

**Base Hospital – Ambulance Service Provider  
Performance Agreement**

Between:

**The Corporation of the City of Kawartha Lakes  
(hereinafter the “Ambulance Service”)**

-and-

**Lakeridge Health  
(hereinafter the “Base Hospital” or “CEPCP”)**

**1. BACKGROUND**

- 1.1. The performance of Controlled Acts described under Section 27 of the *Regulated Health Professions Act* 1991, S.O. 1991 c. 18, as amended may be delegated in accordance with Section 28 of the Act to a person who provides health care services to individuals by a person who is a member authorized by a health profession statute to perform the Controlled Act.
- 1.2. Lakeridge Health operates a Base Hospital Program for Paramedics for an area which includes that served by the Ambulance Service.
- 1.3. The Ambulance Service’s ability to meet its legislatively required obligations is in part dependent upon the performance and service provided by the Base Hospital in areas of training quality, capacity and responsiveness.
- 1.4. The Base Hospital’s ability to meet its legislatively required obligations is in part dependent upon the performance and service provided by the Ambulance Service in areas of training quality, capacity and responsiveness.

**2. DEFINITIONS**

- 2.1. “**ACR**” means Ambulance Call Report as defined by the Ambulance Call Report Completion Manual April 17, 2017 Version 3.0,1 Emergency Health Services Branch Ministry of Health and Long Term Care.
- 2.2. “**Act**” means the *Ambulance Act*, 1990, c. A. 19 and Ontario Regulation 257/00 passed thereunder, as amended;
- 2.3. “**Base Hospital**” means Lakeridge Health, being a base hospital as defined in the Act;

- 2.4. The “**CEPCP**” means the Central East Prehospital Care Program hosted by Lakeridge Health, being a base hospital program as defined in the Act;
- 2.5. The “**Chair**” means the physician appointed by Lakeridge Health through CEPCP as the chair of the CEPCP Medical Advisory Board, being the medical director as defined in the Act;
- 2.6. “**CPSO**” means The College of Physicians and Surgeons of Ontario;
- 2.7. “**CPSO Policy**” means CPSO’s Policy and Guidelines for the Delegation of Controlled Acts and Guidelines for teaching Controlled Acts under Section 28 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 and under the *Medicine Act, 1991*, S.O. 1991, c. 30, as either of those Acts may be amended from time to time, or any successor legislation. The Policy and Guidelines are set out in the CPSO document entitled “The Delegation of Controlled Acts” as that document may be amended or replaced from time to time by CPSO;
- 2.8. “**CQI**” Continuous Quality Improvement, means a program to monitor, evaluate and improve the provision of emergency patient care provided by Emergency Medical Attendants and Paramedics covered by this Agreement;
- 2.9. The “**Medical Advisory Board**” (**MAB**) of CEPCP means the physicians appointed by Lakeridge Health as the physician members of CEPCP;
- 2.10. “**Paramedic**” means an individual employed by the Ambulance Service as a paramedic as defined in the Act;
- 2.11. “**Research**” means any method of evaluating a question involving patients and/or providers. This includes qualitative and quantitative measurements;
- 2.12. “**Ambulance Service**” means the Kawartha Lakes Paramedic Service as operated by City of Kawartha Lakes Paramedic Service; and
- 2.13. All other terms and phrases in the agreement shall be interpreted consistent with their meaning under the Act.

### 3. PURPOSE

The purpose of this document is to establish a foundation of clear understanding between the CEPCP and the Ambulance Service regarding the delegation of Controlled Acts (as per CPSO Policy) to:

- 3.1. Ensure and improve the delivery of safe and effective patient care by Paramedics;

- 3.2. Provide an environment of collaborative and cooperative communication between CEPCP and the Ambulance Service;
- 3.3. Ensure that advances in paramedicine take place in the context of continuous quality improvement and evidence-based practice;
- 3.4. Ensure that this agreement is reviewed and ratified by both parties annually; and,
- 3.5. Establish the roles and responsibilities of the parties in order to meet legislated requirements under the governing Acts and regulations.

