DISCLOSURE	Quality/Patient Safety & Risk Management QRM-030

Issuing Authority (sign & date)	**Debbie Molloy, Vice President** Signed by Debbie Molloy Dated April 27, 2018
Office of Administrative Responsibility	Quality/Patient Safety and Risk Management
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Overview

Eastern Health (EH) is committed to client safety and facilitating a culture that is just and fair, where health care providers understand, and can act upon, their individual, ethical and professional responsibility in disclosing occurrences.

Disclosure is grounded in the spirit of a just and safe culture and allows the client to continue to make informed health care decisions. *Disclosure is the right thing to do.*

A Disclosure Toolkit is available and includes background information to disclosure, a flowchart, a planning checklist, and a variety of examples and questions that will support the disclosure process. Ongoing disclosure education is available to enable health care providers to appropriately participate in the process.

POLICY

Occurrences that have reached the client, have caused harm, or have the potential to cause future harm must be disclosed to the client and/or substitute decision maker (SDM) in a supportive and timely fashion. Disclosure of a close call that does not pose a future health risk is discretionary.

All public communications related to disclosure is managed through the Strategic Communications department in consultation with the Chief Executive Officer (CEO).

Scope

Applies to all staff and agents of Eastern Health.

Purpose

To assist staff and agents of Eastern Health with the processes of disclosure.
To ensure that clients/families or SDM's are receiving all the necessary information related to their care.

Procedure

1. Any employee or agent that observes, discovers, or participates in an occurrence (Reporter) must ensure safe client care and secure a safe environment.

2. The Reporter must document the occurrence on the electronic Occurrence Reporting Form. Reporters that do not have access to the electronic occurrence reporting system must complete a paper form and submit it to the area manager (See Occurrence Reporting Policy, QRM – 080). The attending physician/practitioner, and/or most appropriate clinician, is notified of the occurrence.

3. For occurrences with a Level 4, 5 or 6 severity rating (See Severity Rating Scale under Guideline), or any occurrence or series of similar occurrences, including close calls, that raise significant quality and/or safety concerns, the manager of the area where the occurrence happened must be contacted immediately. The manager then notifies the appropriate director (and site administrator, where appropriate). The manager of the program/department/site contacts a member of the Quality/Patient Safety and Risk Management department for guidance and support.
    - After hours, call the Site Clinical Coordinator, site manager or the relevant person on-call.
    - The person on-call who receives the report on the occurrence immediately notifies the appropriate director (and site administrator, where appropriate. If another program, or service area is involved in the occurrence, the respective manager and director for that program/service is also notified.
    - The director confirms the event and notifies the respective Vice-President (VP) and others as deemed appropriate. The VP is responsible for notifying the Chief Executive Officer of occurrences that raise safety and quality concerns and providing regular updates of the disclosure process, where necessary.

4. The manager for the area where the occurrence happened assesses the nature of the occurrence and, depending on the severity of harm or potential of future harm, plans the disclosure process. If the occurrence is a

level 1, 2 or 3 severity rating, the manager and/or care provider discloses the event to the client/family and/or SDM (e.g. medication error with no adverse effect). If an occurrence is assessed as (severity rating 4–6), the manager, in conjunction with the physician/practitioner and/or program leadership and/or executive management determines:

a) the most appropriate disclosure method: individual client disclosure and/or public notification,
b) the most appropriate person to lead the disclosure process, and
c) what resources may be needed to advise the team (e.g. ethicist, legal counsel, Quality and Clinical Safety Leader, etc.).

5. Multi-client and/or multi-jurisdictional occurrences are often very complex, requiring prompt action, coordination, and communication (individual client disclosure and/or public notification if appropriate). A leader to coordinate disclosure in these types of occurrences is designated by the Executive Team. In the case of a multi-jurisdictional occurrence, a liaison leadership official is designated to coordinate activities and act as the main channel for dialogue for the organization and between other jurisdictional liaison officials.

6. The appropriate manager informs the care provider(s), and/or team involved of debriefing and counseling supports available (arranged through Employee Assistance Program), and/or Pastoral Care and Ethics supports (arranged through Pastoral Services). Care providers may contact their professional bodies/associations (e.g. union, professional association, relevant protective society) at their own discretion for information and/or supports that may be available.

7. Disclosure takes place within one to two days following the discovery of an occurrence (where possible), depending upon the physical and/or emotional ability, and willingness, of the client and/or SDM to participate.

8. Practical and emotional support may be required for the client, SDM, and/or family member. Resources required for support are provided by and/or arranged through Eastern Health.

9. After the disclosure meeting, the manager and/or designate will document the details of the disclosure meeting and provide a copy to the client, family or SDM. All documentation provided to the client, family or SDM is placed on the health record.

