REPORT:
CITIZEN ADVISORY GROUP MEETING

Saturday, February 20, 2021

Citizen Advisory Group
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8:30 AM—12:30 PM

AGENDA ITEMS

Item 1: CASLPO: Public Explanatory Document to Accompany New Standards

CASLPO has developed for the first time, a new explanatory document for the public to accompany new standards that audiologists and speech-language pathologists must follow when providing services.

We are asking CAG Members if CASLPO has achieved the right balance for the public in terms of information about the standards. We want to make sure that the public, patients, and families understand the purpose of the standards, know what to expect when receiving services, and know how to ask for clarification of the standards, if required.

Item 2: CNO: Areas of Risk in Nursing

CNO seeks to be proactive in assessing, addressing, and minimizing risk to the public using a variety of strategies throughout our operations.

As we embark on modernizing the CNO Standards of Practice, we would like to better understand areas of harm or risks that patients and caregivers encounter when receiving health care services.

Item 3: CPSO: Early Resolution Process

CPSO is committed to engaging those who make a complaint in a meaningful and timely manner. As part of our effort to support complainants we've provided information about an early resolution process called Alternate Dispute Resolution (ADR) on our website for public review.

We are interested in receiving feedback on the public information available regarding the early resolution process (which includes ADR) as well as validating the resolution process.

CITIZEN ADVISORY GROUP (CAG) REPORT
Saturday, February 20, 2021
Facilitator: Misha Glouberman

The session was called to order at 8:30 a.m. with welcoming comments and an outline of the day's program.

Members convened in small groups in Zoom ("breakout rooms") to meet fellow Members.

DISCUSSION ITEMS:

ITEM 1: COLLEGE OF AUDIOLOGISTS AND SPEECH LANGUAGE PATHOLOGISTS (CASLPO) – PUBLIC EXPLANATORY DOCUMENT TO ACCOMPANY NEW STANDARDS

Q. Do you find the draft Document useful? In what context would this be useful to someone?

Some Members described the draft Explanatory Document as very useful, easy to read, and appreciated that CASLPO created this virtual care resource for the public. Other Members thought that the existing language could be less technical and more user-friendly for certain audiences (e.g., immigrants, newcomers, or English Second Language [ESL]).

Members thought that the draft Explanatory Document would be useful for those who are already comfortable with using virtual care, while the more profession-geared Standards provide good information for a patient or caregiver who may have upcoming virtual care services.

Members highlighted a few considerations around receiving virtual care from an audiologist (AUD) or a speech-language pathologist (SLP). Some of these considerations were:

- Not everyone may be comfortable with virtual care (does not address those who are uncomfortable with virtual care and should consider language and hearing issues);
- Not everyone (e.g., remote communities or those living in poverty) may have access to high-speed internet, a webcam, or a quiet space to access virtual care; and
- Whether the government would recognize virtual hearing tests and if hearing aids would be covered (important to know as a consumer which services are covered under OHIP).

Q. Is the information clearly presented? Are there ways it could be clearer?

Members felt that the draft Explanatory Document could benefit from additional information around CASLPO and the care and services provided by AUDs and SLPs, such as:

- CASLPO's role in protecting the public and explaining concepts like the public registry and practice advice (this information may not be known to the general public);

- A basic explanation of the roles of and services offered by AUDs and SLPs (i.e., the services could be listed as plain-language bullets for easy understanding); and
- Outline the benefits of receiving virtual care services from an AUD or SLP (e.g., especially for services that are particularly challenging to provide virtually).

Additional suggestions from Members to make the draft Explanatory Document clearer were to:

- Use simple and user-friendly language (i.e., ensure the reading level is appropriate so it is accessible to wider audiences, including youth, older adults, ESL, and ensure the resource available in languages other than English);
- Make it more visually appealing using infographics, pictures, and text boxes; and
- Ensure the Explanatory Document is kept to one page.

Q. Does this draft Explanatory Document contain the information you would need? Is there information you would need that isn't in this Document?

Members suggested the following topics could be addressed in the Explanatory Document:

- Concerns about privacy, confidentiality, and security (i.e., how a patient can access virtual care services if they do not own the necessary technology and whether it would be appropriate to use public computers at a library or café for virtual appointments);
- Patient rights (e.g., what to expect; rights throughout the process; proposed benefits of virtual care; which virtual care services are and are not covered by OHIP) and guidance on what you can do if the appointment did not go as expected (e.g., can end the consultation, how to find another provider, and information on how to file a complaint);
- Clarify how the Standards apply to patients who receive virtual care from an Ontario-licensed AUD or SLP and are located in another province (e.g., in the Gatineau area); and
- How the draft Explanatory Document applies to family members and whether they can or cannot help during virtual appointments (and should also include a section for children).

