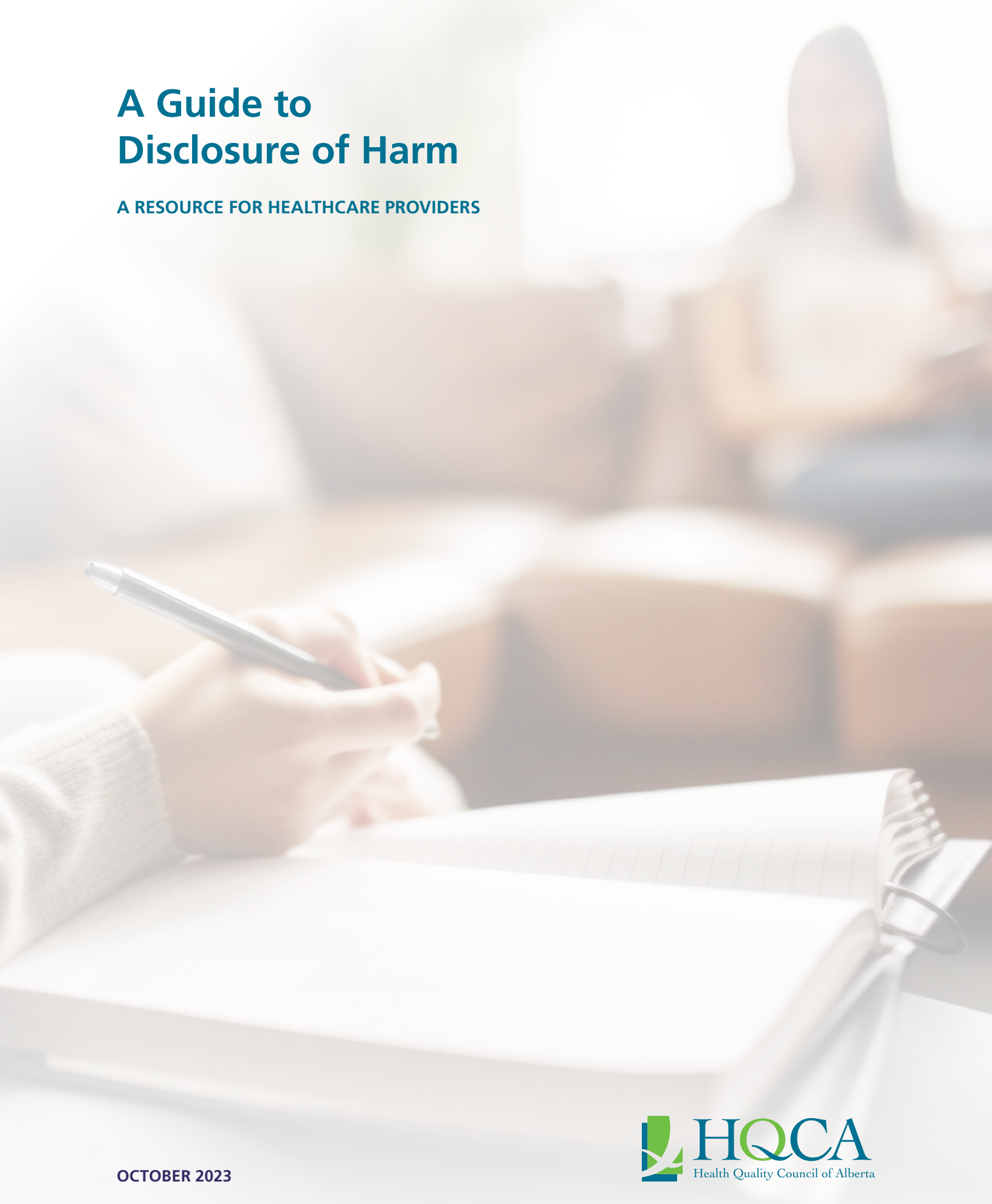
# A Guide to Disclosure of Harm

## A RESOURCE FOR HEALTHCARE PROVIDERS



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HQCA
Health Quality Council of Alberta

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# A Guide to Disclosure of Harm

## When something goes wrong

As a **healthcare provider*** you strive to deliver care that is safe. But things don't always go as planned: sometimes people receiving care are **harmed**. When this happens, it is upsetting for everyone involved.

Someone who has been harmed while receiving healthcare deserves to receive timely, open, respectful, and transparent communication. **Disclosure** is the process that guides this communication.

