

TITLE

DISCLOSURE OF HARMSCOPE

Provincial

DOCUMENT

PS-95-01

APPROVAL AUTHORITY

Quality Safety and Outcomes Improvement Executive Committee

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Not applicable

PARENT DOCUMENT TITLE, TYPE AND NUMBER

Recognizing and Responding to Hazards, Close Calls and Clinical Adverse Events Policy (#PS-95)

SCHEDULED REVIEW DATE

November 01, 2020

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

If you have any questions or comments regarding the information in this document, please contact the Policy & Forms Department at policy@ahs.ca. The Policy & Forms website is the official source of current approved policies, procedures, directives, standards, protocols and guidelines.

OBJECTIVES

- To outline the key steps of the Disclosure of Harm process when a **patient** has been harmed, there is potential for **harm** in the future or there will be a change in patient care or monitoring as a result of a **clinical adverse event** (CAE).
 - In this procedure, references to the patient will include the **family** if the patient wishes.
- To ensure that patients receive accurate information related to patient care.
- To ensure that patients' clinical and emotional needs are met.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS**1. The Decision to Disclose**

- 1.1 Disclosure of Harm (**disclosure**) is a formal process involving discussion between a patient, and **staff** and/or **medical staff** about the **events** leading to harm and/or a **close call** in the following circumstances:
 - a) a patient has suffered any degree of harm;

- b) there is any potential for future harm; or
 - c) there will be any change in patient care or monitoring as a result of a CAE.
- 1.2 When an event has occurred and none of the criteria in section 1.1 of this document are met, disclosure is discretionary, but shall be done if it is felt the patient would benefit or would want to know.
- a) If it is unclear whether the patient would benefit from disclosure or would want to know, disclosure shall occur.
- 1.3 The diagram in Appendix A: *Disclosure of Harm Process Map* outlines the steps that should be taken when it is decided that disclosure will occur. Detailed information on each step appears in this document.

2. Disclosure Process

- 2.1 Disclosure may require a series of conversations between patients and staff, medical staff and/or **accountable leaders**.
- 2.2 Disclosure shall be conducted in a truthful, compassionate, empathic, honest and transparent fashion.
- 2.3 Disclosure is comprised of the following stages as required until resolution is achieved.
- a) Resolution will be considered achieved when the patient has been provided:
 - (i) with the most accurate understanding possible about the CAE;
 - (ii) information about any impact to their patient care or their future patient care;
 - (iii) the organization's response; and
 - (iv) any questions and needs expressed by the patient have been addressed by Alberta Health Services (AHS) to the extent possible.
- 2.4 Acknowledgement and Apology
- a) When a decision has been made to disclose (see section 1 of this document), Acknowledgement and Apology is the first stage. This may be provided by any staff or medical staff to meet the immediate needs of the patient. Acknowledgement and Apology shall include:
 - (i) acknowledgement that a CAE has occurred and has resulted in harm or potential for future harm;

- (ii) an **apology** for what has occurred;
 - (iii) if known, an explanation of what has happened, without speculation;
 - (iv) exploration and understanding of the patient's questions and needs, with offers of support as warranted;
 - (v) a commitment to further investigation when necessary and sharing of facts when they are known; and
 - (vi) an explanation of any changes in patient care or monitoring due to the CAE.
- b) Acknowledgement and Apology should occur as soon as practically possible, ideally within the first few hours of recognizing the CAE.
 - c) Acknowledgement and Apology may be initiated by and include relevant staff such as:
 - (i) staff and medical staff involved in the CAE;
 - (ii) the **most responsible health practitioner**;
 - (iii) the **responsible administrative leader**; and/or
 - (iv) the accountable leader.
 - d) In some instances, Acknowledgement and Apology may complete the disclosure requirements and meet the patient's needs. The patient shall be encouraged to contact AHS again should further questions arise.

