NSHEN

ETHICS COMMITTEE MANUAL

2016

By
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in consultation with members of the NSHEN Advisory Council

INTRODUCTION

This manual has been developed as a resource for health care ethics committees. It has a particular focus on creating a manual for those members just joining the committee. However, we hope it will be helpful for the ethics committee as a whole as well as its individual members, new and not-so-new.

There is no one "right" way to use this manual. We encourage you to adapt the content by adding pertinent materials from your institutional and ethics context, and by using the sections in whatever way is best for you. Not all sections may be relevant for your committee and members, while others may spark ideas about future work and development for your ethics work. As well, the topics included in the manual may be more or less helpful for enhancing the ethics competency of individual members and/or your entire committee at any given time. Our hope is that this resource will be a constant "work in progress," one you can draw on for information and links relevant to the growing, changing capacity and needs of your ethics committee and its members.

To that end, we value your feedback and welcome your comments and suggestions for improving the content, layout, format, resource list, examples, or any other aspect of the manual. Also, NSHEN is available to support and respond to your needs to strengthen your ethics capacity and support your ethics committee in whatever way we can. Please feel free to contact us with your ideas, questions, or concerns:

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INTRODUCTION FOR THE ETHICS COMMITTEE CHAIR

As the Chair of your local ethics committee we recommend that you familiarize yourself with the content of the manual so that you can adapt and use it in ways that address your particular needs and organizational context. The overall goal of the manual is to help ethics committee members--new and not-so-new--understand how the committee does its work. Thus adapting the content to better reflect how the committee operates in your particular healthcare context will enhance the likelihood of achieving this goal. Creating your own introduction--for example a letter of welcome--can help to personalize this resource and give your new members a better sense of the ethos of your committee.

Most sections include a short overview of a topic along with one or more examples that can be enhanced by adding relevant illustrations from your own context. We believe this process of "personalization" is important for increasing the manual's value as an education resource for each ethics committee. However, be discerning as you add extra materials, keeping in mind the impact on the size of the manual (recommended it be a 0.5 - 1 inch binder at most). The goal is to enlighten and support, rather than intimidate members! The Checklist page at the end of the Introduction section is a quick reference to aid your personalization process. You should remove it, along with any pages that are instructions to you as committee Chair. Once you have read through the contents of the manual and finished adding your own materials, remove the Checklist page along with this Introduction for the Chair page before making copies for your committee members.

Developing an orientation process is one way to introduce new members to their role and the functioning of your ethics committee can also be very helpful. However, before beginning such a process, it is important to be clear about the specific goals you want it to achieve. For example you may be hoping it will:

- help new members feel more comfortable at their first meeting
- encourage earlier participation of new members at meetings
- increase retention of new members on your ethics committee

Orientation should be an ongoing, active process – simply giving someone a manual or meeting with them once is not likely to achieve the outcomes you are hoping for. Besides the manual, NSHEN is also a resource to consider, e.g., the “Ethics Committee 101” workshop offered by NSHEN covers much of the material found in the manual, and thus can supplement your orientation in terms of equipping new members for their roles.

While your orientation program should be developed with your own committee and particular goals in mind, it may be helpful to consider the following issues:

- Remember that if you are able to achieve the diversity of membership recommended for an ethics committee, not all members may be familiar

with the healthcare system. Checking for hidden assumptions related to this in your orientation materials and process is worth the effort.

- Scheduling a time for you as Chair to meet with new members and welcome them personally is important. Assuring them of your accessibility to help them with their questions or concerns is part of this. During this meeting you can provide each of them with a copy of the manual and explain its use. The meeting also provides an opportunity to assign each of them a *mentor** from among your more experienced committee members. You can also outline basic committee structure and meeting schedule, provide an outline of upcoming education sessions, and point out the list of resources included in the manual.
- At the first full ethics committee meeting it is important to welcome and introduce new members to their committee colleagues. It can also be very helpful to reassure them that it **often takes a year or longer** for new members to feel "up-to-speed" in their new role.
- Finally, once the orientation process has been completed, evaluating it is the only way to know whether you achieved the goals you began with and to shape responsibly its ongoing review and revision.

The manual may be a valuable resource for the "not-so-new" members on your committee as well those just joining the group. It can serve as an educational tool to facilitate all members being "on the same page" when it comes to understanding the workings of your particular committee. It may also facilitate the process of *mentoring*** for those who agree to serve in this capacity if this is part of your orientation process. The usefulness of the manual for all these purposes will be improved by ensuring that all members receive any up-dates or revisions to the manual in a timely and consistent manner.

One last reminder--as you read through <u>each section</u> please take a few minutes to make it more meaningful for your recipients by adding materials specific to your particular ethics committee/institution/health district. At the risk of being overly repetitive, we believe the process of personalizing the manual is an important factor in how useful it will be for you and your committee members.

* If you choose to assign each new member a *mentor* as part of their orientation process, it will be important to identify more experienced ethics committee members who are willing and competent to take on this role. Deciding what the role will be and providing a description of it in terms of expectations of *mentors* will help facilitate their recruitment and fulfillment of the assignment. The manual may be a helpful for resource for them to use in this capacity.

CHECKLIST FOR ADAPTING MANUAL CONTENT

Add to manual if applicable:

- ☐ Welcome from the chair
- ☐ Agendas from the last 3 meetings
- ☐ Minutes from the last 3 meetings
- ☐ Ethics committee annual work plan
- ☐ Terms of reference
- ☐ Mandate of ethics committee
- ☐ History of this ethics committee
- ☐ Mission/vision for the ethics committee
- ☐ Membership and structure of the ethics committee
- ☐ Current membership list
- ☐ Description of procedures and processes used in meetings
- ☐ Description of how ethics committee evaluates its work
- ☐ Ethics committee policies
- ☐ Policies and procedures for documentation
- ☐ Forms for consultation intake and triage
- ☐ Forms for consultations
- ☐ Forms for evaluation
- ☐ Other documentation around consult processes
- ☐ Organizational values or identity statements (mission, vision, values)
- ☐ Organizational policies
- ☐ Relevant organizational policies
- ☐ List of upcoming training and events
- ☐ Org chart showing the ethics committee's relationship to other parts of the organization

Review and revise if applicable:

- ☐ Your first ethics committee meeting
- ☐ Job description for ethics committee members
- ☐ "Hot topics" for the ethics committee
- ☐ Org chart reflecting structure of ethics committee (including subcommittees, consultations team, etc.)
- ☐ Roles and responsibilities for members of the ethics committee

Table of Contents

1.0 Ethics Committee (EC) Overview

This section provides a summary of the nature and role of a healthcare ethics committee and its members. It includes a number of examples drawn from various health districts to illustrate the concepts in practical terms.

1.1 Welcome From the Chair (Sample)

Thank you for your willingness to share your expertise, insight, and time with the ethics committee. We look forward to getting to know you and facilitating your participation in and contribution to our committee.

This manual is part of our orientation process. Our expectation is not that you will read it all at once but that it will act as a resource and a support when you need it as you proceed on your journey as a member of the ethics committee.

Other aspects of the orientation process might include:

- meeting with your assigned mentor before and after the first EC meeting and again following the third meeting
- reading through section one of the manual to familiarize yourself with the nature and role of the EC committee prior to the first meeting
- talking with your mentor about any questions or concerns you have after reading these materials
- identifying possible resources to help prepare you for you role as an EC member

Once again, on behalf of the ethics committee and the organization, I would like to express our gratitude for all that you will bring to the committee.

1.1.1 YOUR ROLE AS AN ETHICS COMMITTEE MEMBER

New members on the ethics committee tend to think about one or more of the following three questions:

- Why me?
- What do I bring to the ethics committee?
- What is my role on the ethics committee?

You have been asked to join the ethics committee because your participation will enrich and strengthen its capacity to do its job. Each individual brings a unique perspective to the committee because of her/his particular experience, history, professional expertise, talents, and character. The broader the diversity of its membership, the stronger the capacity of the committee to examine multiple aspects of the ethics questions or concerns brought to it. The following list provides some examples of roles and responsibilities of ethics committee members.

1. Prepare for and attend meetings in their entirety
2. Participate in/contribute to discussions at meetings
3. Engage respectfully with others' views, being open to exploring issues and to potentially changing one's mind
4. Bring issues forward
5. Participate on various subcommittees as appropriate
6. Avail yourself of opportunities for training/education in ethics
7. Identify personal values and acknowledge them in discussion
8. Participate in evaluation of the committee's function
9. Establish effective, respectful working relationships with other members of the committee
10. Represent the ethics committee to other members of the organization
11. Declare conflicts of interests and maintain confidentiality
12. Encourage others to think about the ethical aspects of their daily practice

In addition to these "responsibilities" other aspects of your role often include:

13. Becoming familiar with the terms of reference and policies relevant to your district EC
14. Mentoring newer members as you gain familiarity with committee function and ethics capacity
15. Providing feedback to the chairperson regarding ongoing education needs
16. Being familiar with the mission, vision, and values statements of your healthcare institution and how these relate to the EC mandate

1.1.2 Top 10 Ethics Committee Functions

1. Provide education around ethics
2. Publicize the EC to the rest of the organization
3. Assist in meeting accreditation standards
4. Assist in policy development and review
5. Develop tools and frameworks for ethical decision making
6. Provide consultation on complex or contentious clinical and organizational ethics issues
7. Build ethics capacity of committee members
8. Build ethics capacity throughout the organization
9. Support the application of an ethics lens in organizational decision making
10. Evaluate the work of the committee

1.2 TERMS OF REFERENCE

It is prudent for an ethics committee to develop, review, and up-date terms of reference to define and clarify its mandate and functioning.

Examples of terms of reference taken from GASHA and CDHA (CHES) are provided in the following pages.

When developing/revising your terms of reference, here are some of the categories included in various districts' terms of reference:

- ☐Purpose
- ☐Membership
- ☐Structure
- ☐Expectations of members
- ☐Liability
- ☐Accountability
- ☐Resources
- ☐Budget
- ☐Reporting
- ☐Recording
- ☐Frequency of meetings
- ☐Evaluation and review
- ☐Supports
- ☐Chair
- ☐Functions
- ☐Nature and scope
- ☐Areas of responsibility
- ☐Objectives
- ☐Guiding principles
- ☐Relationships
- ☐Conduct of meetings
- ☐Quorum
- ☐Vacancies

Capital Health

Revised – April 2009

1.2.1 Example: Terms of Reference

Capital Health Ethics Support
Terms of Reference

PURPOSE

To contribute meaningfully to the building and maintenance of a positive ethical climate in Capital Health by:

- Enabling and facilitating ethics awareness and building health care ethics capacity across the district
- Identifying and responding to particular ethics support needs
- Supporting the actualization of Capital Health's Promise and its Declaration of Health. This includes fostering engagement and alignment with the five identified strategies related to the Declaration of Health: transforming person-centred health care experience; citizen and stakeholder engagement and accountability; transformational leadership; innovating health and learning; and, sustainability.

MODEL

Capital Health Ethics Support (CHES) is comprised of four components, each of which focuses on the provision of a different, significant aspect of ethics support. The components are: Organizational Ethics, Ethics Education, Policy Development and Review, and Clinical Ethics Consultation. Each component has a Coordinator, who is a member of the Coordinators Group. The Ethics Resource Coordinator provides logistical and administrative support for CHES. The Ethics Collaboration with the Dalhousie Department of Bioethics also provides support for CHES and its comprehensive ethics activities.

Capital Health
Ethics Support

MEMBERSHIP / STRUCTURE

Each component is responsible for its membership where new members may be appointed following a recruitment campaign utilizing Capital Health's recommended methods of communication (e.g., CH Update) as well as announcements at ethics-related events and sessions and referrals from current members (e.g., a snowball approach). An emphasis on building diversity and inclusion is a particular focus in recruitment of new members. Members of CHES will reflect a wide variety of perspectives and backgrounds, including, but not limited to:

- Health care professions
- Non-professional employees
- Patient advocates/representatives
- Spiritual care
- Organizational and clinical ethics expertise
- Health law expertise
- Rural/geographic perspectives
- Participation of persons from 'communities of meaning' within Capital Health including different cultural, ethnic, gender, age, and religious perspectives as well as health care receivers, including persons with disabilities

<u>Expectations of Members</u>

1. To act in a mutually respectful and supportive way with other CHES members, those for whom CHES is providing ethics support, and guests.
2. To be open to feedback about one's participation in CHES and/or a particular Component.
3. To abide by any guidelines established for CHES and/or a particular Component.
4. To maintain confidentiality of all matters discussed, materials distributed, and, in particular, patient information.
5. To be aware of Capital Health's Promise and its Declaration of Health.
6. To attend a majority of regularly scheduled meetings. Each Coordinator will review attendance on an individual basis with members of their Component, as needed.
7. To notify the Ethics Resource Coordinator or Component Coordinator with regrets if unable to attend a meeting.

8. To declare any potential, actual or perceived conflict of interests with respect to issues, topics, policies, etc. under discussion and as appropriate, based on the nature of the conflict of interest, excuse one's self from any meeting for the duration of such discussion and to not review or comment on or provide input on any information in relation to such topics.

Selection of Coordinators

Coordinators for CHES are selected on the basis of the following considerations: training and experience in ethics, the ability to facilitate and work with groups, and the ability to provide leadership. Recommendations for Coordinator positions are also informed by feedback from CHES membership and the VP People, before being submitted to the Quality Committee of the Board for approval. When possible and appropriate, Coordinators will be sought within CHES membership. If further recruitment is required, this will be done utilizing Capital Health's recommended methods for communication.

For the Organizational Ethics Coordinator, which is specifically designated as an external person, the recruitment and selection process will be as follows. Recruitment will use Capital Health's recommended methods for communication with the broader Capital Health community (e.g., via the Community Health Boards). Applicants will be asked to submit their CV and responses to questions about their interest in this role, their relevant ethics training and experience, facilitation and leadership abilities. A panel consisting of two members of the Coordinators Group and the Chair of the Quality Committee of the Board (or his/her designate) will review all applications and develop a short list of candidates. The panel will meet with the candidates and then recommend an individual for the position of Organizational Ethics Coordinator.

Quality & NSHEN Liaison

The past Organizational Ethics Coordinator, if available, will serve as the ethics representative on the Quality Committee of the Board (as per their terms of reference). This individual will also serve as the Advisory Council representative for Capital Health for the Nova Scotia Health Ethics Network (NSHEN). This person is responsible for communicating between CHES, the Quality Committee, and NSHEN as appropriate, and attends the Coordinators Group meetings.

LIABILITY

Members of CHES are covered by the NSHOPA liability policy held by Capital Health and fall under item (viii) with reference to the Insured – "Members of a hospital; nursing; and/or retirement home medical advisory boards or committees and members of local branch boards."

ACCOUNTABILITY

- CHES is accountable to the Quality Committee of the Board. The Coordinators Group reports the activities of CHES to this Committee on an annual and as needed basis.
- Each Component is responsible for the fulfillment of their respective activities and will seek support/guidance from the Coordinators Group as appropriate.

- Organizational ethics consultation reports are provided directly to the Quality Committee of the Board, the VP People, and to the CEO.
- CHES communicates regularly with Capital Health's VP People and, as appropriate, the CEO in relation to ensuring that information in relation to CHES activities which may impact Capital Health is provided, protecting confidentiality when necessary.
- The Ethics Resource Coordinator supports the activities of each Component, as appropriate, including the triaging/screening of requests made to the Ethics line.

RESOURCES and BUDGET

The Coordinators Group is responsible for prioritizing and administering the annual budget.

Parking/Mileage/Child Care/Stipend

CHES participants are entitled to receive reimbursement or chits for parking costs and mileage expenses incurred as a result of engaging in CHES activities. If volunteer members (i.e., those not employees of Capital Health) incur child care expenses, these are also reimbursed upon submission of an expense claim. For any Coordinator who is not an employee of Capital Health (such as the Organizational Ethics Coordinator), she/he will be eligible for a stipend. This stipend is meant to cover costs that the Coordinator may incur related to CHES activities and is in recognition of the additional demands of this volunteer position.

REPORTING and RECORDING

The Coordinators provide regular updates of their respective activities, reviews, and consultations to the Ethics Resource Coordinator for documentation and planning purposes. An Annual Report detailing the activities of CHES is developed and shared with the VP People, CEO, and Quality Committee of the Board as well as other members of Capital Health. The membership list for CHES is also included in this report. Meeting minutes are recorded for the Coordinators Group, Organizational Ethics and Ethics Education Components. All minutes are confidential documents that belong to Capital Health and are maintained by the Ethics Resource Coordinator.

Retention of Records

CHES follows policy CH 100-055, *Retention of Records*, and establishes appropriate mechanisms and processes for its correspondence, reports, and minutes.

FREQUENCY OF MEETINGS

Each component has set requirements for the frequency of its meetings, which varies according to the nature and demands of their aspect of ethics support. The Coordinators Group meets at least four times a year.

EVALUATION and REVIEW

Each Component and the Coordinators Group, on an annual basis:

- Develops or re-establishes a set of goals and objectives and/or work plan.
- Implements a process for component evaluation and effectiveness, as appropriate.
- Contributes to the preparation of the CHES Annual Report.
- Reviews the Terms of Reference.

SUPPORTS

Ethics Resource Coordinator – this person provides logistical and administrative support for the different Components and activities of CHES. This includes facilitating communication between the Components and acting as first point of contact via the Ethics line.

Ethics Collaboration with the Dalhousie Department of Bioethics – this Collaboration provides Capital Health with access to comprehensive ethics expertise and support, in accordance with the terms of a service agreement between Capital Health and Dalhousie University. This includes active participation in CHES Components and activities, as appropriate and required.

APPENDICES

- Additional detail for the Coordinators Group and CHES Components, including goals and actions, structure/membership, and coordinator responsibilities.
- Conflict of interest - description

Terms of Reference:

Dated: April 2009
Approved by the Quality Committee of the Board:
Next Review Date:

Capital Health

Capital Health Ethics Support Coordinators Group

GOALS

- To facilitate and ensure communication between and among the CHES components.
- To provide direction and support for CHES including, as appropriate, development of relevant goals and direction(s).
- To facilitate communication with the Quality Committee of the Board, the CEO, the VP People, other members of the Leadership Enabling Team, Capital Health, and the Ethics Collaboration with Dalhousie's Department of Bioethics.

ACTIONS

- To communicate with the Quality Committee, VP People, and, as appropriate, with the CEO, the Leadership Enabling Team and Board of Directors with respect to the ethics needs and activities within Capital Health.
- To communicate about ethics issues and activities for each Component, in order to facilitate appropriate responses and future planning.
- To provide support for addressing questions and/or concerns about membership for any Component. To oversee the development of the Annual Report.
- To annually review the previous year(s) of CHES activities and initiate planning and coordination of future activities. This may include visioning, anticipating future demands, and efforts to position CHES appropriately to continue to provide comprehensive, high quality ethics support to Capital Health.

STRUCTURE / MEMBERSHIP

The Coordinators Group membership shall include the Coordinator from each Component, a Dalhousie Department of Bioethics Ethics Collaborations Team representative, the Ethics Resource Coordinator, and the Quality & NSHEN Liaison.

CHAIR

The Coordinators Group shall nominate one of its members (excepting the Ethics Resource Coordinator) to chair this group on an annual basis. The responsibilities of the Chair include providing reports to the Quality Committee and an overview section for the Annual Report. It also includes working with the Ethics Resource Coordinator to schedule meetings and to develop the meeting agendas, as well as following up on any projects/tasks as required.

MEETING FREQUENCY

The Coordinators Group will meet at least four times per year.

Capital Health

Capital Health Ethics Support
Policy Development & Review

GOALS

- To provide ethics support to the development and review of Capital Health policies with significant ethics elements/dimensions.
- To attend to, and promote, social justice in the development and review of Capital Health policies.
- To build capacity for policy ethics review and analysis within Capital Health.

ACTIONS

- To develop, in conjunction with Organizational Ethics, criteria for the acceptance of requests for CHES participation in policy development and review.
- To triage requests for ethics support for the development/review of Capital Health policies, and to determine which components of CHES, if any, should respond to such requests.
- To assist policy sponsors in the establishment of policy working groups (consisting of primary stakeholders and relevant resource persons) for the development and review of Capital Health policies.
- To assist in, and provide an 'ethics lens' to, the development and periodic review of Capital Health's Policy Development and Implementation Policy.
- To review drafts of proposed new or revised Capital Health policies that have significant ethics content, and to provide written and/or verbal comments and recommendations to the author/developer(s) and sponsor of policies under development/review.
- To be attentive to relevant social justice issues in Capital Health's policy development and review process through: (1) the identification of disadvantaged social groups that will be directly affected by a policy or group of policies under consideration; (2) the recruitment of working group participants from these social groups; and (3) the facilitation of 'engaged participation' of these social groups in the policy development/review process.
- To be attentive to, and to mitigate, power imbalances among those participating as decision-makers, stakeholders and resource persons in policy development and review.
- As appropriate, and with due consideration to the fair allocation of Policy Development & Review's limited resources, to provide ethics support to the implementation of key ethics policies, as requested by relevant policy sponsors.
- To build capacity in ethics review and analysis in Capital Health through the identification, encouragement, and support of 'ethics mentors/influentials' with interest and skills in policy development and review.
- To develop and encourage constructive interfaces between Capital Health's processes for policy development/review and policy implementation, including educational activities related to the latter.
- To communicate, as appropriate, with the Policy Liaison, a member of Organizational Ethics (see below).

STRUCTURE / MEMBERSHIP
Policy Development & Review consists of a Coordinator who has the relevant education and experience to provide comprehensive ethics support to the development and review of health care policies. The membership of Organizational Ethics acts as an on request de facto standing group for Policy Development & Review, as per the functions outlined below, and on an ad hoc basis.

COORDINATOR
The Coordinator is responsible for coordinating and facilitating the activities of Policy Development & Review. This includes prioritizing, and responding appropriately to, requests for policy development and review from members of the Capital Health community. It also includes the identification of policies that would benefit from review by Organizational Ethics, and the referral of these policies to that Component's Policy Liaison. As per CHES protocol, copies of Ethics Review Reports are forwarded to requestors (e.g., policy sponsors and existing working groups), Capital Health's Policy Coordinator and the Ethics Resource Coordinator, the latter for documentation purposes.

POLICY LIAISON
A member of Organizational Ethics is appointed by that Component to act as the Policy Liaison between Policy Development & Review and Organizational Ethics. The Liaison communicates regularly with the Coordinator of Policy Development & Review and facilitates optimal communication between these two Components. The Liaison communicates with the Coordinator of Organizational Ethics when a policy is ready for review. The Liaison provides electronic copies of a relevant Capital Health policy, as well as the Organizational Ethics Policy Review framework, to the membership of Organizational Ethics prior to meetings where this policy is scheduled to be reviewed. After the discussion/dialogue about, and analysis of, a policy is completed by Organizational Ethics, the Liaison meets with the Coordinator of Policy Development & Review to share the outcomes of the Organizational Ethics review of the policy and to contribute, as appropriate, to the generation of an Ethics Review Report which is completed by the Coordinator of Policy Development & Review. The Liaison arranges with the Coordinator of Policy Development & Review to share the content of completed Ethics Review Reports involving Organizational Ethics input with that Component. More than one member of Organizational Ethics may be appointed to act in this role.

MEETING FREQUENCY
Policy Development and Review will meet as necessary.

GOALS

- To provide ethics support for Capital Health with respect to organizational health care ethics issues.
- To provide additional support for the review of policies with significant ethics elements/dimensions.

ACTIONS

- To engage on a proactive and upon request (consultation) basis on organizational health care ethics issues. This may include developing recommendations or policies. Ad hoc working groups may be established by this Component to focus on particular issues. (See relevant Operating Procedures for process for handling organizational ethics requests.)
    - Requests for organizational ethics can come from any member (internal or external) of Capital Health, the Ethics Resource Coordinator and/or other members of CHES. The Coordinator determines if a request is appropriate in consultation with members of Organizational Ethics.
    - Some requests directed to Organizational Ethics may be best dealt with by other CHES Components. As well, other CHES components may come across ethical issues that are more appropriately dealt with by Organizational Ethics. Communication between the Coordinators will facilitate the coordination of a response to these issues.
- To review policies, in conjunction with Policy Development & Review, from an ethical perspective. Requests for policy review will be brought forward by the Policy Liaison (see Policy Development & Review for description of this process and position).
- To identify, as appropriate, inconsistencies or systemic issues in Capital Health that impact on the ability of its members to act in an ethical manner.

MEMBERSHIP / STRUCTURE

Membership will reflect multidisciplinarity, diversity/inclusion, and specific expertise in health care ethics and health law to ensure the ability of this component to respond appropriately to organizational ethics issues. The membership of Organizational Ethics will nominate one (or more) of its members to act as the Policy Liaison.

MEMBERSHIP TERM

Members of Organizational Ethics, including the Coordinator, will be asked to commit to three-year terms with the option of renewal. Membership composition and the position of the Coordinator will be discussed on an annual basis to ensure appropriate continuity and transitions in positions and leadership.

COORDINATOR

The Coordinator is responsible for facilitating and coordinating the functions of Organizational Ethics. This includes prioritizing and responding to requests for organizational ethics consultation and/or policy review (in discussion with the Liaison), and working with the other CHES components and members of Capital Health, as deemed appropriate.

MEETING FREQUENCY

Organizational Ethics will typically meet 10 times a year.

Capital Health

Capital Health Ethics Support
Ethics Education

GOALS

- To build ethics awareness and capacity for ethical practice and decision-making by providing multi-faceted and targeted ethics education across the district.
- To heighten awareness of ethics issues and ethical behaviour in day-to-day practice, decision-making, and organizational processes.

ACTIONS

- To be proactive in identifying and addressing ethics education needs, as well as be responsive to ethics education requests.
- To develop ethics education modules/sessions/tools that focus on ethics issues of identified relevance for members of Capital Health, taking into consideration feedback from other CHES components.
- To facilitate an increased awareness of and engagement in clinical and organizational ethics issues.
- To facilitate ethics education by taking advantage of natural learning moments (including rounds, lunch & learns, etc.).
- To ensure ongoing ethics education of Ethics Education Standing Group members and, as appropriate, other members of CHES.
- To support ethics-related educational activities by other CHES components and Capital Health, including implementation and education with respect to policies with significant ethical aspects.
- To facilitate the development and ongoing activities of the Ethics Interest Group (a group that provides the opportunity for “connection and conversation” related to ethics in Capital Health).

MEMBERSHIP / STRUCTURE

The Ethics Education Component consists of a Standing Group. Other persons, including members of the Ethics Interest Group, may be involved in Ethics Education activities by request of the Component.

COORDINATOR

The Coordinator is responsible for facilitating and coordinating the functions of Ethics Education. This includes developing, with input from Ethics Education members as appropriate, a multi-faceted approach to Ethics Education in Capital Health. It also includes prioritizing and responding to requests for ethics education and support from other CHES components and members of Capital Health.

MEETING FREQUENCY

Ethics Education will typically meet 10 times per year. The Ethics Interest Group will meet at least two times per year.

Capital Health

Capital Health Ethics Support
Clinical Ethics Consultation

GOALS

- To provide clinical ethics consultation and support for physicians, students/learners, hospital staff, patients, 'families' (includes partners and significant others), and friends in response to identified substantive ethical issues directly related to clinical care.

ACTIONS

- To respond to ethics consultation queries and requests in accordance with the Clinical Ethics Consultation Procedures (see relevant Operating Procedures).
- To develop and implement appropriate evaluation of clinical ethics consultations.

MEMBERSHIP / STRUCTURE

All members of the Clinical Ethics Consultation Standing Group may participate in an ethics consultation upon request of the Coordinator. Participants in the Ethics Interest Group (identified for ethics consultations) or other CHES Components may also participate upon request of the Coordinator. A minimum of two and ideally three persons will be involved with each ethics consultation.

COORDINATOR

Upon determination that a request is deemed suitable for an ethics consultation, the Coordinator will assemble the consult team following the Clinical Ethics Consultation Procedures. The Coordinator is ultimately responsible for ensuring these procedures are followed. The Coordinator will also communicate with the Ethics Resource Coordinator to ensure that requests have been met, including a brief report when a consultation is completed (primarily for purposes of record-keeping).

MEETING FREQUENCY

Clinical Ethics Consultation will meet as necessary.

Capital Health

Conflict of Interest
Description

A conflict of interest exists where there is an actual, potential, or perceived divergence between the personal interests of an individual and that person's obligation to uphold the interests and mission of Capital Health, including the activities of CHES. In a conflict of interest situation, an impartial observer might reasonably question whether actions or decisions taken by this individual on behalf of the district or CHES are influenced by consideration of personal interests. A conflict of interest could also exist in circumstances whereby the personal interests of an individual will benefit or could be perceived to benefit as a result of that person's position in, for example, Capital Health. A conflict of interest depends upon the situation and not on the character or actions of the individual. Conflicts of interest must be disclosed, evaluated, and managed by the relevant Coordinator and, as appropriate, Component members, as they can severely undermine the trust relationships that are key to this process.

Suggested reading:

McDonald, Michael. *Ethics and conflict of interest*. The W. Maurice Young Center for Applied Ethics, University of British Columbia.
www.ethics.ubc.ca/people/mcdonald/conflict.htm

Guysborough Antigonish Strait Health Authority
Ethics Committee
Terms of Reference

Preamble:
The Ethics Committee conducts its work within the mission, vision, and values of GASHA, and is particularly conscious of the importance of respect for the dignity of all human beings and for diversity, including that of culture and belief.

