DHA/IWK
Quality Review
Understanding the Legal Framework

Prepared by a Working Group
of Nova Scotia District Health
Authorities and IWK Representatives

"A Guideline Document" July 2006

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DHA/IWK Quality Review: Understanding the Legal Framework

Executive Summary

Quality review is the inspection and evaluation of health care structures, practices or results, conducted or guided by professionals. This review may focus on the entire system or an individual case, based on predetermined criteria. Effective quality review is characterized by multidisciplinary involvement, knowledgeable teams, the application of objective criteria, and a secure review environment. Quality/peer reviews are an extremely important way of assessing and improving the quality of health care services.

The framework provided in this document is designed to assist Nova Scotia District Health Authorities (DHAs) and the IWK Health Centre (IWK) in conducting meaningful quality reviews. It offers tools and practices in providing information for frank and open discussion, while recognizing the impact of statutory and legal obligations on quality review.

The structure and processes of quality review for DHAs and the IWK are influenced by the the *Nova Scotia Evidence Act* (Section 60[2]) and the *Freedom of Information and Protection of Privacy Act of Nova Scotia* (Section 19D[1]). Under these Acts, if certain information has been prepared by a duly Constituted committee formed for the purpose of education or improvement, the obligation to release that information may be waived. In order to maintain this privilege, a Quality Review Committee must be part of an ongoing program, with the relevant sections of the *Evidence Act* and the *FOIPOP* clearly outlined in its terms of reference. The Committee must be part of the quality reporting structure and its terms of reference must clearly outline its responsibility for the study or evaluation of medical care or practice in a hospital. (Under the *Health Authorities Act*, a hospital includes a district health authority and all programs and facilities under its direct administration.)

Trending can be facilitated by collecting key data on a controlled and anonymous basis. Consolidated and analyzed data relating to quality reviews can be reported to the Board. It should be noted that de-identified statistical data are not protected from disclosure by legislation.

The key steps in conducting quality reviews include:

1. Collection of information, based on criteria established by the Committee on selection of cases,
2. Screening/case review conducted by designated Committee members,
3. The Committee will review findings, identify the learnings and improvement opportunities, and make recommendations, and
4. Close the loop – ensure that recommendations are acted upon and accountability reporting is done.

It is important that documented information submitted to the Committee or otherwise created should be properly marked as "**Quality Review Documentation**". A header or footer should appear on evaluation documents that states:

> "This quality review material was prepared pursuant to the *Evidence Act of Nova Scotia*, S. 60(2) and the *Freedom of Information and Protection of Privacy Act of Nova Scotia* S. 19D(1) as amended."

Quality review records are not distributed except through the formal quality structure as outlined in the Committee terms of reference. Mechanisms should be created to share sufficient facts with those who need to know for safety reasons. Discussion about quality reviews beyond the Quality Review Committee should be restricted and all participating individuals must be made aware of the confidentiality issues associated with quality review. In order to maintain both the privilege of quality review information and the privacy of personal information, cases should be presented in the teaching context, whenever possible, as scenarios.

At the end of this document, sample forms are offered for the consideration of health care agencies in their efforts to support meaningful quality review. The forms are not applicable to every agency, and should be adapted to suit individual structures and processes.

Introduction

Purpose

Quality reviews are an important component of health care administration and aid in maintaining and improving delivery of care.[1] The framework provided in this document is intended to assist District Health Authorities and the IWK Health Centre in conducting meaningful quality reviews. It provides guidance on tools and practices that serve to create an environment in which useful information is made available for open and frank discussion while recognizing the impact of legal and statutory obligations on quality review.

Rationale

Numerous compelling reasons for fostering effective, multidisciplinary quality review exist. The most important reason is the improvement of patient care.

Involvement in quality review is stressed in Codes of Ethics[2] and position statements[3] created by professional bodies, included in competencies for professional education programs[4], and required by accrediting bodies[5].

Improvement in patient outcomes are associated with quality reviews. For example, anaesthesiology is acknowledged as the leading medical specialty in addressing issues of patient safety. Anaesthesiologists have been leaders in analysing their work processes through a variety of techniques including direct observation, review of videotapes of real cases, assessment of case presentations at morbidity and mortality meetings, and the use of patient simulators[6]. By applying increasingly more sophisticated analytical techniques,

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[1]Ontario Hospital Association, Quality of Care Information Protection Act Toolkit, 2004, p.9.

[2]Canadian Medical Association, CMA Code of Ethics, update 2004; Canadian Nurses Association, Code of Ethics for Registered Nurses, 2002; Canadian College of Health Services Executives, Standards of Ethical Conduct for Health Services Executives, 2002.

[3]Canadian Nurses Association, Position Statement on Patient Safety, 2003; and Canadian Medical Protective Association, Information Sheet: Disclosure to Quality Assurance Committees in Hospitals, 2004.

[4]In the U.S.A., the Pew Health Professions Commission has produced a set of 21 competencies for successful health professional education and practice in the emerging health care system. Included is taking responsibility for quality of care and health outcomes at all levels.

[5]The residency program accreditation process of the Royal College of Physicians and Surgeons of Canada requires that all participating sites must be actively involved in a formal quality assurance/improvement program including regular review of deaths and complications. The Canadian Council on Health Services Accreditation requires all health care agencies to demonstrate active quality and risk management processes. Most recently, it has introduced required organizational practices which support patient safety goals.

[6]Gaba, David M., "Anaesthesiology as a model for patient safety in health care", BMJ, 2000; 320:785-8.

introducing new technologies and adopting uniform standards of care, intraoperative unexpected death attributable to anesthesia gradually became increasingly rare.

In addition to providing the broadest perspective, multi-disciplinary quality review in which input is offered in a respectful, non-threatening manner can strengthen collaborative relationships among health care professionals.

Definitions

The following terms are defined for use within the context of this document.

Adverse event - an unexpected and undesired incident directly associated with the care and services provided to the patient, or the environment in which the care was provided, which does, or can be reasonably expected to, negatively affect the patient's physical and/or psychological health and/or quality of life[7].

Board Quality Committee - committee of the Board of Governors mandated through the Corporate by-laws of District Health Authorities (as per Chapter 6 of the Act of 2000, the *Health Authorities Act*) to maintain and evaluate a district-wide quality management program that addresses quality control, quality improvement, risk management, and utilization review.

DMAC/MAC (District Medical Advisory Committee) - established to advise the Board of Governors on matters having an impact upon or otherwise involving medical affairs where such impact or involvement is direct or indirect. This committee has many responsibilities, including "the supervision, quality, organization and delivery of all medical care provided by the medical staff"[8].

Disclosure - the imparting, by health care workers to patients[9] of information pertaining to any adverse event affecting (or liable to affect) the patient's interests.

Executive committee - the group responsible for making senior-level decisions within a district health authority or the IWK Health Centre.

Harm - death, disease, injury, psychological effects, and/or disability experienced by a patient.

Healthcare agency - refers to District Health Authorities and the IWK Health Centre.

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[7] Adapted from The Canadian Patient Safety Dictionary, October 2003.

[8] DHA Medical Staff By-laws (General), 2001.

[9] The term "Patient" is used throughout the document for simplicity, but the impact on family and friends must be recognized.

