



TITLE

DISPUTE PREVENTION AND RESOLUTION IN CLINICAL SETTINGS

SCOPE

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Dispute Prevention and Resolution Policy (#PRR-03)

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January 9, 2023

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To provide direction in preventing and resolving **disputes** between **health care professionals** and **patients / alternate decision-makers** when clinical situations occur regarding whether treatments/interventions are in the patient's best interests, harmful, futile or not clinically indicated.
- To provide direction in preventing and resolving disputes between health care professionals and patients / alternate decision-makers when clinical situations occur regarding the provision, withdrawal or withholding of treatment or other interventions in Critical Care services.
- To facilitate a respectful, transparent, culturally sensitive and consistent dispute resolution process.
- To support health care professionals to report and document their management of preventing and resolving disputes.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

- Health care professionals working with patients receiving Critical Care services shall follow this Procedure. There are three levels of activity required, depending on the circumstances. (See Appendix A: *Critical Care Dispute Resolution Model*.)

- Disputes may arise for patients not receiving Critical Care services. In those instances, it is recommended that health care professionals follow parts or all of this Procedure in consultation with:
 - **accountable leaders**, such as operational site and medical leaders (e.g., Executive Director, Senior Operating Officer, Facility Medical Director);
 - the Alberta Health Services (AHS) Health Law Team, as applicable; and
 - Critical Care services, as applicable and available.
- The AHS *Dispute Prevention and Resolution Procedure Checklist* is an administrative tool intended to support sufficient documentation of the required actions outlined in this Procedure. The Checklist shall be retained outside of the patient's clinical **health record** by:
 - the **most responsible health practitioner (MRHP), responsible administrative leader** or accountable leader; or
 - the AHS Health Law Team, when a dispute escalates to the dispute resolution phase.
- When a dispute arises, the Critical Care Physician shall ensure the use of the AHS *Dispute Prevention and Resolution Procedure Checklist* to:
 - facilitate the appropriate steps to prevent or manage a dispute; and
 - report to the Chief Medical Officer and other operational Senior Leaders when disputes escalate.

PROCEDURE

1. Dispute Prevention: Optimizing Communication and Decision-making

To minimize the risk of dispute, health care professionals shall focus on the following actions to optimize communication and decision-making:

1.1 Decision-making capacity

Capacity is presumed but if questioned, assessment of the patient's capacity to make their own decisions shall be undertaken by the Critical Care Physician or MRHP, or others permitted within their scope of practice to perform a capacity assessment, if needed.

- a) The processes shall be followed to identify the alternate decision-maker(s) for a patient with impaired capacity or who lacks capacity. Refer to the AHS *Consent to Treatment/Procedure(s) – Adults with Impaired Capacity and Adults who Lack Capacity Procedure*.

- b) If, at any time during the care of the patient, one or more members of the health care team feels that the alternate decision-maker(s) is (are) not meeting their duties according to applicable legislation, they may seek advice through the Office of the Public Guardian and the AHS Health Law Team.

1.2 Alternate decision-maker(s)

While the health care team may hold discussions with a number of **family** members, it is important to note that there may be one or more alternate decision-makers who have formal authority to make decisions on behalf of a patient who lacks capacity. Decision-making on behalf of a patient who lacks capacity should be done in accordance with the AHS *Consent to Treatment/Procedure(s)* Policy Suite. Involving family members in these situations also requires compliance with the AHS *Privacy Protection and Information Access* Policy.

- a) On admission to the critical care setting, or as soon as practically possible, the health care team should inquire about the presence of a **personal directive**, guardianship order, court orders or any other documents that might aid in determining the patient's wishes, values and beliefs regarding their health care and/or identifying the alternate decision-maker(s) (and their authorities).
- b) The presence of a personal directive or other available, relevant documents to aid in decision-making should be documented in the patient's health record. A copy of all available relevant documents should be placed on the patient's health record (e.g., guardianship orders, forms, etc.).

1.3 Communication and documentation

While communication is a shared responsibility between health care professionals and the patient / alternate decision-maker(s), health care professionals should ensure that numerous reasonable attempts are made for care to be discussed, agreed upon and delivered, through collaboration and communication with the patient before escalating to the point where dispute resolution is necessary.

