Communicating with Patients/Service Users and their families following adverse events in healthcare

Version 2 September 2014

WORKBOOK & REFERENCE MATERIAL
Workbook Contents (Version 2)

Section 1  Introduction and Background                        4
Section 2  An Overview of Open Disclosure                     6
Section 3  Adverse Events                                    10
Section 4  Current Status in the Republic of Ireland         12
Section 5  Adverse Events: What do patients expect from us?  16
Section 6  Adverse Events: The clinicians perspective & considerations 21
Section 7  The Open Disclosure Process                       25
Section 8  Practicing Open Disclosure                        36
Section 9  Summary                                          40
Section 10  Glossary of Terms                                42
Section 11  Appendix                                        43
Section 11  Bibliography                                    47
Communicating with Patients/Service Users and their families following adverse events in healthcare
Section 1: Introduction and Background

A. Welcome and Introduction

Welcome to today’s workshop on “Communicating with Patients/Service Users and their Families following Adverse Events in Healthcare”. This workshop has been designed by the State Claims Agency (SCA) and the Health Services Executive (HSE) with the support of materials provided by the Medical Protection Society (MPS). This workbook is designed as a practical tool to assist healthcare professionals in the implementation of Open Disclosure and to achieve a better understanding of the process involved.

The workshop forms part of the Open Disclosure national implementation programme and is designed to complement existing resources, policies, procedures and guidelines within health and social care services.

It is relevant for all healthcare staff who have contact with patients/service users but particularly for doctors, nurses, midwives, healthcare managers, allied healthcare professionals, quality and risk staff and consumer services staff.

B: Background:

In January 2007, Mary Harney, Minister for Health & Children established the Commission on Patient Safety and Quality Assurance (“the Commission”) and instructed it, among other tasks, “to develop clear and practical recommendations which would ensure the safety of patients”.

In July 2008, the Commission completed its report entitled “Building a Culture of Patient Safety”. The report was published in August 2008 and approved by Government in January 2009. In her foreword to the report, chairperson Dr. Deirdre Madden states…

“When such adverse events occur there must be a system in place that ensures that all those affected are informed and cared for, and that there is analysis and learning from the error to try and prevent the recurrence of such an event”.

Dr. Madden further records the objective of the Commission, namely,

“to make recommendations for organisational, regulatory and educational reform which will create a culture of patient safety for our health system”.

On 27th January 2009, Government approved the Commission’s report and the Minister for Health & Children at that time authorised the setting up of a Steering Group with a remit to drive the implementation of all the recommendations of the Commission’s report as effectively and efficiently as possible.
One of the key recommendations of the report is the development and support of a culture of open disclosure to patients and their family/support person, with the appropriate consent, when an adverse event results in harm to a patient.

The HSE National Healthcare Charter “You and Your Health Service” 2012, states that patients/service users in the HSE can expect “open and appropriate communication throughout your care, especially when plans change or if something goes wrong”.

On the 12th of November 2013, the State Claims Agency and the HSE launched a national policy and national guidelines on open disclosure. Supplementary documents also launched at that time include a patient information leaflet, staff support booklet and staff briefing document. These documents are available to download at www.hse.ie/open disclosure.

Open disclosure is a requirement of the National Standards for Safer, Better Healthcare 2012.

C. Overview of today’s workshop

- An introduction to Open Disclosure
- What is an Adverse Event?
- The current status in Ireland in relation to open disclosure
- What do patients expect following an Adverse Event?
- The Clinicians view and considerations
- The Disclosure Process
- Practising disclosure
- Summary.

D. Your participation

We would like to thank you for your participation today. Open Disclosure is not a new concept and many of you have already been involved in disclosing effectively to patients and their families. Sharing your individual experiences and learning will enhance today’s workshop for all workshop members.

E. Icebreaker:

DVD – The approach to avoid in relation to open disclosure.
Section 2: An Overview of Open Disclosure

What is Open Disclosure?

Open Disclosure is:

“As open, consistent approach to communicating with patients when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event”.

(Australian Commission on Safety and Quality in Health Care, 2008)

Principles of Open Disclosure

Set out below are a set of ten principles to assist healthcare organisations to create and embed a culture of open disclosure. These have been adopted from the UK National Patient Safety Agency. The disclosure process should encompass these principles.

