Alberta Health Services

PROCEDURE

TITLE
DISCLOSURE OF HARM

SCOPE
Provincial

DOCUMENT #
PS-95-01

APPROVAL AUTHORITY
Quality Safety and Outcomes Improvement Executive Committee

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SPONSOR
Quality and Healthcare Improvement

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PARENT DOCUMENT TITLE, TYPE, AND NUMBER
Recognizing, Responding To, and Learning From Hazards, Close Calls, and Clinical Adverse Events Policy (#PS-95)

SCHEDULED REVIEW DATE
June 20, 2025

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.

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OBJECTIVES

- To outline the key phases of the disclosure of harm process which is followed when a **patient** is 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).
- To outline the process the **accountable leader** shall follow to identify patients' clinical, emotional, information, and follow-up needs (if applicable) when harm has occurred during patient care, and how to meet them.
    - References to the patient will include the patient's **family**, if the patient wishes.
- To ensure that **health care providers** involved in a CAE and in the disclosure process are supported by their leaders and the organization.

PRINCIPLES

- Disclosure of harm refers to a required process involving open discussion(s) between a patient and health care provider(s) about the events leading to harm and the harm itself
- Disclosure is conducted in a truthful, compassionate, empathetic, honest, and transparent fashion.
- An acknowledgement of harm and **apology** are important parts of every disclosure conversation and should occur as appropriate throughout disclosure phases including resolution.

- As per Section 26.1 (2) (a) of the *Alberta Evidence Act,* an apology itself cannot be used as evidence of fault or liability in legal proceedings.

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 The decision to disclose shall be done in the following circumstances:

a) a patient has suffered any degree of harm;

b) there is any potential for future harm; and/or

c) there will be any change in patient care or monitoring as a result of a CAE.

1.2 When a CAE has occurred and none of the criteria in Section 1.1 of this Procedure 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.

2. Disclosure Process

2.1 The disclosure of harm process may have several phases to achieve resolution. See Appendix A: *Disclosure of Harm Process Map.*

2.2 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 shall:

a) provide ongoing regular support and communication to the patient related to management of the CAE until resolution;

b) communicate primarily with the patient (or patient spokesperson if the patient identifies one); and

c) provide information about follow-up processes that may occur and associated timelines.

2.3 If the CAE is determined to be more serious in nature, involves multiple patients (refer to Section 8), or has the potential to impact the reputation of AHS, the accountable leader, in conjunction with the **most responsible health practitioner (MRHP)**, shall determine:

a) the most appropriate disclosure method:

(i) individual patient disclosure; and/or

(ii) public informing.

b) who will lead the disclosure (refer to Section 2.4 h) below); and

c) additional supports, advisors, and/or resources.

2.4 Phase 1: Immediate Disclosure

a) When a decision is made to disclose, the acknowledgment and apology should occur as soon as reasonably possible (ideally within the first few hours of recognizing the CAE) based on the patient's physical/emotional ability and willingness to participate in disclosure.

b) Immediate disclosure conversation may be provided by any relevant health care provider (e.g., MRHP, clinical leader, Nurse) and 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 based on the facts of what happened, without speculation;

(iv) exploration and understanding of the patient's questions and needs, with offers of support as warranted;

(v) if needed, a commitment to further investigation when necessary and sharing of facts when they are known;

(vi) if known, an explanation of any changes in patient care or monitoring due to the CAE; and

(vii) if needed, a single point of contact for the patient should further questions arise.

c) If the immediate disclosure conversation fulfills the patient's needs, resolution has been achieved and the disclosure process is complete (refer to Section 3: Resolution).

d) Document disclosure conversations as per Section 10 of this Procedure.

2.5 Phase 2: Ongoing Disclosure

a) If, resolution was not achieved in the immediate disclosure conversation with patient (Phase 1: Immediate Disclosure) continue with ongoing disclosure.

b) The accountable leader and/or the **responsible administrative leader** of the involved area where the CAE occurred, in consultation with the MRHP and health care team as appropriate, shall assess:

(i) the severity of harm or potential for future harm;

(ii) the patient's physical/emotional ability and willingness to participate in ongoing disclosure; and

(iii) whether ongoing disclosure support is necessary for patients and/or health care providers (refer to Section 4 and 5 below).

c) The initial disclosure meeting may include, but is not limited to:

(i) the patient;

(ii) person(s) the patient wishes to be involved in the meeting;

(iii) health care provider(s) involved in previous disclosure conversations; and

(iv) an accountable leader(s) or medical leader(s) as appropriate for the situation and the patient's comfort level.

d) The patient may invite whomever else they wish to the disclosure meeting(s).