Purpose:
- To act as an advisory and consultative body to assist with ethical decision making and to promote the use of ethical principles throughout facilities and programs within the district and at the Board level.
- To encourage reflection and increase the level of consciousness about ethical issues amongst GASHA staff, physicians, patients, families, community members and volunteers.

Objectives:
1. Promote the development of an ongoing process to identify, articulate, clarify and evaluate ethical principles to be used by the GASHA Board, physicians, staff and volunteers in their work. This will involve establishing processes in ethical consultation.
2. Promote awareness of and use of ethical principles by the Board, physicians, staff, and volunteers as they carry out their work.
3. Provide a forum for reflection and discussion of ethical issues.
4. Serve as a confidential resource for Board, physicians, staff, patients/families, managers and/or volunteers for reflection on ethical issues regarding patient care and/or treatment or organizational decisions.
5. Screen documents and decisions referred by the Board or others for matters having ethical implications, and return appropriate recommendations.
6. The ethics committee should be involved in the development and/or review of policies related to ethical issues.
7. Initiate educational activities/programs for Board, physicians, staff, and volunteers about a range of ethical issues. Engage the general public, patients and families in ethics education. Education of the committee itself is an on-going process.
8. Liaise with the Provincial (Nova Scotia) Health Ethics Network (NSHEN).
9. All research projects using human subjects will be reviewed by GASHA research ethics review committee (RERC), a sub-committee of the GASHA Ethics Committee. Documents will be reviewed and presented to the full RERC committee for approval. At least 1/3 of the members on RERC will be appointed by the Mission Assurance Advisory Council. The SMRH

representation on RERC will be to ensure that research proposals to be conducted at SMRH conform to the provisions of the Mission Assurance Agreement and Catholic Health Ethics Guide.

10. The Ethics Committee will review appeals on decisions of RERC as per the RERC Guidelines for submitting research proposals to GASHA.

Note: Professional practice discipline issues will not be dealt with by this body as they should go through the appropriate dispute resolution or complaint mechanism.

Chair/Vice-Chair

The Chair will be appointed from the committee. The term of the Chair will be three years commencing on their appointment date with the possibility of reappointment for one additional term. The Vice Chair will be appointed by the committee.

Membership

All representative members of the GASHA Ethics Committee will be appointed for three years. Normally, no representative member will be appointed for more than two consecutive terms. Terms will commence on September 1.

Member Representation:
Academic Liaison - 1
Clergy -1
Consultant Theologian/Ethicist *- 1
GASHA Board Member - 1
Management Representative – 2
Public Representative – 2
Physician – 2
Representative Long Term Care - 1
Staff Representative – 4 (It is recommended that this includes two nurse representatives and be inclusive of mental health and palliative care)

Ex Officio Members
GASHA Research Ethics Review Committee Chair
Mission Coordinator, SMRH
Spiritual & Religious Care Manager
Vice President Patient Care, GASHA

* In keeping with the relationship between GASHA and St Martha's Hospital, the Consultant Ethicist should be familiar with the contents of the Health Ethics Guide of the Catholic Health Association of Canada

(Legal representation, other members may be added on an ad-hoc basis depending on the issue and topic being discussed).

Note: At least 1/3 of the members will be appointed by the Mission Assurance Advisory Council as the St. Martha's Regional Hospital (SMRH) representatives. The SMRH representation will be to ensure that ethical decisions/recommendations conform to the provisions of the Mission Assurance Agreement and Catholic Health Ethics Guide. Ethical issues related only to practices at SMRH will be directed to this group of representatives. They may invite the full committee to assist in the deliberations.

Meetings
The meetings will be held monthly, with a minimum of eight meetings per year, or at the call of the Chair.

Reporting
The committee will make regular reports to the Quality Management Committee of the Board ensuring that the report is available to the full Board. The RERC will report at each meeting of the GASHA Ethics committee.

Quorum
A quorum shall consist of 50% plus one of the appointed members.

Review
The terms of reference shall be reviewed annually.

This committee will be evaluated after one year to determine the effectiveness of the merger of SMRH and GASHA Ethics committees. SMRH representatives on the committee will meet semi annually for purposes of education and awareness of their role as representatives of Catholic Health on the committee.

1.3 Membership of the Committee

The particular composition of a committee is often determined by the committee's terms of reference or policies. A single individual might fulfill multiple perspectives, but overall the committee seeks diverse perspectives from different locations inside and outside the organization as well as from various professional backgrounds. If your terms of reference do not cover this topic, or if it is valuable to expand on membership and structure for the committee, insert relevant information for your committee here.

Some examples of the types of members found on ethics committees include:

- ☐ Physician
- ☐ Nurse
- ☐ Social worker
- ☐ Lawyer (with health law expertise)
- ☐ Spiritual care provider
- ☐ Lab staff
- ☐ Non-physician/nurse health care providers
- ☐ LGBTQ community
- ☐ Community member
- ☐ Senior leadership (controversial)
- ☐ Public health
- ☐ Patient representative
- ☐ Long-term care
- ☐ Patient advocate
- ☐ Non-clinical staff
- ☐ Middle management
- ☐ Representatives from various care areas (especially those where ethics issues frequently arise, such as ICU, NICU, and palliative care)
- ☐ Ethics expertise
- ☐ Ethics consultation coordinator
- ☐ Risk management
- ☐ Quality
- ☐ Human resources
- ☐ Front-line staff

Some committees have dedicated positions for representatives from particular groups, while others operate with more general guidelines around diversity in membership.

Some topics that you might address in more detail here:

- Recruitment of new members - Although already mentioned in "Introduction to the chair," the concept of community involvement is worth repeating here. Traditionally members have been recruited from within the ranks of healthcare professions. However, intentional thoughtful recruitment from particular communities can add to the breadth of perspectives available for the committee's work. Representation from at least some communities whose interests are frequently overlooked, e.g., mental health, visible minorities, GLBTQ, other marginalized groups, can strengthen the integrity of ethics committee deliberations. Thus it is important to consider how you will include this aspect as you develop and operationalize a recruiting process.
- Diversity and the committee - what sort of diversity are we talking about and why?

- Roles of current members vs. ex officio attendees

1.3.1 Subcommittee Structure

Each ethics committee develops a structure to best address the tasks it is called on to fulfill and the logistics constraints within which it operates. In some districts this structure includes a number of smaller sub-committees, each with a focus on one particular aspect of ethics-related responsibilities. Extending this type of approach even further, within CDHA, the Capital Health Ethics Support service (CHES) is organized into four separate components --organizational ethics, clinical ethics, education support, and policy review--each with a coordinator who recruits members, oversees the work and functioning of the group, and collaborates with the other component coordinators to ensure an integrated approach to the overall ethics work. Together the four components fulfill the equivalent of an ethics committee and its related ethics functions which could be addressed by sub-committees. The decision to use this model, rather than a full committee with one or two sub-committees, was a decision that fit best with Capital Health's needs. As such, this sort of framework is not the only possibility for organizing your ethics committee and the work you do. For example, in some districts individual committee members take on particular tasks as these arise. Any combination or permutation is acceptable including having the committee-as-a-whole address all tasks, depending on how much work the ethics committee is asked to process. The next few pages provide an example of another ethics committee and sub-committee structure - one used in the Cape Breton District Health Authority.

1.3.2 EXAMPLE: CAPE BRETON DISTRICT HEALTH AUTHORITY ETHICS COMMITTEE - SUB-COMMITTEE STRUCTURE AND ROLES

Cape Breton District Health Authority
District Ethics Committee

Sub-Committees

A. Consultation Sub-Committee

The Consultation Sub-Committee will:

1. Advise the Ethics Committee on all aspects of the consultation procedure
2. Recommend resources and continuing education required to conduct consultations
3. Recommend ways and means to promote ethics consultations in the District
4. Evaluate the consultation process and outcomes.

B. Education and Development Sub-Committee

The Education Sub-Committee will:

1. In collaboration with Education and Learning Services determine and recommend education priorities for the District in relation to bioethics.
2. Organize a schedule of "Ethics Rounds" on current clinical and organizational ethical issues (i.e. using telehealth)
3. Organize at least one major seminar or workshop per year which deals with an ethical issue of broad interest to the District (i.e. "spring ethics workshop').
4. Advise on Ethics Committee development including orientation of new members, continuing education, and a standard compilation of resource materials.

1.4 Ethics Committee Meetings

Usually the terms of reference for the ethics committee will outline details and expectations related to meetings. Thus this section provides a template outlining a sample meeting along with examples of meeting agendas and minutes.

1.4.1 Your First Ethics Committee Meeting

Generally the agenda and minutes of previous meeting are circulated in advance – it is helpful to review these before the meeting.

Meetings are relatively informal, and are chaired by the chair of the ethics committee or their designate. Minutes are generally taken, but these tend to focus on recording motions and logistical decisions along with the general shape and content of conversations (rather than transcripts or verbatim minutes that connect particular members with specific discussion points).

Most meetings proceed in the following manner:

1. Review and approval of the agenda
2. Review and approval of the minutes of the previous meeting
3. Review of business arising from the minutes
    a. Often includes updates on ongoing issues, consultations, or policies
    b. Can include plans for upcoming events or activities such as ethics days
    c. Sometimes includes updates on membership, recruitment and long-term planning for the ethics committee
4. Updates from various subcommittees, groups, or other organizations (such as the ethics consult team, advisory councils, the board, community groups, NSHEN, etc.)
5. Discussion of new business
    a. Includes new issues, consultations, or policies for review
    b. Can include striking of planning committees for events and activities
6. Committee education
    a. Discussion of a case or issue
    b. Presentation from another group or committee
    c. Activity to develop facilitation or other skills
7. Adjournment

You will be introduced at the beginning of the meeting and the rest of the committee will introduce themselves to you. You should feel free to ask questions during your first meeting (and beyond) as needed to understand the background to processes and projects; it is valuable for the committee to have the opportunity, through answering these questions, to review what it's doing and why it's engaged with those particular activities.

As a member of the committee, you are there as yourself, bringing perspectives gained from your personal and professional experience to the table. It is not expected that you will always or only be a "representative" for a particular constituency (whether that be youth, the community, patients, families, ethics expertise, non-physician health professionals, physicians, or senior leadership).

1.4.2 SAMPLES OF ETHICS COMMITTEE AGENDAS AND MINUTES

As a generic example, we have included an agenda and minutes taken from the NSHEN advisory council. However, examples from your own committee will provide a better illustration of how your committee operates.

NOVA SCOTIA HEALTH ETHICS NETWORK ADVISORY COUNCIL
AGENDA – MAY 4, 2012

1. MEETING DETAILS			
Location	East Hants	**Meeting Date**	May 4, 2012
Prepared By	K. Mleczko-Skerry	**Meeting Time**	11am-3pm

2. AGENDA ITEMS		
Item	**Description**	**Responsibility**
1	**Call to Order**	Chair
2	**Review/Revise/Approve of Agenda**	All
3	**Approval of Minutes – February 3, & April 4, 2012**	All
4	**Operations Team Updates**	
	4.1 Administrator's Update	K. Mleczko-Skerry
	4.2 Ethicists' Update	C. Simpson / M. Warren
5	**Advisory Council – Business**	
	5.1 Review of Action Items (previous minutes) - Time frame of upcoming events - DoHW Ethics Committee - 2013 Conference Committee -	 All P Murray C Simpson
	5.2 Standing Items - Long Term Care & NSHEN	All
	5.3 Additional Items - Welcome to new "Ethicist" Cathy Simpson	Chair
6	**Information Sharing & Meeting Review**	
	6.1 Advisory Council Roundtable	All
	6.2 Next Meeting **June 1, 2012** **Teleconference** **1pm-3pm**	
7	**Adjournment**	

NOVA SCOTIA HEALTH ETHICS NETWORK ADVISORY COUNCIL
MINUTES – MAY 4, 2012

1. MEETING DETAILS			
Meeting Title	Nova Scotia Health Ethics Network Advisory Council Meeting		
Location	East Hants Resource	**Meeting Date**	May 4, 2012
Prepared By	K. Mleczko-Skerry	**Meeting Time**	11am-3pm
Participants			
Angela Arra-Robar	Nancy Williamson	Chantel Bishop	Christy Simpson
Patricia Murray	Angela Clifton	Anne Simmonds	Linda Dieltgens
Liz Millett	David King	Tracey Williams	
Regrets			
Mary McNally	Stephanie Harvey		

2. AGENDA ITEMS	
Item	**Description**
1	**Call to Order** Liz Millett called the meeting to order at 11:05am.
2	**Review/Revise/Approve of Agenda** The agenda was reviewed and approved as circulated. Items added to agenda: Strategic 5 yr plan, 2013 conference committee, ethics committees & placement, introduction of new members
3	**Approval of Minutes – February 3 & April 4** Both sets of minutes were reviewed and approved.
4	**Operations Team Updates**
	4.1 Administrator's Update K MleczkoSkerry reported that she has been busy with upcoming workshops, plus the changing of the Advanced Policy to another EC 101 in the fall. KMS reported she will be taking a Project Management course through Dalhousie sponsored by NSHEN. The library book loaning process has been increasing in interest. KMS will add a listing of our books available for loan to the NSHEN website. KMS is still waiting for Annual Report sections from members.
	4.2 Ethicists' Update The Ethics Committee 101 workshop was held in Truro last week. It was a smaller group but the audience was very engaged. There was a mix of different districts and the reviews of the day were good. Cathy Simpson will finish the final additions to the Orientation Manual. KMS will format. The All Hazards workshop on April 11 went very well. There was lots of positive feedback. There will be ongoing work on updating the pandemic planning document. NSHEN received a request for information from Truro regarding legislation. J Kirby will be working with Maria Lasheras and the PHIA with the DoHW. There will be an article on this in the NSHEN June newsletter. The discussion of a possible telehealth on PHIA and FOIP was discussed. Cathy Simpson has the content and topics for the newsletters and telehealths all ready for the upcoming year. The next telehealth scheduled for May 30 will be how to identify the ethics issue. Cathy Simpson will take on the NSHEN project of creating a database of cases. Dalhousie has hired a part-time research assistant to help with this database and other research issues that may arise. Each DHA is asked to think about what topic and date they would like for their ethics day for 2012-2013.

	5.1 Review of Action Items (minutes) Time Frame of Upcoming Events – See below. 2013 Conference Committee – See below. DoHW Ethics Committee – The DoHW committee has been moved to Policy & Planning. In doing this, they are trying to build capacity by creating a new ethics committee.
	5.2 Standing Items Long-Term Care Nothing new to report.
	5.3 Additional Agenda Items New Membership David King attended this meeting as the new rep for SWNDHA. Tracey Williams attended this meeting as the new rep for DoHW. Cathy Simpson was introduced as the new interim ethicist with NSHEN replacing Marika Warren while she is off on her maternity leave. Anne Simmonds reported this would be her last meeting as PCHA rep. She is moving to Toronto. There is no representative to replace Anne yet. 2013 Conference Committee - NSHEN is looking for 2 members to join the 2013 conf comm. Angela Arra-Robar and Chantel Bishop have agreed to join for 2013. Discussion was held regarding topic, location, date, time frame of conference. It was decided that NSHEN would have a one-day conference. This will be held October 24, 2012 at the Best Western Conference Centre in Burnside (Dartmouth), NS. The planning committee will decide on layout of day and topic for conference. It was also decided to keep CME accreditation. We will see by evaluations and attendance how the fall date works for events and will decide then whether to change from the March conference to October. Strategic 5 yr plan – Discussion was held regarding the MOU that is up for renewal in December and the next 5 years. The advocacy role will be included in the next 5 yr plan. Since we will be presenting the advocacy piece to the Council of CEO's, we need to make it clear at the beginning this advocacy is for ethics lens only. We will also advocate for LTC in this plan at the CEO table. We will focus on the MOU at the June meeting.
6.0	**Information Sharing & Meeting Review**
	6.1 Advisory Council Roundtable Council discussed ongoing ethics events and issues in each of their respective DHAs.
	6.2 Meeting Check-in Evaluation Council was satisfied with the meeting and content.
	6.3 Next Meeting **June 1, 2012** **1pm-3pm** **Teleconference**
	Adjournment L Millett adjourned the meeting at 3:10pm

1. ACTION ITEMS			
Item	**Action**	**Assigned To**	**Due Date**

1.4.3 Ethics Committee Workplan

Not all committees have a workplan or a strategic plan, but it can be a helpful way to organize and prioritize the work of the committee. The following example is a workplan developed by the AVH ethics committee. You'll see there are a number of different elements included in their plan.

Vision: Healthy people, caring communities, valued healthcare teams and partners.

Mission: Working together to promote and improve the health of individuals, families and communities.

Core Values: Integrity Accountability Respect Collaboration Continuous Improvement Innovation

Strategic Direction 1: **Healthier people and communities through partnering and learning**

Objectives

1.1 Build capacity to use a population health approach across all programs and services in AVH.
1.2 Enhance partnerships to address priority health issues as identified y health status indicators and Community Health Board needs assessments.
1.3 Continue to develop community-based models for the promotion of health and the delivery of primary health care y collaborative teams.
1.4 Create an environment that supports volunteer involvement in AVH services.
1.5 Encourage people to become involved in promoting and maintaining their own health and the health of their families and communities.

Strategic Direction 2: **Appropriate, accessible, safe and quality health care services.**

Objectives

2.1 Enhance collaboration and integration across the range of AVH health services to meet the needs of our population.
2.2 Champion family-centered principles and approaches.
2.3 Foster a culture of quality, patient safety, ethical practice and respect for confidentiality and privacy.
2.4 Improve access to AVH services and programs.
2.5 Streamline processes so teams can plan and perform more effectively and efficiently.

Strategic Direction 3: **Skilled people working in healthy, safe workplaces.**

Objectives

3.1 Recruit and retain highly skilled people by making AVH the employer of choice.
3.2 Foster excellence in leadership throughout the organization.
3.3 Continue to create a healthy and safe workplace.
3.4 Implement a comprehensive and dynamic human resources plan including performance measurement.
3.5 Provide appropriate infrastructure and equipment to support the delivery of health services.
3.6 Enhance communication within and between all AVH programs and services.

Strategic Direction 4: **Continuous learning and excellence in system performance.**

Objectives

4.1 Enhance monitoring and reporting of our health system performance.
4.2 Build capacity to find and use knowledge to support decision-making.
4.3 Enhance the involvement of people in planning and evaluating health services.
4.4 Enhance capacity for ethical decision-making.
4.5 Foster a culture of learning, innovation and best practice.

CCHSA Proactive and Supportive Organization Standards – Ethics

6.3 The organization develops and implements a comprehensive ethics strategy.

Guidelines:

The ethics strategy should include the following: an ethics framework including guiding principles; the integration of organizational and clinical ethics; clear responsibility for the ethics function within the overall organizational structure; and mechanisms to involve staff, service providers, community representatives, and clients in ethics-related issues and decision-making.

6.4 The ethics strategy includes a code of ethics to support business and professional behaviour.

6.5 The organization has processes to handle ethics-related issues and concerns.

Guidelines:

The organization's processes may include set criteria to guide discussions and decision-making concerning ethical issues.

Examples of ethics-related issues may include conflict of interest, issues of non-compliance with the code of ethics, confidentiality, promotional activities, resource allocation, consent, death and dying, and research.

6.6 The organization has a process and set criteria to review the ethical implications of research.

Guidelines:

The process should include but is not limited to: criteria for determining when a research project requires ethics approval; criteria for determining when new innovations should be considered research; and, the participation of clients in the ethics review process.

6.7 An external reviewer or body reviews all the formal research projects in which the organization is involved.

Guidelines:

The review should include: the merits of the research proposal; benefits and risks to the participants and the organization; refusal and exclusion criteria, as applicable; the process for obtaining informed consent; the process used to deal with any harmful effects that may occur in the course of th research; the adequacy of research design, including its compliance with accepted ethics standards; the qualifications of the project's coordinators; the potential impact on the organization's resources; the identification of research sponsors and possible conflicts of interest; and, an assessment again relevant national and/or provincial guidelines and protocols, e.g Research Ethics Boards (REB), tri-council protocols.

6.8 The organization builds ethics capacity amongst its leaders, staff and service providers.

Guidelines:

Opportunities to develop and enhance ethics-related knowledge, skills, and expertise may include formal education and training, the availability of ethics frameworks and tools, forums for case reviews, and the dissemination of best practices in ethics.

6.9 The organization's values and codes of ethics are reflected in decision-making and how services are delivered.

Logic Model for Ongoing Development

Inputs Program Components	**Education**	**Consultation**	**Policy**
Outputs Activities/services that the program provides	Provide ongoing and regularly scheduled ethics education events Provide access to ethics education specifically for Ethics Advisory Committee members Provide ad-hoc education session based on demand or request Provide access to relevant ethics education for multiple disciplines Develop ethics communication strategy	Develop a pool of ethics 'consultants' Develop and formalize consultation process for clinical and organizational issues Provide education and communication re: availability of consultation services	Provide leadership in the development of an organizational process for policy development Develop process for substantive policy review by Ethics Advisory Committee Provide leadership in the development of a decision-making framework Provide education specific to the moral significance of policy development
Outcomes Anticipated, measurable program results			
Effects Long term consequences of program	• Every employee feels they have the capacity to approach ethical issues on their on and from a systematic vs. gut-reaction/individual point of view • Nobody feels lonely or isolated when dealing with an ethical issue; they have a safe place to go • Ethical thinking becomes automatic, integrated in what we do • Throughout all of the organization: employees/board/community are aware of access – breaking the normal barriers of access and awareness • Become leaders in ethics (national/international/etc) • Transparent about where we are in development • Culture – language – continuity • Ambassadors (internal leadership) • Advocacy through action and possible influence on other DHAs • Cases for review accepted from anyone with issue related to AVH • Managing expectations re: committee identity and purpose • Individuals at AVH able to take a step back and think situation through		

Operational Plan

Education					
Outputs	**Objectives / Action Required**	**Time Frame**	**Resources Required**	**Status**	**Outcome(s) / Indicator(s)**
Provide ongoing and regularly scheduled ethics education events *CCHSA Proactive & Supportive 6.8*	• To host one public ethics lecture per year • To provide one full-day ethics workshop per year • To provide ethics intro during all district general orientation sessions • To provide one education session per month on the 3rd Friday of the month • To provide Telehealth access to NSHEN ed on the last Friday of every 2nd month	•	•	•	
Provide access to ethics education specifically for Ethics Advisory Committee members *CCHSA Proactive & Supportive 6.8*	• To develop orientation for committee members • To support the registration/travel of one Ethics Advisory Committee member in the PHEN Intro to Bioethics course per year • To support the attendance of one EAC member per year at the Canadian Bioethics Society Annual Conference	•	•		
Provide ad-hoc education sessions based on demand or request *CCHSA Proactive & Supportive 6.8*	•	•	•		

Provide access to relevant ethics education for multiple disciplines	• To accredit all applicable ethics education event for relevant professions •	•	•		
Develop ethics communication strategy *CCHSA Proactive & Supportive 6.3* *AVH Strategic Direction 3.6*	• To publish ethics info in AVH Source in January, May and September • To develop and maintain ethics website				
Consultation					
Outputs	**Objectives / Action Required**	**Time Frame**	**Resources Required**	**Status**	**Indicator(s)**
Develop a pool of ethics 'consultants'	• To identify individuals with interest and facilitation skills across sites/disciplines • To provide training to EAC members based on ASBH Core Competencies • To develop explicit supporting relationship with NSHEN Ethicist	•	•		
Develop and formalize consultation process for clinical and organizational issues *CCHSA Proactive & Supportive 6.5*	• To develop clear goals for consultation • To develop sustainable strategy to coordinate requests • To develop a district ethics consultation policy • To develop recording/filing requirements for consultation • To develop evaluation framework for consultations	•	•		
Provide education and communication re: availability of consultation services	• To finalize and distribute brochure	•	•		

CCHSA Proactive & Supportive 6.3					
Policy					
Outputs	**Objectives / Action Required**	**Time Frame**	**Resources Required**	**Status**	**Indicator(s)**
Provide leadership in the development of an organizational process for policy development	• To liaise with P&P committees • To review current process for initiating policy development across AVH departments	•	•		
Develop process for substantive policy review by the Ethics Advisory Committee	• To develop criteria that will identify when a policy ought to receive review	•	•		
Provide leadership in the development of a decision-making framework *CCHSA Proactive & Supportive 10.0*	•	•	•		
Provide education specific to moral significance of policy development	•	•	•		

1.5 Ethics Committee Policies and Procedures

The most common document in this category is the committee's terms of reference, already discussed under section 1.2 of this manual. Other policies and procedures might include:

- Conflict of interest
- Confidentiality
- Documentation
    - meetings
    - policy review
    - consults
- Document/file retention (many committees do not have this, but it is worth developing one to guide the filing of documents and files related to your committee's work)
- Evaluation

Attached is one example of an ethics committee-related policy. Commonly such policies address conflict of interest and confidentiality for members. Some committees use their organization's policies while others have crafted their own.

1.5.1 Example of an Ethics Committee Policy and Procedure - CBDHA

Capital Health

ADMINISTRATIVE MANUAL

Policy & Procedure

TITLE:	Disclosure of Adverse Patient Safety Events and Harm	**NUMBER:**	CH 70-006
Effective Date:	October 2010	**Page**	1 of 22
Applies To:	Holders of Administrative Manual		

Table of Contents

Note: For information/direction on Capital Health's formal process for reporting adverse patient safety events, refer to Patient Safety Reporting System Policy CH 100-035.)

Disclosure Policy Quick Reference Guide

Is this an Adverse Patient Safety Event? → No → No action required

Yes
1. Unintended harm to patient related to care or services
2. Harm that may negatively affect Patient's physical and/or psychological health and/or quality of life

↓

Physician, Health Care Provider, Student or Volunteer notifies Manager and Department Head

↓

Health care provider and Manager:

- Assess & ascertain whether adverse patient safety event criteria are met; if so, determine whether type A (one patient) or B (multi-person(s) and/or being of legitimate public interest); if B, report to Director who informs appropriate VP, Risk Management/Patient Safety & Legal Services
- Designate a Disclosure Team (usually Health Care Provider, Manager and Patient Representative)
- Designate initiator of disclosure discussion
- Manager informs Health Care Team of supports

Disclosure team:

- Arranges to meet with patient and disclose adverse patient safety event in a timely manner (*See Internal Disclosure Procedure # 2 to 7*).
- Documents summary in the patient health record
- Offers to meet with patient and conduct post-analysis disclosure as necessary.

LET

- In consultation with Dept. of Health, determines whether to disclose externally (*See External Disclosure Procedure section*), if so,
- Appoints external disclosure team.

Key Points to Remember

Elements of Optimal Disclosure

- Person-Centered Healthcare
- Patient Autonomy
- Recognition
- Acknowledgement
- Factual Explanation
- Assumption of Responsibility
- Regret and Apology
- Honesty and Transparency
- Clarity of Communication
- Timeliness
- Confidentiality
- Support and Advocacy
- Continuity of Care
- Healthcare that is safe
- Leadership Support

Person to initiate disclosure

- Known/trusted by patient
- Good interpersonal/communication skills
- Respectful of cultural, language, gender, and diversity issues
- Good grasp of the factual information
- Well informed about the patient's needs (e.g. capacity)
- Willing/able to express regret/apologize and provide sensitive feedback
- Maintain medium to long term relationship

Initial Discussion

Includes*:*

- Patient advised of identity & role of disclosure team
- Expression of regret and apology
- Factual explanation with appropriate language and terminology
- Potential outcomes/consequences of adverse patient safety event and any harm
- Adequate time for questions
- Support Plan
- Initial plan of care

Does not Include:

- Speculation
- Attribution of blame to specific individuals
- Legal admission of liability
- Denial of responsibility
- Lack of clarity regarding the known facts

PREAMBLE/BACKGROUND

Achieving a culture of patient safety requires open, honest and effective communication between health care providers and their patients. Patients are entitled to information about themselves and about their medical condition or illness, including the risks inherent in health care delivery (Canadian Disclosure Guidelines, CPSI (2008).

Patient and families expect honest, empathic, and respectful communications with their health care providers, and especially when harm has occurred. Open disclosure helps the patient and family, the health care providers involved, and the health organization heal and learn from the harm, which helps make the system safer for all.

When patients have been harmed, they expect a sincere apology and an explanation of what has happened. They also need to see that the organization accepts responsibility and is initiating changes and implementing actions to help prevent the harm from happening again. See Patients for Patient Safety Canada at ***http://patientsforpatientsafety.ca/initiatives/disclosure/***

Capital Health's Our Promise is to create a world-leading haven for people centered-health, healing, and learning. In the Person-Centered Health strategic stream, the patient is welcomed as a full-fledged member of the health-care team. The patient's right to make decisions about his/her own health is respected, and it is recognized that a healthy person needs a healthy community. Capital Health cares for the whole person before us with our hearts, as well as our hands and minds.

Capital Health recognizes that adverse patient safety events rarely arise from a single event and are not usually solely provider-related. They typically arise from a series or cascade of system–related events which often result from latent circumstances in the environment, such as equipment, facilities design, training, maintenance and organizational factors.