10. Any communication sent through the postal system must be sent via registered mail.

INDIVIDUAL DISCLOSURE

Who should disclose:
The decision of who should participate is based upon:

a) who can provide the best information and has an existing relationship with the client,

b) who can provide or has information on applicable supports (i.e. practical and/or emotional),
c) who can coordinate ongoing and follow-up client care, and
d) client preference.

Disclosure of harm generally rests with the attending physician/practitioner; however, when the care related to the occurrence is provided by another health care provider, then the responsibility for disclosure may rest between the appropriate manager and/or program leadership in consultation with the attending physician and/or the executive team. Consideration may be given to having a representative from the Quality/Patient Safety and Risk Management department at the disclosure meeting.

It is recommended that the total number of individuals present should be limited to a maximum of three or four, so as to not overwhelm the client. As well, the client is also given the option of having another person(s) attend with them.

Consideration is given to the ability of the caregiver to participate in disclosure, and it is recommended that the Employee/Family Assistance Program (EFAP), Pastoral Care & Ethics department, and/or professional support services be involved for immediate and ongoing support, when appropriate.

When should disclosure take place:
Disclosure takes place as soon as possible after the discovery of the occurrence, initiated within one to two days (where possible). The client's immediate physical and emotional care needs are of the highest priority; however, consideration must be given to the fact that a delay in communication to the client who is in suspect of an occurrence may cause further stress.

It is recognized that disclosure is a continuing obligation, and there may be several meetings with the client, family and/or SDM to follow up and communicate information after an occurrence. The initial disclosure provides the client, family, and/or SDM with facts known at that time. Follow-up meetings and/or post analysis disclosure meetings provide further facts and discussions relevant to the process.

Where should disclosure take place?
Disclosure takes place in a face-to-face meeting (where possible and where it is reasonable for the circumstances of the specific situation). If disclosure cannot occur in person, a registered letter and a telephone call is appropriate with opportunity for follow-up presented. A telephone call is always followed up with a registered letter. A registered letter should always be followed up with a telephone call. A copy of the letter is placed on the health record, and the telephone call is documented on the health record.

The location, setting, and atmosphere for the disclosure are important. The meeting is comfortable, private, and free from interruptions.

What elements should be included in the disclosure meeting?
- Introductions – the identity and role of all people in attendance.

- Facts – related to the event in language that is clear, open, honest, sincere and culturally sensitive.
  - DO NOT speculate or attribute blame to any individual;
  - Information may include:
    (1) a description of what happened (sequence of events),
    (2) follow-up actions taken (i.e. diagnostic tests, results, changes to treatment plan, obtaining second opinion, etc.),
    (3) consequences/potential outcomes of the harm,
    (4) outline of expectations for future care planning.
- Expression of regret or sympathy that the harm has occurred (e.g. "We are sorry this has happened to you," or "I wish this didn't happen," etc.). (See Disclosure Toolkit – Disclosure Conversations, Page 11.)
- Outline investigative process – let the client know how the occurrence is being managed and what is being done to prevent a reoccurrence to others, if applicable.
- Linkages – a contact person within the disclosure team is appointed.
- Time – provide time for clarification and questions. Allow time for the client to absorb information and time for follow-up discussion. Offer a follow-up meeting.
- Support – offer support in the form of practical (social worker), counseling, spiritual care and/or financial support for unusual travel costs for the disclosure process, if applicable. The organization provides information and/or facilitates access to these supports.

Once the team has decided on the details of the disclosure process for occurrences with a severity rating of level 5 or 6, the VP briefs the Chief Executive Officer (CEO) on the individual disclosure process prior to disclosure, where possible. In cases when public communication for disclosure is needed, the CEO notifies the Board of Trustees of the content and process of disclosure, prior to the public communication.

What should be documented?

The disclosure meeting is documented in the health record by the person who leads the discussion. It includes the following:

- Date & time of meeting;
- Who was present;
- Facts presented;
- Offers of support;
- Questions raised & responses provided;
- Any requests to review the client's health record;
- Follow up plan presented, including the designated key contact for client, family or SDM;
- All related letters and telephone calls (time, date, by whom, reason for contact and if contact was made; if a telephone message was left, the name of the person who the message was left with).

What elements are included in a Post-Analysis Disclosure?

- Follow the same process as the initial disclosure (i.e. introductions, support, time and linkages).

- Provide further facts, and reinforce or correct information provided in previous meetings.
- DO NOT speculate, provide opinions or attribute blame for the occurrence.
- Provide empathy, and extend a further expression of regret.

What should be documented after a Post-Analysis Disclosure?

- Document in the health record all aspects of the meeting as outlined previously for the initial discussion, including any further follow-up meetings, if applicable.
- A copy of any documentation sent to the client/family/SDM is placed in the client's health record.

