

An examination of patient safety incident disclosure reporting at Island Health

Fiann Crane¹, Bart Johnson¹, Lise Berube¹, Marcia Pilon¹, Leta Martin¹, Kate Scott-Moncrieff²

¹. Patient Safety, Island Health, Victoria BC, Canada, ². Mental Health and Substance Use, Urgent Short Term Assessment and Treatment, Island Health, Victoria BC, Canada

Background

Island Health uses the British Columbia Patient Safety & Learning System (BC PSLs), a web-based tool for healthcare professionals to report and learn from patient safety incidents. Data in BC PSLs can be used to improve patient safety and quality of care in BC. Island Health has recently published a new policy and procedure to guide disclosure of patient safety incidents and is in the early stages of developing a disclosure learning and support strategy. Outcomes of this improvement effort will help inform the strategy and serve as a baseline.

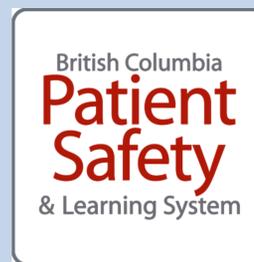
Problem

Island Health has not audited its data on disclosure to know its accuracy, the extent with which disclosure is occurring, or the impediments to reporting disclosure.

Aim

For patient safety incidents that result in serious harm or death:

1. Measure the extent to which disclosure is reported as having occurred
2. Identify the impediments to accurately reporting disclosure in PSLs
3. Use learnings to inform approaches aimed at increasing the accuracy of reporting disclosure of serious harm and death incidents.



Results

- There was alignment between data in PSLs indicating 'Disclosure Occurred?' - Yes' in 3 of 5 patient charts (Table 1)
- Where reporters indicated either 'no' or 'unknown' to 'Disclosure Occurred?' there was no documentation in the patient's chart relating to disclosure (Table 1)
- At Island Health, disclosure is reported to have occurred in 73% of level 4 (serious harm) and 59% of level 5 (death) patient safety incidents (Table 2)
- Provincially, disclosure is reported as occurring in 64.7% of level 4 and 53% of level 5 patient safety incidents (Table 2)

Interview Themes

1. There is an incomplete and inconsistent understanding of what constitutes disclosure i.e., frequently confusing notification with disclosure
2. There are differing approaches to disclosure based on the nature of the incident, the patient's condition and the service or location where care is received
3. Family and/or patients were most commonly identified as the primary targets for disclosure conversations.

Table 1: Alignment between PSLs and patient chart

Response to 'Disclosure occurred' question	PSLS	Documentation of disclosure in patient chart	Alignment %
Yes	5	3	60
No	4	0	100
Unknown	3	0	100
Total	12	3	

Table 2: Patient safety incidents where disclosure occurred, Island Health & Provincially (Nov. 30, 2015-Dec 1, 2018)

	Level 4 Serious Harm			Level 5 Death		
	Disclosure occurred	Total events	Disclosure %	Disclosure occurred	Total events	Disclosure %
Island Health	212	289	73.4%	72	122	59%
British Columbia	1442	2229	64.7%	450	847	53%

From: Patient Safety Learning System mandatory field with response options

Datix Help: Disclosure occurred?

Disclosure involves informing the patient (and /or family) about the event and providing appropriate, ongoing support and information. Refer to your Health Authority's policy on disclosure for more information.

'Disclosure occurred' means "a patient or family is notified of an incident. [It's] confessing to what happened if you were wrong, then letting someone know that a mistake occurred."
PSLS Handler

Discussion

- Island Health reports higher rates of disclosure than the Provincial average
- Although clinicians reported the patient chart was a reliable source of information on disclosure, our chart audit suggests only 60% alignment with reporting 'disclosure occurred' in the PSLs
- There is little published literature on the drivers and impediments to reporting disclosure of patient safety incidents to organizations.
- We learned that there is a poor understanding of what constitutes disclosure. This strongly agrees with what is found in the literature regarding clinicians lack knowledge regarding how and what to disclose about a patient safety incident

Methods

1. Review the literature for the most common reasons for disclosing or not disclosing patient safety incidents to patients and/or family, peers and the organization
2. Determine the proportion of patient safety incidents reported in the PSLs system as disclosed to patients and/or families
3. Compare Island Health with Provincial data
4. Complete a test of reliability on disclosure data in PSLs by conducting 12 chart audits to check for alignment between PSLs data and documentation in the patient's paper and/or electronic chart
5. Interview 10 end-users of PSLs about their understanding of the PSLs disclosure question

Future Direction

Outcomes will:

- Inform a disclosure learning and support strategy
- Form a baseline against which we can evaluate disclosure reporting improvement interventions