(i) If the patient is unable to participate in the disclosure meeting(s), the **alternate decision-maker** shall be engaged in alignment with Section 6.1 of this document and privacy legislation.

(ii) If language interpretation is required and requested by the patient, AHS Interpretation & Translations Services should be involved to ensure the best possible communication rather than relying on family or others.

e) If the health care provider directly involved in the CAE wishes to be part of the disclosure meeting, other members of the disclosure team should be present to provide support. If the health care provider does not wish to be part of the disclosure meeting, then their decision should also be supported.

f) Who Should Disclose?

(i) The health care team should assist in determining the individual(s) who should disclose and participate in disclosure based on;

- patient preference;
- who can provide the best information and has an existing relationship with the patient;
- who can provide or has information on applicable supports;
- who can coordinate ongoing and follow-up patient care; and

(ii) It is encouraged for the MRHP to be present, but the disclosure meeting should not be delayed if the MRHP is not available.

(iii) If the CAE has occurred because of system failure, it may be appropriate for disclosure to involve the responsible administrative leader.

g) It is encouraged that whoever leads the disclosure conversation has participated in the AHS *Disclosure: Communicating Unexpected Outcomes in Healthcare* course.

h) What <u>can</u> be disclosed?

(i) The most accurate factual understanding about the CAE at the time of the disclosure meeting. Another meeting may be necessary following an appropriate investigation.

(ii) Factual information found in the patient **health record** is not protected by Section 9 of the *Alberta Evidence Act* and it can be shared with the patient.

(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.

(v) The names and position title of any healthcare providers who were performing their employment responsibilities in relation to the CAE.

i) What <u>cannot</u> be disclosed?

(i) Information in any form that is created in the course of carrying out quality assurance activities that is protected by Section 9 of the *Alberta Evidence Act*.

(ii) Speculative discussions and beliefs should not be shared.

(iii) Information identifying other patients who might have been involved in the CAE.

(iv) 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*.

j) Where should disclosure take place?

(i) Every reasonable effort is to be taken to ensure disclosure occurs in a face-to-face (i.e., in person) meeting.

(ii) Disclosure conversations should be designed to be in a location that is mutually comfortable, private, and free from interruptions.

(iii) Every consideration should be given to patient preference for the disclosure location.

(iv) If disclosure cannot occur face-to-face, consider the following options for disclosure conversations as determined by the patient:

- virtual (e.g., Zoom);
- telephone call; or
- written response to initiate contact and future discussion.

k) If the disclosure meeting(s) fulfills the patient's needs, resolution (refer to Section 3 below) has been achieved and the disclosure process is complete.

(i) The patient shall be encouraged to contact their health care provider directly or AHS Patient Concerns should further questions arise.

(ii) Document disclosure conversations as per Section 10 below.

2.6 Phase 3: Follow-up Disclosure Meetings

a) Subsequent disclosure meeting(s) may be needed following the initial disclosure meeting(s) to achieve resolution, 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 consideration 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.

3. Resolution

3.1 Disclosure process resolution shall be considered achieved when the patient has been provided:

a) the most accurate understanding possible about the CAE;

b) information about any impact to their patient care or their future patient care;

c) the organization's response; and

d) responses to any questions and needs expressed by the patient to the extent possible by AHS.

4. Patient Support

4.1 The accountable leader, in partnership with the patient, shall assess and provide any supports available, including but not limited to:

a) medical and care needs;

(i) Discuss with the patient if they wish to have their care transferred to other health care providers. If so, facilitate as soon as feasible.

b) emotional needs (e.g., private space, reassurance);

c) spiritual needs (e.g., assisting with finding a spiritual leader or member of a faith or cultural community);

d) information needs;

(i) Provide an AHS single point of contact for communication with the patient.

e) any bills from AHS for related uninsured services shall be held until resolution has been reached and the appropriateness of billing has been considered;

f) practical supports through existing AHS resources such as:

(i) telephone;

(ii) parking;

(iii) food;

(iv) transportation;

(v) accommodation;

(vi) community support;

(vii) additional medical care; and/or

(viii) other considerations as determined by specific circumstances.

g) where practical support costs 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.

