Whom may I contact if I have further questions?

You may contact ______________________________

____ at

____

if you have any questions.

How will I learn about the outcome of the CIRC?

- Staff involved in a CIRC will be informed of the outcome of the review according to the regional health authority or organization policy.

With whom can I not speak about the CI?

- The discussion you have as a part of the CIRC is granted legal privilege.
  - This means that you can not be questioned in legal proceedings about your discussions with the CIRC.
  - This protection will allow you to speak freely with the CIRC about the facts without fear of repercussions.
  - The discussions, activities and conversations you have with the CIRC can not be discussed with anyone else beyond the CIRC.

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The Facts about Critical Incidents and their Disclosure:

Frequently Asked Questions for Health Care Providers

This pamphlet is intended to supplement your regional policies. For more information, refer to your regional policies on Critical Incident Management and Critical Incident Disclosure.

What is a critical incident (CI)?

A critical incident is an unintended event that occurs when health services are provided to an individual and results in a consequence to him or her that:

(a) is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay, and;

(b) does not result from the individual's underlying health condition or from a risk inherent in providing the health services.

Examples of critical incidents might include:

- Being operated on the wrong side or site.
- Receiving the wrong medicine or wrong dose of a medicine that results in serious patient harm.
- Delaying treatment or not receiving treatment when this results in a preventable adverse patient outcome.
- "Breakdowns" in communication during transitions of care that result in serious patient harm.

Anyone (staff, patient or family member) can report a possible critical incident.

What will the health care organization/facility do if a CI happens?

- Provide care for the patient affected by the critical incident.
- Support the staff involved in the critical incident.
- Report the facts of the critical incident to Manitoba Health.
- Apologize to the patient and/or family.
- Give the facts about what happened to the patient and/or family in a clear manner.
- Complete a disclosure record.
- Form a Critical Incident Review Committee (CIRC) to review the event.
- Report the findings of the CIRC to Manitoba Health.

What is the purpose of the CIRC?

- To review the event to learn how to prevent the same thing from happening to someone else.
- To identify problems or contributing factors.
- To identify recommendations that will improve the health care system.

The purpose of the Critical Incident Review is to improve the health care system and make it safer.

How long will the CI review process take?

- The review may take 90 days (or longer) depending on how complex the critical incident is.

What is required to be disclosed by law to patients/families following a CI?

- The facts of what actually occurred regarding the critical incident.
- Any additional facts and the consequences for the individual involved as they become known.
- The actions taken to date and those that will be taken to address the consequences of the critical incident, including any health services, care or treatment that is advisable.

What can't be disclosed by law to patients/families following a CI?

- Any record or information prepared only for the use of a CIRC.
- Any report prepared for and provided by the regional health authority for the purposes of a CIRC.

Who should initially disclose to the patient/family?

- The person best suited to provide disclosure varies, depending upon the situation. Refer to your Critical Incident Disclosure Policy.

When is the initial disclosure best done?

- As soon as possible after the recognition of the event.

Where should the disclosure occur?

- In a quiet, private environment that is comfortable for the patient and their family.

Why do early disclosure?

- To address the patient's/family's concerns openly, honestly and respectfully.
- Early disclosure starts to rebuild the relationship of trust, openness and transparency.
- It's the law.

What needs to be documented following a CI disclosure?

- The facts, the consequences to the individual and the actions taken and to be taken to address the consequences of the critical incident.

Where is disclosure documentation kept?

- In the patient's medical record/chart.

Can the patient, or substitute decision maker, receive a copy of the disclosure note?

Yes, a copy can be requested from the person(s) who provides the disclosure. The law says this is to be provided free of charge. Follow your organization's Release of Information/PHIA policy and procedure.

Where can I go to obtain support if I am involved in a critical incident?

Being involved in a critical incident can be stressful for the health care providers involved. You are not alone. You can obtain support from the following resources:

- Your manager.
- A member of your Critical Incident Stress Management Team.
- Your social worker.
- Your spiritual care worker.
- Your benefit plans, such as Employee Assistance Program.
- Your professional association.
- Your union.