- a) Discussions with the patient / alternate decision-maker(s) and/or family members should be documented by the appropriate member of the health care team on the patient's health record, including who was present, a brief description of what was discussed, any decisions arising from the discussion and any areas of contention or disagreement. Any information about the patient's wishes, values and beliefs that may have been given by or to the family verbally should be charted.
- b) It is essential for **medical staff** to clearly document in the patient's health record any discussions with the patient / alternate decision-maker(s)

regarding the recommended treatment and the basis for the medical staff's treatment decision, as well as the details of any consultations or second opinions that are sought.

- c) Health care professionals should identify and document existing circumstances in which a dispute is more likely to occur, indicating the potential for escalation to a dispute (see Appendix B: *Indicators of Potential for Dispute*).
- d) For additional guidance and support to facilitate decision-making, refer to Appendix C: *Resource Guide*, as appropriate.

1.4 Transitions of care

During transitions in health care for patients (whether it is a transition to another health care professional, between shifts or rotations, to another patient care unit or to another health care facility), care should be taken to ensure that information about goals of care and health care decisions are transferred appropriately among **health care providers** as well as the patient and their family as appropriate.

1.5 Support for patients / alternate decision-makers

Patients / alternate decision-makers should be provided with appropriate information to allow them to make informed decisions. Each critical care unit should have consistent practices to ensure that family members are regularly informed about issues pertaining to the patient's care. Such practices should comply with the AHS *Privacy Protection and Information Access Policy*.

- a) It is recommended that a single point of contact is established to facilitate communications with the patient / alternate decision-maker(s), family and health care team.
- b) Members of the health care team should initiate discussion with the patient / alternate decision-maker(s) to assess which internal and external resources may be appropriate and available to address the patient's / alternate decision-maker(s)' concerns and provide support (see Appendix C: *Resource Guide*).
- c) Patients / alternate decision-makers should be provided with appropriate information about the AHS process to address patient concerns and if necessary, the steps to follow throughout the dispute resolution process.

1.6 Supporting communication in complex decision-making

Health care professionals, the patient / alternate decision-maker(s) and/or family members may identify levels of **moral distress** and may seek individual or team support (see Appendix C: *Resource Guide*).

- a) Units must be sensitive to the stressful nature of these disputes on the health care professionals involved. Steps should be taken to ensure that where appropriate and practical, members of the health care team are rotated appropriately so as to not overburden individual health care providers, as appropriate.

2. Complex Decision-Making Processes Prior to Escalation to Dispute

These processes should be undertaken to assist in complex decision-making prior to proceeding to a formal dispute resolution mechanism.

2.1 Communicate dispute escalation to accountable leaders as appropriate

2.2 Seek consensus

All reasonable means shall be undertaken to reach consensus with the patient / alternate decision-maker(s) that respects the health care professionals' clinical judgment and ethical obligations, and to reach resolution at the point of care closest to the patient.

- a) Operational leaders, including the responsible administrative leader and the accountable leader, AHS Health Law Team and Canadian Medical Protective Association (CMPA) external counsel, may be informed and consulted as appropriate, depending on the level of complexity of the decision-making process.
- b) For patients who are **minors**, health care professionals may refer to the *AHS Complex and Essential Pediatric Medical Process Guideline*, which outlines processes to involve Children Services, Clinical Ethics and other stakeholders.
- c) Decisions should be documented as appropriate on the patient's health record.

2.3 Support for the patient / alternate decision-maker(s)

The primary relationship for decision-making is between the patient / alternate decision-maker(s) and the Critical Care Physician or MRHP. Decision-making support for the patient / alternate decision-maker(s) shall include the following steps:

- a) an ethics consultation with the patient / alternate decision-maker(s) and family members as available and appropriate; and
- b) the provision of resource materials as appropriate, acknowledging that these are supplementary tools which do not replace active communication by members of the health care team.