2.5 Initial Disclosure meeting

- a) When further investigation is required to understand the CAE and/or the impact of the CAE on the patient, an Initial Disclosure meeting with the patient shall occur following the Acknowledgment and Apology stage.
- b) The Initial Disclosure meeting should occur as soon as it is convenient for the patient, preferably within the first few days of recognizing the CAE.
- c) The Initial Disclosure meeting may include, but not be limited to:
 - (i) the patient;
 - (ii) persons the patient wishes to be involved in the meeting;
 - (iii) AHS staff or medical staff involved in the Acknowledgement and Apology stage; and

- (iv) one (1) or more accountable leaders or medical leaders as is appropriate for the situation.
- d) Components of the Initial Disclosure meeting include:
 - (i) an apology for what has occurred;
 - (ii) exploration and understanding of the patient's questions and needs, with offers of support as warranted;
 - (iii) if known, an explanation of what has happened, without any speculation;
 - (iv) helping the patient understand the process for further investigation and further disclosure if it shall occur;
 - (v) as appropriate, an explanation of any changes that may occur in the patient's care or monitoring because of the CAE; and
 - (vi) establishing a key contact in AHS for the patient to help them through the remainder of the disclosure.

2.6 Subsequent Disclosure meetings

- a) A Subsequent Disclosure meeting may be needed following an Initial Disclosure meeting (see section 2.5 of this document) in order to discuss the following, including but not limited to:
 - (i) providing additional facts that may not have been available or known at the Initial Disclosure meeting;
 - (ii) further exploring and understanding patient questions and needs, with offers of support as warranted; and/or
 - (iii) providing explanations, results of reviews and any applicable next steps.
- b) Multiple Subsequent Disclosure meetings may be necessary.

3. Disclosure Planning

- 3.1 The accountable leader and/or the responsible administrative leader of the involved area where the CAE occurred, in consultation with the most responsible health practitioner and/or other staff or medical staff as appropriate, shall assess:
 - a) the severity of harm or potential for future harm;
 - b) the patient's physical/emotional ability to participate in disclosure; and
 - c) whether disclosure support is necessary (see section 4 of this document).

- 3.2 If the patient is unable to participate in disclosure meetings, the **alternate decision-maker** may be engaged regarding disclosure in alignment with section 5.1 of this document and privacy legislation.
- 3.3 The accountable leader may determine to proceed with an Initial Disclosure meeting if they believe that the CAE can be managed at a local level.
- 3.4 If the CAE is determined to be more serious in nature, or has the potential to impact the reputation of AHS, the accountable leader, in conjunction with the most responsible health practitioner shall determine:
- a) the most appropriate disclosure method:
 - (i) individual patient disclosure; and/or
 - (ii) public informing;
 - b) who will lead the disclosure (see section 5.4 of this document); and
 - c) additional supports, advisors and/or resources.
- 3.5 The accountable leader, in partnership with the patient, shall assess any practical and emotional supports the patient may need.
- a) Every effort shall be made to secure these supports through existing AHS resources.
 - b) An AHS senior accountable leader should be consulted when necessary.
 - c) Practical supports may include, but are not limited to:
 - (i) parking;
 - (ii) food;
 - (iii) transportation;
 - (iv) accommodation;
 - (v) community support;
 - (vi) additional medical care; and/or
 - (vii) other considerations as determined by specific circumstances.
 - d) If practical support needs exceed the accountable leader's spending authority as per the AHS *Delegation of Authority for Financial Commitments "Financial Authorization" Matrix* for one (1) year operating expenditures, approval from more senior leadership is required in accordance with the matrix.

- e) If the patient requests a copy of their health care record, the accountable leader shall work with Finance and Access and Disclosure to assure that it is provided promptly without expense to the patient.
 - f) Hold any bills from AHS for any related uninsured services until resolution has been reached and the appropriateness of billing has been considered.
- 3.6 It is the responsibility of the accountable leader to ensure that there is regular communication with the patient via a single point of contact who:
- a) will provide ongoing regular support and communication to the patient related to management of the CAE until resolution;
 - b) will communicate primarily with the patient (or patient spokesperson if the patient identifies one); and
 - c) will provide information about follow-up processes that may occur and associated timelines.
- 3.7 The patient has a partnership role in determining what supports they require throughout disclosure, and in determining when and who should be included in disclosure meetings.
- 3.8 Involvement in a CAE where a patient has suffered harm can be traumatic for staff and medical staff. The responsible leader will connect staff and medical staff to appropriate supports as needed. The responsible leader shall assess staff and medical staff and ensure they are able to continue to provide safe care, but if not, make appropriate arrangements. (See the AHS *Immediate Management of Clinical Adverse Events* Procedure and AHS *Ongoing Management of Clinical Adverse Events* Procedure.)

