Exhibit OO12.bn

Clinical Staff Executive Committee

MEDICAL CENTER POLICY NO. 0293

A. SUBJECT: Disclosure of Outcomes

B. EFFECTIVE DATE: September 1, 2011

C. POLICY:

Patients are informed about the outcomes of their care, including unanticipated outcomes, so that they can make knowledgeable and informed decisions about their current and future care. A known complication or side effect is not an unanticipated outcome, but information about such outcomes should also be provided to the patient. Some outcomes may be attributable to inherent risks associated with the treatment, a confluence of rare and unavoidable circumstances and/or the patient's condition, human error, or issues associated with clinical processes and treatment.

Patients and their families and/or care partners must be informed about the outcomes of care, including unanticipated outcomes. *(*See Medical Center Policy 0024, *Informed Decision-making)*. Information related to outcomes of transfusions is provided in accordance with *Blood Bank Policy No. H83.*

D. DEFINITIONS

Adverse unanticipated outcome: a result that differs significantly from what was anticipated to be the result of a treatment or procedure. An adverse unanticipated outcome may or may not include error.

E. PROCEDURE

1. Priorities for Responding to an Adverse Unanticipated Outcome

   a. The first priority for the healthcare team is to address the current healthcare needs of the patient by assessing the patient's condition and addressing the immediate healthcare needs of the patient. This may include obtaining consultations and recognizing who should assume primary responsibility for the patient's care.

   b. Communicate with patient, family, and/or care partner in a manner that is compassionate and honest. Create or sustain trust by providing patients with a truthful and understandable explanation of the event. State the facts that are known and acknowledge areas of ambiguity or facts not known. Avoid casting blame, speculation, or guesswork.

c. Foster a mutually supportive environment where lessons learned and improved reporting enable better care delivery.

d. Follow through, in a timely manner, on promises made to patients, their family and care partners, and to members of your health care team.

2. Procedure for Disclosure of Adverse Unanticipated Outcome

a. In situations resulting in: (1) temporary harm to the patient and required initial or prolonged hospitalization; (2) permanent patient harm; (3) a required intervention necessary to sustain life; or (4) a patient's death, the patient, family or care provider as soon as practical should be informed of the unanticipated outcome by the attending physicians as outlined in Section E.2.b. below. This includes a thorough, objective description and explanation of the unanticipated outcome, and often occurs after a consult with risk management as some investigation may be required before a disclosure discussion.

b. The attending physician should both disclose and respond to questions in order to provide to the patient, family, or care partner a complete and clear explanation of what occurred and any necessary clinical remedies or treatment options. If more than one service is involved, attending physicians should collaborate on discussing outcomes of care and, when appropriate, participate in the discussion with the patient, family, or care partner.

c. If the attending physician is not able or willing he/she should contact risk management. If the attending remains unwilling or is unavailable, risk management will collaborate with other Health System personnel as necessary to determine an appropriate alternate.

d. Where the unanticipated outcome may be a result of nursing care, the Chief Nursing Officer or her/his designee shall have the disclosure discussion with patients and their families/care partners. In these instances the attending physician shall be included in the review of the facts surrounding the event before the disclosure discussion.

e. In general, the disclosure discussion should clearly communicate the outcome to the patient without engaging in a discussion of fault. If the exact cause of the event remains uncertain, the disclosing party should refrain from speculating as to the cause, and if appropriate, advise the patient, family or care partner that the cause remains unknown. The nature, severity, and cause (if known) of the outcome should be presented to the patient in a calm and non-judgmental manner. The information to be given to the patient, family, or care partner should include facts related to the patient's condition and necessary for informed decision-making.

f. The discussion should include the following:

i. Truthful and compassionate explanation about the outcome including time and place, the circumstances of the outcome for the patient, and potential or anticipated consequences, to the extent known;

ii. Proximate cause of the outcome, if known;

iii. Contact information for the responsible physician;
iv. Contact information of the individuals who will manage the ongoing care of the patient;

v. Support and counseling (internal and external resources) must be offered to the patient, family, or care partner. In collaboration with risk management, assess the additional needs of the patient, family or care partner such as housing, food, etc. and with support of Medical Center senior management, provide assistance as necessary;

vi. Patients, family, or care partner may be told that the events are being reviewed. However, they should not be told about specific quality improvement processes being undertaken or given official reports of those processes. Confidentiality of quality improvement activities must be maintained. Clinicians should contact risk management if there are any questions regarding this section.

g. Communication at this early stage should be focused entirely on managing the patient's condition through the coordinated efforts of the healthcare team. Only clinical information should be communicated. The responsible physician and members of the healthcare team should refrain from offering subjective information, conjectures, or beliefs relating to possible causes of the adverse event and avoid attributing blame to others. Remarks or criticism made by members of the healthcare team who do not have all of the facts may further confuse the situation.

h. Risk management is available to assist in determining how and what should be disclosed to the patient.

3. Report to Appropriate Parties

Various persons, departments, entities, or agencies may need to be notified that an unanticipated adverse outcome as occurred. Internal notification and reporting should be conducted in accordance with University of Virginia Medical Center policies.

4. Documentation in the Medical Record

a. The medical record should contain a complete, accurate and factual record of pertinent clinical information pertaining to the unanticipated outcome and should be completed in a timely manner.

b. The documentation should include:

i. Objective details of the event, including date, time and place, written in neutral, non-judgmental language

ii. The intervention and patient response

iii. Notification of the attending physician

c. Additionally, documentation outlining the disclosure discussion with the patient, family, or care partner should include:

i. Time, date and place of discussion

ii. Names and relationships of those present at the discussion

iii. Documentation of discussion of the unanticipated outcome

***Note**: Documentation should avoid speculation about the cause of the event and blame of individuals involved in the event. Event reports, event analysis, quality improvement conclusions and the like should **not** be included or referred to in the medical record to avoid waiver of the privileges that attach to those documents and analyses. Under no circumstances should the medical record be altered. Late entries about an event should be clearly labeled as such.*

5. Follow-Up and Closure

The ongoing goal in the aftermath of an adverse event is to meet the healthcare needs of the patient and to help manage and address the patient, family, or care partner's emotional needs and concerns. It is critical to assume the burden of maintaining open communication. After the initial discussion has occurred and throughout the event analysis, it may be necessary and appropriate to conduct follow-up discussions until resolution has been reached.

6. Resources Available to Physicians and Staff

a. During this communication process, it is important for the responsible physician to assess his/her own mental and emotional state, and to understand and manage the impact of these variables on subsequent patient communications. Physician Wellness and Faculty and Employee Assistance Program (FEAP) is available to all attending physicians.

b. A patient adverse unanticipated outcome may be stressful to other members of the care team. The Employee Assistance Program (EAP) is also available to all staff.

SIGNATURES:

Robert S Gibson
Robert S. Gibson, MD, President, Clinical Staff

R. Edward Howell
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DATE: 8/26/11

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Approved by Quality Committee
Approved by Clinical Staff Executive Committee