1. Acknowledgement - Healthcare organisations should acknowledge that an adverse event has occurred and initiate the open disclosure process, in line with the national policy and guidelines. This should include an acknowledgment of the impact of the adverse event on the patient/service user and/or their family/support person.

2. Truthfulness, timeliness and clarity of communication - The patient and their family/support person should be provided with factual information which they can understand in a timely manner.

3. Apology: - An apology/expression of regret for any harm or unexpected outcome that the patient has experienced as a result of an adverse event – be it due to error or not.

4. Recognising patient and carer expectations - The patient and their family/support person may reasonably expect to be fully informed of the facts and consequences surrounding the adverse event and to be treated with empathy, dignity and respect. Consider what you would expect in the same situation if this was you or a loved one.

5. Professional Support - Healthcare staff should be encouraged to recognise and report adverse events when they occur and staff should be supported by management and colleagues throughout the incident review and open disclosure process.
6. Risk management and systems improvement – The review of adverse events should be undertaken in line with the applicable HSE standards/policies including the review of recommendations to ensure they are effective and implemented.

7. Multidisciplinary responsibility - To ensure multidisciplinary involvement, medical, nursing and managerial leads need to be identified who will support the process. Open disclosure requires a team approach and relates to all staff involved in the delivery of healthcare.

8. Clinical governance - The open disclosure process should integrate with other clinical governance processes including clinical incident reporting and incident management procedures, systems analysis reviews, consent and privacy and confidentiality procedures. Effective leadership is critical at organizational level.

9. Confidentiality - The information collated following an adverse event is often of a sensitive nature. Patient confidentiality is paramount. Healthcare policies and procedures that take account of privacy and confidentiality for patients and staff in compliance with relevant law should be consulted with.

10. Continuity of care - A key contact person needs to be identified who will act as a contact person for the patient or family/support person to keep them informed of the situation and to ensure they continue to be treated with dignity, respect and compassion. When things go wrong patients may lose confidence in their healthcare provider and require significant reassurance in relation to their care going forward.


A note on disclosure to Family/Next of Kin.

Disclosure to family members/next of kin should be undertaken only with the consent of the patient/service user. When the patient/service user is not able to consent e.g. patient is unconscious or the patient has died, the most senior person e.g. the Consultant should make the decision whether to disclose based on what is in the best interest of the patient/service user and sometimes the public.

A note on the “Apology”

Apologising or expressing regret, in conjunction with saying sorry, is a key component of open disclosure.

One of the principal aims of open disclosure is to restore patient trust in clinicians and the healthcare system. A key element in achieving this is the early acknowledgement of harm by providers and clinicians and an apology or expression of regret for the harm endured. However, ‘Saying sorry’ requires sensitivity and great care.

An apology may or may not imply an acceptance of responsibility for what has occurred whereas an expression of regret is purely an expression of sorrow.

In Summary: Key Components of Principles

- Firstly, when unintended harm occurs, it involves informing patients and carers about what has gone wrong in an empathetic way that includes an expression of regret.
- Secondly, it involves in depth analysis of the problem, including root cause analysis for severe problems.
- Thirdly, it involves a commitment by individuals and organisations to fix the system problems identified.

(Prof. Bruce Barraclough, Australian Council for Safety and Quality in Healthcare, 2002)

Why are these principles being advocated?

- They form the basis of an ethical response
- A “Blame and Shame” culture can interfere with finding the contributory factors and root cause of an adverse outcome. A fair and just approach needs to be taken.
- There is emerging evidence that effective management may improve patient acceptance.

(Barach and Most, 2001)

Empathy

Empathy is the experience of being heard and understood. Empathy involves the healthcare provider acknowledging what has happened while also acknowledging and understanding the impact the event has had on the patient/service user. Open disclosure will not be effective in the absence of empathy.

Patients experience empathy when the doctor/healthcare provider:
- Adopts appropriate body language, vocabulary and tone of voice
- Listens and summarizes their ‘story’ back to them
- Acknowledges and understands the emotion(s) they express
- Picks up and responds to their cues.

Empathy is different to sympathy.
Levels of Transparency required to Impact on Culture Change (Lucian Leape 2014)

• Transparency between clinicians and patients/service users demonstrated by open disclosure following adverse events

• Transparency between clinicians demonstrated by peer review and other mechanisms to share learning.

• Transparency between healthcare organisations demonstrated by shared learning and collaborative working.

• Transparency between both clinicians and organisations and the public demonstrated by public reporting of patient safety data.

