MARSH INSIGHTS:
MULTI-PATIENT INCIDENTS

“Hospital to pay $1.7M in class-action settlement after more than 400 people tested positive for tuberculosis”

“[Class action launched] against Hopital Montfort, located in Ottawa, Ontario, to secure recovery persons whose confidential personal health information was stored on a USB key which was lost by an employee of the hospital. The lawsuit claims $25 million in compensation.”

“Class action lawsuit filed against hospital, former staff and Fleming College”

Similar headlines are becoming increasingly commonplace within the Canadian health care landscape as health care organizations are not only tasked with managing issues related to patient care, safety, and security, but also with the protection of their most important asset: their reputations.

As the health care environment continues to evolve, organizations are tasked with “doing more with less,” resulting in the emergence of systemic issues that often result in adverse events. The landmark study To Err is Human published by the Institute of Medicine in 1999, highlighted these issues in the US specifically citing that a significant number of these adverse hospital events are preventable. Ross Baker’s 2004 Canadian study revealed similarly startling statistics, including:

- 1 out of 13 patients experience adverse events in Canadian hospitals.
- 1 out of 9 adult patients will potentially be given the wrong medication of the wrong dose of a medication.
- 24% of preventable adverse events are related to medication errors. Others include surgery and infections.¹

In addition, there are now also new and emerging risks that include cyber-attacks, privacy breaches, and exposures relating to infectious diseases and hazardous materials.

With this evolution comes the need to identify key tactics and mitigation strategies to ensure the protection of patients and their families, and of the organization as a whole. The ability to respond effectively and efficiently to a large scale event or multi patient incident is critical, because regardless of how low the risk is, patients and their families value early notification.²


LARGE-SCALE ADVERSE EVENTS OR MULTI-PATIENT EVENTS

An adverse event can be defined as “an unintended injury or complication that results in disability at the time of discharge, death or prolonged hospital stay, and that is caused by health care management rather than the patient’s underlying disease process”.

In such events, disclosure is often required. However, attitudes on disclosure vary depending on the organization’s culture and:

- Uncertainty about what patients and their families think should be disclosed.
- Health care providers’ assumptions that focus will be on blaming the health care providers rather than understanding the root causes of the event.
- Uncertainty of potential reactions of patients and their families.
- Skills and knowledge regarding the disclosure process.
- Concerns of potential litigation and implications on insurers.

A study conducted by Prouty, Foglia, and Gallagher (2014) found that recipients of disclosures in large scale adverse events favoured notification – even in low harm, low risk events. This notion was reaffirmed by a 2010 study conducted by Dudzinski et al. that suggested patients prefer being informed – even when it may cause increased anxiety. Failure to communicate adverse events can have detrimental consequences including:

- Transmission of inaccurate information.
- Potential to make uninformed decisions.
- Reputational risks and quality of care.
- Increased social media use can result in widespread news and risks of these incidents going viral.

While the management of large scale adverse events are similar to that of a critical incident, there are inherent differences that need to be considered, such as:

- Impact is much larger, and therefore difficult to keep quiet.
- Reputational risks often mean a larger impact on the organization.
- Resource intensive – response requires a highly coordinated effort by the organization.
- Perception of severity of harm varies from patient to patient.

TYPES OF EVENTS

There are several types of adverse events that have far reaching implications and potential for widespread involvement of multiple patients.

- Diagnostic Errors — In Newfoundland and Labrador, 383 women were misdiagnosed and potentially mistreated as a result of incorrect lab results for oestrogen and progesterone positive breast cancer positive results. In New Brunswick, the integrity and competence of a physician was called into question when


5 Dudzinski, D., Hebert, C., Foglia, M., Gallagher, T. (2010). The disclosure dilemma: large scale adverse events. NEJM 363(10);978-86.

an internal audit revealed a high degree of errors. In Ontario, a radiologist made significant errors in diagnostic testing reviews which have led to several deaths and “potentially significant clinical errors” in approximately 645 cases.

• **Instrument Reprocessing Failures** — In many hospitals across the country, hospitals have implemented stringent sterilization protocols for equipment used for multiple patients. In several cases, there has been a break down in the process resulting in potential exposure to infectious diseases. A Montreal area hospital had to notify 150 patients of a potential exposure due to a failure in the sterilization process in a bariatric surgery suite. It was unclear if the women treated between 2013 and 2014 were affected and the hospital has been testing patients.

• **Privacy Breaches** — as a new and emerging risk in health care, privacy breaches have created a unique challenge for health care organizations. While progress has been made with the integration of electronic health records and electronic medical records, implementation of new legislation regarding privacy (PHIPA), and tracking/monitoring breaches, the increased use of mobile technology (smartphones, laptops, thumb drives) and the risk of loss/theft of these devices creates new exposures. Recent examples include a lost thumb drive at the Montfort Hospital in Ottawa, and a privacy breach at Rouge Valley Health Centre that prompted a class action law suit after 8,000 records were breached by two rogue employees.

**WHEN A LARGE SCALE ADVERSE EVENT OCCURS**

When any adverse event occurs, the primary goal should always be to ensure the safety (immediate and ongoing) of the patients, staff, and members of the health care team. Then the clinical management of the patients becomes paramount. Once the needs of the patients are met, organizations should focus on ensuring that appropriate testing, follow up, and monitoring strategies are in place to safeguard optimal health outcomes. Only once that step is completed should the organization conduct an in depth analysis to determine correlations between health effects (infections) and the cause (exposure).

