Healthcare Excellence Canada
Excellence en santé Canada

Status of Patient Safety Incident Legislation and Best Practices Across Canada

Summary Report
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Contents

About Patient Safety Incident Legislation 3
Cross-jurisdictional Comparison 5
Mandatory Reporting Legislation 5
Mandatory Disclosure Legislation 9
Apology Protection Legislation 12
Quality Assurance Legislation 14
Jurisdictional Highlights 17

About Patient Safety Incident Legislation

Purpose of this Report

This document provides a summary of the status of patient safety incident legislation in federal, provincial and territorial jurisdictions across Canada, and identifies key provisions in legislation across Canada that capture significant policy directions in their patient safety incident legislation.

Background

Healthcare Excellence Canada has prepared a comprehensive background paper on the following four topics:

- mandatory reporting legislation
- mandatory disclosure legislation
- apology protection legislation
- quality assurance legislation

The term "**reporting**" is focused on advising third parties (e.g. regional health authorities, governments, accreditation bodies) generally about patient safety incidents after they occur. Mandatory reporting legislation specifies the circumstances when reporting must take place, and other requirements including the contents of the reports. The term "**disclosure**" is generally used to describe advising those who are impacted by a patient safety incident. Mandatory disclosure legislation specifies the circumstances when disclosure must take place, and other requirements including the contents of the disclosure. **Apology protection** legislation provides that an apology is not an admission of fault or liability. **Quality assurance** legislation prohibits quality assurance information from being used as evidence in legal proceedings. These definitions are not comprehensive, and this document is intended to be used in conjunction with the Background Paper on Comprehensive Patient Safety Incident Legislation.

Policy Purposes of Patient Safety Incident Legislation

There are a number of policy purposes that must be accommodated and reconciled when legislatures are developing or amending patient safety incident legislation. The key policy issues are:

- encourage healthcare professionals to share information and hold open discussions in order to lead to improvements in patient care and safety;
- promote disclosure of patient safety incidents to patients and their families;
- encourage trust in the healthcare system through transparency;
- encourage analysis of patient safety incidents and sharing of results in order to learn from those incidents; and
- encourage reporting of patient safety incidents and dissemination of results following analysis.

In 2007, the Uniform Law Conference of Canada or ULCC developed a Uniform Apology Act following the enactment of apology protection legislation in British Columbia and Saskatchewan. The ULCC concluded that uniform apology legislation is desirable, and noted as follows:

> *Torts are not necessarily confined within provincial or territorial borders. People may do or suffer harm away from home. The human and legal consequences should be predictable across the country. Thus a harmonized legal approach would be beneficial.*

Ideally, there would be consistency across other areas of patient safety incident legislation for the same reason. Patients receive care in different jurisdictions across Canada, and the approach to patient safety incidents ought to be harmonized and predictable.

Cross-jurisdictional Comparison

Mandatory Reporting Legislation

The term “reporting” is focused on advising third parties (e.g. regional health authorities, governments, accreditation bodies) generally about patient safety incidents.

Common characteristics of mandatory reporting legislation:

- **What incidents are reportable**

  Defining events or circumstances which could have resulted, or did result, in unnecessary harm to a patient.

- **People who can report incidents**

  Patients and families are a potentially rich resource for learning and improving patient safety. They can provide timely and important information about the safety of care as much as care providers can.

- **Protection of reporters**

  Reporters are free from fear of retaliation against themselves or punishment of others as a result of reporting.

- **Contents of the incident review report**

  The review and recommendations should focus on changes in systems, processes, or products, rather than targeting individual performance. The identities of the patient, reporter, and healthcare provider are not revealed.

- **Recipient(s) of the initial reported incident as well as the final incident review report**

  Which third parties receive the report and who is responsible for implementing recommended actions in the final report.

- **Timelines for reviewing the incident and creating a final report**

  Reports are analyzed promptly, and recommendations are disseminated to those who need to know. The entity that receives reports is capable of disseminating recommendations.