2.4 Health care team contact for patient / alternate decision-maker(s)

Communication with the patient / alternate decision-maker(s) and family is the responsibility of every member of the health care team but it may be helpful to identify a specific member of the health care team (including but not limited to the Patient Care Manager, Social Worker, Critical Care Physician or MRHP) as a liaison to provide consistent communication over time between the patient / alternate decision-maker(s) and/or family and the health care team. This is unlikely to be required for stays limited to a few days. However, for longer stays, it is recommended, particularly when:

- a) there are frequent changes in the Critical Care Physician or MRHP;
- b) there are language or other communication barriers (refer to AHS Interpretation & Translation Services);
- c) there is need for frequent explanations, discussions and support;
- d) there are multiple family members involved; or
- e) there is emerging conflict or mistrust between the patient / alternate decision-maker(s) and/or family and members of the health care team.

2.5 Supporting communication in complex decision-making

Health care professionals shall support best practice for communication and decision-making, establishing trust where possible through some or all of the following:

- a) participating in discussions with the patient / alternate decision-maker(s) and/or family at the point of care, and in care planning, regular and/or scheduled meetings and multidisciplinary conferences;
- b) acknowledging other influences such as ethnic, cultural and spiritual dimensions, as well as levels of stress that may affect decision-making;
- c) ensuring adequate patient clinical assessment and clinical information through medical sub-specialist consultation and/or an independent second opinion from health care professionals who are external to the primary care team;
- d) achieving consensus among the health care team, whenever possible, prior to meeting with the patient / alternate decision-maker(s) in order to provide clear and consistent information;
- e) accessing additional resources as appropriate including, for example, Clinical Ethics consultation, AHS Health Law Team, CMPA, Social Work, and/or Spiritual Care Advisors (see Appendix C: *Resource Guide*); or

- f) ensuring continuity of care. Discussions and decisions are properly documented in the patient's health record and completion of the AHS *Dispute Prevention and Resolution Procedure Checklist*, as applicable.

Decision-making support for health care professionals should also include the following:

- a) participation in discussions between Critical Care Physicians, other Physicians and/or other health care teams to clarify and agree on a treatment plan; and
- b) participation in multidisciplinary and/or multi-program discussions.

2.6 Timely decisions

Decisions should be made in a timely fashion, allowing adequate time for all parties to understand and consider the choices and implications. Patients / alternate decision-makers and health care professionals should be given adequate time in keeping with the clinical situation, and not be subjected to coercion or undue pressure regarding the decision and alternate options.

3. **Dispute Resolution**

When the situation develops into a dispute, there are steps in addition to those above that are required to resolve the dispute.

3.1 Escalation to a dispute

Key triggers indicating the potential for escalation to a dispute may include:

- a) the deterioration or breakdown of communication between the patient / alternate decision-maker(s) and the health care team;
- b) the refusal by the patient / alternate decision-maker(s) to the provision of treatment or the withdrawal of treatment;
- c) incongruence between the patient's / alternate decision-maker(s)' / family's and care providers' beliefs and expectations regarding clinically appropriate care (e.g., a disagreement with the health care team's plan to withhold further treatment);
- d) the health care team has reason to believe that the wishes, values and beliefs of the patient are not being honoured by the alternate decision-maker(s) or the decisions being made by the alternate decision-maker(s) are not consistent with their legal obligations to the patient;
- e) a situation that compresses the amount of time available for decision-making by any party, such as an urgent decision whether to admit the

patient to a critical care unit or the need to deliver emergency health care;
and/or

- f) a difficult decision is to be made where conflict is anticipated but time for decision-making is not available.

3.2 Acknowledgement of a dispute

When health care professionals and the patient / alternate decision-maker(s) acknowledge that a dispute has arisen, the dispute resolution mechanism shall be activated as follows:

- a) operational leaders, including the responsible administrative leader and the accountable leader, shall be informed and consulted;
- b) the AHS Health Law Team shall be informed and consulted;
- c) Physicians involved in the care of the patient are strongly encouraged to consult the CMPA for guidance; and
- d) the Critical Care Physician shall ensure the *AHS Dispute Prevention and Resolution Procedure* Checklist is initiated, if not already in progress.