#### **4. DELEGATION OF CONTROLLED ACTS**

- 4.1. CEPCP, at Lakeridge Health, through its MAB and the Chair of the MAB, shall establish Base Hospital Programs in accordance with CPSO Policy and provincial guidelines, as may be amended from time to time, to provide for the delegation of Controlled Acts to Paramedics of various levels of the Ambulance Service.
- 4.2. These Base Hospital Programs shall be updated as necessary, but in the same manner as provided for the establishment of the original Base Hospital Program, in order to reflect changes in CPSO policy and provincial guidelines, with appropriate notification to the Ambulance Service.
- 4.3. CEPCP agrees that the physicians appointed as MAB members and Chair of the MAB shall be persons authorized by the Regulated Health Professions Act to perform the delegated Controlled Acts and have the necessary qualifications to be the responsible physicians under the CPSO Policy and the Provincial Base Hospital Roles and Responsibilities document.
- 4.4. The MAB will be responsible for delegating Controlled Acts to Paramedics authorized to perform those acts by the MAB.
- 4.5. The MAB and Ambulance Service will collaboratively determine the Controlled Acts performed by Paramedics employed by the Ambulance Service, based upon medical research, current clinically acceptable standards of medical practice, community needs and financial viability, all of which shall be in accordance with the Act and other applicable laws.
- 4.6. CEPCP will ensure, in cooperation with the Ambulance Service, that an objective training, evaluation, and maintenance of certification and authorization process is provided for each Paramedic.

- 4.7. CEPCP will review compliance to medical directives and medical oversight for the delivery of delegated Controlled Acts and medically directed patient care on a regular basis.
- 4.8. CEPCP will immediately notify the Ambulance Service when the delegation of one or more Controlled Acts has been rescinded by the MAB.

## **5. MEDICAL ADVICE RELATING TO PREHOSPITAL PATIENT CARE AND TRANSPORTATION**

- 5.1. CEPCP will make recommendations to the Ambulance Service with respect to patient care and will assist in the review and validation of patient care elements of the Ambulance Service's policies and procedures as requested by the Ambulance Service.
- 5.2. CEPCP will establish a Program Advisory Committee and other related Committees including a Quality of Care Committee to provide for discussion and resolution of issues regarding patient care.
- 5.3. Where the patient care provided by a Paramedic does not meet a medically acceptable level of safety or medically acceptable level of competence and requires remediation from CEPCP, CEPCP will provide the Ambulance Service and the Paramedic with qualitative and quantitative feedback regarding the nature and type of patient care provided by the Paramedic and the nature of the identified patient care deficiency.
- 5.4. CEPCP will participate in disaster planning and management in cooperation with the Ambulance Service, the Province, local hospitals and other key stakeholders when requested.
- 5.5. The CEPCP MAB or designate(s) will provide advice and review of destination agreements when requested.
- 5.6. The CEPCP MAB or their designate(s) will provide advice and review of tiered response agreements when requested.

## **6. TRAINING**

- 6.1. Lakeridge Health will assist the Ambulance Service in the selection of Paramedics for training to become Advanced Care Paramedics when requested.
- 6.2. Lakeridge Health will be responsible for ensuring that the training of paramedics by CEPCP for receiving the delegation of Controlled Acts is in accordance with provincial standards and the CPSO Policy.

- 6.3. The CEPCP MAB will be responsible for approving the training curricula of Paramedics in CEPCP training programs for the delegation of Controlled Acts in accordance with provincial standards and for ensuring that Paramedics trained at other locations or institutions are evaluated and able to demonstrate the level of competency required by CEPCP.
- 6.4. Lakeridge Health will develop and provide reports to the Ambulance Service about the training activities they provide for the Paramedics.

## **7. MAINTENANCE OF CERTIFICATION AND AUTHORIZATION TO PERFORM DELEGATED ACTS**

- 7.1. CEPCP will ensure that an objective candidate training evaluation and maintenance of certification and authorization process is provided for each Paramedic candidate.
- 7.2. The Ambulance Service will advise CEPCP of any changes in the employment status of a Paramedic that may affect his/her certification.
- 7.3. The Ambulance Service will facilitate remedial training required by CEPCP for the continued certification and authorization of a Paramedic for the delivery of Controlled Acts.
- 7.4. CEPCP will deliver, in collaboration with the Ambulance Service, continuing education as required by the provincially approved standards, to all Paramedics.
- 7.5. The Ambulance Service will facilitate the CEPCP continuing medical education programs by providing administrative support for scheduling.
- 7.6. The Ambulance Service may provide assistance by mutual agreement to CEPCP in its delivery of continuing education, maintenance of certification and authorization processes.
- 7.7. CEPCP will specify a remedial plan within a 2 week period of identifying clinical deficiencies or deactivation of a paramedic.
- 7.8. The remedial plan should not take longer than 30 calendar days to complete unless extenuating circumstances exist.
- 7.9. CEPCP will make all reasonable efforts to provide remediation activities local to the Ambulance Service when requested.

