What You Need to Know About Initial

Disclosure:

Disclosure is the process by which a patient safety event

is communicated to the patient/client/resident/family by a healthcare provider. (CPSI, 2011)

Health care professionals have an obligation to disclose to patient's/client's/resident's/families when harm has happened.

The person best suited to provide disclosure to the patient/client/resident/family varies, depending upon the situation. Refer to your organizational Disclosure Policy.

The initial disclosure is best done as soon as possible after the recognition of the patient safety event.

An early disclosure conversation is important to address any concerns families of the patient/client/resident/ may have openly, honestly and respectfully. Early disclosure starts to rebuild the relationship of trust, openness and transparency.

The disclosure conversation should occur in a quiet, private environment that is comfortable for the patient/ client/resident/family.

What is a Patient Safety Event?

A patient safety event is an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient.

(*Disclosure Working Group. Canadian disclosure guidelines: being open and honest with patients and families. Edmonton, AB: Canadian Patient Safety Institute; 2011.)

What is a Critical Incident?

A critical incident is an unintended event that occurs when health services are provided to an individual and results in a consequence to an individual that: (a) is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay, and; (b) does not result from the individual's underlying health condition or from a risk inherent in providing the health services.

Not all patient safety events are critical incidents.

Manitoba has legislation* that defines critical incidents and the requirements for how they are managed.

This includes that verified critical incidents are reviewed by a Critical Incident Review Committee (CIRC) and reported to Manitoba Health.

*** The Health Services Governance and Accountability Act**

Patient Safety Events and Disclosure: Information for Healthcare Providers

This pamphlet is intended to supplement your organizational policies. For more information, refer to your organizational policies/procedures on patient safety events and disclosure

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Initial Disclosure continued:

The facts of the event and initial disclosure should be documented in the patient's/client's/resident's health record.

After disclosing the harmful event, it is natural to follow with a sincere apology.

Manitoba's Apology Act allows health professionals to apologize freely, without creating liability. For more information refer to The Apology Act.

The patient/client/resident/family has a right to receive a copy of the health record. Follow your organization's Release of Information/PHIA Policy and Procedure.

Following a verified critical incident, by law, the following is must be initially disclosed to patient's/client's/ resident's/families:

- The facts of what occurred regarding the critical incident.
- Any additional facts and outcomes for the patient/ client/resident involved as they become known.
- The actions taken to date and those that will be taken to address the outcomes of the critical incident, including any health services, care or treatment that is advisable.

The CIRC:

Once a patient safety event is verified as a critical incident, a Critical Incident Review Committee (CIRC) will be established. When possible, the CIRC will collaboratively review the event, identify the root cause(s) and/or contributing factors. This may involve interviews, a health record review, literature/best practice review and a review of the facilities policies and procedures.

Any information prepared solely for the use of, or developed by a CIRC, and records and reports of the CIRC, are privileged and confidential.

The discussion you have as a part of the review is granted legal privilege.

- This means that you cannot be questioned in legal proceedings about your discussions with the CIRC.
- This protection will allow you to speak freely with the CIRC about the facts without fear of repercussions.
- The discussions, activities and conversations you have as part of the CI review cannot be discussed with anyone else beyond the CIRC for purposes of the CIRC.
- Information, records or reports prepared by or for the purposes of the CIRC are protected by law and cannot be disclosed.

Based on the findings of the review, the CIRC will develop recommendations and actions to improve the healthcare system and patient safety.

The review may take 90 business days to complete. The review findings and recommendations will be reported to Manitoba Health. and are communicated to the patient/ client as part of final disclosure.

For some reviews, Patient Safety Learning Advisories (PSLAs) are created to share the lessons learned from the event.

Support Available:
Being involved in a patient safety event can be difficult and stressful.

Emotional support may help you deal with the feelings you have after a critical incident. For more on the resources available please see the Mental Health and Wellness Resource Finder at: https://sharedhealthmb.ca/services/mental-health/mental-health-and-wellness-resource-finder/

You may also obtain support from the following:

- Your manager or supervisor
- A member of your critical incident stress management team
- Your social worker
- Your spiritual care worker
- Your benefit plans, such as Employee Assistance Program (EAP)
- Your professional association
- Your union
- Physicians at Risk **204-237-8320** (Physicians and medical learners)

- Other _____