PUBLIC NOTIFICATION

Where feasible, the disclosure of an occurrence to clients should occur individually prior to public notification and follows the procedures outlined under Individual Disclosure. However, communication to the public may be warranted in some occurrences and/or events where:

- Rapid contact with large numbers of clients is beyond the capacity of EH to accomplish within a reasonable and appropriate timeframe.
- Uncertainty exists as to whether a list of clients involved or impacted by the occurrence is accessible or complete.
- Incorrect information is starting to circulate to the public.
- An event may raise public concerns about Eastern Health's ability to provide quality care.

Public notification does not take the place of individual disclosure. Each client affected by the occurrence should be contacted individually. The decision of how a client, family or SDM is contacted (in person, telephone, registered mail) must be weighed out, with consideration given to the urgency to reach a new diagnosis or make a treatment decision as well as the severity of the event, the number of people affected and the practicality of disclosing with a one- or two-day timeframe.

MULTI-CLIENT DISCLOSURE

Sometimes a single client occurrence leads to the discovery that others may have been affected. At times, there may be an occurrence where the outcome of harm is uncertain until a review or client testing is complete. When a multi-client occurrence is discovered, a designated lead person from EH guides the process.

In a multi-client occurrence, where the number of clients affected is small and the event is fairly straight forward, EH may be able to communicate directly with each client and there may be no need for or advantage to public notification. However, when it is decided by the CEO that public notification is needed, every effort is made to disclose an adverse event to the client before providing public information; recognizing that news about events breaks so rapidly that this may not always be achievable. Multi-client disclosure is guided by the following:

Multi-client occurrence involving harm

- Follow the same process as internal disclosure, when possible.

- Individual disclosure should be planned so that all clients involved receive information at approximately the same time.
- If individual disclosure is not practical initially, follow the public notification process and then follow up with the individual disclosure process.

Multi-client occurrence involving no harm or unknown harm

- Disclosure can occur by telephone, registered letter, or in person, as appropriate. If disclosure is done by telephone, follow up should be done by letter, and if disclosure is done by registered letter, it should be followed up by a telephone call.
- Provide opportunity for follow up.

MULTI-JURISDICTIONAL DISCLOSURE

Clients often receive care/treatment in various hospitals, facilities, and health authorities. As a result, an occurrence may be discovered in a different jurisdiction than where it actually happened. When this occurs, the healthcare organization and/or health care provider/clinician reports the event to the jurisdiction where the event happened, and that organization (where the event occurred) leads the disclosure process. A designated lead person is assigned by each hospital/facility/authority to liaise in this process.

The designated lead person for the organization taking the lead for disclosure, in consultation with the appropriate manager and/or Executive Team, will decide on the appropriate pathway for disclosure (individual and/or public communication). If this is discovered to be a multi-client event, the procedure for multi-client disclosure should be followed. Privacy and confidentiality must be maintained. Coordination of the disclosure process requires effective communication between the facilities and/or health authorities and the Department of Health and Community Services.

Reporting to the Department of Health and Community Services:

In the event of a multi-patient disclosures and any other disclosure that may raise public concern about the quality of health and community services, the Minister of Health and Community Services must be informed by way of a written briefing or verbally for urgent information.

The written briefing note is prepared for the Chief Executive Officer by the most appropriate Vice President. The CEO sends the note to the Assistant Deputy Minister/ Deputy Minister of Health and Community Services or other designated departmental official.

Guideline

Severity Rating Scale for Occurrences

Non-Client Related (NCR): NCR will be used for an event not directly related to client care.

Level 0: **(Close Call)** An event did not occur or reach the client but may require further management.

Level 1: An event occurred, but the client was not harmed.

Level 2: An event occurred that resulted in the need for increased client assessment, but the client was not harmed and there was no treatment required.

Level 3: An event occurred that resulted in the need for treatment and/or intervention and caused temporary client harm.

Level 4: An event occurred that resulted in temporary client harm which negatively impacted the client's health or quality of life.

Level 5: An event occurred that resulted in permanent change in the ability of the client to function as they did before the event.

Level 6: An event occurred that resulted in client death.