- **Protection of information generated through the investigating and reporting of critical incidents**

Information that is gathered through the review and investigation of a critical incident is subject to protections that are similar to those provided by legislation protecting quality assurance information.

As noted in the WHO Guidelines, reporting is only of value if it leads to a constructive response. Research shows that a crucial step to learn from incident reporting is about "closing the loop" between reporting and feedback for learning. Despite the importance of "closing the loop" between reporting and feedback, there is very little guidance in the legislation regarding what must be done by the external entity that receives the report.

This type of reporting to third parties may be combined with public reporting, which is intended to foster accountability to the public.

There is also federal legislation that covers mandatory reporting. The Protecting Canadians from Unsafe Drugs Act (also known as Vanessa's Law) received royal assent on November 6, 2014. The goals of Vanessa's Law are set out in the statute as follows:

- to strengthen safety oversight of therapeutic products throughout their life cycle;
- to improve reporting by certain healthcare institutions of serious adverse drug reactions and medical device incidents that involve therapeutic products; and
- to promote greater confidence in the oversight of therapeutic products by increasing transparency.

Vanessa's Law has been coming into force in stages as regulations are developed.

For **Mandatory Reporting legislation**, the following are exemplars: New Brunswick's *Health Quality and Patient Safety Act*, Northwest Territories' *Hospital Insurance and Health and Social Services Administration Act*, Saskatchewan's *Provincial Health Authority Act* and Manitoba's *Regional Health Authorities Act*.

Cross-Jurisdictional Comparison of Mandatory Reporting Legislation

Jurisdiction	Mandatory Reporting Legislation?	Additional Information
British Columbia	Yes	Pertains to private and public hospitals only.
Alberta	Yes	Pertains to residential addiction treatment services only.
Saskatchewan	Yes	
Manitoba	Yes	

Ontario	Yes	Pertains to critical incidents in hospitals and medication incidents / adverse drug reactions in long-term care homes only.
Quebec	Yes	
Nova Scotia	No	
New Brunswick	Yes	
Prince Edward Island	No	
Newfoundland & Labrador	Yes	Provides for regulations to set out the details of reporting, and the regulations have not yet been finalized.
Yukon	No	
Northwest Territories	Yes	
Nunavut	No	

Opportunities for improvement

The World Health Organization published "Draft Guidelines for Adverse Event Reporting and Learning Systems" in 2005 ("WHO Guidelines"). The following principles are identified in the WHO Guidelines as benchmarks for successful reporting systems:

- Non-punitive: Reporters are free from fear of retaliation against themselves or punishment of others as a result of reporting.
- Confidential: The identities of the patient, reporter, and institution are never revealed.
- Independent: The reporting system is independent of any authority with power to punish the reporter or the organization.
- Expert analysis: Reports are evaluated by experts who understand the clinical circumstances and are trained to recognize underlying system failures.
- Timely: Reports are analyzed promptly and recommendations are rapidly disseminated to those who need to know, especially when serious hazards are identified.
- Systems-oriented: Recommendations focus on changes in systems, processes, or products, rather than targeting individual performance.
- Responsive: The agency that receives reports is capable of disseminating recommendations. Participating organizations commit to implementing recommendations whenever possible.

Mandatory reporting legislation can reflect these principles by providing for:

- timelines for those who report patient safety incidents;
- contents of reports in order to facilitate analysis and dissemination of results;
- consistent terminology in order to allow for accurate comparisons and compilation / dissemination of results across jurisdictions;
- protection from retaliation for persons who report patient safety incidents;
- confidentiality for persons who report and those who are involved in the patient safety incidents;
- protection for the reports from production in legal proceedings that is similar to protection of quality assurance information; and
- obligations for recipients of the reports to analyze the information and disseminate the results.

Mandatory Disclosure Legislation

The goal of mandatory disclosure legislation is to ensure consistent communication to patients and families when a patient safety incident has occurred.

