RISK
NOTE

Disclosure of Incidents

OVERVIEW OF ISSUE

Disclosure of facts related to incidents involving patients (including clients and residents) and/or families is an ongoing process starting immediately after an incident and continuing through to the end of the review process. Disclosure of an incident that reaches the patient is the right thing to do professionally and ethically and must always be carried out regardless of whether it may or may not decrease the probability of a related medical malpractice claim.

KEY POINTS

- Disclosure is an ongoing process that should take place as soon as it is practical to do so.

THINGS TO CONSIDER

General principles

- Strive for openness, honesty, respect, sincerity, empathy, the recovery of trust, and the promotion of healing;
- Recognize the phenomenon of "second harm", i.e. trauma resulting from insensitive and inadequate handling of the incident, and support healthcare providers involved in patient incidents;
- Avoid isolating the patient and/or family and ensure ongoing communication and engagement through to resolution;
- Ensure all communications are culturally and linguistically appropriate;
- Address any patient and/or family needs (e.g. clinical, emotional) as soon as possible;
- Offer practical support (e.g. reimbursement for any reasonable out-of-pocket expenses);
- Consider development/use of an information sheet for patients and/or families outlining key elements of the incident management process;
- Ensure provincial legislation/regulations are adhered to regarding disclosure of critical incidents.
- Disclosure is not a one-time event and occurs over time as new information becomes known.

Immediate response and initial disclosure to patients and/or families

- Wherever possible, ensure immediate response and disclosure is led/co-led by the most responsible practitioner (MRP) or attending clinician with a pre-established care relationship;
- Address immediate clinical, psychological and emotional needs including offering support from psychology/social work/pastoral care as appropriate;
- As soon as practical, communicate the facts of what occurred, the consequences for the patient, and treatment and follow up to address these consequences;
- Express remorse, empathy and compassion (e.g. "I am truly sorry this happened") even if the etiology/causes of the event are not yet known;
- Acknowledge the patient and/or family's pain and distress;
- Avoid speculation, jumping to conclusions, and assigning blame;
- Appoint a staff member (e.g. unit/area manager) to act as key contact and liaison for the patient and/or family if different from the MRP;
- Discuss the organization's commitment to finding

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out what happened, why, and steps to reduce the risk of similar incidents in the future;

- Provide a high level overview of the incident analysis process and potential timelines;
- Ask the patient and/or family what questions they hope the analysis will address;
- Discuss the opportunity for the patient and/or family to provide input into the analysis and explore how and when they might prefer to do this (i.e. interview by patient relations);
- Establish the frequency with which the patient and/or family want to be updated on the progress of the analysis (e.g. set times or as new information becomes available).

Ongoing Communications

- Provide updates to the patient and/or family as promised. If a delay in reporting back is encountered, apprise them of the situation and apologize. The MRP and/or previously identified key contact staff member will likely provide these updates.

Post analysis disclosure

- Depending on the incident and with advanced preparation and planning, post analysis disclosure could be carried out by the MRP and/or previously identified key contact and/or member(s) of the review team and/or other senior administrator. Whoever is carrying out the disclosure should:
  - Reiterate apology (e.g. “we deeply regret this occurred”);
  - Provide an overview of what happened (do not speculate, be factual), highlighting any new facts uncovered in the analysis;
  - Not comment on or suggest whether the involved healthcare provider(s) breached the ‘standard of care’;
  - Outline recommendations for improvement (if permitted by legislation); the steps (taken and planned) to reduce the risk of similar incidents in the future;
  - Identify a key contact (if different from the one previously identified) if the patient and/or family want to receive periodic updates on recommendations implementation;
  - Record the disclosure discussion (including apology) in the health record or patient relations file.
- The patient and/or family could be provided a copy of the written summary of the post analysis discussion that is recorded in the health record or patient relations file.

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