Disclosure is an established practice in Canada and many other countries. It is widely accepted as the right thing to do. Yet, it doesn't always happen as intended. Several barriers to effective disclosure have been identified, including fear about potential consequences – such as loss of trust, threat of legal action, or reputational damage. Lack of skill in disclosure conversations and the absence of a **just culture** are also barriers. These barriers lead to a gap between policy and practice identified in the literature as the "disclosure gap."[1-5]

These barriers can be addressed by:

- Developing policies and guidelines for managing and reporting **patient safety incidents** that have caused harm
- Providing education and support for the patient and **support person(s)** and for the healthcare provider(s)
- Using a **trauma-informed approach** to disclosure conversations
- Gathering feedback from patients and staff after disclosure to inform ongoing improvement[6]
- Most importantly, embedding policies and processes within an overarching commitment to promoting a just culture

**Barriers to disclosure include fear of potential consequences: loss of trust, threat of legal action, or reputational damage; lack of skill in disclosure conversations; and the absence of a just culture.**

*"I firmly believe that everybody that day was working with my son's best intentions. The way the health authority handled this error has been incredible. Their openness to understand that there are safety defects in the system, and their openness to work with me and to try to fix them, have been unlike anything I've experienced in my own healthcare career to this point."*

***– Mom (a pharmacist) of a young child given the wrong IV (Saskatchewan Health Authority, 2015, 1:39)[7]***

Disclosure can be difficult for everyone involved. A systematic approach can help you manage patient safety incidents** compassionately, support healing for those harmed and providers, and use learning to improve care.

This guide provides an overview of disclosure and the disclosure process. It is not a comprehensive framework for disclosure nor a substitute for education and support for those leading or having disclosure conversations.

*See Glossary on page 17. All bolded terms in this document are defined in the Glosssary

**Also referred to as "incidents" in this document

# The Foundation for Disclosure

## Defining disclosure

Disclosure is an open discussion with a **patient** and identified support person(s) about an incident that harmed the patient. It typically involves an ongoing exchange of information over a period of time. Disclosure is not simply a one-way sharing of information. It is intended to be a meaningful dialogue and must include the patient perspective and their experience of the incident.

## Why disclosure is important

Disclosure is the ethical thing to do. Patients have a right to know what's happened during their care. Open and timely disclosure can benefit patients, family members, and providers by:

- Restoring trust within the patient-provider relationship[3,4]
- Ensuring patients and families can make informed choices in the patient's care plan[2]
- Understanding harm from the patient perspective and identifying the support they or their support person(s) need to address the impact of the harm (effects on their health and emotional well-being, trauma, and life disruptions)[6, 8]
- Providing patients, healthcare providers, and the organization an opportunity to heal[2, 4, 6, 7, 9]
- Promoting a just culture, where learning from patient safety incidents is viewed as an opportunity to make the healthcare system safer[2, 9]

## Disclosure within a just culture

Disclosure does not stand alone; it is embedded in an organization's response to patient safety incidents and a culture in which the principles of patient safety are promoted and upheld.

In the past, attitudes about such incidents were grounded in a culture of blame and shame, often leading to secrecy, embarrassment, and fear of punishment. In a just culture, safety incidents and threats are seen as opportunities to learn about healthcare system weaknesses and make changes.

A fair and transparent process looks at all the factors that may have contributed to 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 healthcare system safer.

**If not done well, disclosure can lead to anger and frustration, and cause further harm. Patients have said the way they were treated after being harmed was more traumatic than the incident itself.**

*"It was about two years later … we had that meeting, and it was from the very moment we were both in that same room that it felt complete. It felt like the circle had now come around, and that we were able to sit and talk about what happened and about the impact it had on both of us … what we had gone through was so similar."*

***– Daughter of a woman given a fatal dose of the wrong medication, who waited two years to meet with the head of the team involved (Patient Safety by Healthcare Excellence Canada, 2015, 9:00)[10]***

Disclosure of harm supports a just culture by enabling open discussions needed for learning and improving. The HQCA has resources to support you in conducting a fair and systematic review of a patient safety incident. (See Resources on page 14.) These include a framework and tools for a just individual assessment process to evaluate the actions or inactions of healthcare workers.

# Understanding Disclosure

Every situation is different, and harm can be experienced in many different types of healthcare settings. A common understanding of disclosure supports a consistent approach across the healthcare system.

## Threshold for disclosure

When a patient safety incident or close call happens, transparency with the patient is important. The requirement for disclosure may vary based on the specific situation and the harm experienced.

Professional requirements, organizational policies, and generally accepted practices determine when disclosure is necessary and when it is optional.

Disclosure *must* occur any time a patient is harmed while receiving healthcare or there is a risk of future harm.

**Example:** A patient is given the wrong dose of medication and has a serious reaction to it.

Disclosure *should also* occur when there is no apparent harm to the patient but the potential for harm remains, or there are changes to care or monitoring. Disclosure supports an open and trusting relationship with the patient and enables the patient and support person(s) to watch for any change in condition.