In legislation, it's important to provide clarity on:

- **Who must disclose**
  As healthcare is delivered in teams, it's important to be clear on who is responsible for disclosing the incident to the patient and family.
- **Events that trigger the duty to disclose**
  Defining events or circumstances which could have resulted, or did result, in unnecessary harm to a patient.
- **Information to be disclosed**
  Including the facts, consequences, health services provided as a result of the incident, and the recommendations and steps taken to avoid the incident from happening again.
- **Timing of disclosure**
  Disclosure is an ongoing process where information should be disclosed to the patient and family as it becomes available. Recommendations and steps taken for improvement that were made should also be shared with the patient and family.
- **Information to be recorded in the patient record**
  Proper documentation of the incident and disclosure is conducted and is shared with the patient and family.

These legislative provisions complement legislation protecting quality assurance information. Facts that are discovered through the quality assurance process are not shielded from disclosure.

When comparing the legislation in place, it was discovered that the terminology used in legislation is not consistent, and the same term is defined differently. This becomes a higher risk when patients from other jurisdictions travel for treatment.

For **mandatory disclosure** legislation – New Brunswick's *Health Quality and Patient Safety Act*, Newfoundland / Labrador's *Patient Safety Act** and Manitoba's *Regional Health Authorities Act* are exemplars. Currently, 8 of 13 jurisdictions in Canada have mandatory disclosure legislation in place.

Cross-Jurisdictional Comparison of Mandatory Disclosure Legislation

Jurisdiction	Mandatory Disclosure Legislation?	Additional Information
British Columbia	No	
Alberta	Yes	Pertains to residential addiction treatment services only.
Saskatchewan	Yes	Pertains to personal care homes only.
Manitoba	Yes	
Ontario	Yes	Pertains to critical incidents in hospitals and medication incidents / adverse drug reactions in long-term care homes only.
Quebec	Yes	
Nova Scotia	No	
New Brunswick	Yes	
Prince Edward Island	No	
Newfoundland & Labrador	Yes	Provides for regulations to set out the details of disclosure, and the regulations have not yet been finalized.*
Yukon	No	
Northwest Territories	Yes	Provides for regulations to set out the details of disclosure, and the regulations have not been finalized.
Nunavut	No	

Opportunities for improvement

Although many jurisdictions have mandatory disclosure legislation, many do not cover the breadth of patient safety incidents that occur. It is important to ensure legislation covers all healthcare sectors. Mandatory disclosure legislation should specify what must be disclosed to the patient as soon as possible after the patient safety incident occurs, as well as what must be disclosed following an incident review. The following information should be disclosed to the patient and noted on the patient record: a record of when the disclosure was made; the material facts of what occurred with respect to the patient safety incident; a description of the cause or causes, if known; the consequences for the patient as they become known; and the actions taken and recommended to be taken to address the consequences to the patient. Following

initial disclosure, patients should be informed of the systemic steps, if any, that have been or will be taken in order to avoid or reduce to risk of future similar patient safety incidents.

Apology Protection Legislation

Apology protection legislation helps facilitate transparency between organizations, care providers and patients and families when patient safety incidents occur. By providing legal protection to organizations and care providers, organizations and individuals can express sympathy surrounding the incident without the fear that these discussions can be considered an admission of fault or liability and be used against them in court. It is believed that when organizations and providers can demonstrate compassion, this will lead to quicker resolutions.

The Uniform Law Conference summarizes the goals of apology protection as follows:

- to encourage timely, less litigious modes of resolving legal disputes
- to encourage inter-personal reconciliation
- to encourage personal responsibility

Apology protection legislation has been enacted across Canada with 12 of 13 jurisdictions having legislation in place. The provisions in all jurisdictions are consistent and based on the *Uniform Apology Act*.