POLICY

1. The Disclosure of Adverse Patient Safety Events and Harm Policy:
   - 1.1. provides guidance and direction in those circumstances in which disclosure of adverse patient safety events and the harm associated with them is or may be indicated;
   - 1.2. provides clear procedures for disclosure;
   - 1.3. applies to both Type A and Type B events (See **Definitions**);
   - 1.4. recognizes the importance of an open patient safety culture; and
   - 1.5. follows the principles of a Just Culture that ensures that staff and health care providers are not penalized for their involvement in the reporting of adverse patient safety events and for participating in disclosure processes.
2. All Capital Health physicians, health care providers, volunteers and students are to inform their manager and department head, and other appropriate person (eg. Risk Management/Patient Safety), about patient safety events that may meet the criteria of an adverse patient safety event.
   - 2.1. Examples of events that require reporting through the Patient Safety Reporting System (PSRS) and that require disclosure are outlined in ***Appendix A.*** The manager/department head is to inform the appropriate director who is accountable for ensuring the processes as outlined in this policy are implemented.
3. Disclosure of information regarding an adverse patient safety event should take place as soon as possible after recognition that the adverse patient safety event has occurred.

4. Adverse patient safety events involving patients are discussed with the patient directly, or if the patient lacks capacity, with the patient's substitute decision-maker. At such time as the patient has regained capacity, discussion of the adverse patient safety event takes place with the patient directly.
5. Nothing in this policy prevents a health care provider from individually disclosing minor events directly to patients at the time of the patient safety event occurring.
   5.1. Events at Impact Classification Level 1-4 in the Patient Safety Reporting System do not necessarily require designation of an Disclosure Team.
   5.2. Examples of such events, in some circumstances, are medication omission, extra dose of medication, and rejection of blood samples requiring redraw depending on patient impact.
6. Although the procedures of the policy specifically address actions to be undertaken in the event of an adverse patient safety event (as defined in the **Definitions** section), disclosure of patient safety events (e.g. near miss events) that do not meet the harm criterion of an adverse patient safety event is strongly encouraged for the purposes of informing the patient and staff and to prevent similar events in future.
   6.1. In order to facilitate learning and the development/maintenance of a positive patient safety culture, Capital Health recognizes the importance of reporting all patient safety events (including near misses) through the *Patient Safety Reporting System* whether or not they have resulted in harm to the patient.
7. **Expected outcomes** of implementing this policy include**:**
   7.1. Patients receive prompt and timely disclosure and are fully informed about adverse patient safety events and any associated harm that has occurred to them.
   7.2. Patients receive a timely, respectful and sincere apology in accordance with this Policy.
   7.3. Patients have their concerns and fears openly addressed and respected.
   7.4. Open communication between patients and their health care providers that respects and addresses the patient's needs.
   7.5. The disclosure process supports a positive patient safety culture, improves the quality of care, and facilitates learning from adverse patient safety events.

GUIDING PRINCIPLES & VALUES

1. In a culture of patient-centered health care, patient safety and ethics, failure to properly disclose adverse patient safety events has the potential to undermine public confidence in health care providers and health care organizations. The use of well thought-out processes for managing adverse patient safety events can facilitate systems improvements in health care organizations and contribute in important ways to the prevention of further adverse patient safety events.
2. A number of ethics principles and values including but not necessarily limited to those outline in number 3 below should inform decision-making regarding the disclosure of adverse patient safety events. It important to recognize and acknowledge that, in some circumstances/contexts, these principles and values, and the moral obligations that arise

from them, are in conflict/tension and, as such, require careful balancing by decision makers.

3. **Respect for persons:**

3.1 *Truth telling* – a basic, widely accepted ethics principle and a key component of accountability, one of Capital Health's core values. Health care organizations and those working within them have a fundamental obligation to be honest and open in their communications with patients, their 'families'/substitute decision makers, and the public.

3.2 *Trust* – understood in the health care context as the reliance and related expectation that health care organizations and those working within them act so as to put the interests of patients first. The earning of the public's trust is an important moral obligation of health care organizations.

3.3 *Autonomy* – as interpreted in the disclosure of adverse patient safety events context, the patient has the 'right to (fully) know' about an adverse patient safety event that has affected or potentially affected him/her and has the right to make informed choices about her/his future health care and treatment.

4. **Patient welfare**

4.1 *Beneficence* – the obligation of health care organizations and providers to provide meaningful health benefits to patients/families and the public.

4.2 *Nonmaleficence* – the obligation to 'first, do not harm' or as little as possible, i.e., the responsibility of health care organizations and health care providers to mitigate/reduce burdens to patients and the public.

5. **Justice**

5.1 *Traditional justice* – social benefits (including health and health care) and burdens are to be fairly distributed/allocated.

5.2 *Formal justice* – like individuals and groups should be treated alike unless there is a demonstrable *relevant* difference between them that would justify different treatment.

5.3 *Social justice* – includes the obligation to meaningfully engage participants from vulnerable social groups in health care decision making, e.g., disadvantaged persons who may be affected by adverse patient safety events and their disclosure.

5.4 *Procedural justice* – the requirement that we collectively develop and follow fair due processes.

BEST PRACTICE GUIDELINES: Elements of Optimal Disclosure:	
• Person-centered healthcare • Patient Autonomy • Recognition • Acknowledgement • Factual Explanation • Acknowledgement of Responsibility • Expression of Regret & Apology	• Honesty and Transparency • Clarity of Communication • Timeliness • Confidentiality • Support and Advocacy • Continuity of Care • Leadership support

DEFINITIONS

Adverse patient safety event:	A patient safety event which results in unintended harm to the patient and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition and may negatively impact a patient's physical and/or psychological health and/or quality of life. (Adapted CPSI 2008). ***Note:*** *See also* ***Appendix A*** *for a list of events that are reportable through the PSRS and require disclosure.*
Apology:	An expression of sympathy or regret, a statement that one is sorry (CPSI 2008).
Appropriate health care provider:	An attending health care provider who is familiar with the patient and has responsibility for providing health care in the treatment domain in which the adverse patient safety event occurred or potentially occurred.
Appropriate manager/director:	The manager/director (or designate) who is responsible and accountable for standards of care in the clinical unit or area in which the adverse patient safety event occurred or potentially occurred.
Autonomy:	The patient's right to control what happens to his or her body, and is the cornerstone of the informed consent discussion (CPSI 2008).
Disclosure:	The process by which an adverse event is communicated to the patient by healthcare providers. ➢ *Initial Disclosure* is the initial communications with the patient as soon as reasonably possible after the adverse patient safety event. ➢ *Post-analysis Disclosure* is the subsequent communications with a patient about known facts related to the reasons for the harm after an appropriate analysis of the adverse patient safety event. (CPSI 2008)
Harm:	An outcome that negatively affects the patient's health and/or quality of life (CPSI 2008)
Informing:	Providing information about adverse events and performance of the health care system to the public, mainly through the media (CPSI 2008).

Just Culture:

A key element of a broader patient safety culture that seeks to reconcile professional accountability and the need to create a safe environment in which to report adverse patient safety events. Healthcare providers in a just culture are fully aware of the expectations of the organization and are held professionally accountable for the quality of their work in a fair way. Adverse events are viewed in the context of identifying system contributors in order to improve safety. *(CPSI, 2008)*

Just Culture is:

- Reporting of patient safety events.
- Promoting open discussions & learning from patient safety events.
- Improving & implementing change(s) based on patterns & trends.
- System accountability identified in the context of where the event occurs.
- Holding individuals accountable for their own performance and/or blame-worthy events, but not system issues.
- Developing “blame-free/blameworthy” organizational policies to manage patient safety events and support patient safety but not penalize staff for reporting.
- Investigations fair and free of bias regardless of the event outcome or hindsight.
- Ensuring feedback to staff.

Near Miss:

An accident or situation that “almost happened “to a patient. Also known as a close call, it may or may not have reached the patient. The near miss has not affected the patient nor caused harm but the potential for harm exists. This harm could have caused an injury or loss to the patient had the timing, location and circumstances been different.

Patient(s):

Denotes all clients, inpatients, outpatients, residents and Veterans who reside in or are cared for through any of the district facilities, programs or services. (For the purposes of this document, ‘patient’ means patient, or, if the patient is incapacitated, the substitute decision-maker).

Patient Safety Event:

Any event affecting a patient which can include near misses, adverse events, errors when determined to be so on investigation, adverse drug, vaccine, contrast reactions and any other event determined to affect patient safety or well-being.

Note: World Health Organization working definition of a

	patient safety event used for the development of the International Patient Safety Classification is a process or act of omission or commission that resulted in hazardous health care conditions and/or unintended harm to the patient. An event is identified by a generalized high-level, discrete, auditable term or group of terms. *(WHO July 2006)*
Reporting:	The communication of information about an adverse event or near miss by health care providers, through appropriate channels inside or outside of health care organizations, for the purpose of reducing the risk of reoccurrence of adverse events in the future (CPSI 2008).
Substitute decision-maker (Consent to Treatment Policy):	If the patient is not capable of consenting, consent must be obtained from the patient's Substitute Decision Maker ("SDM"). The patient's SDM is to be determined from persons, **in this order of priority**: • a person who the patient, when competent, appointed as SDM under the *Medical Consent Act prior to April 1, 2010 or the Personal Directives Act on or after April 1, 2010.* This may be referred to as a medical power of attorney, a personal directive or a living will; • legally appointed guardian; • the spouse, registered domestic partner or common-law partner, if the spouse, registered domestic partner or common-law partner is currently cohabitating with the patient in a conjugal relationship, and in the case of a common-law partner has cohabitated with the patient for at least one year; • an adult child of the patient; • a parent of the patient; • an adult brother or sister of the patient; • a grandparent of the patient; • an adult grandchild of the patient; • an adult aunt or uncle of the patient; • an adult niece or nephew of the patient; • any other adult next of kin of the patient; and • the Public Trustee.
Transparency:	As used in this policy implies openness, communication, and accountability**.**
Type A adverse patient safety event:	An adverse patient safety event that affects or potentially affects a particular patient.
Type B adverse patient safety event:	An adverse patient safety event which affects or potentially affects:

1. multi-person or groups of affected individuals, and/or
2. issues that are of legitimate public interest. This may involve other health organizations and districts.

PROCEDURE

INTERNAL DISCLOSURE

As per the adverse patient safety event definition, in the event that a patient safety event occurs and it is recognized that it may meet the definition of an adverse patient safety event health care providers and/or staff inform their appropriate manager and/or department head of the event immediately.

1. Initial Disclosure Analysis

1.1. The appropriate health care provider and manager meet as soon as reasonably possible to perform an initial assessment of the event and to determine whether the event meets the definition of adverse patient safety event contained in this policy.

Note: A determination that the event does not meet the definition of an adverse patient safety event requires confirmation by Risk Management/Patient Safety and/or Legal Services.

1.1.1. In the absence of the manager, consult the director to assist in the initial assessment of the event and determine if the event meets the threshold for disclosure.

1.1.2. In the absence of the manager and director, consult with:

1.1.2.1. QEII HSC – the administrative coordinators.

1.1.2.2. Other Capital Health sites – the site-responsible person or administrator-on-call.

1.1.2.3. Risk Management/Patient Safety and/or Legal Services, as necessary.

1.2. If the health care provider and manager determine that the event may meet one or both of the criteria of a **type B adverse patient safety event**, immediately report the results of the initial assessment to the appropriate director, who in turn consults with the appropriate Vice-President, the Vice-president Performance Excellence & General Counsel and Risk Management/Patient Safety.

1.3. For **type B adverse patient safety events,** follow a decision-making framework such as the one contained in **Appendix B**.

1.3.1. The decision-making framework aims to assist in a step-by-step process of bringing the relevant stakeholders together, clarifying the issue, gathering and examining the relevant information, identifying possible response options, considering the benefits and burdens of each and to whom, selecting a response(s), developing and implementing a comprehensive strategy, and evaluating the outcomes.

2. Initial Disclosure Team

2.1. If it is determined that an adverse patient safety event has occurred, the appropriate health care provider and manager (or appropriate director in the absence of the appropriate manager) jointly designate an initial disclosure team and determine who will initiate the disclosure discussion with the patient.

2.1.1. If it is determined that the adverse patient safety event occurred in an external health organization and/or district outside the health organization currently providing care, the appropriate manager, director, or VP informs the appropriate administrative coordinator or site-specific person/administrator-on-call who, in turn, informs the senior administrator of the originating organization of the adverse patient safety event in a confidential manner.

2.1.2. Normally, the initial disclosure team consists of the appropriate health care provider(s), the appropriate manager, and the appropriate patient representative (if available).

2.1.3. In the designation of membership of the initial disclosure team, respect the patient's wishes, if any, to not interact with specific members of the health care team.

2.1.4. Respect the option/obligation of members of the initial disclosure team to consult with their professional organizations and/or indemnifiers prior to participating in disclosure discussions. {See References: Canadian Disclosure Guidelines (CPSI, 2008) & communicating with your patient about harm: Disclosure of Adverse Events (CMPA 2008).}

2.1.4.1. Consultations and communications with professional organizations and/or indemnifiers should not inordinately delay the timing of the initial disclosure discussion.

2.1.5. Provide the patient with the option of arranging for an external support person(s) of his/her choice to attend the initial and any subsequent disclosure discussions.

2.1.5.1. Other potential, internal support persons, (e.g. spiritual care provider and the clinical unit social worker), may attend the initial disclosure discussion and provide subsequent support to the patient at the discretion of the patient

2.1.6. Inform the patient of the option to contact Capital Health Ethics Support.

BEST PRACTICE GUIDELINES: **Initial Disclosure – Initiating Disclosure**

- Be person (s) known to and trusted by the patient;
- Have good interpersonal and communication skills;
- Be respectful of cultural, language, gender and diversity issues;
- Have a good grasp of the relevant, factual information;
- Be well informed about the particular needs of the patient (e.g. capacity);
- Be willing and able to apologize and express regret, and provide sensitive feedback to the patient; and
- Be able to maintain a medium to long-term relationship with the patient to provide information and support.

2.1.7. During the initial disclosure discussion, the disclosure team provides information about the adverse patient safety event to the patient, taking into account the best practice guidelines as highlighted in this policy.

2.1.8. In the event that the disclosure team disagrees about the optimal time of the initial disclosure discussion, immediately consult Risk Management & Patient Safety and/or the VP Performance Excellence for assistance.

BEST PRACTICE GUIDELINES: Initial Disclosure – Timing & Threshold

- Adequate time for initial analysis of the relevant information;
- Timing consistent with normal care practices around the provision of health care information to patients;
- Clinical condition of the patient (e.g. capacity);
- Patient/substitute decision-maker preferences;
- Availability of key, involved staff and appropriate communicators;
- Availability of the patient's 'family' and support persons;
- Availability of potential support staff (e.g. patient representative, social worker, spiritual care provider);
- Patient comfort and availability of a patient-centered location for disclosure which is as private as possible in the circumstances.

3. The **initial disclosure discussion** contains the following elements:

3.1. The identity and role of all people in attendance.

3.2. An empathic expression of regret and apology from the care-providers, the health care team and the organization; this is acceptable and encouraged in support of the CDHA Promise for Person-centered Health.

3.2.1. When the health care team and/or the organization is responsible, accept responsibility and apologize.

- An early expression of regret communicates concern and empathy for the patient and his/her family;
- An expression of regret or an apology during subsequent discussions may be important to the patient and his/her family;
- An apology is not an expression of liability and, as such, apologies are protected under the Province of Nova Scotia *Apology Act**.

3.2.2. In the disclosure discussion, avoid the use of legal terminology, such as negligence, fault and failure to meet the standard of care.

Note: In brief, the Province of Nova Scotia *Apology Act* states…that an apology made by or on behalf of a person in connection with any matter does not constitute an express or implied admission of fault or liability by the person in connection with that matter,… nor a confirmation of a cause of action or acknowledgement of a claim in relation to that matter for the purpose of the Limitations of Actions Act. It does not void insurance coverage; …and may not be taken into account in any determination of fault or liability in connection with the matter. (3 (1) a-d).

WHAT PATIENTS WANT: When it has been found that harm has occurred, the patient has the right to:

- Be informed about potential harm ;
- A comprehensive and timely investigation of the facts;
- An opportunity to provide input into the investigation;
- Empathy, understanding, and support during what might a very stressful time; and
- Honest, open and transparent disclosure of the facts.

Patients for Patient Safety Canada: Principles of Disclosing Harm.

3.3. An accurate explanation of what happened, including:

3.3.1. all factual information that an individual in the particular circumstances of the patient would reasonably wish to know about the adverse patient safety event,

3.3.2. the potential outcomes/consequences of the adverse patient safety event, and

3.3.3. information which allows the patient to make fully informed decisions about his or her future health care and treatment.

3.4. Efforts to facilitate the patient's understanding of the information provided including:

3.4.1. ample time to ask questions,

3.4.2. the use of appropriate language and terminology, and

3.4.3. awareness and appreciation of the patient's culture, language, education level and special needs.

This includes asking the patient to repeat back the essential elements of the information that has been provided to ensure that he/she has understood the information.

3.5. Offers of practical and emotional support including facilitation of ongoing, regular contact between the patient and the appropriate patient representative, if the patient desires this. This includes the offer of consultation with a spiritual care provider(s), the clinical unit social worker(s), etc.

3.5.1. If it is anticipated that the patient will require or benefit from long term support, the clinical team (e.g. psychological counselling, social work consultation, etc.) initiates access to appropriate resources as desired by the patient.

3.6. Presentation of an initial care plan to the patient/substitute decision-maker for consideration.

3.7. The initial steps taken to manage the adverse patient safety event, how the adverse patient safety event will be reported to appropriate organizational authorities, and what will happen next.

4. The content of the initial and subsequent disclosure discussions does **not** include the following:

4.1. Speculation regarding the adverse patient safety event or the potential harm associated with it;

4.2. attribution of blame to specific individuals, health care providers, and/or health organizations/districts;

4.3. admission of liability with respect to health care providers and/or health organizations;

4.4. denial of responsibility by healthcare providers and/or the health organization; and

4.5. intentional omission of and/or lack of clarity regarding the known facts.

WHAT PATIENTS EXPECT: When it has been found that harm has occurred the patient expects:

- To be fully informed about the harm in a timely manner;
- An apology in a timely, respectful, and sincere manner;
- Information about accountability and responsibility;
- To receive a complete and comprehensive investigative report about the adverse event and to have these reports shared with the appropriate individuals or agencies;
- To be kept informed of how the harm will be prevented from happening again;
- To be provided with opportunities to be part of the improvement process; and
- To be offered fair and timely compensation.

Patients for Patient Safety Canada: Principles of Disclosing Harm.

5. At the close of the initial disclosure discussion, a member of the initial disclosure team provides a **verbal summary** of the content of the initial disclosure discussion to the patient.

5.1. Subsequently the patient representative or appropriate manager documents a **written summary** of the content of the initial disclosure discussion in the progress notes, including a summary of the discussion, the patient's response and plan for follow up.

5.2. The patient may view the written progress note and have the opportunity at a later time to discuss the content with the disclosure team.

5.3. The patient may request copies of his/her health record through the Release of Information process as outlined in CH 30-015 *Release of Information from the Health Record.*

6. The manager informs the health care provider(s), and other members of the attending health care team of the availability of critical incident stress debriefing (arranged through Human Resources), and the availability of individual counselling arranged through direct contact with their Employee Assistance Program (EAP) provider.

7. Post - Analysis Disclosure

7.1. In those circumstances in which a Quality Review Process is conducted:

7.1.1. The appropriate vice-president and/or Director in collaboration with one or more members of the initial disclosure team, including the patient representative as necessary, offers the patient the opportunity to participate in a post-analysis disclosure meeting to provide the patient with:

7.1.1.1. further relevant facts about the adverse patient safety event,

7.1.1.2. the identified factors that contributed to the adverse patient safety event, and

7.1.1.3. information on what has been and will be done to avoid recurrence of similar adverse patient safety events.

EXCEPTIONS*: In most cases there will be complete disclosure of the findings of the event review. Information may be withheld or restricted in the following circumstances:*

- *when it is considered that disclosure of information may adversely affect the health of the patient where it has been determined there is reasonable cause for that assessment, and that assessment is documented and corroborated in the health record by the multi-disciplinary team; and/or*
- *where investigations are pending by the Office of the Chief Medical Examiner; and/or*
- *where contractual arrangements with insurers preclude disclosure of specific information; and/or*
- *where information is protected from disclosure under legal professional privilege or qualified privilege under the Nova Scotia Evidence Act and/or the Freedom of Information and Protection of Privacy Act.*

8. As required, Capital Health provides reasonable travel, meal and accommodation costs, including facility parking to facilitate face-to-face feedback and/or discussion of both the disclosure as well as the post-analysis disclosure with the patient and their support person.

EXTERNAL DISCLOSURE

BEST PRACTICE GUIDELINES: Threshold for External Disclosure

- External disclosure to the public is considered to be one possible response to adverse patient safety events in those circumstances in which one or both criteria of a type B adverse patient safety event are met. Decision-making about whether, and how, to externally disclose an adverse patient safety event requires the use of a decision-making framework such as the one contained in Appendix B.
- External disclosure is attentive to the following principles and values, among others: respect for persons, privacy/confidentiality, honesty, clarity, openness transparency and timeliness.
- The performance of optimally conducted external disclosure facilitates 'the building of a culture of person-centered health care, citizen engagement, patient safety and ethics' as described in Capital Health's ***Our Promise.***
- Permission of the patient **must** be obtained before information that could potentially identify the patient is released externally.
- A third party may publicly disclose information about an adverse event without providing notice to Capital Health or seeking the participation and approval of Capital Health. Given this possibility, planning for external release of information should be undertaken in the event of an adverse event and particularly in type B adverse event circumstances.

1. If the external disclosure working group using the decision making framework in Appendix B recommends external disclosure and the Leadership Enabling Team (LET) concurs with this recommendation, the appropriate VP Person-centered Health informs the appropriate contact at the NS Department of Health or similar provincial authority in another province and/or other affected Health Districts and authoritative bodies (e.g., Health Canada), that external disclosure of an adverse patient safety event will occur. The following procedures apply:

    1.1. As required by the Nova Scotia Disclosure of Adverse Events Policy (2005), the Department of Health and the Health District *"shall participate in collaborative communication planning when informing the public about adverse events"* which*:*

        1.1.1. involves a multi-person disclosure;

        1.1.2. perceived as a public health hazard; or

        1.1.3. has the potential to undermine public confidence in the health system.

    1.2. The Leadership Enabling Team (LET), through the direction of the appropriate VP Person-centered Health and the VP Performance Excellence & General Counsel approves an External Disclosure Communications Team.

        1.2.1. The team consists of appropriate clinical expertise, risk management, legal services, corporate communications, and any other relevant personnel, as appropriate, to manage the external disclosure communication process.

        1.2.2. This team usually consists of the same individuals who constituted the external disclosure working group which used the decision-making framework to make a recommendation regarding external disclosure to LET, with additional expertise/staff.

    1.3. The External Disclosure Communications Team, supported by Marketing and Communications, develops a communication strategy and plan for disclosure of the relevant information to appropriate external stakeholders.

        1.3.1. As directed by the Provincial Healthcare Disclosure Policy, in the event of an adverse patient safety event involving multiple jurisdictions or health districts (e.g. the adverse patient safety event is identified in a different organization than in which it occurred), the communication strategy and plan is informed by knowledge of existing "*procedures whereby a receiving organization informs an originating organization of an adverse patient safety event.".*

    1.4. The External Disclosure Communications Team seeks approval from LET for a comprehensive communications plan (before external disclosure occurs).

    1.5. The entire External Disclosure Communication Team implements the communication plan, led by Marketing and Communications.

    1.6. Consistent with Capital Health's Media Relations policy (CH 70-025), Marketing and Communications designates and supports an authorized spokesperson(s) to address media enquiries in a timely, consistent and accountable manner.

        1.6.1. During media interviews regarding the adverse patient safety event, the designated Capital Health spokesperson(s) represents involved health care providers, unless the External Disclosure Communications Team deems that it is appropriate that they represent themselves.

2. The content of the initial external disclosure, any post-analysis disclosure(s), and subsequent discussions follow and are informed by all the processes and best practice guidelines outlined for internal disclosures within this policy.

RELATED CAPITAL HEALTH DOCUMENTS

Policies

CH 70-005 Management of Serious Clinical Occurrences (Under revision)

* Quality Review Process (Under Development and will replace CH policy 70-005)

CH 70-025 Media Relations

CH 100-035 Patient Safety Reporting System

Appendices

Appendix A - Examples of Adverse Patient Safety Events that Require Disclosure to Patients

Appendix B - An Organizational Ethics Decision Making Framework: Disclosure of Significant Adverse Events Version

Policy Aids & Pamphlets *(To be issued)*

Capital Health Disclosure Policy Information for Patients and Families (2010)

Checklist for Disclosure of Adverse Patient Safety Events and Harm – Initial Disclosure Team (2010)

Disclosure of Adverse patient safety events and Harm – Guide to Disclosure Pocket Guide for Staff (2010)

REFERENCES

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Appendix A:
Examples of Adverse Patient Safety Events that Require Disclosure to Patients

Examples of adverse patient safety events that are reportable through PSRS and require disclosure to patients and their families/substitute decision-maker include but **are not limited to** the following:

1. **Care Management Events:**
    a) Patient death or serious disability associated with a haemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products (ABO: blood group system consisting of groups A, B, AB, O and HLA: Human Leukocyte Antigen) ;
    b) Maternal death or serious disability associated with labour or delivery in a low-risk pregnancy;
    c) Medication event leading to the death or serious disability of patient due to incorrect administration of drugs related to:
        i. Omitted dose;
        ii. Wrong dose;
        iii. Dose preparation;
        iv. Wrong time;
        v. Wrong rate of administration;
        vi. Wrong route;
        vii. Wrong patient; and
        viii. Adverse drug/vaccine or contrast reaction.
    d) Patient death or serious disability associated with an avoidable delay in treatment;
    e) Patient death or serious disability associated with an electric shock or elective cardio version ;
    f) Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended;
    g) Patient death or serious disability associated with an intravascular air embolism that occurs during care;
    h) Patient death or serious disability associated with hypoglycaemia, the onset of which occurs during care;
    i) Patient death or disability as a result of failure to treat abnormal diagnostics; and
    j) Accidental extubation
2. **Criminal Events:**
    a) Any instance where a criminal or alleged criminal event results in harm to a patient(s).

b) Any instance of care ordered by or provided by an individual impersonating a clinical member of staff;

c) Abduction of a patient of any age;

d) Sexual assault on a patient within or on the grounds of the health care facility; and

e) Death or significant injury of a patient resulting from a physical assault or other crime that occurs within or on the grounds of the health care facility.

3. Device or Product Events:

a) Patient death or serious disability associated with:

i. Use of contaminated drugs, devices, products;

ii. The use or function of a device in a manner other than the device's approved use;

iii. Failure or malfunction of a device or medical equipment; and

iv. Intravascular air embolism.

4. Environmental Events:

a) Any incident in which a line designated for oxygen or other gas came to be delivered to a patient and contains the wrong gas or is contaminated by toxic substances;

b) Patient death or serious disability due to a nosocomial infection;

c) Patient death or disability as a result of treatment from the following:

i. Burn incurred from any source;

ii. A slip, trip or fall;

iii. Electric shock; and

iv. Use of restraints or bedrails.

5. Patient Protection Events:

a) Discharge of an infant or child to the wrong person;

b) Patient death or serious disability associated with elopement (AWOL- Absent With out Leave);

c) Patient suicide, attempted suicide or deliberate self-harm resulting in serious disability; and

d) Intentional injury to a patient by a staff member, another patient, visitor or other person.

6. Surgical Events:

a) Surgery performed on the wrong body part;

b) Surgery performed on the wrong patient;

c) Wrong surgical procedure performed on the wrong patient;

d) Retained objects after surgery or other procedure;

e) Unexpected patient death during or immediately post-surgical procedure

f) Unforeseen serious disability or neuro-cognitive deficit post-surgical procedure; and

g) Patient death or disability as a result of any anaesthesia-related event (e.g. intra-operative or immediate post-operative death in an ASA Class I patient).

Appendix B:
Decision Making Framework for
Disclosure of Significant Adverse Patient Safety Events

(Revision - August 2010)

Process Steps

1. Identify & assemble relevant stakeholders to form an ad hoc disclosure working group; consider inclusion of:
   - 1.1 Participants from vocational/organizational groups that will/could be directly affected
   - 1.2 Members of the public: citizens/'health care receivers' and, in particular, members of potentially affected disadvantaged social groups
   - 1.3 Relevant expert resource persons, e.g., ethics, health law, and communications support
   - 1.4 Participants from the provincial Departments of Health and Health Promotion

2. Identify the legitimate decision makers and how recommendations will be reached by the working group, e.g.
   - 2.1 Decision makers for external disclosure, e.g., CEO and/or LET (established by policy)
   - 2.2 Recommendations reached by a consensus of working group members that 'all can live with'; if not possible, by vote or secret ballot

3. Identify & reflect on:
   - 3.1 The ethics principles and values at play in disclosure of adverse events circumstances and the potential for conflict/tension among them

4. Confirm that the circumstances under consideration constitute an adverse event:
   - 4.1 Refer to policy definition
   - 4.2 If not, should they be handled/treated as such for recommendation-making purposes?

5. Consider all relevant information/evidence:
   - 5.1 Examine and discuss 'the context' from all relevant standpoints and perspectives, e.g., those of potentially affected patients and their 'families', health care providers, the organization and the public
   - 5.2 With the assistance of relevant participating experts, determine the type, and best possible quantification, of risk to the potentially affected, e.g., evidence-based, theoretical, perceived, etc. with associated best-estimate percentages

6. Identify the possible disclosure options in the circumstances under consideration, e.g.
   - 6.1 Non-disclosure
   - 6.2 Disclosure to the affected/potentially affected
   - 6.3 External disclosure to other health organizations and/or the public.

