



TAHOE FOREST HEALTH SYSTEM

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Department: Governance - AGOV
Applies To: System

Disclosure of Error or Unanticipated Outcome to Patients/Families, AGOV-1503

PURPOSE:

- A. This policy and procedure provides guidance and direction regarding communication of outcomes of treatment, including unanticipated outcomes.
1. To address the issue of the disclosure of unexpected outcomes to patients/families.
 2. To create a standardized mechanism for identifying, reporting, investigating, trending and resolving unexpected outcomes.
 3. To honor the dignity of our patient and ensure patient safety, our patients will be provided meaningful information regarding the status of their condition and care, including, but not limited to, unanticipated outcomes of treatment.

POLICY:

It is Tahoe Forest Health System's policy to support the rights of patients to be active participants in decisions about their healthcare. Patients will be provided with sufficient information necessary to make an informed decision about treatment. In addition, patients and/or family will be informed about the outcomes of treatment, including outcomes of treatment that differ significantly from anticipated outcomes or known errors. Tahoe Forest Health System will promptly communicate an unanticipated outcome as defined below to the patient and/or the patient's family.

PROCEDURE:

A. Reporting

The individual identifying the unintended event / unanticipated outcome will:

1. Take the necessary immediate action to mitigate harm to the patient that may result from the unanticipated event.
 2. Immediately notify the patient's treating Physician, the Nurse Manager/Department Director/ Supervisor, and the Risk Manager or Director of Quality & Regulations.
 3. Complete an Event Report in accordance with the Health System's safety risk management reporting system (see Event Reporting, AQPI-06).
- B. It is the responsibility of every employee to immediately report a known error or unanticipated outcome to their immediate Supervisor and to the Risk Manager or Director of Quality & Regulations. An involved member or the Medical staff can report the event directly to the Director of Quality and Regulations, the

Risk Manager or via the confidential Physicians' Performance Improvement line, extension 3269. An investigation of the facts surrounding the unanticipated outcome will be conducted in a non-punitive manner. The principles of the Just Culture Model will be incorporated to evaluate events (See A Culture of Safety, AGOV-01).

- C. Any investigation of an unanticipated outcome will be conducted in accordance with the Health System's safety risk management reporting system policy Event Reporting, AQPI-06. All reports of unexpected outcomes will be documented and evaluated for further action, including disclosure of the outcome to the patient and/or the patient's representative as appropriate.

D. Disclosure

1. If a known error or unanticipated outcome has occurred, disclosure is necessary.
2. Disclosure of the event should occur as soon as is practical after being recognized and when the patient is ready physically and psychologically to receive the information. The Chief Nursing Officer, Nurse Manager/Department Director, Risk Manager, and the treating physician will determine the most appropriate time and manner for disclosure. Every reasonable effort should be made to notify the patient, and/or the patient's representative, no later than 24 hours after the event is discovered. If it is not possible to communicate with the patient, the initial communications should begin with those members of the family or health-care proxy who will be representing the patient in further discussions.
3. Utilize the TFHD Disclosure Checklist (attachment A) in preparation for the meeting with the patient or family.
4. Language barriers:
 - a. For non English speaking or those requiring sign language for the deaf TFHD will always use an interpreter according to our policy Interpreter/Translator Services, DPTREG-28 .
 - b. The family will be permitted to have their own interpreter present for the disclosure conversation however, all parties will be instructed that the interpreter according to policy Interpreter Translator Services, DPTREG-28 will be the official translation for the medical record.
5. The Chief Nursing Officer, Nurse Manager/Department Director, Risk Manager, and treating physician or their designees may participate as appropriate, in the disclosure process. The disclosure conference will not be made alone by either Medical Staff or hospital staff. Hospital and the insurance attorney or legal representative will not routinely participate in the disclosure conference. If an attorney or legal representative for the hospital or treating physician is present the family must be notified of their participation and allowed to have legal representation themselves.
6. The treating physician has ultimate responsibility for disclosure of unanticipated outcomes resulting from his/her care, and the treating physician should be encouraged to accept this responsibility. The hospital leadership should provide necessary support to enable the treating physician to perform this responsibility.
7. If there is an unanticipated outcome associated with non-physician staff, the responsibility to make the disclosure will rest on hospital leadership, and the treating physician will be made aware of the planned disclosure prior to its occurring. The treating physician will be permitted to attend the disclosure conference at their discretion.
8. The patient and/or patient's representative may choose a reasonable party to attend the disclosure conference. It should be confirmed if any party is an attorney.
9. If there is a *perceived* unanticipated outcome associated with a physician or the Medical Staff, the