Cross-Jurisdictional Comparison of Apology Protection Legislation

Jurisdiction	Apology Protection Legislation?
British Columbia	Yes
Alberta	Yes
Saskatchewan	Yes
Manitoba	Yes
Ontario	Yes
Quebec	Yes
Nova Scotia	Yes
New Brunswick	Yes
Prince Edward Island	Yes
Newfoundland & Labrador	Yes
Yukon	No
Northwest Territories	Yes
Nunavut	Yes

Opportunities for improvement

The Uniform Law Conference of Canada or ULCC was founded in 1918 to harmonize the laws of the provinces and territories of Canada, and where appropriate the federal laws as well. The work of the ULCC with the development of the *Uniform Apology Act* has influenced the development of apology protection legislation across Canada. As such, apology protection legislation provides an example of the importance of model legislation in ensuring that there is consistency across jurisdictions. Yukon is the only Canadian jurisdiction without apology protection legislation.

Quality Assurance Legislation

The fundamental purpose behind quality assurance legislation is to ensure patient safety incidents are analyzed in a manner that encourages open discussion and fosters system improvement. For that reason, this legislation prohibits quality of care information from being used as evidence in legal proceedings.

Common characteristics of the legislation include:

- What type of healthcare body is establishing the committee
- Whose communications are protected
- What communications and information are protected
- Definition of Legal Proceedings
- Impact of Legislation Governing Access to Information
- Prohibition on Use in Legal Proceedings
- Involvement of Patients
- Legislative Review

It is essential to acknowledge that there are very strong countervailing policy issues, including openness with patients and their families and transparency regarding how health services providers deal with patient safety incidents. Quality assurance legislation is intended to complement mandatory disclosure legislation by making it clear that legislation protecting quality assurance information does not interfere with disclosure to patients and their families. An explicit recognition of the need to accommodate these policy issues is an important part of the legislative scheme.

The principle of transparency and public accountability is also a policy concern. The public is keen to know about patient safety incidents in the publicly-funded healthcare system and what is being done to learn and prevent them. Some believe that having this information available to the public will improve accountability. These policy issues may be reconciled and accommodated by ensuring that protection for quality assurance information is limited to clearly articulated and well-defined circumstances.

For this particular legislation – Ontario's *QCIPA 2016* and Nova Scotia's *Quality-improvement Information Protect Act* are exemplary. Ontario is the only province with a preamble for quality assurance protection legislation, and this could be considered in other jurisdictions. It provides an important tool for interpretation of the legislation in the future, and explicitly acknowledges the key policy directions that must be accommodated and reconciled.

Cross-Jurisdictional Comparison of Quality Assurance Legislation

Jurisdiction	Quality Assurance Legislation?	Additional Information
British Columbia	Yes	Legislation can be amended to clarify that certain categories of information are not protected e.g., the facts, causes of the incident, consequences for the patient, actions or recommended actions to address the consequences for the patient, and steps to avoid the risk of future patient safety incidents.
Alberta	Yes	Legislation can be amended to clarify that certain categories of information are not protected e.g., the patient record, facts, the causes of the incident, consequences for the patient, actions or recommended actions to address the consequences for the patient, and steps to avoid the risk of future patient safety incidents.
Saskatchewan	Yes	Legislation can be amended to clarify that certain categories of information are not protected e.g., the causes of the incident, consequences for the patient, actions or recommended actions to address the consequences for the patient, and steps to avoid the risk of future patient safety incidents.
Manitoba	Yes	
Ontario	Yes	
Quebec	Yes	
Nova Scotia	Yes	
New Brunswick	Yes	
Prince Edward Island	Yes	Legislation can be amended to clarify that certain categories of information are not protected e.g., the causes of the incident, consequences for the patient, actions or recommended actions to address the consequences for the patient, and steps to avoid the risk of future patient safety incidents.
Newfoundland & Labrador	Yes	
Yukon	Yes	Legislation can be amended to clarify that certain categories of information are not protected e.g., the facts, causes of the incident, consequences for the patient, actions or recommended actions to address the consequences for the patient, and steps to avoid the risk of future patient safety incidents.

Jurisdiction	Quality Assurance Legislation?	Additional Information
Northwest Territories	Yes	Legislation can be amended to clarify that certain categories of information are not protected e.g., the patient record, facts, the causes of the incident, consequences for the patient, actions or recommended actions to address the consequences for the patient, and steps to avoid the risk of future patient safety incidents.
Nunavut	Yes	Legislation can be amended to clarify that certain categories of information are not protected e.g., the patient record, facts, the causes of the incident, consequences for the patient, actions or recommended actions to address the consequences for the patient, and steps to avoid the risk of future patient safety incidents.

