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Open Disclosure

Health Care Professionals Handbook



**A HANDBOOK FOR HEALTH CARE PROFESSIONALS TO ASSIST WITH
THE IMPLEMENTATION OF THE OPEN DISCLOSURE STANDARD**



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While this document gives some guidance on legal issues, it does not claim to provide legal advice. Hospitals and other organisations implementing the Standard will need to seek their own legal advice on implementing the Open Disclosure Standard. Organisations implementing the Open Disclosure Standard remain fully responsible for managing their legal risks

**FOR MORE INFORMATION ABOUT OPEN
DISCLOSURE IN THIS ORGANISATION CONTACT:**

**THE PERSON RESPONSIBLE FOR
CLINICAL RISK AT THIS HOSPITAL IS:**

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This handbook is designed as a practical tool to assist health care professionals in the implementation of the Open Disclosure Standard and to achieve greater understanding of the process involved.

The handbook forms part of the Open Disclosure Education and Organisational Support Package developed in 2002-2003 by the Clinical Practice Improvement Unit- Northern Sydney Health and the Pam McClean Cancer Communications Centre for the Open Disclosure Project. Information contained in the handbook will be relevant for doctors, nurses, allied health professionals and those who are clinical managers. In using any of these strategies local policies and guidelines should be considered. The handbook is designed to compliment existing resources that provide guidance on many of the issues covered by the Standard. The Education and Organisational Support Package has a number of components including the following:

- Interactive CD Rom
- Facilitators handbook for the:
 - Open Disclosure Workshop and Trigger Video
 - Ward In-service Training Module
- Managers Handbook
- Health Care Professionals Handbook
- Open Disclosure Implementation Toolkit

Implementation of the Open Disclosure Standard should be considered in the context of local policies and guidelines. This Handbook is designed to compliment existing local resources that provide guidance on many of the issues covered by the Standard. Information will be relevant for doctors, nurses, allied health professionals and clinical managers.

What is Open Disclosure?

OPEN DISCLOSURE is about providing an open, consistent approach to communicating with patients following an adverse event. This includes expressing regret for what has happened, keeping the patient informed, and providing feedback on investigations including the steps taken to prevent an event from recurring. It is also about providing information that will enable systems of care to be changed to improve patient safety.

The Ethical Basis for Open Disclosure

OPEN DISCLOSURE is in accord with evolving ethical practices in medicine supporting greater openness with patients and increased involvement of patients in their own care. It is a fundamental ethical requirement that patients are treated with honesty and openness at all times.

The public expects health care professionals to put patients' interests first. If patients perceive that they are not being given an open and honest account of an adverse event, this damages their trust in the health care professional and the organisation in which they are receiving care.

An ethical framework for disclosure relies upon respect for patient autonomy. Respecting patient autonomy requires health professionals to actively provide patients with information about all aspects of their care and help them to understand it. Patients have a right to be free of any mistaken beliefs concerning their conditions. This will allow patients to make informed decisions without undue influence or coercion. Only through full disclosure is a patient able to make informed decisions regarding their lives, their situation and future medical care.

Key Terms

FOR THE purpose of the Open Disclosure Standard, the following terms are defined and will be used accordingly in this handbook.

Adverse event — An incident in which unintended harm resulted to a person receiving health care.¹

Expression of regret — An expression of sorrow for the harm experienced by the patient.

Individual responsible for clinical risk — Health care organisations need to designate responsibility for the management of risks associated with the delivery of clinical care. The person responsible needs to be of sufficient seniority to have credibility and be able to drive change to effect improvements. He or she will oversee the implementation of the open disclosure process within the organisation.

Support person — Information about an adverse event will be given to a patient's nominated "support" person in appropriate circumstances, taking account of the patient's wishes, confidentiality and privacy requirements and the organisation's internal policies. The nominated support person/persons may be any individual, identified by the patient as a nominated recipient of information regarding their care. This may include family, friend, partner or those who care for the patient.

In cases of a dispute between, say, family and partners or friends about who should receive information, the patient's wishes, expressed on the admission form, should be paramount. In addition, some people have a legal relationship which entitles them to receive information (for example, in some cases, a parent, legal guardian or an executor).

Given the complexities, references to "support person" should be read with the words, "where appropriate".

However, it is highly recommended that nominated support persons be involved in the open disclosure process from the outset so as to be able to give appropriate support and care to the patient.

¹ Wilson, Runciman, Gibberd (1995) 'Quality in Health Care Study', *Medical Journal of Australia* 163 (9): 458-471.

Open Disclosure

A patient's perspective

HEATHER HAD A BABY

Heather was admitted to a large public hospital to give birth, which was performed by caesarean section. Post-operatively she developed internal bleeding but it was not noticed for two hours. Her low blood pressure was put down to a bad reaction to an epidural top up.

A specialist was called in urgently and operated on to stop the haemorrhaging, but Heather was very ill and spent three weeks in hospital. The day after the adverse event the Senior Registrar spoke to Heather, but she was not able to take in much. It took nearly three weeks before the Senior Registrar returned to explain things to Heather's husband. As a result he has never believed the hospital's explanation.

