MEMO

Thunder Bay Regional Health Sciences Centre

To: All Staff and Professional Staff

From: Quality and Risk Management

Date: March 26, 2025

RE: **Updated Policy: QM-70 – Mandatory Disclosure of Harm/Critical Incidents**

For circulation to All Staff and Professional Staff.

Please be advised, the Hospital's Mandatory Disclosure of Harm/Critical Incidents (QM-70) policy has been revised.

Actions Required

- All – Review the updated policy to familiarize yourself with key policy changes and as a refresher on procedural steps.
- Managers – Review this memo and the attached poster with your staff during Safety/Quality Huddles and post in your department.

Policy Changes

- **Scope Change:**
  Volunteers removed as out of scope.
- **New Definition Added:**
  Clinical Debrief (aka "Hot Debrief"): Following a critical incident, a meeting to summarize the case, determine what went well and opportunities for improvement, and highlight where actions are required.
- **Procedure 5.1 Updated:**
  Upon the discovery of harm (any level), the healthcare team should meet as soon as possible to discuss. This may just be a conversation with the Department Manager, or for more serious events/critical incidents, a clinical debriefing (aka "hot debrief") should occur. Members of this debrief team may include involved Staff, Professional Staff, Managers, Directors, Section Chiefs, Quality and Risk Management, the Executive Vice President(s) and Chief of Staff.

Process Reminders

- Please see the attached poster.

If you have any questions, please email: TBRHSC.QualityandRiskManagement@tbh.net