Administrative Policy Manual

Section:	Quality	**Number:**	XIX - 10
Title:	Consumer Feedback	**Date:** (O)	1997-10-01
Issuing Authority:	V.P. - Corporate Affairs	**Page:**	1 of 7

Position Statement

The Health Care Corporation of St. John's believes that consumer feedback to health care personnel, programs and services is very important. We encourage our consumers to share their compliments, concerns and complaints with us. This feedback process helps ensure that the Health Care Corporation is assisting individuals and families to achieve the highest level of health care possible. The consumer feedback process will help identify areas of strength as well as improvement opportunities and initiatives that can be implemented.

It is recognized that individual consumers may be more inclined to compliment or complain than others. Some areas of the organization are more prone to receive compliments/complaints based on the nature of service/care provided. In consultation with Program staff a variety of mechanisms and initiatives will be developed to encourage consumers to provide feedback.

Policy:

Compliments

The Health Care Corporation believes that positive consumer feedback toward health care personnel, programs and/or services is very important and should be shared throughout the area and/or Health Care Corporation.

Procedure:

1. Directors/Managers will share feedback with staff as received. Staff may choose to disclose this feedback to co-workers or keep the feedback private.

2. The method of sharing complimentary information is to be determined by the program/area manager. Possible methods of doing so would be electronic messaging, newsletter or internal memo.

3. If a compliment is received at Corporate Office, or if a compliment received by one department also compliments another department, the compliment should be copied and distributed to the areas concerned.

4. All Program/Departments should report on the number and type of compliments received to their Program Quality Initiatives Committee (Internal Advisory Committee) on a quarterly basis.

Policy:

Complaints/Improvement Opportunities

The Health Care Corporation encourages people who use our services to express concerns and complaints to staff with whom they come in contact. It is expected that all complaints from patients, families, visitors, physicians, employees, volunteers, or vendors will be responded to within 48 hours and dealt with as expediently as possible. All serious complaints will be reported and treated through the occurrence reporting process.

Definitions:

Serious Complaint

Serious complaint is a complaint that has resulted from, or identifies the potential for an occurrence and has implications for external involvement, (i.e. Police, Minister's Office, media, legal) or demands major corrective action within the Program/ Department. It is perceived to have significant risk to patient, staff, property, finance or reputation.

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Minor Complaint

Minor complaint is a complaint that can be resolved at a staff or division level. Perceived risk to patient, staff, property, finances or reputation is minimal.

Guidelines:

1. All serious complaints will be documented on an Occurrence Report Form and forwarded to the appropriate Director for investigation and follow-up. Contact should be made in person or by phone as mail system may delay communication of the complaint by several days.

2. When receiving a complaint, the following information will be ascertained, if possible, and documented on the occurrence report form:

   - the general nature of the complaint
   - names of other parties involved
   - the outcome the complainant expects
   - the anticipated action the complainant may take if issue is not dealt with to his/her satisfaction

   Inform the complainant of an expected time frame for response and who will respond.

3. If the complaint involves allegations of physical or verbal abuse, refer to Administrative policy *on Harrassment in the Workplace (Respectful Workplace).*

4. Any person taking an anonymous complaint should:

   - ascertain the credibility of the complainant
   - obtain sufficient information to enable follow-up
   - advise the complainant of any limitation to the investigation or action that can be taken

5. The annual report of each Program/Department to the Corporate Quality Initiatives Committee will include the number and type of complaints, the resolution and the trends. The Quality Initiatives Department will prepare a quarterly/annual summary of serious complaints.

Procedure:

Minor Complaint

1. Minor complaints, either verbal or written, will be resolved at the staff level if possible. If the staff member is unable to resolve the complaint, it will be immediately reported to the manager. The clinical manager on-call may be notified after hours at the discretion of the staff member.

2. Staff who received the complaint will report the issue and resulting outcome to their appropriate Division Manager/Division Clinical Chief/Department Manager.

3. Division/Department Managers may track minor complaints as part of their quality monitoring activities.

Serious Complaint

1. Serious complaints will be directed to the Division/Department Manager/Division Clinical Chief as appropriate. Clinical manager on-call may be notified after hours at the discretion of the staff member.