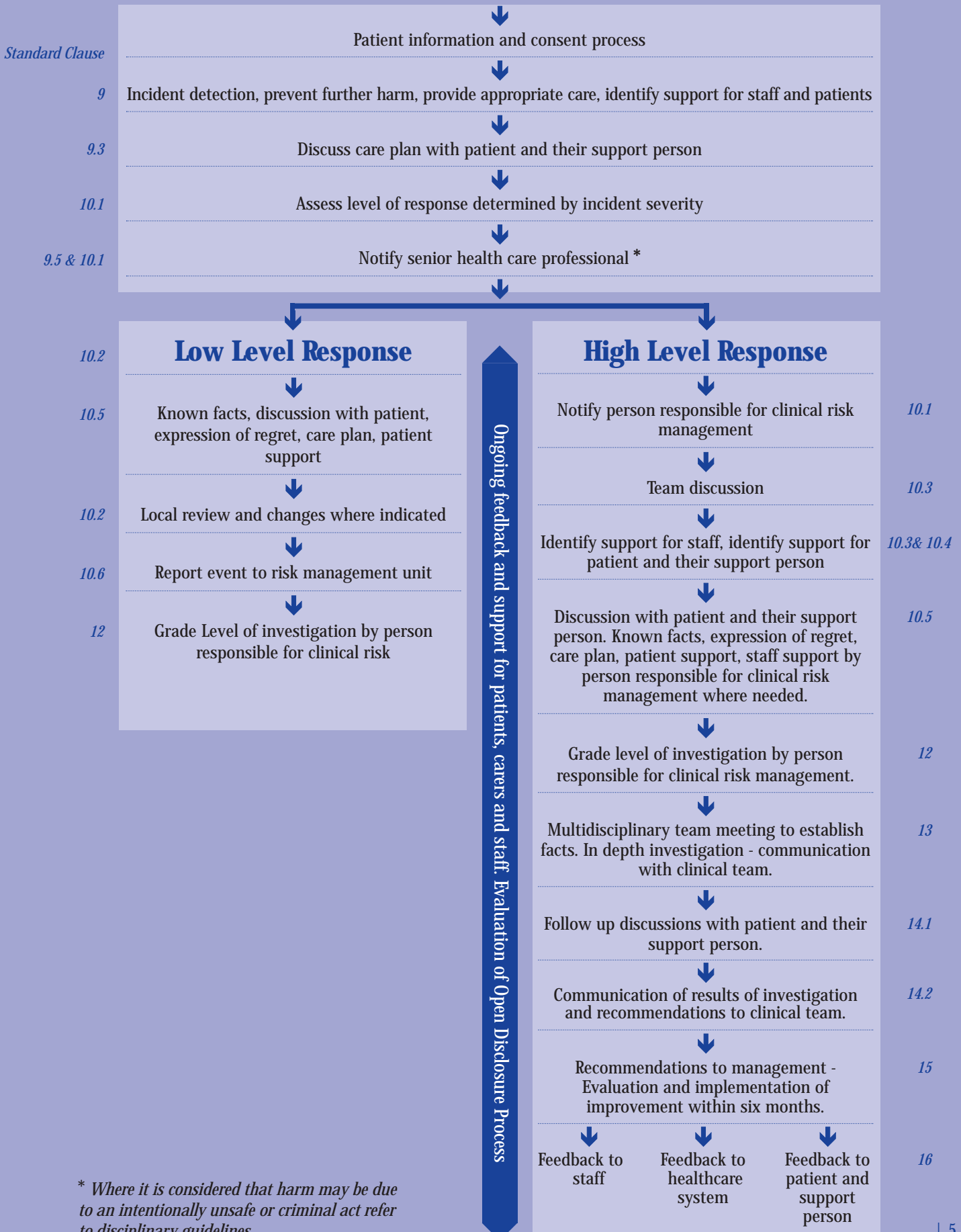
After Heather returned home she started to have terrible nightmares and was crying every day. She could not stop thinking about what had happened. She arranged an appointment with the specialist who performed the operation that had saved her life. She arrived during usual surgery hours with a long list of questions but there was not enough time.

Heather left feeling angry but said nothing. She did not want to seem ungrateful to the person who had given her such good care. The doctor thought he had explained things rather well and Heather had given him no reason to think otherwise.

Heather decided to find out what happened for herself. She applied for her medical records under FOI. She felt more betrayed and angry as she discovered certain facts that she was not told at the time.

Twelve months later she wrote to the specialist to complain about the answers she was given. To her great admiration he invited her back for an appointment at the end of the day. Her husband, a lawyer, attended with her. They spent two hours talking through all the issues. The doctor was candid and open and admitted that the registrars had taken too long to realise she was bleeding because they were inexperienced. Heather was relieved. She did not want to blame anyone, but she wanted an honest explanation. The specialist also apologised for the incident and for appearing to dismiss her questions at the first interview. The information and apology lifted some of Heather's heavy burden of pain, anger and mounting bitterness.

Open Disclosure Flow Chart



Open Disclosure at a Glance – A Guide for the Busy Clinician

THIS GUIDE provides a step-by-step summary of elements of the open disclosure process that are particularly relevant to clinicians.

STEP 1 Identify that harm has occurred.

STEP 2 Prevent further harm.

STEP 3 Determine the level of response:

- Low Level Response;
- High Level Response.

(See page 7 of this Handbook for further information on assessing the level of response.)

Consider requirements to notify an insurer or professional indemnity organisation if you become aware that there might be cause for a complaint by the patient, where there may be some question of liability or as directed by contractual arrangements with your insurer.

LOW LEVEL RESPONSE

STEP 4 Notify the senior health professional responsible as appropriate (may be nurse unit managers, Senior Medical Specialist, Senior Allied Health Professional) and provide appropriate clinical care.

STEP 5 Inform the patient of what has happened and what has been done to prevent further harm. Include an expression of empathy or regret and any signs to look out for that may require a change in care.

Don't:

- Speculate or blame others
- Blame yourself
- Criticise or comment on matters outside your own experience
- Admit liability.

(see page 16 'Examples of words to use - Initial Discussion with patient'.)