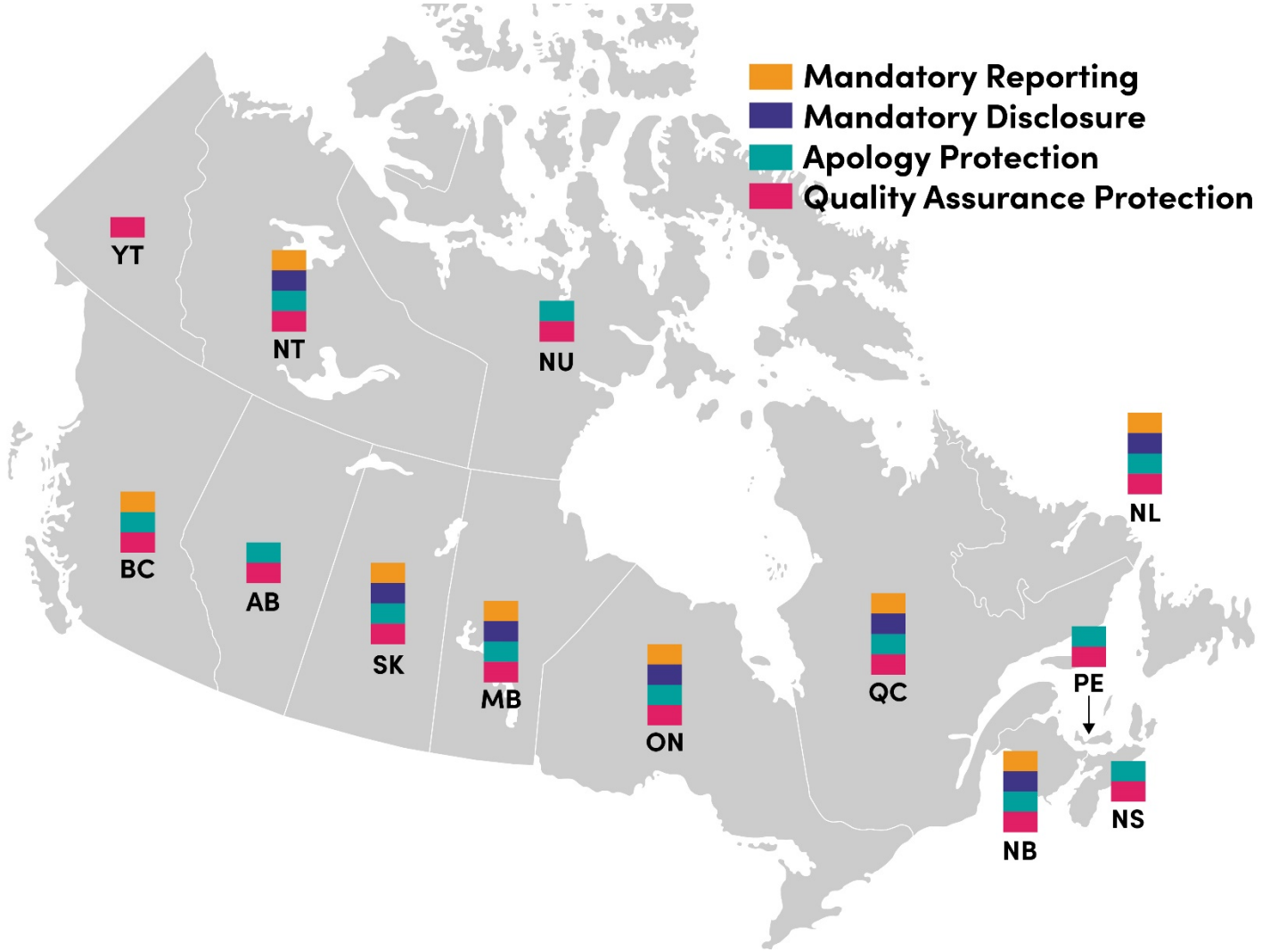
Opportunities for improvement

Legislation can clarify that the following categories of information do not receive protection:

- information contained in a patient record;
- information that consists of facts contained in a record of a patient safety incident;
- information relating to a patient in respect of a patient safety incident that describes,
    - facts of what occurred with respect to the patient safety incident,
    - what the quality of care committee or entity establishing the committee has identified as the cause or causes of the incident,
    - the consequences of the patient safety incident for the patient, as they become known,
    - the actions taken and recommended to be taken to address the consequences of the patient safety incident for the patient, including any healthcare or treatment that is advisable, or
    - the systemic steps that a health facility or the entity establishing the committee is taking or has taken in order to avoid or reduce the risk of future similar incidents.

Legislation should specifically permit sharing of quality assurance information among quality of care committees.

Jurisdictional Highlights – Status of Patient Safety Incident Legislation



British Columbia

Legislation Type	Current State
Mandatory Reporting Legislation	A regulation under BC's Hospital Act requires that private and public hospitals report serious adverse events. There is limited coverage. Further, the legislation needs to be updated in order to reflect current policy directions.
Mandatory Disclosure Legislation	BC does not have legislation mandating disclosure.
Apology Protection Legislation	BC is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format. (BC was the first province to enact apology protection legislation.)
Quality Assurance Protection	BC has legislation mandating protection of quality assurance information, however, it needs to be updated in order to reflect current policy directions.

Comments on Future Legislative Development: BC has limited patient safety incident legislation. There is no mandatory disclosure legislation, and there are significant gaps in the mandatory reporting legislation, including a lack of protection for reporters from retaliation.

Alberta

Legislation Type	Current State
Mandatory Reporting Legislation	Alberta has recently enacted legislative provisions mandating disclosure for residential addiction treatment services. There is a major gap in coverage.
Mandatory Disclosure Legislation	Alberta has recently enacted legislative provisions mandating disclosure only for residential addiction treatment services. There is a major gap in coverage.
Apology Protection Legislation	Alberta is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format.
Quality Assurance Protection	Alberta has legislation mandating protection of quality assurance information, however, it needs to be updated in order to reflect current policy directions.

Comments on Future Legislative Development: Alberta has moved very cautiously into the development of patient safety incident legislation. This presents an opportunity to consider leading policy positions and incorporate them into legislation.

Saskatchewan

Legislation Type	Current State
Mandatory Reporting Legislation	Saskatchewan has mandatory reporting legislation in statutes governing the Provincial Health Authority, medical imaging, and personal care homes.
Mandatory Disclosure Legislation	Saskatchewan has legislation mandating disclosure for personal care homes. As a result, there is a gap in coverage.
Apology Protection Legislation	Saskatchewan is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format.
Quality Assurance Protection	Saskatchewan has legislation mandating protection of quality assurance information.

Comments on Future Legislative Development: Saskatchewan is a leader in Canada in the enactment of mandatory reporting legislation. Their legislation incorporates Critical Incident Reporting Guidelines which were first published in 2004. There is very limited coverage for mandatory disclosure legislation which presents an opportunity to consider leading policy positions and incorporate them into legislation.

Manitoba

Legislation Type	Current State
Mandatory Reporting Legislation	Manitoba has mandatory reporting legislation (*Regional Health Authorities Act)*.
Mandatory Disclosure Legislation	Manitoba has mandatory disclosure legislation (*Regional Health Authorities Act)*.
Apology Protection Legislation	Manitoba is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format.
Quality Assurance Protection	Manitoba has quality assurance legislation *(Manitoba Evidence Act).*

Comments on Future Legislative Development: Manitoba did a comprehensive update of patient safety legislation in 2005 and maintains provisions in separate statutes. It is the leading Canadian example of legislation that incorporates current policy directions using this model. This model works best where the requirements are placed in legislation that regulates regional health authorities, in order to ensure broad coverage.