4. Disclosure Process Support

- 4.1 Alberta Health Services (AHS) is committed to ensuring that staff and medical staff feel supported and prepared through all stages of the disclosure. Disclosure can be very challenging. It is especially important that those involved with complex or difficult disclosures receive the necessary support throughout disclosure.
- 4.2 Patient Safety will maintain an up-to-date list of resources, education and list of contacts on the Disclosure Resource page on Insite (see Appendix B: *Disclosure Resources and Education*).
- 4.3 Assistance with planning, preparation and disclosure meetings (i.e., Acknowledgement and Apology, Initial Disclosure, Subsequent Disclosure) can be obtained from the following resources:
- a) accountable leaders;

- b) medical leaders;
 - c) clinical ethicist;
 - d) administrator on-call; and/or
 - e) certified faculty of the Disclosure of Unanticipated Medical Outcomes (DUMO) workshop.
- 4.4 All staff and medical staff involved in disclosure are encouraged to seek guidance from the appropriate liability protection association as appropriate, including but not limited to AHS Legal & Privacy, the Canadian Medical Protective Association (CMPA) or the Canadian Nurses Protective Society (CNPS).

5. Disclosure Process Overview

5.1 Disclosure Concerning Adult Patients

- a) If the patient has capacity, disclosure shall occur with the patient and whomever else the patient wishes, once appropriate consent for information sharing is obtained from the patient.
- b) If the patient lacks capacity, disclosure shall occur with the identified alternate decision-maker. The alternate decision-maker may also consent to include whomever they wish to be involved. The patient should be engaged to the extent possible. This means it may be necessary to repeat the initial disclosure discussion if the patient's capacity or mental state improves. See the AHS *Consent to Treatment / Procedure(s)* Policy and procedures for alternate decision-maker options.
- c) If there are any questions about the patient's capacity to consent, the accountable leader shall be contacted immediately to determine to whom disclosure should occur.
- d) Where the patient has died, only individuals authorized by law to exercise the patient's rights under the *Health Information Act* (Alberta) may be included in disclosure. These persons may also consent to include whomever they wish to be involved.

5.2 Disclosure Concerning Patients with Acute Physical or Mental Conditions

- a) All patients, including those who are suffering from acute symptoms of a physical or mental condition, should be engaged in disclosure. However this may impact the timing of the disclosure discussion. There should be consideration of the balance between the patient's interests in knowing about the CAE and the risk of clinical de-compensation, including the risk of harm to self or others.

- b) While the patient's acute symptoms of a physical or mental condition are the highest priority, consider that a delay in disclosure may create further stress and may damage the trusting relationship.

5.3 Disclosure Concerning Pediatric Patients

- a) Disclosure where the affected patient is a pediatric patient shall usually occur with the patient's **legal representative** (e.g., parent, guardian). After discussion with the legal representative, it may be desirable to repeat the initial disclosure with the child at the legal representative's request.
- b) Where the pediatric patient has been treated as a **mature minor**, disclosure can start with the patient; however, this may change depending on the nature and complexity of the CAE. Prior to disclosure, the accountable leader shall determine the patient's ability to understand the disclosure and the patient's wishes regarding others' involvement, including the pediatric patient's legal representative.

5.4 Who Should Disclose

- a) The decision about who should disclose and participate in disclosure is based on:
 - (i) who can provide the best information and has an existing relationship with the patient;
 - (ii) who can provide or has information on applicable supports (e.g., practical and/or emotional);
 - (iii) who can coordinate ongoing and follow-up patient care; and
 - (iv) patient preference.
- b) Generally the most responsible health practitioner should provide disclosure.
 - (i) If the CAE has occurred because of a system failure, it may be appropriate for disclosure to involve the responsible administrative leader.
 - (ii) If the most responsible health practitioner is not directly involved in the CAE, consensus among the accountable leader, the responsible administrative leader and the most responsible health practitioner shall determine who should be involved in disclosure.
- c) The total number of individuals present should be limited to a number comfortable for the patient. The patient shall be invited to bring whomever else they wish and be asked to share the names of additional invitees.