Risk Manager will immediately notify the affected treating physician, the Chief of Staff, and the Physician's Department Chair

10. The Director of Quality and Regulations and/or the Risk Manager will conduct an investigation under policies Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35 and Root Cause Analysis, AGOV-46. The results of the investigation will be reported to the Medical Staff Quality Committee and thereafter to the Quality Committee of the Board of Directors as appropriate.

E. Disclosure will include:

1. A clear explanation of the known error or unanticipated outcome to the patient and/or patient's representative, when appropriate. Disclosure will be limited to a factual explanation of the circumstances, and an explanation of the impact of the unanticipated outcome and/or error on the patient's treatment, the prognosis, and steps taken to mitigate the harm.
2. A clear statement indicating that a review will take place to learn as much as possible about the unanticipated outcome and/or error in order to prevent similar unintended outcomes in the future.
3. Information regarding resources available to support and comfort the patient and/or family, including, offering Patient Advocate assistance.
4. Expressions of empathy to include, as appropriate, an expression of sympathy for the patient's inconvenience, distress, discomfort or that TFHD did not meet the patients service or quality expectations.
5. An apology as appropriate for the circumstances.

F. Disclosure shall not include:

1. Acceptance of liability, placement of fault, statements of causation, or other statements that may be inappropriate given the status of the investigation.

G. Documentation

1. Documentation of disclosure of unanticipated outcomes shall be made in the medical record by the treating physician, Risk Manager, or other appropriate individual participating in the disclosure. The documentation of the disclosure should include:
 - a. The health care professional, physician or representative from Quality, who informed the patient, shall document in the medical record that the discussion took place with the patient or with the patient's representative (by name and relationship) with the date, time and signature.
 - b. The identity of any interpreter whose services may have been used.
 - c. Any follow-up discussions with the patient, family member or surrogate should be similarly noted, including an estimation of when patient or family will be met with again.
 - d. All hospital and medical staff representatives participating in the disclosure will meet ahead of time to go over the facts as they are known at the time and agree on an approach for the disclosure. Refer to the Disclosure Checklist (attachment A).

SPECIAL INSTRUCTIONS/DEFINITIONS:

- A. *Unanticipated Outcome* – A condition (unexpected or unintended) or a result that differs significantly from the anticipated result of a treatment or procedure **and** results in harm to the patient. Harm includes, but is not limited to, death, permanent disability, temporary disability, the need for transfer to a higher level of care, the prolongation of hospitalization, or the need for additional diagnostic studies or therapeutic interventions.

- B. *Disclosure* – communication, to patient or patient's designated representative, of information regarding the unanticipated results of a diagnostic procedure, medical treatment, nursing/hospital care, or surgical intervention.

REPORTING OF THE EVENT

A. Internal Reporting

California State law requires that a process be in place for reporting and tracking events. (See Event Reporting (Quantros), AQPI-06 and Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35.

B. Reporting to Outside Agencies:

Refer to administrative policy Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35. The Director of Quality and Regulations is the only District employee authorized to make event reports to outside agencies. An Adverse Event reported to California Department of Public Health (CDPH) will also be reported to the accrediting agency, Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association.

Related Policies/Forms:

[A Culture of Safety, AGOV-01](#)

[Event Reporting \(Quantros\), AQPI-06](#)

[Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35](#)

[Root Cause Analysis, AGOV-46](#)

[Interpreter Translator Services, DPTREG-28](#)

References:

[Cal Evid Code §1157](#)

All revision dates:

12/2017, 01/2016, 09/2015, 11/2013, 10/2013, 03/2010, 03/2009

Attachments:

[TFHD Disclosure Checklist \(Attach A\).docx](#)

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	12/2017
	Sarah Jackson: Executive Assistant	12/2017