

### How long will this critical incident review take?

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

### Who may you contact if you have questions about the critical incident review process?

You may contact \_\_\_\_\_  
at \_\_\_\_\_  
if you have any questions.

Please contact your healthcare provider (e.g. doctor or nurse) directly, if you have questions about your ongoing care.

### How can you learn more about critical incidents?

Go to: [www.gov.mb.ca/health/patientsafety/](http://www.gov.mb.ca/health/patientsafety/)

### How can you learn more about patient safety?

Go to: [www.mips.ca](http://www.mips.ca)

### What if you need help coping with a critical incident?

Emotional support may help you deal with the feelings you have after a critical incident. For help, call **Klinik Community Health, 204-788-8222 or 1-833-788-8222, 24 hours/day.**

# A Guide to a Critical Incident and Disclosure:



## We Are Sorry

We are sorry that a critical incident has occurred. We want to provide you with an explanation of what has happened.

We understand that you may be feeling many emotions. This is common. It is a hard time for you and your family. We understand that this is difficult and upsetting for all concerned. We want you to know the situation is being taken very seriously.

When people receive healthcare services they expect to receive safe care. Healthcare providers do their best to ensure this is the case. However, unexpected things can happen that cause unintended harm. An unexpected event can result from the healthcare provided and not due to the patient's illness or the usual risks with a specific treatment. When this event happens, it is called a **critical incident**. When healthcare providers discuss the facts about a critical incident with the patient, this process is called **disclosure**.



## Information for Patients and Families

Adapted with permission from: Australia Commission on Safety and Quality in Health Care; Health Quality Council of Alberta; and British Columbia Patient Safety & Quality Council



### How does the law define a critical incident?

A critical incident (CI) is an *unintended* event that occurs when health services are provided to a person and result in an effect to him or her that:

- Is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay; and
- Does not result from the person's underlying health condition or from a risk inherent in providing the health services. This means the unintended event does not result from the patient's illness or the risk in treating the illness, but from the healthcare provided.

### What are some examples of a critical incident?

There are many examples of unintended incidents that are viewed to be critical incidents. Some are:

- Being operated on the wrong side or site.
- Receiving the wrong medicine or wrong dose of medicine that results in organ damage such as kidney damage.



### What will the healthcare organization/facility do?

This healthcare organization will:

- Register the critical incident with Manitoba Health.
- Give you the facts about what actually happened in a clear manner.
- Complete a disclosure record that includes:
  - The facts of what actually happened as they become known.
  - Details of how this event will or possibly may impact on your health.
  - The actions taken or to be taken to deal with the results of the critical incident. This may include health services, care or treatment advised for the patient.
- At your request, provide you with a copy of the disclosure record free-of-charge.
- Review the event to learn how to prevent the same thing from happening to someone else.
- Report the investigation findings to Manitoba Health.

### What can you expect from us?

You can expect:

- An apology – we are sorry this happened.
- To be treated with care, attention and respect.
- Open and honest communication so you understand the facts about what happened. This will occur as soon as possible.
- Someone will contact you again, if and when new facts become known.
- To be told what has been done so far and what will happen next.



You can expect the organization/facility to review:

- The how and why of the event.
- Recommended changes to improve patient safety to try to prevent the same harm from happening again.
- The process to improve the health system, not to assign blame.

### Where may you get a copy of the disclosure record?

Upon request, the organization will provide you with a copy of the disclosure record free-of-charge.

The disclosure record, including the facts of what actually happened with the critical incident and the effects, will be written in the medical record/chart.

The patient, or the person authorized to act on the patient's behalf, may get a copy of the disclosure record by calling

\_\_\_\_\_ at

\_\_\_\_\_

Upon request, a full review of your medical record/chart is available.

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

A critical incident review committee studies the event and makes recommendations and suggests ways to improve the safety of patient care.