- d) Every effort should be made to create a supportive environment that allows the staff and/or medical staff directly involved in the CAE to participate in disclosure and apologize on their own behalf. This allows for more open sharing of information and facilitates healing of all individuals involved in the CAE.
- e) If language interpretation is required, a health care translator, not a family member, is necessary to ensure the best possible communication.

5.5 Where Disclosure Should Take Place

- a) Every reasonable effort is to be taken to ensure disclosure occurs in a face-to-face meeting.
- b) Disclosure meetings should be designed to be in a location that is comfortable, private and free from interruptions.
- c) Consideration should be given to patient preference for the disclosure location.
- d) If disclosure cannot occur face-to-face:
 - (i) disclosure initiated by a telephone call should be followed up with a registered letter;
 - (ii) disclosure initiated by a registered letter should be followed up with a telephone call; and
 - (iii) a copy of the registered letter shall be sent to the accountable leader involved in managing the CAE and the telephone call shall be documented in the **health record**.

5.6 What Should Be Disclosed

- a) AHS shall provide:
 - (i) the most accurate factual understanding about the CAE as possible following appropriate investigation;
 - (ii) if known, how the CAE occurred;
 - (iii) any known impact on the patient's care now or in the future;
 - (iv) any steps agreed to be taken by AHS in response to the CAE including any steps that will be taken to minimize the chances of similar events occurring in the future; and
 - (v) the names and position title of any staff, medical staff, midwifery staff or contractors who were performing their employment or contractual responsibilities in relation to the CAE.

5.7 What Cannot Be Disclosed

- a) Legislation may restrict information that can be shared during disclosure.
- b) The following information cannot be shared with the patient unless consent from individuals who will be identified has been obtained:
 - (i) information identifying other patients who might have been involved in the CAE; and
 - (ii) any administrative measures actioned with respect to staff or medical staff including any disciplinary action or action taken under the *AHS Medical Staff Bylaws* or the *AHS Midwifery Staff Bylaws*.

5.8 Apology

- a) An apology is an important part of every disclosure conversation and should occur as appropriate throughout disclosure.
- b) Apologies acknowledging responsibility shall be made when the complete facts are known and such responsibility has been determined.
- c) As per the *Alberta Evidence Act* (Alberta), an apology itself cannot be used as evidence of fault or liability in legal proceedings.

5.9 Documentation

- a) Disclosure conversations shall be documented in the health record by the person who leads the discussion. Documentation includes the following:
 - (i) date, time and location of meeting;
 - (ii) who was present;
 - (iii) consents obtained;
 - (iv) facts presented and by whom;
 - (v) offers of support to patient;
 - (vi) questions raised by patient and responses provided and by whom;
 - (vii) care and treatment discussed and provided;
 - (viii) requests to review the patient's health record;
 - (ix) follow-up plan presented;
 - (x) the designated patient spokesperson;

- (xi) list of any outstanding questions from the patient; and
 - (xii) details of any telephone calls (time, date, by whom, reason for contact and if contact was made, if a telephone message was left, the name with whom the message was left).
- b) Patients may request any information contained in their health record in accordance with privacy legislation and AHS policies.
 - c) The accountable leader shall maintain all correspondence and records regarding the CAE as per the AHS *Clinical Documentation* Directive and AHS *Clinical Documentation Process* Directive.

6. Multi-location Disclosure Process Overview

- 6.1 Patients often receive care/treatment in various health care locations (i.e., hospitals, clinics and continuing care facilities). As a result, a CAE may be discovered in a different health care location than where it actually happened or by a health care professional different than those involved directly with the CAE.
- a) When this occurs, the health care location staff and/or medical staff report the CAE to the health care location where the CAE occurred. Agreement shall be reached as to which health care location shall assume the lead role in disclosure, with the other health care locations being encouraged to participate.
 - b) These situations can include complex privacy and legal considerations. Advice and appropriate clarification may need to be included in planning disclosure.
 - c) An individual experienced in disclosure shall be assigned by each health care location to liaise in this process. The individual designated by the health care location taking the lead in disclosure, in consultation with the accountable leader and Executive Leadership Team, shall decide on the appropriate pathway for disclosure (individual and/or public informing).
 - d) If this is discovered to be a multi-patient CAE, the procedure for multi-patient disclosure shall be followed (see section 7 of this document).