3.3 Response to a dispute

Initial processes in response to disputes include any combination of the following, in no particular order:

- a) Health care team consensus: The health care team should consider consults as appropriate (e.g., Clinical Ethics, governing bodies, other health care professionals) and attempt to reach a clear consensus regarding the appropriate treatment(s) to be offered. If consensus cannot be achieved among the health care team, the patient / alternate decision-maker(s) should be informed of the differences of opinion regarding options for treatment.
- b) With other members of the health care team as appropriate, the Critical Care Physician or MRHP shall review the history and current status with the patient / alternate decision-maker(s). This discussion, to be documented on the patient's health record, should include:
 - (i) prognosis and the patient's / alternate decision-maker(s)' wishes relating to treatment, and the MRHP's recommended treatment plan;
 - (ii) exploration of why the patient / alternate decision-maker(s) wishes treatment to be commenced, continued or discontinued;

- (iii) rationale for introducing, continuing, withholding or withdrawing life-support treatment;
- (iv) description of palliative care if appropriate; and
- (v) offer of ongoing support from Social Work, Spiritual Care and Clinical Ethics to assist the patient / alternate decision-maker(s) and family with their needs. This support is also available to the health care team (e.g., AHS Leadership, Clinical Ethics, Employee and Family Assistance Program).

3.4 Lack of agreement among alternate decision-makers

Where alternate decision-makers with equal legal authority do not agree about a decision on behalf of a patient (e.g., parents of a minor), this situation may require intervention to resolve their differences.

- a) For adult patients, reviewing relevant legal documents such as the patient's personal directive may help to resolve the disagreement. Health care professionals should:
 - (i) ensure the patient's direction and wishes set out in the relevant legal documents are followed; and
 - (ii) consider whether the alternate decision-makers are making decisions consistent with their legal obligations to the patient.
- b) For patients who are minors, health care professionals should consult with the AHS Health Law Team and may refer to the AHS *Complex and Essential Pediatric Medical Process* Guideline which outlines processes to involve Children Services, Clinical Ethics and other stakeholders.

3.5 Formal processes for dispute resolution

More formal processes to resolve dispute include, but are not limited to the following (these processes may not all be applicable and may occur in varying order depending on the individual situation):

- a) Negotiation: The Critical Care Physician or MRHP or designated members of the health care team should attempt to negotiate a plan of treatment that is acceptable to the patient / alternate decision-maker(s) and the health care team who are actively involved in the patient's care.
- b) Second opinion: If not already undertaken, the patient / alternate decision-maker(s) should be given the opportunity to request an additional opinion and AHS shall take all reasonable steps to facilitate one.

- (i) A range of options should be provided along with the constraints and challenges associated with each option.
 - (ii) The range of consultation could extend from a medical sub-specialty or a second Critical Care Physician, to medical opinions from another institution outside the Zone or province.
 - (iii) The Critical Care Physician or MRHP and the patient / alternate decision-maker(s) should decide, based on consensus, what would be most appropriate. Their decision should be based on content expertise required, clinical scenario, perceived need for objectivity, risks of transporting the patient and timeliness.
 - (iv) The consultation should be based on direct assessment of the patient and review of the relevant investigations and other data, and documented in the patient's health record.
 - (v) The patient / alternate decision-maker(s) should also be provided with a copy of pertinent information from the health record to facilitate a second opinion.
- c) Trial of therapy: A time-limited trial of therapy may result from the negotiation between the decision-maker and the health care team. Trials of therapy require informed consent or a court order.
 - d) Transfer of care: Reviewing whether there is a need to change the members of the health care team (i.e., change of relationships).
 - e) Exploring the use of other internal and external resources (see Appendix C: *Resource Guide*).

3.6 Legal counsel

Involvement of legal counsel should include any or all of the following, as appropriate:

- a) notification of the AHS Health Law Team;
- b) notification of legal counsel for Child and Family Services (through the AHS Health Law Team);
- c) notification of CMPA and request for assistance of legal counsel by involved Physicians. (Physicians are strongly encouraged to contact the CMPA for assistance if not previously contacted. This contact is particularly important when a dispute remains unresolved after a series of internal and informal processes have been followed); and

- d) provision of information about access to external independent legal resources for the patient / alternate decision-maker(s) and family.

3.7 Transfer of care

Under certain conditions, it may be desirable to transfer the care of the patient to an alternative health care professional based upon numerous factors (e.g., availability, resources). The alternative should be decided by consensus by the Critical Care Physician or MRHP and the patient / alternate decision-maker(s). Depending on the patient's care needs and risk of transport, the patient may be transferred to the care of another Critical Care Physician in the same care setting, to another facility within the Zone or province, or a facility outside of the province.