Hospital - a building, premise or place approved by the Minister and established and operated for the treatment of persons with sickness or disease, and includes a facility, a maternity hospital, a nurses' residence and all buildings, land and equipment used for the purposes of the hospital or a body corporate established to own or operate a hospital, or a program approved by the Minister as a hospital (*Hospitals Act*).

Legal proceedings - the institution of a sequence of steps by which legal judgments are invoked.

Material facts - information pertaining specifically to the patient's care.

Morbidity and mortality rounds - a review or assessment of care provided to specific individuals using detailed screening criteria to ascertain whether morbidity or mortality was avoidable, and to provide recommendations for improved care.

Near Miss - an event or circumstance which has not affected the patient nor caused harm but the potential for harm exists. This near miss "almost happened" but may not have reached the patient due to chance, corrective action, and/or timely intervention.

Privilege - the classification of information which, though it may be relevant to a legal proceeding, is protected from disclosure.

Program (vs. Project) - a course of activities or actions undertaken to achieve a certain result, usually a long-term, multi-departmental segment of overall service delivery. A project has a start and end date and usually a smaller scope than a program.

Quality Review - the inspection and evaluation of health care structures, practices, or results, conducted or guided by health care practitioners. A review may focus on the entire system of care or on an individual case based on predetermined criteria.

Review Officer - an independent ombudsman appointed by the Governor in Council under the *Freedom of Information and Protection of Privacy Act*, who accepts appeals from applicants who are not satisfied with the response they received from a public body as a result of an application under the Act.

Random/targeted audit - a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change[10]. Audits can be chosen at random or specifically focused (targeted) on a set of triggers.

Root Cause Analysis (RCA) - a systematic process of investigating a critical incident or an adverse outcome or a near miss to determine the multiple, underlying contributing

[10]From web-based Wikipedia http://en.wikipedia.org/wiki/Clinical_audit including references from **National Institute for Health and Clinical Excellence** or **NICE**, an agency of the National Health Service in the United Kingdom.

factors. The analysis focuses on identifying the latent conditions that underlie variation in performance and, if applicable, developing recommendations for improvements to decrease the likelihood of a similar incident occurring in the future.

Statutory Obligation - statutes are laws passed by provincial or federal legislatures. The requirement to comply with these laws is referred to as statutory obligation.

Tissue review - review of pathology reports of tissue removed during surgery to determine whether surgery was necessary, correctly performed and consistent with diagnosis.

Triggers - certain medications, laboratory values, or events that often provide clues that an adverse event has occurred. Many tools have been developed to assist in conducting a retrospective review of patient records using triggers to identify possible adverse events. Some tools include a list of known adverse events triggers and instructions for measuring the number and degree of harmful events.

Utilization Review - examination and evaluation of the appropriateness of the use of an organization's or a service's resources[11].

Overview of Quality Review

Quality review is the inspection and evaluation of health care structures, practices, or results, conducted or guided by professionals.[12] This review may focus on the entire system of care or on an individual case based on predetermined criteria. Quality review includes (but is not limited to) such activities as:

- review of occurrence reports
- morbidity and mortality rounds
- utilization review
- care audits
- tissue review
- case review
- incident investigation
- root cause analysis

The key features of quality review are involvement of professionals and an agenda for review of care and its components. Quality review has evolved to encompass multidisciplinary involvement and inclusion of a broad scope of system issues. To be effective, quality review teams should be knowledgeable in the structures and processes of care being reviewed. An environment in which individuals feel secure in participating with

[11]Canadian Council on Health Services Accreditation, AIM Accreditation Program, Second Edition, 2003.

[12]Adapted from Berwick, DM, "Peer Review and Quality Management :Are they compatible?" QRB 1990; 16(7): 246-251) in CMA, "Quality of Care: Issues and Challenges in the 90s", 1992.

candour and objectivity is crucial to meaningful reviews. This can be achieved by protecting participants from retaliation and fears of increasing potential liabilities.

In order to ensure that review is based on justifiable, appropriate and valid aspects of care, objective criteria should be applied [13].

The quality review process is outlined in detail in later sections of this document.

Legal Protection of Quality Reviews

It is recognized that for quality reviews to meet their purpose, persons involved in the reviews need to be as open and detailed as possible in their assessment of cases. Accordingly, issues arise as to the protection of such quality review information from disclosure in legal proceedings, primarily malpractice actions. It is clear that without assurances that such information is protected from disclosure in legal proceedings, health care professionals may and do refuse to participate in such reviews or agree to participate in such reviews only if the information is not recorded or if no information is attributed to them.

To address the concern that information generated by a quality review could be disclosed in a legal proceeding, Section 60(2) of the *Evidence Act*, R.S.N.S., 1989, c.154 was enacted. This was followed some time later by Section 19D(1) of the *Freedom of Information and Protection of Privacy Act*, S.N.S., 1993, c.5 (*FOIPOP*). These legislative provisions are routinely described as the "Quality Assurance Privilege". It is important to understand what is meant by the word "privilege" in this context and how information generated during a quality review is protected by it.

This part of the framework reviews historical types of privilege, primarily provided for in common law (judge-made law in specific legal actions), and then describes the legislative privilege which is afforded by Section 60(2) of the *Evidence Act* and Section 19D(1) of *FOIPOP*.

[13] A list of desirable characteristics of review criteria, established through consensus by an international group of quality improvement experts, may be of interest when developing criteria. Reference: Hearnshaw, HM, Harker, RM, Cheater, FM, Baker, RH, Grimshaw, GM, " Expert Consensus on the desirable characteristics of review criteria for improvement of health care quality", Quality in Health Care, 2001; 10: p. 176.

Key Points Regarding Legislated Quality Assurance Privilege

The *Evidence Act* provides protection to hospitals against disclosure of certain information to a legal proceeding if the information is prepared for use by a duly constituted committee formed for the ongoing process of education or improvement.

The *Freedom of Information and Protection of Privacy Act* contains protection from release of certain information by public bodies to an applicant if the information is prepared for use by a duly constituted committee formed for the ongoing process of education or improvement.

Privilege under the Acts does apply to documents prepared for the purpose of a quality review committee such as opinions, judgments pertaining to causative factors, audits, interview reports, investigations, evaluations, root cause analysis, follow up, etc.

Privilege under these Acts does not apply to medical or hospital records pertaining to the patient or factual information contained in a record of an incident regarding the provision of healthcare to the patient.

Privilege is applicable to a Quality Review Committee that is part of an ongoing program (not established for ad hoc review) with purpose and functions linked to the relevant sections of the *Evidence* and *FOIPOP Acts* clearly outlined in its Terms of Reference.