Supporting Documents *(References, Industry Best Practice, Legislation, etc.)*

- Apology Act, S.N.L. 2009, c. A -10.1 http://www.assembly.nl.ca/legislation/sr/annualstatutes/2009/a10-1.c09.htm
- Canadian Disclosure Guidelines (CPSI, 2012)
- College of Physicians and Surgeons of Newfoundland and Labrador (2006)
- Disclosure Policy Mandatory Elements, Department of Health and Community Services, 2014
- Report of the Task Force on Adverse Health Events, 2008
- Provincial Occurrence Reporting Policy, Mandatory Elements, Department of Health and Community Services, 2017

Linkages

- Disclosure Toolkit – Eastern Health
- Multi-Regional Crisis Management Protocol
- Occurrence Reporting and Management (QRM – 080)
- Social Media (COM-100)

Key Words

- Occurrence
- Adverse Event
- Disclosure
- Close call
- Harm
- Reporter

Definitions & Acronyms

Adverse Health Event	An occurrence that results in an unintended outcome which negatively affects a patient's health or quality of life.
Agents	A person, other than an employee, authorized by Eastern Health to act on its behalf. This term includes physicians, volunteers, and pastoral care workers as well as staff of contractors and other persons working within Eastern Health Facilities or affiliated with Eastern Health.
Client	Refers to patient, client, resident in acute care, long term care and community setting.
Close Call	A potential occurrence that did not actually occur due to chance, corrective action or timely intervention.
Disclosure	The process of informing affected patients and families about any occurrence that may have occurred as part of a health service and has reached the patient, caused harm of has the potential to affect the patient's health in the future.
Harm	An outcome that negatively affects a patient's health and/or quality of life.
Occurrence	An undesired or unplanned event that does not appear to be consistent with the safe provision of health services.
Post-Analysis Disclosure	Subsequent disclosure conversations following the initial disclosure meeting that is documented in the health record.

"Reach the Client"	The occurrence made contact with the client, got to the client or arrived at the client. After this contact, the client may have or not have been affected or impacted. Example: client received Tylenol in error. Disclosure is necessary because the occurrence "reached" the client; however, physiologically there may have been no identifiable ill effects or negative impact.
Reporter	Employee(s) and physicians who participated in, witnessed, or had knowledge of the occurrence.
SDM	Substitute Decision Maker

DISCLOSURE TOOLKIT

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Introduction

Eastern Health supports a culture where safety and quality health care is both respected and lived. Communicating occurrences is an embedded component of quality health care and allows us to move knowledge into action in order to mitigate injury and prevent similar events. Acting upon the value of integrity, Eastern Health has developed the Disclosure policy and accompanying Toolkit to reflect, and facilitate, honest and open communication between employee/caregiver groups, communities and clients. Eastern Health recognizes that clients have a right to be informed about all aspects of their care.

The Canadian Patient Safety Institute has been a guiding force in raising awareness on how disclosure supports a safer culture for clients and care providers. The *Canadian Disclosure Guidelines* (CPSI, 2011) has been a major resource in the development of Eastern Health's Toolkit, allowing us to promote a clear and consistent approach for disclosure processes. We support the use of the CPSI disclosure guidelines. Communicating occurrences helps the client make informed health care decisions and gives healthcare providers and leaders the information necessary for building a safer healthcare system. Disclosure is a client's right, and a healthcare provider's responsibility.

Depending upon the nature of the event, the disclosure process may be fairly straightforward, such as a manager discussing a level 2 occurrence (i.e. medication error with no harm) with a client or substitute decision maker (SDM), or the process may be more complex requiring various supports and/or partnerships. The toolkit includes information, a flowchart, a planning checklist, and a variety of examples and questions that will support, and guide, the decision-making process for disclosing an occurrence and/or close call. The Disclosure Toolkit needs to be read in conjunction with the Disclosure policy QRM – 030.

Importance of Disclosure

Disclosure of occurrences has many positive benefits to the client, caregiver, and organization. Disclosure allows that client to make informed health care decisions and reaffirms a trusting relationship between client and caregiver. It allows the caregiver to express regret when things do not go as planned. When disclosure is absent, according to Taylor (2007), anger, frustration, need for information, and to prevent a re-occurrence to someone else, is often the motivator of litigation, rather than financial compensation. Taylor goes on to say that it is the "insult" rather than the "injury" that often drives litigation in cases of mild to moderate harm (p. 27). Eastern Health is a teaching organization that builds knowledge through people, research, literature, and events. Initiating open communication with clients when an occurrence happens ensures opportunity for discovery and learning. Prevention of further occurrences is possible in an open, honest, and safety conscientious culture. *Disclosure is the right thing to do.*

Professional & Ethical Responsibilities for Disclosure

Disclosure that is open, honest, and sincere is a practice that is ethically, legally, and professionally supported. According to Taylor (2007), "it is firmly entrenched in law that a physician, dentist or other primary care provider has a legal duty to disclose errors (p. 12). Furthermore, physicians, nurses and other clinicians through their professional bodies are guided by standards of practice that clearly outline their role and obligations to disclose when an occurrence has occurred.