STEP 6 The senior health professional should nominate an appropriate member of the team to do a local investigation to determine causes of the incident and provide recommendations for changes and improvement to management. Where appropriate the most senior health care professional involved will have the ultimate responsibility for ensuring this occurs.

STEP 7 Document the discussion and any further action in the medical record. Send completed Incident report to the person responsible for clinical risk.

HIGH LEVEL RESPONSE

STEP 4 Notify the senior health professional and provide appropriate clinical care. Confirm the level of response required.

STEP 5 Notify the person responsible for clinical risk where a high level response is required.

STEP 6 Team discussion to:

- establish basic agreed clinical facts;
- identify who will take responsibility for discussion with the patient and carer;
- consider patient support requirements;
- identify immediate support needs for staff involved;
- ensure a consistent approach by all team members to disclosure to the patient and carer.

STEP 7 Initial disclosure discussion with the patient:

Introduce all present:

- Acknowledge that an adverse event has happened;
- Express empathy and regret;
- Ask the patient and/or carer what their understanding is of what happened;
- Relate known facts;
- Discuss further treatment required;
- Explain how this will change anticipated care and any short-term effects the patient may experience;
- Advise the patient that an investigation will occur and explain how feedback will be provided;

HIGH LEVEL RESPONSE (continued)

- Provide the patient with the name and contact number of the person disclosing or the person nominated to manage the ongoing disclosure process;
- Document the discussion in the medical record.

Many of the points above should be repeated or expanded upon in subsequent meetings with the patient and family.

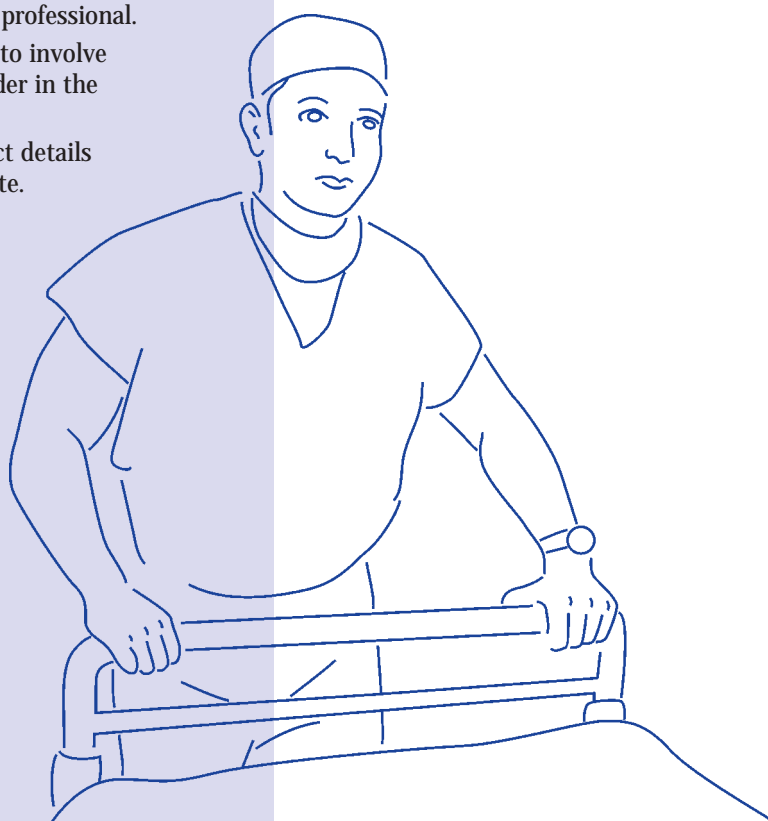
Don't:

- Speculate or blame others
- Blame yourself
- Criticise or comment on matters outside your own experience
- Admit liability.

STEP 8 Members of the health care team will have some responsibility for assisting in the investigation, developing and implementing recommendations.

STEP 9 The follow-up discussion:

- This discussion should occur at the earliest practical opportunity (may be a few days after the event or at the first follow-up appointment).
- Wherever possible the health care professional who did the initial disclosure discussion should do the preliminary follow-up discussion.
- Give the patient feedback on the progress to date.
- Be prepared to answer queries.
- Offer the patient and family an opportunity to discuss the situation with another health professional.
- Ask the patient if they would like to involve their GP or community care provider in the discussion.
- Ensure that the patient has contact details if further issues arise at a later date.
- If the patient requests the attendance of their legal representative they should also be encouraged to have a carer present to provide emotional support. The individual responsible for clinical risk should also be informed and they may wish to be present.
- Consider consulting insurers and professional indemnity organisations as appropriate.
- Document the discussion and outcomes.
- Ensure carer support for the patient.
- If required by the patient or their support person make sure an interpreter is present.



Assessment of Level of Response

THE FOLLOWING matrix is a tool to be used by health professionals to assist in the assessment of the level of response to an adverse event.