7. Through brainstorming and facilitated dialogue:
   - 7.1 Identify and discuss the benefits and burdens of the possible disclosure options, and to whom

7.2 Assess alignment of the possible disclosure options with the step 3. identified ethics principles and values, e.g., respect for persons, patient welfare, justice (see Guiding Principles & Values section of policy)

8. Choose the 'go forward' recommended disclosure option(s)
   8.1 Includes articulation of the ethics principles and values underlying the recommendation and how these were pragmatically applied by working group members

9. Develop and implement a comprehensive care and communication strategy including:
   9.1 Specific care plans for harmed and potentially harmed persons
   9.2 Attention to prevention of similar adverse events – necessary systems change, relevant education, etc.
   9.3 Optimal communication to patients/'families' and the public, as appropriate

10. Review the disclosure recommendation and monitor/evaluate the outcomes including:
   10.1 Checking for consistency with other disclosure recommendations
   10.2 Ensuring that 'lessons learned' inform future uses of the framework

1.6 Education for the Ethics Committee

There are a number of ways that the committee can build its own capacity, both in terms of improving the confidence and skills of individual members and in terms of improving the function of the committee as a group. The following is a list of possible approaches to on-going education:

- Brief summaries of journal articles provided by members of the committee (with committee members taking turns)
- Discussion of a case from the literature, news media, or entertainment media as part of regular meetings
- Take a case and analyze it through the lens of a particular ethical theory (theory is drawn from a hat).
- Practice using policy review process on existing policies
- NSHEN annual conference
- Canadian Bioethics Society annual conference
- Workshops offered by NSHEN (ethics consultation, policy, ethics 101)
- Provincial Health Ethics Network (PHEN)'s distance education course http://phen.ab.ca/disted/index.asp
- Clinical Ethics Summer Institute http://www.clinicalethics.ca/
- Georgetown Intensive Bioethics Course http://kennedyinstitute.georgetown.edu/programs/ibc.cfm
- Educational Activities for Ethics Committees (see examples in section 1.6.1)

1.6.1 Example Education Activities

Some of the activities that ethics committees have undertaken to provide education in their organizations include:

- Brown bag lunch speaker series
- Journal clubs
- Discussion groups
- Visits by ethics committee members to various units
- Ethics days
- Public lectures and forums
- Theatrical production and discussion
- Presentation as part of grand rounds
- "Did you know" tent cards on cafeteria tables
- "Did you know" facts on posters, flip charts, etc
- Film series with public discussion
- Presentation as part of employee discussion
- Discussion evenings with health-related groups (such as cancer survivors)
- Case discussion
- Quizzes
- Trivia
- Case discussion on the organizations intranet

Education can focus on specific ethics issues of interest to a particular team, service, or profession, the existence and function of the ethics committee, or on professional development for ethics committee members.

1.7 A VERY BRIEF HISTORY OF ETHICS COMMITTEES

Ethics committees first started appearing in North America in the 1970s and proliferated during the 1980s. Several factors contributed to their emergence, including the establishment of transplant committees, institutional review boards (IRBs) or research ethics boards (REBs), therapeutic abortion committees (TACs) and abortion selection committees, dialysis selection committees, medical-moral committees in some Catholic hospitals, and the emergence of contentious end-of-life decisions that went on to be pivotal legal cases, for example Karen Ann Quinlan, New Jersey 1976, Baby Doe, Indiana 1982, and Cruzan, Missouri 1988.

The mandate and functioning of ethics committees have shifted somewhat since those early days. There has been a shift from a paternalistic focus (dominant in healthcare at that time) to a focus on respect for autonomy (Dax Cowart case, 1973 in the US, raised the issue of an individual's right to limit care). In line with this change in perspective, ethics committees have less to do with final decision-making and more to do with providing recommendations to be taken into account in the decision-making process. Typically these recommendations refer to the reasoning process employed and issues to be kept in mind as decisions are being formulated. Historically healthcare professionals made up the membership of ethics committees because they were considered to have the special "expertise" needed for ethics-related decision-making, but this view no longer holds. Currently increasing attention to diversity of membership and composition is helping ethics committees address their up-dated mandate.

Ethics committees traditionally provide support for teams to identify and address ethics issues. Their activities tend to focus in one or more of the following three areas: ethics education, policy review or recommendations, and ethics consultation. They are generally multidisciplinary and often involve members of the community or public as well.

YOUR DISTRICT ETHICS COMMITTEE

Should you decide to write up the history of the ethics committee in your organization, addressing the following questions will help to focus your account:

- why it was established
- who was originally involved
- what its original mandate was and why
- activities the committee undertook and why
- how and why the committee has changed over time

1.7.1 EXAMPLE: IWK ETHICS COMMITTEE HISTORY

The following pages outline the history of the IWK Health Centre's ethics committee as submitted by a past Chair of that committee.

History of the IWK Ethics Committee
2003-2008

This document serves as a summary of the activities of the IWK Ethics Committee since it was formed in September 2003 with a reporting relationship to the President and CEO, and at the CEO's request, to the Board of Directors for improved transparency. The mandate of the Committee included (Terms of Reference attached):

- Clinical ethics consultation
- Policy review
- Organizational ethics
- Ethics education

The Ethics Committee submits a quarterly report summarizing the activities of the Committee to the President and CEO. Goals and objectives were developed in the winter of 2007 that aligned with the Strategic Plan and they were presented the CEO and President as well as the Executive Team in April 2007. At their request the Chair and the Clinical Ethics Consultation Coordinator made presentations to the three programs and their morbidity, occurrence and mortality committees, as well as, the Professional Practice Council to highlight the ethics resources within the IWK. Also in the Spring of 2007, a subcommittee was formed to develop an education plan to raise the profile of ethics within the Health Centre.

Terms of Reference

Terms of reference were approved in January 2004 and included purpose of the Committee, expectation of members, and multi-disciplinary membership including representatives from:

Obstetrics
Gynecology
Nursing
Social work
Middle Management
Non-clinical support from within the IWK and
Bioethics representative from Dalhousie University
Health law representative from Dalhousie University
Community representative
Consumer representative

Efforts are made to bring diversity to the table. The Terms of Reference were revised in the spring of 2007 and approved by the executive leadership team in the summer.

Additional members added include:

- Quality representative (September 2006)
- Spiritual Care (September 2006)
- Mental Health and youth advocate (October 2006)
- A second community representative (May 2007)

A couple of visitors have been welcomed as observers to our regular meetings for limited periods of time; that is, a health law associate specializing in health law and policy from the Dalhousie Health Law Institute and a PhD (or was Cathy a Masters) focusing on studies in Bioethics. These observers and members who are not Health Centre staff are required to sign a Confidentiality Agreement.

Clinical Ethics Consultation

Ten clinical ethics consultants were recruited and oriented in the spring of 2004. They represented diverse areas across the Health Centre including genetics, palliative care, neonatal and mental health. A process for clinical ethics consultation was developed in 2004 by Dr. Christy Simpson and Fiona McDonald including an intake process, process for ethical review and evaluation.

Policy Review

A process for policy review was drafted in the first year and included development of criteria for the Ethics Committee to apply to policy review and criteria for policy writers to reference to determine if review of the policy with an ethics lens would aid the development. Our feedback process was revised on two occasions to improve receptivity of policy writers and to assist them in understanding the rationale for feedback from our review through an ethics lens.

- Initially, feedback was formatted to align with the sections of the policy.
- Later, while the section by section format continued, a rationale column was added to the document to indicate the applicable ethical principles and organizational values that should be considered.
- Presently, feedback is provided from a more global perspective; that is, the ethical principles and values are highlighted and specific areas of the policy are referred to that could be revised to remind IWK readers of its values and ethical principles.

Approximately ___ policies have been submitted to the Ethics Committee since its inception in late 2003 (attached list).

Organizational Ethics

A defined process was created for intake, ethical discussion and evaluation of organizational issues referred to the Ethics Committee. Some issues include:

- Using skills attained through a position at the Health Centre to run a business in the private sector
- Use of patient information for educational purposes
- Participation in clinical trials involving expensive drugs that are not funded at the completion of the trial
- Criteria for awards and scholarships

Education and Enhancement of Ethical Capacity

A number of different formats are used for education of the members of the Committee, the clinical ethics consultants and staff at the IWK Health Centre including:

- Munchie Monday Jan 2005

- annual orientation for new members of the IWK and Capital Health ethics committees, and current members and clinical ethics consultants are invited to attend.
- A web page on the IWK Intranet, Pulse, to inform staff about the mandate of the committee, how to access the Ethics Committee as a resource and existing powerpoint sessions; e.g. Clinical Ethics Consultation and Organizational Ethics.
- An audio session on the Intersection of Ethics and Risk Management from the American Society of Risk Management in June 2006.
- Occasionally education sessions on topics of interest to the committee are presented at the start of the Committee meeting; e.g. moral distress, hope, gender reassignment surgery, medical error.
- CDs are available to members from two talks by Dr. Nuala Kenny in February and March 2007 – Health System Reform and the Public-Private debate and Ethical Issues in Resource Allocation.
- A subcommittee is actively involved with Quality Resources to create a Partners in Care document to replace the patients rights and responsibilities document. This will be presented to Executive Leaderships Team this spring.
- Ethics and Accreditation Workshop attended by Chair in May 2004.
- A Health Canada seminar on Ethical Frameworks and Decision making in Health Care Policy in March 2006.
- At least three members of the Committee have attended the Canadian Bioethics Society's Annual General Meeting that has rich educational sessions on ethics in health care.
- The Ethics Committee has been advocating with Quality Resources for the addition of an administrative policy coordinator to provide a consistent contact for the development of non-clinical policy development for the IWK.

Nova Scotia Health Ethics Network (NSHEN)

After two years of planning, a telehealth session launched NSHEN province-wide in February 2008. The three partners in this initiative are the Department of Health, Dalhousie University's Department of Bioethics, and the nine district health authorities and the IWK. Despite the ongoing search for an ethicist, to work in collaboration with the two ethicists at Dalhousie, the Administrator was hired in January and has taken a leadership role with the Network. This network generated a lot of excitement across the province and will be a wonderful resource for health care ethics in Nova Scotia. The first annual education day was held in Truro in April. In addition, Anne McGuire, our President and CEO has been actively involved in promoting the Network and recruiting the Ethicist.

Attachments

Terms of Reference
Current Goals and Objectives document
Pulse (intranet) page
List of Policies reviewed

Submitted by:

Fran O'Brien
Past Chair
IWK Ethics Committee

1.8 Ethics Committee Tools

There are a number of more formalized tools such as decision-making frameworks that can help to systematize an ethics committee's approach to the process of analysis and decision-making, particularly for very complex, multi-level issues. The NSHEN website includes a page concerning the use of decision-making frameworks, which offers the following description:

> *The goal of ethics-informed decision-making frameworks is to facilitate the balanced application of various relevant 'lenses' (e.g., clinical practice, legal, business, communications, ethics, etc.) to decision-making at multiple organizational levels. From the perspective of a health care organization's internal stakeholders and the public, the use of such frameworks enhances accountability for the decisions made, as compared to more traditional, 'top-down' approaches*.

However, no matter how comprehensive the "tool," no single framework or approach can provide the "ultimate" answer. Each one is designed from a particular perspective, which means committee members must be alert during their deliberations to discovering the "blind spots" introduced or simply not addressed by such tools.

The following pages provide an example of an ethics "tool" used by AVH. You will find other examples on the NSHEN website at http://www.nshen.ca/toolsandframeworks.html. Any other tools, decision-making frameworks, organizational resources, or other supports used by your ethics committee should be included here.

Ethics Advisory Committee Contact Info: (902) 365-1730 or cmacpherson@avdha.nshealth.ca
V1: March 25, 2008

AVH Ethics Tool: A Guide for Addressing Ethical Issues

An ethical issue is any issue which represents:

- a conflict of values (organizational, personal, or professional) or ethical principles
- a violation of commonly accepted ethical principles (eg. autonomy)
- a violation of accepted organizational, personal or professional values
- a significant undue hardship or inappropriate harm to any stakeholder

Can I use this tool? Yes. This tool was developed for all AVH staff, physicians and volunteers.
When can I use it? Anytime you encounter an issue that you think might be an ethical issue. This tool will help you clarify the issue you are faced with and help identify possible courses of action.
What if I have questions about this tool or about the issue I am faced with? You may contact the Ethics Advisory Committee confidentially at any time. Contact information is at the top of each page.

OUR CORE VALUES

At Annapolis Valley Health, we believe in:

- **Integrity**: Our decisions and actions reflect our commitment to accepted ethical and professional conduct. We work to ensure that our conduct earns the support and trust of all segments of the public that we serve.
- **Accountability**: We make rational, informed decisions based on the needs of our communities and best available evidence. We are accountable for our actions and the effective, sustainable management of resources.
- **Respect**: We are committed to working in ways that promote dignity, fairness and respect.
- **Collaboration**: We work together with our communities and other partners to achieve improved services and healthier communities.
- **Continuous Improvement:** We are committed to quality and evaluation.
- **Innovation:** We seek opportunities to evaluate, change, grow, and improve by fostering learning, inquiry and discovery.

OUR EXPECTED BEHAVIOURS

Everyone in AVH is expected to:

- Treat each other with dignity, fairness and respect;
- Communicate in an open, honest and respectful way;
- Avoid using any kind of abuse, harassment, aggression or violence;
- Be responsible for our actions and behaviours; and
- Respect and support each person or group's human rights.

We as the staff, doctors, volunteers and student of AVH will:

- Come to work ready to do our job or volunteer service;
- Keep all personal information about patients, clients and health care team members private;
- Act safely;
- Follow all AVH policies, procedures and guidelines; and
- Support our AVH values.

Adapted from: (1) Sudbury Regional Hospital (2006) Guidelines for Ethical Decision-making & (2) Frolic, A. (date?) A Method for Ethical Deliberation: RICE

PRINCIPLES AND CONCEPTS IN HEALTHCARE ETHICS

Delivery of health services is a continual process of balancing values, principles and interests in the allocation and delivery of health services. Commonly, principles or values come into conflict and must be reflected upon to help you decide how to proceed. Below are some of the important principles and concepts in healthcare ethics. These, in addition to the Core Values and Expected Behaviours unique to AVH listed on the previous page, are important to consider as you address your issue.

- **Beneficence**: to "do good". This requires that providers perform acts that will benefit clients. Good care requires that the provider understands the client from a holistic perspective that respects the client's beliefs, feelings, wishes and values, as well as those of the client's family or significant others. Beneficence involves acting in ways that demonstrate caring, listening, supporting and nurturing.

- **Best Interests**: to consider the benefits and risks for stakeholders of a proposed course of action from the following perspectives: physical, mental, emotional and spiritual.

- **Confidentiality:** the obligation to keep patient and organizational information confidential. Professional standards and privacy legislation provide guidance on the conditions under which health information can be ethically and legally disclosed.

- **Fidelity**: faithfulness to the relationship and/or to your role. The sacred trust related to this relationship. Persons must act in accordance with their respective roles.

- **Justice:** the obligation to be fair to all people, regardless of their race, sex, sexual orientation, marital status, medical diagnosis, social standing, economic level, and/or religious beliefs. There are several types of relevant justice considerations. Distributive justice calls on us to distribute benefits and burdens fairly on the basis of legitimate health needs and available resources. Formal justice requires that we treat individuals and groups of persons/patients the same unless there is a demonstrable *relevant* difference among them that justifies different treatment. Attention to social justice involves the identification and reflective consideration of the particular disadvantages and vulnerabilities of individuals and groups of persons who will be directly affected by health care decision making. Procedural justice asks us, among other things, to ensure that participants from all the relevant stakeholder groups are engaged in a defensible, accountable and transparent decision making process.

- **Non-Maleficence:** protection from harm. This requires that providers do not harm their client, even if they cannot protect themselves. Hazards in the workplace may put the client at risk. Staff are expected to identify such risks and act to prevent harm.

- **Paternalism:** the practice of controlling, monitoring or deciding what is good for an individual rather than letting him choose for himself (the opposite of autonomy). This includes restricting someone's freedom to act to prevent him from harming himself (eg. Use of restraints, suicide prevention) and restricting someone's autonomy. Paternalism is rarely justifiable with a mentally competent adult client.

- **Quality of life:** the principle that mere biological existence does not in itself have value; rather that life gives rise to activities and experiences which provide pleasure, satisfaction and well-being. The person whose life is in question is the only reliable judge of that life's quality.

- **Respect for Autonomy:** the right to self-determination, independence and freedom. It involves the provider's willingness to provide information to the client so that they may make informed decisions and subsequently respect a client's right to choose what is right for him or herself, even if the provider does not agree with the client's decision. Informed consent is an example of how this principle is applied.

- **Veracity:** being truthful or not intentionally misleading or deceiving clients. Based on mutual trust and respect for human dignity, this would require open and honest communication in a way that helps clients deal with the anxiety this knowledge may create. Concealing or guarding clients from the truth to "protect" them is rarely ethically justifiable.

A GUIDE TO CLARIFY AND ADDRESS THE ISSUE…

1. Identify your biases and intuitions. What are your gut feelings about the case? What are the sources of your intuitions (e.g. your moral training, professional norms, personal history, social position, religious beliefs, relationships with the people involved, etc.)? What is your role in this case? What are your expectations and goals as they pertain to this case?

2. Clarify the question. What is the issue that needs to be addressed? What are the values at issue (from page 2)?

3. Who needs to be a part of the decision? Who is accountable for making the decision?

4. Identify major stakeholders (client, family member, caregiver, health professional, etc.) and their expectations, values and goals. This ought to be discovered in conversation with these stakeholders.

Stakeholder	Their expectations/values	Their goals

5. What are the relevant (known) facts? This includes reference to the contributing polices, values, feelings, beliefs, legislation, evidence (sometimes these are in conflict).

6. How significant are the possible harmful consequences of the existing situation? List the possible harms. Important to clarify the context and define the immediacy of the situation.

7. What are the possible approaches to address this issue? You are not limited to exploring only three possible alternatives and remember that doing nothing is an option and needs to be explored as well.

Possible Alternative #1	Possible Alternative #2	Possible Alternative #3
Possible Alternative: **Do nothing**	Possible Alternative:	Possible Alternative:
Which values/principles are aligned with this alternative?	Which values/principles are aligned with this alternative?	Which values/principles are aligned with this alternative?
Which values/principles are in conflict with this alternative?	Which values/principles are in conflict with this alternative?	Which values/principles are in conflict with this alternative?

Upon ethical analysis, the best possible alternative is #____.

8. Why is this the best approach? When you say it out loud, does it sound reasonable? Can you live with it?

9. Describe your plan for action and communication. Who needs to hear the decisions? Who will communicate it?

10. How will this decision be evaluated?

11. How confident are you that you have made a good decision?

✓	**Confidence Level in having reached a good decision**
	Extremely Confident: Do not need to revise your decision. Have reached consensus with stakeholders. It sounds reasonable when you say it out loud. All are in agreement and would readily be the messenger of the decision.
	Very Confident: Should not need to revise your decision. Have reached a decision stakeholders can agree to. It stands the test of publicity and is the best decision, given the circumstances.
	Somewhat Confident: Might need to revise your decision. Some discomfort remains with stakeholders. Some discomfort when you state the decision publicly (when you say it out loud it doesn't seem reasonable). Continue to work through or consult with the AVH Ethics Advisory Committee.
	Not very confident: Should revise your decision. Discomfort expressed by stakeholders. Doesn't sound reasonable when you say it out loud. Consult with the AVH Ethics Advisory Committee.
	Not at all Confident: Cannot achieve agreement on the best course of action. Revisit the evidence, policies, clarify values, consult with the AVH Ethics Advisory Committee. Seek to revise your decision.

1.9 Glossary of Common Bioethics Terms

This section contains a list of terms commonly encountered in bioethics. While not an exhaustive list, it provides a quick and easy reference to many of the concepts you will hear over the course of your time with the district EC.

Ethics and Ethics Consultation Terms

Excerpted from:
IWK Ethics Tool: A Guide for Addressing Ethical Issues (2009)
http://www.iwk.nshealth.ca/download.cfm?DownloadFile=B938A529-00F6-424F-214405A3B8B74C14

Appendix A: Principles and Concepts in Healthcare Ethics

Beneficence: To "do good". This requires that providers perform acts that will benefit clients. Good care requires that the provider understands the client from a holistic perspective that respects the client's beliefs, feelings, wishes and values, as well as those of the client's family or significant others. Beneficence involves acting in ways that demonstrate caring, listening, supporting and nurturing.

Best interests: The benefits and risks for stakeholders of a proposed course of action, considered from the following perspectives: physical, mental, emotional and spiritual.

Clinical ethics: Addresses ethical issues that arise "at the bedside" and between patients, families, and health care providers in the context of direct patient care.

Confidentiality: The obligation to keep patient and organizational information confidential. Professional standards and privacy legislation provide guidance on the conditions under which health information can be ethically and legally disclosed.

Fidelity: Faithfulness to the health care relationship and/or your role and the trust related to this relationship. Persons must act in accordance with the expectations surrounding their respective roles.

Justice: The obligation to be fair to all people, regardless of their race, sex, sexual orientation, marital status, medical diagnosis, social standing, disability, economic level, and/or religious beliefs. *Distributive justice* requires a fair distribution of resources, based on legitimate health needs and available resources. *Formal justice* requires that individuals and groups of people or patients the same unless there is a demonstrable difference between them that justifies different treatment. *Social justice* involves attention to the disadvantages and vulnerabilities of certain groups who will be directly impacted by health care decision making. *Procedural justice* asks us, among other things, to ensure that participants from all the relevant

stakeholder groups are engaged in a defensible, accountable and transparent decision making process.

Moral uncertainty: Occurs when one is unsure what the most morally appropriate course of action is.

Moral dilemma: Occurs when two or more opposing courses of action seem to be correct and an agent can only carry out one of them.

Moral distress: Occurs when one is confident as to the morally appropriate course of action but is unable to act in accordance with that course of action.

Non-Maleficence: Avoidance of or protection from harm. This requires that providers do not harm their client, even if they cannot protect themselves. Hazards in the workplace may put the client at risk. Staff are expected to identify such risks and act to prevent them.

Organizational ethics: Addresses ethical issues that arise in the process of or as a result of decision making at senior leadership or management levels in an organization and which may have significant impact on patient care.

Paternalism: The practice of controlling, monitoring, or deciding what is good for an individual other than letting them choose for themselves (the opposite of autonomy). This includes restricting someone's freedom to act to prevent them from harming themselves (e.g.: the use of restraints, suicide prevention) and restricting someone's autonomy. Paternalism is rarely justifiable with a mentally competent adult client.

Quality of life: The principle that mere biological existence does not in itself have value; rather that life gives rise to activities and experiences that provide pleasure, satisfaction and well-being. The person whose life is in question is the only reliable judge of that life's quality.

Respect for autonomy: The right to self-determination, independence and freedom. It involves the provider's willingness to provide information to the client so that they may make informed decisions and subsequently respect a client's right to choose what is right for them, even if the provider does not agree with the client's decision. *Informed consent* is an example of how this principle is applied.

Veracity: Being truthful or not intentionally misleading or deceiving clients. Based on mutual trust and respect for human dignity, this would require open and honest communication in a way that helps clients deal with the anxiety this knowledge may create. Concealing or guarding clients from the truth to "protect" them is rarely ethically justifiable.

EXCERPTED FROM:
INTEGRATED ETHICS GLOSSARY
http://www.ethics.va.gov/docs/integratedethics/IntegratedEthics_Glossary.pdf

Best practice: A technique or methodology shown by experience and/or research to lead reliably to a desired result. In ethics, best practice refers to the ideal established by ethical and professional norms and standards, such as communicating information to patients in language they can understand.

Ethical practices in end-of-life care: The domain of health care ethics concerned with how well a facility addresses ethical aspects of caring for patients near the end of life. It includes decisions about life-sustaining treatments (such as cardiopulmonary resuscitation or artificially administered nutrition and hydration), futility, treatments that hasten death, etc.

Ethical practices in the everyday workplace: The domain of ethics concerned with how well the facility supports ethical behavior in everyday interactions in the workplace. It includes treating others with respect and dignity, adhering to appropriate boundaries in workplace relationships, and the organization's ethical climate.

Ethical practices in health care: Decisions or actions that are consistent with widely accepted ethics standards, norms, or expectations for a health care organization and its staff. Note that in this context "ethical" conveys a value judgment—i.e., that a practice is good or desirable; often, however, "ethical" is used simply to mean "of or relating to ethics," as in the phrase "ethical analysis" referring to analysis that uses ethical principles or theories.

Ethical practices in resource allocation: The domain of ethics concerned with how well a facility demonstrates fairness in allocating resources across programs, services, and patients, including financial resources, materials, and personnel.

Ethics: The discipline that considers what is right or what should be done in the face of uncertainty or conflict about values. Ethics involves making reflective judgments about the optimal decision or action among ethically justifiable options.

Ethics case: An isolated situation involving specific decisions and actions, that gives rise to an ethical concern, i.e., that gives rise to uncertainty or conflict about values. (See also, ethics issue.)

Ethical concern: Uncertainty or conflict about values.

Ethics consultation in health care: The activities performed by an individual or group on behalf of a health care organization to help patients, providers, and/or other parties resolve ethical concerns in a health care setting. These activities typically involve consulting about active clinical cases (ethics case consultation), but also include analyzing prior clinical case or hypothetical scenarios, reviewing documents from an ethics perspective, clarifying ethics-related policy, and/or responding to ethical concerns in other contexts not immediately related to patient care. Ethics consultation may be performed by an individual ethics consultant, a team of ethics consultants, or an ethics committee.

Ethics consultation service: A mechanism in a health care organization that performs ethics consultation.

Ethics issue: An ongoing situation involving organizational systems and processes that gives rise to ethical concerns, i.e., that gives rise to uncertainty or conflicts about values. Ethics issues differ from ethics cases in that issues describe ongoing situations, while cases describe events that occur at a particular time, and issues involve organizational systems and processes, while cases involve specific decisions and actions.

Ethics quality: Practices throughout the organization are consistent with widely accepted ethics standards, norms, or expectations for a health care organization and its staff. Ethics quality encompasses individual and organizational practices at the level of decisions and actions, systems and processes, and environment and culture.

Ethics quality gap: With respect to an ethics issues, the disparity between current practices and best practices.

Ethics question: A question about which decisions are right or which actions should be taken when there is uncertainty or conflict about values.

Preventive ethics: Activities performed by an individual or group on behalf of a health care organization to identify, prioritize, and address systemic ethics quality gaps.

Patient privacy and confidentiality: The domain of health care ethics concerned with how well a facility protects patient privacy and confidentiality. It includes patients' control of personal health information, respect for patients' physical privacy, conditions under which information may/must be shared with third parties, etc.

Shared decision making with patients: The domain of health care ethics concerned with how well a facility promotes collaborative decision making between clinicians and patients. It includes matters of decision-making capacity, informed consent, surrogate decision makers, advance directives, etc.

Values: In the health care setting, strongly held beliefs, ideals, principles, or standards that inform ethical decisions or actions, such as beliefs that people shouldn't be allowed to suffer, or principles and standards of respect for persons, nondiscrimination, truth telling, informed consent, etc.

EXCERPTED FROM

CALIFORNIA PACIFIC MEDICAL CENTRE - PATIENT FRIENDLY DEFINITIONS OF MEDICINE TERMS

http://www.cpmc.org/services/ethics/faq.html#Patient Friendly Definitions of Medicine Terms

Diagnostic Terms

Brain death: This term describes a person whose brain has ceased to support all essential functions of the body, including thinking, feeling, breathing, and most other bodily functions. People with this condition, even if their heart is beating, never recover. If the brain dead person is attached to a breathing machine, some signs of life, such as heart beat and skin color, will be present but the person is actually physically and legally dead.

Persistent vegetative state (PVS): This term describes the physical destruction of those parts of the brain that support thinking, perception and feeling, leaving only those parts of the brain that support breathing, digestion, heart regulation and other metabolic functions; "persistent" refers to the medical judgment that the destruction is so severe that recovery will not occur. Unlike patients pronounced "brain dead", persons in PVS are not legally dead, but they are completely and permanently unaware of their surroundings.

Treatment Terms

Dialysis: A technique to substitute for the function of failed kidneys by circulating blood out of the body and through a purification process. It can occur continually in an ICU setting or for several hours each week as an out-patient.

Hydration: Providing fluid needed for support of life. Most of us stay hydrated by drinking liquid orally. If a patient cannot do this, a tube can be inserted into their vein, nose or even directly into their stomach to provide nutrients and fluid.

Pressors: Certain drugs that cause constriction of the blood vessels that are used to maintain blood pressure in seriously ill persons.

Tube feeding: Providing nutrients, usually combinations of protein, carbohydrates and vitamins processed into a liquid, and delivered through a tube inserted down the throat or surgically fixed into the intestines.

Ventilator/Respirator: A machine designed to supply air to lungs when they are incapable of natural inhalation, to which patient is attached by a tube passed down or inserted in the trachea.

Intensity of treatment Terms

Code status: A medical term that states whether procedures called CPR should be used when a patient's heart stops or they stop breathing.

