CancerCare Manitoba
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GOVERNING DOCUMENTS

Policy and Procedure

Title:	**Critical Incident Disclosure**
Policy Number:	02.004
Effective Date:	December 1, 2011
Last Revision Date:	November 9, 2017
Approving Body:	President and CEO
Authority:	CancerCare Manitoba Act
Responsible Officer:	Chief Medical Officer
Delegate:	Chief Medical Officer
Contact:	Quality, Patient Safety & Risk Department
Applicable to:	All CCMB employees, medical staff, volunteers, students, and other individuals associated with CCMB

1.0 **BACKGROUND:**

"Disclosure is the process, either in writing or verbally, of informing the patient/family or other individuals authorized by regulation to receive information about critical incidents. Provincial legislation requires health care organizations to disclose when an incident occurs to patients or their families."
https://www.gov.mb.ca/health/patientsafety/ci/disclosure.html

2.0 **PURPOSE:**

2.1 To promote a clear, consistent and timely approach to disclosure of critical incidents.

2.2 To facilitate patient/healthcare provider communications that respect and address patient needs and strengthen relationships.

2.3 To promote interdisciplinary teamwork.

3.0 **DEFINITIONS:**

3.1 Patient – all patients, clients and residents receiving health care.

3.2 Family – the patient's blood relatives and/or significant others.

3.3 Critical Incident (CI) – an unintended event that occurs when health services are provided to an individual and results 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 planned health services.

3.4 Disclosure – is the process (verbal and written) of informing the patient or family about the care they have received that has been deemed a Critical Incident. There are two specific types of disclosure.

3.4.1 Initial Disclosure

3.4.1.1 Provides information which includes:
- A description of the serious and undesired consequence;
- An apology, on behalf of CCMB, for the harm done;

- Facilitating further/additional necessary medical attention that may be required;
- Offering a second opinion, if appropriate;
- Copies of the medical record (if desired);
- An explanation of Critical Incident;
- An explanation of the safety review process that will follow;
- An explanation of the purpose of the safety review process.

3.4.1.2 The individuals required at the Initial Disclosure are, at a minimum:

- The patient's attending physician (or delegate);
- A member of the Patient Representative Office;
- A member of the Quality, Patient Safety & Risk Department.

3.4.2 Final Disclosure

3.4.2.1 Provides information which includes:

- An apology, on behalf of CCMB, for the harm done;
- A brief and generic description of the safety review findings;
- Identification of the key recommendations to be implemented;
- Location of the Patient Safety Learning Advisory (PSLA) on the Manitoba Health, Seniors and Active Living (MHSAL) website;
- Offer of a written summary of what was discussed during the disclosure;
- Provision of a "Critical Incident Disclosure – Patient Survey" to the patient/family at a later date.

3.4.2.2 The individuals required at the Final Disclosure are, at a minimum:

- A member of the Patient Representative Office;
- A member of the Quality, Patient Safety & Risk Department (preferably the CI Lead);
- The patient's attending physician (or delegate).

4.0 **POLICY:**

4.1 All CancerCare Manitoba employees, Medical Staff, volunteers, students, and other individuals associated with CCMB shall:

4.1.1 Report Critical Incidents to the appropriate individuals. See CCMB Policy "Event and Critical Incident Reporting" # 02.024.

4.1.2 Disclose facts about the Critical Incident by following the procedure outlined in this policy and appendices.

4.2 When a Critical Incident happens in a **facility not directly managed by CCMB**, for example a Community Cancer Program site, employees and Medical Staff involved shall:

4.2.1 Follow the protocol of reporting and communicating outlined in the policy of their site.

4.2.2 Notify the Quality Patient Safety and Risk Department and the Executive Leadership at CancerCare Manitoba who will assess and decide on the need for

collaboration between CancerCare Manitoba and the other facility in the disclosure and/or subsequent formation of a Critical Incident Review Committee (CIRC).

4.3 The individual making the disclosure shall refer to the guidelines in this policy before making a disclosure. For an overview checklist, see Appendix A. Individuals making a disclosure may seek legal advice from the CancerCare Manitoba legal counsel. Medical Staff who provided clinical care related to the Critical Incident may wish to obtain advice from the Canadian Medical Protection Association.

