RISK NOTE

Critical Incidents – Disclosure Documentation

OVERVIEW OF ISSUE

The occurrence and disclosure of a critical incident needs to be documented in the health record. When a critical incident is disclosed, documentation of the disclosure should contain certain elements which should follow the applicable provincial/territorial statute(s).

The aim of this Risk Note is to standardize what is documented about critical incident disclosures.

KEY POINTS

- The disclosure of a critical incident should be documented in the health record and should follow required elements as per applicable statute(s).

THINGS TO CONSIDER

Who Should Document and When

- The disclosure and documentation of a critical incident should be completed only after there has been a formal determination that the incident should be delineated as critical. This should occur as soon as is practicable after the critical incident occurs.
- Documentation should occur after the disclosure meeting with the patient/family so there is a written record of the disclosure discussion.
- The person who takes the lead in the disclosure meeting is typically the individual who documents however this will vary with organizational policy.

What Should Be Documented

- The following elements should be documented following the disclosure discussion:
  - Patient name;
  - Patient address;
  - Patient health record number;
  - The fact that this relates to a critical incident disclosure;
  - Date of disclosure;
  - Time of disclosure;
  - Location of disclosure;
  - Names and roles of those involved in disclosure, i.e. healthcare organization staff;
  - Names and relationships of family members;
  - Material facts of what occurred with respect to the critical incident (include critical incident date and time, if known);
  - Facts of the cause or causes of the critical incident, if known;
  - Actions taken and recommended to be taken to address the consequences to the patient of the critical incident, including any healthcare or treatment that is advisable;
  - Questions raised and answers provided (including offers of assistance);
  - Name and title of individual who will follow-up with the patient/family as required;
  - Who the disclosure was documented by.

Disclosure of Systemic Steps to Avoid or Reduce the Risk of Further Incidents

- There is no requirement that the disclosure of systemic steps, if any, the healthcare organization is taking or has taken in order to avoid or reduce the risk of further similar critical incidents needs to be documented in the health record. This information typically comes to light after the initial disclosure with the patient/family.

Documentation of Subsequent Disclosure(s)

- Subsequent disclosure(s) should be communicated to the patient/family when information becomes available and should be documented, i.e. in the risk management or patient relations file.

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REFERENCES

- Canadian Medical Protective Association. (2017). Disclosing harm from healthcare delivery: Open and honest communication with patients. (3rd Ed.).
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- Manitoba Institute for Patient Safety. (2018). A guide to critical incident and disclosure: Information for patients and families.
- Public Hospitals Act, Revised Statues of Ontario. (1990, Reg. 965). Hospital Management.

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