Team Name: Quality, Planning & Performance Team Lead: Regional Lead - Quality, Planning & Performance Approved by: Regional Lead – Corporate Services & Chief Financial Officer	Reference Number: ORG.1810.PL.002 Program Area: Quality, Planning & Performance Policy Section: General
Issue Date: May 26, 2015 Review Date: February 15, 2017 Revision Date: January 5, 2023	Subject: Disclosure Process - Critical Incidents

Use of pre-printed documents: Users are to refer to the electronic version of this document located on the Southern Health-Santé Sud Health Provider Site to ensure the most current document is consulted.

POLICY SUBJECT:
Disclosure Process - Critical Incidents

PURPOSE:
The purpose of this policy is to provide direction, education and guidance for healthcare professionals on a documented and coordinated process to disclose critical incidents to patients/residents/clients and families.

As part of the disclosure process practical, emotional/psychological support is offered to patients/residents/clients/families and staff involved in a critical incident.

BOARD POLICY REFERENCE:
Executive Limitation (EL-1) Global Executive Restraint & Risk Management
Executive Limitation (EL-2) Treatment of Clients
Executive Limitation (EL-3) Treatment of Staff
Executive Limitation (EL-7) Corporate Risk
Executive Limitation (EL-9) Communication and Support to the Board

POLICY:
Southern Health-Santé Sud core values of integrity, excellence, respect, compassion, and innovation reflect our ethical obligation to be honest and forthcoming about critical incidents within the healthcare system which supports a non-punitive, transparent, and learning environment.

DEFINITIONS:

Client – refers to all patients, clients, or residents.

Critical Incident – an unintended event that occurs when health services are provided to an individual and result in a consequence to him or her that:

- is serious and undesired such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay; and
- does not result from the individual's underlying health condition or from a risk inherent in providing the health services.

To be deemed a critical incident, the injury or harm to a client is substantial or significant. i.e.) A client was administered the wrong medication and died.

Disclose/Disclosure – the verbal and/or written process of informing the client and/or family, where appropriate, of the facts of what happened, the actions taken or are to be taken to address the outcome for the client.

Apology – a sincere and honest expression of regret and remorse with a desire to make amends which does not create legal liability. The words "I am sorry" needs to be part of any apology.

Family – refers to the client's immediately family and/or significant other, substitute decision maker, public trustee, or power of attorney, as appropriate.

Spokesperson – the most appropriate person to disclosure information to the client and/or family on behalf of Southern Health-Santé Sud. Consideration is given to who has the appropriate knowledge of the event detail and who has developed a trusting relationship with the client/family.

IMPORTANT POINTS TO CONSIDER:

The Legislative Assembly of Manitoba's Bill 202- *"The Apology Act"* indicates evidence of an apology made by or on behalf of a person in connection with any matter is not admissible in court as evidence of the fault or liability of the person in connection with the matter.

The Legislative Assembly of Manitoba Bill 17- "*The Regional Health Authorities Amendment and Manitoba Evidence Amendment Act",* there is a duty to inform the patient and/or substitute decision maker about a critical incident.

Accreditation Canada Leadership Standards Required Organization Practices 15.6 states: A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.

PROCEDURE:

1. The initial disclosure process by a spokesperson commences once, in consultation with a Patient Safety Coordinator, an event has been determined to meet the threshold of a reportable Critical Incident to Manitoba Health, as per the Management of a Critical Incident Checklist (ORG.1810.PL.001.FORM.02).