2. A preliminary investigation will be conducted by the Manager. Guideline 3 above will supersede this in cases of alleged abuse

3. In conjunction with the Program/Department Director/Clinical Chief, the manager will make every effort to resolve the complaint.

4. Program/Department Director/Clinical Chief will notify the appropriate Vice President and other Programs/Departments as deemed appropriate.

5. If the complaint involves another Program/Department, the appropriate Director will be involved in the complaint investigation.

6. All serious complaints will be documented and followed up in accordance with the Administrative policy on *Occurrence Reporting.*

7. Ordinarily, response to the complainant will be made by the person handling the complaint. This will involve speaking with the complainant within a reasonable time frame, usually within 24 to 48 hours. If there is undue delay in our ability to respond to the complaint specifically, the complainant should be advised of this and provided with an expected time frame for response. The outcome will be document on the Occurrence Follow-up form.

8. Depending on the circumstances, a written response may be given to the complainant by the appropriate Director/Chief in consultation the Corporate Risk Manager and Vice President.

9. Consultation with the Health Care Corporation insurer and/or legal counsel will be coordinated with the Risk Manager.

Communication Guidelines When Responding To Consumer Feedback

When dealing with a consumer or family member who has a concern about health care received, it is important to keep the following in mind:

1. Be a good listener. Patients or family members who are upset need to feel that their concerns are being taken seriously. Few things are more important to people than their own health or the health of loved ones. Sometimes all people want is to vent their frustration at a particular time; they may not even want follow-up action. Although it is natural for a staff person to want to defend his or her colleagues or organization, this usually does not help. In most cases, it serves to further upset an already distraught person.

2. Focus on resolutions, not problems. You will help reassure a consumer or family member if you present possible solutions instead of focusing on what has gone wrong.

3. Ask the person for details so you will be able to follow-up on their concern thoroughly. You will need names of patients, staff, physician, site, unit, time, incident and anything else that will allow you to investigate an issue in short time.

4. Be clear to consumers and others about the complaint processes in place. Let them know who will investigate the concern, and who they should then contact if they are not happy with the outcome.

5. Let people know that you will get back to them on an agreed upon time, and make sure you call back before or by that time. Even if you don't have all the answers at that time, it is still important to make the call. This way the individual is reassured that you and other appropriate staff are working on the concern (i.e. you have contacted the Division Manager who is now consulting with staff in the unit).

6. As difficult as it may be, try not to take the complaint personally. Sometimes you will be a target for a person's distress because you are seen as representing the organization which caused the problem.

Policy:

Solicited Consumer Feedback

Requests for consumer feedback is an integral part of the Health Care Corporation's Quality Initiatives Program. This feedback may take the form of consumer surveys, structured or unstructured interviews, in person or mail out of written questionnaires, telephone surveys or focus group sessions.

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Procedure:

1. All consumer feedback surveys used by a Program/Department should be approved by that Program/Department Quality Initiatives Committee (Internal Advisory Committee).

2. Assistance in the development of appropriate requests for feedback can be obtained from the Quality Initiatives Department or Corporate Consumer Feedback Committee.

3. Information compiled through these feedback activities must be forwarded to the Program manager and the Program/Department Quality Initiatives Committee (Internal Advisory Committee).

Administrative Policy Manual

Section:	Quality	**Number:**	XIX - 11
Title:	Critical Occurrence/Incident Review	**Date: (O)**	1999-09-30
		(Revised)	2002-06-20
Issuing Authority:	V.P. – Quality and Planning	**Page:**	1 of 4

Pamela Elliott

Policy:

A critical occurrence/incident review is any situation that, because of its nature, may be a significant risk to the clients, staff, reputation or finances of the Health Care Corporation of St. John's. Outcomes that may result are:

- interruption in normal departmental/clinical activity
- extensive news coverage
- extensive public scrutiny
- adverse effect on normal operations
- extension of the normal capacity of the organization to respond
- legal or financial liability

The following critical occurrences/incidents which may result in the above noted outcomes will be investigated following this process:

- missing patient
- suicide/suicide attempt
- significant patient injury
- unexpected patient death
- criminal activity
- employee dishonesty (e.g. theft)
- breach of confidentiality
- assault/abuse
- employee dismissal

Certain critical occurrences/incidents that are specific to Programs/Departments should be identified by the leadership team and communicated throughout the Program/Department. Investigation of these critical occurrences/incidents should also follow this procedure. All occurrences are to be documented using the Health Care Corporation of St. John's Occurrence Report form.

