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Ensuring Patient Safety

A closer look at the Quality of Care Information Protection Act (QCIPA)

Louise Shap

In the last few years, the release of a number of landmark reports including the Baker Norton Report "Patient Safety and Healthcare Error in the Canadian Healthcare System" and the CIHI/CIHR study "Improving the Quality of Healthcare in Canadian Hospitals" has triggered wide spread awareness and discussion about the need to improve patient safety.

In 2002, the National Steering Committee on Patient Safety issued a comprehensive report, "Building a Safer System: A National Strategy for Improving Patient Safety in Canadian Healthcare", that recommended a national strategy to reduce the incidence of adverse events in Canada.

In 2003, the First Minister's Accord on Healthcare Renewal outlined broad commitments related to patient safety and undertook to take a leadership role in implementing the recommendations of the National Steering Committee on Patient Safety. In addition, the federal budget announced the provision of $10 million annually in response to the National Steering Committee on Patient Safety report, and the creation of the Canadian Patient Safety Institute.

In March 2004, the Ontario Hospital Association and the Ministry of Health and Long-term Care announced Canada's first Patient Safety Support Service to provide hospitals with assistance to improve patient safety practices.

Consistent with the growing awareness of patient safety and healthcare errors, there has been a significant shift away from a culture of punishment and blame toward creating an environment that supports identification and reporting of near misses and adverse events. Recognizing that human error is inevitable, and that systemic factors contribute to most near misses and adverse events, hospitals are implementing strategies to help predict and prevent such occurrences by fostering reporting for the purpose of prevention and improve-

ment in the provision of care.

Creating a safe and secure environment where candid discussion of a near miss or adverse event can take place requires that the individuals participating in the discussion trust that the information being disclosed will be kept confidential, and that they will not be penalized for participating in the review process. The Quality of Care Information Protection Act, 2004, (QCIPA) has been drafted to facilitate open and honest communication by protecting information prepared by or for a quality of care committee from disclosure in legal and other types of proceedings.

What is the purpose of the QCIPA?

QCIPA was enacted as Schedule B to the Health Information Protection Act, 2004 and it came into force on November 1, 2004. QCIPA applies to quality of care information collected by or for a quality of care committee, and sets out the how quality of care information must be collected, protected and disclosed.

The purpose of QCIPA is to improve patient safety and quality of care by encouraging hospital staff and physicians to share information about a potentially unsafe act without being concerned that the information that they provide will be used against them or their colleagues in any disciplinary actions.

Unless the regulations state otherwise, QCIPA generally prevails over other Ontario legislation including the Personal Health Information Protection Act, 2004 ("PHIPA"). Under the QCIPA general regulation, only the Independent Health Facilities Act, 1990 prevails.

What is a quality of care committee?

A quality of care committee is a committee specifically designated as such by a health facility. Health facilities are defined to include: hospitals, independent health facilities, psychiatric facilities and institutions governed by the Mental Health Act, 1990 long-term care facilities, licensed medical laboratories and the Ontario Medical Association, in respect of its quality assurance activities with licensed medical laboratories and specimen collection centres.

The function of a quality of care committee is to:

> Carry on activities for the purpose of studying, assessing or evaluating the provision of healthcare with a view to improving or maintaining the quality of the healthcare or the level of skill, knowledge, and competence of the persons who provide the healthcare.

A quality of care committee must be formally designated in writing as such for the purposes of QCIPA, and the terms

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of reference of the committee must be available to the public on request. If reviews are conducted by individuals or groups that have not been designated as a quality of care committee, or by individuals or groups that are performing acts that have not been delegated by a quality of care committee, these reviews will not be protected under the QCIPA. Similarly, reviews carried out by a properly designated quality of care committee that are not conducted for the purpose of improving or maintaining quality of care, will not be protected under the QCIPA. These reviews may only be protected by the traditional types of privilege such as solicitor client privilege, litigation privilege or privilege under the common law. If a health facility wishes to avail itself of the protections provided by the QCIPA, it must ensure that its programs are set up and maintained in accordance with the QCIPA.

In addition to ensuring that a quality of care committee has been properly designated, hospital administrators will want to consider how to structure the committee so that the protections afforded by QCIPA can best be applied. For example, whether a multifunctional committee should be designated as the quality of care committee or whether there should be more than one quality of care committee with the ability to delegate certain responsibilities to another individual or committee for the specific purpose of the quality of care review, are questions that each institution will have to address.

What is quality of care information?

The definition of quality of care information is tied to its relationship to a quality of care committee.