Ontario

Legislation Type	Current State
Mandatory Reporting Legislation	Ontario has mandatory reporting legislation focused on critical incidents in hospitals and medication incidents / adverse drug reactions in long-term care homes. As such, there is a gap in coverage.
Mandatory Disclosure Legislation	Ontario has mandatory disclosure legislation focused on critical incidents in hospitals and medication incidents / adverse drug reactions in long-term care homes. As such, there is a gap in coverage.
Apology Protection Legislation	Ontario is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format with one exception. The standard format provides that an apology cannot be used as confirmation or acknowledgment of a cause of action to extend a limitation period. The Ontario legislation does not affect whether an apology constitutes an acknowledgment of liability for the purposes of a limitation period.
Quality Assurance Protection	Ontario has legislation mandating protection of quality assurance information that incorporates leading policy directions.

Comments on Future Legislative Development: Ontario enacted legislation protecting quality assurance information at the same time as health information legislation in 2004 (QCIPA 2004). As such, it had an opportunity to review legislation protecting quality assurance legislation from other Canadian jurisdictions. Following the implementation of QCIPA 2004, there were a number of comments and concerns. The legislation was completely updated in 2016 following an extensive consultation with published results. The current legislation, QCIPA 2016, is very useful because it explicitly reflects and incorporates key policy concerns. The provisions in QCIPA 2016 provide a useful template for a variety of policy issues. Legislation regarding mandatory reporting and mandatory disclosure requires an update in order to provide broader coverage.

Quebec

Legislation Type	Current State
Mandatory Reporting Legislation	Quebec has mandatory reporting legislation.
Mandatory Disclosure Legislation	Quebec has mandatory disclosure legislation.
Apology Protection Legislation	Quebec is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format.
Quality Assurance Protection	Quebec has legislation mandating protection of quality assurance information.

Comments on Future Legislative Development: Quebec is the only civil law jurisdiction in Canada. (The rest are common law.) Quebec has comprehensive patient safety incident legislation.

New Brunswick

Legislation Type	Current State
Mandatory Reporting Legislation	New Brunswick enacted mandatory reporting legislation in 2018.
Mandatory Disclosure Legislation	New Brunswick enacted mandatory disclosure legislation in 2018.
Apology Protection Legislation	New Brunswick is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format.
Quality Assurance Protection	New Brunswick has legislation mandating protection of quality assurance information. New Brunswick enacted comprehensive patient safety legislation in 2018 that supplements the protection in the Evidence Act. Specifically it provides for the creation of quality of care and safety of patients committees, and stipulates that no statement made or answer or evidence given in the course of any quality review by the quality of care and safety of patients committee is admissible in evidence against any person in any court or at any inquiry or in any other proceedings.

Comments on Future Legislative Development: New Brunswick is the first Canadian jurisdiction that has standalone comprehensive patient safety legislation. The *Health Quality and Patient Safety Act* covers apology protection, mandatory disclosure and mandatory reporting of patient safety incidents, and quality assurance protection. A comprehensive statute makes it easier to ascertain policy directions and the inter relationships among the different provisions. The *Health Quality and Patient Safety Act* is an excellent model for jurisdictions, such as Alberta and Yukon that have not enacted legislation in key areas. The provisions in the *Health Quality and Patient Safety Act* provide a useful template for a variety of policy issues. Further, the statute uses the term “patient safety incidents” which is the preferred terminology.

Nova Scotia

Legislation Type	Current State
Mandatory Reporting Legislation	Nova Scotia does not have mandatory reporting legislation.
Mandatory Disclosure Legislation	Nova Scotia does not have mandatory disclosure legislation.
Apology Protection Legislation	Nova Scotia is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format.
Quality Assurance Protection	Nova Scotia did a comprehensive update of legislation mandating protection of quality assurance information and enacted a standalone statute in 2015 (*Quality-improvement Information Protection Act*).