**Example:** A patient is given the wrong dose of medication; no harm is anticipated, but additional blood work is required.

Disclosure *may* occur if the incident did not cause harm or if harm was narrowly avoided. Consider how the patient would benefit from knowing or what they would want to know. Disclosure *should* occur if there is a similar, ongoing risk, or if the patient is aware of the incident.

**Example:** A wrong dose of medication is identified before being administered.

It can be challenging to disclose incidents where harm is minimal or not apparent. You may worry about causing unnecessary anxiety for patients, having time to disclose effectively, and determining what the patient would want to know. Patients generally want to know if something has gone wrong and may in fact already know or suspect it. Disclosure helps to maintain a trusting relationship and supports the patient in being actively engaged in their healthcare. Sometimes it is the patient who identifies the harm or reports an incident. You may feel defensive in that situation, but remember that the patient is in the best position to know when they've been harmed. Listen to them, and commit to following up once you have gathered more information.

**To a healthcare provider, a patient's partial loss of hearing from complications during surgery might not seem like significant harm; but if that patient is a musician, hearing loss is life-changing and potentially career ending. Understanding the whole person will lead to more compassionate disclosure.**

### BRING A PERSON-CENTRED CARE PERSPECTIVE TO DISCLOSURE

Harm may be physical or psychological. It is commonly defined as an unexpected outcome for the patient, resulting from the care or services provided, which negatively affects the patient's health, well-being, or quality of life.

Because of personal circumstances or past experiences with the healthcare system – which may include harm or trauma – patients may view an incident very differently than healthcare providers do. Understanding the patient's perspective is essential to effective disclosure.

For example, even if no serious physical harm occurs, a medication error that requires ongoing monitoring and blood work may be devastating to a patient with an extreme fear of needles. Being aware of that fear helps you understand what support a patient may need.

## What to disclose

What patients want to know from disclosure is well established,[1, 4, 5, 11] and should always include:

- Acknowledgment that a patient safety incident has occurred
- A genuine and sincere **apology** (see page 10 for more about apology protection in Alberta)
- An explanation of what and why the incident happened
- Actions that have been or will be taken to improve safety in the future

You likely won't know all the facts by the first conversation. Different types of information will be available at each step of the process. Be sure to explain this to the patient. Don't wait until you have all the facts before disclosing to the patient. If you delay, you may miss the opportunity to restore trust in the relationship.

Share information that gives patients an accurate understanding of the incident and harm that occurred.

Be up front with patients when information can't be shared. Patients often want to know if a staff member will be disciplined, for example. Explaining at the outset why you can't tell them – whether for legislative reasons or out of concern for the staff person's privacy and well-being – will increase the patient's trust in the disclosure process. Patients who don't fully understand why certain information is being withheld may turn to other channels including litigation or complaints processes.[8]

**Disclosure is an exchange of information over time. It is not a one-time, one-way sharing of information.**

*"We wanted to know what had happened and why it had happened. … When those meetings were not forthcoming after the medical examiner's report, we decided to sue, because that is the only avenue that was open, the only recourse. No one would talk with us – it was so frustrating. We didn't want to sue – we wanted answers."*

***– Mom whose daughter died as a result of a missed diagnosis. (Patient Safety by Healthcare Excellence Canada, 2013, 4:38)[12]***

### INCLUDE

- Information that is factual and agreed upon through consensus among the healthcare team before beginning the disclosure process
- Information related only to the event itself

### LEAVE OUT

- Opinions, speculation, and statements of blame
- Information about other patients involved, if any
- Administrative or disciplinary action taken against individual healthcare providers

## Who should disclose

Providers who were directly involved with the patient when harm occurred should participate in disclosure. Patients and their support person(s) most often want to hear from them. When the providers don't participate, patients may suspect information is being withheld or the provider is "hiding" behind the protection of the organization or legislation.

A team approach ensures that everyone who should be present is included. When deciding who should attend, consider:

- The nature of the incident and the harm experienced
- The information being shared
- The relationship between the team members and the patient and support person(s)
- The current and future needs of the patient and support person(s)
- The emotional readiness of the involved providers to participate
- Individual skills in effectively disclosing the harm

A healthcare provider typically leads the initial disclosure, supported by leadership as needed. Conversations during and after investigation are often led by a leader. When deciding who should lead, think about:

- Who is best able to share with the patient and support person(s) what happened and the consequences of the harm the patient has experienced
- Who has an ongoing relationship with the patient
- Who can discuss any changes to the plan of care
- Who can be an ongoing point of contact to support the patient through the process

Disclosure of incidents involving significant harm or that resulted in a death should be supported by a leader with experience in disclosure.