Cardiac resuscitation (CPR): A method of attempting to restart heart beat and breathing when these functions suddenly fail. These methods include chest compression, mouth to mouth breathing, use of drugs and electric shock.

Full code: In the event of sudden failure of the heart or lungs, the medical team will use aggressive measures including CPR to restore heart and lung function.

Do not resuscitate (DNR): The decision by a patient or appropriate decision makers not to use the methods of cardiac resuscitation to restart heart beat and breathing. If these methods are not used, the patient will quickly die. [Note: in some organizations these decisions are known as a do not attempt resuscitation (DNAR) order or allow natural death (AND).]

Comfort Care: The decision to stop efforts to keep a person alive and to emphasize medical efforts to relieve pain and discomfort in expectation of death.

Palliative Care: Similar to Comfort Care; a medical and nursing specialty that emphasizes relief of pain, and physical and psychological discomfort for patients whose condition cannot be definitively cured. Some of the patients seeking palliative care have a long and chronic condition while others are near the end of their lives.

2.0. Your Ethics Committee and the Organization

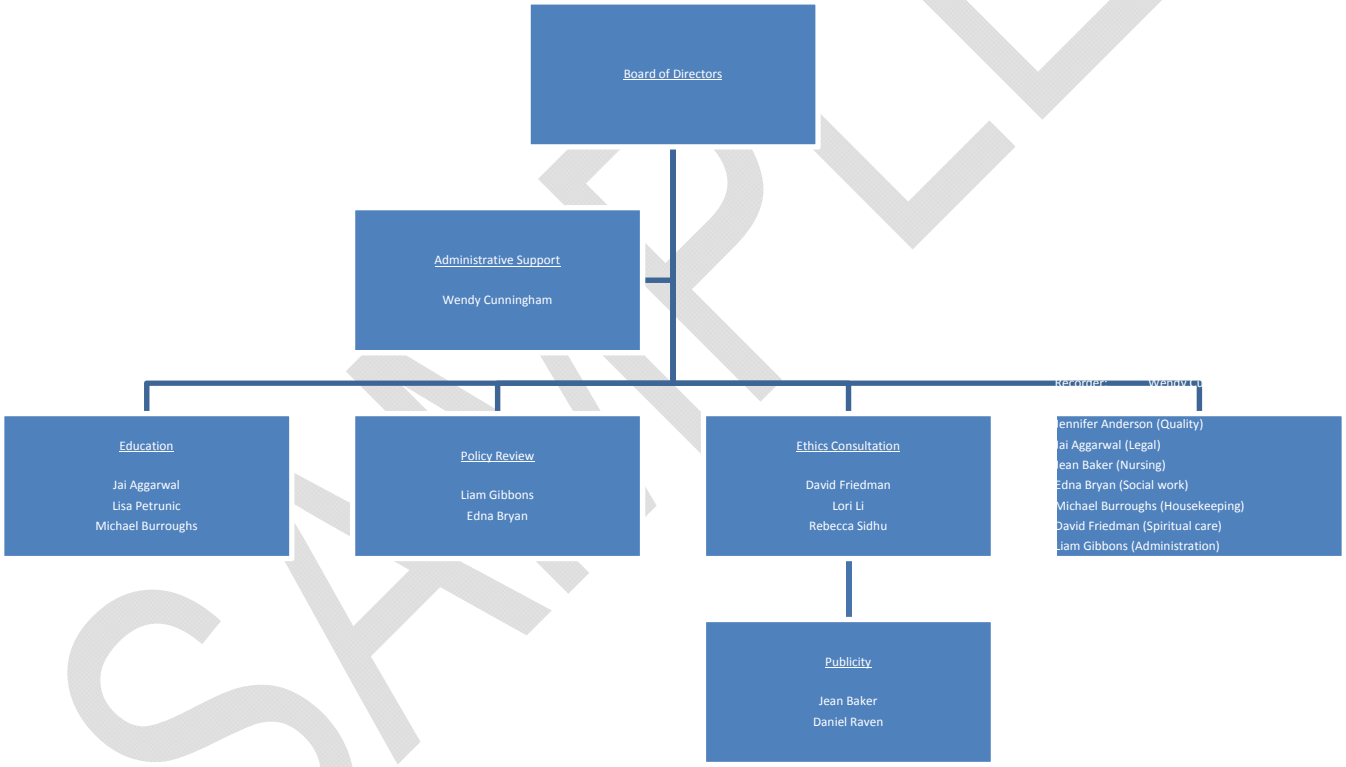
This section outlines how your ethics committee fits within the broader healthcare organization. It also includes important background documents such as mission, vision, and/or values statements developed by your healthcare organization and by others as an illustration of these guiding principles. Finally some examples of ethics-related policies or guidelines have also been included.

2.1 Organizational Chart

As previously mentioned, there is no one "right" way to organize the ethics committee in your healthcare institution. The organizational charts that follow have been developed for a non-existent ethics committee to illustrate there is more than one way an ethics committee might be organized including its reporting structure. *All the names in the chart are fictitious and do not represent any district's actual ethics committee make-up.* An organizational chart provides a visual representation of the person, department, or board your ethics committee reports to within the healthcare organization. This is an important factor to consider given the sensitive nature of much of the work done by ethics committees.

Following the chart there is a sample of the roles and responsibilities of the various components within the chart, and then another example of a possible reporting structure.

2.1.1 Sample Fictional Ethics Committee Organizational Chart



Roles and Responsibilities:

Chair:

Acts as the main contact for the committee
Sets the agenda for meetings
Facilitates meeting

Recorder:

Records minutes
Distributes minutes

Members:

Attend meetings
Participate in committee work (as appropriate)
Contribute to discussions

Mandates

Education Sub-Committee:

To organize an annual Ethics Day event
To coordinate and publicize telehealth sessions
To organize ad-hoc educational events in response to needs identified in the organization

Policy Review Sub-Committee:

To apply an ethics lens to policies as requested by administration or the board.

Ethics Consultation Sub-Committee:

To coordinate the ethics consultant service
To recruit new members for the consultant service

Publicity Sub-Committee:

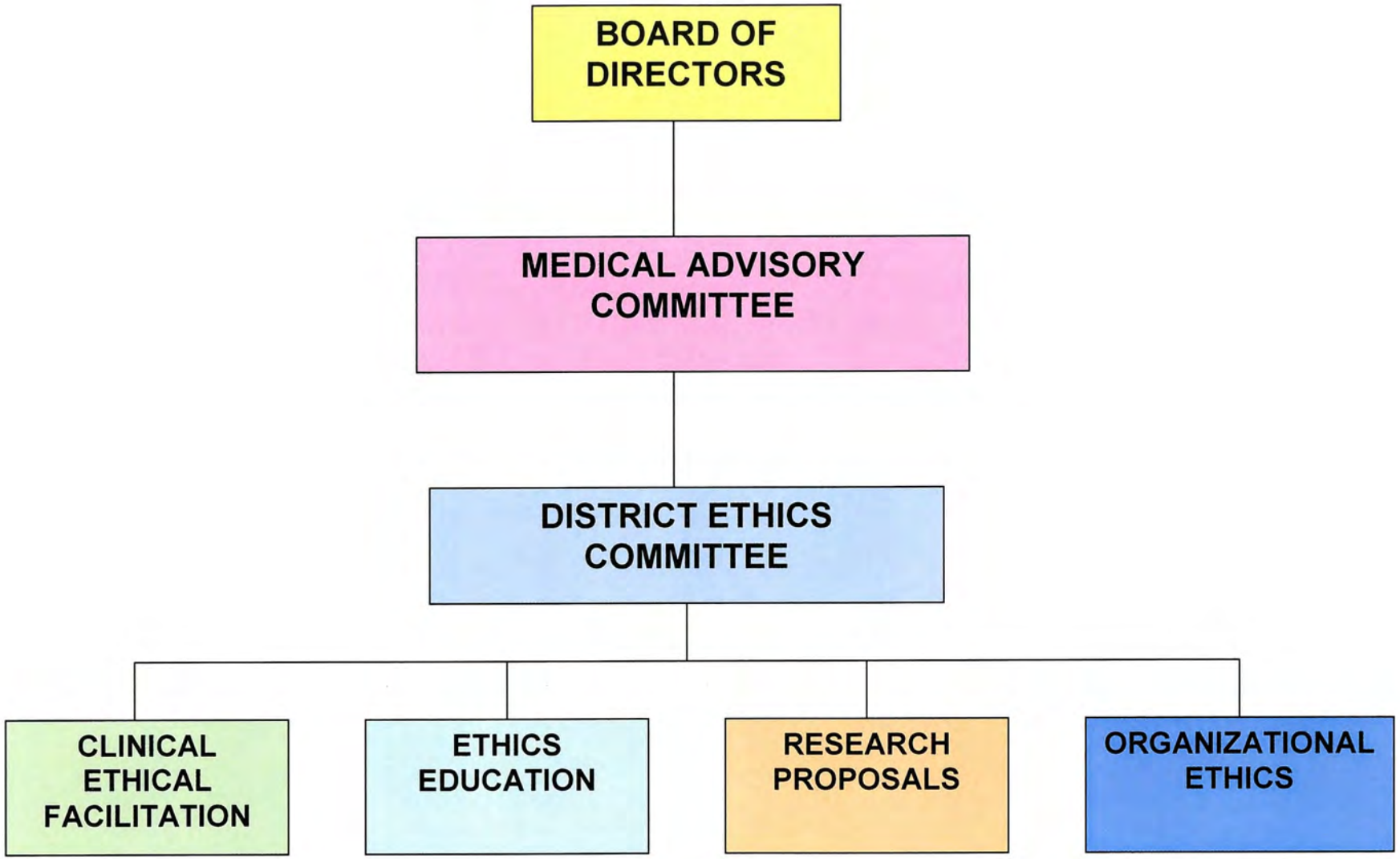
To publicize the work of the ethics committee to the organization
To publicize the work of the ethics committee to the public

Membership Guidelines:

The committee should be multidisciplinary with representation, if possible, from the following groups:

Nursing
Medical staff
Administration
Community
Housekeeping
Support staff
Patients and families
Spiritual care

Rehabilitation
    Social work


BOARD OF DIRECTORS
MEDICAL ADVISORY COMMITTEE
DISTRICT ETHICS COMMITTEE
CLINICAL ETHICAL FACILITATION
ETHICS EDUCATION
RESEARCH PROPOSALS
ORGANIZATIONAL ETHICS

2.2 Organizational Values

We often see an organization's values displayed publicly in its tagline, "Mission" and/or "Vision" statements. The following are examples drawn from the IWK Health Centre and from CDHA.

2.2.1 EXAMPLE: CDHA MISSION, VISION, AND VALUES

MISSION

Our desire is to become, as a society, a world-leading haven or health, healing and learning.

World-leading. We are committed to discovering and enacting leading-edge, evidence-based practices in care, research, education and advocacy.

Haven. We are committed to helping to create and sustain a safe and enriching environment for well-being.

Health. We are committed to supporting an approach that moves beyond mere absence of illness and disease to one that acknowledges optimal well-being as the sum of our physical, emotional, mental and spiritual states.

Healing. We are committed to supporting the natural restorative capabilities of the human body.

Learning. We are committed to seeing ourselves as a community of learners with those we serve and those who serve us. We are all members of learning networks designed to realize our individual and collective health.

PROMISE (VISION)

We, the members of the organization called Capital Health – the employees, physicians, learners and volunteers – are people caring for people. We care for the whole person before us. We care with our hearts as well as our hands and our minds. We care by bringing to bear the sum of our individual knowledge and humanity. We care by helping to build a better tomorrow, as lifelong learners, educators of the next generation and researchers of new frontiers in health and healing. We care by embracing our place in he broader community and working with our friends and neighbours to address the many social conditions that affect well-being. We do all this so that, together, we can realize our shared vision of healthy people, healthy communities.

VALUES

Our Promise is grounded in integrity, and it calls on each of us to be courageous, caring, accountable and inquisitive.

Integrity

Integrity means to act honestly, ethically and morally, and to do what is necessary to align our beliefs, our words, our behaviour and our actions.

Courageous

By courageous we mean having the strength to challenge the status quo. Courage calls on us, individually and collectively, to be leaders in doing the right thing for the people, community and planet that we serve – to do what is necessary to live Our Promise as we face tough issues and make difficult decisions.

Caring
Caring means having compassion and concern for others in a way that embraces a person's physical, spiritual, mental, intellectual and emotional well-being. We do this, as Our Declaration of Health states, with our hearts, hands and minds. And we speak here not just of those we care for, but of each other within the Capital Health community and, indeed, the broader world in which we live.

Accountable
Being accountable means taking responsibility for our words and actions in open and transparent ways. It encompasses sustainability by changing the way we think about our resources, whether they be people or buildings, dollars and cents or earth and air. With our citizens, we are changing the way we think about these resources because we want them to be around for tomorrow's communities.

Inquisitive
Inquisitive reflects our essence as an academic health sciences network that is eager for and supportive of new knowledge. We value curiosity about finding new ways of being, doing, caring and exploring, and we share our knowledge in the pursuit of improved health, health care and the systems in which they operate.

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Our Core Values and Beliefs

Care and Passion

- Taking pride in providing safe, high quality care to the populations we serve
- Building successful relationships with patients and families as partners in decision-making and care
- Making a positive difference in people's lives
- Contributing to a culture of inclusion and diversity

Excellence and Leadership

- Building our reputation for excellence in the Maritime community and beyond
- Contributing to a sustainable health care system through formal and informal partnerships
- Pursuing excellence in care, teaching and research through a spirit of discovery and innovation
- Leveraging our reputation and influence to advocate for the health of the population
- Being accountable for our relationships, decisions and actions

Worklife and Relationships

- Bringing collaboration and teamwork to all that we do
- Creating a supportive work environment that values and respects all members of our team
- Being open and honest
- Supporting employees, physicians and volunteers in achieving and maintaining a healthy lifestyle

Our Mission

- To make a difference in the health and well being of women, children, youth and families
- To bring together care, research, teaching and advocacy for the best possible results
- To be global leaders in research and knowledge sharing

Our Vision

Healthy families. The best care

2.3 Organizational Policies and Guidelines

Policies from various healthcare organizations cover topics such as:

- Policy for policies
- Consent policy
- DNR policy
- Disclosure
- Patient safety
- Confidentiality policy
- Conflict of interest policy
- Infection control policy
- others

Unlike the policies mentioned in section 1.5 that were directly related to ethics committee functioning, the policies in this section have a significant ethics dimension but no concrete association with the ethics committee per se. These are policies that apply to the the work of all within the healthcare organization including the ethics committee. It is important for members of the ethics committee to be particularly familiar with them as they are often pertinent to the matter under discussion in a given ethics consultation.

Some examples of this sort of policy are included in the pages that follow.

2.3.1 Examples of Organizational Policies and Guidelines - CBDHA & CDHA

ADMINISTRATIVE MANUAL

POLICY & PROCEDURE

Category:	Patient and Community Relations	Policy Number:	3 - 001
Distribution:	DISTRICT-WIDE	Page:	1 of 4
Approved by:	Chief Executive Officer	Effective Date:	17/09/2007 (O)
		Review Date:	23/06/2009 (R)

CONFIDENTIALITY

Policy

Confidentiality is an essential element of the clinical relationship and is critical to quality care. Any individual with access to personal, patient and corporate information must abide by the Cape Breton District Health Authority policies regarding privacy, security and confidentiality.

Confidentiality is a requirement of employment and must be maintained at all times both on and off duty. The Cape Breton District Health Authority is bound by law to protect the confidentiality of Cape Breton District Health Authority information.

Purpose

The Cape Breton District Health Authority depends on **all** users of Cape Breton District Health Authority Information to protect the confidentiality of the information to which they have access and for which they are responsible. Emphasis on a person=s right to privacy and confidentiality is incumbent on all users of Cape Breton District Health Authority information.

Definitions

Confidentiality means the obligation of a custodian or organizations to protect the information entrusted to it and not misuse or wrongfully disclose it.

Security includes the measures taken to protect personal information from unauthorized or unintentional loss, theft, access, use, modification or disclosure.

Principles of Confidentiality

- All employees and persons associated with the Cape Breton District Health Authority will be responsible for maintaining the confidentiality of information accessed, handled, or viewed in the course of their work.
- Confidentiality applies to all information which is written, spoken, stored in a computer, microfiche, photographed, videoed or otherwise learned.
- Confidentiality will extend not only to patient information but also to all information not readily available to the public, including information regarding employees and the business affairs of the Cape Breton District Health Authority. Examples include the patient health record, seeing people you know who are receiving care at the Cape Breton District Health Authority or any off site area, business or program planning being done at Cape Breton District Health Authority, overheard conversation, reports, files, faxes, etc.
- Communication of confidential Cape Breton District Health Authority information will be acceptable only in the performance of the employees duties and responsibilities.
- Disclosure of Cape Breton District Health Authority information not in the course of Cape Breton District Health Authority business will be considered a breach of confidentiality.
- Obligations to maintain confidentiality of information will continue after employment /contract/association/appointment with the Cape Breton District Health Authority ends.
- All employees are responsible to understand and abide by Cape Breton District Health Authority policy.

Procedures Associated with Confidentiality

- Access to information does not imply authority to have access to particular information. Access is **authorized** to the extent to which there is a requirement to perform ones duties and responsibilities at the Cape Breton District Health Authority. Although it may be possible to access more Cape Breton District Health Authority information than is required, staff and persons associated with the Cape Breton District Health Authority are **only authorized** to access the information they require to perform their duties.
- Discussion will not take place in public areas (elevators, lobbies, cafeterias, hallways, off premises, etc.), where such information may be overheard by those who do not have a need for such information, or in the presence of persons not entitled to such information. In clinical setting during patient care activities,
(Example: Day Surgery, Emergency Department, Recovery Room) where this may not be feasible, due regard must be had for confidentiality.

- Personal information (original or copies) cannot be removed from the Cape Breton District Health Authority facilities and program sites.

  The only exception to this provision are:
  a) for the direct provision of patients care; and
  b) where required by law (e.g. to comply with subpoena or court order).

- Patient records or other confidential information whether in manual or electronic form will not be left open or unattended in public places.

- Personal information that is needed to further patient care will be collected and used only for the purposes for which it was collected, unless specific authorization is received.

- It is a breach of confidentiality to disclose any personal information (including medical, social, personal, financial, etc.) without the written consent of the patient concerned or unless required or authorized by law for any reason other than necessary communication between care providers.

- Confidential information must be destroyed appropriately; paper and microfiche must be shredded, tapes and discs must be erased and information on electronic devices (i.e. personal computers, laptops, laboratory equipment) must be destroyed according to industry standard. Confidential information must not be discarded via routine waste/garbage.

- All employees will sign a Pledge of Confidentiality acknowledging their understanding of their obligations regarding confidentiality.

- If staff, physicians, students or volunteers are aware that information is not being kept confidential, they must report this to their supervisor/manager.

- All non-Cape Breton District Health Authority employed individuals; i.e. non-staff physicians, students, volunteers, researchers and others associated with the Cape Breton District Health Authority must sign a Pledge of Confidentiality, accepting personal responsibility for maintaining the confidentiality of any information obtained through the course of their duties. Copies of this pledge are available from their departments. Once signed, the associated departments must store the forms. Any other non-Cape Breton District Health Authority employee who does not fit into the above categories must contact Human Resources to obtain a pledge. If these individuals require access to the NShIS, they must sign a Conditions of Appropriate Use form.

Non Adherence to Cape Breton District Health Authority Policies

Any misuse of information will be considered a breach of confidentiality and will be subject to disciplinary action, up to and including termination of employment and/or placement. The steps to appropriate disciplinary/dismissal action will be collaboration between the Manager/Director and the Human Resources Department.

Supplemental References

COACH, Canada=s Health Informatics Association. Guidelines for the Protection of Health Information (2001)

Canadian Institute of Health Research. Questions and Answers Regarding the Personal Information Protection and Electronic Documents Act.

Preliminary Draft of the Pan-Canadian Health Information Privacy and Confidentiality Framework

The Hospitals Act of NS (1989)

Canadian Health Record Association

* * *

CAPE BRETON DISTRICT HEALTH AUTHORITY

DECLARATION OF CONFIDENTIALITY
STAFF/AFFILIATE/VOLUNTEER

I hereby acknowledge that as a staff member, affiliate or volunteer of the Cape Breton District Health Authority, I may be entrusted with knowledge of or have access to the personal and private data of patients/persons of the Cape Breton District Health Authority. I hereby undertake not to divulge any of this knowledge nor discuss it with any unauthorized person, either during the time of my employment or thereafter, except in the course and execution of my duties as a staff member, affiliate or volunteer. I also acknowledge that a breach of this undertaking may result in disciplinary action up to and including discharge.

_____ _____

Signature Date

I have explained the implication of signing the Declaration of Confidentiality to

_____ and am satisfied that he/she is aware of the necessity of

(Name of staff/affiliate/volunteer)

confidentiality.

_____ _____

Signature Date

(Policy Reference #3-01)

ADMINISTRATIVE MANUAL

POLICY & PROCEDURE

Category:	**Administrative Overview**	**Policy Number:**	**1-110**
Distribution:	**District Wide**	**Page:**	**1 of 2**
Approved by: _____ **Chief Executive Officer**		**Effective Date:**	**2002/09/10**
		Review Date	**28/08/2007 (r)**

CONFLICT OF INTEREST - EMPLOYEES

All employees of the Cape Breton District Health Authority are required to declare any situation(s) which is, or has the potential or appearance to be in conflict with the mission statement, philosophy, business or other interests of the District.

Conflict of interest can arise where there is harm to the employer's interests, including the employer's reputation. Such harm might arise where an employee's conduct, including off duty employment:

1. Involves the unauthorized use of information or material that is exclusive to the District, including the District's name or phone number.

2. Involves outside interests that materially encroaches or may encroach on time or attention that should be devoted to the District. This includes activities that are performed on the employer's time or is causing unauthorized absence from the employer's work.

3. Takes advantage of an opportunity for financial or personal gain that properly belongs to the District.

4. Provides private or confidential information to an outsider on District business opportunities.

5. Permits the employee to sell or buy from the employer or causes the presumption of preferential treatment between the District and an outside organization.

Responsibility of the Employee:

1. Inform the District through the Departmental Director (Vice President if the employee is a Departmental Director) of a possible conflict of interest or outside employment, including self-employment, of a substantive nature.

2. Ensure that there is no solicitation of business during working hours.

3. Disqualify himself from any action on behalf of the District if any suspicion of preference might be attached to the action.

Responsibility of the Departmental Director:

1. Review the circumstances of the situation against the criteria of the policy and consult with Human Resource Services.

2. Inform the next senior level of management of the possible conflict of interest.

3. Inform the employee to take appropriate precautions between the District and outside employment to avoid any suspicion of conflict. If a business transaction is involved, the employee must disqualify himself from any action on behalf of the District if any suspicion might be perceived.

4. Ensure that the employee does not engage in any solicitation during working hours and that the District is not compromised by the employee's outside business.

Responsibility of Human Resource Services:

1. Review the outside activity to determine if there is a potential conflict with present employment at the District.

2. Ensure that a letter outlining the responsibility of the employee is given by the Departmental Director and a copy placed in Human Resource Services file. A copy is given to the appropriate Vice President.

* * *

ADMINISTRATIVE MANUAL

POLICY & PROCEDURE

Category:	**Administrative Overview**	**Policy Number:**	**1 - 115**
Distribution:	**District-Wide**	**Page:**	**1 of 2**
Approved by :	_____ **Chief Executive Officer**	**Effective Date:**	**2003 /04/01(O)**
		Revised Date:	**28/08/2007 (R)**

CONFLICT OF INTEREST - VOLUNTEERS

POLICY

All volunteers of the Cape Breton District Health Authority are required to declare any situation(s) which is, or has the potential or appearance to be in conflict with the mission statement, philosophy, business or other interests of the District. Conflict of interest can arise where there is harm to the employer's interests, including the employer's reputation. Such harm might arise where a volunteer's conduct:

1. Involves the unauthorized use of information or material that is exclusive to the District, including the District's name or phone number.

2. Takes advantage of an opportunity for financial or personal gain that properly belongs to the District.

3. Involves the pursuit of volunteer placement solely for the purpose of future employment.

4. Provides private or confidential information to an outsider on District business opportunities.

5. Permits the volunteer to sell or buy from the employer or causes the presumption of preferential treatment between the District and an outside organization.

PROCEDURE

Responsibility of the Volunteer

1. Inform the Volunteer Coordinator, Unit Manager or supervising CBDHA staff member of a possible conflict of interest.

2. Ensure that there is no solicitation of business during volunteer hours.

3. Disqualify himself from any action on behalf of the District if any suspicion of preference might be attached to the action.

Responsibility of the Immediate Supervisor/Executive Sponsor
The immediate supervisor/executive sponsor of the volunteer might be a Manger, Director, etc. The volunteer works in this individual's program/service/unit.

1. Review the circumstances of the situation against the criteria of the policy.

2. If appropriate, consult with the Director of Pastoral Care/Volunteer Services or the Director of Human Resources.

3. Inform the volunteer to take appropriate precautions between the District and outside employment to avoid any suspicion of conflict. If a business transaction is involved, the employee might disqualify himself from any action on behalf of the District if any suspicion might be perceived.

4. Ensure that the volunteer does not engage in any solicitation during volunteer hours and that the District is not compromised by the employee's outside business.

Responsibility of the Director of Pastoral Care & Volunteer Services

1. Review the circumstances of the situation against the criteria of the policy and consult with Human Resource Services.

2. Inform the next senior level of management of the possible conflict of interest.

3. Inform the volunteer to take appropriate precautions between the District and outside employment to avoid any suspicion of conflict. If a business transaction is involved, the employee might disqualify himself from any action on behalf of the District if any suspicion might be perceived.

4. Ensure that the volunteer does not engage in any solicitation during volunteer hours and that the District is not compromised by the employee's outside business.

Responsibility of Human Resource Services

1. Review the outside activity to determine if there is a potential conflict with present volunteer placement.

2. Give a letter outlining the responsibility of the volunteer to the Volunteer Coordinator, Unit Manager and/or supervising CBDHA staff member, who should in turn give a copy of the letter to the volunteer. Place a copy of this letter in the Volunteer's file.

* * *

Capital Health

ADMINISTRATIVE MANUAL

Policy & Procedure

TITLE:	Disclosure of Adverse Patient Safety Events and Harm	**NUMBER:**	CH 70-006
Effective Date:	October 2010	**Page**	1 of 22
Applies To:	Holders of Administrative Manual		

Table of Contents

Note: For information/direction on Capital Health's formal process for reporting adverse patient safety events, refer to Patient Safety Reporting System Policy CH 100-035.)

Disclosure Policy Quick Reference Guide

Is this an Adverse Patient Safety Event? → No → No action required

Yes
1. Unintended harm to patient related to care or services
2. Harm that may negatively affect Patient's physical and/or psychological health and/or quality of life

↓

Physician, Health Care Provider, Student or Volunteer notifies Manager and Department Head

↓

Health care provider and Manager:

- Assess & ascertain whether adverse patient safety event criteria are met; if so, determine whether type A (one patient) or B (multi-person(s) and/or being of legitimate public interest); if B, report to Director who informs appropriate VP, Risk Management/Patient Safety & Legal Services
- Designate a Disclosure Team (usually Health Care Provider, Manager and Patient Representative)
- Designate initiator of disclosure discussion
- Manager informs Health Care Team of supports

Disclosure team:

- Arranges to meet with patient and disclose adverse patient safety event in a timely manner (*See Internal Disclosure Procedure # 2 to 7*).
- Documents summary in the patient health record
- Offers to meet with patient and conduct post-analysis disclosure as necessary.

LET

- In consultation with Dept. of Health, determines whether to disclose externally (*See External Disclosure Procedure section*), if so,
- Appoints external disclosure team.

Key Points to Remember

Elements of Optimal Disclosure

- Person-Centered Healthcare
- Patient Autonomy
- Recognition
- Acknowledgement
- Factual Explanation
- Assumption of Responsibility
- Regret and Apology
- Honesty and Transparency
- Clarity of Communication
- Timeliness
- Confidentiality
- Support and Advocacy
- Continuity of Care
- Healthcare that is safe
- Leadership Support

Person to initiate disclosure

- Known/trusted by patient
- Good interpersonal/communication skills
- Respectful of cultural, language, gender, and diversity issues
- Good grasp of the factual information
- Well informed about the patient's needs (e.g. capacity)
- Willing/able to express regret/apologize and provide sensitive feedback
- Maintain medium to long term relationship

Initial Discussion

Includes:

- Patient advised of identity & role of disclosure team
- Expression of regret and apology
- Factual explanation with appropriate language and terminology
- Potential outcomes/consequences of adverse patient safety event and any harm
- Adequate time for questions
- Support Plan
- Initial plan of care

Does not Include:

- Speculation
- Attribution of blame to specific individuals
- Legal admission of liability
- Denial of responsibility
- Lack of clarity regarding the known facts

PREAMBLE/BACKGROUND

Achieving a culture of patient safety requires open, honest and effective communication between health care providers and their patients. Patients are entitled to information about themselves and about their medical condition or illness, including the risks inherent in health care delivery (Canadian Disclosure Guidelines, CPSI (2008).

Patient and families expect honest, empathic, and respectful communications with their health care providers, and especially when harm has occurred. Open disclosure helps the patient and family, the health care providers involved, and the health organization heal and learn from the harm, which helps make the system safer for all.