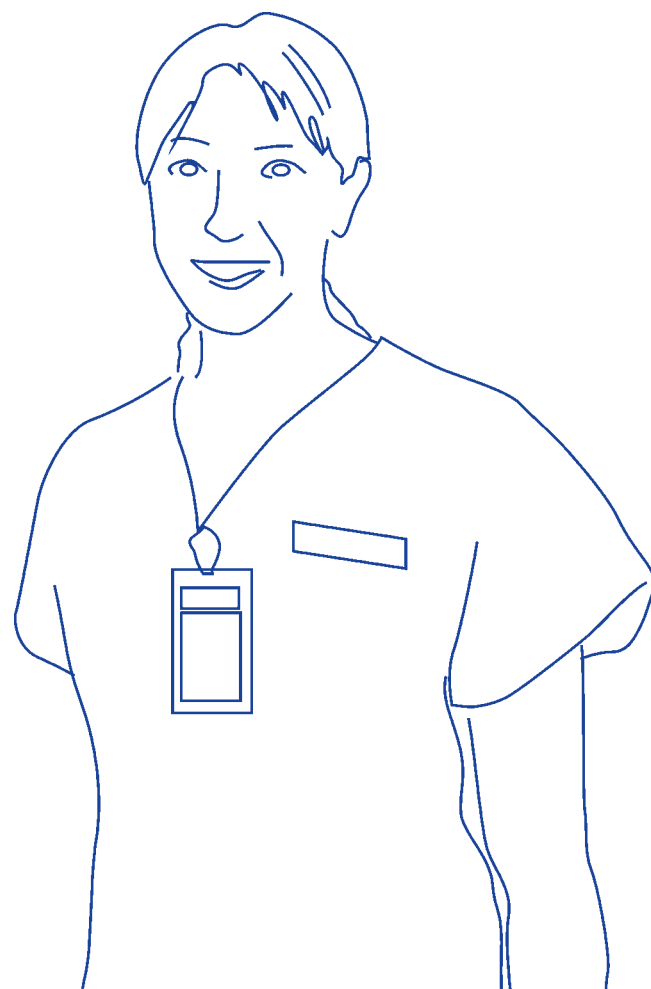
<i>Level of Response</i>	<i>Consequence</i>	<i>Action</i>
High	Death or major permanent loss of function not related to the natural condition of the patient. Permanent lessening of body function not related to underlying condition of patient or where surgical intervention or transfer to higher level of care required	Immediately notify person responsible for management of clinical risk Disclosure process by senior health care professional In-depth investigation and feedback
Low	No permanent injury, no increased level of care required	Local management, incident report and disclosure by senior health professional

EXAMPLES OF ADVERSE EVENTS REQUIRING HIGH LEVEL RESPONSE

- Unexpected death (not associated with the normal progression of disease)
- Suicide
- Assault
- Unexpected return to theatre
- Delayed or missed diagnosis causing permanent injury or requiring increased level of care
- Fall out of bed with resulting fracture.

EXAMPLES OF ADVERSE EVENTS REQUIRING LOW LEVEL RESPONSE

- Fall out of bed with no permanent injury sustained
- Cannula infection
- Incorrect diagnostic test performed
- Medication error with no permanent injury or increased level of care required.



Open Disclosure & Legal Issues for Health Professionals

ISSUES OF LIABILITY WHEN DISCUSSING ADVERSE EVENTS

In discussions with the patient and their support person under the open disclosure process, health care professionals may:

- acknowledge that an adverse event has occurred;
- acknowledge that the patient is unhappy with the outcome;
- express regret for what has occurred;
- provide known clinical facts and discuss ongoing care (including any side effects to look out for);
- indicate that an investigation is being, or will be undertaken to determine what happened and prevent such an adverse event happening again;
- agree to provide feedback information from the investigation when available; and
- provide contact details of a person or persons within the health care organisation whom the patient can contact to discuss on-going care (see Clause 16.1 of the Standard).

Health care professionals need to be aware of the risk of making an admission of liability during the open disclosure process. In any discussion with the patient and their support person during the open disclosure process, the health care professional should take care to avoid the following:

- state or agree that they are liable for the harm caused to the patient;
- state or agree that another health care professional is liable for the harm caused to the patient; or
- state or agree that the health care organisation is liable for the harm caused to the patient.

DOCUMENTATION

Communications and documents (including emails) which have been produced in response to an adverse event may have to be disclosed later in any legal proceedings or in response to a freedom of information application. As with all documentation it is important that care is taken in all communications and documents, stating as

fact only what is known to be correct. This should not inhibit the recording of events because thorough and accurate documentation will often assist rather than damage a defence, particularly where there is delay between any legal proceedings and the adverse event.

DEFAMATION

In the context of open disclosure it is possible that a health care professional or other person could be defamed by virtue of a statement, either verbal or written, “published” by an organisation or health care professional to another person. For example, this could occur by a health care professional alleging that another professional is incompetent. It is only necessary for the communication to be made to one other person, for an action for defamation to arise. It is not even necessary for a person to be referred to by name, in order to be defamed, if it can be shown that the person could be readily identified.

In some circumstances, which should be detailed in the organisation’s open disclosure policy, it may be necessary to undertake the open disclosure process in tandem with other legal or investigative processes so as to appropriately utilise:

- legal professional privilege; or
- qualified privilege legislation.

Legal professional privilege applies only in limited circumstances and may be used where an organisation or legal adviser requires documents to be created (e.g. reports, witness statements) for the purpose of obtaining or giving legal advice on the incident or for use in legal proceedings, should this eventuate.

Qualified privilege legislation has been enacted by the Commonwealth, all States and the ACT and protects from disclosure to third parties certain information generated as a result of particular quality assurance activities.²

The Commonwealth and State legislation (but not the ACT’s) requires that persons who acquire information solely as a result of their membership of, or an association with, a committee or project that attracts qualified privilege must not make a record of or divulge information to any person, with limited exceptions.

2. *Health Act 1993* (ACT), *Health Administration Act 1982* (NSW) (ss.20D-20K), *Health Services Act 1991* (Qld) (ss. 30-38), *Health Commission Act 1976* (SA) (s. 64D), *Health Act 1997* (Tas), *Health Services Act 1988* (Vic) (s. 139), *Health Services (Quality Improvement) Act 1994* (WA) and *Health Insurance Act 1973* (Cth) (Part VC).

Many of the adverse events which trigger the open disclosure process will not trigger a quality assurance activity under the legislation (assuming that the legislation applies in a particular case), and accordingly, in many cases of an adverse event, that legislation and the qualified privilege will not apply. In these circumstances, the open disclosure process will not be affected by the qualified privilege legislation.