Physicians

College of Physicians and Surgeons of Newfoundland and Labrador

"Patients have a right to know their present medical status, not only as an intrinsic right but also so that they may make informed decisions about their health care. Patients have a right to know when an adverse outcome of health care treatment has affected their present medical status. Leaving it to a client, a substitute decision maker or another health care provider to discover or act upon an adverse outcome is not consistent with the rights of clients outlined above, and in some circumstances the resultant delay may do harm to the client. The medical practitioner, who was the most responsible physician for the health care treatment during the course of which the adverse outcome occurred, should disclose the adverse outcome to the patient." (College of Physicians and Surgeons of Newfoundland and Labrador, 2006)

Canadian Medical Association

"Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient." (Canadian Medical Association, 2004)

Nurses

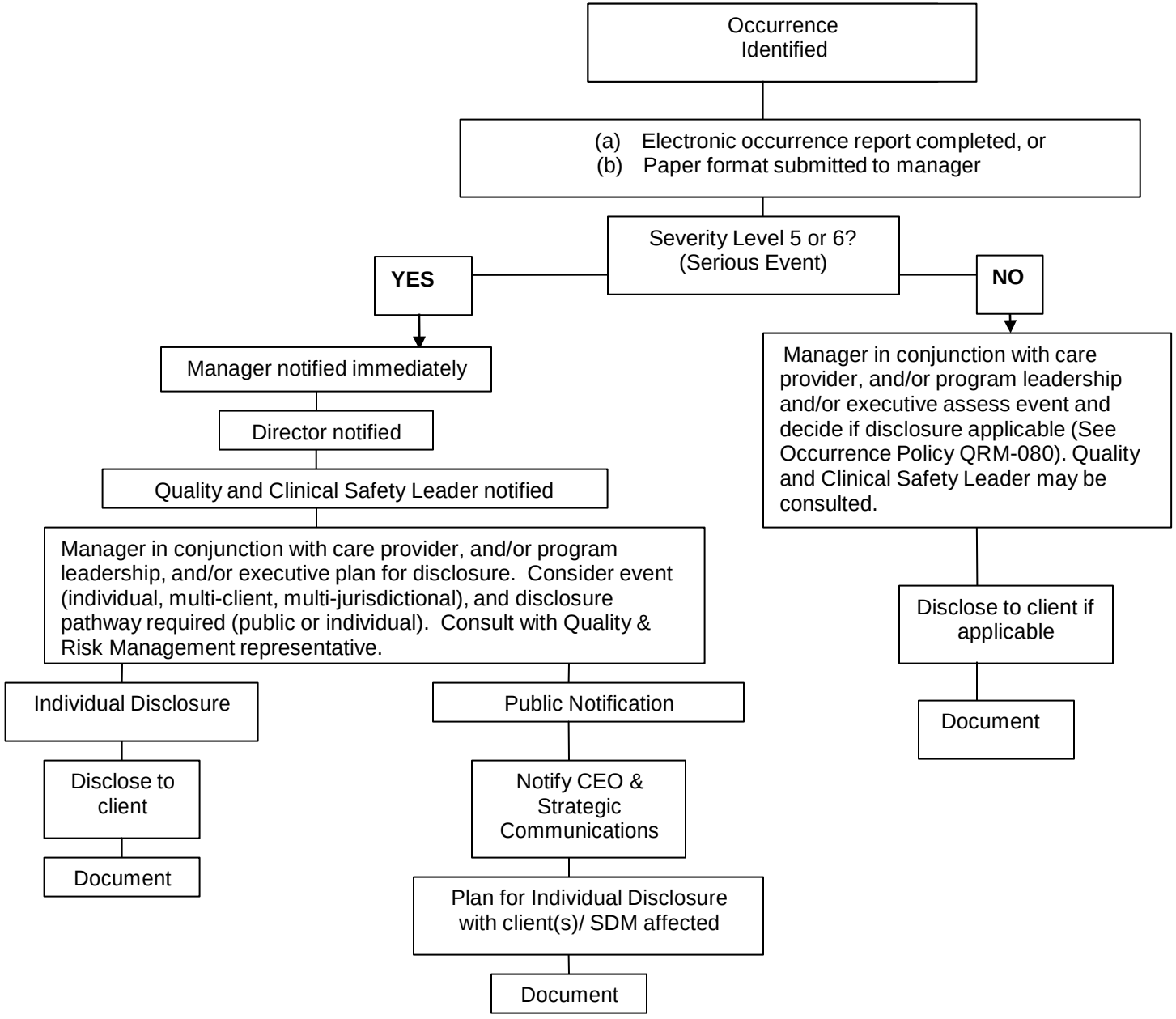
Association of Registered Nurses of Newfoundland and Labrador

"The duty to identify and address unsafe and unethical situations is a professional, ethical, and legal responsibility arising out of the RN's obligation to protect clients from harm and to uphold the integrity of the nursing profession." (ARNNL, 2008)

Canadian Nurses Association

"Nurses admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event. They work with others to reduce the potential for future risks and preventable harm." (Canadian Nurses Association, 2008)

Disclosure Flowchart



Disclosure Preparation:

Consider:

1. Setting
2. Tone
3. Participants
4. Supports* (for client &/or team/member
5. Facts
6. Follow-up
7. Investigation
8. Debriefing
9. Contact person
10. Privacy & confidentiality

*Ethics, EAP, counselling, legal counsel, Pastoral Care, financial, etc.

