to quality of care information is essential for a transparent, accountable and always improving health system.

Protection for nurses and other health professionals

As stated above, RNAO is unequivocal in its support for the need for transparency in reviewing critical incidents in hospitals. There is also a need to balance this with an appropriate level of confidentiality for the health professionals involved in critical incidents. It is RNAO's view that, in the absence of appropriate assurance of confidentiality, health professionals may be hesitant to speak openly about the causes of critical incidents, thus hindering the ability to learn from them. In order to combat a culture of blame and move towards a "just culture"[4] and "learning culture," regulation 965 must also include a clause that mandates hospitals to have a policy that enables clinicians to discuss critical incidents without fear of repercussions and ensuring confidentiality during the review of critical incidents, both when QCIPA is invoked and when it is not.

Conclusion

Quality of care in Ontario hospitals is of paramount importance. Regulatory amendments that strengthen the ability to learn from critical incidents are imperative. Access to the quality of care information gleaned from the review of these incidents is essential for a transparent, accountable, and always improving health system. Transparency must be balanced with appropriate confidentiality, both for patients, their families, and health professionals. RNAO believes that the above recommendations advance a balanced and shared vision for Ontarians and their hospital care. Thank you for giving us the opportunity to present our views. We look forward to ongoing collaboration.

Summary of Recommendations:

1. Proceed with the proposed amendment to Subsection 2 (6) of the Regulation to strike out "Subject to the Quality of Care Information Protection Act, 2004."

2. Proceed with the proposed amendments to Section 2 of the Regulation including:
   2.1 - Establishment of a system for ensuring a committee reviews every critical incident
   2.2 - Participation of a hospital staff member with responsibility in patient relations in each review
   2.3 - Interviewing the patient/substitute decision maker as part of the review process

3. Clearly delineate who is to be involved in review committee. Include representation from registered nurses, nurse practitioners and other health professionals.

4. Define in this and/or other relevant legislation/regulation, the circumstances under which QCIPA may be invoked to ensure that information is not unnecessarily shielded from patients, families or the public in the name of quality improvement.

5. Proceed with the proposed amendment to Subsection 2(5) to add the clause specifying that the cause or causes of critical incidents can be disclosed to the affected patient, or their substitute decision-maker.

6. Define the upper limits of "timely" and ensure that it is no more than four weeks from the beginning of the process to patient and/or family notification of results.

7. Strengthen proposed amendment to Section 23 to allow the Minister to request records of reviews of critical incidents by establishing a publicly-available database.

8. Include a clause in regulation that mandates hospitals to have a policy that enables clinicians to discuss critical incidents without fear of repercussions and ensuring confidentiality.

References:

[1] Registered Nurses' Association of Ontario. (2011). *RNAO Bill 173 Submission: Preserve Access to Quality of Health Care Information. Speaking Notes: Standing Committee on Finance and Economic Affairs*. Retrieved from: http://rnao.ca/sites/rnao-ca/files/Bill_173_Speaking_Notes.pdf
[2] Registered Nurses' Association of Ontario. (2011). *RNAO Bill 173 Submission: Preserve Access to Quality of Health Care Information. Speaking Notes: Standing Committee on Finance and Economic Affairs*. Retrieved from: http://rnao.ca/sites/rnao-ca/files/Bill_173_Speaking_Notes.pdf
[3] Quality of Care Information Protection Act (QCIPA) Review Committee. (2014). *QCIPA Review Committee Recommendations*. Retrieved from: http://www.health.gov.on.ca/en/common/legislation/qcipa/docs/qcipa_rcr.pdf
[4] Khatri, N., Brown, G.D., & Hicks, L.L. (2009). From a blame culture to a just culture in health care. *Health Care Manage Rev*, *34*(4), 312-322.