7. Multi-Patient Disclosure Process Overview

- 7.1 A single patient CAE may lead to the discovery that others may have been affected. At times, there may be a CAE where the number of patients affected is uncertain until a review is complete.
- 7.2 When a multi-patient CAE is discovered, the Executive Leadership Team shall designate an individual experienced in disclosure to plan and coordinate the process.

- 7.3 The complexity of multi-patient CAEs may necessitate creation of a multidisciplinary steering team to manage the CAE (see the AHS *Immediate Management of Clinical Adverse Events* Procedure and AHS *Ongoing Management of Clinical Adverse Events* Procedure) and plan disclosure. This may include:
- a) persons with clinical expertise regarding the CAE;
 - b) accountable leaders;
 - c) supports for patients, staff and/or medical staff;
 - d) Community Engagement & Communications;
 - e) Clinical Ethics Service;
 - f) Legal & Privacy; and/or
 - g) Information & Privacy.
- 7.4 In a multi-patient CAE where the number of affected patients is small and the facts of the CAE are clear, the disclosure team may be able to communicate directly with each patient and there may be no need for public notification.
- 7.5 When it is decided by the Executive Leadership Team that public informing is warranted, every effort shall be made to disclose the CAE to the affected patients and staff before public informing (see section 8 of this document); however, it must be recognized that this may not always be achievable. Multi-patient disclosure is guided by:
- a) Multi-patient disclosure involving harm:
 - (i) Follow the same process as individual disclosure, when possible.
 - (ii) Individual disclosure should be planned so that all involved patients receive consistent information as close to the same time as possible.
 - (iii) If individual disclosure is not practical initially, follow the public notification process and then follow up with individual disclosure.
 - b) Multi-patient disclosure where it is unknown whether harm occurred:
 - (i) Disclosure can occur by telephone, registered letter, or in person, as appropriate. See section 5.5 (d) of this document.
 - (ii) Provide opportunity for follow-up if questions arise.

8. Public Informing Process

- 8.1 Public informing may be warranted in some CAEs where:
- a) rapid contact with large numbers of patients is beyond the capacity of AHS to accomplish within a reasonable and appropriate timeframe;
 - b) uncertainty exists as to whether a list of patients involved or impacted by the CAE is accessible or complete;
 - c) incorrect information is starting to circulate to the public; and/or
 - d) a CAE may raise public concerns about AHS' ability to provide quality care.
- 8.2 Public informing does not take the place of individual disclosure. When feasible, each patient affected by the CAE should be contacted individually prior to public informing (see section 5 of this document). The decision about how a patient is contacted (i.e., in person, telephone, registered mail) must be weighed, with consideration given to:
- a) the urgency to make any treatment decisions;
 - b) the severity of the CAE;
 - c) the number of people affected; and
 - d) the practicality of disclosing within a reasonable timeframe.
- 8.3 When feasible, involved staff and medical staff should be informed prior to public informing.
- 8.4 Informing of other stakeholders shall be in compliance with privacy and other applicable policies and procedures.
- 8.5 If public informing is to occur, coordinate with the Community Engagement & Communications department.

DEFINITIONS

Accountable leader means the individual who has ultimate accountability to ensure consideration and completion of the listed steps in the management of the Alberta Health Services *Disclosure of Harm* Procedure. Responsibility for some or all of the components of management may be delegated to the appropriate level responsible administrative leader, but accountability remains at the senior level.

Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor's legal representative, a guardian, a 'nearest relative' in accordance with the *Mental Health Act*

(Alberta), an agent in accordance with a Personal Directive, or a person designated in accordance with the *Human Tissue and Organ Donation Act* (Alberta).

Apology means a genuine expression of sympathy or regret, a statement that one is sorry for what has happened. An apology includes an acknowledgement of responsibility if such responsibility has been determined after analysis of an adverse event.

Clinical adverse event (CAE) means an event that reasonably could or does result in an unintended injury or complications arising from health care management, with outcomes that may range from (but are not limited to) death or disability to dissatisfaction with health care management, or require a change in patient care.

Close call means an event that has potential for harm and is intercepted or corrected prior to reaching the patient.

