Potential impact of the New Quality of Care Information Protection Act, 2015 on hospitals

APRIL 8, 2016 4 MIN READ

Related Expertise

- Health

Authors: Michael Watts, David Solomon

Bill 119, the *Health Information Protection Act, 2015*, was "carried on division" at second reading before the Legislative Assembly on February 18, 2016, and is being considered by the Standing Committee on Justice Policy. If passed at third reading and proclaimed, it will repeal and replace the *Quality of Care Information Protection Act, 2004* (QCIPA 2004) with the *Quality of Care Information Protection Act, 2015* (QCIPA 2015).

QCIPA 2015 reflects the Ontario government's response to the Recommendations of the QCIPA Review Committee dated December 23, 2014. The Committee was asked by the Health Minister to review current practice in the interpretation and implementation of QCIPA 2004 and its intersection with other related legislation, and to make recommendations for improvement, if needed. As set out in the Executive Summary of the Recommendations, many individuals and organizations have raised concerns that QCIPA 2004 is being used to prevent patients and families from being fully informed about what went wrong in a particular critical incident and what will be done to improve care in the future. There are also concerns that QCIPA 2004 has inhibited the sharing of information about critical incidents among institutions in Ontario.

In the course of the Committee's "deliberative dialogue" with patients and families who had experience with critical incidents, six principles that should guide the investigation of critical incidents were adopted by the Committee as the principles underlying the report, including that:

- Critical incident investigations should assume good intentions from all parties,
- Critical incident investigations should be patient inclusive,
- Critical incident investigations should be *transparent*,
- Staff need to communicate effectively with patients and families before, during and after critical incident investigations,
- Critical incident investigations should entail an obligation to share lessons, and
- Critical incident investigations should be consistent and predictable.

On the basis of these principles, the Committee made twelve recommendations, all of which the Ontario government has committed to implementing through Bill 119. Because the implementation of these changes represents a fundamental overhaul of QCIPA 2004, the government has elected to replace QCIPA 2004 altogether. At the beginning of QCIPA 2015, for example, there is a lengthy preamble that is absent from QCIPA 2004 which sets out similar principles, including that "[t]he people of Ontario and their Government: … Believe that quality health care and patient safety is best achieved in a manner that supports openness and *transparency* patients and their authorized representatives regarding patient health care."

In implementing the guiding principles the new provisions of QCIPA 2015 include noteworthy amendments to definitions, including:

- Introduction of a definition of "critical incident" that means "any unintended event that occurs when a patient receives health care from a health facility that, (a) results in death, or *serious disability, injury or harm* to the patient, and (b) does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing the health care." The definition is intended to prevent over-application of QCIPA 2015 to less serious incidents, such as "near misses" that do not result in harm to any patient,
- A redefinition of "health facility" to include a "prescribed entity that provides health care," which could allow the Health Minister to prescribe virtually any public or *private* health facility as being subject to QCIPA 2015 (e.g., Out-of-Hospital Premises, long-term care homes, private clinics, etc.),
- A redefinition of "quality of care committee" to include a prescribed "quality oversight entity" that performs "quality of care functions," and which might oversee not only health facilities but also health care providers or classes of health facilities or providers, and
- A redefinition of "quality of care information" that reinforces protections over "discussions and deliberations of a quality of care committee," while carving out information that should be disclosed relating to the facts of a critical incident, causes identified by a quality of care committee, consequences of the critical incident for the patient, and any actions taken or recommended, including any systemic steps to avoid or reduce the risk of future similar incidents.

QCIPA 2015 also provides for the disclosure of quality of care information *among* committees of different facilities for the purposes of carrying out common quality of care functions and making systemic improvements to quality of care across the province. Finally, QCIPA 2015 confirms that nothing in it interferes with existing legal requirements for health facilities to interview patients and their authorized representatives after a critical incident, and disclose information relating to critical incidents to patients and their authorized representatives as required by law. Accordingly, hospitals and other health institutions should review and update their quality of care committee charters and related critical incident policies in response to QCIPA 2015 if and when it becomes law.

This article originally appeared in *Hospital News.*