4.2 The patient may request any information contained in their health record in accordance with privacy legislation and AHS policies.

a) If the patient requests a copy of their health care record, the accountable leader shall work with AHS Finance and Access and Disclosure to assure that it is provided promptly without expense to the patient.

4.3 The clinical or accountable leader may at any time, provide the patient and the family with contact information for the Patient Relations department. Refer to the AHS *Patient Concerns Resolution* Policy and AHS *Patient Concerns Resolution Process* Procedure.

a) The Patient Relations Department may be contacted by the clinical or accountable leader for advice on how:

(i) the clinical or accountable leader may best facilitate the concern review process; or

(ii) the Patient Relations department may assist in facilitating the concern review process.

b) Initiation of the Patient Concerns Resolution Process does not replace the ongoing management of the CAE and/or the disclosure of harm process by the accountable leader.

5. Health Care Provider Support

5.1 Involvement in a CAE where a patient has suffered harm can be traumatic for health care providers involved. The responsible leader shall connect health care providers to available supports as needed and ensure they are able to continue to provide safe care, and if not, make appropriate arrangements.

5.2 AHS is committed to ensuring that health care providers feel supported and prepared through all phases of the disclosure. This allows for more open sharing of information and facilitates healing of all individuals involved in the CAE.

5.3 Assistance with planning, preparation, and disclosure meetings may be obtained from the following resources:

a) accountable leaders;

b) medical leaders;

c) Clinical Ethicist;

d) administrator on-call;

e) certified faculty of the AHS *Communicating Unexpected Outcomes in Healthcare* course; and/or

f) Provincial Patient Safety on Insite or the AHS external website for disclosure of harm support resources.

5.4 All health care providers involved in disclosure may 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).

6. Special Considerations for Various Patient Populations

6.1 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.

6.2 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.

c) 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.

6.3 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 may 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. Refer to AHS *Complex and Essential Pediatric Medical Process* Guideline and supporting resources.

7. Patient Receiving Care in Multiple Locations

7.1 As patients often receive care/treatment in multiple health care locations with different health care providers (e.g., hospitals, clinics, and continuing care facilities), a CAE may be discovered:

a) in a different location than where it actually happened; and/or

b) by a health care provider that was not directly involved with the CAE.

7.2 In these situations, the person who identifies a potential CAE should report it to their accountable leader. This accountable leader should then reach out to accountable leaders at other health care location(s) where the CAE may have occurred.

a) The accountable leader at the health care location where the patient is located will be responsible for organizing a disclosure conversation, 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 should 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, shall decide on the appropriate pathway for disclosure (individual and/or public informing).

8. Multiple Patients Involved in a Single CAE

8.1 Investigations may lead to the discovery that multiple patients are affected by a CAE. The number of patients affected may be uncertain until a review is complete.

8.2 When a multi-patient CAE is discovered, a senior leader shall designate an individual experienced in disclosure to plan and coordinate the process.

8.3 The complexity of multi-patient CAEs may necessitate creation of a multidisciplinary steering team to manage the CAE 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) **Patient Safety representative**;

e) Community Engagement & Communications;

f) Clinical Ethics;

g) Health Law; and/or

h) Information & Privacy.

8.4 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.

8.5 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 (refer to Section 9); however, it must be recognized that this may not always be achievable.

a) For multi-patient disclosure involving harm:

(i) follow the same process as individual disclosure, when possible; and

(ii) individual disclosure(s) should be planned so that all involved patients receive consistent information as close to the same time as possible.

b) For multi-patient disclosure where it is unknown whether harm occurred:

(i) Disclosure may occur by telephone, registered letter, virtual, or in person, as appropriate; and

(ii) provide the opportunity for follow-up if questions arise.

9. Public Informing

9.1 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) the CAE may raise public concerns about AHS' ability to provide quality care.

9.2 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 (refer to Section 2). The decision about how a patient is contacted (i.e., in person, telephone, registered mail) must be weighed, with consideration given to the:

a) urgency to make any treatment decisions;

b) severity of the CAE;

c) number of people affected; and

d) practicality of disclosing within a reasonable timeframe.

9.3 When feasible, involved health care providers should be informed prior to public informing.

9.4 Informing of other stakeholders shall be in compliance with privacy and other applicable policies and procedures.

9.5 If public informing is to occur, accountable leaders will coordinate with AHS Community Engagement & Communications department.

10. Documentation

10.1 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.