Comments on Future Legislative Development: Nova Scotia had the benefit of the experience with Ontario's QCIPA when developing a standalone statute that focuses on protection of quality assurance information. Nova Scotia's *Quality-improvement Information Protection Act* incorporates leading policy directions. This important work on quality assurance protection legislation provides Nova Scotia with a good foundation for the development of patient safety incident legislation in two other areas: mandatory disclosure legislation, and mandatory reporting legislation.

Prince Edward Island

Legislation Type	Current State
Mandatory Reporting Legislation	PEI does not have mandatory reporting legislation.
Mandatory Disclosure Legislation	PEI does not have mandatory disclosure legislation.
Apology Protection Legislation	PEI is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format.
Quality Assurance Protection	PEI has legislation mandating protection of quality assurance information. However, it needs to be updated in order to reflect current policy directions.

Comments on Future Legislative Development: PEI has limited patient safety incident legislation. This presents an opportunity to consider leading policy positions and incorporate them into new legislation.

Newfoundland & Labrador

Legislation Type	Current State
Mandatory Reporting Legislation	Newfoundland / Labrador enacted mandatory reporting legislation in 2017 (*Patient Safety Act*).
Mandatory Disclosure Legislation	Newfoundland / Labrador enacted mandatory disclosure legislation in 2017 (*Patient Safety Act*).
Apology Protection Legislation	Newfoundland / Labrador is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format.
Quality Assurance Protection	Newfoundland / Labrador has legislation mandating protection of quality assurance information.

Comments on Future Legislative Development: Newfoundland / Labrador has recently enacted legislation that covers mandatory reporting and mandatory disclosure. There is still a great deal of detail left to be set out in the regulations. This is another jurisdiction that is following the trend to have standalone statutes that address patient safety matters rather than incorporating the provisions into more general legislation.

Yukon

Legislation Type	Current State
Mandatory Reporting Legislation	Yukon does not have mandatory reporting legislation.
Mandatory Disclosure Legislation	Yukon does not have mandatory disclosure legislation.
Apology Protection Legislation	Yukon is the only jurisdiction without apology protection legislation.
Quality Assurance Protection	Yukon has legislation mandating protection of quality assurance information, however, it needs to be updated in order to reflect current policy directions.

Comments on Future Legislative Development: Yukon has not developed patient safety legislation in the key areas of apology protection, mandatory disclosure, and mandatory reporting; this presents an opportunity to consider leading policy positions and incorporate them into legislation.

Northwest Territories

Legislation Type	Current State
Mandatory Reporting Legislation	NWT enacted mandatory reporting legislation in 2016 *(Hospital Insurance and Health and Social Services Administration Act)*. The Act provides for regulations to set out the details of critical incident reporting, and the regulations were finalized in 2020.
Mandatory Disclosure Legislation	NWT enacted mandatory disclosure legislation in 2016 (*Hospital Insurance and Health and Social Services Administration Act)*. The Act provides for regulations to set out the details of critical incident disclosure, and the regulations have not been finalized.
Apology Protection Legislation	NWT is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format.
Quality Assurance Protection	NWT has legislation mandating protection of quality assurance information, however, it needs to be updated in order to reflect current policy directions.

Comments on Future Legislative Development: NWT has incorporated current policy directions in the regulation setting out the details of mandatory reporting (Critical Incident Reporting and Investigation Regulation). To date, there is no regulation setting out the details of mandatory disclosure. This is an opportunity to consider leading policy positions and incorporate them into mandatory disclosure legislation.

Nunavut

Legislation Type	Current State
Mandatory Reporting Legislation	Nunavut does not have mandatory reporting legislation.
Mandatory Disclosure Legislation	Nunavut does not have mandatory disclosure legislation.
Apology Protection Legislation	Nunavut is one of 12 jurisdictions with apology protection legislation that follows a fairly standardized format.
Quality Assurance Protection	Nunavut has legislation mandating protection of quality assurance information, however, it needs to be updated in order to reflect current policy directions.

Comments on Future Legislative Development: Nunavut has not developed patient safety legislation in the key areas of mandatory disclosure and mandatory reporting. This presents an opportunity to consider leading policy positions and incorporate them into legislation.