Thunder Bay Regional Health Sciences Centre

UPDATE: QM-70

Mandatory Disclosure of Harm/Critical Incidents

QM-70 provides an overview of managing harm/critical incidents at Thunder Bay Regional Health Sciences Centre (the Hospital), as required by legislation.

What's new?

- **Scope Change:**
  Volunteers removed as out of scope.
- **New Definition – 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

- Disclosure is required for **all** levels of harm, whether mild, moderate, severe or critical incident.
- Disclosure of critical incidents should not be provided by a healthcare professional in isolation of Hospital administration.
- **Definition – Critical Incident:**
  Any unintended event that occurs when a patient receives treatment in a hospital:
  a) That results in death, or serious disability, injury or harm to the patient;
  b) Does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment.
- Reporting for all incidents will follow the processes outlined in policy **QM-60** *Incident Learning System (ILS): Reporting, Investigation and Trending of Incidents and Near Misses*.

If you have any questions, please contact:
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