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Multi-client and/or multi – jurisdictional occurrence:

Consider:

1. Lead spokesperson
2. RHA liaison person
3. Lead contact

Planning for Disclosure

Event: Consider the severity and magnitude of the event when planning for any disclosure. If this is a multi-client event or a case of severe harm or loss of life, consideration to who should be present during the planning phase is essential. Senior Leadership, Communications, Risk Management Consultant, Quality and Clinical Safety Leader, Ethicist, EAP, Pastoral Services, or other services may be involved and/or consulted during any phase of an adverse event and disclosure process, if needed. The Disclosure Policy (QRM -030), will provide guidance.

- □ Review Disclosure Policy (QRM-030).
- □ Determine if Disclosure is applicable in this event.
- □ Is the client/family/SDM ready for this information? Ensure timing is right.
- □ Read "Examples of Disclosure," Page 9 in Toolkit.

Participants: The team responsible for disclosure should be decided upon through consultation with the most appropriate care giver and the most appropriate Program Leader. Decide who will lead the disclosure meeting (who is most knowledgeable about the event, and who can explain the future care plan). If client has requested a certain individual not to be present, this should be considered.

- □ Consider number of individuals (maximum of 3-4 from organization).
- □ Consider client preferences.
- □ Consider involving Quality and Clinical Safety Leader.
- □ Consider involving Risk Management Consultant.
- □ Consider involvement of other Professionals and/or Senior Management.
- □ Does the disclosure leader have the communication skills to lead the disclosure?

Preparation: Prior to the disclosure meeting, it is essential that the disclosure team be knowledgeable about the facts surrounding the occurrence and the follow-up plan. The medical record should be reviewed. Assemble all relevant documentation, and be prepared to review the chart with the family. Everyone should agree on the information that will be presented to the client and how, when and where the disclosure will happen. Give careful consideration to how the information will be communicated; the client's response and emotional reaction may depend more on how the news is delivered than by the words actually spoken. Discuss the possible questions and/or concerns that may be raised and how they will be answered. Discuss what is not appropriate to be communicated in a disclosure meeting (i.e. opinions, speculation and/or the attribution of blame to any individual).

- □ Read “Frequently Asked Questions About Disclosure” (Toolkit – Page 12).
- □ Disclosure team reviews health record.
- □ Assemble relevant documentation and have health record available for review.
- □ Discuss and agree upon facts to be disclosed.
- □ Anticipate possible questions and/or concerns and consider plausible answers.
- □ Discuss information not appropriate for inclusion in a disclosure meeting (i.e. speculation and/or blame, legal admission of liability, denial of responsibility, lack of clarity regarding the known facts).
- □ Decide and agree upon who attends the disclosure meeting and when, where, and how the disclosure meeting will happen.
- □ Discuss follow-up plan with consideration to practical and/or emotional support, if applicable.
- □ Designate contact person from team for future contact, if applicable.
- □ Consider a date and time for subsequent meetings and/or post-analysis meeting, if applicable.
- □ Consider how the expression of regret/apology will happen (See “Disclosure Conversations,” Page 11 in Toolkit).
- □ Prepare to discuss the investigative process and the steps taken to avoid a similar event.
- □ Ensure any and all letters sent are registered so they can be tracked.

Disclosure Meeting: Disclosure is needed for client healing and a re-establishment of trust between clients, their families and healthcare providers. Effective communication of an occurrence is essential and consistent with the core values of Eastern Health: truth, honesty, and respect. The failure to properly disclose an occurrence has the potential to undermine client and public confidence in our healthcare providers and our healthcare system. During the meeting, avoid medical jargon, provide time for questions, allow time for information to be absorbed, and be mindful of body language. Provide factual information that is truthful and delivered in a sincere, empathetic manner. Be prepared for variances in responses and emotion; if met with anger, do not respond in kind. Acknowledge anger and use listening skills, when appropriate. Let the client voice anger and frustration; it is important for the client to have this outlet. Providing an apology or an expression of regret is appropriate. An apology should not be taken as an admission of legal responsibility. Statements such as “I am so sorry you have had this experience,” or “I regret that these events have occurred” may be helpful; avoid words such as “negligence,” or “fault.”