## Disclosure benefits the provider, too

Talking directly with the patient can benefit the healthcare providers involved in an incident. It gives the provider the chance to share some of their own emotions, and the deep impact the event likely had on them as well. When those conversations are well facilitated and support for all parties is available, talking about the incident can help everyone heal.[1, 3, 4]

Not all healthcare providers involved in the patient's care will be able to participate in the disclosure process. Keep them informed along the way, so they know what information was shared, and make sure they know who the patient can speak to if they have more questions. This can ensure consistent communication and sensitivity toward the patient and support person(s).

*"One of the things that challenged me to move beyond the error was the fact we were never given the opportunity just to say the simple thing that we were sorry."*

***– Former head of pharmacy for Calgary hospitals (Patient Safety by Healthcare Excellence Canada, 2015, 8:20)[10]***

### A NOTE ABOUT QUALITY ASSURANCE REVIEWS AND PRIVACY LEGISLATION

In Alberta, reviews of patient safety incidents may fall under a broader Quality Assurance Committee (QAC) as defined by Section 9 of the *Alberta Evidence Act*.[13] Facts that are confirmed in the patient's chart or verified by the investigating committee should be disclosed to the patient and family.

If Section 9 protection is applicable or if you are unsure, refer to organizational policies and consult with leadership to ensure disclosure meets legislated requirements. If a safety review is conducted outside of QA protection the same principles would apply.

In most cases, the *Health Information Act* defines the information that can be disclosed and under what circumstances. Where services are not covered under the Alberta Health Care Insurance Plan – for example, some physiotherapy or chiropractic care – the *Personal Information Protection Act* would apply.

## Disclosing to the patient

Disclosure should be made to the patient. Work with the patient to identify family members or others they may want involved in the process. Support for the patient is important, particularly for disclosure meetings that may occur over the long term.

Other considerations include:

- The patient's ability to understand the situation
- The nature of the information being provided
- The availability of emotional support immediately following disclosure

If the patient cannot participate in a disclosure conversation for medical or cognitive reasons, check if there is a legal decision-maker who needs to be involved. Other special circumstances that affect how disclosure happens are referenced on page 14.

## Disclosure meetings

Sometimes the initial disclosure conversation meets the patient's needs. In cases where more meetings are necessary, plan the process with the patient and support person(s):

- Confirm the patient wants to meet again and who they want to support them.
- Determine where and when they want to meet and what supports are required.
- Identify the key person who will answer the patient's questions.
- Ask the patient who they feel should be included from the healthcare team in follow-up meetings.
- Identify a contact person if the patient has questions or concerns between meetings.
- Agree on a timeline for future updates and meetings.

Disclosure meetings are often difficult. Patients and their support person(s) may need time to think about and fully understand what was shared in the initial conversation. Be patient. They may ask for more meetings and for ongoing communication as questions arise between meetings.

A patient may ask to record a meeting. Check your organization's policy on recording conversations before answering.

Think about where disclosure will occur and try to accommodate the patient's preference. The setting should be comfortable, private, and quiet. Ensure there will be no interruptions, such as from pages or phones. The setup of the room should support open dialogue. Avoid a seating plan that involves healthcare providers on one side of a table and the patient and support person(s) on the other: it may set an adversarial tone to the meeting.

**Limit the number of people participating in disclosure meetings to ensure the patient's comfort. Too many healthcare providers in the room can be intimidating and create a power imbalance, which can break down trust.**

Make sure to understand any barriers a patient might have to attending an in-person meeting. This could include caregiving responsibilities, work commitments, or the need to travel to the meeting location. Work with the patient to find ways to address these barriers. If an in-person meeting isn't feasible, ask the patient's preference for an option such as a virtual platform, telephone call, or written summary.

Before disclosure, you may need to notify and consult legal counsel and liability protection associations, such as the Canadian Medical Protective Association or Canadian Nurses Protective Society, and other insurers. Internal resources within your organization may also be available to help you prepare for a disclosure meeting.

**The setup of the room should support open dialogue. Don't seat healthcare providers on one side of a table and the patient and their support person(s) on the other: it may set an adversarial tone to the meeting.**

*"One physician was very forthcoming, and we could certainly see the remorse in his eyes … He realized that the changes he made, how he practises differently now because of [our daughter's] death, were gifts to us."*

***– Mom whose daughter died as a result of a missed diagnosis. (Patient Safety by Healthcare Excellence Canada, 2013, 7:55)[12]***

# The Disclosure Process

Disclosure can be a complex and emotionally charged process that should be managed with compassion, respectful communication, and support for those affected. A systematic approach helps achieve this.

The disclosure process must adapt to individual situations, but it generally occurs in two broad stages: initial disclosure and post-analysis disclosure.

## Initial disclosure

First and foremost, when harm occurs, address the patient's immediate healthcare needs and provide emotional support to the patient and support person(s).