2. The designated spokesperson completes the education power point session on the Healthcare Provider Site (HPS) titled "Disclosure Process" prior to an initial disclosure.
3. The spokesperson(s) initial contact is in person, by telephone, and/or an invitation to meet in person, dependent on the situation i.e.) patient transferred to a higher level of care/inter-facility transfer/discharged home, etc.
   - If attempts to reach a client/family are unsuccessful a registered letter is sent. Contact a Patient Safety Coordinator for assistance.
   - Offer an in-person private meeting at a mutually agreed upon location to the client and/or family.
   - The meeting place can occur at a different location other than the facility as the client and/or family may not feel comfortable returning to the facility where the harmful event occurred.
4. The Spokesperson may have another healthcare team member not involved in the critical incident take notes during the initial disclosure, if so desired.
5. The following steps for initial disclosure by a spokesperson include:
   - Offering an apology for the event. i.e.) "We are very sorry and regret that this happened."
   - Validate and offer support for the client and/or family which may include a referral to another health care provider as deemed appropriate i.e.) Mental Health Worker, Social Worker, Spiritual Care Provider, and/or Support groups. As required, provide the Crisis Response Services phone number (1-888-617-7715) to assist in immediate support.
   - Provide the client and/or family with the opportunity to ask questions or seek clarification.
   - Inform the client and/or family that a critical incident review will be undertaken by a Patient Safety Coordinator. The Patient Safety Coordinator will connect with the client/family to discuss the event.
   - Provide the client/family with the pamphlet Patient/Resident/Client and Family Critical Incident and Disclosure Guide.
   - Offer a copy of the Disclosure Record to Clients/Patients and Families (ORG.1810.PL.002.FORM.01) to the affected person or their authorized designate, at no cost.
   - The original Disclosure Record to Clients/Patients and Families stays on the client's health record and a copy is sent to the Patient Safety Coordinator.
6. Document on the Disclosure Record to Clients/Patients and Families
   - The date, time, and location of the meeting.
   - The names of those present during the disclosure.
   - The facts of what is known at the time of the event (what happened, not why it happened).
   - The outcome for the client as a result of the critical incident.
   - Actions that were taken, or are to be taken, to address the outcome including any health services, care, or treatment. (Psychological and Physical)
   - Questions raised and the answers given.
   - The client and/or family response to the critical incident review process.
   - Any written information given to the patient and/or family e.g.) Patient/Resident/Client and Family Critical Incident and Disclosure Guide or a copy of the Disclosure Record to Clients/Patients and Families.

7. The Director of Health Services/Manager/Client Service Manager offers support /debriefing for the health care providers involved in a critical incident that may include:
   - Providing a copy of the Patient Safety Events and Disclosure: Information for Healthcare Providers.
   - Offer Employee Assistance Program – call 1-800-590-5553; accessible 24 hours.
   - Offer Manitoba Physician at Risk Program – call 1-204-237-8320; hotline checked daily.
   - Referral to Manager Occupational Safety & Health program.
   - Referral to a Spiritual Care Provider.
8. The Patient Safety Coordinator(s) establishes a Critical Incident Review Committee (CIRC) to review the critical incident. The purpose of the review is to gather as much information as possible and to analyze the information for the purpose of learning and system improvement. A review of the client's health record, interviewing staff, physicians, client/patient/family, and others as appropriate is to gain a better understanding of the sequence of events. According to legislation the interview process is legally privileged, confidential and cannot be used in a court of law.
   - Preference for final disclosure is discussed during the interview process with the client/family. The final disclosure process with the client/family is to discuss the findings from the critical incident review and any system recommendations/ suggestions.
   - The client/family is provided a written letter of apology on behalf of Southern Health-Santé Sud that includes a summary of the event e.g.) Patient Safety Learning Advisory (PSLA). The final disclosure meeting occurs in person at a mutually agreed upon location, by telephone, virtually, and/or registered letter as per client/family wishes.
9. Following all critical incident reviews feedback is sought from clients, families, and team members involved in the disclosure process about their experience. The information is used to make improvements, when needed, to the disclosure process.

SUPPORTING DOCUMENTS:

ORG.1810.PL.002.FORM.01 - Disclosure Record to Clients/Patients and Families

REFERENCES:

Accreditation Canada Leadership Standard Required Organizational Practice 15.6 Ver.14 November 22, 2021

Healthcare Excellence Canada. *Canadian Disclosure Guidelines: Being open with patients and families*. (Accessed October 26, 2022)

Manitoba Health Critical Incident Reporting and Investigation | Patient Safety | Manitoba Health | Province of Manitoba (gov.mb.ca) (Accessed on October 26, 2022)

Shared Health "Patient/Resident/Client and Family Critical Incident and Disclosure Guide" March 2022

Shared Health "Patient Safety Events and Disclosure: Information for Healthcare Providers" March 2022

Southern Health-Santé Sud "Management of a Critical Incident Checklist", ORG.1810.PL.001.FORM.02 December 7, 2017

The Apology Act (June 21, 2022) C.C.S.M. c. A98 (gov.mb.ca) (Accessed on October 26, 2022)

The Legislative Assembly of Manitoba- Bill 10 The Regional Health Authorities Amendment Act (Health System Governance and Accountability) (Accessed on October 26, 2022)

The Legislative Assembly of Manitoba -Bill 17 The Regional Health Authorities Amendment and Manitoba Evidence Amendment Act (gov.mb.ca) (Accessed on October 26, 2022)
The Legislative Assembly of Manitoba-Bill 202 The Apology Act (Accessed on October 26, 2022)
The Manitoba Evidence Act (June 21, 2022) C.C.S.M. c. E150 (gov.mb.ca) (Accessed on October 26, 2022)