QCIPA defines quality of care information as:

- information collected by or prepared for a quality of care committee for the sole or primary purpose of assisting the committee in carrying out its functions; or
- information that relates solely or primarily to any activity that a quality of care committee carries on as part of its functions.

Quality of care information is not:

- information contained in a patient's chart (maintained for the purpose of providing healthcare);
- information found in a record that was generated as a requirement of law; or
- factual information contained in an incident report regarding the provision of healthcare to a patient (unless the facts are fully recorded in the patient's health record).

As noted above, quality of care information does not include information about the patient recorded in the patient's chart. Quality of care information further excludes factual information about the patient's care obtained during a review that is not noted in the patient's record, as well as new facts learned during the course of the review. Since factual information is not quality of care information, isolating and incorporating the factual elements of an incident report into a patient's health record, may protect the quality of care information contained in the incident report from disclosure.

When is quality of care information prohibited from being disclosed?

Quality of care information that is collected by or prepared for a quality of care committee cannot be disclosed except as permitted by the QCIPA. This information is not admissible in evidence in a proceeding and no person can be permitted or required to disclose quality of care information in a proceeding. Proceedings are broadly defined by the QCIPA to include a proceeding that is within the jurisdiction of the legislature and that is held in, before or under the rules of a court, a tribunal, a commission, a justice of the peace, a coroner, college committee, arbitrator or mediator.

Quality of care information may not be requested and it cannot be volunteered. In addition, except in certain circumstances, information collected for the purpose of a quality of care committee cannot be disclosed or accessed by a patient, or by his or her family/substitute decision maker.

> "A member of the quality of care committee who discloses information in good faith or under the harm reduction provision will be granted immunity and no action may be taken against him or her."

When can quality of care information be disclosed?

Quality of care information may be disclosed to the management of a facility if the quality of care committee believes that the disclosure is required for the purpose of maintaining or improving healthcare. Management is defined as including members of the senior management staff, the board of directors, governors or trustees. Management may share the information that has been disclosed to agents or employees of the facility, if necessary for the purpose of maintaining or improving the quality of care.

Quality of care information may be disclosed for the purpose of eliminating or reducing significant risk of bodily harm, and despite the provision of the PHIPA personal health information may be disclosed to a quality of care committee for the purposes of the committee without the patient's consent.

Disclosure of quality of care information in contravention of the QCIPA is an offense as is retaliation against someone who participated in such a process. A member of the quality of care committee who discloses information in good faith or under the harm reduction provision will be granted immunity and no action may be taken against him or her.

Who may provide quality of care information to a quality of care committee?

Anyone may provide any information to a quality of care committee to further the functions of the committee. However, a person to whom quality of care information has been disclosed is restricted in his or her subsequent use and disclosure of the information and may only use the information for the purpose for which it was disclosed.

When to designate information as quality of care information?

Once information has been designated as quality of care information, it cannot be disclosed or made admissible in a "proceeding", which has been defined in the QCIPA as including an Ontario court, tribunal, commission, arbitration or a committee of a College within the meaning of the Regulated Health Professions Act, 1991. It is therefore noteworthy that while quality of care information cannot be used in any proceedings against that health facility, it similarly may not be used in any proceedings in which the health facility may seek to vindicate its actions. As such, a health facility that has a quality of care committee, and seeks to designate information as quality of care information, should give careful consideration to any possible future uses of that information. There may be occasions when it may not be in the best interests of the health facility to designate such information as quality of care information. L&G

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FAQs: PHIPA

Personal Health Information Protection Act, 2004 ("PHIPA") came into force on November 1, 2004. Below are some Frequently Asked Questions regarding PHIPA

Kathy O'Brien

What is the so-called "circle of care"?
PHIPA deems a person to have given implied consent to disclose their personal health information within the "circle of care" for the purpose of providing healthcare to that patient. The term isn't actually found in PHIPA, but it means the following health information custodians: healthcare practitioners, CCACs, service providers to CCACs, public hospitals, private hospitals, mental hospitals, psychiatric facilities, independent health facilities, homes for the aged, nursing homes, pharmacies, laboratories, ambulances, and community health or mental health centres.

How can we tell whether we have a patient's "implied consent"?
The elements of implied consent are two-fold:

The hospital must post a notice, where the patient is likely to see it, describing how it intends to collect, use and disclose the patient's personal health information; and

The notice must give the patient the option to withhold consent. For example, "Unless you tell us not to, we will tell anyone who calls the hospital or visits the hospital asking about you that you are in the hospital (room #, extension #). We will also share your basic health condition."