A health care organisation which has the qualified privilege legislation available to it should include in its internal open disclosure policy, the circumstances where it is likely that a quality assurance activity under the legislation will be invoked.

Insurance considerations

An adverse event may involve more than one insurer because of the range of health care professionals that make up a multidisciplinary team. In some cases there may be conflicting interests, so it is important that you are fully aware of your responsibilities in regard to your insurance policy.

Many policies of insurance granted by insurers and medical defence organisations will require the insured to notify and take early advice from the insurer, usually within a certain period of time following the adverse event (“the notification requirement”).

Medical defence organisations and other indemnifiers may provide medico-legal advisory services to their members and may wish to discuss and assist in the open disclosure process.



Frequently Asked Questions

WHY IS OPEN DISCLOSURE IMPORTANT?

As knowledge about health grows and the use of new technologies increases, the provision of health care is becoming more complex. In this context, health care organisations need to create an environment that encourages the identification and reporting of adverse events so that opportunities for learning can be identified and acted on. In working towards an environment that is as free as possible from adverse events, there is a need to move away from blaming individuals to focusing on establishing systems of organisational responsibility.

Improving health care safety begins with ensuring that communication is open and honest, and that it is immediate. This includes communication between health care professionals and patients and their carers. It also includes communication between health care professionals, health care managers and all staff.

Open communication following an adverse event will:

- Improve patient safety through improved systems learning;
- Increase trust between patients and clinicians;
- Assist patients in becoming more active participants in their care.

IS THE OPEN DISCLOSURE STANDARD MANDATORY?

While this Standard is not mandatory, it has been developed with active involvement by accreditation agencies and professional bodies and is likely to become the accepted standard of care provided by health care professionals and institutions. The Standard was endorsed by all the Health Ministers in July 2003.

SHOULD ADVERSE EVENTS BE DISCLOSED TO PATIENTS WHERE NO HARM IS APPARENT?

While disclosure is required where harm has occurred, it may be appropriate to disclose where no harm is immediately apparent. If there is reasonable likelihood of harm resulting in the future as a result of the incident, then disclosure should be initiated. This is a matter of judgement by the health care team. Disclosing to the patient following the event allows them to take an active part in their care and to know the signs and symptoms that they should look

out for. This will reduce the patient's concerns about any delays in their recovery. Furthermore, it will help to build trust between the patient and health care professional.

DOES IT CAUSE MORE HARM TO LET PATIENTS KNOW WHEN AN ADVERSE EVENT HAS OCCURRED?

All adverse events that have caused harm or may have done so require disclosure. A patient may be unnecessarily concerned about a delay in their recovery or may not know why they are experiencing certain symptoms. An example of this could be someone who bled more than expected in surgery. The patient feels tired and listless, and is unsure why. Several days later, blood tests indicate there is a need for a transfusion. Telling the patient of the blood loss and the potential signs and symptoms when it occurred initially would have allowed the patient to be more actively involved in their care and caused them less worry. If you are concerned that disclosure may cause further harm or complicate recovery due to the emotional and psychological state of the patient then you may defer the disclosure discussion. However, it should be noted that this approach should only be taken in extreme cases and should not be used to postpone disclosure indefinitely.

HOW CAN I DECIDE WHEN SOMETHING HAS HAPPENED THAT REQUIRES DISCLOSURE?

Disclosure is required where a patient has suffered some harm (physical or psychological) as a result of treatment. This may be a recognised complication or be a result of human or systems error. If you are unsure, obtain a second opinion from a colleague or an appropriate clinician manager. If the decision is made that the incident does not require disclosure, this should be a decision that is defensible in public. The Open Disclosure Standard allows for information to be withheld only in extreme extenuating circumstances, and in these cases reasons for non-disclosure must be documented in the medical record.

WILL OPEN DISCLOSURE INCREASE LITIGATION?

There is no conclusive evidence that open disclosure increases or decreases litigation. Research on why patients sue doctors indicates that anger, frustration and a desire to know what happened are likely to drive litigation. It may be appropriate in some cases to make an early recommendation to hospital managers and insurers for a prompt and fair out of court settlement.

Litigation may be reduced if patients appreciate the fallibility and honesty of the health care professional. If you do not disclose and serious mistakes come to light later on your patient may think you were trying to cover up and become more angry and litigious. If the case does go to trial it may also show you to be callous and unsympathetic to a jury.

WHAT SHOULD I DO IF I NOTICE HARM HAS BEEN CAUSED TO A PATIENT WHILE UNDER THE CARE OF ANOTHER CLINICIAN OR TEAM?

Always speak first to the senior clinician of the team involved. If they are unwilling to initiate the disclosure process you could initially try to persuade them. If they are unwilling to do so, refer the matter to the person responsible for clinical risk or medical administration. In the case of the adverse event requiring immediate remedial care, then the most senior clinician identifying the incident should initiate the disclosure process.

WON'T I GET OTHERS INTO TROUBLE IF I DISCLOSE?

Fear of implicating friends, colleagues and members of the team is a significant barrier to open disclosure. However, there is greater chance of causing problems by not disclosing that something has gone wrong. You could be involving friends in deceitful or fraudulent behaviour by "covering up". If the clinical facts and sequence of events that led to the adverse event are unclear, or if there is some dispute about the facts, you should not offer opinion or conjecture during your discussions with the patient. It is rare for there to be any great certainty about whether an error was made, who made it or whether the error contributed to the adverse event. If you are unsure what to say, seek guidance from the person in your organisation responsible for clinical risk.

WHAT IS AN ADMISSION OF LIABILITY?