- □ Introductions.
- □ Disclose facts – dispel inaccuracies. Do not assume that the client has a full understanding or knowledge of the occurrence.
- □ Express sympathy or regret; apologize, if appropriate.
- □ Discuss short-term and long-term consequences of the harm. What is the impact to the client?
- □ Discuss follow-up care plan.

□ Discuss steps to the investigative process and facts known to date.
□ Provide time for questions and clarification.
□ Offer practical and/or emotional supportive services (i.e. counseling, spiritual, financial, etc.).
□ Provide key contact person for further follow-up.
□ Note any unanswered questions, and follow up with client (or SDM) as soon as possible.
□ Discuss follow-up meeting, if applicable.

Documentation: Documentation of the details of the meeting and all contact and attempts for contact is essential. It provides a record of who, what, where, when, and how of different disclosure processes. The person who discloses to the patient/SDM should document in the client's health record. All contact through letters, telephone and voice messages or attempts to contact should be documented in the health record by the person making the contact.

Document:
□ Date, time, and location of disclosure meeting.
□ Date and time of any telephone or letter contact, or attempts to contact (by whom and why. If telephone messages left, document who message was left with.
□ Participants.
□ Facts disclosed.
□ Follow-up plan.
□ Offers of practical and/or emotional supportive services.
□ Key contact person.
□ Any request for review of client's health record.
□ Any other relevant information.

Post-Disclosure: Dealing with an occurrence and disclosure is often a very stressful and emotional time for all caregivers involved. Consideration should be given to debriefing immediately, or as soon as possible, after a disclosure meeting. As well, caregivers should be given information regarding Employee Assistance Programs, counseling, Pastoral Care Services and/or any professional support programs/groups that may be available.

Consider:
□ Debriefing session.
□ Professional services.

Examples of Disclosures

*These examples are theoretical, and should be used as a guide. Each clinical situation will present with unique complexities that will require coordination and input from the care team and program management. A quality safety leader should be consulted for moderate to severe incidents, or as needed.

Occurrence	Severity Level	Person Disclosing	Conversation
Penicillin administered to client with known allergy to Penicillin	Severity level – 5 (client admitted to ICU for Respiratory support)	Physician (Program Director and Quality Leader present)	Expression of Regret: Mr. X, we are very sorry and wish that this had not happened. Facts: You were given penicillin, a medication that you are allergic to. As a result, you had a severe allergic reaction. (Be comprehensive with factual information.) Follow-up: We would like to run some tests over the next while. Also, we would like to get some further allergy testing done. We realize that this has been a very stressful time on you and your family, and has created some financial difficulties for you and your family. We would like to offer you some counseling services to help with that. We realize that you may have questions over the next while, and would like for you to take this number to reach me (or X), so that we can provide that support to you. Questions: Allow time for questions.
Client information faxed to local business instead of intended Long Term Care home	Severity level - 3	Program Manager	Expression of Regret: We are very sorry that your personal health information went to the wrong person. Facts: We have investigated this and what happened is the person sending the information keyed in the wrong last digit. Instead of going to the fax machine over at Kare Nursing Home, it went to Lillies Bakery. We have immediately spoke with management at the bakery and recovered the information. We did discuss with the manager the

			confidentiality of this information and the disclaimer that we have on all of our faxes. The manager assures us that she…. etc. Follow-up: I want you to know that we are speaking to staff immediately about the need to recheck all outgoing fax #s. As well, I want you to take my telephone # and call me if you have any questions that you may think of over the next while.
A Supervised Access Worker has acted sexually inappropriately with a child in their care. Parents need to be notified.	Severity Level: 4	Manager and Social Worker	Expression of Regret: We are very sorry that this (give details of complaint) has happened to your child while in our care. Facts: We received a report that your child (use name) may have been touched inappropriately by one of the workers. Follow up: We are taking this report very seriously and will be contacting the RNC immediately. Child (use name) will need to have a medical assessment, and we can accompany him/her to the Janeway with you. At present, we have removed "name" and he/she is presently with a counselor. Please be assured that our Human Resources department is very involved and are investigating the complaint regarding our employee as well.

Disclosure Conversations

Avoid using words such as *wrong, error, mishap, incorrect, inadvertent, mistake, negligence, fault,* accident*;* or *failing to meet the standard of care.*

For all conversations, an early expression of regret communicates concern and sympathy. Thereafter, the conversation should focus on what is helpful; details, facts, and follow-up care. A caring attitude and tone that portrays genuine sincerity is essential for healing after an adverse event.