In our experience in ROI transparency is also required between staff/clinicians and the organisation i.e. between staff/clinicians and management staff to enable internal shared learning across all directorates/divisions.

Results in: Improved outcomes, fewer errors, happier patients and lower costs.
Section 3: Adverse Events

What is an Adverse Event?

An adverse event is:

“an undesired patient outcome that may or may not be the result of an error”.

or

“an incident which resulted in harm”

(World Health Organization, 2009)

Patient Outcomes:

- Near Miss: An incident that did not cause harm (also known as a close call).

- Mild – Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term and no or minimal intervention (e.g. extra observation, investigation, review or minor treatment) is required. E.g. Wrong medication administered with short term mild effects.

- Moderate – Patient outcome is symptomatic requiring intervention. (e.g. additional operative intervention or additional therapeutic treatment ), or causing permanent or long term harm or loss of function.

- Severe – Patient outcome is symptomatic requiring life-saving intervention or major surgical or medical intervention, shortening life expectancy or causing major permanent or long term harm or loss of function

- Death – on the balance of probabilities death was caused or brought forward in the short term by the incident.

(WHO: The conceptual Framework for the International Classification for Patient Safety: Version 1,1 2009)
Adverse Events: How common are they?

- Studies conducted in North America, Britain, Europe, Australia and New Zealand have shown that the percentage of adverse events occurring in hospitals is between 3 and 17% with an average of 10%.
- Medical error is clearly the Number One problem in healthcare, contributing to more deaths in the USA than motor vehicle accidents, falls, drowning and plane crashes combined.
- Most medical errors are related to system problems, not individual negligence or misconduct, and most are preventable.
- Medical errors can be reduced significantly if healthcare delivery systems are improved.
- 50% or one in every two adverse events can be prevented.

*(Teb and Associates, 2010)*

**Quote from Atul Gawande (Surgeon)**

“We look for medicine to be an orderly field of knowledge and procedure but it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals and at the same time lives on the line.”

*(Complications: A Surgeon’s notes on an imperfect science, 2003)*
Section 4: Current Status in the Republic of Ireland

Legal Considerations

In its report “Building a Culture of Patient Safety” the Commission states:

“The system of compensation of medical negligence in Ireland is not conducive to an open and honest communication process… Clinicians and risk managers are fearful of the consequences if they inform patients of an adverse event and often the event remains undisclosed and therefore the lessons from the event are never learned or shared with others who may be in similar situations in the future”.

At the same time the Commission acknowledged, as a general principle:

…”that every patient is entitled to honest and open communication regarding his/her healthcare… If something happens to a patient in the course of treatment and care which impacts or could impact on the person’s health or quality of life, the patient should be informed of this event, given an adequate explanation of the event and reassured that measures have been taken to prevent such an event occurring again in the future to him/ her or to anyone else”.

Currently in Ireland when a healthcare facility and / or clinician participates in an open disclosure process, they do so in the knowledge that any disclosure communication, whether made orally, in writing or inferred from conduct, may be relied upon in other proceedings e.g. in support of a claim for compensation or complaint to a clinician’s relevant regulatory body.

Healthcare facilities and clinicians need to be aware of the risk of making an admission of liability during an open disclosure meeting(s). While an expression of regret / empathy for what has occurred to a patient/ service user is recommended, an admission of liability is not. Where a duty of care is breached, liability for medical negligence may arise. To determine negligence, a three stage test must be satisfied as follows; (i) A person is owed a duty of care (ii) A breach of that duty of care is established (iii) As a direct result of that breach, legally recognized harm has occurred, (Bryden and Storey, 2011). The issue of liability is therefore determined within the context of legal proceedings should the patient/service user decide to pursue a civil claim. It is a matter for the hospital’s HSE legal team in conjunction with the State Claims Agency to make a decision on, once the causal factors have been fully investigated.

The Commission acknowledged the difficulties such a legal environment presents and made recommendations with regard to providing legal protection / privilege for open disclosure and clinical audit, in the belief that patient safety is best served by healthcare facilities and clinicians being free to participate fully in open disclosure and clinical audit. Some of the key recommendations include:

Recommendation 4.17: Legislation should be enacted to provide legal protection / privilege for open disclosure. Such legislation should ensure that open disclosure, which is undertaken in good faith in compliance with national standards developed in accordance with the recommendation above, cannot be used in litigation against the person making the disclosure.