5.0 **PROCEDURE:**

5.1 The individual providing care or their immediate supervisor shall:

5.1.1 Ensure immediately that the patient receives prompt intervention for any harm suffered or anticipated.

5.1.2 Communicate to the patient and their family that the appropriate individual shall discuss what is currently known about the event with them as soon as it can be arranged.

5.1.3 Discuss with their immediate supervisor the communication needs and arrange for disclosure by the appropriate individual.

5.2 A Critical Incident Review Committee will be assigned (See "Event and Critical Incident Reporting" CCMB Policy 02.024).
Please see Appendix A: Procedure and Checklist for CI Disclosure.

6.0 **REFERENCES:**

6.1 Event and Critical Incident Reporting (ECIR), CCMB Policy 02.024.

Policy Contact: All enquiries relating to this policy should be directed to:	
Name:	Venetia Bourrier
Title/Position:	Director, Quality Patient Safety & Risk Department
Phone:	204-787-2158
E-mail:	vbourrier@cancercare.mb.ca
Address: (if required):	

DOCUMENTATION	
Policy Location: This policy is located (hard and e-copy formats):	
1.	The original signed and approved policy is on file in the Executive Office, CCMB
2.	The e-copy is on file in the CCMB Governing Documents Library on SharePoint
3.	

Revision History:				
Date	**Version**	**Status**	**Author**	**Summary of Changes**
dd/mm/yyyy	#	Initial, Draft Final Minor/Major revision		
01/12/2011	1	Initial		
09/11/2017	2	Revision	QPSR	Updated definitions and CI process to reflect current processes. Added flow sheet for process.
07/02/2018	2	Revision	CPMT	Reviewed and approved by CPMT

Approvals Record: This Policy requires approval by:		
Approval		
Date	**Name / Title**	**Signature**
Feb 7 2018	Clinical Programs Management Team (CPMT)	Approved by CPMT February 7, 2018.

FINAL APPROVAL:		
Date	**Name / Title**	**Signature**
Feb 28 2018	Dr. P. Czaykowski Chief Medical Officer, CCMB Chair of CPMT	*Original signed by* *Dr. P. Czaykowski*

APPENDIX A

Procedure for Disclosure of a Critical Incident

1.0 The **physician** providing care should be the most appropriate person to disclose the event details of the incident to the patient and/or family. The determination of this physician will be influenced by:

i) Setting and type of event
ii) The individual who is most responsible for the patient's care
iii) Consideration of the following:
- Who is most knowledgeable about the event
- Existing relationship with patient and family
- Ability to explain future care plan
- Patient's (or family's if applicable) preference

2.0 The physician will be assisted by an appropriate delegate determined by the Quality, Patient Safety & Risk Department and/or a Patient Representative who will provide his/her contact information along with the pamphlet "A Guide to a Critical Incident and Disclosure: Information for Patients & Families".

3.0 Disclosure should be provided at the earliest practical opportunity and preferably within one to two days after discovery of the incident or whatever is most convenient to the patient. Subsequent disclosure discussions should also occur in a timely fashion. Rare circumstances may deem a different timeline be instituted, which will be decided amongst the CCMB Quality and Executive Leadership and documented.

3.1 Disclosure should, to the extent possible, occur:
- In person;
- At a location and time of the patient's (or family's, if applicable) preference;
- In a private area to maintain confidentiality; and
- Be free from interruptions.

CHECKLIST FOR DISCLOSURE PROCESS

Adapted from CPSI (Canadian Patient Safety Institute) "Canadian Disclosure Guidelines: Being Open with Patients and Families" (2011)

Ensure immediate patient care needs are met.
Ensure patient, staff and other patients are protected from immediate harm.

DISCLOSURE PROCESS PLAN

- Gather existing agreed upon facts;
- Establish who will be present at the meetings(s), and who will:
  - Lead the discussion during the meeting(s)
  - Be the point of contact for the family
  - Support those providers involved in the incident and
  - Coordinate the disclosure process;
- Set when the initial discussion will occur;
- Formulate what will be said and how effective disclosure will be accomplished;
- Locate a private area to hold disclosure meeting, free of interruptions;
- Be aware of your emotions and those of providers involved in the process and seek support if necessary;
- Anticipate the patient's emotions and ensure support is available to the patient and to those whom the patient chooses to be part of the discussion such as family, friends, or religious representatives.