Initial disclosure with the patient and support person(s) should happen as soon as possible based on the patient's circumstances – ideally within hours of the incident and at most within one to two days. Initial disclosure may involve a single discussion or a series of conversations, depending on what happened, the harm experienced, and how much is known about what happened.

It's unlikely that all the facts will be known at the time of first disclosure. Your first conversation will likely focus on the patient's current clinical condition and any changes to the care plan. It is okay to say there are more questions than answers at this stage. Offer a commitment to get more information and follow up.

Before starting a disclosure conversation, make sure that the patient is aware of the process and knows what to expect. In disclosure meetings, the patient should understand who is involved and what their role is. This helps reduce confusion, fear, and concern.

Initial disclosure should include the following, in the order appropriate to the situation:

- An acknowledgment that an incident has occurred resulting in harm or potential for harm
- A sincere apology
- Based on what is known at the time, a factual statement about what happened, free of jargon and speculation
- Time for the patient and/or support person(s) to respond to or clarify information about the facts presented
- An opportunity for the patient and family to share their thoughts about the incident and the impact for them both clinically and personally
- An explanation of the potential consequences for the patient, including both short- and long-term effects and any changes in care or monitoring
- Offers of emotional and practical support as required based on the needs of the patient and/or support person(s)
- If known, any actions that were taken or will be taken to improve safety
- A brief overview of the process that will follow (if relevant) and what the patient and support person can expect to learn and when
- An offer for future meetings, what to expect from those meetings, and a key contact for their questions
- Confirmation of preferred method and time for further contact and meeting preferences
- Time for clarification and questions from the patient and support person(s)

**Initial disclosure with the patient and support person(s) should happen as soon as possible based on the patient's circumstances – ideally within hours of the incident and at most within one to two days.**

## Ongoing and post-analysis disclosure

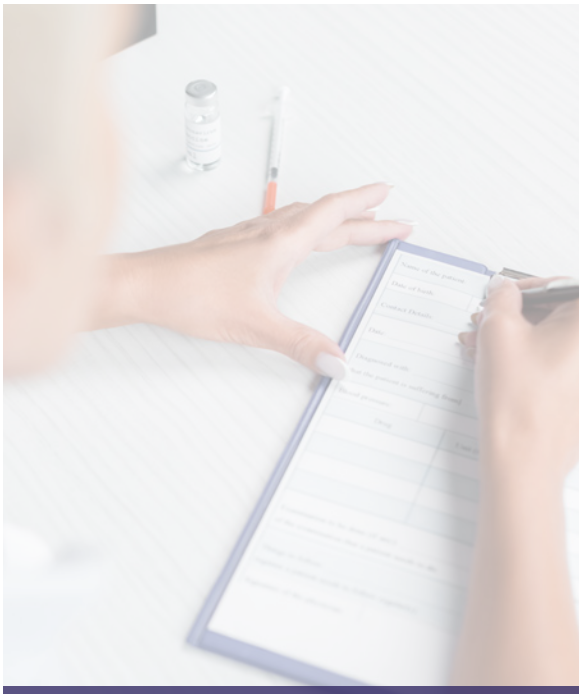
Most cases of disclosure require ongoing conversations as information becomes available. Post-analysis disclosure occurs when a review has been completed.[9]

After the first conversation, disclosure meetings provide an opportunity to:

- Share additional facts as information becomes available, and check back with the patient periodically if the review is a lengthy one
- Respond to any patient questions and listen to anything the patient wants to share
- Clarify or reinforce information discussed in prior meetings
- Continue to offer emotional and practical support
- Offer further apology based on the findings of the review, including a statement of responsibility if appropriate
- Share additional actions that have been or will be taken to improve safety

In follow-up meetings, include the same elements as the initial disclosure meeting:

- An acknowledgment the incident occurred
- An apology
- An explanation of what happened
- Any actions taken to reduce the risk of others being harmed



**It's unlikely that all the facts will be known at the time of first disclosure. Your first conversation will likely focus on the patient's current clinical condition and any changes to the care plan. It is okay to say there are more questions than answers at this stage. Offer a commitment to get more information and follow up.**

### A NOTE ABOUT APOLOGY IN DISCLOSURE

A critical element of disclosure is the apology. A genuine apology demonstrates compassion, validates the experience of the patient, and helps restore the relationship.

The nature of the apology will depend on the information known at the time of the disclosure conversation. An apology during an initial disclosure may simply express regret for what has occurred. A further apology with an admission of responsibility may be made in a later meeting if indicated by the systematic analysis of the incident. Regardless of the specific words used, the apology must be sincere and relevant to the harm experienced.