When patients have been harmed, they expect a sincere apology and an explanation of what has happened. They also need to see that the organization accepts responsibility and is initiating changes and implementing actions to help prevent the harm from happening again. See Patients for Patient Safety Canada at http://patientsforpatientsafety.ca/initiatives/disclosure/

Capital Health's Our Promise is to create a world-leading haven for people centered-health, healing, and learning. In the Person-Centered Health strategic stream, the patient is welcomed as a full-fledged member of the health-care team. The patient's right to make decisions about his/her own health is respected, and it is recognized that a healthy person needs a healthy community. Capital Health cares for the whole person before us with our hearts, as well as our hands and minds.

Capital Health recognizes that adverse patient safety events rarely arise from a single event and are not usually solely provider-related. They typically arise from a series or cascade of system–related events which often result from latent circumstances in the environment, such as equipment, facilities design, training, maintenance and organizational factors.

POLICY

1. The Disclosure of Adverse Patient Safety Events and Harm Policy:
   1.1. provides guidance and direction in those circumstances in which disclosure of adverse patient safety events and the harm associated with them is or may be indicated;
   1.2. provides clear procedures for disclosure;
   1.3. applies to both Type A and Type B events (See **Definitions**);
   1.4. recognizes the importance of an open patient safety culture; and
   1.5. follows the principles of a Just Culture that ensures that staff and health care providers are not penalized for their involvement in the reporting of adverse patient safety events and for participating in disclosure processes.
2. All Capital Health physicians, health care providers, volunteers and students are to inform their manager and department head, and other appropriate person (eg. Risk Management/Patient Safety), about patient safety events that may meet the criteria of an adverse patient safety event.
   2.1. Examples of events that require reporting through the Patient Safety Reporting System (PSRS) and that require disclosure are outlined in *Appendix A*. The manager/department head is to inform the appropriate director who is accountable for ensuring the processes as outlined in this policy are implemented.
3. Disclosure of information regarding an adverse patient safety event should take place as soon as possible after recognition that the adverse patient safety event has occurred.

4. Adverse patient safety events involving patients are discussed with the patient directly, or if the patient lacks capacity, with the patient's substitute decision-maker. At such time as the patient has regained capacity, discussion of the adverse patient safety event takes place with the patient directly.
5. Nothing in this policy prevents a health care provider from individually disclosing minor events directly to patients at the time of the patient safety event occurring.
   5.1. Events at Impact Classification Level 1-4 in the Patient Safety Reporting System do not necessarily require designation of an Disclosure Team.
   5.2. Examples of such events, in some circumstances, are medication omission, extra dose of medication, and rejection of blood samples requiring redraw depending on patient impact.
6. Although the procedures of the policy specifically address actions to be undertaken in the event of an adverse patient safety event (as defined in the **Definitions** section), disclosure of patient safety events (e.g. near miss events) that do not meet the harm criterion of an adverse patient safety event is strongly encouraged for the purposes of informing the patient and staff and to prevent similar events in future.
   6.1. In order to facilitate learning and the development/maintenance of a positive patient safety culture, Capital Health recognizes the importance of reporting all patient safety events (including near misses) through the *Patient Safety Reporting System* whether or not they have resulted in harm to the patient.
7. **Expected outcomes** of implementing this policy include:
   7.1. Patients receive prompt and timely disclosure and are fully informed about adverse patient safety events and any associated harm that has occurred to them.
   7.2. Patients receive a timely, respectful and sincere apology in accordance with this Policy.
   7.3. Patients have their concerns and fears openly addressed and respected.
   7.4. Open communication between patients and their health care providers that respects and addresses the patient's needs.
   7.5. The disclosure process supports a positive patient safety culture, improves the quality of care, and facilitates learning from adverse patient safety events.

GUIDING PRINCIPLES & VALUES

1. In a culture of patient-centered health care, patient safety and ethics, failure to properly disclose adverse patient safety events has the potential to undermine public confidence in health care providers and health care organizations. The use of well thought-out processes for managing adverse patient safety events can facilitate systems improvements in health care organizations and contribute in important ways to the prevention of further adverse patient safety events.
2. A number of ethics principles and values including but not necessarily limited to those outline in number 3 below should inform decision-making regarding the disclosure of adverse patient safety events. It important to recognize and acknowledge that, in some circumstances/contexts, these principles and values, and the moral obligations that arise

from them, are in conflict/tension and, as such, require careful balancing by decision makers.

3. **Respect for persons:**

   3.1 *Truth telling* – a basic, widely accepted ethics principle and a key component of accountability, one of Capital Health's core values. Health care organizations and those working within them have a fundamental obligation to be honest and open in their communications with patients, their 'families'/substitute decision makers, and the public.

   3.2 *Trust* – understood in the health care context as the reliance and related expectation that health care organizations and those working within them act so as to put the interests of patients first. The earning of the public's trust is an important moral obligation of health care organizations.

   3.3 *Autonomy* – as interpreted in the disclosure of adverse patient safety events context, the patient has the 'right to (fully) know' about an adverse patient safety event that has affected or potentially affected him/her and has the right to make informed choices about her/his future health care and treatment.

4. **Patient welfare**

   4.1 *Beneficence* – the obligation of health care organizations and providers to provide meaningful health benefits to patients/families and the public.

   4.2 *Nonmaleficence* – the obligation to 'first, do not harm' or as little as possible, i.e., the responsibility of health care organizations and health care providers to mitigate/reduce burdens to patients and the public.

5. **Justice**

   5.1 *Traditional justice* – social benefits (including health and health care) and burdens are to be fairly distributed/allocated.

   5.2 *Formal justice* – like individuals and groups should be treated alike unless there is a demonstrable *relevant* difference between them that would justify different treatment.

   5.3 *Social justice* – includes the obligation to meaningfully engage participants from vulnerable social groups in health care decision making, e.g., disadvantaged persons who may be affected by adverse patient safety events and their disclosure.

   5.4 *Procedural justice* – the requirement that we collectively develop and follow fair due processes.

BEST PRACTICE GUIDELINES: Elements of Optimal Disclosure:	
• Person-centered healthcare • Patient Autonomy • Recognition • Acknowledgement • Factual Explanation • Acknowledgement of Responsibility • Expression of Regret & Apology	• Honesty and Transparency • Clarity of Communication • Timeliness • Confidentiality • Support and Advocacy • Continuity of Care • Leadership support

DEFINITIONS

Adverse patient safety event: A patient safety event which results in unintended harm to the patient and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition and may negatively impact a patient's physical and/or psychological health and/or quality of life. (Adapted CPSI 2008).
Note: *See also* ***Appendix A*** *for a list of events that are reportable through the PSRS and require disclosure.*

Apology: An expression of sympathy or regret, a statement that one is sorry (CPSI 2008).

Appropriate health care provider: An attending health care provider who is familiar with the patient and has responsibility for providing health care in the treatment domain in which the adverse patient safety event occurred or potentially occurred.

Appropriate manager/director: The manager/director (or designate) who is responsible and accountable for standards of care in the clinical unit or area in which the adverse patient safety event occurred or potentially occurred.

Autonomy: The patient's right to control what happens to his or her body, and is the cornerstone of the informed consent discussion (CPSI 2008).

Disclosure: The process by which an adverse event is communicated to the patient by healthcare providers.

- *Initial Disclosure* is the initial communications with the patient as soon as reasonably possible after the adverse patient safety event.
- *Post-analysis Disclosure* is the subsequent communications with a patient about known facts related to the reasons for the harm after an appropriate analysis of the adverse patient safety event. (CPSI 2008)

Harm: An outcome that negatively affects the patient's health and/or quality of life (CPSI 2008)

Informing: Providing information about adverse events and performance of the health care system to the public, mainly through the media (CPSI 2008).

Just Culture:

A key element of a broader patient safety culture that seeks to reconcile professional accountability and the need to create a safe environment in which to report adverse patient safety events. Healthcare providers in a just culture are fully aware of the expectations of the organization and are held professionally accountable for the quality of their work in a fair way. Adverse events are viewed in the context of identifying system contributors in order to improve safety. *(CPSI, 2008)*
Just Culture is:

- Reporting of patient safety events.
- Promoting open discussions & learning from patient safety events.
- Improving & implementing change(s) based on patterns & trends.
- System accountability identified in the context of where the event occurs.
- Holding individuals accountable for their own performance and/or blame-worthy events, but not system issues.
- Developing "blame-free/blameworthy" organizational policies to manage patient safety events and support patient safety but not penalize staff for reporting.
- Investigations fair and free of bias regardless of the event outcome or hindsight.
- Ensuring feedback to staff.

Near Miss:

An accident or situation that "almost happened "to a patient. Also known as a close call, it may or may not have reached the patient. The near miss has not affected the patient nor caused harm but the potential for harm exists. This harm could have caused an injury or loss to the patient had the timing, location and circumstances been different.

Patient(s):

Denotes all clients, inpatients, outpatients, residents and Veterans who reside in or are cared for through any of the district facilities, programs or services. (For the purposes of this document, 'patient' means patient, or, if the patient is incapacitated, the substitute decision-maker).

Patient Safety Event:

Any event affecting a patient which can include near misses, adverse events, errors when determined to be so on investigation, adverse drug, vaccine, contrast reactions and any other event determined to affect patient safety or well-being.
Note: World Health Organization working definition of a

	patient safety event used for the development of the International Patient Safety Classification is a process or act of omission or commission that resulted in hazardous health care conditions and/or unintended harm to the patient. An event is identified by a generalized high-level, discrete, auditable term or group of terms. *(WHO July 2006)*
Reporting:	The communication of information about an adverse event or near miss by health care providers, through appropriate channels inside or outside of health care organizations, for the purpose of reducing the risk of reoccurrence of adverse events in the future (CPSI 2008).
Substitute decision-maker (Consent to Treatment Policy):	If the patient is not capable of consenting, consent must be obtained from the patient's Substitute Decision Maker ("SDM"). The patient's SDM is to be determined from persons, **in this order of priority**: • a person who the patient, when competent, appointed as SDM under the *Medical Consent Act prior to April 1, 2010 or the Personal Directives Act on or after April 1, 2010.* This may be referred to as a medical power of attorney, a personal directive or a living will; • legally appointed guardian; • the spouse, registered domestic partner or common-law partner, if the spouse, registered domestic partner or common-law partner is currently cohabitating with the patient in a conjugal relationship, and in the case of a common-law partner has cohabitated with the patient for at least one year; • an adult child of the patient; • a parent of the patient; • an adult brother or sister of the patient; • a grandparent of the patient; • an adult grandchild of the patient; • an adult aunt or uncle of the patient; • an adult niece or nephew of the patient; • any other adult next of kin of the patient; and • the Public Trustee.
Transparency:	As used in this policy implies openness, communication, and accountability.
Type A adverse patient safety event:	An adverse patient safety event that affects or potentially affects a particular patient.
Type B adverse patient safety event:	An adverse patient safety event which affects or potentially affects:

1. multi-person or groups of affected individuals, and/or
2. issues that are of legitimate public interest. This may involve other health organizations and districts.

PROCEDURE

INTERNAL DISCLOSURE

As per the adverse patient safety event definition, in the event that a patient safety event occurs and it is recognized that it may meet the definition of an adverse patient safety event health care providers and/or staff inform their appropriate manager and/or department head of the event immediately.

1. Initial Disclosure Analysis

1.1. The appropriate health care provider and manager meet as soon as reasonably possible to perform an initial assessment of the event and to determine whether the event meets the definition of adverse patient safety event contained in this policy.

Note: A determination that the event does not meet the definition of an adverse patient safety event requires confirmation by Risk Management/Patient Safety and/or Legal Services.

1.1.1. In the absence of the manager, consult the director to assist in the initial assessment of the event and determine if the event meets the threshold for disclosure.

1.1.2. In the absence of the manager and director, consult with:

1.1.2.1. QEII HSC – the administrative coordinators.

1.1.2.2. Other Capital Health sites – the site-responsible person or administrator-on-call.

1.1.2.3. Risk Management/Patient Safety and/or Legal Services, as necessary.

1.2. If the health care provider and manager determine that the event may meet one or both of the criteria of a **type B adverse patient safety event**, immediately report the results of the initial assessment to the appropriate director, who in turn consults with the appropriate Vice-President, the Vice-president Performance Excellence & General Counsel and Risk Management/Patient Safety.

1.3. For **type B adverse patient safety events,** follow a decision-making framework such as the one contained in Appendix B.

1.3.1. The decision-making framework aims to assist in a step-by-step process of bringing the relevant stakeholders together, clarifying the issue, gathering and examining the relevant information, identifying possible response options, considering the benefits and burdens of each and to whom, selecting a response(s), developing and implementing a comprehensive strategy, and evaluating the outcomes.

2. Initial Disclosure Team

2.1. If it is determined that an adverse patient safety event has occurred, the appropriate health care provider and manager (or appropriate director in the absence of the appropriate manager) jointly designate an initial disclosure team and determine who will initiate the disclosure discussion with the patient.

2.1.1. If it is determined that the adverse patient safety event occurred in an external health organization and/or district outside the health organization currently providing care, the appropriate manager, director, or VP informs the appropriate administrative coordinator or site-specific person/administrator-on-call who, in turn, informs the senior administrator of the originating organization of the adverse patient safety event in a confidential manner.

2.1.2. Normally, the initial disclosure team consists of the appropriate health care provider(s), the appropriate manager, and the appropriate patient representative (if available).

2.1.3. In the designation of membership of the initial disclosure team, respect the patient's wishes, if any, to not interact with specific members of the health care team.

2.1.4. Respect the option/obligation of members of the initial disclosure team to consult with their professional organizations and/or indemnifiers prior to participating in disclosure discussions. {See References: Canadian Disclosure Guidelines (CPSI, 2008) & communicating with your patient about harm: Disclosure of Adverse Events (CMPA 2008).}

2.1.4.1. Consultations and communications with professional organizations and/or indemnifiers should not inordinately delay the timing of the initial disclosure discussion.

2.1.5. Provide the patient with the option of arranging for an external support person(s) of his/her choice to attend the initial and any subsequent disclosure discussions.

2.1.5.1. Other potential, internal support persons, (e.g. spiritual care provider and the clinical unit social worker), may attend the initial disclosure discussion and provide subsequent support to the patient at the discretion of the patient

2.1.6. Inform the patient of the option to contact Capital Health Ethics Support.

BEST PRACTICE GUIDELINES: Initial Disclosure – Initiating Disclosure

- Be person (s) known to and trusted by the patient;
- Have good interpersonal and communication skills;
- Be respectful of cultural, language, gender and diversity issues;
- Have a good grasp of the relevant, factual information;
- Be well informed about the particular needs of the patient (e.g. capacity);
- Be willing and able to apologize and express regret, and provide sensitive feedback to the patient; and
- Be able to maintain a medium to long-term relationship with the patient to provide information and support.

2.1.7. During the initial disclosure discussion, the disclosure team provides information about the adverse patient safety event to the patient, taking into account the best practice guidelines as highlighted in this policy.

2.1.8. In the event that the disclosure team disagrees about the optimal time of the initial disclosure discussion, immediately consult Risk Management & Patient Safety and/or the VP Performance Excellence for assistance.

BEST PRACTICE GUIDELINES: Initial Disclosure – Timing & Threshold

- Adequate time for initial analysis of the relevant information;
- Timing consistent with normal care practices around the provision of health care information to patients;
- Clinical condition of the patient (e.g. capacity);
- Patient/substitute decision-maker preferences;
- Availability of key, involved staff and appropriate communicators;
- Availability of the patient's 'family' and support persons;
- Availability of potential support staff (e.g. patient representative, social worker, spiritual care provider);
- Patient comfort and availability of a patient-centered location for disclosure which is as private as possible in the circumstances.

3. The **initial disclosure discussion** contains the following elements:

3.1. The identity and role of all people in attendance.

3.2. An empathic expression of regret and apology from the care-providers, the health care team and the organization; this is acceptable and encouraged in support of the CDHA Promise for Person-centered Health.

3.2.1. When the health care team and/or the organization is responsible, accept responsibility and apologize.

- An early expression of regret communicates concern and empathy for the patient and his/her family;
- An expression of regret or an apology during subsequent discussions may be important to the patient and his/her family;
- An apology is not an expression of liability and, as such, apologies are protected under the Province of Nova Scotia *Apology Act**.

3.2.2. In the disclosure discussion, avoid the use of legal terminology, such as negligence, fault and failure to meet the standard of care.

Note: In brief, the Province of Nova Scotia *Apology Act* states…that an apology made by or on behalf of a person in connection with any matter does not constitute an express or implied admission of fault or liability by the person in connection with that matter,… nor a confirmation of a cause of action or acknowledgement of a claim in relation to that matter for the purpose of the Limitations of Actions Act. It does not void insurance coverage; …and may not be taken into account in any determination of fault or liability in connection with the matter. (3 (1) a-d).

WHAT PATIENTS WANT: When it has been found that harm has occurred, the patient has the right to:

- Be informed about potential harm ;
- A comprehensive and timely investigation of the facts;
- An opportunity to provide input into the investigation;
- Empathy, understanding, and support during what might a very stressful time; and
- Honest, open and transparent disclosure of the facts.

Patients for Patient Safety Canada: Principles of Disclosing Harm.

3.3. An accurate explanation of what happened, including:

3.3.1. all factual information that an individual in the particular circumstances of the patient would reasonably wish to know about the adverse patient safety event,

3.3.2. the potential outcomes/consequences of the adverse patient safety event, and

3.3.3. information which allows the patient to make fully informed decisions about his or her future health care and treatment.

3.4. Efforts to facilitate the patient's understanding of the information provided including:

3.4.1. ample time to ask questions,

3.4.2. the use of appropriate language and terminology, and

3.4.3. awareness and appreciation of the patient's culture, language, education level and special needs.

This includes asking the patient to repeat back the essential elements of the information that has been provided to ensure that he/she has understood the information.

3.5. Offers of practical and emotional support including facilitation of ongoing, regular contact between the patient and the appropriate patient representative, if the patient desires this. This includes the offer of consultation with a spiritual care provider(s), the clinical unit social worker(s), etc.

3.5.1. If it is anticipated that the patient will require or benefit from long term support, the clinical team (e.g. psychological counselling, social work consultation, etc.) initiates access to appropriate resources as desired by the patient.

3.6. Presentation of an initial care plan to the patient/substitute decision-maker for consideration.

3.7. The initial steps taken to manage the adverse patient safety event, how the adverse patient safety event will be reported to appropriate organizational authorities, and what will happen next.

4. The content of the initial and subsequent disclosure discussions does **not** include the following:

4.1. Speculation regarding the adverse patient safety event or the potential harm associated with it;

4.2. attribution of blame to specific individuals, health care providers, and/or health organizations/districts;

4.3. admission of liability with respect to health care providers and/or health organizations;

4.4. denial of responsibility by healthcare providers and/or the health organization; and

4.5. intentional omission of and/or lack of clarity regarding the known facts.

WHAT PATIENTS EXPECT: When it has been found that harm has occurred the patient expects:

- To be fully informed about the harm in a timely manner;
- An apology in a timely, respectful, and sincere manner;
- Information about accountability and responsibility;
- To receive a complete and comprehensive investigative report about the adverse event and to have these reports shared with the appropriate individuals or agencies;
- To be kept informed of how the harm will be prevented from happening again;
- To be provided with opportunities to be part of the improvement process; and
- To be offered fair and timely compensation.

Patients for Patient Safety Canada: Principles of Disclosing Harm.

5. At the close of the initial disclosure discussion, a member of the initial disclosure team provides a **verbal summary** of the content of the initial disclosure discussion to the patient.

   5.1. Subsequently the patient representative or appropriate manager documents a **written summary** of the content of the initial disclosure discussion in the progress notes, including a summary of the discussion, the patient's response and plan for follow up.

   5.2. The patient may view the written progress note and have the opportunity at a later time to discuss the content with the disclosure team.

   5.3. The patient may request copies of his/her health record through the Release of Information process as outlined in CH 30-015 *Release of Information from the Health Record*.

6. The manager informs the health care provider(s), and other members of the attending health care team of the availability of critical incident stress debriefing (arranged through Human Resources), and the availability of individual counselling arranged through direct contact with their Employee Assistance Program (EAP) provider.

7. **Post - Analysis Disclosure**

   7.1. In those circumstances in which a Quality Review Process is conducted:

      7.1.1. The appropriate vice-president and/or Director in collaboration with one or more members of the initial disclosure team, including the patient representative as necessary, offers the patient the opportunity to participate in a post-analysis disclosure meeting to provide the patient with:

         7.1.1.1. further relevant facts about the adverse patient safety event,

         7.1.1.2. the identified factors that contributed to the adverse patient safety event, and

         7.1.1.3. information on what has been and will be done to avoid recurrence of similar adverse patient safety events.

EXCEPTIONS: *In most cases there will be complete disclosure of the findings of the event review. Information may be withheld or restricted in the following circumstances:*

- *when it is considered that disclosure of information may adversely affect the health of the patient where it has been determined there is reasonable cause for that assessment, and that assessment is documented and corroborated in the health record by the multi-disciplinary team; and/or*
- *where investigations are pending by the Office of the Chief Medical Examiner; and/or*
- *where contractual arrangements with insurers preclude disclosure of specific information; and/or*
- *where information is protected from disclosure under legal professional privilege or qualified privilege under the Nova Scotia Evidence Act and/or the Freedom of Information and Protection of Privacy Act.*

8. As required, Capital Health provides reasonable travel, meal and accommodation costs, including facility parking to facilitate face-to-face feedback and/or discussion of both the disclosure as well as the post-analysis disclosure with the patient and their support person.

EXTERNAL DISCLOSURE

BEST PRACTICE GUIDELINES: Threshold for External Disclosure

- External disclosure to the public is considered to be one possible response to adverse patient safety events in those circumstances in which one or both criteria of a type B adverse patient safety event are met. Decision-making about whether, and how, to externally disclose an adverse patient safety event requires the use of a decision-making framework such as the one contained in Appendix B.
- External disclosure is attentive to the following principles and values, among others: respect for persons, privacy/confidentiality, honesty, clarity, openness transparency and timeliness.
- The performance of optimally conducted external disclosure facilitates 'the building of a culture of person-centered health care, citizen engagement, patient safety and ethics' as described in Capital Health's ***Our Promise.***
- Permission of the patient **must** be obtained before information that could potentially identify the patient is released externally.
- A third party may publicly disclose information about an adverse event without providing notice to Capital Health or seeking the participation and approval of Capital Health. Given this possibility, planning for external release of information should be undertaken in the event of an adverse event and particularly in type B adverse event circumstances.

1. If the external disclosure working group using the decision making framework in Appendix B recommends external disclosure and the Leadershift Enabling Team (LET) concurs with this recommendation, the appropriate VP Person-centered Health informs the appropriate contact at the NS Department of Health or similar provincial authority in another province and/or other affected Health Districts and authoritative bodies (e.g., Health Canada), that external disclosure of an adverse patient safety event will occur. The following procedures apply:

   1.1. As required by the Nova Scotia Disclosure of Adverse Events Policy (2005), the Department of Health and the Health District *"shall participate in collaborative communication planning when informing the public about adverse events"* which:

      1.1.1. involves a multi-person disclosure;

      1.1.2. perceived as a public health hazard; or

      1.1.3. has the potential to undermine public confidence in the health system.

   1.2. The Leadership Enabling Team (LET), through the direction of the appropriate VP Person-centered Health and the VP Performance Excellence & General Counsel approves an External Disclosure Communications Team.

      1.2.1. The team consists of appropriate clinical expertise, risk management, legal services, corporate communications, and any other relevant personnel, as appropriate, to manage the external disclosure communication process.

      1.2.2. This team usually consists of the same individuals who constituted the external disclosure working group which used the decision-making framework to make a recommendation regarding external disclosure to LET, with additional expertise/staff.

   1.3. The External Disclosure Communications Team, supported by Marketing and Communications, develops a communication strategy and plan for disclosure of the relevant information to appropriate external stakeholders.

      1.3.1. As directed by the Provincial Healthcare Disclosure Policy, in the event of an adverse patient safety event involving multiple jurisdictions or health districts (e.g. the adverse patient safety event is identified in a different organization than in which it occurred), the communication strategy and plan is informed by knowledge of existing "*procedures whereby a receiving organization informs an originating organization of an adverse patient safety event.*".

   1.4. The External Disclosure Communications Team seeks approval from LET for a comprehensive communications plan (before external disclosure occurs).

   1.5. The entire External Disclosure Communication Team implements the communication plan, led by Marketing and Communications.

   1.6. Consistent with Capital Health's Media Relations policy (CH 70-025), Marketing and Communications designates and supports an authorized spokesperson(s) to address media enquiries in a timely, consistent and accountable manner.

      1.6.1. During media interviews regarding the adverse patient safety event, the designated Capital Health spokesperson(s) represents involved health care providers, unless the External Disclosure Communications Team deems that it is appropriate that they represent themselves.

2. The content of the initial external disclosure, any post-analysis disclosure(s), and subsequent discussions follow and are informed by all the processes and best practice guidelines outlined for internal disclosures within this policy.

RELATED CAPITAL HEALTH DOCUMENTS

Policies

CH 70-005 Management of Serious Clinical Occurrences (Under revision)

* Quality Review Process (Under Development and will replace CH policy 70-005)

CH 70-025 Media Relations

CH 100-035 Patient Safety Reporting System

Appendices

Appendix A - Examples of Adverse Patient Safety Events that Require Disclosure to Patients

Appendix B - An Organizational Ethics Decision Making Framework: Disclosure of Significant Adverse Events Version

Policy Aids & Pamphlets *(To be issued)*

Capital Health Disclosure Policy Information for Patients and Families (2010)

Checklist for Disclosure of Adverse Patient Safety Events and Harm – Initial Disclosure Team (2010)

Disclosure of Adverse patient safety events and Harm – Guide to Disclosure Pocket Guide for Staff (2010)

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Appendix A:
Examples of Adverse Patient Safety Events that Require Disclosure to Patients

Examples of adverse patient safety events that are reportable through PSRS and require disclosure to patients and their families/substitute decision-maker include but **are not limited to** the following:

1. **Care Management Events:**
    a) Patient death or serious disability associated with a haemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products (ABO: blood group system consisting of groups A, B, AB, O and HLA: Human Leukocyte Antigen) ;
    b) Maternal death or serious disability associated with labour or delivery in a low-risk pregnancy;
    c) Medication event leading to the death or serious disability of patient due to incorrect administration of drugs related to:
        i. Omitted dose;
        ii. Wrong dose;
        iii. Dose preparation;
        iv. Wrong time;
        v. Wrong rate of administration;
        vi. Wrong route;
        vii. Wrong patient; and
        viii. Adverse drug/vaccine or contrast reaction.
    d) Patient death or serious disability associated with an avoidable delay in treatment;
    e) Patient death or serious disability associated with an electric shock or elective cardio version ;
    f) Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended;
    g) Patient death or serious disability associated with an intravascular air embolism that occurs during care;
    h) Patient death or serious disability associated with hypoglycaemia, the onset of which occurs during care;
    i) Patient death or disability as a result of failure to treat abnormal diagnostics; and
    j) Accidental extubation
2. **Criminal Events:**
    a) Any instance where a criminal or alleged criminal event results in harm to a patient(s).

Appendix A:
Examples of Adverse Patient Safety Events that Require Disclosure to Patients

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    c) Medication event leading to the death or serious disability of patient due to incorrect administration of drugs related to:
        i. Omitted dose;
        ii. Wrong dose;
        iii. Dose preparation;
        iv. Wrong time;
        v. Wrong rate of administration;
        vi. Wrong route;
        vii. Wrong patient; and
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    g) Patient death or serious disability associated with an intravascular air embolism that occurs during care;
    h) Patient death or serious disability associated with hypoglycaemia, the onset of which occurs during care;
    i) Patient death or disability as a result of failure to treat abnormal diagnostics; and
    j) Accidental extubation
2. **Criminal Events:**
    a) Any instance where a criminal or alleged criminal event results in harm to a patient(s).

b) Any instance of care ordered by or provided by an individual impersonating a clinical member of staff;

c) Abduction of a patient of any age;

d) Sexual assault on a patient within or on the grounds of the health care facility; and

e) Death or significant injury of a patient resulting from a physical assault or other crime that occurs within or on the grounds of the health care facility.

3. **Device or Product Events:**

a) Patient death or serious disability associated with:

i. Use of contaminated drugs, devices, products;

ii. The use or function of a device in a manner other than the device's approved use;

iii. Failure or malfunction of a device or medical equipment; and

iv. Intravascular air embolism.

4. **Environmental Events:**

a) Any incident in which a line designated for oxygen or other gas came to be delivered to a patient and contains the wrong gas or is contaminated by toxic substances;

b) Patient death or serious disability due to a nosocomial infection;

c) Patient death or disability as a result of treatment from the following:

i. Burn incurred from any source;

ii. A slip, trip or fall;

iii. Electric shock; and

iv. Use of restraints or bedrails.

5. **Patient Protection Events:**

a) Discharge of an infant or child to the wrong person;

b) Patient death or serious disability associated with elopement (AWOL- Absent With out Leave);

c) Patient suicide, attempted suicide or deliberate self-harm resulting in serious disability; and

d) Intentional injury to a patient by a staff member, another patient, visitor or other person.