We regularly allow chart reviews (for research purposes) to be conducted by our physicians without patient consent. Will PHIPA change this?
Yes. Any research, including chart reviews, conducted without the patient's consent must follow the detailed Research Ethics Board review process outlined in PHIPA (section 44 and further elaborated upon in Regulation 329/04).

Under PHIPA, can we report gunshot wounds to the police?
No. There is other legislation that has been introduced by the Ontario government that, if and when passed, will require hospitals to report the fact of a gunshot wound victim to the local police. However, until that legislation (Bill 110) is passed, there is still a requirement to obtain patient consent to disclose a gunshot wound to police, unless disclosure is "necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons" (section 40).

What happens if we find out an employee has accessed a patient's record without needing to?
Under PHIPA the hospital has a new legal duty to notify any patient whose record has been accessed by an unauthorized person, at the first reasonable opportunity. Any employee, volunteer, professional staff member or student who is aware that personal health information has been lost, stolen, or accessed by an unauthorized person is also required to report that information to the hospital. The hospital's privacy policy must have a section requiring compliance from all employees, volunteers, professional staff members, and students, and disciplinary action for breach of the privacy policy must be taken by the hospital.

How will our hospital's relationship with our foundation change?
PHIPA and its regulations dictate that only the name of the patient and the patient's mailing address (or the name and mailing address of the patient's substitute decision-maker) can be disclosed to the foundation without the patient's consent (express or implied), for fundraising purposes. Even with the patient's consent, the following conditions apply to the disclosure of

personal health information to a foundation for fundraising purposes:

- The patient must be given notice that his or her personal health information will be disclosed to the foundation for fundraising purposes and given the chance to withhold consent for 60 days;
- All further solicitations must provide the patient with an easy way to opt out of receiving the solicitations; and
- The communications cannot include any information about the individual's healthcare or state of health.

Hospitals should cease to provide personal health information to their parallel foundations until they have a commitment from the foundation to comply with these requirements. Hospitals should request and review the foundation's privacy policy to ensure it is in compliance with these requirements.

Our foundation regularly sends out campaign contribution requests to the community at large. Will this be a violation of PHIPA if a recipient has recently been discharged from the hospital?

No, as long as the foundation is sending a general mailing and that mailing is not based on names and contact information received from the hospital. If the mailing is based on names and contact information received from the hospital, the foundation must not target any patients who were admitted to or treated at the hospital less than 60 days ago.

We have physicians carrying on private practice from offices they rent in our hospital. Must they comply with our privacy policy?

No. Physicians carrying on a private medical practice on hospital premises are not agents of the hospital. They are responsible for their own personal health information that they collect as health information custodians. Physicians are, however, required to comply with the hospital's privacy policy and information practices where they are acting as agents of the hospital and collecting, using or disclosing the personal health information of hospital patients. L&G

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Top TEN Trends for 2010

Applied Management Systems, Inc. (AMS), Massachusetts-based healthcare management consulting firm, has released the following Top Ten Trends for Healthcare Management for 2010.

1. Focus on patient safety
Hospitals will dedicate themselves to preventing medical errors and improving patient safety at all levels of the organization. Wireless will be an enabler — helping to merge and deliver information to avoid errors.

2. Electronic medical records arrive
Electronic medical records will become a reality. Transportable "e-records" will help to support higher quality care, while protecting patient privacy and cutting costs. Cell phones will become the "key" and only communication device we will need.

3. Cost containment
As healthcare costs continue to increase, driven by medical inflation and volume growth, policymakers will consider limits on reimbursement rates for doctors and hospitals as well as technologies to reduce costs in the long term. Administrators will again be asked to do "more with less."

4. Pay for performance
Incentives to reward physicians and hospitals for quality care and improved outcomes will take hold. Modeled after the Centers for Medicare and Medicaid Services' voluntary quality-indicator reporting system, similar "pay for performance" incentives will help improve the quality of patient care.

