Safety and Quality

TOOL 5

Open Disclosure

A guide for patients/ consumers beginning an open disclosure process

Government of South Australia

SA Health

Contents

About this guide

This guide has been designed to help you when an incident resulting in harm has occurred. It will also be useful if this has occurred to a relative, friend or someone you care for.

This guide talks about health services (including hospitals) and doctors and nurses, but also covers health care provided in other health facilities and by other healthcare providers.

Please use this guide in any way that helps you – write in it, bring it to meetings and show it to your healthcare providers.

What is an incident?

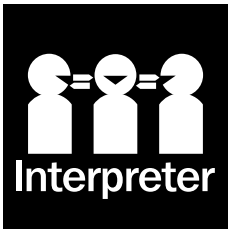
Incident (harm) This is an incident that led to patient/consumer harm. Such incidents can either be part of the health care process, or occur in the health care setting (ie while the patient/consumer is admitted to, or in the care of a health service organisation).

Incident (no harm) This is an error or system failure that reaches the patient / consumer but does not result in patient harm.

Near miss (no harm) This is an incident that did not cause harm but had the potential to do so.

What is the open disclosure process?

The process of communicating with you when things haven't gone as expected is called open disclosure.



What if I need an interpreter or translator?

If you need to have an interpreter or translator present, please tell the healthcare staff. They will arrange interpreting and translating services, for you.

1. Introduction to open disclosure

Every day many thousands of patients/consumers are treated by clinicians, healthcare providers and organisations in Australia. Occasionally an incident resulting in harm occurs.

Australian health services are working to improve the way they handle an incident when it occurs. Part of improving the way health services manage these situations is being open with you about what happened. The process of communicating with you when an incident occurs is called open disclosure.

What is open disclosure?

Open disclosure is open discussion about an incident that happened during care which caused harm to a patient/consumer.

If you have been harmed during your treatment, your doctor, nurse or a health service representative should talk with you, your family, carer and/or support person about it.

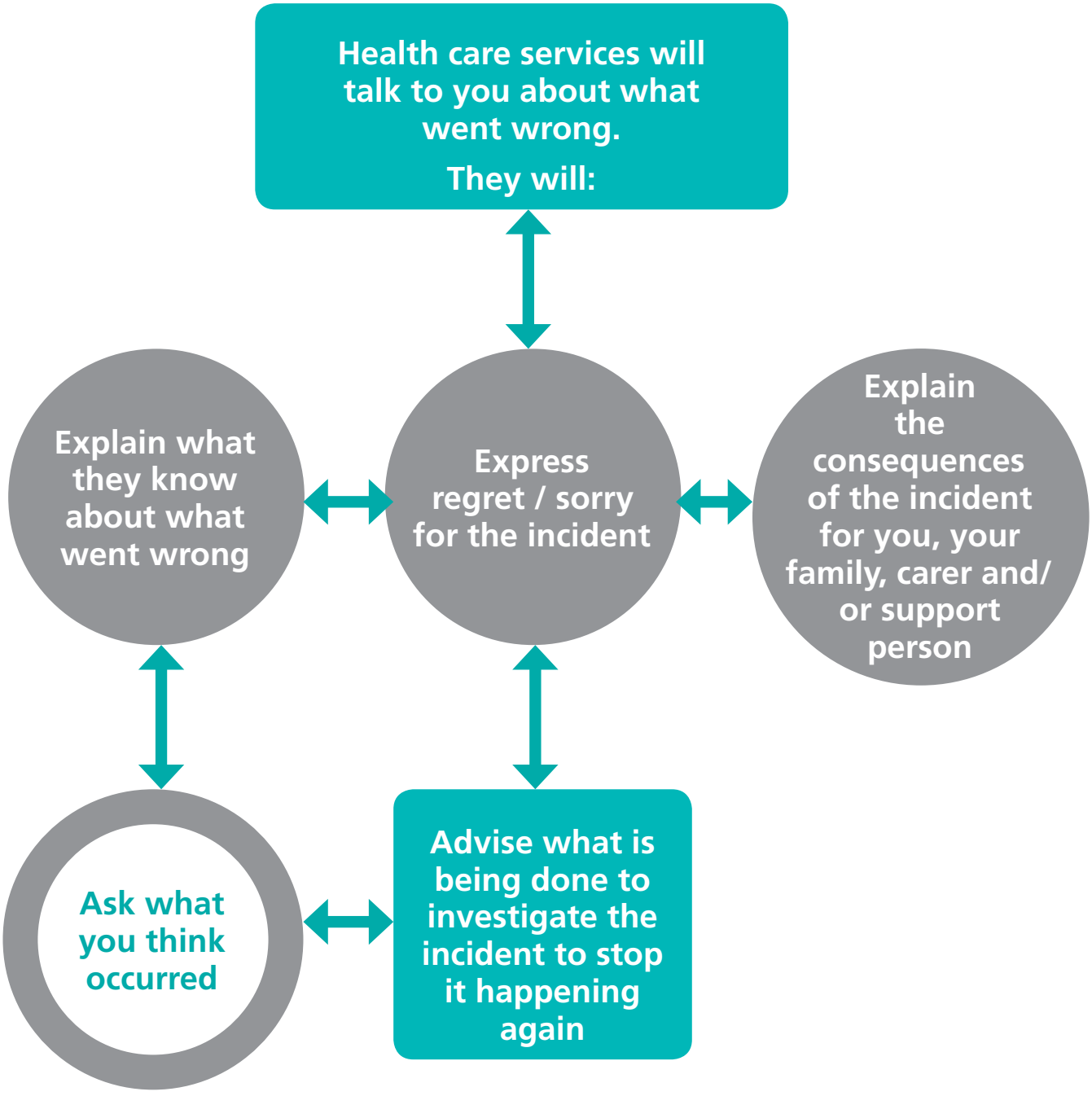
Open disclosure can:

- improve patient safety through improved understanding of how things go wrong
- contribute to learning from what caused things to go wrong and to prevent them in the future
- increase trust between you and your healthcare providers
- assist you to become more active in your care.

Healthcare providers encourage their staff, as well as patients/consumers and their family or carers, to identify and report when things go wrong or when patients are harmed so that care can be improved.

Open disclosure does not affect your rights in any way. For example, you are still able to talk to a solicitor about making a claim for the harm you have experienced.

What can you expect from the open disclosure process?



2. What to expect from open disclosure

If an incident occurred, it is important that someone with knowledge of what has occurred talks with you, your family, carer and/or support person.

For incidents which have resulted in harm, your doctor or nurse will talk with you about what happened. They should talk with you as soon as they are aware of the incident.

Sometimes the best person to notice if harm has occurred is you. If you think a serious incident has occurred and no one has spoken to you, please talk to your doctor, nurse or other health service staff.

If you are harmed, a meeting will be arranged between you, (your family, carer and/or support person) and the senior health service staff to discuss what happened. At this meeting the senior health service staff will:

- tell you what they know about the incident
- explain exactly what went wrong and, where possible why it happened
- express regret, including the words "I am/we are sorry"
- treat you with empathy, respect and consideration
- provide you with support appropriate to your needs
- develop an open disclosure plan with you, which will list what you wish to achieve from future meetings and any questions you have that you would like followed up
- listen and answer your questions.

Where will the meeting take place?

The meeting is held in a private area in the health service. If the suggested location of the meeting does not suit you for any reason, tell the person who is arranging the meeting and they will organise an alternative location.

When will the meeting take place?

The meeting should occur as soon as possible after the incident (if possible, within 48 hours). Sometimes it can take a few days to arrange a time that is suitable for everyone.

If the suggested time does not suit you, tell the person arranging the meeting so they can arrange a more convenient time. If you are feeling too unwell or do not want to talk, you can ask for the meeting to happen when you feel ready for it.

Before the meeting, you may want some time to:

- prepare questions to ask
- decide who you would like to bring to the meeting to support you
- decide if you would like to seek a second opinion about your ongoing care
- make a list of the help that you might need because of the incident, like childcare. Please see page 14 for more information on getting help or support.

Who from the health service comes to the meetings?

These meetings are usually attended by the doctor and other team members caring for you. Medical, nursing or other health service staff may also come to the meeting. However you can choose whom you would like to attend by telling the person who is arranging the meeting. You can also ask that your General Practitioner (GP) be invited to attend if you wish.

Some health services will have at least one person who will go to every meeting. Often this person is the Patient Safety Manager or a senior doctor. Other health services will ensure that a senior representative with knowledge of the incident will attend each meeting (although it may not always be the same person).

You can request that certain individuals attend, or not attend, the meeting.

Who supports you during the meeting?

If possible you should bring at least one support person of your choice to the meeting. They could be a member of your family, a carer or a close friend. Your health service should encourage you to bring a support person to the meeting. You can bring more than one support person.

Choose a specific person (a family member, friend or carer) who you would like to be a contact person during the process. Consider:

- someone you are comfortable with and can talk to easily
- someone who is able to take the time to be with you, if needed
- someone to whom the health service can give personal information about you.

Why should I come to the meeting?

Patients/consumers who have been harmed by treatment often say that they cope much better once they understand what happened. By talking to health service staff in the meeting, you will help them better understand your feelings. Also, the health service can learn from patients/consumers who have been harmed whilst in their care, about how to improve services to make sure it doesn't happen again. Sharing your experience may help to stop the same harm happening to someone else.

3. The open disclosure meeting

At the beginning of the meeting, all the doctors, nurses and health service staff who are present should introduce themselves, explain what they can do and why they are at the meeting.

What will be said during the open disclosure meeting?

When the health service staff meet with you, your family, carer and/or support person about the incident, they will:

- listen while you tell them about what you think went wrong and how it makes you feel
- explain what they know about what went wrong
- express regret including the words "I am/we are sorry"
- tell you what is being done to investigate the incident and to stop it happening again
- explain the consequences of the incident for you and your care
- discuss any changes to your ongoing care plan
- answer your questions
- ask if you need any other support and explain how they can help to arrange any support that you need.