INITIAL DISCLOSURE

- Introduce the participants to the patient, functions and reasons for attending the meeting;
- Use language and terminology that is appropriate for the patient;
- Describe the agreed upon facts of the patient safety incident and its outcome known at the time;
- Describe the steps that were and will be taken in the care of the patient (changes to care plan as applicable);
- Avoid speculation or blame;
- Apologize using the words "I'm sorry". Inform the patient of the process for analysis of the event and what the patient can expect to learn from the analysis, with appropriate timelines;
- Inform the patient of the process for investigating and what the patient can expect to learn from the investigation, with appropriate timelines;
- Allow time for questions and clarify whether the information is understood;
- Be sensitive to cultural and language needs;
- Offer to arrange subsequent meetings;
- Offer practical and emotional support such as spiritual care services, counseling and social work, as needed;
- Facilitate further investigation and treatment if required.

SUBSEQUENT AND FINAL DISCLOSURE

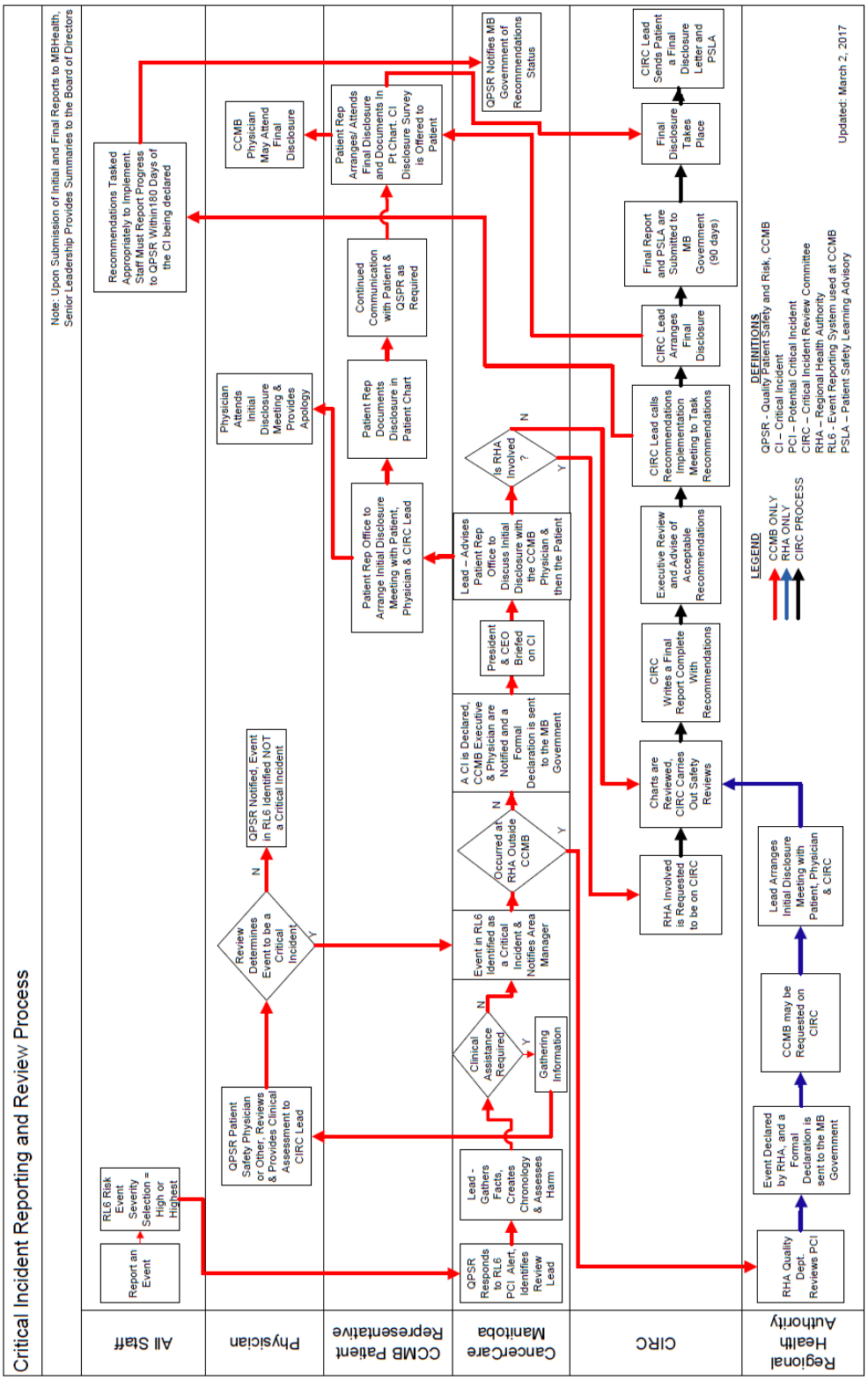
- Continued practical and emotional support as required, for the patient, family and providers;
- Reinforcement or correction of information provided in previous meetings;
- Further factual information as it becomes available;
- A further apology which might include an acknowledgement of responsibility for what has happened as appropriate;
- Describe any actions that are taken as a result of internal analyses such as system improvements.