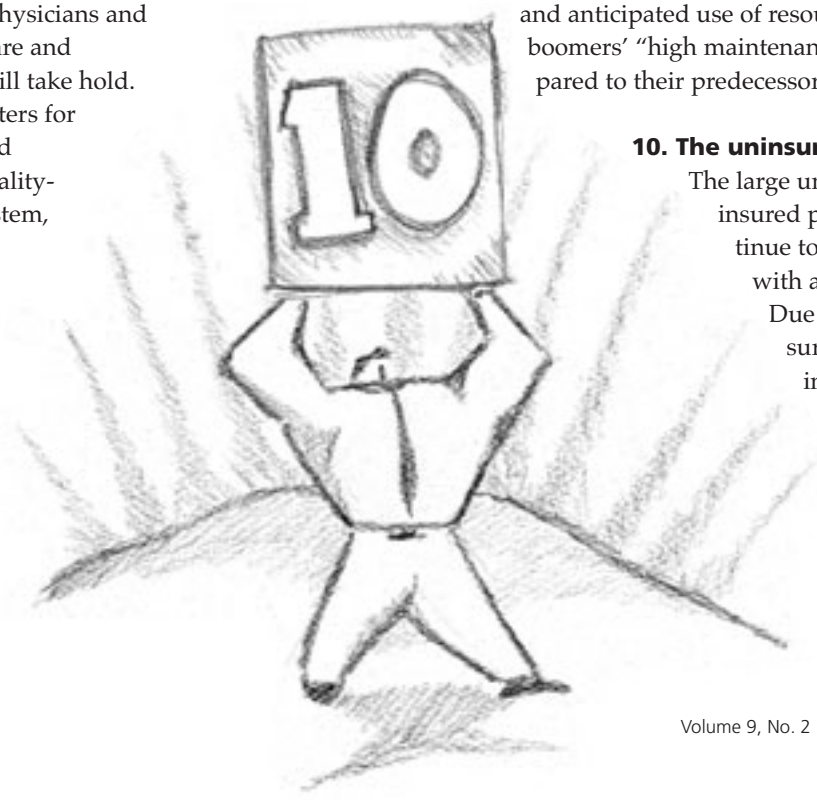
5. IT gets respect
As information technology is recognized as a vital part of hospital operations, consuming a higher percentage of the organization's budget, IT management will become an integral part of the clinical management process and member of the management team.

6. Consolidation of insurers
Insurers will continue to consolidate creating additional leverage in contract negotiations. Similar to company pension plans, U.S. health insurance will become defined contribution not defined benefit.

7. Nurse staffing
Following California's legislation that sets mandatory staffing levels in reaction to nursing shortages, more states will consider similar legislation, prompting a deep fissure within the industry over whether such laws are necessary or harmful to staff and patients. The laws themselves will cause more shortages.

8. Healthcare professional shortage
As demand outpaces supply, the industry will increase compensation and develop pro-active recruitment programs to help promote healthcare careers at higher education institutions.

9. Here come the baby boomers!
The aging "baby boom" generation presents a major public policy concern for long-term care due to its size and anticipated use of resources, as well as boomers' "high maintenance" reputation compared to their predecessors.



10. The uninsured
The large uninsured and underinsured population will continue to present the system with a grave dilemma. Due to economic pressures the many working poor and young workers in their 20s will choose to be uninsured.

Source: www.aboutams.com

Abstracts

Importance of Independent Audit Committee

Recent governance studies are putting great emphasis on the critical role of the audit committee in a corporation's risk management and financial control systems. Although these reports are targeted at the for-profit sector of publicly offered corporations, the principles apply equally to not-for-profit and charitable corporations. A charitable corporation must be able to withstand significant scrutiny with respect to its financial integrity, in order to ensure that stakeholders (such as the Ministry of Health and Long-Term Care, Canada Customs and Revenue Agency, the Public Trustee, and the community at large) – like public company shareholders – are receiving value for their "investment" in the corporation.

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Private Member's Bill Demands Transparency at Hospital Board Level

Under current law, there is no obligation for the board of a public hospital to hold meetings that are open to the hospital's corporate members, the press, or the public at large. Practice across the province is by no means uniform – some hospital boards encourage the press and public to attend board meetings, and move in camera to discuss sensitive or confidential matters; other hospital boards allow guests to attend only upon express invitation.

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Current Strategies to Improve Patient Safety in Canada: An Overview of Federal and Provincial Initiatives

This article provides an overview and examples of current initiatives based on reviews of documents and websites, interviews with key informants in several provinces and attendance at patient safety meetings in several cities. As we shall see, although several provinces are beginning to address the patient safety issues, there remain important challenges of leadership, coordination and learning that are essential in gaining public confidence in the safety of our healthcare system.

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How much is enough? Patients' Right-to-Know v. Privacy Rights of Healthcare Providers

A physician may have a duty of care to disclose his or her own medical condition if that condition poses a material risk to the physician's patient. Find out how liability may arise in negligence from a physician's failure to meet this duty when harm is caused to the patient as a result.

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Volunteer Trustees: Professionally Recruited?

Governance of hospitals and healthcare systems in Canada has undergone of many changes, in parallel to the profound health reform that has occurred in every region of Canada in the 1990s. Government-ordained mergers or hospital closures have abolished many hospital boards altogether. Mergers/consolidations and regionalization have also resulted in a single board now being responsible for many hospitals and often many healthcare facilities and programs.

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