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Procedure:

1. The person who first becomes aware of a critical occurrence should notify the Division Manager who will notify the Program/Corporate Director. After hours, the Site Clinical Coordinator is to be notified, and will in turn notify the appropriate Program/Corporate Director and Vice President on-call.

2. The Program/Corporate Director or Clinical Leadership Team will meet with the Risk Manager or Quality Initiatives representative to determine the process for investigation of the occurrence. Normally, the Program/Corporate Director will initiate and coordinate the investigation, and chair all team meetings.

3. The Program/Corporate Director will notify the following individuals as appropriate, and ensure immediate activities have been initiated:

Member	Immediate Activity
Program/Corporate Director and QI	Meet to determine who will chair investigative team and designates who liaises with family
Manager	Liaises with staff Identifies need for Critical Incident Stress Debriefing (access through EFAP Coordinator)
V.P.	Communicates to CEO, Corporate Team and Board; communicates to Health and Community Services/ Government
Clinical Chief	Liaises with Medical Staff
Corporate Communications	Develops strategic message for stakeholders and media
Quality Initiatives (Risk Manager)	Notifies insurer; secures and reviews chart and related documents and equipment. If student is involved notifies appropriate school.

Member	Immediate Activity
Human Resources Policy and Employee Relations	As required – may be needed to investigate issue if potential employee discipline, or occupational health and safety violation
Professional Practice Coordinator	Identify standards of care and/or professional practice related to situation, identifies violations as applicable
Representatives of other affected departments/ clinical areas/educational facility	As required

Note: If any of the Leadership Team members are involved in the Critical Occurrence, the Vice President will designate alternates to investigate.

4. A face to face meeting of all team members will be held by the next working day. At this meeting, the following will be determined:

   - clarification of team members' roles
   - other members to be involved
   - expected activities of investigating team
   - determination of meeting schedule

5. The full team should meet at least once during the process, to discuss progress and to close the investigation.

6. A decision to conduct a review of the incident (as per the Care Service Review Guidelines) will be made by the team.

Documentation

1. The Program/Corporate Director is responsible for documenting the activities of the team.

2. At the end of the investigation, all notes should be collected and secured in one file. The person to hold the file will be determined by the team.

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Reporting

1. The activities of the investigation will be reported to the Program/Corporate Department Leaders, who in turn will report to the Corporate Quality Initiatives and Board Quality Initiatives Committees. The report should include a synopsis of the event, analysis to identify root cause, and an action plan.

Section:	Quality	**Number:**	XIX - 15
Title:	Occurrence Reporting	**Date:** (O)	1997-10-22
Issuing Authority:	V.P. - Corporate Affairs	**Page:**	1 of 6

Policy:

Occurrence involving patients, visitors, others and property of the Health Care Corporation of St. John's must be investigated and reported using the Corporate Occurrence Report form.

The Occurrence Reporting process is a component of the Health Care Corporation's Quality Plan in ensuring the ongoing monitoring, evaluation and improvement of the quality of care and service.

Definitions:

Occurrence

Any event, accident, error or circumstance which is not in keeping with expected process or outcome of care or service. Occurrences may result in an injury to an individual, damage or loss of equipment or property.

Staff related occurrences arising from a work related injury or potential injury will be recorded on the Staff Incident/Occurrence form. Professional Practice related issues will be noted on the Professional Practice Issues Occurrence form.

Outcome

The result of a particular event.