## **8. CONTINUOUS QUALITY IMPROVEMENT**

- 8.1. The Ambulance Service will make available electronic copies and raw data, as it exists, of all Ambulance Call Reports (ACRs) for the purposes described in

section 10. Where otherwise agreed, appropriate and in use, and at **no cost** to the Ambulance Service, electronic copies of ACRs will be provided to CEPCP.

- 8.2. CEPCP will develop and implement a continuous quality improvement program to monitor and evaluate paramedic activities related to the performance of Controlled Acts and other patient care activities, that is consistent with recognized industry standards for Quality Management Systems: (for example the principles of ISO 9001:2000 registered programs and/or ASQI) through the following activities:
  - 8.2.1. Monitoring the delivery of Controlled Acts and other patient care activities through statistical process control, chart audits, observation rideouts, outcome studies, and error and “near-miss” reporting; and,
  - 8.2.2. Providing recommendations to the Ambulance Service with respect to medical equipment, pharmaceuticals, and supplies that are required for the performance of Controlled Acts in accordance with applicable standards when requested.
- 8.3. The Ambulance Service will notify CEPCP of deficiencies in ACR completion, medical equipment, pharmaceuticals, and supplies required for the performance of Controlled Acts of a systemic nature.
- 8.4. CEPCP will provide a monthly summary ACR Audit Report to the Ambulance Service within 2 weeks of the end of each month.

## **9. AMBULANCE SERVICE/CEPCP LIASION**

- 9.1. CEPCP and the Ambulance Service will collaboratively schedule liaison meetings to ensure timely formal communication about Base Hospital and Ambulance Service initiatives. These topics and initiatives may include medical directive reviews, local initiatives, education activities and schedules, CQI reporting, and any concerns or questions identified by either party. The meeting frequency will be scheduled on a biannual basis and shall be held at the Ambulance Service. It is also understood and agreed by both parties that in addition to these meetings that inquiries of or communications to each other are expected to occur on an as needed basis via the most expedient and effective means. The goal of the liaison process is open and clear communication.
- 9.2. CEPCP and the Ambulance Service agree that there will be two regional Program Advisory Committee meetings, hosted by Lakeridge Health, scheduled each year.

## **10. INFORMATION SHARING**

### **10.1. Issues Resulting in Information Sharing**

- 10.1.1. Complaints received by the Ambulance Service or clinical deficiencies identified by the Ambulance Service pertaining to medical delegation issues will be forwarded to CEPCP for their investigation and action. CEPCP shall liaise with the Ambulance Service with respect to its investigation and action.
- 10.1.2. CEPCP will investigate complaints it receives pertaining to medical delegation issues. CEPCP will notify the Ambulance Service of the receipt of the complaint/concern and provide the Ambulance Service with a summary of the outcome of the investigation.
- 10.1.3. All other issues received by CEPCP will be forwarded to the Ambulance Service for their review and action.
- 10.1.4. CEPCP will contact the Ambulance Service immediately when a major or critical error is identified.
- 10.1.5. CEPCP will contact the Ambulance Service within 24 hours when a major or critical error is confirmed.

### **10.2. Lead Investigative Organization**

- 10.2.1. The Ambulance Service will be the lead investigative organization regarding all operational issues regardless of the origin of the complaint/concern.
- 10.2.2. CEPCP will be the lead investigation organization regarding all clinical issues involving medical delegation and medical oversight regardless of the origin of the complaint/concern.