Types of Legal Privilege

"Privilege" is defined in law to mean something which releases one from the performance of a duty or obligation or exempts one from a liability which one would otherwise be required to perform or sustain in common with all other persons. In the context of information, "privilege" is usually defined as the classification of information which, though it may be relevant to a legal proceeding, is protected from disclosure. There are other types of privilege, for example, doctor patient privilege, executive privilege, husband wife privilege, journalist privilege, etc., however, in the context of legal privilege, there are four main categories as follows:

a) solicitor-client;
b) litigation;
c) non-solicitor-based common law; and,
d) legislative quality assurance privilege

a) Solicitor- Client Privilege

The broadest privilege is solicitor-client privilege and this would ordinarily refer to communications, as between a lawyer and his or her client. Such communications

would be protected from disclosure in any court. The concept of solicitor-client privilege is important in the context of potential legal liability for health care entities in that health care entities may retain legal counsel in situations where quality of care issues arise and where there is a potential for a legal claim in relation to those quality of care issues.

b) Litigation Privilege

"Litigation Privilege" is sometimes considered to be a subset of solicitor-client privilege, however, it is not as broadly protected as solicitor-client privilege. This privilege relates to information which is prepared in contemplation of or for the predominant purpose of litigation. This privilege is also important in the context of malpractice exposures in relation to health care facilities.

c) Non-solicitor-based Common Law Privilege

Where statutory protection is not available, courts will determine whether the information in question is protected from disclosure. Such court determinations are often based on precedents established in court judgments. The common law privilege is based on four criteria, which are sometimes referred to as the "Wigmore Principles". These criteria are:

1. that the communications must originate in confidence, that they will not be disclosed;
2. that the element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties;
3. that the relation must be one which in the opinion of the community ought to be sedulously fostered; and
4. that the injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.

Essentially, application of this fourth criterion involves a balancing of the interests of the person to access to their information versus the harm which would be done to the objectives of quality assurance investigations if the information was disclosed. It is interesting to note that until January 2005, Ontario health care facilities relied on the concept of common law privilege to protect quality assurance information from disclosure in legal proceedings. In fact, quality assurance information was protected from disclosure in a very recent case of the Ontario Supreme Court (*Steep et al. v. Scott et al*. (2002, 62 O.R. (3D) 173)[14].

[14] In Steep v. Scott, Master Egan of the Ontario Superior Court of Justice did not agree that the outcome of the claim for privilege depends on whether a review was limited to a single incident or pertain to the overall assessment of physician's skills. Rather, Master Egan applied the Wigmore criteria, in addressing the established process for reviewing incidents at the hospital. This matter pertained to events regarding the birth of the minor plaintiff. The defendant hospital claimed privilege of correspondence exchanged between

(footnote continues on Page 10)

d) Legislative Quality Assurance Privilege

1. Section 60(2) - *Nova Scotia Evidence Act*

Section 60(2) of the *Evidence Act* provides that a witness in any legal proceeding, whether or not they are a party to that legal
proceeding is "**excused from answering any question as to any proceedings before, or producing any report, statement, memorandum, recommendation, document or information of, or made by:**

(a) a research committee of a hospital;
(b) hospital committee established for the purpose of studying or evaluating medical or hospital care or practice in a hospital; or
(c) a research committee recognized by the Minister of Health and Fitness and approved for the purpose of this Section,

and that is used in the course of, or arising out of any study, research or program carried on by a hospital or any such committee for the purpose of education or improvement in medical or hospital care or practice".

The term "legal proceeding" is defined as "any civil proceeding, inquiry or proceeding before any tribunal, board or commission or arbitration, in which evidence is or may be given, and includes as action or proceeding for the imposition for the punishment by a fine, penalty or imprisonment for the violation of provincial enactment". It is noteworthy that the term "legal proceeding" does not include criminal proceedings pursuant to the federal Criminal Code. In the case of criminal code proceedings, legal counsel must be involved in providing direction on action required.

Perhaps the most relevant provisions of Section 60(2), particularly in relation to the conduct of quality investigations, are that the committee conducting the investigation must be a committee as defined under that section and the function of the committee must meet the provisions of Section 60(2), i.e., it must be information arising out of any study, research or program carried on by a hospital or any such committee for the purpose of education or improvement in medical or hospital care or practice.

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the medical director of the hospital and the head of the obstetrics department for the purpose of a quality assurance review by a sub-committee of the MAC. The function of the sub-committee was to review individual cases to ensure that the care provided to patients met expected standards. Following the receipt of the letter from the medical director, the head of the obstetrics department discussed the chart and events surrounding the labour and delivery of the minor plaintiff with the nurses and physicians and provided a report to the medical director. In the course of the interviews, the nurses and physicians were told that the discussion would remain confidential and that the purpose was to ascertain whether there were quality of care issues which required remediation. Master Egan found that the Wigmore criteria were met. (Health Law in Canada, Mar 2005, Vol. 25, No. 3, p. 49)

2. Section 19D(1) - *Nova Scotia Freedom of Information and Protection of Privacy (FOIPOP) Act*

The *Freedom of Information and the Protection of Privacy Act*, which applies to public sector organizations, was enacted to ensure accountability and transparency of government as well as to protect the privacy of individuals with respect to personal information about themselves held by public bodies and to provide individuals with a right of access to that information. The *FOIPOP Act* is overseen by the Minister of Justice. Under the Act, a Review Officer who is appointed by Order-in-Council, may review decisions made by public bodies and municipalities in response to applications for access to records in the custody and control of those bodies. The Review Officer may make recommendations for the decision of public bodies to be changed or adjusted, or may confirm the decision, but does not have the power to make final and binding orders. If an applicant is not satisfied with the outcome of a review, an appeal may be made to the Supreme Court of Nova Scotia.

In 1996, a major issue arose as to whether Section 60(2) of the *Evidence Act* could be used to prevent the disclosure of information in the context of a *FOIPOP* application for release of information. The Nova Scotia Supreme Court in *Freedom of Information and Protection of Privacy Act* (1996), 137 D.L.R.(4th), found that despite Section 60(2) of the *Evidence Act*, the information regarding review of suicides at a particular Nova Scotia hospital would be disclosed. Subsequent to this the Medical Society of Nova Scotia provided direction to the physicians of Nova Scotia in relation to their participation in quality assurance/peer reviews. Essentially, this direction limited the participation of physicians in such reviews. Following this Section 19D(1) was added to the *FOIPOP Act* so that a **"hospital may refuse to disclose to an applicant a record of any report, statement, memorandum, recommendation, document or information that is used in the course of or arising out of any study, research or program carried by or for the local public body or any committee of the local public body for the purpose of education or improvement in medical care or practice".**

Accordingly, pursuant to the *Evidence Act* and Section 19D(1) of *FOIPOP*, information which meets the criteria outlined in Section 19D(1) of *FOIPOP*, may not be accessed by patients or anyone else.

As indicated previously, for the Section 19D(1) privilege to apply, the health care entity must be a hospital (defined to mean a hospital as defined under the *Hospitals Act* and which, under the *Health Authorities Act*, includes a district health authority and all programs and facilities under its direct administration, i.e. public health, addiction services, etc.) and the information must be produced in the course of or arise out of any study, research or program whose purpose is education and improvement in medical care or practice.

The reference to the word "program" in Section 19D(1) is integral in that it requires that the review of any one incident must arise as a result of a program or study which is structured to review such incidents, either based on their severity or other generally applicable criteria. The privilege is unlikely to apply in the context of a review which is done by an ad hoc group or meeting which was not previously created or contemplated to be created (e.g. an ad-hoc group or committee which is set up solely for review of previously unanticipated particular incidents which are investigated when it is determined that there is potential liability.

For example, in the *FOIPOP* Review Officer's decision in case number FI-03-50, it was essential to the application of the Section 19D(1) privilege that the review of a particular death arose as a result of the hospital's program for reviewing all deaths which occurred. It is integral that committees which have quality assurance as their objective indicate clearly (e.g. in Terms of Reference) that this is their objective and that they are created to conduct studies, research or programs for the purpose of education or improvement in medical care or practice.