10.2 Disclosure discussions and/or conversation(s) shall be documented in the health record by the person who leads the discussion. Documentation includes the following:

a) date, time, and location of meeting;

b) who was present;

c) facts presented and by whom;

d) offers of support to patient;

e) questions raised by patient and responses provided and by whom;

f) care and treatment discussed and provided;

g) requests to review the patient's health record;

h) follow-up plan presented;

i) the designated patient spokesperson;

j) list of any outstanding questions from the patient; and

k) 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).

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). This also includes what was previously known as the substitute decision-maker.

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.

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.

Guardian means, where applicable:

For a minor: a guardian as defined by the *Family Law Act* (Alberta), a divorced parent with custody of the minor, or a person appointed pursuant to a will, personal directive, court order, agreement or by authorization of legislation (e.g., *Child, Youth and Family Enhancement Act* [Alberta]).

For an adult: an individual appointed by the Court in accordance with the *Adult Guardianship and Trusteeship Act* (Alberta) to make decisions on behalf of the adult patient when the adult patient lacks capacity.

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 care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Health record means the collection of all records documenting individually identifying health information in relation to a single person.

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.

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 AHS to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of their practice.

Patient means all persons, inclusive of residents and clients, who receive or have requested health care or services from Alberta Health Services and its health care providers. Patient also means, where applicable:

a) a co-decision-maker with the person; or
b) an alternate decision-maker on behalf of the person.

Patient safety representative means the staff employed to promote quality patient care and patient safety at a site, program, business area, Zone, or provincial level.

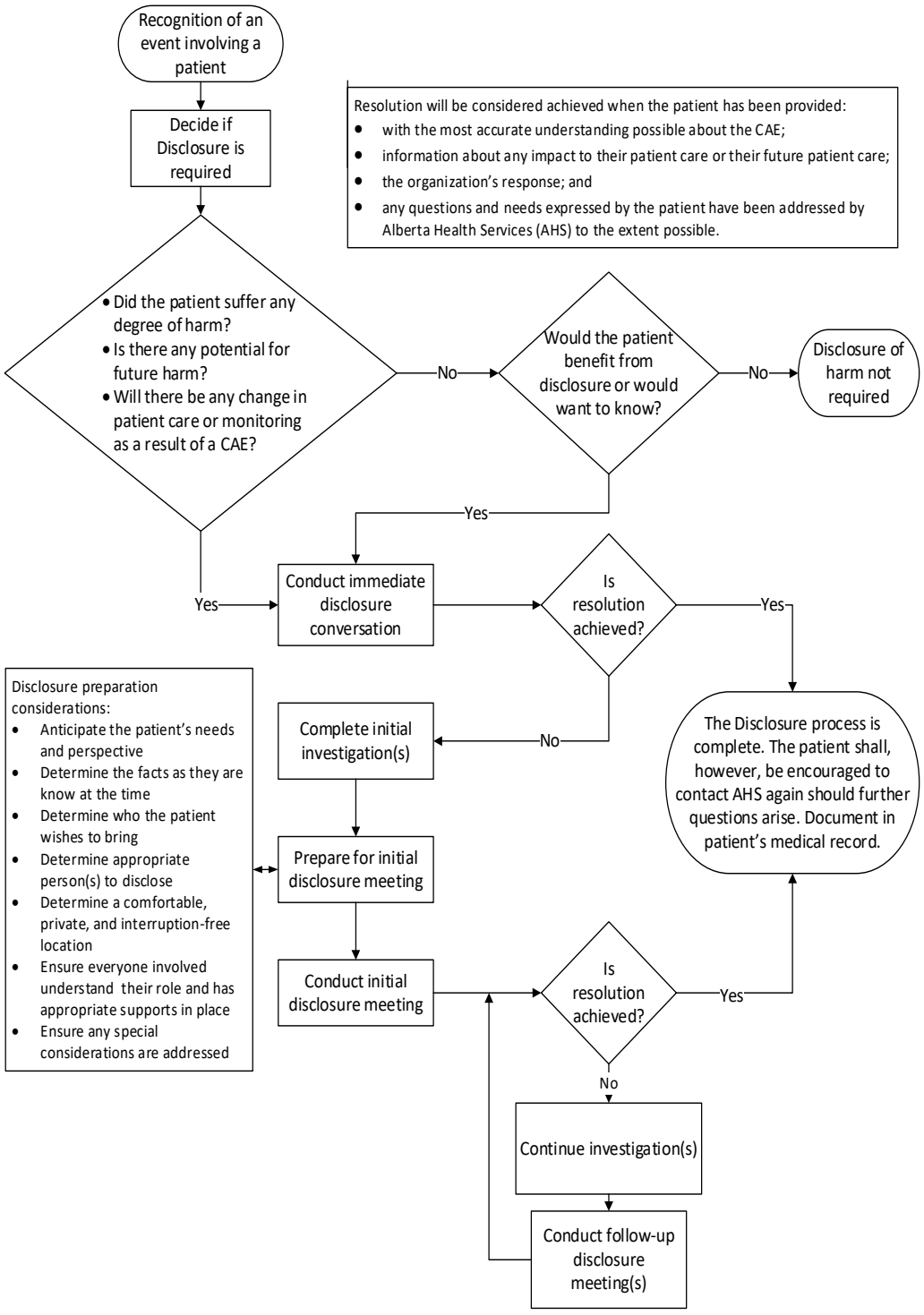
Responsible administrative leader means the most senior administrative or medical leader involved in helping to manage the AHS *Disclosure of Harm* Procedure. For example:
a) Nurse Manager or Program Manager and/or Medical lead/Director, Clinical Section Chief, or Clinical Department Site Chief; or b) 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.