Clinical Outcome

The assessment and treatment the patient may need arising from an occurrence:

- **non apparent** - no problem and no assessment required
- **assessment/no intervention** - patient is assessed by a physician and no testing or treatment is required
- **assessment/minor intervention** - patient is assessed, diagnostic testing is done, minor treatment is administered (bandage) e.g. bruise, skin tear, first degree burn
- **assessment/major intervention** - patient assess, diagnostic testing and major intervention required, e.g. surgery, fracture, major laceration requiring suturing, third degree burn, extended stay, admission to hospital
- **death** - if death follow Administrative policy on *Reportable Death* policy, and *The Fatalities Act*

Non-clinical Outcome

Refers to the results in a non-patient care related occurrence. Example of non-clinical outcome could be:

- police involved (take badge number)
- complaint resolved
- legal action commenced
- property

Loss Control

Refers to the preservation or securing of information, evidence and documentation in order to assist in the investigation of an occurrence. Also it will assist in the event of a medical/legal situation arising from the occurrence.

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Procedure:

Responsibilities

Occurrence Report forms are available through Stores at each site.

All Staff

Any staff members that observes/discovers the occurrence, after providing immediate attention to the situation, shall:

1. Initiate an Occurrence Report at the time of the occurrence according to the guidelines which include:

   a) entering applicable demographic information or, if a patient addressograph, at top of form;

   b) entering date, time, location, Program/Division/ Department and site;

   c) indicating the event(s) that best describe the occurrence, or filling in the blank after "other" as necessary;

   d) completing all applicable areas on the report, checking more than one box, as necessary;

   e) recording only factual information about the occurrence in Section 6 - Brief Statements of Fact; do not express personal opinion, find fault or lay blame.

2. Document facts of patient's condition on health record where applicable. Do not place Occurrence Report or reference Occurrence Report on health record.

3. Notify in-charge person, manager, attending physician or Clinical Chief as appropriate as soon as possible.

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4. Initiate "loss control" if occurrence is a result of equipment, object, medication, etc. This will include securing equipment, device or other pertinent evidence so that it is not repaired or put back in service before the necessary investigation is completed.

5. Participate in follow-up of occurrence with manager.

6. Forward the completed form to the Program/Department Director/Clinical Chief for further action.

Program/Department Management

1. Review the occurrence; initiate an investigation and follow-up process. Assistance of the staff most involved with the occurrence will be required.

2. Discuss all occurrences resulting in actual or potential patient injury or that have implication for significant complaint with the patient or family. Open communication and ongoing discussion with patient and family is expected.

3. Forward completed occurrence form, within 48 hours, to staff in Quality Initiatives linked with your Program/Department.

4. Report significant occurrences immediately to the applicable Vice President or Vice President on-call and to Risk Manager by next working day.

5. Notify appropriate Program/Department Director if occurrences relate to other Programs/Departments.

6. Follow-up is required for all significant complaints or occurrences that result in patient injury and when the occurrence involves other Programs/Departments. When follow-up is completed prepare "Occurrence Follow-up form" and forward copy to appropriate Quality Initiatives staff member, or if appropriate, to your applicable Vice President.

Quality Initiatives Department

1. Monitor, trend and provide summary reports on occurrences to the Program/Department Leadership on a quarterly basis and upon request.

2. Retain all original occurrence reports and copies of related follow-up forms.

3. Assist Programs/Departments, upon request, with the investigation and "loss control" activities of significant occurrences.

4. Assist Programs/Departments in identifying, controlling or preventing their risk issues.

5. The Risk Manager liaises with insurer and/or legal counsel as appropriate.

Loss Control

1. When there is an occurrence or someone is injured, the first responsibility is to the injured person or to ensure the area is safe in the case of a property issue.

2. When the immediate issue is handled, staff should consider controlling the potential for loss. Loss control is the responsibility of all staff.

3. The person most immediate to the occurrence will commence initial "loss control". The manager, in consultation with the Risk Manager/Quality Facilitator, will follow-up on the initial activities.