Disclosure means the formal process involving an open discussion between a patient and staff of Alberta Health Services about the events leading to a serious clinical adverse event, hazard or harm.

Event means any occurrence involving the provision of patient care to a patient by Alberta Health Services staff and medical staff, students or volunteers.

Family(-ies) means 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 health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

Harm means an unexpected outcome for the patient, resulting from the care and/or services provided, that negatively affects the patient's health and/or quality of life.

Health record means the Alberta Health Services legal record of the patient's diagnostic, treatment and care information.

Legal representative means the following in relation to a minor, as applicable:

- a) guardian; or
- b) nearest relative as defined in the *Mental Health Act* (Alberta),

who has the authority to consent to treatment for a minor formal patient or minor who is subject to a Community Treatment Order.

Medical staff means physicians, dentists, oral and maxillofacial surgeons, podiatrists, or scientist leaders who have an Alberta Health Services Medical Staff appointment.

Mature minor means a person aged less than 18 years, who has been assessed and determined as having the intelligence and maturity to appreciate the nature, risks, benefits, consequences, and alternatives of the proposed treatment/procedure, including the ethical, emotional and physical aspects.

Most responsible health practitioner means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is

authorized by Alberta Health Services to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of his/her practice.

Patient means an adult or child who receives or has requested health care or services from Alberta Health Services and its health care providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients and outpatients.

Responsible administrative leader means the most senior administrative or medical leader involved in helping to manage the Alberta Health Services *Disclosure of Harm* Procedure. For example:

- a) Nurse Manager or Program Manager and/or medical lead/director, clinical section chief or clinical department site chief;
- Or
- b) non-clinical manager, site/facility lead, Director, Executive Director, or Vice-President and/or facility/community medical director, clinical section chief, clinical zone department head, Senior Medical Director, Zone Medical Director.

Staff means all Alberta Health Services employees, midwifery staff, students, and other persons acting on behalf of or in conjunction with Alberta Health Services.