Following these suggestions from Members, CASLPO advised that their website already contains plain-language information written for the public (e.g., CASLPO's mandate, Public Register, and Practice Advice) that could be useful to include in the Explanatory Document.

Given that Members agreed that the Explanatory Document should be kept to a maximum of one page, Members were asked through a show of hands:

Q. To what degree is it helpful to add information to the Explanatory Document? Definitions roles of the college what is practice advice

- Provide the additional information through hyperlinks (not directly in the Document);
- Include the additional information directly in the Document (without hyperlinks); or

- Mix of the two (include some information directly in the Document and some information through hyperlinks).

The majority of Members agreed that a mix of the two would be the most helpful.

ITEM 2: COLLEGE OF NURSES OF ONTARIO (CNO) – AREAS OF RISK IN NURSING

To prioritize areas of risk where there is the greatest potential for harm to the public, CNO asked the CAG to reflect on instances of harm or risk of harm they had witnessed or experienced while receiving care from a nurse in order to better understand the risk of harm from their perspective.

Members were asked to reflect on instances that were meaningful to them and to think about the broad thoughts and themes (i.e., concerns and areas of risk) that emerged. To help facilitate this discussion, CNO provided a list of examples ("themes") where gaps in care may result in risk of harm to patients and invited Members to think more broadly and provide their thoughts and feedback.

Q. Please describe a situation(s), where you have experienced or witnessed, either as a patient or a caregiver, harm or risk of harm associated with nursing care.

Following the breakout rooms, Members returned to the larger group and were asked if any of their accounts of harm or risks of harm fell under any of the following themes provided by CNO:

Theme	Count
Providing medication	6
Transitions in care	5
Communicating with patients and/or health team	12
Respect and dignity	11
Boundaries	3
Maintaining privacy and confidentiality	2

Several Members thought that system-level factors (i.e., institutional or workplace policies; available resources; hospital funding) could result in nurses being overworked which in turn could reduce the quality of nursing care provided and increases the risk of harm to patients:

- Nurses are not always working on an individual basis which could affect their communication with patients and/or the health team (i.e., nurses cannot stop and communicate as much as they would like to);
- Nurses being overworked could result in making small mistakes that could result in big consequences (i.e., small mistakes made lead to larger impacts down the line);
- Despite these constraints, nurses must recognize that each patient is different and ensure that they do not rely on previous assumptions which may interfere with the care patients receive (i.e., personal biases create barriers to nurses being respectful).

Additional concerns and risks of harm identified by Members included the following:

- There is a lack of comfort and transparency when patients are transitioning from hospital care to retirement homes, hospices, or any other external care facility: a skills development/approach towards transitions in care is needed for nurses to ensure patients are not forgotten and left behind;
- The possibility of nurses stealing medication; and
- Providing home care during COVID-19 (e.g., a nurse taking off their mask to attend to phone calls or not properly sanitizing).

Q. What is missing from the list?

Members' feedback largely focused on the importance of nurses honing their "soft skills" around appropriately communicating and educating patients and caregivers to prevent harm:

- Communicate with and respect the input of the patient's family or caregivers as they often know the patient best (i.e., sometimes their input on proposed treatments is disregarded which can lead to inefficiencies and risk of harm);
- Ensure vulnerable populations (e.g., those with mental health concerns or visible minorities) are treated with respect and receive the same standard of care as others;
- Patient-centered care may suffer when patients do not receive adequate education (e.g., a patient who did not receive instructions on how to use equipment to perform a procedure on themselves at home led to big mistakes); and
- Harm may arise if nurses pose barriers to, or prevent, a patient's ability to access other members of the care team (i.e., it is important to create an environment where patients feel comfortable approaching other providers on the team if they have concerns).

Members highlighted the following additional concerns that could be added to the list:

- Risks involving "shortcuts" to make work faster for nurses instead of being less painful for the patient (e.g., IV insertion) or instances of not following up on high-risk matters;
- Nurses working while impaired or if they are incapacitated by a physical or mental condition that negatively impacts their ability to provide nursing care; and
- Sexual abuse (e.g., there was a suggestion to allow patients to be able to choose a nurse of the gender they are most comfortable with).

The possibility of nurses acting as an advocate for the broader health care system was also highlighted (i.e., if nurses have a duty to be a whistleblower when they see things going wrong in the health care system in order to prevent greater harm to society).