Differences between the *Evidence* and *FOIPOP Acts*

	Evidence Act	***FOIPOP Act***
scope	hospitals, committees established by the Minister of Health	hospitals
review authority	binding interpretation by judge	decisions of Review Officer not under statutory jurisdiction; ultimate interpretation by judge
process	invoked during legal proceedings	invoked through request of private citizens
legally tested	yes - there has been clear direction from courts regarding the applicability of section 60 (2) at both the Supreme Court and Appeal levels[15]	yes - F1-03-50 hospital decision upheld

[15] MacKenzie vs. Kutcher.

What is not subject to the quality assurance privilege

Section 19D(1) of *FOIPOP* and Section 60(2) of the *Evidence Act* specifically indicate that this legislative quality assurance privilege does not apply to medical or hospital records pertaining to a patient. Factual information or material facts, such as the sequence of events, patient care and patient status, is often contained on the patient record. However, information that a physician was contacted by a nurse reporting on the condition of the patient even if not recorded in the chart, is a material fact.[16]

Whereas an "incident report" may trigger a quality review, information contained on such reports may not be privileged. The review, not the triggering event or report, is subject to privilege.

Information produced during a quality review is subject to the quality assurance privilege. Quality review information includes such items as opinions, audit results, interview reports, evaluations, and root cause analyses.

Deidentified recommendations (not linked to cases) emanating from quality reviews may not be subject to privilege.

	Privileged Information	**Non-privileged Information**
Material facts pertaining specifically to the patient's care		•details of event affecting the patient •patient's health status •patient's course of treatment and care
Information produced during quality review	•opinions • audit results •interview reports •evaluations •root cause analyses	•material facts, even if not recorded elsewhere, such as on the patient record or an incident report

Immunity

Section 60(2) of the *Evidence Act* specifically indicates that individuals participating in good faith in quality reviews are not subject to liability as a result of such participation.

[16] Ontario Hospital Association, Quality of Care Information Protection Act Toolkit, 2004, p.28

Roles and Responsibilities in Quality Review

District health authorities and provincial healthcare centres were established to *govern, plan, manage, monitor, evaluate and deliver health services in a health district* in accordance with the *Health Authorities Act*[17] [19a]. Through his/her responsibility to monitor the quality of the health system and as provided for in the Act, the Minister has created by-laws with respect to the role of the district board of directors[18]. Each district health authority must have a Quality Management Committee that *shall maintain and evaluate a district-wide quality management program that addresses quality planning control, quality improvement, risk management, and utilization review* [11.6.2]. A similar committee is under review at the IWK.

The Boards' governing responsibilities are to ensure adequate resources for quality management to occur, to receive reports on quality and to approve actions to address deficiencies. This is consistent with leadership standards of the Canadian Council on Health Services Accreditation.

Responsibilities and mechanisms for routing quality information within the health care agency and ensuring follow-up must be clearly articulated.

Review Structures

Quality reviews are conducted under the direction of committees established by the district or hospital expressly for the purpose of education or improvement in medical or hospital care or practice. Ideally the committees are multidisciplinary in composition. They are situated within the agency's quality reporting structure which ultimately reports to the board of directors.

Any properly constituted quality review committee can also delegate quality review functions to a sub-committee (ad hoc or permanent) or to an individual (internal or external to the organization) performing functions on behalf of the committee. For example, a district committee can establish a sub-committee performing quality review in a specific hospital within the district.

Committees which include quality review as their sole or partial responsibility may include (but are not limited to) the following areas of focus:

- patient care
- medical audit
- nursing audit
- infection control

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[17] *Health Authorities Act*, Chapter 6 of the Acts of 2000, province of Nova Scotia, June 2000.

[18] Corporate By-laws of District Health Authorities, July 2001.

- mortality and morbidity
- quality improvement
- tissue audit
- patient safety
- risk management

A committee need not solely be committed to quality review to qualify, provided that the committee at issue performs **as part of its responsibilities** "a function" for the study or evaluation of medical or hospital care or practice in a hospital. If a committee performs more than one function its functions should be clearly separated[19].

Membership of a hospital committee is not restricted to internal employees and physicians. Rather, the committee can include persons internal to the hospital, or persons external to the hospital, or a combination of both. The mandate of a committee makes it a "hospital committee" as defined under S. 19D(1) *FOIPOP* and S. 60(2) *Evidence Acts*, not the internal or external status of its members.

All quality review committees must maintain Terms of Reference (a template, as an example, is included in Appendix A) which include the following information:

- the purpose of the committee
- scope of the mandate
- reference to article of the *Evidence Act/FOIPOP Act*
- reporting structure
- membership
- triggering events or information sources
- role in initiating external reviews (if needed) and seeking expert input beyond the committee membership as required
- restrictions to the distribution of records (e.g. minutes and recommendations)
- identification of documents
- retention of records

Conducting Quality Reviews

The nature of quality reviews will vary depending on the nature of the issue being reviewed. A review should be as extensive or involved as is necessary to accomplish the purpose of the review. Timeliness of reviews is critical to optimizing recall of conditions and events. The value of reviews is seriously hampered by the decay of memory which can occur within days of an event. Sample templates that may be used to facilitate reviews and that support process guidelines are included in Appendix B. Templates may not be suitable for all situations.

[19] British Columbia Health Care Protection Program, Risk Management, Guidelines to Section 51 of the *Evidence Act*, 2002, p. 6.

The key steps in conducting quality reviews, once structure and Terms of Reference are established, include:

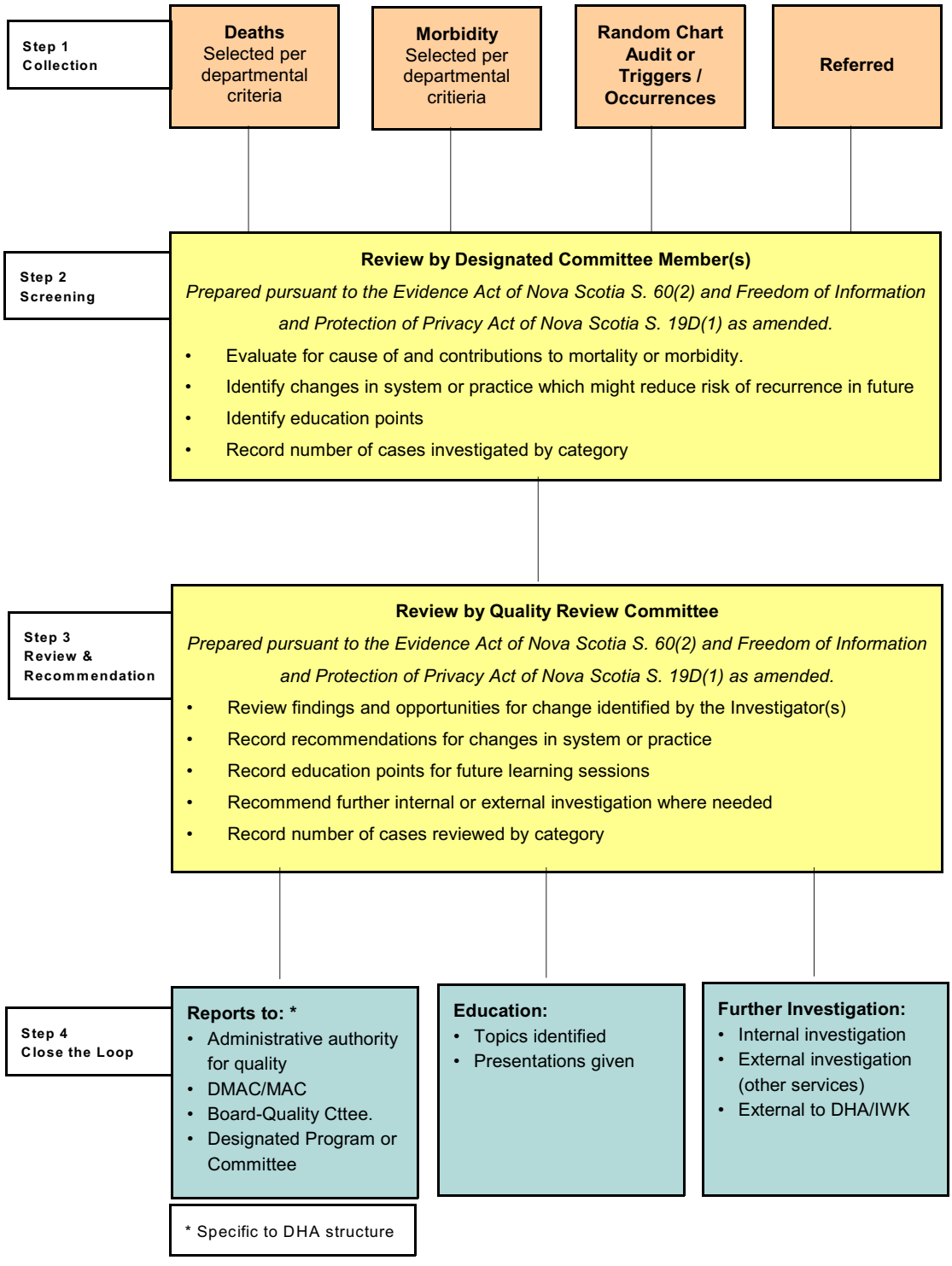
1) collection of information to prompt review - committees must establish criteria for the selection of cases;

2) screening - designated committee members are assigned to review cases;

3) review and recommendation - properly constituted committees review findings and identify learning and improvement opportunities; and,

4) close the loop - recommendations are acted upon and accountability reporting occurs.

Flowchart of Quality Review Process



Meeting Management

The quality review committee may ask third parties (internal or external non-permanent committee members) to assist in review, to consult on specific issues, or to participate in the entire review. Third parties should only be present for pertinent aspects of any committee meeting, restricting access to information on a need to know basis.

All participating individuals (committee members and third parties) must be made aware of the confidentiality issues associated with quality review. For example, this can be achieved by including the standard conditions of participation in correspondence to third parties (restriction of case discussion, marking documents as "being compiled for the purposes of submission to the quality review committee", etc.).

Quality review records are not distributed except through the formal quality structure as outlined in the Terms of Reference.

Discussion about quality reviews beyond the Quality Review Committee should be restricted. Mechanisms should be created to share sufficient facts with those who need to know for safety reasons.

Other review processes and requirements of professional regulatory bodies are applied for cases involving discipline.

Record Keeping

Documented information created for submission to the quality review committee or created through the quality review process should be properly marked as Quality Review documentation and, where possible, include headers and/or footers such as "This quality review material was prepared pursuant to the *Evidence Act of Nova Scotia* S.60(2) and *Freedom of Information and Protection of Privacy Act of Nova Scotia* S. 19D(1) as amended".

Quality review information should be retained as long as it is required by the committee for purposes of quality improvement.

Should material facts (pertaining specifically to the patient's care) not previously in the patient's medical record be learned in the course of review, the facility's disclosure policy provides processes for disclosure to the patient. It should be noted that in the event of a legal action, legal counsel will advise on disclosure of material facts.

To qualify as quality review documentation, it is not necessary for the committee to actually meet as a whole to review, as long as the documentation was compiled for submission to the quality review committee.

Getting Started in Establishing the Review Process

This section provides the steps a healthcare agency should take to formalize existing or establish new, ongoing mechanisms for quality review within the provincial legislative framework. While adhering to the legislated requirements for maintaining quality assurance privilege, opportunities to tailor the structures and processes to the needs of the healthcare agency exist.

Getting Started:

1. In order to build support for this process, the mandate will be communicated through the DMAC/MAC and the DHA/IWK Executive with defined reporting as per Terms of Reference.

2. By service, team, and/or site, identify committee members:
   a. Include multidisciplinary membership: physicians, nurses, pharmacists, physio (if appropriate e.g. orthopaedics), may include members external to the service e.g. include anaesthesia on the surgical committee.
   b. Identify the chair will be established (by appointment or selected by committee) as well as term for the position.

3. Call initial meeting:
   a. First agenda to include: review of Terms of Reference
   b. Establish meeting ground rules[1] (see below)
   c. Establish criteria to be used to set agenda: e.g. will all deaths be reviewed? May select regular infection rate review, regular audits as defined by service such as all re-admissions post specific surgical procedure, etc
   d. Establish meeting frequency (should be at least quarterly)

4. Establish how the process will work:
   a. Chair and other (vice chair or rotation of members) will review all cases (using standardized worksheet) and bring forward a summary of cases reviewed. One or two cases will be reviewed in depth and recommendation for change will be included in the meeting notes. (Appendix C-see templates)

   OR

   b. Will members rotate through the role of reviewing cases as above?

[1] An example of meeting ground rules: "SNIT" - S - say your piece, N - no finger pointing, I - no interrupting, T - towards collaboration

c. Develop trigger questions[2] to be used during the discussion:
   i. Were approved/current clinical guidelines applied to the care of the patient?
   ii. Were the diagnostics consistent with the circumstances? And interpreted successfully?
   iii. Was the outcome expected in the circumstances?
   iv. Was the documentation appropriate?
   v. Were there systemic factors negatively affecting care?
   vi. If relevant, what needs to change, and who will be accountable to implement?

5. After each meeting, collect and dispose of any information that has been circulated on cases reviewed.

6. Meeting notes will include: Number of Cases Reviewed, Number of Mortality Cases, Number of Morbidity Cases, Random/Targeted Audit Cases, Cases referred from Other Sources e.g. Patient Rep/complaints, Adverse Event report/review, Unusual Occurrences, Medication Occurrences. Meeting notes will also include: recommendations along with action plan and accountability with follow-up expected at the next meeting. (Appendix B-see templates)

7. After 12 months, review the committee process and revise as necessary.

Monitoring for Quality Improvement Purposes

Identification of patterns or trends in system deficiencies and unexpected outcomes is important for improving care. Collecting key data elements associated with quality reviews in a controlled and anonymized manner can facilitate trending. Data analysis and consolidation form the basis of accountability reporting to the Board related to quality reviews, but it must be noted that de-identified statistical data are not protected from disclosure by legislation. Beyond the patient's name, identifying data may include such things as date and type of procedure, and place of residence. Appendix C contains examples of data elements that could be considered for inclusion in a DHA/IWK Quality Review database.