### **10.3. Responsibility of Lead Investigative Organization**

- 10.3.1. The lead investigation organization is assigned the authority and responsibility to co-ordinate and/or investigate a complaint or identified issue.
- 10.3.2. The lead investigation organization is responsible for completion of the investigation report.
- 10.3.3. If CEPCP is the lead agency, the final concluding report will be copied to the Ambulance Service.
- 10.3.4. If the Ambulance Service is the lead agency, clinical aspects of the report must be copied to CEPCP.

#### 10.4. Information To Be Shared

10.4.1. Subject to applicable privacy law as described below, the following information may be shared between the organizations:

- 10.4.1.1. Written/typed incident reports completed as a result of an investigation under section 10.1;
- 10.4.1.2. ACRs for the purposes of quality assurance or pertaining to an investigation. See Appendix A relating to local data sharing agreement;
- 10.4.1.3. Final report of concluding actions; and
- 10.4.1.4. Other details as deemed appropriate by the lead agency.

### 11. FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY

11.1. **PHIPA.** The Ambulance Service acknowledges that the CEPCP is a health information custodian bound by the *Personal Health Information Protection Act, 2004*, S.O. 2004 c. 3, Sched. A (PHIPA) and that any personal health information provided to Lakeridge Health in connection with the Agreement may be subject to that Act. The Ambulance Service further acknowledges that CEPCP is subject to the *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F.31 and that this Agreement shall be interpreted in accordance with that Act.

11.2. **MFIPPA and PHIPA.** Lakeridge Health acknowledges that the Ambulance Service is bound by the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990 c. M.56 (MFIPPA) and is a health information custodian bound by PHIPA and that any information provided to the Ambulance Service in connection with the Agreement may be subject to disclosure in accordance with MFIPPA or PHIPA.

11.3. **Confidentiality of records.** Each Party shall ensure that all personal information or personal health information (data) in its custody or under its control is managed in accordance with the provisions PHIPA and any other applicable legislation, including MFIPPA and the Quality of Care Information Protection Act (QCIPA) and applicable internal policies. At all times this data when stored or transmitted electronically will be protected using utilizing industry standard encryption methods, where the encryption method utilized will be no less than AES128. Each party will ensure both electronic and physical safeguards are in place granting only authorized parties access to this data. These safeguards will include: complex passwords that are changed every 120 days, utilizing a password change history of 12 entries, electronically locking equipment when not in use, not sharing credentials between staff and physically locking areas containing equipment that houses this data.

### 12. RESEARCH

- 12.1. The parties acknowledge that Lakeridge Health is required to obtain the approval of the Director of the Emergency Health Services Branch of the Ministry of Health and Long-Term Care for interventional studies or other studies involving Lakeridge Health's resources and that any such studies are subject to the approval referred to herein.
- 12.2. Subject to the approval referred to above, CEPCP, where funded, will collaborate with the Ambulance Service for all clinical research protocols, and where funded to do so, collaborate with the budget for those activities.
- 12.3. The Ambulance Service, at its discretion, may agree to support research conducted by CEPCP with in-kind or financial resources; any such support jointly agreed to by the Ambulance Service and CEPCP shall be included in the budget of each study protocol.
- 12.4. CEPCP and the Ambulance Service will seek advice and input from each other for all publications at least 90 days prior to submission for publication without peer review or, when applicable, submission of the manuscript for peer review. CEPCP and the Ambulance Service each agree to keep confidential prior to publication all information contained in a publication or manuscript that has been submitted by the other for advice and input.
- 12.5. Authorship on any document submitted for publication will be granted in accordance with the guidelines outlined in the Uniform Requirements for manuscripts submitted to biomedical journals (NEJM Vol. 336 (4); 1997: pp309-315) as regularly updated and published.
- 12.6. CEPCP and the Ambulance Service will acknowledge the other party's contributions to the study and/or publication, which do not meet the Uniform Requirements for authorship, in any publication or presentation derived from the study.

### **13. HOLD HARMLESS CLAUSE**

- 13.1. Each Party shall defend, indemnify and hold harmless the other, its elected officials, officers, employees and agents from and against all claims, actions, losses, expenses, costs or damages caused by the Party's negligence or wilful misconduct in relation to the subject matter of this Agreement or any other cause, save and except that which is caused by the negligence, errors or omissions of the Party or those for whom it is in law responsible. Notwithstanding anything contained herein, neither party shall be liable to the other party for any special or indirect damages, however caused.