3.8 Situations of impasse

Where the above procedural steps have been followed, and there is an impasse at which treatment or interventions requested by the patient / alternate decision-maker(s) are considered by the health care team to be harmful, futile, not clinically indicated or not in the patient's best interests, and does not agree with the MRHP's determination of appropriate treatment options, or the patient / alternate decision-maker(s) wishes treatment which AHS does not offer/provide, the Critical Care Physician shall proceed as follows:

- a) Together with the health care team and in consultation with the AHS Health Law Team, ensure that appropriate steps in this Procedure have been undertaken by completing the AHS *Dispute Prevention and Resolution Procedure Checklist*.
- b) The Critical Care Physician or MRHP shall develop a proposed treatment plan in consultation with the unit Medical Director and the unit Patient Care Manager. The unit Medical Director and the unit Director / Executive Director will notify relevant senior leadership as identified in the Checklist for the purpose of information and consultation. These stakeholders include the relevant facility and Zone physician and administrative leads. It is the responsibility of each level of leadership to ensure that their senior lead is informed and consulted as appropriate.
- c) The Facility Medical Director, in consultation with the relevant stakeholders including the Zone Medical Lead, shall prepare the Checklist and the proposed treatment plan as recommended by the Critical Care Physician or MRHP, which may be accompanied by a briefing note. This package will require sign-off by the Zone Medical Lead and AHS Health Law Team.

- d) The AHS *Dispute Prevention and Resolution Procedure* Checklist, proposed treatment plan and briefing note (as applicable), collectively the “package”, is then forwarded to the Chief Medical Officer. The Chief Medical Officer will review the package, consider whether actions taken align with AHS values and the objectives and standards set by the Policy and Procedure. Having assessed the package, the Chief Medical Officer shall proceed as follows:
- (i) inform the AHS executive, and other AHS stakeholders as appropriate, of the circumstances and the intention to change the patient’s care in accordance with the Critical Care Physician or MRHP’s assessment of appropriate treatment; and
 - (ii) inform the Critical Care Physician or MRHP of AHS’ support and any additional recommended actions for their consideration and decision to proceed with the proposed treatment plan.
- e) Once the above steps have been completed, in consultation with the AHS Health Law Team, the Critical Care Physician or MRHP informs the patient / alternate decision-maker(s) and/or family of the intent to pursue the proposed treatment plan and provides the patient / alternate decision-maker(s) and/or family with written reasonable advance notice of when the treatment plan will be implemented.
- (i) The notice above shall include a statement that the patient / alternate decision-maker(s) and/or family are entitled to seek legal advice.
 - (ii) Once the notice period has expired and if no legal proceedings have been initiated by the patient / alternate decision-maker(s) and/or family, the consulting Critical Care Physician or MRHP and the health care team may, in appropriate circumstances, proceed with the treatment plan after obtaining legal advice (e.g., from AHS Health Law Team and CMPA).

DEFINITIONS

Accountable leader means the individual who has ultimate accountability to ensure consideration and completion of the listed steps in the management of the *Dispute Prevention and Resolution in Clinical Settings* Policy Suite. Responsibility for some or all of the components of management may be delegated to the appropriate level responsible administrative leader, but accountability remains at the senior level.

Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor’s legal representative, a guardian, a ‘nearest relative’ in accordance with the *Mental Health Act* (Alberta) or an agent in accordance with a Personal Directive or a person designated in accordance with the *Human Tissue and Organ Donation Act*. This also includes what was previously known as the substitute decision-maker.

Capacity means the ability for the patient to 1) understand the nature, risks, and benefits of the procedure and the consequences of consenting or refusing; and 2) understand that this explanation applies to them.

Dispute means a disagreement between the patient and health care professionals regarding the provision and/or withdrawal of treatment or the undertaking of other interventions. Possible manifestations of disputes vary widely and may include: evidence of ongoing problems associated with decision-making not responsive to the usual measures to address communication issues between health care professionals and patients; patients warning that they are considering or have initiated legal proceedings; and/or, health care professionals expressing significant moral distress about patient care.

Family (-ies) means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including but not limited to, family members, friends, and informal caregivers.