An adverse event will usually not be a result of individual error or negligence. However, discussions about unintended harm may cause some patients or families to infer that there was some wrongdoing by individual clinicians or the organisation that caused the adverse event. An admission of liability is a statement that may be used in a lawsuit against you either by a patient or family or by another defendant. However, the statement alone cannot be used as the sole proof. For example, in a negligence action the plaintiff will still have to prove that you owed a duty of

care, that you breached the standard of care, and that the injury that occurred was due to that breach of care. Statements such as “I made a bad decision that caused your heart attack” or “it was my fault this occurred” could be construed as an admission of liability and should not be made. The Standard states that care should be taken not to blame yourself or others when disclosing information to patients. This is to help ensure that the rights of all involved in the process are respected, particularly before a thorough investigation has been carried out and the factors leading to the adverse event are determined.

The Standard notes that there is a clear distinction between an admission of fact on the one hand (“we lacerated your liver during the course of the operation”), versus an admission of liability for negligence (“the liver laceration constitutes a breach of my duty of care to you and that breach has caused you injury”) on the other. The Standard also states that the initial phase of the open disclosure process (Clause 10.5) should include only those facts that are known and agreed on by the multidisciplinary team. The Standard states that in discussions with the patient and their support person under the open disclosure process, health care professionals may:

- acknowledge that an adverse event has occurred;
- acknowledge that the patient is unhappy with the outcome;
- express regret for what has occurred;
- provide known clinical facts and discuss ongoing care (including any side effects to look out for);
- indicate that an investigation is being or will be undertaken to determine what happened and prevent such an adverse event happening again; and
- agree to provide feedback information from the investigation when available;
- provide contact details of a person or persons within the health care organisation whom the patient can contact to discuss on-going care (see Clause 16.1 of the Standard).

3. Open Disclosure Legal Review (2002) prepared by Corrs Chambers Westgarth for the Open Disclosure Project. Copies of the Legal Review are available on the Open Disclosure CD Rom or from the Australian Council for Safety and Quality in Healthcare.

DOES AN APOLOGY OR AN EXPRESSION OF REGRET MEAN ADMITTING LIABILITY?

The Open Disclosure Legal Review identified that an apology is not an admission of liability; there are no legal impediments to an appropriately worded expression of regret.³

If you admit fault then you may be admitting liability.

Avoid statements such as:

- “I’m sorry – I appear to have made an error in judgement.”
- “I apologise for this mistake.”
- “It is my fault that this has happened.”

WILL AN APOLOGY JEOPARDISE MY ENTITLEMENT TO INDEMNITY INSURANCE?

Each insurer and medical defence organisation has their own requirement, however, there is a clear distinction between admission of facts and admission of liability. If you do not admit liability then your comments cannot and will not compromise your indemnity insurance. Most insurers and medical defence organisations actively encourage open communication and an appropriately worded apology.

SHOULD I NOTIFY MY INSURER BEFORE BEGINNING OPEN DISCLOSURE?

Your immediate and prime concern will be for the care and support of the patient. Initial action therefore should be aimed at treating the immediate clinical requirements of the situation. Having done this, most MDO’s have a 24-hour advice service for guidance about how to deal with unanticipated outcomes. You should contact your MDO as soon as practicable for advice about how to deal with an adverse event. This should not delay the initial process of acknowledging that an adverse event has occurred and expressing empathy and regret for what has happened to the patient and their support person.

CAN I NOTIFY MY INSURER DURING THE OPEN DISCLOSURE PROCESS?

Most insurers require you to notify them as soon as possible after you become aware that there might be cause for complaint by the patient or where there may be some question of liability. It is important that you are familiar with the notification requirements of your MDO or insurer. The Open Disclosure Standard encourages health care professionals to consult with their insurers and professional advisers where appropriate; however, this should not hinder your involvement in the open disclosure process. If at

any stage of the process you have concerns, you should contact your MDO or indemnity insurer.

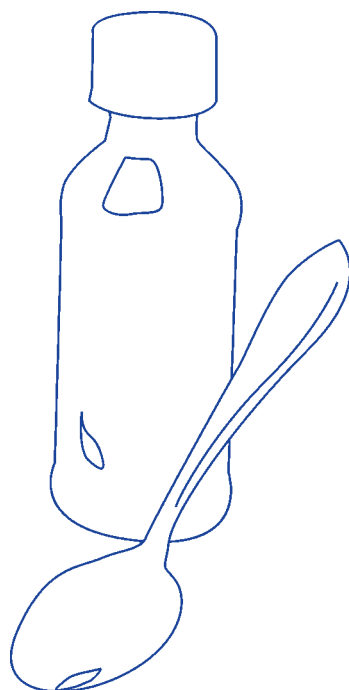
WHAT WILL HAPPEN TO MY PROFESSIONAL REGISTRATION IF I DISCLOSE?

Open disclosure will not generally affect your professional registration. However, where you may have been involved in a series of events which included consistent behavior that fell below the acceptable standard of care, this may be referred to the appropriate professional regulatory body for investigation.

WHAT RIGHTS DO I HAVE IF I AM INVOLVED IN AN ADVERSE EVENT?

The interests and circumstances of individual staff may not be the same as that of the organisations or of other staff, particularly where it appears that the incident may lead to disciplinary proceedings or give rise to legal liability. Organisations must also take into account the rights of health care professionals. These include:

- The right to seek appropriate legal advice and to disclose information to legal advisers in a manner that ensures that it attracts legal professional privilege.
- The right to be treated fairly by the institution and to receive natural justice and procedural fairness.
- The right not to be defamed.
- The right – and on some occasions, the contractual obligation – to seek appropriate advice and guidance from their “indemnifiers” (be they insurers or medical defence organisations).