An apology is not considered an admission of liability.[13] In Alberta, Section 26.1(2)(a) of the *Alberta Evidence Act* (RSA 2000, C.A., 18) states that "an apology made by or on behalf of a person in connection with any matter does not constitute an express or implied admission of fault or liability by the person in connection with that matter" and "shall not be taken into account in any determination of fault or liability in connection with that matter."

Section 26.1(3) further states that "evidence of an apology made by or on behalf of a person in connection with any matter is not admissible in any court as evidence of the fault or liability of the person in connection with that matter."

The review of a patient safety incident using a systematic approach leads to a better understanding of the situation and actions that can be taken to improve safety (see Resources, page 14). Sharing that information through the post-analysis disclosure can help to meet the patient's emotional and information needs. When a patient suffers serious harm, they and their family often find meaning in the experience by knowing what happened to them will improve safety for others.

The disclosure process should be considered complete only when the patient:

- Feels they have an accurate understanding of the incident and actions taken to improve safety
- Has the information necessary to make informed decisions about their care
- Has answers to their questions to the extent the organization can provide them

Patients may be harmed further if disclosure fails to meet their clinical, emotional, and information needs. Maintain open lines of communication: answer questions as they arise and check how the patient is doing. Make sure the patient feels their needs have been met before closing the file.

**Disclosure is not intended to be a one-way sharing of information. Although providing clear and factual information to the patient is important, hearing their view of the incident is of equal value. Patients are reliable observers of what is happening in the environment and with their care. They have ideas to improve safety based on first-hand knowledge of what happens to and matters to patients.**

**Create measures to evaluate your disclosure processes and the outcomes for patients and providers. Ongoing improvement is important.**

Sometimes, a patient may feel the disclosure process can't resolve their situation. They may choose to discuss their concerns with the Office of Alberta Health Advocates or the relevant regulatory college (i.e., College of Physicians and Surgeons of Alberta, College of Registered Nurses of Alberta) and should be supported to do so. In some cases, concerns may come up that are outside the scope of the disclosure conversation. Those concerns should be acknowledged and addressed appropriately through an internal or external concerns resolution processes.

## Documentation

The healthcare provider who led each discussion should document an objective reflection of what happened in the disclosure meeting. Document in the progress notes or similar part of the patient's chart the initial disclosure meeting, phone conversations, and any other meetings that occur while the patient is still receiving care. Documentation lets the healthcare team know what information was provided to the patient and family. It ensures a common understanding of, and consistent communication about, the facts of the event. Always refer to and follow your organization's documentation policies.

Document the details of the disclosure meetings:

- Date, time, and location of the meetings
- Names of those present
- Known facts that were presented
- Any offers of support that were made
- Responses from the patient and/or support person(s)
- Questions raised by the patient and/or support person(s) and the responses provided
- Plans agreed to for the ongoing disclosure process, including timeline, key contact information for the organization, and any outstanding questions from the patient

Because disclosure meetings can be difficult for everyone participating, review the facts, decisions, and next steps at the end of each meeting to ensure everyone has a shared understanding. Designate a notetaker so the person leading the conversation can give their full attention to the patient and support person(s). Give the patient and support person(s) a copy of the meeting documentation. This supports openness and transparency.

**Consider individual perceptions and experiences regarding figures of authority and gender when deciding who will lead the disclosure. Those perceptions may interfere with effective communication.**

## Communicating effectively during disclosure

Disclosure may be something you are called upon to do infrequently, and so your opportunities to use and improve your disclosure skills may be limited. Access to training and education, and support from others with more experience, is essential.

Disclosure meetings are difficult not only for the patient and support person, but also for those disclosing the harm. To communicate effectively in these conversations, you must be able to approach the situation with empathy and sensitivity while also providing information in a clear, calm, and concise manner.

You can communicate more effectively in a disclosure meeting by adjusting the approach to the patient's needs:

- Use simple language and avoid medical or technical terms, jargon, or acronyms, unless the patient wants more technical information.
- Speak slowly and provide enough information for the patient and support person(s) to understand what is happening without overwhelming them.
- Confirm that what has been said has been understood.
- Pay attention to body language.
- Use a trauma-informed approach.
- Resist any urge to interrupt, and accept moments of silence in the conversation.
- Use active listening techniques.
- Pause frequently to allow information to be taken in, and check for questions and understanding.
- Ensure cultural safety – respect cultural values, and provide appropriate supports and resources as determined by the patient.
- Provide professional translation services if needed so the burden does not fall on a support person.
- Understand the patient's preferences and accommodate any needs or disabilities, whether visible or not.

To offer empathy and trauma-informed care, you should keep in mind that the patient may have been harmed before. Their past experiences may have shaken their trust in the healthcare system and affect how they receive the information you share.