Health care professional means an individual who is a member of a regulated health discipline, as defined by the *Health Disciplines Act* (Alberta) or the *Health Professions Act* (Alberta), and who practises within scope and role.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Health record means the collection of all records documenting individually identifying health information in relation to a single person.

Medical staff means Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists, or scientist leaders who have an Alberta Health Services Medical Staff appointment.

Minor means a person aged less than 18 years.

Moral distress means significant angst occurring when personal cherished values and beliefs come into conflict or are placed in jeopardy due to decisions related to a patient. The person feeling the moral distress could be the patient, a member of the patient's family, the patient's proxy decision-maker, a member of the health care team, or an administrator.

Most responsible health practitioner (MRHP) means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by Alberta Health Services to perform the duties required to fulfil the delivery of such a treatment/procedure(s) within the scope of their practice.

Patient means all persons, inclusive of residents and clients, who receive or have requested health care or services from Alberta Health Services and its health care providers. Patient also means, where applicable:

- a) a co-decision-maker with the person; or
- b) an alternate decision-maker on behalf of the person.

Personal directive means a written document in accordance with the requirements of the *Personal Directives Act* (Alberta), in which an adult names an agent(s) or provides instruction

regarding their personal decisions, including the provision, refusal and/or withdrawal of consent to treatments/procedures. A Personal Directive (or part of) has effect with respect to a personal matter only when the maker lacks capacity with respect to that matter.

Responsible administrative leader means the most senior administrative or medical leader involved in helping to manage the Dispute Prevention and Resolution. For example:

- a) Nurse Manager or Program Manager and/or Medical Lead/Director, Clinical Section Chief or Clinical Department Site Chief; or
- b) non-clinical Manager, Site/Facility Lead, Director, Executive Director, or Vice President and/or Facility/Community Medical Director, Clinical Section Chief, Clinical Zone Department Head, Senior Medical Director, or Zone Medical Director.

REFERENCES

- Appendix A: *Critical Care Dispute Resolution Model*
- Appendix B: *Indicators of Potential for Dispute*
- Appendix C: *Resource Guide*
- Alberta Health Services Governance Documents:
 - *Clinical Documentation Directive* (#1173)
 - *Clinical Documentation Process Directive* (#1173-01)
 - *Collection, Access, Use, and Disclosure of Information Policy* (#1112)
 - *Complex and Essential Pediatric Medical Process Guideline* (#HCS-230-01)
 - *Consent to Treatment/Procedure(s) Policy Suite* (#PRR-01)
 - *Consent to Treatment/Procedure(s) – Adults with Impaired Capacity and Adults who Lack Capacity Procedure* (#PRR-01-02)
 - *Dispute Prevention and Resolution in Clinical Settings Policy* (#PRR-03)
 - *Patient Concerns Resolution Policy* (# PRR-02)
 - *Patient Concerns Resolution Process Procedure* (PRR-02-01)
 - *Privacy Protection and Information Access Policy* (#1177).
- Alberta Health Services Forms:
 - *Dispute Prevention and Resolution Procedure Checklist (for Critical Care Services)* (#21096)
 - *Telephone Interpretation Request Form* (#09966)
- Alberta Health Services Resources:
 - *Dispute Prevention and Resolution Quick Reference Guide*
- Non-Alberta Health Services Documents:
 - *Adult Guardianship and Trusteeship Act* (Alberta)
 - *Family Law Act* (Alberta)
 - *Human Tissue and Organ Donation Act* (Alberta)
 - *Mental Health Act* (Alberta)

VERSION HISTORY

Date	Action Taken
January 9, 2020	Revised, includes change in Title from <i>Dispute Prevention and Resolution in Critical Care Settings</i>
Click here to enter a date	Optional: Choose an item