Communication with the Patient

EFFECTIVE communication is pivotal to the open disclosure process. Remember that patients, their families and carers may become upset or angry when they have suffered an adverse event. This is a natural response and should be taken into consideration in your response to the situation. Take care not to become angry or react defensively in this situation. An adverse incident is an emotionally charged event for all parties. The prime concern is to support the patient.

HANDY HINTS FOR DISCUSSIONS WITH THE PATIENT AND THEIR FAMILY

- Arrange a face-to-face meeting that allows adequate time for detailed discussion as soon as possible after an adverse outcome has occurred.
- Tell the patient at the beginning of the discussion how much time you have.
- Listen actively and respectfully to the patient.
- Always discuss the problem with the patient in an open manner.
- Use plain English and avoid technical terms or jargon wherever possible, for instance use ordinary everyday words for body parts, diseases and procedures.
- Spend time with the patient and offer support and concern for the situation that the patient now faces.
- If a patient contacts you, prioritise to respond quickly as it indicates that you are taking the matter seriously.
- Acknowledge the validity and intensity of the emotions the patient and/or carer may feel, including fear, anger and pain.
- If the patient or their support person is angry find out why he or she is angry first. It is often futile to try and talk to them about something different from what they are angry about.
- Where a carer or family member is also present, include them in your dialogue where appropriate.
- In all discussions avoid defensiveness and laying blame. Avoid statements that include words such as fault, blame or feel responsible.
- If you are the treating doctor, arrange any appropriate referral for further treatment.
- Ensure the patient is closely followed up when a referral is made.

CHOOSING THE INDIVIDUAL TO MAKE THE DISCLOSURE

The individual making the disclosure should be the most senior health care professional involved. Ideally this person will:

- know the patient and be known by the patient;
- be familiar with the circumstances of the adverse event;
- be of sufficient seniority to be credible;
- have good interpersonal skills;
- have received training in open disclosure;
- be able to communicate clearly in everyday language;
- be able and willing to offer reassurance and feedback to patients and carers;
- be willing to maintain a medium-to long-term relationship with the patient where possible.

ASSISTANCE WITH INITIAL DISCUSSION

If you are the person who will be disclosing, you should be able to nominate someone to assist you with the disclosure interview. Ideally this would be someone with experience or training in communication and open disclosure or may be someone that you feel will give you the support needed.

ROLE OF INDIVIDUAL SUPPORTING THE DISCLOSING HEALTH CARE PROFESSIONAL

This person may:

- act as “sounding board” to the disclosing health care professional in determining how best to present the issues for discussion;
- lead the discussion of clinical issues in any meeting with the patient and their carers or act as an “independent”, supportive observer, depending upon the wishes and needs of the disclosing health care professional;
- in cases where the relationship breaks down between the patient and the health care professional in charge of the case, the individual supporting the disclosing health care professional may act, with the patient’s agreement, as his or her substitute in the disclosing role;
- assist the individual responsible for clinical risk to understand the clinical issues and participate in the multi-disciplinary analysis.

CONSULTATION WITH PATIENT REGARDING THE INDIVIDUAL TO MAKE THE DISCLOSURE

If for any reason it becomes clear during the initial discussion that the patient would prefer to speak to a health care professional other than the one responsible for their care, then the patient’s wishes should be respected and an appropriate substitute, in consultation with the patient, should be provided.

USE OF A SUBSTITUTE HEALTH CARE PROFESSIONAL TO DISCLOSE

In exceptional circumstances, where it is not possible for the most senior health care professional responsible to be present, or in cases where the patient does not wish to speak to this person, he/she may delegate responsibility for the process to an appropriate substitute.

SUPPORT FOR HEALTH CARE PROFESSIONALS

Health care professionals who have been involved in an adverse event may be angry with themselves or someone else for what occurred. They may feel that they have let the patient down. Staff members who are in some way involved with an adverse event may experience the following:

- feelings of guilt and sadness;
- anxiety about its effect on the patient;
- anxiety about the possible reactions of colleagues;
- concern about the possible effects on future employment;
- inhibited ability to work effectively and to co-operate with the proper investigation of the event.

It is important that the person who is conducting the disclosure does so in an objective and professional manner. If there are concerns that this individual will be unable to communicate effectively, or will incriminate themselves or other members of the team, then they should be provided with an opportunity to express their emotions in a safe environment as early as possible. This will help to resolve the issue and prevent the individual from responding inappropriately or defensively during the disclosure interview. When deciding on who should be the person to take the lead in the disclosure discussion these issues should be considered.

In cases that require a high level response, the decision on who will make the disclosure should be made in consultation with the person responsible for clinical risk or a senior manager,

and in most cases they or someone with appropriate skills and experience should be present at the disclosure discussion.

WHERE THERE IS DIFFICULTY ENGAGING THE PATIENT AND THEIR SUPPORT PERSON IN THE DISCUSSION

Patients may for many reasons reject health care professionals' expressions of sympathy and explanations. If this happens:

- it is important that information is not forced on to an unwilling listener;
- document the facts of the disagreement in the patients' records using statements such as 'didn't want to discuss' instead of 'refused to listen';
- make arrangements to meet with the patient again after a suitable interval, depending on the patient's condition.