[2] The Canadian Patient Safety Institute has developed useful questions, based on human factors principles, which can help move analysis from immediate causes to contributing factors when reviewing instances where problems with care occurred. See Canadian Root Cause Analysis Framework: a tool for identifying and addressing the root causes of critical incidents in healthcare, 2005. www.cpsi-icsp.ca.

Utilizing Quality Review Information for Education

Lessons learned through case review are valuable tools for education of health practitioners. It must be noted that the *Evidence* and *FOIPOP Acts* acknowledge the importance of education. Privilege applies to quality review information **that is used in the course of, or arising out of any study, research or program carried on by a hospital or any such committee for the purpose of education or improvement in medical or hospital care or "practice"**. Thus those who are witness to quality review information which may be included during such activities as patient, service and grand rounds cannot be compelled to divulge it during legal proceedings. In order to maintain both the privilege of quality review information, and privacy of personal information, cases should be presented in the teaching context, to the extent possible, as scenarios without reference to names, dates or other identifying information. It may be prudent for any Terms of Reference to teaching mechanisms (e.g. grand rounds) to clearly identify the purpose.

Other Legal Obligations

Agencies must maintain mechanisms to comply with reporting as required by law.[3] Where broad power exists for the Minister or an officer with designated legislated authority to compel information, this information can only be used in the context of the Acts which contain these provisions. Section 60(2) of the *Evidence Act* would still provide protection in the context of a legal proceeding.

For example, a legal duty to report exists for:

- deaths under certain circumstances (must be reported to the Medical Examiner under the *Fatality Investigations Act*)
- suspected child abuse (must be reported to Children's Aid under the *Children and Family Services Act*)
- certain communicable diseases (must be reported to a Medical Officer of Health under the *Health Protection Act*)
- suspected abuse or neglect of adults living in the community (must be reported under the *Adult Protection Act*)

[3] A useful reference is contained in the Statutory Reporting Requirements: A Guide for Nova Scotia Physicians, Issued April 30, 2003, a summary of legislation pertinent to physicians; available on the College of Physicians and Surgeons of Nova Scotia website : www.cpsns.ns.ca/statutory-reporting.htm.

- suspected abuse of adults in care (must be reported under the *Protection of Persons in Care Act* - not yet proclaimed)

In Summary

In summary, quality/peer reviews are an extremely important way of assessing and improving the quality of health care services. Some of the most important components of quality review include:

- ensure that committees developed pursuant to legislative provisions and their functions meet the definition and purposive criteria as outlined in Section 19D(1) of *FOIPOP* and Section 60(2) of the *Evidence Act*s of Nova Scotia.

- adopt practices which maintain confidentiality of information prepared for quality review purposes.

- apply multidisciplinary input to review criteria and discussions.

Sample forms are offered for the consideration of healthcare agencies in their efforts to support meaningful quality review. The forms are not applicable to every agency and should be adapted to suit individual structures and processes.

APPENDIX A: Sample Terms of Reference

(terminology should be adapted to each organization)

DHA/IWK
Care Team/Department (STATE NAME OF DEPARTMENT)
Quality Review Committee

TERMS OF REFERENCE

REPORTS THROUGH: The most appropriate senior medical and/or administrative committee to the Board.

CHAIRPERSON: May be appointed by department chief and/or executive or selected by committee membership. Length of term to be determined by each DHA/IWK

MEMBERSHIP: Participation in Quality Review Committee work should reflect the multidisciplinary approach to care. All health professional staff members (including learners) are encouraged to take part in Quality Review work. In addition, the committee may include from time to time or on a regular basis experts/specialists who are internal or external to the DHA.

I. PURPOSE *(These Purpose statements MUST appear in all Terms of Reference)*

The Care Team/Department (STATE NAME OF DEPARTMENT) Quality Review Committee is a hospital/district committee established for the purpose of quality assurance, and specifically to study and evaluate medical or hospital care or practice within the Department (STATE NAME OF CARE TEAM/DEPARTMENT).

The Care Team/Department (STATE NAME OF DEPARTMENT) Quality Review Committee is part of the District Health Authority's/IWK quality improvement program. The information and documents generated by the Care Team/Department (STATE NAME OF DEPARTMENT) Quality Review Committee are used for the purpose of education or improvement in medical or hospital care or practice. The information used during the meetings and the reports that follow are protected pursuant to the *Evidence Act* of Nova Scotia S. 60(2) and *Freedom of Information and Protection of Privacy Act* of Nova Scotia S. 19D(1) as amended.

II. FUNCTIONS

1. Collect and review information to identify issues related to quality of care and services; depending on the volume and nature of deaths normally experienced in a specific service; the service may conduct a review of all deaths, a random sample, or deaths that meet specific criteria. In addition, services will establish criteria that determine factors affecting morbidity that would be reviewed as part of their Quality Review process.

2. Maintain a liaison with the following division-level Quality Review Committees: for those departments that have divisions, list each division's Quality Review Committee.

3. Maintain liaison with the appropriate Quality Review Committees within the structure of the organization.

4. Upon identification of areas in care, service and standards which may benefit from change or consideration and are process or structure related, make recommendations within the department to address issues. If the issue cannot be addressed at the care team/department level, or if the issue has implications beyond the care team/department, then the committee should refer it to the District Medical Advisory Council - Quality Committee (DMAC-QC), healthcare agency-wide Morbidity Committee or other committees as appropriate (in many districts, this will be the DMAC directly). The referral should include a timeframe for consideration and reporting back to the Quality Review Committee.

5. Maintain a record of committee activities. Provide a statistical report of the number of cases reviewed, recommendations identified, and action, to the parent committee of the care team/department (or designated committee as per organizational structure), to Quality/Risk Management and to DMAC-QC; These records do not include: names of patients, staff members or physicians rather they contain aggregate information and recommendations that will often form the focus of department quality improvement initiatives.

6. Maintain program/department-wide accessibility and awareness of the committee. Review the committee mandate;

7. The Care Team/Department's (STATE NAME OF DEPARTMENT) Executive Council (or designated committee as per the organizational structure) and the DMAC-QC is responsible for a) overseeing the implementation of recommendations; b) evaluating effectiveness of recommendations; and c) annual review of recommendations to identify themes and trends leading to quality improvement of patient care and services.

8. In the event that an external review is requested by the Quality Review committee, that report is protected pursuant to the *Evidence Act* of Nova Scotia S. 60(2) and *Freedom of Information and Protection of Privacy Act* of Nova Scotia S. 19D(1) as amended.