REFERENCES

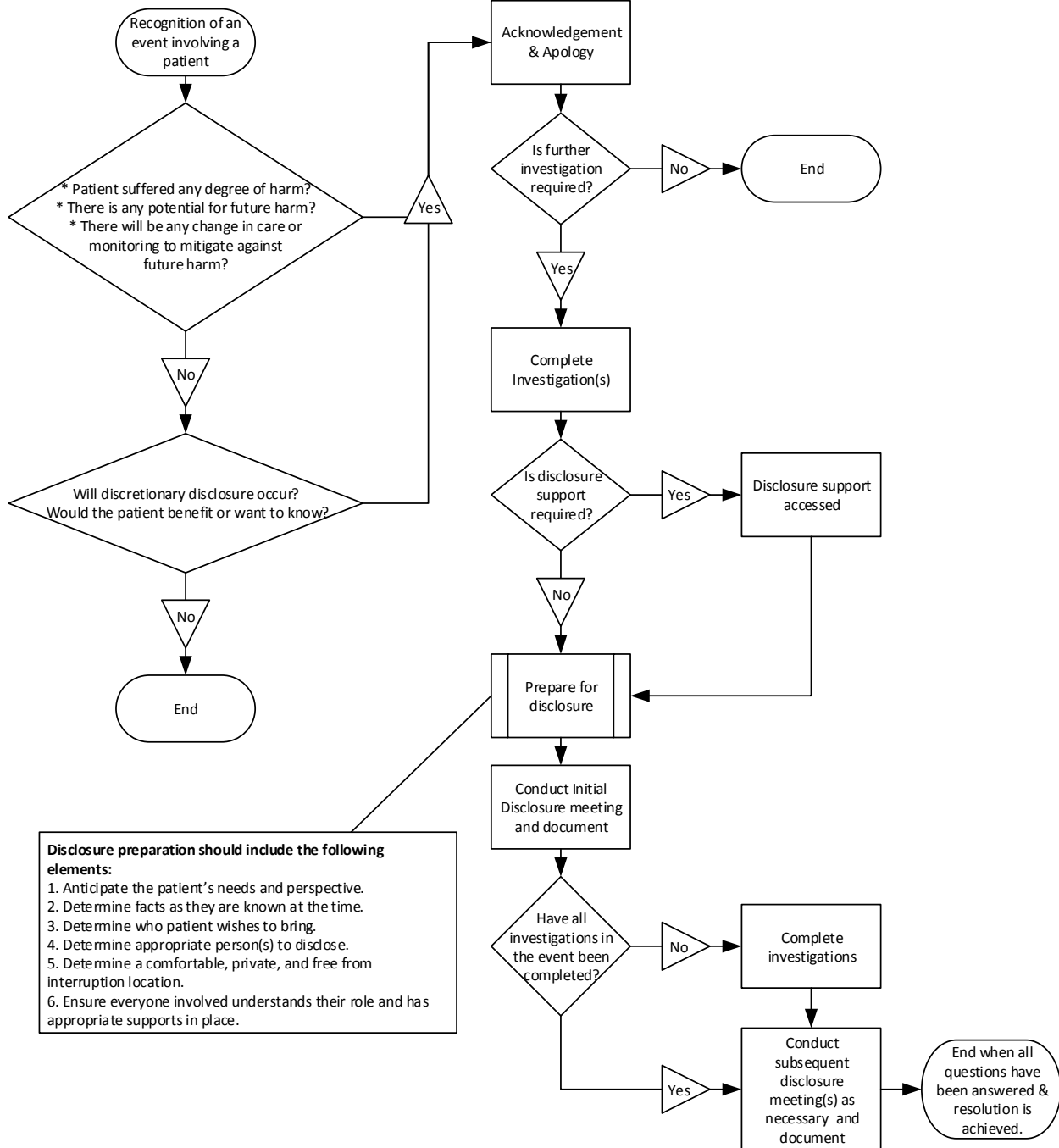
- Appendix A: *Disclosure of Harm Process Map*
- Appendix B: *Disclosure of Harm Resources and Education*
- Alberta Health Services Governance Documents:
 - *Clinical Documentation Directive* (#1173)
 - *Clinical Documentation Process Directive* (#1173-01)
 - *Consent to Treatment/Procedure(s) Policy* (#PRR-01)
 - *Immediate Management of Clinical Adverse Events Procedure* (#PS-95-02)
 - *Medical Staff Bylaws*
 - *Midwifery Staff Bylaws*
 - *Ongoing Management of Clinical Adverse Events Procedure* (#PS-95-03)
- Non-Alberta Health Services Documents:
 - *Alberta Evidence Act* (Alberta)
 - *Canadian Disclosure Guidelines* (Canadian Patient Safety Institute)
 - *Disclosing harm from health care delivery: Open and honest communication with patients* (Canadian Medical Protective Association)
 - *Disclosure of Harm to Patients and Families; Provincial Framework* (Health Quality Council of Alberta)
 - *Family Law Act* (Alberta)
 - *Health Information Act* (Alberta)

VERSION HISTORY

Date	Action Taken
November 01, 2017	Non-substantive change
Click here to enter a date	Optional: Choose an item

APPENDIX A

Disclosure of Harm Process Map



APPENDIX B**Disclosure of Harm Resources and Education****Resources**

The following resource handouts are available on the Disclosure of Unanticipated Medical Outcomes page on the external AHS website:

- Preparing for disclosure meetings
- Communicating with the patient
- Supporting patients involved in adverse events
- Supporting physicians and staff involved in adverse events
- Coaching and mentoring
- Approaching challenges

List of AHS Contacts for Disclosure Support

Please see the Disclosure of Unanticipated Medical Outcomes page on AHS external website.

Patient Relations is available to:

- Assist patient if they wish to make a formal complaint or commendation.
- Provide additional third party support to patient.
- Support and collaboration with staff / medical staff for complaint resolution.

Patient Relations can be reached at 1-855-550-2555 or patientfeedback@ahs.ca

Disclosure of Unanticipated Medical Outcomes Workshop

This powerful four-hour workshop provides the participant with insight into the patient experience following an unanticipated outcome; how expectations are created, and what happens when the organization's response does not meet these expectations. The workshop provides the opportunity to learn about and discuss disclosure as a large group, and to practice disclosure discussions in small groups.

To register go to My Learning Link or email Quality & Patient Safety Education at qpse@albertahealthservices.ca