### **14. TERM AND ANNUAL REVIEW**

- 14.1. The Parties agree that this Agreement shall continue to be in force until it is terminated by either party by providing at least 30 days' written notice to the other party. The parties agree that they will meet on an annual basis to review this Agreement and that such review shall occur more than 30 days in advance of the anniversary of the execution of this Agreement. The review shall be conducted by the senior management staff of the Ambulance Service and CEPCP's manager(s) responsible for the CEPCP program.
- 14.2. In the event that there is a dispute with respect to this Agreement, the parties agree to refer the matter to the next level of management for further discussion and consideration. With respect to CEPCP, the matter shall be referred to the President and CEO. With respect to the Ambulance Service, the matter shall be referred to the Chief Administrative Officer.

**IN WITNESS WHEREOF** the Parties hereto have duly executed this Agreement.

**The Corporation of the City of Kawartha Lakes**

Per:

\_\_\_\_\_  
Cathie Ritchie  
Clerk

\_\_\_\_\_  
Date

\_\_\_\_\_  
Andy Letham  
Mayor

\_\_\_\_\_  
Date

**Lakeridge Health**

Per:

\_\_\_\_\_  
Name  
President & Chief Executive Officer

\_\_\_\_\_  
Date

## Appendix A - Disclosure of Patient Safety Incidents and Harm

### Introduction

The purpose of this Addendum is to:

1. Affirm that patients, their Substitute Decision Maker (SDM) or legal representative are entitled to be informed of all aspects of their care including the right to disclosure of harm that may have occurred during the course of receiving pre-hospital health care.
2. Create a standardized mechanism to disclose patient safety incidents without the attribution of blame.
3. Ensure patients, their SDM or legal representative will receive prompt and thorough interventions for any harm suffered or anticipated, during pre-hospital health care.
4. Ensure Patients, their SDM or legal representative receive the required information as soon as practical.
5. Affirm that disclosure is a process that includes the initial disclosure and post analysis disclosure. Disclosure is an ongoing process that begins when harm is identified and continues through to subsequent discussions depending on the nature of the event.

### Definitions

**“Apology”** – A genuine expression that one is sorry for what has happened. Includes a statement of responsibility if such is determined after analysis (CPSI, 2011).

**“Harm”** – Impairment of structure or function of the body and/or any deleterious effect arising there from. Harm includes disease, injury, suffering, disability and death (CPSI, 2011).

**“Disclosure”** – the process led by the Ambulance Service in cooperation with the Base Hospital by which a Patient Safety Incident is communicated to the patient or substitute decision maker by the Ambulance Service (CPSI, 2011) and for the purpose of the policy means:

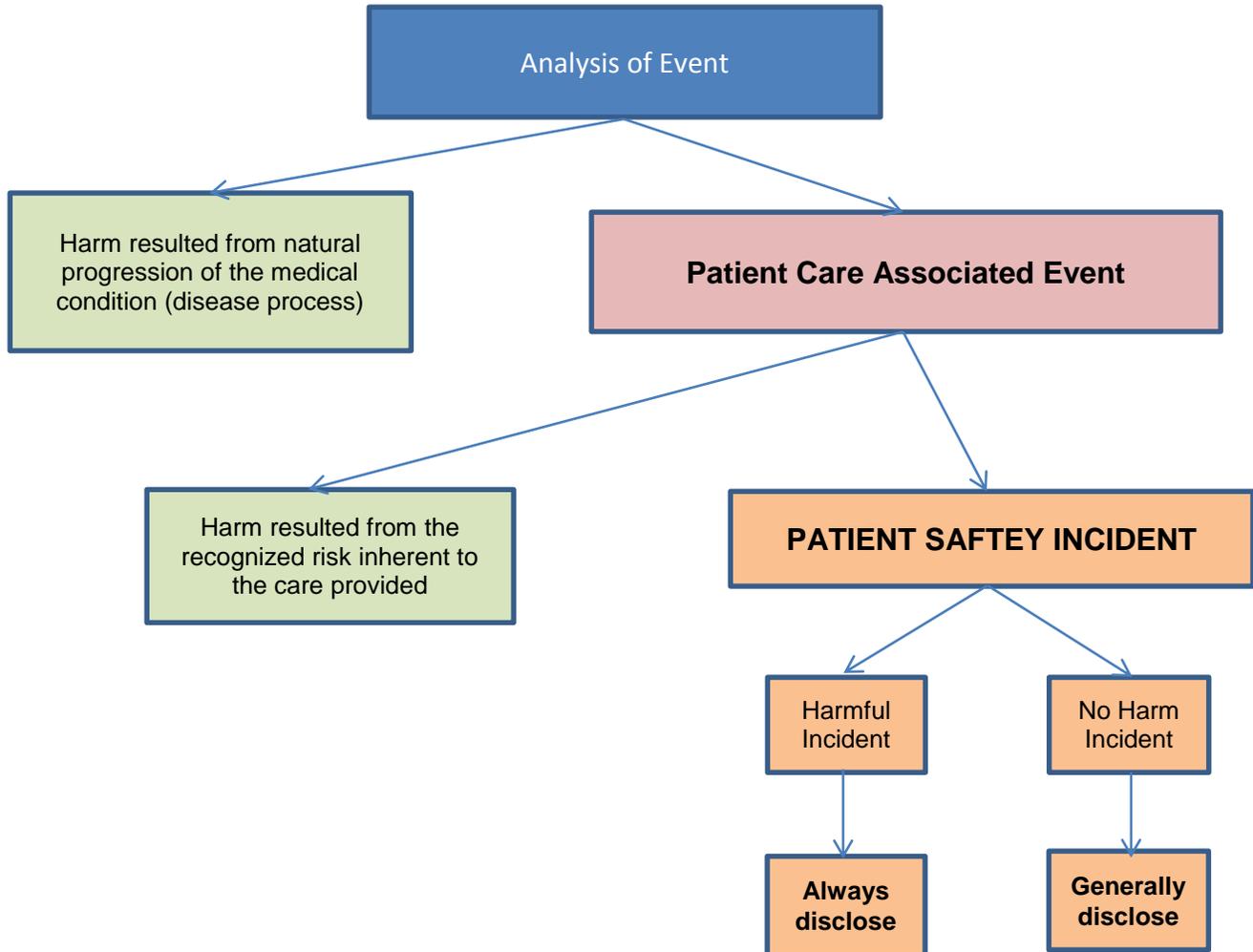
- Initial Disclosure – the discussion led by the Ambulance Service that occurs with the patient or substitute decision maker as soon as reasonably possible after a patient safety event has been reviewed by the programs.
- Post Analysis Disclosure – this second stage of disclosure by the Ambulance Service occurs after an analysis of a patient safety event identifies contributing factors to the event. The patient or substitute decision maker should be updated on this information through continued discussions by the Ambulance Service.

**“Patient Safety Incident”** – An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient (CPSI, 2011). Includes:

- Harmful incident – a Patient Safety Incident that resulted in harm to the patient.
- No Harm incident – a Patient Safety incident which reached the patient but no discernible harm resulted.