Strong emotions often surface during disclosure meetings. Your team should recognize and have control of their own emotions before beginning disclosure. While it is important to keep emotions in check, patients need to see genuine concern and engagement from the healthcare provider. Anticipating the reaction of the patient and support person(s), and considering how the team will respond, can help prevent defensive statements that can further erode trust. Take a break when emotions are running high to allow people time to regain control, or book another time to continue the conversation if people are too upset.

You may be tempted to create a script for a disclosure meeting to ensure the messaging is consistent and the key points are made. It's important to have a plan for what to say and a clear understanding of the facts that can be shared, but a scripted disclosure may seem insincere. Following a rigid communication plan may also make it more difficult for the patient and family to share their experiences and concerns, and for the healthcare team to respond appropriately in the moment. Be prepared without creating the impression that the discussion is contrived.

## Emotional and practical support

Offer emotional and practical support to the patient at both the initial disclosure meeting and over the long term, such as:

- The availability of a nurse or other team member who knows the patient well
- Access to a social worker, counselling services, chaplain, or support programs
- Over the long term, referrals to grief programs, support groups, or counselling
- Help with parking, accommodation, or transportation, and how expenses will be approved

Check your organization's policies to understand what type of support you're able to offer, including approval of expenditures. If you're a sole practitioner or work in a small clinic, the type of support you can offer may be limited. If that's the case, be clear up front about what the patient can and can't expect.

**Imagine someone who was harmed in hospital due to a medication error now learning that the community pharmacist gave them the wrong prescription. Or a patient whose treatment was delayed due to lost paperwork now hearing that a mix-up with their lab work has delayed their surgery.**

Healthcare providers often feel a variety of emotions following a disclosure meeting. All those involved in the disclosure process need emotional support. Allowing time for the team to debrief after a disclosure meeting can help address the thoughts and feelings that arise. Where available, offer private counselling through employee assistance programs or referrals to local community counselling services. Offers of help should include both short- and long-term support.

Healthcare providers who were involved in the patient's care when the harm occurred may have additional need for support. It is common to experience:

- Self-doubt around one's ability to provide care
- Fear for the well-being of the patient
- Symptoms of depression, disappointment, self-blame, shame, and fear [2, 4]
- Fear of losing one's job or licence

*"Fear, disappointment, humiliation, failure – all of those thoughts were running through my mind as we were going through that immediate period."*

***– Former head of pharmacy for Calgary hospitals (Patient Safety by Healthcare Excellence Canada, 2015, 6:14)[10]***

Create opportunities for these providers to talk with colleagues in a safe space. This can help ease feelings of isolation and contribute to a just culture. Peer support has been shown to help healthcare providers involved in a patient safety incident. Healthcare Excellence Canada offers a Healthcare Worker Support Toolkit that you may find useful (see Resources, at right).

Be consistent in using a fair and transparent process to evaluate the action or inaction of the individual providers involved in the incident. This further contributes to a just culture in which providers feel supported.

The HQCA Just Culture website offers information about developing a safety culture as well as a process for Just Individual Assessment following a patient safety incident (see Resources, at right).

## Special circumstances

You may need to adapt your approach to disclosure in special situations, such as large-scale events or disclosure involving children or people with mental illness. The Canadian Disclosure Guidelines[9] offer guidance in such cases. You are encouraged to incorporate this information into your policies as appropriate; you may need to consult with legal counsel in some circumstances.

Disclosure of death or life-changing harm is very challenging. While the principles and process for disclosure remain the same, the discussions should be led by a skilled facilitator. Additional supports, advice, and resources may be needed.

## A final note

Despite everyone's best intentions, things can go wrong and patients can be harmed. What happens after the harm has occurred – how the incident is reported, disclosed, and reviewed – is important to helping everyone heal and to improving patient safety. Our healthcare system is safer when we learn from and talk about our mistakes.

## Resources

**HQCA Just Culture website:**
https://justculture.hqca.ca

**Healthcare Excellence Canada, Healthcare Worker Support Toolkit:**
https://www.healthcareexcellence.ca/en/resources/creating-a-safe-space-psychological-safety-of-healthcare-workers-peer-to-peer-support/creating-a-safe-space-healthcare-worker-support-toolkit/

**Alberta Health Services, Disclosure of Harm:**
https://www.albertahealthservices.ca/info/page9405.aspx#:~:text=Alberta%20Health%20Services%20acknowledges%20that,the%20right%20thing%20to%20do

**HQCA Systematic Systems Analysis: A Practical Approach to Patient Safety Reviews guidebook:**
https://hqca.ca/resources-for-improvement/patient-safety-review-guidebook

*"We wanted to know what had happened and why it had happened. And we also wanted reassurance that they were actually taking steps to make sure it didn't happen again. That is how we find meaning in [our daughter's] death."*

***– Mom whose daughter died as a result of a missed diagnosis. (Patient Safety by Healthcare Excellence Canada, 2013, 4:38)***

**Our healthcare system is safer when we learn from and talk about our mistakes.**

# APPENDIX: Summary of the Disclosure Process

## Plan for disclosure

- ✔ Gather existing agreed-upon facts.
- ✔ Determine who will be at the meeting and who will lead the discussion.
- ✔ Anticipate emotions and how to respond.
- ✔ Inform the patient of a possible safety incident, and describe the disclosure process and what to expect.
- ✔ Confirm the logistics of the meeting (time and place), considering patient preferences and needs.