DOCUMENTATION

Document the disclosure discussion in the patient's electronic chart (VMO Questionnaire "Critical Incident Disclosure") and include:

- The time, place and date of disclosure discussion;
- The names and relationships of all attendees;
- The facts presented in the discussion;
- Offers of assistance and the response;
- Questions raised and the answers given;
- Plans for follow-up with key contact information for the organization.

APPENDIX B


Critical Incident Reporting and Review Process
Note: Upon Submission of Initial and Final Reports to MBHealth, Senior Leadership Provides Summaries to the Board of Directors
All Staff
Physician
CCMB Patient Representative
CancerCare Manitoba
CIRC
Regional Health Authority
Report an Event
RL6 Risk Event Severity Selection = High or Highest
QPSR Patient Safety Physician or Other, Reviews & Provides Clinical Assessment to CIRC Lead
Review Determines Event to be a Critical Incident
QPSR Notified, Event in RL6 Identified NOT a Critical Incident
Physician Attends Initial Disclosure Meeting & Provides Apology
Recommendations Tasked Appropriately to Implement. Staff Must Report Progress to QPSR Within180 Days of the CI being declared
CCMB Physician May Attend Final Disclosure
Patient Rep Arranges/ Attends Final Disclosure and Documents In Pt Chart. CI Disclosure Survey is Offered to Patient
Continued Communication with Patient & QSPR as Required
Patient Rep Documents Disclosure in Patient Chart
Patient Rep Office to Arrange Initial Disclosure Meeting with Patient, Physician & CIRC Lead
QPSR Responds to RL6 PCI Alert, Identifies Review Lead
Lead - Gathers Facts, Creates Chronology & Assesses Harm
Clinical Assistance Required
Gathering Information
Event in RL6 Identified as a Critical Incident & Notifies Area Manager
Occurred at RHA Outside CCMB
A CI is Declared, CCMB Executive & Physician are Notified and a Formal Declaration is sent to the MB Government
President & CEO Briefed on CI
Lead – Advises Patient Rep Office to Discuss Initial Disclosure with the CCMB Physician & then the Patient
Is RHA Involved ?
QPSR Notifies MB Government of Recommendations Status
RHA Involved is Requested to be on CIRC
Charts are Reviewed, CIRC Carries Out Safety Reviews
CIRC Writes a Final Report Complete With Recommendations
Executive Review and Advise of Acceptable Recommendations
CIRC Lead calls Recommendations Implementation Meeting to Task Recommendations
CIRC Lead Arranges Final Disclosure
Final Report and PSLA are Submitted to MB Government (90 days)
Final Disclosure Takes Place
CIRC Lead Sends Patient a Final Disclosure Letter and PSLA
RHA Quality Dept Reviews PCI
Event Declared by RHA, and a Formal Declaration is sent to the MB Government
CCMB may be Requested on CIRC
Lead Arranges Initial Disclosure Meeting with Patient, Physician & CIRC
LEGEND
CCMB ONLY
RHA ONLY
CIRC PROCESS
DEFINITIONS
QPSR - Quality Patient Safety and Risk, CCMB
CI – Critical Incident
PCI – Potential Critical Incident
CIRC – Critical Incident Review Committee
RHA – Regional Health Authority
RL6 - Event Reporting System used at CCMB
PSLA – Patient Safety Learning Advisory
Updated: March 2, 2017