Q. Is there anything that the nurse could have done differently in that situation?

Members reflected on situations that they had personally experienced or witnessed and shared how things could have been handled differently. The major theme of this discussion was that

better communication could have improved the situation, especially by listening to the patient or caregiver and/or integrating them as part of the care team:

- Many of the Members noted that the nurse could have shown more empathy and kindness in their situations as well as taking their concerns more seriously.
- Members also discussed that nurses could be more objective and not carry personal biases while working with patients.
- One Member noted that the nurse could have "slowed down" and reflected on what they were doing to adapt to patient's needs. During this discussion, one Member felt that the nurse's assessment and decision-making process could have been more transparent.

ITEM 3: COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO (CPSO) – EARLY RESOLUTION PROCESS

Members reviewed CPSO's Alternative Dispute Resolution (ADR) webpage to provide feedback on the public information available regarding the early resolution process (which includes ADR).

Q. Is the ADR process clear? How could it be clearer?

Most Members agreed that the description of the ADR process was clear: the overview of the process is laid out well, it is easy to read, and the bullet points are well-used.

However, several Members noted it was difficult to *find* this information through the main CPSO website and suggested including the ADR webpage under the 'Public' dropdown menu for easier navigation (especially since the public may not know these processes are available to them).

A few Members felt it was unclear that it is the complainant's decision whether to participate in the process or not and some Members thought clarity was needed around the types of concerns that are appropriate to be resolved through ADR (compared to those concerns with significant allegations or risk of harm which must go through the formal complaints process).

Other constructive suggestions from Members to improve the clarity of ADR process included:

- While easy to follow, the language could be more friendly for the public (i.e., ensure that the information is at a grade six reading level for those who may not be health-literate);
- What happens if the doctor does not agree to ADR and where that leaves the patient (and if the resolution is binding and if this information available on the public register);
- Who other than the patient is entitled to use ADR in cases where the patient is unable to undergo the ADR process themselves (e.g., lawyer, family member, or caregiver);
- How long the ADR process would take and clarity that the process is offered to patients at no cost;

- Whether the patient has a choice in the mediator (CPSO investigator) for ADR (this could appear "top-down" if patients are not able to agree to the mediation *and* the mediator but acknowledged that patients are able to agree or disagree to participate in this format);
- How the doctor-patient relationship would continue after going through ADR and how this could affect the relationship compared to the formal complaints process (i.e., concerns around notification and potentially compromising their relationship); and
- If doctors with a pattern of minor concerns would still be eligible for ADR.

Q. Keeping in mind that the complaints process could be viewed as a negative or emotionally-charged process, does knowing about ADR help reassure you that CPSO wants to meaningfully engage with complainants and make the experience more positive?

Feedback from Members was positive with constructive suggestions regarding messaging and complainant engagement in the processes: Members saw the potential benefits of ADR but wanted to ensure that patients are supported and respected throughout the processes.

Key points from Members during this discussion included the following:

- ADR is a step in the right direction: while it may not be considered "positive" (any dispute or conflict by its definition is hard) it could be considered "better;"
- Power imbalances exist between the doctors and patients (i.e., doctors are well informed about the relevant rules and laws, while in contrast complainants may go into the process cold; acknowledged that it takes a lot to make a complaint in the first place);
- If the doctor-patient relationship does end, patients should be assured that confidentiality around the ADR process will be maintained so there are no pre-existing issues with the patient's new doctor (i.e., doctors have an obligation not to share);
- Having a third party (the mediator) communicate the desires and concerns from the patient's perspective through ADR is beneficial; and
- Regular reviews of the ADR process should be conducted using data collected on the number of resolutions and complainants being satisfied.

While most Members agreed that knowing complainants are called within two days made them feel confident that CPSO is taking concerns seriously, the importance of keeping complainants informed and updated throughout the process was highlighted.

REFLECTIONS ON THE DAY:

Members discussed some areas that went well at the meeting and what could have been done differently.

Q. What went well?

- Well-organized (the timing of the meeting; no technical issues; and good facilitator);

- Questions being provided via chat during the Zoom breakout room discussions was useful (as was using the chat feature in general); and
- The size of the breakout rooms.

Q. What could be done differently?

- Zoom: actively encourage the use of the chat feature as an optional channel for engagement and the groups could have been mixed up one more time (i.e., per item);
- Suggestion to consider involving Members in framing the discussion questions; and
- Suggestion to have a Partner college representative speak to each agenda item and share what they hope to get from the Members to narrow the conversations.

Adjournment

Members were thanked for their input and feedback, and the meeting was adjourned at 12:30 p.m.