Full Version 10. Know The Process when Harm Happens

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Sometimes, unintended harm or injury can happen to a patient who is receiving healthcare services.

Patients expect to receive safe healthcare services. Healthcare providers do their best to give safe care. However, unplanned things can happen to patients that cause them serious harm. Ask questions. Get involved in your care.

In Manitoba, the regional health authorities' facilities have clear steps for reporting unintended, harmful incidents. Patients and families:

- Must be notified, as soon as possible, if a critical incident occurs
- Have the right to report critical incidents they believe occurred
- Can call the Critical Incident Reporting Line at 788-8222 in Winnipeg or their regional health authority (outside of Winnipeg)

What is a critical incident (CI)?

A CI is an unplanned and undesired event that occurs when a patient receives health services.

- It results in serious harm to the patient (injury, disability, death).
- It is not related to the patient's main health condition.
- It results from the healthcare service provided.
- Examples - surgery on the wrong body part, wrong dose of medicine resulting in organ damage

What is disclosure?

Disclosure is the process of telling patients and families about harmful incidents. This includes the facts about a critical incident.

What will the healthcare facility do if you had a critical incident?

- It will take care of your health needs.
- The facility will review the situation to see if it was a CI.
- If you had a CI, the healthcare facility will:
    - Give you the facts about what really happened in a clear manner
    - Complete a written disclosure record that includes:
        - The facts of what actually happened, as they become known
        - How the CI will affect your health
        - Actions taken or to be taken to deal with the results of the CI
        - At your request, give you a free copy of the disclosure record
        - Look into the event to try to prevent it from happening to anyone else
        - Report the findings to Manitoba Health

What can you expect?

You can expect:

- An apology
- To be treated with care and respect
- Open and honest talks with providers as soon as possible
- To be contacted if new facts become known
- To be told what was done so far and what will happen next
- A review of the how and why of the event with recommendations to improve patient safety
- The review may take 90 days or longer depending on how complex the CI is.
- A free copy of the disclosure record if you ask for it
- The name of a contact person if you have any questions

How can you get a copy of the disclosure record?

- The disclosure record is kept in your medical record.
- You can ask for a free copy when the disclosure meeting takes place.
- You may have to put your request in writing. If you are unable to do this, ask the facility or your advocate to help make a written request.
- The facility must help you and reply to your request openly, accurately, completely and as soon as possible. Source A Guide to the Personal Health Information Act.
- Facilities (trustees) must provide you with the facts that you request. They cannot give the names of who did what that resulted in the harm.

Manitoba's Personal Health Information Act (PHIA) states situations where the facility may refuse to share some types of information. In these cases, the facility must:

- Tell you in writing why the facts can't be provided.
- Tell you that you have the right to complain to the Manitoba Ombudsman.

How will the healthcare facility prevent the same thing from happening to someone else?

- A Critical Incident Review Committee studies the CI. It suggests how to improve the safety of patients. Its recommendations are sent to Manitoba Health with a 3-month status update.

How long will the CI review take?

- The review may take up to 90 days or longer if the situation is complex.

Whom do you call if you have questions?

- Ask the provider for the name of the patient representative and/or patient safety contact.

What are your rights and responsibilities as a patient?

Most medical care involves some level of risk for patients. You need to know and understand any risks before you agree to treatments.

- You have the right to know about the benefits, risks, success rates, and other options for treatment. This is called informed consent. See *Know Your Patient Rights.*
- Ask questions before you agree to treatments.
- You need to understand fully the facts that providers share with you.
- You have the right to a second opinion before agreeing to any treatments.

What supports may be necessary if harm happens?

You may need:

- Emotional and practical supports
- Timely access to other services such as testing, treatments, or transfers to specialists
- An assigned staff member to see that practical/emotional supports are in place
- Access to information about social workers, counseling, homecare service, and community or spiritual supports
- Access to language interpreters and visual or hearing supports to be sure you know the facts

How can you learn more about Critical Incidents (CI)?

- Go to the Legislative Assembly of Manitoba: http://web2.gov.mb.ca/bills/38-3/b017e.php

How can you learn more?

- Go to www.mips.ca and www.safetoask.ca.
- Call the office of the Manitoba Ombudsman at 982-9130 in Winnipeg or 1-800-665-0531 toll-free in Manitoba.

Resources

- Manitoba Institute for Patient Safety (MIPS) websites: www.safetoask.ca and www.mips.ca.
    - *Critical Incident and Disclosure Resource Materials (posters and pamphlets)* http://mips.ca/hp-critical-incidents.html
- *A Guide to a Critical Incident and Disclosure: Information for Patients and Families.* Winnipeg, MB: Manitoba Institute for Patient Safety; November 2009. http://mips.ca/assets/guide_to_ci_and_disclosure-update-2016.pdf
- *Canadian Disclosure Guidelines*. Disclosure Working Group. Edmonton, AB: Canadian Patient Safety Institute; 2008. www.patientsafetyinstitute.ca/English/toolsResources/disclosure/Pages/default.aspx
- *Communicating with your Patient about Harm: Disclosure of Adverse Events*. Canadian Medical Protective Association. www.cmpa-acpm.ca/cmpapd04/docs/resource_files/ml_guides/disclosure/introduction/index-e.html
- Ombudsman Manitoba. www.ombudsman.mb.ca
- *Patient Safety Primer: Error Disclosure*. Agency for Healthcare Research and Quality (United States). www.psnet.ahrq.gov/primer.aspx?primerID=2