When something goes wrong

Information for patients who've been harmed during healthcare

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As a patient, you expect safe healthcare. But things can go wrong – even with skilled healthcare providers in environments and spaces designed to be safe.

When something goes wrong in healthcare, we call it a patient safety incident. Most incidents are minor and cause no harm. But if something happens and you are harmed, someone should talk with you (and anyone you wish to have with you for support) as soon as possible.

This process is called *disclosure*. Disclosure should focus on you and your needs, bring the right people together to talk about and learn from what happened, and help make the healthcare system safer. The discussion may involve one or more meetings over time.

What to expect if something goes wrong

Someone familiar with the situation will talk to you and your support person(s). They may ask other people to be part of the conversation to provide support or answer questions. At first, they may not have all the facts about what happened and why. But they will explain what they know at the time and make a plan with you to follow up once more information is known. They'll also talk about any changes to your care that may be needed because of the incident, like blood work or other tests.

Having someone with you for support

You're welcome to bring one or more friends or family members with you to disclosure meetings for emotional support and to help make sure you get the information and help you need. This should be someone who:

- You are comfortable with and can talk to easily
- You agree can hear personal information about you
- Can take the time to be with you

Your role in the disclosure process

Come with your questions, your understanding of what happened, and any notes you've written down. If the process hasn't been explained, ask how it works and what you can expect. Ask for the information and support you need. If you feel you aren't getting it, ask for another meeting.

Disclosure discussions can be an emotional experience for everyone. Depending on the situation, you may be dealing with many emotions including anger, fear, and grief. When something goes wrong, healthcare providers will also experience sadness, fear, and self-doubt about what happened. Being able to sit with you and talk about what happened can support your healing and theirs.

It's important to remain focused on understanding the facts of what happened, why it happened, and what can be done to improve safety. The providers involved want to work with you to understand the incident and to make sure that your care needs are met. If you're uncomfortable, or if you feel worried that talking about your concerns might affect your care going forward, you can ask to have a manager join the conversation. You can request a second opinion or a transfer to another care team if you continue to have concerns.

You can start the disclosure process yourself. If you think something has gone wrong in your care, talk to your healthcare provider or ask to speak with a manager. For example, you can say:

"Things didn't go as I expected. Who can I talk to about my concerns?"

"I feel something has gone wrong with my care and I would like to talk to someone about that."

You can expect:

- To be treated with respect and understanding
- An honest, open, and timely disclosure of what went wrong and how it affects you
- A sincere and timely apology
- An explanation if there is information that can't be shared
- An opportunity to share in your own words your perspective about what happened
- To have a say in the review of the incident and offer your ideas to improve safety
- To choose a support person(s) to be with you at meetings and receive information
- To be told who you can contact with any concerns throughout the process
- To be kept informed about the review process and what is being done to make care safer
- Accountability from the healthcare team

You should be offered:

- The time to ask as many questions as you need to and have them answered in a way you can understand
- Follow-up meetings if it takes time to learn all the facts about the incident
- A second opinion about your care from another healthcare provider if you wish
- The support you need, including emotional support, information, or referral to other healthcare professionals
- Interpreter services and other practical support

Disclosure is an exchange of information over time. It is not a one-time, one-way sharing of information. It is important that you, as the patient, have the chance to tell your story in your own words.

IMPROVING SAFETY

When a patient safety incident occurs, a review may be done. These reviews are meant to identify system-level things that may have contributed to the incident – and not to point the finger at an individual healthcare provider. A safety review takes a step back and looks at the bigger picture, so nothing is missed.

Blame is a barrier to safety

If reviews focus on blaming individuals, people naturally feel afraid. Incidents go unreported, and these hidden problems continue to endanger patients. A fair and open review looks at all the factors that may have played a part in someone's actions or decisions. When healthcare workers know they'll be judged fairly, they're much more likely to speak up when something happens – and that makes the system safer.

For example, a pharmacist may have given you the wrong medication, but the medication label might have closely resembled another product, or the medications might have been stored in the wrong place. A fair review looks at the whole process to see all the possible ways to improve. This includes asking you for your thoughts and ideas. It can take weeks or even months to review the details thoroughly. You should be kept informed along the way.

Sometimes disclosure can't include everything

The healthcare team should be open and honest with you. There may be things the team can't tell you about for privacy reasons – for example, if any other patients were harmed or what happens to the provider involved. In some cases, legislation prevents this information from being shared. It's also important to know that disclosure will not provide you with a full investigative report, legal advice, or financial settlement. Ask questions if you don't understand.

YOU CAN HELP MAKE HEALTHCARE SAFER – FOR YOURSELF, LOVED ONES, AND OTHERS

Talk to your healthcare provider any time you think something has gone wrong. Write down your questions and a timeline of the event as you know it.

You can help prevent patient safety incidents by taking an active role in your healthcare. The HQCA website has **resources** to help you do so when working with your healthcare team. Visit **hqca.ca/info**

The Alberta Health Charter describes roles and responsibilities for the patient and the provider within the health system. See **https://www.alberta.ca/alberta-health-charter.aspx**

The Office of the Alberta Health Advocates provides support and advice in dealing with concerns about health services in Alberta. Learn more at **https://www.alberta.ca/office-of-alberta-health-advocates.aspx**