6. **Surgical Events:**

a) Surgery performed on the wrong body part;

b) Surgery performed on the wrong patient;

c) Wrong surgical procedure performed on the wrong patient;

d) Retained objects after surgery or other procedure;

e) Unexpected patient death during or immediately post-surgical procedure

f) Unforeseen serious disability or neuro-cognitive deficit post-surgical procedure; and

g) Patient death or disability as a result of any anaesthesia-related event (e.g. intra-operative or immediate post-operative death in an ASA Class I patient).

Appendix B:
Decision Making Framework for
Disclosure of Significant Adverse Patient Safety Events
(Revision - August 2010)

Process Steps

1. Identify & assemble relevant stakeholders to form an ad hoc disclosure working group; consider inclusion of:
   1.1 Participants from vocational/organizational groups that will/could be directly affected
   1.2 Members of the public: citizens/'health care receivers' and, in particular, members of potentially affected disadvantaged social groups
   1.3 Relevant expert resource persons, e.g., ethics, health law, and communications support
   1.4 Participants from the provincial Departments of Health and Health Promotion

2. Identify the legitimate decision makers and how recommendations will be reached by the working group, e.g.
   2.1 Decision makers for external disclosure, e.g., CEO and/or LET (established by policy)
   2.2 Recommendations reached by a consensus of working group members that 'all can live with'; if not possible, by vote or secret ballot

3. Identify & reflect on:
   3.1 The ethics principles and values at play in disclosure of adverse events circumstances and the potential for conflict/tension among them

4. Confirm that the circumstances under consideration constitute an adverse event:
   4.1 Refer to policy definition
   4.2 If not, should they be handled/treated as such for recommendation-making purposes?

5. Consider all relevant information/evidence:
   5.1 Examine and discuss 'the context' from all relevant standpoints and perspectives, e.g., those of potentially affected patients and their 'families', health care providers, the organization and the public
   5.2 With the assistance of relevant participating experts, determine the type, and best possible quantification, of risk to the potentially affected, e.g., evidence-based, theoretical, perceived, etc. with associated best-estimate percentages

6. Identify the possible disclosure options in the circumstances under consideration, e.g.
   6.1 Non-disclosure
   6.2 Disclosure to the affected/potentially affected
   6.3 External disclosure to other health organizations and/or the public.

7. Through brainstorming and facilitated dialogue:
   7.1 Identify and discuss the benefits and burdens of the possible disclosure options, and to whom

7.2 Assess alignment of the possible disclosure options with the step 3. identified ethics principles and values, e.g., respect for persons, patient welfare, justice (see Guiding Principles & Values section of policy)

8. Choose the 'go forward' recommended disclosure option(s)
   8.1 Includes articulation of the ethics principles and values underlying the recommendation and how these were pragmatically applied by working group members

9. Develop and implement a comprehensive care and communication strategy including:
   9.1 Specific care plans for harmed and potentially harmed persons
   9.2 Attention to prevention of similar adverse events – necessary systems change, relevant education, etc.
   9.3 Optimal communication to patients/'families' and the public, as appropriate

10. Review the disclosure recommendation and monitor/evaluate the outcomes including:
   10.1 Checking for consistency with other disclosure recommendations
   10.2 Ensuring that 'lessons learned' inform future uses of the framework

3.0 Consultation

Consultations of various sorts comprise the primary focus and role for most healthcare ethics committees. These processes can follow a number of different formats and each ethics committee must decide the format that best suits its mandate, make-up, and level of expertise. The following pages outline various aspects to consider within the general topic of ethics consultation.

3.1 Types of Consultation

The type of consultation an ethics committee offers can depend on many factors, including capacity and skills of committee members, organizational needs, and available supports.

Consultation can take different forms:

- Single consultant – one person is responsible for the entire consult process
- Small group – a small team of consultants, often two or three, selected from the ethics committee or the consultation subcommittee, is responsible for the entire consult process. In some cases the consultants doing intake and triage might be different from the consultants who run the consult meeting itself.
- Whole committee – the entire ethics committee is responsible for the consult process (this often works best for retrospective consultations or organizational consultations.

Consultation can also have different focuses:

- Clinical ethics consultation – addresses clinical issues, most often related to direct patient care
- Organizational ethics consultation – addresses organizational and systemic issues, often related to issues such as resource allocation and policy
- Debrief - one or two members of the consultation group (single consultant, sub-committee, or EC as a whole) meets with members of a clinical team to process "moral residue"--ongoing distress or confusion left in the aftermath of an emotionally difficult issue or consultation

3.2 Consultation Processes

In general, consultation involves the following process steps:

- Intake
- Triage
- Notification
- Discussion/deliberation/discussion/analysis
- Documentation
- Debriefing
- Evaluation

The following pages provide examples of guides for consultation taken from CBDHA & CDHA (CHES).

GUIDE FOR ETHICS CLINICAL CONSULTATION

Complete this guideline before doing an Ethics Referral review:

1. Identify the stakeholders

2. Ensure the facts of the ethical issue are clear

3. Define the primary conflict and its relationship to the following biomedical principles: doing good, doing no harm, justice including equitable distribution of resources, and client autonomy

4. Identify the most reasonable options that can be taken

5. Identify the possible consequences of those options

6. Discussion or notes

7. Response back to requester

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3.2.1 Example: Organizational Ethics Process

Capital Health Ethics Support
Organizational Ethics

Process for Handling Organizational Ethics Requests[1]

Request

- any member of the Capital Health community, including members of Capital Health Ethics Support, may submit a request for an organizational ethics consultation

Intake of request

- the Organizational Ethics Coordinator is the main contact point for requests; members receiving requests will forward them onto the Coordinator who will:
    - clarify the issue/reason for the request with the requestor, in person or by phone
    - find out what the requestor is asking of Organizational Ethics
    - assess the urgency of the request
        - If an issue is urgent, Organizational Ethics members commit to moving forward with this process as expediently as possible
    - indicate the process (e.g., steps below including evaluation) and that the Coordinator will be in touch in a specified time frame
    - complete the organizational ethics request form (attached)
        - at this stage, sensitivity to possible power imbalances and/or recrimination against the requestor heightens the importance of maintaining confidentiality
        - the requestor will be informed about the organizational ethics request process, including what will happen if a request is accepted or refused and relevant notification steps
        - if still interested in moving forward, the requestor submits a written request for triaging purposes

Ad hoc triaging group

- members: the Coordinator and at least one other member of Organizational Ethics
- members have a responsibility to declare any conflicts of interest[2]
- the group will assess the request and apply the Triaging Criteria (attached)

---

[1] This process was originally developed, with minor revisions, from the IWK Organizational Ethics - Process for Handling Organizational Ethics Requests (2004). The Organizational Ethics appreciates the use of this document, and notes that further revisions to the process have since been made.

[2] This attention to conflict of interest extends throughout the consultation process and coincides with the Expectations of Members listed in the Terms of Reference for CHES. See the Terms of Reference for the definition of conflicts of interest.

  - Examples may include: changes in practice related to patient populations, decisions that may unduly impact members of particular cultural/ethnic/spiritual groups, an ethics perspective on resource allocation decisions, input into the strategic direction/mission/vision/values of the region, proposal re: partnering with industry, etc.
  - Organizational Ethics, including the triaging group, recognizes that some requests will be made by persons in positions with less power and/or in a position of conflict of interest that prevents them from pursuing other options. This will be factored into the decision to accept/refuse a request and any other options/means of support offered to the requestor.
- will report to Organizational Ethics about any requests and the decision about how to proceed
- if the ad hoc group is uncertain about a request, the group will bring it to Organizational Ethics with any relevant information; all efforts will be made to not unduly delay triaging the request and responding to the requestor

Process

- ***Refusal*** – contact the requestor and explain why the request is refused; offer other supports if appropriate and/or identifiable such as risk management, human resources, professional bodies, etc.
  - Organizational Ethics is aware of the need to support the role of clinical ethics consultation in Capital Health. For cases in which the issue is focused on care in a particular situation (e.g., not relating to a broader policy issue or patient population issue), the recommendation will be to work within the clinical ethics consultation process. Organizational Ethics does have, in effect, a quality assurance role with respect to clinical ethics consultation in that it will receive, from the coordinator, reports (in general terms) about ethics issues, how the consultations proceeded, any identified learning issues or errors by the consultants, etc.

- ***Acceptance*** – contact the requestor and explain what the process will be
  - Includes disclosure of the notification steps indicated below.
  - Sensitivity to power imbalances and possible recrimination to the requestor will be part of any information gathering. It may not be possible to maintain confidentiality for the requestor when a request moves forward; the requestor will be informed of this possibility at the time his/her request is accepted. If applicable, every effort will be made to protect the confidentiality of patient information, using non-identifying information related to any patients in Capital Health where possible.
  - Organizational Ethics members commit to meeting on an as needed basis for either option described below
    - <u>Two options for organizational ethics consultation</u> depending on the nature of the request (the triaging group will recommend which option to follow):

      1. <u>By Organizational Ethics</u>: The Coordinator or designate brings the issue forward for Organizational Ethics discussion. If any further information is required, this information will be collected and presented and/or the

requestor (and possible others at their request) will be invited to discuss the issue with the Organizational Ethics. Organizational Ethics will arrive at recommendations or suggestions related to the issue and provide a report (see below).

Or,

2. By consultation team: An organizational ethics consultation team is brought together on an ad hoc basis to work on the presenting issue, consisting of a minimum of three persons. This team may consist solely of Organizational Ethics members, if sufficient expertise/knowledge exists to handle the request. If not, additional, external person(s) as dictated by the nature of the request will be invited to participate. The external persons can be members of Capital Health and/or persons outside of Capital Health.[3] This may include pulling in expertise of others as needed (e.g., a person with business ethics training). The consultation team will have a minimum of 2 Organizational Ethics members and, as the team increases in size, at least, fifty-percent of the membership will be Organizational Ethics members. The triaging group and/or Organizational Ethics will make recommendations about who should be involved in this team. The organizational ethics consultation team will determine how to best proceed (e.g., meet with the requestor and other stakeholders, arriving at consensus recommendations if appropriate and/or possible, engaging in further research, etc.). This team will report back to the Organizational Ethics about the issue and any recommendations. Organizational Ethics will review this information and either support or revise the recommendations (if the latter, this must be discussed with the organizational ethics consultation team and any dissension recorded).

- As part of the completion of the organizational ethics consultation, Organizational Ethics will provide a final report (usually written) with any recommendations or suggestions, as appropriate, to the:
    - Requestor
    - Quality Committee
    - As appropriate, the most responsible VP(s) and person(s) in related management roles

Notification

Upon acceptance of an organizational ethics request for consultation, in addition to notifying the requestor, the persons in the following positions will be notified:

- Chair, Quality Committee of the Board
- As appropriate, the most responsible VP(s) and CEO

[3] It is understood that any members of the organization ethics consultation team that are external to Capital Health will abide by Capital Health confidentiality requirements and the requirements of Organizational Ethics.

Notification will include a general description of the organizational ethics issue and indicate that Organizational Ethics has accepted this request and will be initiating an organizational ethics consultation. Notification will typically be by letter to the identified persons. The Coordinator of Organizational Ethics is responsible for notification.

Distribution and discussion of reports

Maintaining confidentiality of reports as they are developed and distributed, and consistency of process, is important. Accordingly, the following measures will be followed:

- Reports will not be transmitted electronically
- Reports will contain a 'DRAFT' watermark on committee working copies
- All drafts must be destroyed in a confidential manner once a replacement draft and/or the final report is prepared
- Once the report is finalized, CHES committee copies will be watermarked with 'COMMITTEE COPY—FINAL'
- Copies of the report prepared for the requestor(s), Chair of the Quality Committee of the Board, and so on will not contain a watermark – copies will be limited to the number needed for the Organizational Ethics and these individuals
- If any member of the committee is approached regarding a report, either by the requestor or others (non-media), they should be directed to contact the Coordinator of Organizational Ethics. If the request is media-related, the request should be directed to Marketing and Communications.
- Following the release of the written consultation report, a brief verbal report to the Quality Committee of the Board will be made at its next meeting by a member of CHES. This provides the opportunity for dialogue about the report and for addressing any questions.

Conclusion of process

Two stopping points for organizational ethics consultation exist:

1. The requestor declares that he/she is satisfied by, or withdraws from, the process
   - at this point, the relevant individuals will be notified that the consultation has stopped and that no final report will be generated for this request
   - based on a majority vote of Organizational Ethics, the process will either stop here or Organizational Ethics will take the place of the requestor
   - if the latter option is invoked, this would be in situations where Organizational Ethics believes that the process is not yet completed and/or there are additional ethics issues to explore (this may occur even if the requestor is satisfied)
   - this approach recognizes that, on some occasions, it may be that the requestor withdraws due to an inability to continue with the process, even though the originating issue still needs to be addressed
   - in the event Organizational Ethics continues with the request, the committee will inform the requestor, indicate that they no longer have reporting responsibilities to the requestor, and, as applicable, every effort will be made to minimize harm to the requestor

- If Organizational Ethics wishes to move forward with the issue at hand, a new organizational ethics request process will begin at that time with the regular notification steps, etc.

2. A majority of Organizational Ethics is satisfied that the organizational ethics request has been dealt with sufficiently and/or the matter has been resolved
   - this is in accordance with the terms of reference of Organizational Ethics
   - the requestor may or may not agree with this assessment; the reasons for Organizational Ethics' decisions will be explained to the requestor and form part of the final report

Evaluation

All requests, and related decisions, dealt with by the ad hoc triaging group will be reported in general terms to Organizational Ethics. If any concerns about the outcome of the triaging process are expressed, committee members will examine the triaging process, including the reasoning utilized for accepting/rejecting a request.

At the end of an organizational ethics consultation, the consultation team will be responsible for debriefing with one additional member of Organizational Ethics. Attention to the process, what worked, what may need to be changed, if any errors or mistakes were made, learning issues, etc. will form the primary focus of the debriefing. Any important or significant issues, lessons learned, etc. will be reported to the whole Organizational Ethics.

For organizational ethics consultations handled by the whole Organizational Ethics, it is understood that debriefing will occur as part of the conclusion of this process.

Feedback from participants will also be sought (e.g., from the requestor). This will involve a short series of questions (attached). Where possible, the Ethics Resource Coordinator will contact the participants two months after the process has been completed and/or the final report has been distributed for this evaluation.

Follow-up

6-12 months following the release of a consultation report, the Ethics Resource Coordinator will send a feedback form (with the report's recommendations listed as a reminder) to the Chair of the Quality Committee of the Board with a request for an update. This follow-up is done in order to gain an improved understanding of how consultation reports are used by the Quality Committee of the Board.

Records

In all cases, Organizational Ethics will retain records of the requests received and how they were handled (for six years). A summary of the presenting issues and recommendations will be provided in the annual reports to the Quality Committee, in addition to the forwarded reports and recommendations for each issue. As much as

possible, efforts to protect confidentiality in all reports and recommendations will be made. A copy of the final consultation report will become part of the permanent records for Organizational Ethics. These records are maintained by the Ethics Resource Coordinator.

Capital Health Ethics Support
Process for Handling Organizational Ethics Requests

Approved Date: July 25, 2004
Revised and approved: January 2006
Amended: March 2006
Revised and approved: January 2009

Next Review Date: January 2012

Capital Health

Organizational Ethics Consultation Process
Triaging Criteria

When a request is brought forward to Organizational Ethics, the following criteria will be used to assess whether the Committee will accept or reject the request:

1. Assessment of whether the request involves a significant organizational ethics issue for Capital Health.
    a. This includes consideration of the issue in light of Capital Health's values, mission, vision, and strategic directions.
    b. This includes examination of the issue on the basis of accepted ethical values and principles, including beneficence, justice (fairness of process, resource allocation, etc.), autonomy, and confidentiality.

2. Assessment of whether the issue could benefit from the application of an ethics lens.
    a. Additional considerations or perspectives may broaden the discussion of the issue and/or draw attention to new features of the issue which in turn may make a difference (add value) to how it is understood and addressed.

3. Assessment of the issue will take into account other processes within Capital Health.
    a. As appropriate, information on alternative mechanisms for addressing the issue will be explored.
    b. As appropriate, requests will be redirected to other established processes within Capital Health which are mandated by legislation, bylaws, regulations or policy that may more appropriately and adequately address these issues, e.g., to Occupational Health and Safety for issues related specifically to staff safety.

4. When appropriate based on the type of organizational ethics request received, the Coordinator of Organizational Ethics will contact the most responsible VP(s) by telephone to determine whether there is a direct relationship of the organizational ethics issue to employee/staff disciplinary and/or legal proceedings, as per the exclusion criterion. Such information must be provided (following the telephone discussion) by the end of the next business day, in order to ensure the efficiency of the triaging process.

Exclusion Criterion:
Organizational ethics consultation will not be initiated (including notification) during the time frame that a presenting organizational ethics issue arising directly from specific employee/staff disciplinary and/or legal proceedings is the subject of formal employee/staff disciplinary and/or legal proceedings.

Version 2.0: January 2005; Revised: January 2009

Capital Health

Organizational Ethics Consultation Request Form

This form is to be completed by the Coordinator. The first section is completed in conjunction with the requestor; the second section is completed in conjunction with the ad hoc triaging group. This document is to be kept confidential and used only for the purposes of the organizational ethics consultation process.

Section One:

1. Briefly describe the situation or concern that has led you to request an organizational ethics consultation.

2. What do you see as the ethical issue(s)?

3. Who are the concerned parties (e.g., who else is or could be involved)?

4. What has been done so far to deal with the situation?

5. Additional Comments:

Consultation requested by:_____

Date and phone#: _____

Capital Health

Section Two:

Members of the ad hoc triaging group: _____

_____

_____

ACCEPT / REFUSE the request (circle one).

Reasons:

If request accepted, recommendations for Organizational Ethics about how to proceed:

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CAPITAL HEALTH ETHICS SUPPORT
ORGANIZATIONAL ETHICS CONSULTATION EVALUATION

About 2 months ago, you asked for or took part in a consultation process overseen by Capital Health's Organizational Ethics. In an effort to continually assess and improve the effectiveness and efficiency of this process we are asking for your feedback.

The questionnaire will require 10-15 minutes of your time; all your responses will be kept **confidential** to be used in improving the consultation process and for education of the committee members. General themes that arise from these consultations may be used in reports from the committee, but anonymity will be maintained for all responses.

You are under no obligation to complete this form and may choose to omit any questions you are not comfortable with. Thanking you in advance for your help with this important process.

---

1. **Were you a person who:**

☐ **asked for the consultation**
or
☐ **took part in the consultation** *(skip to Question #7)*

2. **I contacted Capital Health Ethics Support because…**
(please describe the main concern/issues(s) as you remember it/them).

3. **The concern/issue(s) that were actually considered during the consultation process included:**
(please describe all that you remember).

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Your rating Please check (✓) the appropriate answer in the corresponding box		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable
4.	**Organizational Ethics responded to my request in a timely manner.**						
5.	**The consultation process met my expectations.**						
6.	**The consultation process helped address my concern/issue(s).**						

7.	**In my opinion, the people involved with the consultation process (e.g., Organizational Ethics members):**	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable
a.	asked helpful questions						
b.	helped clarify the concern/issue(s)						
c.	seemed to know what they were doing						
d.	provided helpful input						
e.	were respectful of me						
f.	were respectful of all those involved						
g.	encouraged appropriate participation						
h.	considered the concern/issue(s) adequately						
i.	explored appropriate options for responding to the concern/issue(s)						

8.	**Because of this ethics consultation process:**	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable

Capital Health

a.	I understand the concern/issue(s) differently						
b.	I see the concern/issue(s) more clearly						
c.	I was able to consider new possibilities related to the concern/issue(s)						
d.	discussions about the concern/issue(s) improved						
e.	I am more comfortable with bringing forward this type of concern/issue						
f.	I am more comfortable with this kind of ethics process						

9.	**As a result of this process, there have been changes to:**	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable
a.	My approach to this type of concern/issue						
(Please explain)							
b.	My workplace (e.g. policy changes, better communication, etc.)						
(Please explain)							

10. **a) What I liked about the process was:**

b) What I did not like about the process was:

11. a) At the time of the process, I remember feeling:

Capital Health

b) **Now that some time has passed, I am feeling:**

Please share any additional comments you may have about this process.

THANK YOU!
Please return this survey to:

Karin Walsh
Ethics Resource Coordinator
VG Site, Centennial 1-031H

Capital Health

Quality Committee of the Board
Feedback Form

As part of the organizational ethics consultation process, the Capital Health Organizational Ethics respectfully requests feedback and/or an update on the following organizational ethics consultation:

Consultation Report: [FILL IN TITLE OF REPORT AND ITS NUMBER]

The recommendations included as part of this report were:

[FILL IN RECOMMENDATIONS – DIRECTLY FROM CONSULTATION REPORT]

Any feedback and/or update with respect to this consultation report and its recommendations will be greatly appreciated. Please send reply to:

Karin Walsh
Ethics Resource Coordinator
VG Site, Centennial 1-031H

3.3 Consultation Forms

The following are some sample intake forms to guide and triage consultation services.

Colchester East Hants
HEALTH AUTHORITY

Organizational Clinical Ethics Committee
Consultation Request Form

To request a **clinical ethics consultation**, complete this form and submit it to the Chair of the Triage Subcommittee of the Organizational Clinical Ethics Committee. For **organizational ethics consultation** requests (e.g., ethical implications of organizational decisions and practices on patients, staff, and community, such as resource allocation, policy review from an ethics lens), please contact the Chair of the Triage Subcommittee directly.

Date: _____ Time (Please use 24hr clock): _____

IDENTIFYING INFORMATION

Name of referring person: _____
Telephone: (day) _____ (night/cell) _____
Relationship of referring person to the client/patient: _____
Patient's Name: _____
Hospital/Service Site: _____

REASON FOR REQUEST

1. Please check area(s) of concern.

- ❒ Do not Resuscitate (DNR)
- ❒ Withdrawal/Withholding Treatment
- ❒ Consent & Capacity
- ❒ Patient Rights
- ❒ Difficult treatment decisions
- ❒ Substitute Decision Making
- ❒ Advance directives
- ❒ Substitute Decision Making
- ❒ End of Life Care
- ❒ Communication barrier
- ❒ Professional responsibility
- ❒ Confidentiality/Disclosure
- ❒ Truth telling
- ❒ Organizational
- ❒ Policy Development/Review
- ❒ Other _____

2. Briefly describe the ethical dilemma, issue, question, or concern.

_____
_____
_____

3. What has been done so far (e.g., discussion with patient/family/health care team)?

_____
_____
_____
_____

4. Have relevant district policies been consulted (e.g., Consent to Treatment, Advance Directives)?

Yes ❒ No ❒ Unsure ❒

5. Is there legal or disciplinary action pending?

Yes ❒ No ❒ Unsure ❒

6. Additional comments:

_____

_____

_____

7. Append any information you feel would be helpful.

_____ _____

Signature *Date*

SUBMITTING YOUR REQUEST

Jody Sark, PhD Psychologist
Chair of Triage Subcommittee
Organizational Clinical Ethics Committee
Jody.sark@cehha.nshealth.ca
(902) 893-5554 x2200

TRIAGE COMMITTEE USE ONLY

1. Urgency (< > 24 hr): _____
2. Notify requester that
   a. Request was received ❒ Date/Initial: _____
   b. Request was triaged ❒ Date/Initial: _____
   c. Consent to proceed with consult if applicable ❒ Date/Initial: _____
3. Does the situation lend itself to the making of an ethics recommendation? Yes ❒ No ❒
4. Is there a role for others?
   a. Occupational Health & Safety ❒
   b. Human Resources ❒
   c. Quality & Decision Support ❒
   d. Risk Management ❒
   e. Organizational Ethics Consultation ❒
   f. Research Ethics Committee ❒
5. Debriefing/evaluation of process. ❒ Date/Initial: _____

Capital Health

Organizational Ethics Consultation Request Form

This form is to be completed by the Coordinator. The first section is completed in conjunction with the requestor; the second section is completed in conjunction with the ad hoc triaging group. This document is to be kept confidential and used only for the purposes of the organizational ethics consultation process.

Section One:

1. Briefly describe the situation or concern that has led you to request an organizational ethics consultation.

2. What do you see as the ethical issue(s)?

3. Who are the concerned parties (e.g., who else is or could be involved)?

4. What has been done so far to deal with the situation?

5. Additional Comments:

Consultation requested by: _____

Date and phone#: _____

Section Two:

Members of the ad hoc triaging group: _____

_____

_____

ACCEPT / REFUSE the request (circle one).

Reasons:

If request accepted, recommendations for Organizational Ethics about how to proceed:

Capital Health

CAPITAL HEALTH ETHICS SUPPORT
ORGANIZATIONAL ETHICS CONSULTATION EVALUATION

About 2 months ago, you asked for or took part in a consultation process overseen by Capital Health's Organizational Ethics. In an effort to continually assess and improve the effectiveness and efficiency of this process we are asking for your feedback.

The questionnaire will require 10-15 minutes of your time; all your responses will be kept **confidential** to be used in improving the consultation process and for education of the committee members. General themes that arise from these consultations may be used in reports from the committee, but anonymity will be maintained for all responses.

You are under no obligation to complete this form and may choose to omit any questions you are not comfortable with. Thanking you in advance for your help with this important process.

---

1. **Were you a person who:**

☐ **asked for the consultation**
or
☐ **took part in the consultation** *(skip to Question #7)*

2. **I contacted Capital Health Ethics Support because...**
(please describe the main concern/issues(s) as you remember it/them).

3. **The concern/issue(s) that were actually considered during the consultation process included:**
(please describe all that you remember).

Capital Health

	Your rating Please check (✓) the appropriate answer in the corresponding box	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable
4.	**Organizational Ethics responded to my request in a timely manner.**						
5.	**The consultation process met my expectations.**						
6.	**The consultation process helped address my concern/issue(s).**						

7.	**In my opinion, the people involved with the consultation process (e.g., Organizational Ethics members):**	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable
a.	asked helpful questions						
b.	helped clarify the concern/issue(s)						
c.	seemed to know what they were doing						
d.	provided helpful input						
e.	were respectful of me						
f.	were respectful of all those involved						
g.	encouraged appropriate participation						
h.	considered the concern/issue(s) adequately						
i.	explored appropriate options for responding to the concern/issue(s)						

8.	**Because of this ethics consultation process:**	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable

a.	I understand the concern/issue(s) differently						
b.	I see the concern/issue(s) more clearly						
c.	I was able to consider new possibilities related to the concern/issue(s)						
d.	discussions about the concern/issue(s) improved						
e.	I am more comfortable with bringing forward this type of concern/issue						
f.	I am more comfortable with this kind of ethics process						

9.	**As a result of this process, there have been changes to:**	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable
a.	My approach to this type of concern/issue						
(Please explain)							
b.	My workplace (e.g. policy changes, better communication, etc.)						
(Please explain)							

10. **a) What I liked about the process was:**

b) What I did not like about the process was:

11. **a) At the time of the process, I remember feeling:**

b) Now that some time has passed, I am feeling:

Please share any additional comments you may have about this process.

THANK YOU!
Please return this survey to:

Karin Walsh
Ethics Resource Coordinator
VG Site, Centennial 1-031H

Capital Health

Quality Committee of the Board
Feedback Form

As part of the organizational ethics consultation process, the Capital Health Organizational Ethics respectfully requests feedback and/or an update on the following organizational ethics consultation:

Consultation Report: [FILL IN TITLE OF REPORT AND ITS NUMBER]

The recommendations included as part of this report were:

[FILL IN RECOMMENDATIONS – DIRECTLY FROM CONSULTATION REPORT]

Any feedback and/or update with respect to this consultation report and its recommendations will be greatly appreciated. Please send reply to:

Karin Walsh
Ethics Resource Coordinator
VG Site, Centennial 1-031H

Capital Health

Organizational Ethics Consultation Request Form

This form is to be completed by the Coordinator. The first section is completed in conjunction with the requestor; the second section is completed in conjunction with the ad hoc triaging group. This document is to be kept confidential and used only for the purposes of the organizational ethics consultation process.

Section One:

1. Briefly describe the situation or concern that has led you to request an organizational ethics consultation.

2. What do you see as the ethical issue(s)?

3. Who are the concerned parties (e.g., who else is or could be involved)?

4. What has been done so far to deal with the situation?

5. Additional Comments:

Consultation requested by: _____

Date and phone#: _____

Capital Health

Section Two:

Members of the ad hoc triaging group: _____

_____

_____

ACCEPT / REFUSE the request (circle one).

Reasons:

If request accepted, recommendations for Organizational Ethics about how to proceed:

3.4 Skills for Consultation

The following description of skills for consultation were taken from the American Society for Bioethics and Humanities' draft for the second edition of the *Core Competencies for Health Care Ethics Consultation.* If you would like to review this resource in its entirety please contact Krista.MleczkoSkerry@iwk.nshealth.ca.

In addition to this table outlining the agreed-upon consultation skill set, it is helpful to have some understanding of and facility with a process known as "deliberative engagement." This is described further in the section following the table.

3.4.1 Example - List of Ethics Consultation Skills

Table 2: Skills for Ethics Consultation

Ethics consultants must have a variety of "basic" skills, which are used in straightforward cases, and "advanced" skills, which may be required in more complex cases.