Investigating what happened

It can sometimes take weeks or months to investigate an incident and so at the first meeting all the facts about what happened might not be known.

A main contact person (staff member) will provide you and your support person their contact details, and how they will keep you informed about the investigation process.

Preparing for your first open disclosure meeting

You can use this page to write down **questions** to ask and **things to say** in the open disclosure meeting

Example: You might like to consider how you will let staff know about how you feel about the incident etc.

Use this space to attach the business card, or to write down the name and contact details, of your main contact person. This person will keep you up to date with progress in investigating the incident.

Taking notes during your first open disclosure meeting

You can use these pages to take notes in the open disclosure meeting.

Notes

4. How will the health service investigate what happened?

Health services use many different methods to investigate what happened, however for serious incidents most health services use a comprehensive structured process.

It may be necessary to assemble a team of experienced healthcare providers and clinicians (with different specialties or from other health services) to investigate the incident. The investigation can take many weeks and will also look for ways to improve the health system.

You will then be kept aware of the progress of the investigation and the recommendations arising from it.

What if I have ideas about what happened?

If you have ideas you would like to share with the investigating team, you should get in touch with your main contact person. Anything you say about what you think went wrong and your experiences will assist the investigation.

5. Getting the results from the investigation

Once the incident has been investigated, you should be told the recommendations.

The health service will arrange a second meeting to give you the results of the investigation and tell you what they are doing to try and help prevent the incident from happening again.

What if the information cannot be freely discussed?

Each state and territory has laws about how the information discovered during incident investigation can be used. This sometimes causes confusion about what the health service can tell you about the investigation.

The laws may mean that, under certain conditions, the information created during the incident investigation (like reports or notes from interviews) cannot be released (even during a court case or to the coroner). Such details are part of the investigation and may remain confidential to the investigating team.

The reason behind these laws is to encourage healthcare providers and clinicians to talk honestly and openly about problems and failures. This makes sure that the things that go wrong can be fully investigated, to make the system safer for everyone. For example, health services are required to report to their Local Health Network regarding any changes resulting from harm incidents. This ensures that any lesson learnt will be applied across the health system.

Further meetings

Open disclosure may require more than one meeting.

For example, there may be a lot of information for you to process at the first meeting. You may also feel emotional during the first meeting.

Follow-up meetings may be arranged to:

- answer any further questions you may have
- inform you of how the investigation is progressing
- provide any other support or information to you as required

Preparing for your second open disclosure meeting

You can use this page to write down questions to ask and things to say in the open disclosure meeting.

Taking notes during your second open disclosure meeting

You can use these pages to take notes in the second open disclosure meeting.

Notes

6. Getting help, support or more information

When an incident resulting in harm has occurred, it can be difficult and can affect you and your family in many aspects of your lives.

The health service can help you to manage some of these things. They may be able to arrange child care, provide parking vouchers or help arrange for your relatives or carers to visit you. Most health services have social workers and liaison officers who can help you to access the support you need.

If necessary, your doctor could provide you with a certificate for additional sick leave. Your relatives may also be able to access carer's leave to help you in your recovery, and sometimes they will need a certificate from your doctor for this.

Many patients/consumers find it upsetting to think or talk about the incident. If this is the case, you could consider talking to a counsellor or clinical psychologist. Your doctor or social worker will be able to recommend a professional you can talk to.

You can use this space below to attach business cards or write down the name and contact details of counsellors, health service liaison staff or other people who can arrange the help you need.

How do I find out more about open disclosure?

You can find the *Australian Open Disclosure Framework* and supporting resources on the website of the Australian Commission on Safety and Quality in Health Care at www.safetyandquality.gov.au/opendisclosure

South Australia has their own policies and guidelines about open disclosure and these are available on the SA Health website at www.sahealth.sa.gov.au/safetyandquality

Open disclosure does not affect your existing rights

For example, you are still able to talk to a solicitor about making a claim for the harm you have experienced. You can also still contact the Health and Community Services Complaint Commissioner. See contact details below.

How do I make a complaint?

In the first instance, you can make a complaint to the health service. Ask your health service contact for assistance.

If you wish to make a further complaint, you can contact the Health and Community Services Complaints Commissioner (HCSCC).

Telephone: 08 8226 8666
Fax: 08 8226 8620
Toll free in SA: 1800 232 007
Website: www.hcscc.sa.gov.au

Reference:

Australian Commission on Safety and Quality in Health Care
Level 7, 1 Oxford Street, Darlinghurst NSW 2010
GPO Box 5480, Sydney NSW 2001

Telephone: (02) 9126 3600 (international +61 2 9126 3613)
Fax: (02) 9126 3613 (international + 61 2 9126 3613)
Email: mail@safetyandquality.gov.au
Website: www.safetyandquality.gov.au

For more information

SA Health
Safety and Quality Unit
Telephone: 08 8226 6539
www.sahealth.sa.gov.au/safetyandquality

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This document has been reviewed and endorsed by SQCAG* for consumers and the community July 2016.

Interpreter

BY NC ND

www.ausgoal.gov.au/creative-commons

*SA Health Safety and Quality Community Advisory Group.

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