III. NATURE & SCOPE

1. Review specific care team/department-related information to identify recommendations related to quality of care and services within the care team/department;

2. Recommendations related to the process that may have resulted in mortality or morbidity may be reviewed by the committee;

3. Other issues brought to the committee as required;

4. Minutes/meeting summary notes shall be distributed to all committee members (see section II, # 5 above). Master copies of the minutes and any correspondence related to the committee are maintained by the Care Team/Department (STATE NAME OF DEPARTMENT) Quality Review Committee for a period as determined by the committee; and,

5. The Care Team/Department (STATE NAME OF DEPARTMENT) Quality Review Committee will meet at least 4 times per year.

IV. LIMITATIONS/SCOPE

1. While the Care Team/Department (STATE NAME OF DEPARTMENT) Quality Review Committee will review cases with morbid implications, deaths, and may review cases identified through patient complaints, it is NOT a forum for review of patient complaints;

2. The Care Team/Department (STATE NAME OF DEPARTMENT) Quality Review Committee will not provide feedback or information to patients, families, or their agents. Such requests lie outside the mandate of this committee, and will be coordinated by the Division Head in counsel with the Department Head (or Quality Team Head in counsel with the Care Team);

3. The Care Team/Department (STATE NAME OF DEPARTMENT) Quality Review Committee is not a disciplinary committee.

V. PROCESS FOR REVIEW

1. Cases are identified by members of the division, care team, department, occurrence reporting process, patient representatives, or others including the DMAC-QC;

2. If a case reviewed by the Care Team/Department (STATE NAME OF DEPARTMENT) Quality Review Committee:

    a. Reveals only a single division or department level issue, with no broader DHA/IWK issues (e.g. issues touching on any other division, care team or department), that committee shall enact their solution locally, and report the case to the Care Team/Department's (STATE NAME OF DEPARTMENT) Executive Council for documentation only; or,

    b. Reveals a broader DHA/IWK issues (e.g. touching on any other division care team or department, or with the potential to impact any other division, care team or department), that case shall be referred to the appropriate quality committee within the structure of the organization.

APPENDIX B: Sample Forms

Pre-circulated to QR Committee Members Only

Sample
DHA's/IWK
Quality Review Committee
_____ (Department/Care Team)
(terminology should be adapted to each organization)

Agenda
_____date

_____location

1. Review recommendations from previous meeting

   i) Recommendation #1 follow-up by_____
   ii) Recommendation #2 follow-up by_____
   iii) Etc

2. New cases, presented by Quality Review Committee chair or designate

   #1
   #2
   #3
   #etc.

3. Next meeting

Review Guidelines:
1. **No names of patients, staff members or physicians should be used within the context of this review**
2. **No paper will leave the room; it will be collected by the chair and shredded**
3. **Confidentially is essential**
4. **All opinions should be voiced openly**
5. **The purpose is NOT to find blame, rather to identify fact for improvement of care**
6. **The purpose is to draw from specific cases to make improvements for the future**
7. **LIMITATION - this is not a forum for discipline or for feedback to family/patient; see Terms of Reference**

Prepared pursuant to the Evidence Act of Nova Scotia S. 60(2) and Freedom of Information and Protection of Privacy Act of Nova Scotia S. 19D(1) as amended.

Destroy after Review by Quality Review Committee

Sample
Case Review: Time Lines
(terminology should be adapted to each organization)

For use by Assigned Reviewer(s) to describe sequence of events for Complex Cases

Case Review Identification Number _____

Brief Description of Occurrence:

_____

_____

_____

Date & Time	Area	What occurred; Documentation; etc.	Comments

Prepared pursuant to the Evidence Act of Nova Scotia S. 60(2) and Freedom of Information and Protection of Privacy Act of Nova Scotia S. 19D(1) as amended.

Destroy after Review by Quality Review Committee

Sample
Quality Review Worksheet for Mortality Review
(terminology should be adapted to each organization)

PATIENT identifier for quality review purposes only:		**Previous Visit or Admission Within 30 Days: Yes ☐ No ☐** **ED ADM: Yes ☐ No ☐**	
SEX: Female Male	**ADM DATE:**	**D/C DATE**	**LOS:**
ATTENDING PHYSICIAN:		**CONSULTANTS**	
ADMITTING DIAGNOSIS:			
CAUSE OF DEATH:			
Was Code Blue initiated:	**Yes ☐ No☐ N/A ☐**		
Any concerns re: Code Procedure?	**Yes ☐ No☐ Comment:**		
FINAL DIAGNOSIS:			
DNR (Do Not Resuscitate) Status:	**Yes ☐ No☐**		
Was discussion with patient/family regarding resuscitative measures documented? Yes ☐ No ☐ N/A ☐			
Did patient have an Advance Directive ?	**Yes ☐ No☐**		
Co-morbid condition was documented	**Yes ☐ No☐**		
Autopsy Performed	**Yes ☐ No☐ Autopsy Requested but Refused ☐**		
☐ Expected Mortality ☐ Unexpected Mortality ☐ Medical Examiner's Case Yes ☐ No☐ **☐ Mortality Not Expected On Admission But Expected At Time Of Death**			

A. GENERAL SCREENING

Yes	*No*	*N/A*	*Check Appropriate box for each question:*
☐	☐	☐	**Medical Record lacks a death note by a physician?**
☐	☐	☐	**Was death associated with adverse event or drug reaction?**
☐	☐	☐	**Was the diagnostic workup adequate?**
☐	☐	☐	**Were abnormal lab, x-ray, other test results or physical findings addressed?**
☐	☐	☐	**Would this patient have been suitable for the organ donation program?** **If "NO", why not? / Comments:** **If "YES", was this discussed with the next of kin? Comments:**
☐	☐	☐	**Under optimal conditions would this death have been preventable?**

B. AUTOPSY SCREENING

Yes	*No*	*Check Appropriate box for Autopsy Criteria: (see page2)*
☐	☐	**Death within 48 hours of a surgical or invasive procedure, including radiology?**
☐	☐	**Death associated with diagnostic failure?**
☐	☐	**Death associated with adverse event or drug reaction?**
☐	☐	**Death within 48 hours of admission?**

C. DISPOSITION OF REVIEW: Based on the above screening:

Yes	*No*	*Check Appropriate box for Response:*
☐	☐	**No further review necessary**
☐	☐	Refer to the _____Department/Division for peer review
☐	☐	**Refer to the Quality Review meeting**

***Fatality Investigations Act* (2001)Enacted June 2003.**

Following must be reported:

- Death as a result of violence, suspected suicide or accident;
- Death as a result of suspected misadventure, negligence or accident on the part of the attending physician or staff;
- Cause of death has not been determined;
- Stillbirth or neonatal death where maternal injury has occurred or is suspected before admission or during delivery;
- Death occurred within ten days of an operative procedure or under initial induction, anesthesia or recovery from anesthesia from the operative procedure;
- Death declared on arrival to an emergency department;
- Death while detained or in custody in a correctional facility;
- Death while an inmate in a hospital or facility;
- Death in the custody of Children's and Family Services;
- Death in the custody of a peace officer or as a result of the use of force by a peace officer while on duty;
- Death of a person committed to a facility who dies when not on the premises or in actual custody;
- Death of a person who has died as a result of disease or ill health; an injury; or a toxic substance introduced into the person that is probably caused or is connected to their occupation or employment.

Prepared pursuant to the Evidence Act of Nova Scotia S. 60(2) and Freedom of Information and Protection of Privacy Act of Nova Scotia S. 19D(1) as amended.

Destroy after Review by Quality Review Committee

Sample
Committee Case Review Form
_____Program/Team
(terminology should be adapted to each organization)

Once details of the case are presented by the assigned reviewer(s), the committee analysis may be guided by the considerations or trigger questions contained below:

Reason or Source for Case Review:
❑ *Adverse Event* ❑ *Established Team/Committee Trigger* ❑ *Patient* ❑ *Morbid Event (injury, harm, worsening of condition)* ❑ *Referred by Committee Member* ❑ *Referred by Non-Committee Member*

❑ *Other*_____

Case Review Identification Number:_____

Were the diagnostics consistent with the circumstances? And interpreted successfully?