4. Loss control activities:

    a) If the occurrence involves equipment, arrange for the object to be secured in order to prevent it from being repaired or put back in service before the investigation/ assessment is completed. Equipment should be assessed

and determined to be safe for use before being reinstated for use (consultation with the Facilities Manager/ Biomedical Engineer and Risk Manager is recommended).

b) If disposable items are being used, retain the item until the investigation is completed.

c) Secure and physically lock up any records (including notes, test results, monitoring strips, X-rays or other diagnostic films). This ensure that the records are not lost or altered. Coordinate with Program Leadership, Risk Manager and Health Records.

d) Secure applicable policies and procedures.

e) Needs of the various individuals should be anticipated and may include:

- emotional support to the patient/family (Pastoral Care, Bereavement support, etc. Employee and Family Assistance Program is available to employees and medical staff. "Response to Stress" assistance is arranged through Employee and Family Assistance Program
- providing opportunity for patient/family to review chart
- providing a copy of the chart to the physician for Canadian Medical Protective Association

Reference: Peer Review Policy and Reportable Death Policy

Administrative Policy Manual

Section:	Legal/Ethics	**Number:**	VI - 41
Title:	Guidelines on Disclosure of Adverse Events	**Date:**	2004-09-09
Issuing Authority:	V. P. - Medical Services	**Page:**	1 of 3

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Policy:

The Health Care Corporation of St. John's is committed to candid and timely disclosure to patients and substitute decision-makers of adverse events, particularly those that may cause risk to a patient.

An Adverse Event is defined as:

1. An unexpected and undesired incident directly associated with the care or services provided to the patient; and/or

2. An incident that occurs during the process of providing health care and results in patient injury or death; and/or

3. An adverse outcome for a patient, including an injury or complication.
(Patient Safety Dictionary, 2003, p. 39)

All physicians, nurses, allied health professionals, students and support staff of the Health Care Corporation of St. John's are expected to be prompt and diligent in responding appropriately upon discovery of an adverse event.

Procedure:

1. Provide prompt attention to the situation to eliminate or reduce immediate and potential risks.

2. Initiate an Occurrence Report (Administrative Policy XIX-15).

3. Notify appropriate manager(s) who will seek assistance from those who might assist with reporting and follow-up on the error or event (e.g. Management of Program /Department or Quality and Systems Improvement Department).

4. A student must inform his/her clinical and academic supervisor immediately upon becoming aware of an adverse event.

Preparation for Disclosure

5. (a) The practitioner and/or the clinical team, in conjunction with the Program Leadership Team and/or Executive Management, will determine the most appropriate person(s) to disclose information to the patient or substitute decision-maker. This would be determined by considering if the event pertained to treatment procedure, medication, equipment, personnel, environment or other factors.

(b) Consideration should be given to having at least one other person from the Program or Department attend the meeting, as well as a representative of the Quality and Systems Improvement Department, to disclose the information pertaining to the event.

Disclosure

6. Arrangements should be made as soon as possible to meet with the patient or substitute decision maker to disclose what is known about the event.

7. The person making the disclosure should be aware of the following:

(a) Concentrate on what happened and the possible consequences. Avoid too much detail and technical language.

(b) Remain factual. Refrain from providing opinions on the care and/or service of others.

(c) Take the lead in disclosure; don't wait for the patient to ask. Invite questions now and later.

(d) Outline a plan of care to rectify the harm and prevent recurrence for this patient and others.

(e) Offer to obtain second opinions where appropriate.

(f) Offer the option of a family meeting.

(g) Document the discussion in the patient's health record.

(h) Determine the need for follow-up meeting and who should attend.

(i) Be prepared for strong emotions and offer personal support and support from others.

(j) Accept responsibility for outcomes, but avoid attributions of blame.

(k) Apologies are appropriate.

Documentation of Disclosure

8. Documentation of disclosure ***must*** be placed in patient's health record.

9. If the patient and/or substitute decision maker refuses to participate in a disclosure discussion, this refusal must be documented in the patient's health record. The opportunity to discuss the event at a later time should be communicated.

Other Related Policies, Professional Codes Of Ethics, And Legislation:

- Administrative Policy VI-10 on Consents.
- Administrative Policy VI-40 on Guidelines for Disclosure of Difficult News.
- Administrative Policy XIX-15 on Occurrence Reporting.
- Codes of Ethics: Ethics Codes, Standards, and Guidelines for Professionals Working in a Health Care Setting in Canada. Toronto. Hospital for Sick Children, Bioethics Department, 1992.
- Access to Information and Protection of Privacy Act, 2002, Government of Newfoundland and Labrador.