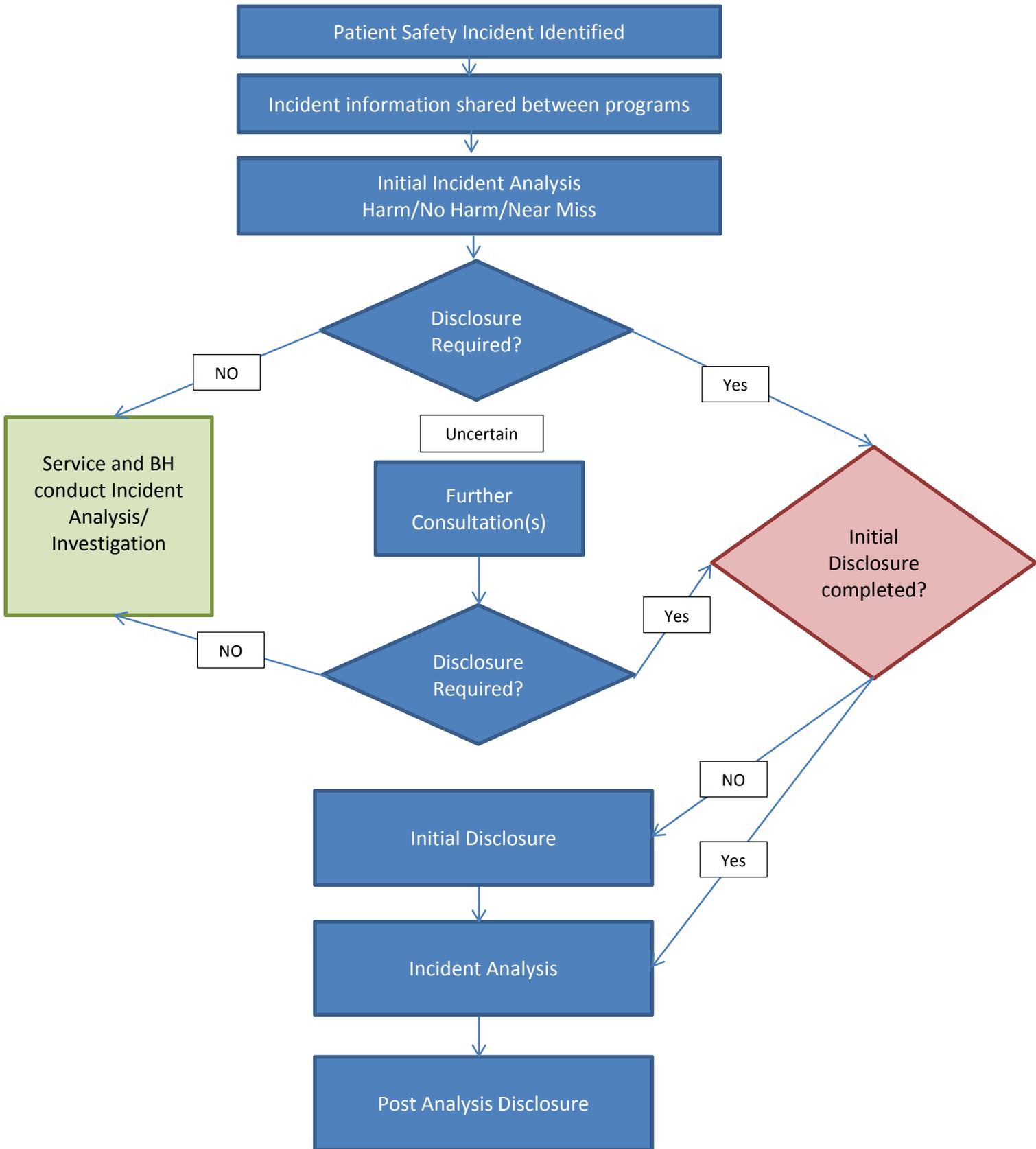
## Indications for Disclosure

Even with the best of care and skill, almost all medical investigations or treatments may result in harm. This holds true in the pre-hospital care environment as well. Whenever a patient suffers harm, whatever the reason, the healthcare provider or organization has an obligation to communicate to the patient about that harm and, if applicable, the event that led to that harm. (CPSI, 2011).



Disclosure is indicated if there has been any harm related to a patient safety incident, or if there is a risk of potential future harm. When uncertain about whether harm has occurred, further consultation may be required including, if appropriate, consulting legal counsel.

In deciding whether to disclose a no-harm incident the Ambulance Service and Base Hospital should consider whether a reasonable person would want to know about the event in the circumstances. Disclosures for "no-harm" events are to follow the same process as when a patient suffers harm.



## **Disclosure Process**

The Ambulance Service and the Base Hospital will work cooperatively on all steps of the disclosure process once a Patient Safety Incident has been identified.

- The Patient Safety Incident will be discussed by both programs to determine if harm occurred and if a Disclosure is required.
- Disclosure should occur as soon as reasonably possible after an incident. However consultation with legal counsel or risk management may be required by either the Ambulance Service or Base Hospital. A period of up to five common working days may be required for a consultation period. In cases where information is required for ongoing patient care, Disclosure may occur immediately.
- In circumstances where Disclosure is not required, each program will conduct an Incident Analysis/Investigation following their own internal processes.
- Where it has been determined that a Disclosure is required the programs will plan and execute the initial Disclosure which shall be delivered by the Ambulance Service, the Incident Analysis and Post Analysis Disclosure
- Paramedics are required to report circumstances where they have identified a Patient Safety Incident to the staff at the receiving facility. In some cases staff at the receiving facility may complete an initial disclosure without notification of the Ambulance Service or Base Hospital. In these circumstances the Ambulance Service and Base Hospital will complete the Incident Analysis and Post Analysis Disclosure.