Expressions of Sympathy/Regret	Statements that may not be helpful.
"I'm sorry you had this complication". I am following up to better understand the circumstances and will meet with you later to discuss it. Let's talk about how we can help you (client, family, and/or SDM) right now.	"I'm sorry you had this complication, but those are the risks involved"
"I am sorry for the delay in your (surgery, treatment, appointment, test, etc.). I am following up on this to see what happened, looking at our booking processes, and will ensure that you get your care without any further delays.	Sorry your surgery was cancelled, but the nurse didn't send the OR booking slip down in time. If she had, everything would have been a go.
"I wish that you had a different outcome with this treatment, and I am sorry you and your family have been through such a difficult time. Right now we are unclear to what may have happened, but are looking into the events that led up to the incident. We would like to meet with you tomorrow to give you an update. What can we do for you right now to help?	"I hate it when things go wrong. I really feel bad for you. If I could, I would turn back the clock and make things right"
"I realize that there was a breakdown in our communication and, as a result, you did not fully understand the preparation required for the test (surgery, appointment, treatment, etc.). I regret that I did not make sure you understood the instructions before you left my office. How about we go over the pamphlet now before your test next week."	"If only you had asked me before you left, or at least told me that you were taking those medications. Now I feel terrible that your surgery was put off because of this."

Frequently Asked Questions About Disclosure

If I apologize during disclosure, would this be implying a legal responsibility for what has happened?
A statement expressing that one is sorry that an event has happened, should not be taken as an admission of legal responsibility. In fact, according to Taylor (2007), there is little evidence to show that courts have taken an apology as a basis to a malpractice suit. However, failure to communicate openly to clients, take responsibility, and apologize is the impetus behind more than two-thirds of malpractice suits (Harvard Hospitals, 2006). Apologizing is an important part of disclosure and is consistent with an open culture for safety. It is important to note that several provinces in Canada, including Newfoundland, have moved to introduce Apology Legislation which prevents apologies from being admissible in legal proceedings as an admission of responsibility. Newfoundland has an Apology Act, S.N.L. 2009, c. A – 10.1 that was assented May 2009. The CPSI recommends that certain words and phrases such as “negligence”, “fault”, or “failing to meet a standard of care” should always be avoided and are inappropriate in any disclosure conversation.
What will I say if a client, family or SDM asks about being financially compensated?
When an occurrence happens within the organization and a caregiver believes there may be liability involved, it is important to discuss with the manager. The manager will then consult with the Risk Management Consultant in the Quality and Risk Management department. If compensation has not been discussed prior to a disclosure conversation, and family are now inquiring, the client/family/SDM should write a letter to the hospital asking for compensation. This letter will be given to our insurers, and they will open a file and initiate their review for the compensation request.
What if the client or family wants to tape, type or write notes during the disclosure conversation?
There is no doubt that there is discomfort involved at any time when one knows they are being taped. The disclosure conversation is about providing facts, expressing regret, and providing a follow-up plan. In our culture of safety, we value transparency, honesty and respect, and it would be advisable to proceed with a client’s request for taping, typing, or writing. The alternative may send the message that we are not being honest, or may not to follow through on what we are saying.

What if the client, family or SDM refuses to participate in a disclosure conversation?
The caregiver's legal and ethical responsibilities for disclosure are clear for many good reasons; however, there may be times when a client declines to participate. In this event, the caregiver should contact the Risk Management Consultant and document all efforts to disclose on the client record.
What resources are available to me when preparing for a disclosure conversation?
The Disclosure of Adverse Events policy (QRM -030) contains essential information for disclosure conversations. The Disclosure Toolkit will provide information, examples, and checklists to help with the full spectrum of disclosure, from preparation to documentation. The program manager is an essential resource to the process of both occurrence reporting and disclosure. As well, the Quality and Clinical Safety Leader is another resource and can provide guidance when needed. The Canadian Patient Safety Institute has developed disclosure guidelines that can provide further information to this toolkit. The website for these guidelines can be found under *References.*
I know that disclosure needs to happen; however, I don't know if I can really do that. I am not feeling that strong myself. What do I do?
It is important to talk to your manager about your concerns. If you need the assistance of the Employee Assistance Program, Pastoral Care, and or consultation with an Ethicist, your manager can help you with the details of how to access these services. You may want to check with your professional association to talk with someone regarding any professional or legal questions you may have regarding your responsibilities as a caregiver for disclosure or other types of support that may be available to you.
What caregiver is responsible for disclosure of an adverse event?
The responsibility of disclosure usually rests with the most responsible care provider, usually the physician. However, depending upon the situation, the disclosure may be done by the manager and/or other most responsible caregiver (i.e. social worker, nurse practitioner, nurse, etc). What is most important to consider is who is most knowledgeable about the situation, who has an established relationship, who can explain the care plan, and/or if the client has a preference. Deciding who will take the lead in the disclosure conversation needs to be discussed in the planning stage with the care team. The goal is to ensure the client gets the right information, from the right person.

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