APPENDIX A

Critical Care Dispute Resolution Model

	Level	Conditions/Circumstances	Response
Dispute Prevention: Optimizing Communication and Decision-making	0	<p style="text-align: center;">Usual Practice</p> <ul style="list-style-type: none"> No risks/flags identified. No identified problems with decision-making. 	<p>Baseline Measures:</p> <ul style="list-style-type: none"> Best practices for communication, decision-making, patient/family-centred care, etc. Generally, only care team resources required (including medicine, nursing, social work). Interpreters as required.
	1	<p style="text-align: center;">Increased Risk</p> <p>One or more flags/risks identified.</p>	<p>Baseline measures plus:</p> <ul style="list-style-type: none"> Other internal resources such as Clinical Ethics, Spiritual Care, cultural support, medical subspecialty consultation, Palliative Care, Psychology. Consider external resources such as cultural brokers, community spiritual leaders.
Complex Decision-making	2	<p style="text-align: center;">Problems with Decision-making</p> <ul style="list-style-type: none"> Evidence of problems associated with decision-making not responsive (or not anticipated to respond to) baseline measures & use of internal resources. Care providers express concern about direction/goals of care. 	<p>Baseline measures plus:</p> <ul style="list-style-type: none"> Intensive use of internal and/or external resources, including CMPA*, if appropriate.
Dispute Resolution	3	<p style="text-align: center;">Evidence of Dispute</p> <ul style="list-style-type: none"> Evidence of ongoing problems associated with decision-making not responsive to (or not anticipated to respond to) baseline measures and use of internal resources. Family is threatening to or has initiated legal proceedings. Care providers express significant moral distress about patient care. 	<p>Baseline measures and other internal and external resources as appropriate plus:</p> <ul style="list-style-type: none"> AHS Health Law Team and CMPA*. Patient Relations Department to be notified.

*CMPA = Canadian Medical Protective Association

APPENDIX B

Indicators of Potential for Dispute

1. Circumstances in which dispute is more likely to occur may include (Note: These are not in ranked order):
 - existing barriers to effective communication, including language barriers, hearing or speech impairment;
 - incongruence between family's and care providers' beliefs and expectations: for example, hope for recovery versus discontinuing life-prolonging treatment and moving to comfort measures only;
 - patient's impaired judgment from mental illness or other cause;
 - family is having difficulty processing information due to rapidly changing clinical circumstances, overwhelming emotions, or other causes;
 - prior admissions or prolonged stay in critical care environments, often correlated with complex condition, poor prognosis or other confounding circumstances;
 - lack of clarity regarding who from a family speaks for a patient;
 - fluctuating competence of a patient;
 - obvious discord within a family regarding directions/goals of care;
 - marked differences in religious and/or cultural beliefs and values between the patient/family and care providers;
 - circumstances in which there is possible or confirmed legal, spiritual or cultural ramifications of death for family members (e.g., murder or suicide);
 - any of several factors that may lead to distrust of care providers or a breakdown in communication between family and care providers, including:
 - family's belief that there has been prior occurrence of an error or system failure,
 - family's prior experience with significant unanticipated outcomes, and/or
 - frequent changes in care providers;
 - moral distress amongst care providers;
 - disagreement amongst care providers regarding clinically appropriate care; and
 - obvious breakdown of trust between patients and care providers.
2. Elements contributing to stress:
 - Patient and/or family are from outside of the province.
 - Patient and/or family have a health practitioner background.
 - Family or other alternate decision-makers are actively involved in the provision of care at home.
 - Health care professionals, the patient and/or family are labelling or stereotyping the other party.

APPENDIX C

Resource Guide

Resources for health care team and patients and/or families to support and facilitate decision-making in critical care.

Note: These are not in ranked order.

INTERNAL RESOURCES	EXTERNAL RESOURCES
Cultural support: e.g., Aboriginal Liaison, Diversity Services, etc.	Define/identify Cultural Brokers*
Social Work	
Clinical Ethics	
Spiritual Care	Community spiritual leaders
Translation and Interpretation Services/Interpreters**	
Medical subspecialty consultation	
2 nd medical opinion	2 nd medical opinion
Psychology (limited access)	Psychology
Designated Capacity Assessors	
	Other resources as identified by family
Patient Relations Department 1-855-550-2555	Patient Relations Department Call 1-855-550-2555 or Email: patient.feedback@ahs.ca
Patient Experience Consultant	
Palliative Care	
Alberta Health Services Health Law Team	Legal (Canadian Medical Protective Association)

*Typically has some health care background.

**There is a need for interpreters who have the necessary skills and are able to provide continuity. If family members are translating, it may be difficult because it might be the first time that they hear bad news. There may be an issue of who the health care team trusts and who the family trusts.