Recommendation 7.11: Legislation should be enacted to give exemption from Freedom of Information legislation and to grant legal protection from disclosure to data related to patient safety and quality improvement that are collected and analysed by healthcare organisations for internal use or shared with others solely for purposes of improving safety and quality.
**Update:** It is anticipated that the upcoming Health Information Bill will contain provisions in it affording some degree of protection for healthcare personnel in relation to the open disclosure process. Minister Alan Shatter, indicated in 2014, in his role as previous Minister for Justice, that the Government may also introduce legislation to mandate open disclosure.

Healthcare facilities and clinicians can consult with their relevant professional indemnity service(s) in advance of participating in an open disclosure process, if required.

**Agencies supporting Open Disclosure**

- Health Service Executive (HSE)
- State Claims Agency (SCA) / Clinical Indemnity Scheme
- Medical Protection Society (MPS)
- Medical Council
- Nursing and Midwifery Board of Ireland (NMBI) previously ABA
- CORU
- Health Information and Quality Authority (HIQA)
- PHECC
- The Mental Health Commission (MHC)
- World Health Organization (WHO)

**What are these agencies saying about Open Disclosure?**

**HSE**

“A patient can expect open and appropriate communication throughout your care especially when plans change or if something goes wrong.”

*(You and Your Health Service, 2010)*

“Safety Incident Management occurs within the framework of the principles of open disclosure, integrated risk management, just culture and fair procedures. This policy must be read within the context of the HSE/SCA Open Disclosure National Guidelines 2013.”

*(HSE Safety Incident Management Policy 2014)*
“At the heart of open disclosure lies the concept of open, honest and timely communication. Patients and relatives must receive a meaningful explanation when something goes wrong.”

(Mr Ciarán Breen, Director of the SCA, 2015)

The Medical Protection Society (MPS)

“In our experience, many complaints arise from poor communication. Once you have established the facts, we advocate a policy of full and open communication. An explanation may be all that is needed to reassure a patient and avoid any escalation.

A wall of silence after an adverse incident can provoke formal complaints and legal action. If it is clear that something has gone wrong, an apology is called for and it should be forthcoming. Contrary to popular belief, apologies tend to prevent formal complaints rather than the reverse. We can advise you on how to manage such a situation if you are concerned.”

(MPS Members Handbook)

Medical Council

“Patients and their families are entitled to honest, open and prompt communication with them about adverse events that may have caused them harm”.

(Medical Council’s Guide to The Professional Conduct and Ethics for Registered Medical Practitioners, 2009)

Nursing and Midwifery Board of Ireland (NMBI)

“Safe quality practice is promoted by nurses and midwives actively participating in incident reporting, adverse event reviews and open disclosure”

(Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives December 2014)

CORU

“If a service user suffers harm, speak openly and honestly to them as soon as possible about what happened, their condition and their ongoing care plan”

(The Codes for Dietitians 2014, Speech and Language Therapists 2014 and Occupational Therapists 2014)

Health Information and Quality Authority (HIQA)

“Service providers fully and openly inform and support service users as soon as possible after an adverse event affecting them has occurred, or becomes known and continue to provide information and support as needed.”

(HIQA National Standards for Safer Better Healthcare 2012)
“PHECC is committed to the process of open disclosure as included in the Education and Training Standards since 2007. We believe that the open disclosure process encourages the reporting of adverse events which leads to a manifestation of the patients’ autonomy and ultimately leads to opportunities for systems improvement and delivery of the highest standards of care delivery.

In addition PHECC is committed to information being available following the incident review as being an essential component of an open disclosure policy.”

(Statement from PHECC April 2015)

The Mental Health Commission

“The Mental Health Commission fully endorses Open Disclosure and communicating with service users and their families following adverse events in healthcare. As Open Disclosure is now national policy, the Commission will be making it a requirement in its revised Code of Practice on the Notification of Deaths and Incident Reporting “.

Statement from the Mental Health Commission May 2015

World Health Organisation (WHO)

“The inclusion of open disclosure processes in many hospitals today reflects the increasing importance of professionalism and honesty with patients and their carers. This in turn is increasing opportunities for partnerships with patients”.

http://(www.who.int/patientsafety/education/curriculum/who_mc_topic-8.pdf)
Section 5: Adverse events: What do patients expect from us?