REFERENCES

- Appendix A: *Disclosure of Harm Process Map*
- Alberta Health Services Governance Documents:
  - *Clinical Documentation* Directive (#1173)
  - *Clinical Documentation Process* Directive (#1173-01)
  - *Complex and Essential Pediatric Medical Process* Guideline (#HCS-230-01)
  - *Delegation of Financial Authority Policy Suite (#1166)*
  - *Immediate and Ongoing Management of Clinical Adverse Events* Procedure (#PS-95-02)
  - *Medical Staff Bylaws*
  - *Midwifery Bylaws*
  - *Patient Concerns Resolution Process* Policy (#PRR-02)
  - *Patient Concerns Resolution Process* Procedure (#PRR-02-01)
  - *Patient Safety Alerts, Safer Practice Notices, and Patient Safety Memos* Procedure (#PS-95-05)
  - *Patient Safety Learning Summary* Procedure (#PS-95-06)
  - *Recognizing, Responding To, and Learning From Hazards, Close Calls, and Clinical Adverse Events* Policy (#PS-95)
  - *Reporting of Clinical Adverse Events, Close Calls, and Hazards* Procedure (#PS-95-04)
- Alberta Health Services Resources:
  - *Disclosure - Communicating Unexpected Outcomes (CUO) For Clinicians*
  - *Disclosure - Communicating Unexpected Outcomes (CUO) For Leaders*
  - *Delegation of Human Resources Authority Matrix*
  - Disclosure of Harm Resources
- Non-Alberta Health Services Resources:
  - *Alberta Evidence Act*
  - *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)

APPENDIX A

Disclosure of Harm Process Map



Cranston Ridge Medical Clinic (CRMC)

Policy Title: Disclosure of Harm

Effective Date: 15 October 2019

Review Date: 14 October 2029

Approved By: Medical Director

Applies To: All CRMC Staff, Contractors, Physicians, Nurses, Students, and Volunteers

1. Purpose

To outline the formal disclosure process at CRMC when a clinical adverse event (CAE) occurs, causing harm, potential harm, or requiring changes to patient care.

The policy ensures patients are informed in an honest, empathetic, and respectful manner and that staff receive appropriate support.

2. Scope

Applies to all clinical and administrative staff involved in or witnessing an adverse event.

Includes patients receiving care at CRMC, their families, or alternate decision-makers.

3. Disclosure Principles

- Disclosures must be truthful, timely, and compassionate.

- A sincere apology should be provided without delay.

- Documentation of the disclosure must be recorded in the patient chart.

4. Process

Phase 1 – Immediate Disclosure: Acknowledge the incident and apologize.

Phase 2 – Ongoing Disclosure: Provide updates, explanations, and address questions.

Phase 3 – Resolution: Ensure patient needs are met, and final documentation is completed.

5. Documentation

All discussions, patient responses, questions, and care changes must be documented in the EMR.

A single point of contact will be assigned to ensure follow-up.

6. Staff Support

Staff involved in CAEs will be offered emotional and professional support.

Debriefing and guidance will be coordinated by the Clinical Manager.

7. References

- Alberta Health Evidence Act

- CMPA and CNPS Disclosure Guidelines

- CRMC Incident Reporting Procedure