<table>
<thead>
<tr>
<th>Clinical Adverse Event</th>
<th>Disclosure</th>
<th>Immediate Management</th>
<th>Just Culture</th>
</tr>
</thead>
</table>
| Could or does result in an unintended injury or complications arising from health care management. outcomes may result in death, disability, dissatisfaction with health care management, or require a change in patient care. | When to disclose:  
• When patients have suffered any harm  
• If there is potential for future harm  
• There will be change in patient care or monitoring | Requires immediate response and assessment.  
Must include a review of documentation regarding the clinical adverse event and discussions with relevant staff and physicians. | An environment where everyone feels safe, encouraged, and enabled to discuss quality and safety concerns. |

<table>
<thead>
<tr>
<th>Never Event</th>
<th>Outstanding Recommendations</th>
<th>Section 9</th>
<th>Timeline One</th>
</tr>
</thead>
</table>
| Distinguished from other events as being adverse events that:  
• Are serious  
• Are largely preventable  
• Have preventative measures  
• Must be reported at least quarterly to the quality and safety committee  
An initial assessment or timeline must be completed to determine if system issues resulted in the never event. | Recommendation owners must update recommendation tracker within 90 days. | Specific legislation protecting the discussions, proceedings and documents prepared for the purposes of quality assurance activities from legal discovery. | A chronological report of all information found in clinical documentation related to a clinical adverse event. |