WHERE THERE IS A BREAKDOWN IN THE RELATIONSHIP BETWEEN THE CARE TEAM AND THE PATIENT

Sometimes, despite the best efforts of health care staff or others, the relationship between the patient and/or carer and the health care professional breaks down. They may not accept the information provided or may not wish to participate in the open disclosure process. In this case, the following strategies may assist:

- Deal with the problem earlier rather than later.
- Where the patient agrees, ensure that carers are involved in discussions from the beginning.
- Ensure the patient has access to support and interpreter services.
- Where the senior health professional is not aware of the relationship breakdown, provide mechanisms for communicating early warning signs (eg patient communicating concern to other members of the team, lodging a Freedom of Information application).
- Offer the patient and carer another contact person with whom they may feel more comfortable. This could be another member of the treating team or the individual with responsibility for clinical risk.
- Use a mediation or conflict resolution service to help identify the issues between the health care organisation and the patient, and to look for a mutually agreeable solution.
- Involve the conciliation service of the local health complaints office if the patient wants to lodge a formal complaint.

WRITTEN COMMUNICATION WITH THE PATIENT FOLLOWING THE DISCUSSION

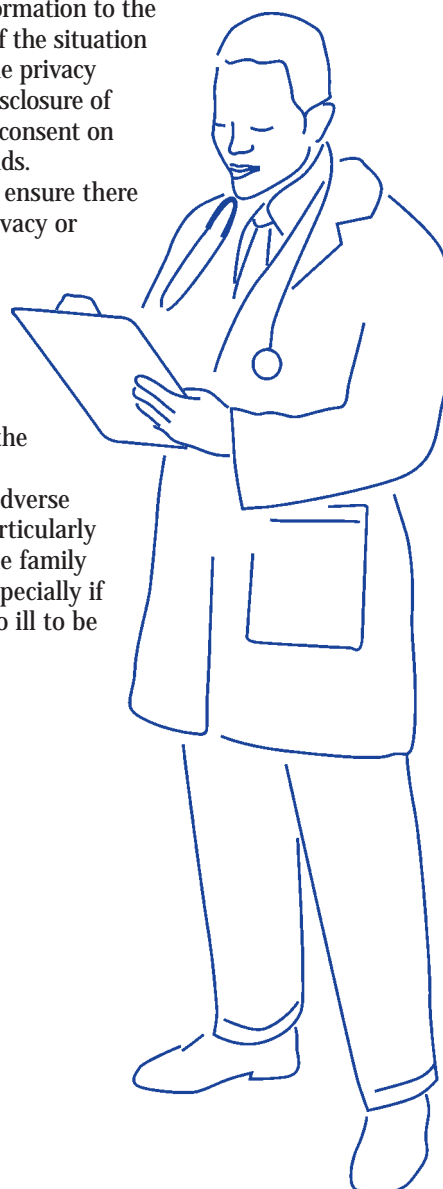
For high level incidents, or where the patient has requested, at the completion of investigations, write a letter to the patient covering all the matters raised during the discussion and the results of the investigation. The CEO or their delegate should sign the letter. In cases where litigation is anticipated they may choose or be contractually obliged to seek advice on the content of the letter from the appropriate insurer.

COMMUNICATION WITH FAMILY MEMBERS

In some jurisdictions, patients have rights to privacy and confidentiality of personal information or health records by virtue of legislation. There may be circumstances where the patient's family should be told about the adverse event before giving the information to the patient, particularly if the situation is life threatening. The privacy legislation permits disclosure of information without consent on compassionate grounds.

The safest way to ensure there is not a breach of privacy or confidentiality is to obtain the consent of the patient to disclose specified information to nominated persons. This can be done at the time of admission.

Where a serious adverse event occurs, it is particularly important to keep the family or carer informed, especially if the patient is still too ill to be told in detail.



Examples of Words to Use - Initial Discussion with Patient

These are examples of phrases that may assist in the disclosure process. However, they should be used as a guide only and not be read out verbatim.

Area of discussion	Examples
1. Expression of regret	<ul style="list-style-type: none"> — <i>“I am very sorry this has happened.”</i> — <i>“I realise it has caused great pain/distress/anxiety/worry.”</i>
2. Known clinical facts as determined during the initial team discussion	<ul style="list-style-type: none"> — <i>“We have been able to determine that ...”</i> — <i>“Unfortunately has happened.”</i> — <i>“We are not sure exactly what happened at present; however, we will be investigating the matter further and will give you more information as it becomes available.”</i>
3. Patients questions/concerns	<ul style="list-style-type: none"> — <i>“How do you feel about this?”</i> — <i>“Do you have any questions about what we have discussed?”</i> — <i>“What do you think might have happened?”</i> — <i>“You must be feeling pretty disappointed/angry/upset/distressed about this.”</i> — <i>“I think I would feel the same way too.”</i>
4. Discussion of ongoing care	<ul style="list-style-type: none"> — <i>“I have reviewed what has occurred and this is what I think we need to do next.”</i> — <i>“I’ll be with you every step of the way as we get through this and here is what I think we need to do now.”</i>
5. Any side effects to look out for	<ul style="list-style-type: none"> — <i>“You may at some later time experience...in this event you should...”</i>
6. What happens next (investigation of the adverse event and feedback)	<ul style="list-style-type: none"> — <i>“Our organisation takes this very seriously and we will be looking into the incident to see if we can find out what caused it.”</i> — <i>“We will be taking steps to learn what happened so that we can prevent this from happening to someone else.”</i>
7. Contact details in case of further concerns or questions	<ul style="list-style-type: none"> — <i>“I know its hard to take everything in but I’m happy to go over it again at another time.”</i> — <i>“We are happy to provide you with information on the outcomes of the investigation and the changes that we have made as a result.”</i> — <i>“Would you like me to contact you to set up a further meeting?”</i> — <i>“Would you prefer a letter that outlines the facts and outcomes of the investigation?”</i> — <i>“Here is my phone number. You can contact me if you have any questions or you change your mind about a further meeting to discuss what happened.”</i>