Was the outcome expected in the circumstances? _____

Was the documentation appropriate?_____

Were there process or system concerns affecting care for this patient? If so, what were the underlying factors negatively affecting care?

Consider the following lenses:

- Patient-condition/complexity/seriousness
- Personnel-physicians, nurses, others involved-competence/skills and knowledge/Physical and Mental Stressors/Verbal Communication/Written Communication/Supervision and Seeking Help
- Documentation-timely and appropriate charting
- Environment-Housekeeping/Control of physical environment/Movement of patients between units/sites
- Equipment-Malfunction/failue/reliability/Unavailability/Maintenance/Management/Alarms/Warning/Indicators
- Organization-Hierarchical arrangement of staff members within the unit/Span of control/Levels of decision-making
- Regulations/Policies-policies and procedures

If relevant, what needs to change, and who will be accountable to implement?

Prepared pursuant to the Evidence Act of Nova Scotia S. 60(2) and Freedom of Information and Protection of Privacy Act of Nova Scotia S. 19D(1) as amended.

Destroy after Review by Quality Review Committee

Sample Quality Review Committee
_____ (Department/Care Team)
SUMMARY MEETING NOTES
(terminology should be adapted to each organization)

Date:_____ **Chair: _____**

_____ Number of Cases Reviewed	_____ Mortality Cases
_____ Cases Open	_____ Morbidity Cases
_____ Cases Closed	_____ Random/Targeted Audit Cases
	_____ Referred from Other Source
	___Adverse Event

Recommendation #1

Action Plan: _____

_____

_____

Referred to:_____ **Bring Forward Date:_____**
☐ Case Closed (DDMMYY_____)

Recommendation #2

Action Plan: _____

_____

_____

Referred to:_____ **Bring Forward Date:_____**
☐ Case Closed (DDMMYY_____)

Recommendation #3

Action Plan: _____

_____

_____

Referred to:_____ **Bring Forward Date:_____**
☐ Case Closed (DDMMYY_____)

Prepared pursuant to the Evidence Act of Nova Scotia S. 60(2) and Freedom of Information and Protection of Privacy Act of Nova Scotia S. 19D(1) as amended.

APPENDIX C: Sample Data Elements

Data Element Suggestions/Examples for a DHA Managed Quality Review Database
(Any of these data elements can be expanded as per operational requirements at the DHA level.)

The data elements listed below are designed to capture broad categorizations related to a variety of Quality Review activities. In many instances cases are reviewed and there are no adverse events identified, therefore no classification will be required and no level of harm assigned. The large majority of mortality reviews would be a good example of detailed reviews where no adverse event has been identified by the Review Team. However, these case reviews may result in recommendations being identified by the Review Team regarding process or system improvement opportunities such as on-going bereavement support for families, or improvements in the organ donation process as two examples. These recommendations should be captured and categorized in the database as outcomes of the Quality Review process. Where case reviews have identified an adverse event, data elements have been provided as examples of broad data collection strategies. Capturing all review data by quarter allows the DHA/IWK to compare results from quarter to quarter in order to monitor and report on trends.

Data Element Suggestions/Examples:

Date of Review
- ddmmyear

Date of Event
- ddmmyear

Quarter (select one)
- Quarter 1: April 1 - June 30
- Quarter 2: July 1- September 31
- Quarter 3: October 1- December 31
- Quarter 4: January 1- March 31

Time of Event
- __ : __ hrs.

Type of Quality Review (select one)
- Morbidity Review
- Mortality Review
- Root Cause Analysis
- Failure Modes Effects Analysis (FMEA)
- Medication Occurrence Review
- Unusual Occurrence Review
- Complaint Review
- Ontario Coroner's Inquest Review (local application issues)

Adverse Event Type (select one)
- Birth Event
- Diagnosis Event

- ☐ Surgical Event
- ☐ Treatment Related Event
- ☐ Medication Event
- ☐ Not Applicable - No Adverse Event

Classification (select all that apply)

- ☐ **System**
  - ☐ Lab Results
  - ☐ Test Results
  - ☐ Diagnostic Information
- ☐ **Communication**
  - ☐ Hand Off (provider to provider)
  - ☐ Hand Off (location to location)
  - ☐ Documentation
- ☐ **Treatment**
  - ☐ Failure of Planning
  - ☐ Failure of Recognition
  - ☐ Failure to Rescue
  - ☐ Delay in Treatment
  - ☐ Missed Diagnosis
- ☐ **Facility**
  - ☐ Equipment Failure
  - ☐ Emergency Paging
  - ☐ Design - Human Factors
- ☐ **Not Applicable - No Adverse Event**

Contributing Factors (select all that apply)

- ☐ Fatigue
- ☐ Reduced Staff
- ☐ Increased Acuity
- ☐ Complex Care
- ☐ Multitasking
- ☐ Interruptions
- ☐ Distractions
- ☐ Not Applicable - No Adverse Event

Level of Harm (select one)

- ☐ Level 0: Near Miss
- ☐ Level 1: No harm/detectable harm - there was no injury or harm or no harmful effect to the patient and no potential risk identified
- ☐ Level 2: Minimal temporary harm - requires little or no intervention
- ☐ Level 3: Minimal permanent harm - requires initial but not prolonged intervention
- ☐ Level 4: Moderate temporary harm - requires initial but not prolonged hospitalization
- ☐ Level 5: Moderate permanent harm - requires intensive but not prolonged hospitalization
- ☐ Level 6: Severe temporary harm - requires intervention necessary to sustain life but not prolonged hospitalization
- ☐ Level 7: Severe permanent harm - requires intervention necessary to sustain life and prolonged hospitalization, long term care or hospice
- ☐ Level 8: Drastic outcome as a result of an event

Recommendations (select one)

- ☐ Yes
- ☐ No

Recommendation Classification (select all that apply)

- ☐ Process Improvement/Redesign
- ☐ System Improvement/Redesign
- ☐ Policy Development/Revision
- ☐ Procedure Development/Revision
- ☐ Team Learning Opportunity
- ☐ Individual Learning Opportunity
- ☐ Product Change
- ☐ Report to Health Canada
- ☐ Practice Issue Forwarded to Discipline Chief

APPENDIX D: Quality Review Working Group Members

Catherine Gaulton, Capital District Health Authority
General Counsel (in consulting capacity to the Working Group)

Mary-Ann Hiltz, IWK Health Centre
Director, Quality Resources and Decision Support Services

Maria Kuttner, Department of Health
Manager, Quality Division

Angela LeBlanc, Southwest Nova District Health Authority
Risk Manager & Manager of Infection Control

Dr. Shaun MacCormick, Colchester East Hants Health Authority
Chief of Staff

Nancy MacEachern, St. Martha's Regional Hospital
Nursing Services Manager

Kathleen Martin, Capital Health
Director, Quality and Risk Management

Catherine Syms, Cape Breton District Health Authority
Risk Management/Patient Liaison Coordinator (past member)

Barbara Young, Pictou County Health Authority
Director, Quality/Utilization Management and Decision Support