Exercise 2:

Watch the ‘Mastering Adverse Outcomes’ DVD provided by the MPS.
Focus on the patient.
As you are watching it think about what the patient’s needs are.
What does the patient require/expect from the GP during this consultation?
What does the patient expect in relation to her ongoing care following the consultation?

During the consultation:

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Following the consultation – Going forward:

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Managing the Open Disclosure Process using the MPS A.S.S.I.S.T. Model

The A.S.S.I.S.T. model is used by the Medical Protection Society to assist staff in the discussion of adverse events with patients and/or their families/support person.

ACKNOWLEDGE - SORRY - STORY - INQUIRE - SOLUTION - TRAVEL

ACKNOWLEDGE:
- There has been a problem – i.e. the adverse event
- The impact and any distress the patient has experienced as a result of this.

SORRY:
Express regret/sorrow
- For the patient’s experience if an error has not occurred or if it is not clear initially that an error has occurred.
- Apologise for any established failings in care and/or for any errors identified.

STORY:
Listen to and establish the patient’s story without interruption and summarise:
- Ask the patient to tell you the story from their perspective and to include a description of how the adverse event has impacted on them.
- Summarise their story back to them – i.e. relay your understanding of what they have said.

INQUIRE:
- Seek questions the patient would like answered
- Request permission to provide further information
- Commit to provide answers to questions at a later stage when you are unable to provide answers at this time.

SOLUTION:
- Seek the patients ideas on the way forward
- Request permission to propose some thoughts of your own
- Negotiate and agreed a plan.

TRAVEL:
- Avoid abandonment – Reassure them that their care going forward will not be compromised.
- Specifically express your desire to continue with their care
- Maintain or increase contact with the patient even if one of your colleagues will be providing most/all of the ongoing care.
What are patients saying?

Patients want:

- A truthful discussion
- To have their story heard and acknowledged
- Information to their level of satisfaction
- An expression of regret or sorrow
- Information on how similar outcomes will be prevented in the future
- An agreed plan for ongoing care and follow-up.


Exploratory Study 2010: Clinical Indemnity Scheme (CIS)

- CIS agreed to assist with research with patients or their families who had been involved in an adverse event, on whose behalf claims were settled by the State Claims Agency
- To provide an insight into Irish patients’ experiences of adverse events
- To assist in determining the outcomes desired by patients and their families following an adverse event
- To provide an insight into the factors (if any) that prompted patients or their families to take legal action following an adverse event.

Reasons for taking legal action - Comments from patients and their families

- “I consulted legal representatives to represent me and my family at the inquest into my husband’s death. As the hospital never acknowledged the two serious incidents that led to my husband’s death I felt I needed a solicitor to help me communicate with them”.
- “I felt that they thought that offering me compensation without acknowledging the wrong in not giving me any explanation would make it ok”.
- “I felt forced to take legal action because it was the only action open to me. I took the matter to a solicitor because I felt I had an obligation to others as well as to myself to do so”.
- “Staff were secretly telling me that a mistake had been made! It was very obvious to the maternity hospital that a mistake had been made but they focused on closing ranks and protecting the organisation and healthcare professionals involved. I was told my daughter would be dead within 12 months…”
The responses from Irish patients are consistent with the findings of other studies conducted worldwide as follows:

**Why patients sued**

- Patients felt rushed
- No explanations given
- Felt less time spent
- Felt ignored.

(Hickson et al 1994)

- 91% wanted to prevent a recurrence
- 90% wanted an explanation
- 68% wanted the doctor to know how they felt
- 45% due to attitude of hospital staff following error.

(Vincent et al 1994)

**No action taken**

- Patient perceived sufficient time spent
- Explained the consultation process
- Confirmed patient understanding
- Offered emotional support.

(Levinson et al 1997, Moore et al 1994)

**What motivates patients to commence litigation after an adverse outcome?**

- To correct deficient standards of care
- To find out what happened and why
- To enforce accountability
- Compensation for accrued and future costs.

(Vincent 1994, Bismark 2006)

**The Importance of Open Disclosure for Patients**

- The process can assist with providing closure for the patient/family and quicker emotional recovery
- It can help to rebuild trust and confidence within healthcare
- Patients are more willing to continue an effective relationship with the Health Care Provider (HCP)
- Open disclosure prevents misconceptions about what caused the adverse event.
- Open disclosure allows facilitation of the patient in decision making about their future care.
- Feelings of desertion after an adverse event are a major contributor to litigious intent.
HSE says sorry over meningitis death of baby

“Afterwards the solicitor for the family stated that her clients were very happy that the case had been resolved and that the letter of apology was ‘worth its weight in gold’ to the baby’s mother”.