## Initial discussion(s)

- ✔ Ensure everyone is introduced and explain the purpose of the conversation.
- ✔ Encourage the patient or support person(s) to relate their experience of the incident and its impact.
- ✔ Acknowledge the incident and explain any facts that are currently known.
- ✔ Apologize for the incident.
- ✔ Acknowledge the consequences for the patient and implications for their ongoing care.
- ✔ Provide an opportunity for the patient to respond to or clarify the facts presented.
- ✔ Offer practical and emotional support to the patient and support person(s).
- ✔ Answer questions honestly, without speculation or blame.
- ✔ Discuss what happens next – the ongoing plan for care and any further review or followup.
- ✔ Summarize the key points of the discussion and next steps if further disclosure is required.
- ✔ Provide the patient and support person(s) with a contact name for any follow-up concerns or questions.
- ✔ Document in the health record that disclosure has occurred and the details of the discussions.
- ✔ Provide the patient with a written summary of the discussion including facts presented, questions raised and answered, and identified next steps.

## Post-analysis disclosure plan

- ✔ Through a systematic incident review process, such as the Systematic Systems Analysis, establish what happened, why, and recommendations to improve the system.
- ✔ Confirm which facts and outcomes from the review can be shared with the patient per organization policy and privacy laws, and what cannot be included.
- ✔ Determine who will be at the meeting and who will lead the discussion.

## Subsequent and post-analysis disclosure meetings

- ✔ Reinforce or clarify information provided in the initial meeting.
- ✔ Apologize, and offer a statement of responsibility if appropriate following the analysis.
- ✔ Share any additional facts that have become available.
- ✔ Describe any actions taken as a result of the incident review process.
- ✔ Listen to any further information the patient wants to share.
- ✔ Respond to any questions.
- ✔ Continue to address emotional and practical support needs of the patient, support person(s), and providers.
- ✔ Discuss next steps – plan for care, additional follow-up if needed, and options for pursuing the matter further if the patient and support person(s) are dissatisfied with the outcome.
- ✔ Document in the health record that disclosure has occurred; include a factual summary of the meeting(s).
- ✔ Provide the patient with a written summary of the discussion that includes the facts presented, questions raised and answered, and the identified next steps with timelines. Ask the patient and support person(s) to verify the summary.

# Glossary

| TERM | DEFINITION |
|---|---|
| Apology | An expression of sympathy or regret, a statement that one is sorry or any other words or actions indicating contrition or commiseration, whether or not the words or actions admit or imply an admission of fault in connection with the matter to which the words or actions relate.[13] |
| Disclosure | An open discussion or series of discussions with a patient about an incident(s) that resulted in harm to that patient while they were receiving healthcare. |
| Harm | An unexpected outcome for the patient, resulting from the care and/or services provided, that negatively affects the patient's health, well-being, and/or quality of life. Harm may be physical or psychological. |
| Healthcare provider | An organization or individual who provides health services. |
| Just culture | Just culture is about the way in which an organization and individuals respond when something goes wrong with patient care. In a just culture, healthcare providers are supported and treated fairly. People feel safe to discuss patient safety incidents and safety concerns without fear of blame. Threats to patient safety are seen as opportunities to learn about weaknesses in the healthcare system that need to be addressed. Individual actions are assessed within the context of the system and they are not held accountable for system factors beyond their control.[14] |
| Patient | Patient means an adult or child who receives or has requested healthcare or services in the healthcare system. This term is inclusive of residents, clients, inpatients, and outpatients. |
| Patient safety incident | An event that could have resulted, or did result, in unnecessary harm to a patient.[9] Also referred to as an event, harm event, adverse event, or error. |
| Support person | One or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the healthcare system. This may include, but is not limited to, family members, legal guardians, translator, Elder, patient advocate, integrity officer, friends, or anyone else considered by the patient to be essential to their safety and well-being. |
| Trauma-informed approach | A trauma-informed approach to care acknowledges that healthcare organizations and care teams need to have a complete picture of a patient's life situation – past and present – in order to provide effective healthcare services with a healing orientation.[15] |

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