• **Exposure** is the proximity to or contact with the potential cause such as pathogen or environmental hazards such as radiation that have the potential to cause patient harm.

• **Look Back** is the process by which patients and or staff are identified who have incurred potential risk of exposure. There is an explicit intent for notification.

**LARGE SCALE DISCLOSURE**

Organizations are often tasked with managing the expectations of not only patients, but also families, lawyers, and insurance companies. And oftentimes, anxiety and emotions run high. In order ensure effective and efficient communication, health care organizations need to have a clear set of policies and procedures in place to manage a large-scale disclosure, including notification of patients, the public, coordination of potential follow ups and/or diagnostic and laboratory testing, as well as regulatory and legislative requirements.

Disclosure policies should contain specific information regarding what is documented, who is responsible for the documentation, and who is leading the disclosure. In a large scale adverse event, disclosure should be made on a case by case basis. According to the CMPA, “the threshold for notifying patients should be the existence of a realistic possibility of harm, as opposed to a theoretical risk of harm”. This analysis is complete, the CMPA suggests answering the following questions to aid in the decision making process around disclosure:

---

1. Has the review confirmed harm occurred to patients? If yes, disclosure and appropriate care and follow should occur.

2. Has the review confirmed there are patients that have possibly been harmed? If yes, then appropriate follow up and care should occur.

3. Does the review indicate what happened was a “near miss” (harm did not reach the patients) and therefore no harm has occurred? If so, disclosure to patients is generally not required.⁸

**DOCUMENTING AND COMMUNICATION IN LARGE SCALE ADVERSE EVENTS**

Each organization will have a unique process in the communication and documentation policies and procedures of large scale adverse events. It is imperative that the appropriate personnel, both internal and external, are notified in an efficient and timely manner. Depending on the circumstances or the event, the following persons should be notified:

- Most responsible provider (MRP).
- Legal counsel (internal and outside as needed).
- Insurance carrier.
- Regulatory bodies, as needed, including Public Health (in the event of infectious diseases exposure).
- Law enforcement, if required.⁹,¹⁰

What information to provide, however, should be decided on a case-by-case basis. According to the CMPA, in the event of an adverse event, the following information should be considered for disclosure:

- Factual information regarding the event, clinical advice relating to the harm (or the potential for harm) resulting from the event.
- A care plan that includes follow up, diagnostic, and laboratory testing as required, treatment options, and follow up advice.
- Information regarding the potential involvement of outside agencies including Public Health in the event of a contagious or reportable infectious diseases exposure.
- Contact information.
- Information hotline or resources to help patients and their families manage anxiety and stress the result of this event.
- Recommended sources of information.

While apologies may be an effective way of managing adverse events, they must be well thought out and clearly articulated, conveying sincerity to the patient and their families. (Organizations should consider their own policies regarding apologies (as part of, or separate from, their disclosure policies) which should be created in collaboration with legal counsel. In the United States, as of 2012, 36 states have implemented “I’m sorry” laws, and recent studies have revealed that apologies may have favourable impact on claims and litigation. One study conducted by Ho and Liu (2010) found that cases involving the most severe injuries “settle about 20% faster, in states with apology laws, and average claim payments are reduced by a range of $55,000 - $73,000.”¹¹

---

⁸ Ibid


MANAGING THE MEDIA AND COORDINATING MEDIA RESPONSE

Legislation such as the Freedom of Information Act has increased the complexity of the health care environment. Organizations need to ensure that their media policy is sound, efficient and strategic. Whenever a multi-patient incident occurs, the organization should always assume there will be media involvement; a designated spokesperson can help the organization respond tactfully while protecting the privacy of their patients, families, and staff. With Rideout v. Labrador Corp [2007], a class action lawsuit was brought forward against a hospital after the plaintiff found that a media release was issued publicly prior to her own notification, leaving her “…distraught, horrified and in a state of nervous shock…[fearing] for her health and the health of her family.”[para7]12

All staff including physicians should receive guidance on managing the media and should familiarize themselves with the media relations policies of the organization. However, core should always remain the patient, their privacy, and the privacy of the health care providers. Regardless of the approach adopted by the organization, media relations should be tactful to minimize the negative implications on the careers and or reputation of the health care team and the organization. Legal advice should always be sought when developing the media relations strategy.

CONCLUSION

As health care organizations continue to struggle with meeting the needs of their communities, provision of quality and efficient care remains a paramount strategic initiative for Canadian hospitals. The challenge however, lies in the development and delivery of these services in a manner that is rooted in safety and patient-centred care.

Through greater transparency and accountability to the public, health care organizations are facing increasingly complex exposures and risks from large-scale adverse events and class action law suits. Marsh Risk Consulting, risk consulting division of Marsh Canada, has developed a checklist based on best practices from national and international safety organizations including the Canadian Patient Safety Institute (CPSI), Joint Commission: Accreditation, Health Care, Certification (JCAHCC), and Department of Veterans Affairs (VHA). Our checklist provides a blueprint for health care organizations manage large scale or multi patient adverse events and is designed based on evidence based best practices and can be modified to meet the individual needs of each organization.

Please contact Nora Constas to request a complimentary version of this checklist.