(Irish Herald 9th July 2011)

Margaret Murphy, Patient Advocate: World Health Organisation

“Open disclosure is not about blame, it is not about accepting blame, it is not about apportioning blame. It is about integrity and being truly professional”.

and the reason

“You hold our lives in your hands and we as patients want to hold you in high regard”.
Section 6: Adverse Events -
The clinicians’ perspective & considerations

Exercise 3

Watch the DVD. Consider the feelings and emotions of the doctor whose patient is being referred to by their medical colleague.

Consider that you are this doctor and write down all the feelings you may be experiencing and your possible reactions to this conversation.

The Importance/Benefits of Open Disclosure for Staff

• Improved staff recovery.

• It encourages a culture of honesty and openness.

• Staff are more willing to learn from adverse events.

• It enhances management and clinician relationship.

• It leads to better relations with patients and their families.

• Maintains personal and professional integrity

• Lightens the burden of guilt

• Allows for reflective learning
Why disclosure is difficult

- Fear of being reported to Professional Body
- Fear of litigation
- Fear of the media
- Fear concerning professional advancement
- Fear with regard to reputation
- Uncertainty with regard to extent of information to be disclosed
- Lack of training and guidance for healthcare professionals
- Fear of the patient’s/family’s response.
- Lack of resources impacting on time required for open disclosure eg. poor staffing levels

The University of Michigan Health System (UMHS)

- The UMHS is a major public academic centre located in Ann Arbour, Michigan
- In July 2001, the UHMS began responding to all new and open claims by ‘admitting fault and offering compensation when an internal investigation reveals medical error’
- By February 2003 the disclosure programme was completely incorporated with patient safety efforts
- Three main principles were identified around risk management / claims response, compensate quickly and fairly, defend vigorously and reduce patient injuries by learning from their experience
- The average claims processing time has reduced from 20.3 months to just 8 months
- Total insurance reserves dropped by more than two-thirds
- Average litigation costs have more than halved
- The savings from the programme were invested into patient quality and safety initiatives

The six recognised stages of staff reaction following an adverse event

1. **Chaos**: Error realised and recognised. How and why did it happen. Care for the patient.
2. **Intrusive reflections**: Re-evaluate the event. Haunted re-enactments of the event. Self isolation.
4. **Enduring the inquisition**: Realisation of seriousness. Wonder about repercussions. Who can I talk to?
5. **Obtaining emotional first aid**: Seeking personal and professional support. Where can I turn to for help?

- Despite a desire to move on, many professionals find it difficult to do so. This stage has three potential paths:
  - Dropping Out—changing professional role, leaving the profession or moving to a different practice location.
  - Surviving—performing at the expected performance levels (“doing OK”) but continue to be affected by the event.
  - Thriving—making something good out of the adverse event.

Debriefing for employees

“On the basis of research results organisations should be focusing on training their managers to be able to provide timely, empathic and practical support and information in the aftermath of a traumatic event”.

(Research commissioned by the British Occupational Health Research Foundation)

Debriefing: The Purpose

- To acknowledge the reality
- To stabilise
- To provide practical support
- To give written information
- To show the organisation cares.

Debriefing: The Process

- Host a non-hierarchical meeting
- Homogenous group
- On site and close by
- Refreshments
- Support: Practical, Emotional, Social
- Information: Leaflet
- Needs: Assess
- Follow-up.

Note: Professional debriefing should only be undertaken by appropriately trained personnel.
Resources

• Employing organisation

• Work Colleagues/Peers

• Managers

• Your own GP

• EAP/Occupational Health

• The HSE Policy for Preventing and Managing Critical Incident Stress 2012 developed by the National Health and Safety Advisers Group.

• The HSE and State Claims Agency staff support booklet 2013: Supporting staff following an adverse event: The “ASSIST ME” model.
Section 7: The Open Disclosure Process

The type of disclosure required will be defined by the degree of harm the service user has experienced and the level of additional interventions/treatments required as a result of this harm. It will also depend on the nature of the event and when the adverse event becomes known e.g. the service user may have been discharged home prior to becoming aware of the event. Disclosure meetings may vary from disclosure at the patient’s bedside/clinic setting to formal planned open disclosure meetings which will usually be required when a service user has experienced moderate/severe harm or the service user has died and a meeting with his/her family is required.