## **How to Make Disclosure**

Disclosure should occur over two stages: an “initial Disclosure” and a “post-analysis Disclosure”. Initial Disclosure should be provided to the Patient by the Ambulance Service on a prompt basis, and should reflect known facts and immediate next steps in providing health care. Post-analysis Disclosure should be provided by the Ambulance Service once the Patient Safety Incident has been investigated, and the facts relating to that event have been determined. Post-analysis Disclosure generally consists of an update to the initial Disclosure.

The following guidelines should inform how Disclosure is made (whether initial Disclosure or post-analysis Disclosure):

- avoid using the term “error” because it often misrepresents the reasons for an Patient Safety Incident – it also carries with it a sense of blame that is often inappropriate, especially before all the facts are known;
- ask the Patient if he/she would like another person present (e.g. spouse);
- use plain language and avoid medical terminology;
- do not speculate or blame others;
- impress on the Patient how seriously both programs are taking the situation;
- summarize and test for the Patient’s understanding of the facts;
- allow the Patient time to express his or her feelings; and
- allow time for questions.

### **Disclosure Team**

The choice of who will participate/lead in the disclosure meetings is informed by: setting, type of Patient Safety Incident, the severity of the incident and Ambulance Service or Base Hospital Policy.

Consideration for team members:

- Base Hospital Medical Director or designate.
- Ambulance Service Paramedic Chief or designate.
- Base Hospital Clinical lead (Clinical Manager or Coordinator).
- Ambulance Service Professional Standards lead or equivalent.
- The most responsible paramedic provider.

### **Disclosure Location**

The choice of setting and location for Disclosure meetings is important. Meetings should be, to the extent possible:

- In person.
- At a location and time of the patient's preference.
- In a private area to maintain confidentiality.
- In a space that is free from interruptions.

### **What to Disclose at the Initial Disclosure Meeting**

At the initial Disclosure meeting the following information should be provided:

- A description of the Patient's clinical condition as it now exists.
- A description of the facts of the Patient Safety Incident and its outcome, as known at the time.
- An Apology.
- An outline of the steps taken, and the recommended options and decisions, in the care of the Patient.
- The investigative process for the Patient Safety Incident, and what the Patient can expect to learn from the investigation, including appropriate timelines.
- An offer of future meetings, including contact information for relevant individuals.
- An offer of practical and emotional support.

### **Documenting the Initial Disclosure Meeting**

The following information should be documented in respect of the initial Disclosure meeting:

- Time, location and date of meeting.
- Name and roles of those present.
- Facts presented.
- Participants' reactions and responses.

- Questions raised by Patient (and anyone accompanying the Patient) and answers given.
- Agreed-upon next steps.

### **What to Disclose at a Post-Analysis Disclosure Meeting**

At the post-analysis Disclosure meeting with the Patient, the following information should be provided as part of the Disclosure:

- A description and discussion of newly uncovered facts relating to the Patient Safety Incident, if any, including what steps have been taken to prevent similar harm to others.
- An Apology.
- Any appropriate emotional support for all those involved.

### **Documenting the Post-Analysis Disclosure Meeting**

The following information should be documented in respect of the post-analysis Disclosure meeting:

- Time, location and date of meeting.
- Name and roles of those present.
- Facts presented.
- Whether an Apology was provided and what was said in respect of the Apology.
- Participants' reactions and responses.
- Questions raised by Patient (and anyone accompanying the Patient) and answers given.
- Plan for any further follow-up, as necessary.

References;

*The Apology Act, 2009*, S.O. 2009, c. 3.

*Canadian Disclosure Guidelines: Being open and honest with patients and families.* Edmonton AB: Canadian Patient Safety Institute: 2011

*Communicating with your patient about harm.* Disclosure of Adverse Events, The Canadian Protective Association, 2009