Skill Area	Individual/At Least One Group Member Needs	Every Team Member Needs	Every Committee Member Needs	Individual/at least one member can access
1. Skills necessary to identify the nature of the value uncertainty or conflict that underlies the need for ethics consultation (see p. 23).	Advanced	Basic	Basic	NR*
2. Skills necessary to analyze the value uncertainty or conflict (see p. 23)	Advanced	Basic	Basic	NR
3. The ability to facilitate formal and informal meetings (see pp. 16, 24)	Advanced	Basic	NR	NR
4. The ability to build moral consensus (see p. 24)	Advanced	Basic	Basic	NR
5. The ability to utilize institutional structures and resources to facilitate the implementation of the chosen option (see p. 24)	Advanced	Basic	NR	NR
6. The ability to access relevant ethics literature, policies, guidelines, and standards, including (see p. 23)	Advanced	Basic	NR	NR
6. The ability to document consults and elicit feedback regarding the process of consultation so that the process can be evaluated (see pp. 18, 24)\	Advanced	Basic	NR	NR
7. The ability to listen well and to communicate interest, respect, support, and empathy to involved parties (see p. 24)	Advanced	Basic	Basic	NR
8. The ability to educate involved parties regarding the ethical dimensions of the case (see p. 24)	Advanced	Basic	NR	NR
9. The ability to elicit the moral views of the involved parties (see p. 24)	Advanced	Basic	NR	NR
10. The ability to represent the views of the involved parties to others (see p. 24)	Advanced	Basic	NR	NR
11.The ability to enable the involved parties to communicate effectively and be heard by other parties (see p. 24).	Advanced	Basic	NR	NR
12. The ability to recognize and attend to various relational barriers to communication (see p. 24)	Advanced	Basic	Basic	NR
13. Ability to effectively run an HCEC service (see p. 25).	Advanced	NR	NR	NR
14. QI and evaluative skills (see p. 24).	Basic	NR	NR	Advanced
15. Ability to communicate and collaborate effectively with other responsible individuals, departments, or divisions within the institution (see p. 25).	Advanced	Basic	NR	NR

*NR = Not Required

Table 3: Knowledge for Ethics Consultation

Health care ethics consultants require basic introductory-level knowledge in some areas and more advanced detailed understanding of topics in others. We distinguish between knowledge that individuals or team members must bring to the consultation process ("needs") and knowledge that individuals or team members must have available to the consultation process ("can access"). All consultants should be aware of their limitations so that they know when they need to seek out those who might have specialized knowledge.

Knowledge Area	Individual/ at Least One Member of the Group Needs	Every Team Member Needs	Every Committee Member Needs	Individual/at least one member can access
1. Moral reasoning and ethical theory as it relates to ethics consultation (see p. 28)	Advanced	Basic	Basic	NR*
2. Bioethical issues and concepts that typically emerge in ethics consultation (see p. 28)	Advanced	Basic	Basic	NR
3. Health care systems as they relate to ethics consultation (see p. 30)	Advanced	Basic	Basic	NR
4. Clinical context as it relates to ethics consultation (see p. 30)	Advanced	Basic	Basic	NR
5. Health care institution in which the consultants work, as it relates to ethics consultation (see p. 31)	Advanced	Basic	Basic	NR
6. Local health care institution's policies relevant for ethics consultation (see p. 32)	Advanced	Basic	Basic	NR
7. Beliefs and perspectives of patient and staff population where one does ethics consultation (see p. 32)	Advanced	Basic	Basic	NR
8. Relevant codes of ethics, professional conduct and guidelines of accrediting organizations as they relate to ethics consultation (see p. 33)	Basic	NR	NR	Advanced
9. Health law relevant to ethics consultation (see p. 33)	Basic	Basic	Basic	Advanced

*NR = Not Required

3.4.2 Ethics Consultation Skills: Deliberative Engagement

Dealing with Challenging Questions

- Resource allocation
- End of life decision making
- Substitute decision making
- Complementary medicine
- Personal responsibility for health
- Others

Remember: There will be issues on which you have strong opinions. This highlights the need for self-awareness regarding when you can't effectively engage in discussion (i.e., can't see or appreciate the "other side"). The debate needs to stay focused on issues, not on individuals (or their views/beliefs).

Disagreement

- Productive disagreement
  - Focus on common goal
  - Listening
  - Mutual respect
- Unproductive disagreement
  - Dismissive body language
  - Unwillingness to collaborate or compromise
  - Focusing only on defending one's own position
  - Unwillingness to understand other points of view
  - Shutting down appropriate conversation

Benefits of "productive disagreement" include:

- Anger and other emotions can be acknowledged
- Fully explore full range of perspectives
- Avoids "groupthink"
- Accountability
- Can facilitate discovery of novel, collaborative solutions

Approaches to Deliberative Engagement

"*Deliberation refers to the interaction and dialogue between participants. They do not just accept each other's beliefs and persuasions, but will explore these. Listening, probing and dialogue characterize this process, rather than confronting, attacking and defending.*

Central features of dialogue are openness, respect, inclusion and engagement... Conditions for dialogue are the willingness of stakeholders to participate, to share power and to change in the process." (Tineke Abma. Bert Molewijk, & Guy Widdershoven, 2009)

Key Elements of deliberative engagement:

- Gathering of the 'right' deliberators (relevant stakeholders, including health care receivers and the public) and resource persons
- Development and use of a relevantly-targeted decision making framework
- Skilled facilitation
- Deliberators' adoption of an 'engaged participation' role
- Agreement on, and adoption of, deliberative terms of engagement
- Collaborative consideration of relevant substantive principles and values
- Sharing of 'gut responses' and starting positions
- Collaborative exploration and critical analysis of the issue/question under consideration through deliberative dialogue – may include development of options and comparison of their benefits and burdens
- (hopeful) Development of a consensus that 'all can live with' and support outside of the deliberative forum, with acknowledgement of dissenting opinions
- Determination of relevant recommendation(s), as appropriate
- Optimal communication: openness and transparency about process, outcomes and reasons

Remember...

'Through deliberative engagement, relevant stakeholders "consider facts from multiple perspectives, converse with one another to think critically about options, and through reasoned argument refine and enlarge their perspectives, opinions and understandings." (Sandy Campbell (CIHR deliberative priority setting module), 2010)

3.5 Possible "Hot Topics" for the Ethics Committee

The following list is compiled from issues currently under consideration by the ethics committee, come up frequently for the committee, have historically been difficult for the committee to address, or have been addressed recently by the committee. Some are concerned with policy development or review, some with organizational issues, and some with clinical issues. These are common issues you might want to think about.

Common Topics:

- Consent policy
- Informed choice
- Process around long-term care placements
- Smoking policy
- Substitute decision-making/end-of-life issues
- Education for staff and public regarding *The Personal Directives Ace*
- Social media policy

3.6 LEGISLATION

The following links to particular legislation websites are likely to be relevant to some of the ethics cases that your ethics committee will address:

Federal

- *Canada Health Act* - http://laws-lois.justice.gc.ca/PDF/C-6.pdf

Provincial

- *Provincial Directives Act*
  http://nslegislature.ca/legc/PDFs/annual%20statutes/2008/c008.pdf
  - Personal Directives Act resources - http://www.gov.ns.ca/just/pda/
  - Personal Directives Act regulations (including forms for capacity assessment) - http://www.gov.ns.ca/just/regulations/regs/pdpersdir.htm
- *Involuntary Psychiatric Treatment Act*
  http://nslegislature.ca/legc/PDFs/annual%20statutes/2005%20Fall/c042.pdf
- *Personal Health Information Act*
  http://nslegislature.ca/legc/PDFs/annual%20statutes/2010%20Fall/c041.pdf
- *Hospitals Act* http://nslegislature.ca/legc/statutes/hosptls.htm
- *Health Protection Act* http://nslegislature.ca/legc/statutes/healthpr.htm
- *Adult Protection Act* http://nslegislature.ca/legc/statutes/adultpro.htm

4. EVALUATION

Evaluation of the ethics committee's work is important for quality assurance and to help guide ongoing efforts to enhance ethics capacity. The nature of ethics work makes it something of an evaluation challenge, but this does not mean we should ignore the task. The following pages provide some examples of forms used in various districts and for various aspects of ethics evaluation.

4.1 ETHICS COMMITTEE EVALUATION

GOALS

The goal of ethics committee evaluation, like other forms of effectiveness measures, is to ensure that the ethics committee is serving the purposes for which it was intended. Evaluation should therefore measure whether the ethics committee is having the desired effect in particular areas. Evaluation can also be a tool to guide the activities of the committee or identify new areas where attention is needed in order to meet its mandate. Questions committees might consider in this effort include:

- Are we raising the right issues?
- Are we facilitating rich discussion?
- Are we bringing in key stakeholders? Anyone we are missing...consistently?
- Policy reviews - are they timely, addressing relevant policies, comprehensive?
- Consultations - pre/post surveys

MEANS

There is relatively little research on ethics committee evaluation (apart from comments around the challenges that surround it). There are also very few, if any, validated tools for evaluation of ethics committee activities. Various strategies that have been used for evaluation of ethics committee include:

- self-evaluation
- verbal feedback after consultation
- verbal feedback after education sessions
- formal feedback after consultation (written or online)
- formal feedback after education sessions (written or online)
- data on number of requests for support received
- data on number of consultation /education sessions/discussions arising from requests
- surveys to gauge progress on identified needs (as determined by an initial needs assessment or other instruments)
- general surveys of efficacy

Some of the challenges arise because there is no consensus regarding what constitutes success or efficacy for a committee – for example, low request numbers might reflect success or efficacy in building ethics capacity throughout the organization to address most ethics issues at the level of the team or service. Low request numbers might also reflect a lack of awareness of the ethics committee and/or consultation service, a distrust or dissatisfaction with the committee or consult service, or difficulties that teams are having in identifying specific ethics issues. Likewise, high request numbers might indicate success in publicizing the availability of ethics support and trust and satisfaction with the assistance provided by the ethics committee or consult team, or it might be indicative of failure to educate teams and patients regarding what is or is not an ethics issue, of areas where ethics capacity still needs to be built in the

organization, or of an ongoing systemic problem that the ethics committee or consult service has not been able to successfully address.

NSHEN's experience with evaluation is that it can be challenging to get survey responses, especially if there is a gap between activity and evaluation or if the focus is the functioning of NSHEN generally. There is important information, however, regarding long-term effects of education and consultation that can only be obtained retrospectively.

There is currently Canadian research underway regarding the evaluation of ethics activities, and NSHEN will disseminate the results of this study. The Veterans Affairrs Integrated Ethics program has a form for evaluating consultations at http://www.va/gov/vaforms/medical/pdf/10-0502-fill.pdf. A hard copy is included on the next page/. NSHEN's standard evaluation form for ethics activities (adapted by permission from the form used by CHES (CDHA)) is also provided as an example.

There is currently Canadian research underway regarding evaluation of ethics activities, and NSHEN will disseminate the results of this study. The Veterans Affairs Integrated Ethics program has a form for evaluation of consultations at http://www.va.gov/vaforms/medical/pdf/10-0502-fill.pdf. A hard copy is included on the next page. Likewise, NSHEN's standard evaluation form for ethics activities is on the page after that.

4.1.1 EVALUATION FORMS

The following are sample evaluation forms--one used by Veterans Affairs in the US and another by NSHEN.

OMB 2900-0750
Estimated Burden 5 minutes

Department of Veterans Affairs

Ethics Consultation Feedback Tool

This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, VA may not conduct or sponsor, and you are not required to respond to a collection of information unless it displays a valid OMB number. VA anticipates that the time expended by all individuals who complete this survey will average 5 minutes. This includes the time it will take to read instructions, gather necessary facts and fill out the form. Customer satisfaction surveys are used to gauge customer perceptions of VA services as well as customer expectations and desires. The results of this survey will lead to improvement in the quality of service delivery by helping to shape the direction and focus of specific programs and services. Submission of this form is voluntary and failure to respond will have no impact on benefits to which you may be entitled.

Recently, you spoke with someone from the Ethics Consultation Service. The job of the service is to help patients, families, and staff work through difficult patient care decisions by listening to what everyone thinks and helping people decide the best thing to do. In order to help improve the Ethics Consultation Service, we ask that you take a few minutes to complete this form.

DIRECTIONS: For each of the following statements, please place an "X" in the box that best describes your most recent experience with the Ethics Consultation Service.

Rate the Ethics Consultant(s) on:	Excellent	Very Good	Good	Fair	Poor	Don't Know
Making you feel at ease	☐	☐	☐	☐	☐	☐
Respecting your opinions	☐	☐	☐	☐	☐	☐
Being an expert in ethics	☐	☐	☐	☐	☐	☐
Giving you useful information	☐	☐	☐	☐	☐	☐
Explaining things well	☐	☐	☐	☐	☐	☐
Clarifying decisions that had to be made	☐	☐	☐	☐	☐	☐
Clarifying who is the right person to make the decision(s)	☐	☐	☐	☐	☐	☐
Describing possible options	☐	☐	☐	☐	☐	☐
Clearing up any disagreements	☐	☐	☐	☐	☐	☐
Being easy to get in touch with	☐	☐	☐	☐	☐	☐
Being timely enough to meet your needs	☐	☐	☐	☐	☐	☐
Providing a helpful service	☐	☐	☐	☐	☐	☐
Overall, my experience with the Ethics Consultation Service was:	☐	☐	☐	☐	☐	☐

Did the consultation service make any recommendations?	Yes ☐	No ☐	Don't Know ☐
If yes, were the recommendations generally followed?	Yes ☐	No ☐	Don't Know ☐
Do you have any comments or suggestions for the Ethics Consultation Service?	Yes ☐	No ☐	Don't Know ☐

Nova Scotia
Health Ethics
Network

NSHEN Ethics Education Evaluation

Please return to the session organizer or:
fax: 470-7388
email: krista.mleczkoskerry@iwk.nshealth.ca

Session: _____ Date: _____

Name: (optional) _____ Tel/Email: _____

Please evaluate the session by circling the number that best reflects the extent of your agreement with the statement:

	Strongly Disagree				Strongly Agree
1. I learned something new in this session	1	2	3	4	5
2. The session was relevant to my work	1	2	3	4	5
3. The facilitator(s) presented the material well.	1	2	3	4	5
4. The content of the session and method(s) used to present were effective.	1	2	3	4	5

On this topic I would like more info about:

1.

2.

3.

This session could have been improved by...

Other comments?

Other education sessions I would like to see offered in the future:

1.

2.

3.

Thank you for your feedback!

NSHEN

5.0 RESOURCES

This section provides examples of the various sources for bioethics resources, online and in other formats. NSHEN also has reading lists and a "lending library" for your use. We are also happy to consult with you to facilitate finding resources related to particular situations or concerns.

5.1 Top 10 Online Bioethics Resources (links up to date as of 21.03.12)

1. Hastings Center Report
   http://www.thehastingscenter.org/Publications/HCR/Default.aspx
2. Integrated Ethics – Veterans Affairs (US-based) – general resources, support for consultation
   http://www.ethics.va.gov/integratedethics/index.asp
3. CMAJ Bioethics for Clinicians Series
   http://www.cmaj.ca/cgi/collection/bioethics_for_clinicians_seriesCNA Ethics in Practice Series
   http://www.cna-aiic.ca/en/improve-your-workplace/nursing-ethics/ethics-in-practice/
4. Provincial Health Ethics Network (PHEN) website – general & topic-specific resources
   http://www.phen.ab.ca
5. Virtual Mentor (US-based) – cases (or starting points for cases)
   http://virtualmentor.ama-assn.org/
6. Nuffield Council (UK-based)
   http://www.nuffieldbioethics.org/
7. Joint Centre for Bioethics (University of Toronto)
   http://www.jointcentreforbioethics.ca/index.shtml
8. Bioethics Topics (University of Washington)
   http://depts.washington.edu/bioethx/topics/index.html
9. Introduction to Moral Theory (University of San Diego)
   http://ethics.sandiego.edu/theories/Intro/index.asp
10. Nova Scotia Health Ethics Network (NSHEN)
    http://nshen.ca

5.2 Other Resources

DVDs

Television
House, M.D.
Grey's Anatomy
Scrubs

Films
My Sister's Keeper
Gattaca
Music Within
The Savages
Charlie Bartlett
Michael Clayton
The Soloist
Rachel Getting Married
Stop-Loss
Little Miss Sunshine
Away From Her
Thumbsucker
What's Eating Gilbert Grape?
Awakenings
A Beautiful Mind
Iris
The Hours
Eternal Sunshine of the Spotless Mind
Wit
Outbreak
Rain Man
Regarding Henry
The Madness of King George
Lorenzo's Oil
Girl Interrupted
Gone Baby Gone
Dying Young
Drugstore Cowboy
Diving Bell and the Butterfly
Cocoon
As Good As It Gets
Benny and Joon

Books – Fiction

My Sister's Keeper – Jodi Picoult
Never Let Me Go – Kazuo Ishiguro
Diving Bell and the Butterfly – Jean-Dominique Bauby
Tuesdays with Morrie – Mitch Albom
Oryx and Crake – Margaret Atwood
The Year of the Flood – Margaret Atwood
Fourteen Stories: Doctors, Patients, and Other Strangers – Jay Baruch
Bloodletting and Miraculous Cures – Vincent Lam

Books – Nonfiction

The Spirit Catches You and You Fall Down – Anne Fadiman
Complications: A Surgeon's Notes on an Imperfect Science – Atul Gawande
Better: A Surgeon's Notes on Performance – Atul Gawande
The Checklist Manifesto: How To Get Things Right – Atul Gawande
Final Exam: A Surgeon's Reflections on Mortality – Pauline Chen
A Nurse's Story: Life, Death and In-between in an Intensive Care Unit – Tilda Shalof
The Making of a Nurse – Tilda Shalof
In the Realm of Hungry Ghosts – Gabor Mate
Doctors and Patients: An Anthology – Cecil Helman, ed.
Not Yet: A Memoir of Living and Almost Dying – Wayson Choy

Books - Reference

Encyclopedia of Bioethics – Stephen G. Post
Case Studies in Public Health Ethics 2nd ed. – Steven S. Coughlin and Colin L. Soskolne
Ward Ethics: Dilemmas for Medical Students and Doctors in Training – Thomasine K. Kushner and David C. Thomasma
Stories Matter: The Role of Narrative in Medical Ethics – Rita Charon and Martha Montello, eds.
Staying Alive: Critical Perspectives on Health, Illness, and Health Care – Dennis Raphael, Toba Bryant and Marcia Rioux
Smart Mice, Not-So-Smart-People: An Interesting and Amusing Guide to Bioethics – Arthur L. Caplan
The Roles and Responsibilities of the Ethics Consultant: The Retrospective Analysis of Cases – N. Lester
Public Health Ethics: Theory, Policy, and Practice – Ronald Bayer et al., eds.
Organizational Ethics in Health Care: Principles, Cases, and Practical Solutions – Philip J. Boyle, et al.
Narrative Matters: The Power of the Personal Essay in Health Policy – Fitzhugh Mullan, Ellen Ficklen, and Kyna Rubin
Medicine and Social Justice: Essays on the Distribution of Health Care
Medical Readers' Theatre: A Guide and Scripts
Long-Term Care Decisions: Ethical and Conceptual Dimensions
Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom

An Introduction to Health Care Organizational Ethics
Improving Competence in Clinical Ethics Consultation: An Education Guide
Health Care Ethics in Canada (new ed. forthcoming)
An Ethics Casebook for Hospitals: Practical Approaches to Everyday Cases
Ethical Dimensions of Health Policy

Dependence and Autonomy in Old Age: An Ethical Framework for Long Term Care
Clinical Ethics - A Practical Approach to Ethical Decisions in Clinical Medicine (new ed. forthcoming)
Classic Cases in Medical Ethics
Caring for Patients from Different Cultures: Case Studies from American Hospitals
Caring for Patients at the End of Life: Facing An Uncertain Future Together
Alternative Medicine and Ethics
50 Activities for Promoting Ethics Within the Organization

Journals
Hastings Center Report
Journal of Clinical Ethics
Kennedy Institute of Ethics Journal
Cambridge Quarterly of Healthcare Ethics
American Journal of Bioethics
International Journal of Feminist Approaches to Bioethics
Journal of Medical Ethics
Bioethics

Online Resources:
Integrated Ethics (USA Veterans' Affairs)
Virtual Mentor:
Hastings Center Discussion:
CMAJ Bioethics for Clinicians:
Provincial Health Ethics Network (PHEN):
CNA Ethics in Practice Series:
World Café: http://www.theworldcafe.com/
Bibliography of literary resources (fiction):
http://highschoolbioethics.georgetown.edu/bibliographies/webfictionbooks.pdf
Bibliography of literary resources (nonfiction):
http://highschoolbioethics.georgetown.edu/bibliographies/webnonfictionbooks.pdf
Bibliography of film resources:
http://highschoolbioethics.georgetown.edu/bibliographies/BioethicsMoviesListTable.pdf
TED talks: http://www.ted.com/talks
Readers' Theater: http://www.ecu.edu/cs-dhs/medhum/newsletter/v2n1theater.cfm and
http://www.ecu.edu/cs-dhs/medhum/theater.cfm

Podcasts

White Coat Black Art: http://www.cbc.ca/whitecoat/index.html?copy-podcast
The Current: http://www.cbc.ca/thecurrent/podcast.html (sometimes discusses topical issues in health)
Ideas: http://www.cbc.ca/ideas/podcast.html (sometimes addresses larger-scale challenges in health
The Bioethics Channel:
http://itunes.apple.com/WebObjects/MZStore.woa/wa/viewPodcast?id=301896826
Purdue University Bioethics Seminar Series: http://itunes.apple.com/podcast/purdue-university-bioethics/id302010509
Hastings Center Report Podcast: http://itunes.apple.com/us/podcast/the-hastings-center-bioethics/id341446013 (describes content of current issue)

NSHEN: http//nshen.ca

- workshops, ethics education days
- Telehealth sessions
- newsletter
- district specific resources, e.g., links to patient/family ethics-related brochures, policies and procedures

6.0 Raising Awareness about the Ethics Committee

A capable, accessible ethics committee can be a tremendous resource within a healthcare organization. If it is made up of individuals from diverse backgrounds who are committed to enhancing ethics capacity at personal, group, team and institutional levels the resource will be that much more valuable. However, a competent, accessible ethics committee is only a valuable resource if people in the organization are aware of its existence, mandate, and know how to access it. Raising this awareness can be a major challenge depending on the size of the organization and the priority assigned to improving ethics capacity on an organizational scale. One aspect of awareness raising is identifying an institutional "champion," someone willing to be an ally in your PR efforts for the ethics committee. The following are some of the strategies that have been used by various committees to increase the visibility, profile, and reputation of the ethics committee.

- Recruitment campaigns for new members
- Production of brochures for inclusion in patient materials
- Production of a patient and family ethics tool that is included in patient materials
- Production of a tool to help staff address ethics issues
- Posters
- Bookmarks
- Posters, flip charts, and tent cards with “Did you know...” questions about ethics
- Pocket cards
- Having members of the ethics committee go around to different units and groups to talk about the work of the ethics committee
- Participating in new employee orientation
- Get the organization’s PR people involved
- Ethics day activities
- Posting cases for discussion on the intranet
- Developing and maintaining a website devoted to the ethics committee, its mandate, function, structure, and information on how to access it
- On-line links to ethics-related sites and resources
- Information on TV sets in waiting room areas
- Broadly distributed advertisements for ethics education events
- Short surveys to assess ethics needs/interests within the institution
- Taking part in district orientation sessions

A staff survey developed CHA is included as an example in this section because the use of this survey helped staff become more aware of the existence and relevance of the ethics committee within their organization. This was a novel approach to "raising awareness" with respect to their local ethics committee.

6.1 Example: Cumberland Health Authority

ETHICS REVIEW AND NEEDS ASSESSMENT

The CHA Ethics Committee exists to (from CHA Ethics Framework 2009)

- *To identify and promote the ethical principles and foundation values which support the moral philosophy of the organization and guide ethical behavior.*
- *To protect the interests of all parties by functioning as a resource to those involved in patient care decision making processes and ensuring a process for clinical consultation.*
- *To support and facilitate educational programs related to ethics, ethical decision making and associated issues.*
- *To review, revise, and/or make recommendations with regard to new or ongoing research programs involving live/human subjects that are conducted with, or by members of, the Cumberland Health Authority.*
- *To review policies with significant ethical dimensions and provide feedback to services, departments and other levels of the organization. The Health Ethics Committee can be utilized as a resource for staff at any stage of policy development.*

As part of its ongoing Quality Improvement activities the Ethics Committee is looking for your feedback. Please take a few minutes to complete this questionnaire.

1. Given your personal understanding of ethics, list the 3 most frequent ethical dilemmas (without being too specific) you encounter in your work with the CHA, whether with patients, families or colleagues.
   _____
   _____
   _____

2. When facing an ethical issue, what do you do? Who would you speak to in order to address an ethical dilemma?
   _____
   _____

3. How well do you feel you are able to identify ethical issues in your daily work? (scale 1-5 with 5 being "very able to identify ethical issues) 1 2 3 4 5

4. How well do you feel your colleagues are able to identify ethical issues in your daily work? (scale 1-5 with 5 being "very able to identify ethical issues) 1 2 3 4 5

5. Do you know about the CHA Clinical Consultation Team ____ Yes ___ No
   If yes do you know how to obtain a consultation ____ Yes ___ No

6. What educational initiatives in ethics would be most useful to you in your work?
   _____
   _____
   _____

7. Do you have suggestions for how best to deliver education programs to you, your department or service?
   _____
   _____

8. Would you be interested in becoming a member of the CHA Ethics Committee? If so please submit your expression of interest to N. Williamson (nwilliamson@cha.nshealth.ca, 902-667-6631 or by inter hospital mail. Name _____ Department _____ Facility _____

9. Thank you for your time and input completed questionnaires can be forward to N. Williamson (nwilliamson@cha.nshealth.ca, 902-667-6631 or by inter hospital mail. Draft 1, January 6, 2012

Additional information about the patient care situation ...

Ethics and the Ethics Committee:

What is "ethics" in health care?

In health care settings, ethical questions arise when ***"the right thing to do"*** is unclear, or when people disagree about what is best for a patient.

What is the Ethics Committee?

The Ethics Committee is made up of health care workers and people from the community that have a variety of backgrounds. We work together to try to protect the rights of people in the health care system by being a resource for those who make decisions about patient care.

Our role is to increase awareness and knowledge about "ethics" in our district.

The Committee is an education resource for health care workers and can advise the District's on the ethical part of policies and priorities.

Good ethical decision making within and outside the Ethics Committee is guided by our District's "Values" statement:

Our Values:

Integrity: We are honest, principled and ethical.

Equity: We are inclusive, equitable and fair.

Respect: We respect diversity and the dignity and worth of all persons.

Excellence: We are dedicated to high quality, holistic care and continuous improvement.

Commitment: We are committed to working together with our partners to promote health.

Innovation: We value learning, creativity and innovation and find ways to turn challenges into opportunities.

South West Health
Working Together for Better Health
Shelburne · Yarmouth · Digby

The Ethics Committee

The Ethics Committee is available, on request, to help District personnel, patients and families explore options for their difficult ethical questions and dilemmas related to health care.

What is the Right Thing To Do?

For more information contact:
Ethics Committee Chair
742-3542 ext. 798

Revision date: September 2, 2004

The Ethics Consultation Process: what you need to know...

How can the Ethics Committee help in Ethics Consultation?

The Ethics Committee is available to patients, their families and health care professionals, to help them identify, understand and resolve difficult healthcare ethics questions.

The Ethics Committee is a consultative & advisory body and does not make decisions regarding a person's care or the organization's policies.

Who can refer for a consultation?

The Ethics Committee will accept referrals from physicians, staff, volunteers, families and patients where an ethical issue or dilemma regarding patient care exists.

Why would someone be referred?

Generally, ethical questions arise when ***"the right thing to do"*** is not clear or when people disagree about what is best for a person who requires care.

How are referrals made?

A referral can be made by filling out the form that is a part of this brochure. If you need help to decide whether or not an Ethics Consultation would help you, please feel free to talk to the Ethics Committee Chair or any of the committee members by calling 742-3542 Ext 798 or go to our website: www.swndha.nshealth.ca and click on the Ethics contact link.

What information is needed?

The Ethics Committee will expect a completed referral form, including:

- A clear and honest statement of the problem
- An idea about what has already been done to deal with the issue
- The name of the person(s) making the referral
- An idea of how urgent the problem is

What does the ethics consultation consider?

Ethics consultations consider the following ethical principles (guidelines that help us make the best possible decisions about patient care):

- Respect for patient autonomy and self-determination
- Beneficence (doing good)
- Non-maleficence (not doing harm)
- Justice and fairness

What results can be expected?

All consultations are confidential and are bound by the same policies and procedures as other patient and organizational records.

The Ethics Committee role is **advisory only.** The final decision about a health related issue lies with the patient (or legal representative) and the doctor involved.

Ethics consultation provides a facilitated forum for thoughtful exploration of how to act well and make morally good choices based on beliefs and values about life, health, suffering and death.

Complete, tear off and return to:
Ethics Committee, 5th Floor Yarmouth Regional Hospital, 60 Vancouver St., Yarmouth, N.S. B5A 2P5

Request for Ethics Consultation (Referral) Form

Date: _____ **Type of Referral** *(check one)*: ☐ EMERGENCY ☐ URGENT ☐ For Regular Meeting

Referral completed by: _____

Contact information of person making referral *(telephone # and/or e-mail address)*: _____

_____

Relationship to referred case: _____ **Unit or organization:** _____

Statement of ethical dilemma: Please include clear details of the patient care situation in which the issue(s) arose:
(additional space on reverse side)
_____