Process Overview

- Preparation and key contact
- Disclosure Type – Single/multiple/retrospective?
- Disclosure lead - Who?
- Timing of disclosure
- Where?
- What to disclose?
- Postponing disclosure
- Documentation - pre, during and post
- Common Pitfalls

Objective of the Open Disclosure meeting

The objective of the disclosure meeting is to provide factual information to the patient/family/support person in a sensitive and empathetic manner in addition to arranging further supports if required and to facilitate ongoing care.

Preparation & Key Contact

- Preparation prior to the actual disclosure meeting(s) is crucial.
- A preliminary team discussion to establish the clinical facts at the time of the event needs to take place prior to meeting with the patient/family/support person.
- To establish the facts takes time and not all facts need to be established prior to this first meeting.
- A key contact person needs to be identified that will act as a contact person (not the lead discloser) for the patient/family/support person.
- Think ahead and plan responses to questions which may arise.
- Consider if additional supports are required for the meeting e.g. interpreter. It is recommended that a family member is not used as an interpreter.

**Disclosure Lead - Who?**

A decision must be made as to who will lead the disclosure in addition to what other personnel should be present. This decision needs to take account of the following points:

- The service user’s preference as to who should be in attendance.
- What has happened?
- Which healthcare provider knows most about what has happened?
- Which healthcare provider has an existing relationship with the service user?
- Who can explain the future care plan for the service user?
- Who in the service has had training/experience in relation to open disclosure?
- It is recommended and usually expected by service users and their families that the discussion is lead by the most senior clinician/senior professional who may be supported by other members of the multidisciplinary team who are providing care to the service user. If this person cannot be present his/her absence should be explained in a sensitive manner.
- Consider if the most senior clinician/most senior professional is the most appropriate person to lead in the disclosure? He/she may not be in a position at the time to disclose what happened, particularly if the outcome has been catastrophic for the service user? Consideration should be given to the impact of the adverse event on them and how they are coping.
- Consider the communication skills of the proposed lead discloser – good communication skills are critical to an effective disclosure process.
- Establish if there are multiple specialities involved and if so, who should be involved and who should lead out in the open disclosure process e.g. radiology/laboratory/other clinical specialty.
Sample Open Disclosure Team:

**Key Contact:**
*Role*
- Liaison with service user
- Arrange meetings
- Organise additional supports if required.
- Meet service user on initial arrival.

**Lead Discloser:**
*Role*
- Introductions
- Factual explanation with empathy and sincerity.
- Discussion and reassurance regarding ongoing care.

**Deputy Discloser:**
*Role*
- To assist the lead discloser.
- To help answer questions.
- To ensure understanding of the information provided.

**Note Taker:**
*Role*
- Listening
- Confidentiality
- Accuracy.
Timing of disclosure

Ideally disclosure should take place as soon as is practicable. It is important to give the patient and their family/support person enough notice so they can also prepare for the meeting. Disclosure meetings should be undertaken in daylight hours and not during a night shift.

The appropriate timing of disclosure may not always be clear and can be dependent on a number of factors such as:

- The degree of harm the service user has experienced i.e. the clinical status of the service user following the adverse event.
- The availability of the service user i.e. when an adverse event becomes known following the service user’s discharge home e.g. missed diagnosis.
- The availability and agreement of the service user to attend a meeting.
- The known facts available at that time.
- Multiple disclosures i.e. multiple service users involved.
- Consideration as to whether disclosure could be more harmful than beneficial?

Deferring/postponing disclosure

Deferral, either temporary or permanent, may be a consideration in the following circumstances:

- The service user has died and has no known relatives.
- The service user has left the country and cannot be contacted.
- The service user refuses open disclosure – may not be ready.
- There may be a risk of violence perpetrated/threatened by the service user.
- There is no evidence that the service user will benefit from open disclosure.
- The service user is extremely ill or dying – disclosure to the nominated next of kin/family member(s)/support person(s) should be considered in these circumstanceswithin the confines of patient confidentiality.

NOTE: Only in exceptional circumstances, based on the clinical interests of a service user, is it likely that a service user will not benefit from open disclosure. The reason(s) for non-disclosure should be documented by the clinician in the service user’s clinical record and senior management should be informed via internal governance processes. Decisions in relation to disclosure/non-disclosure should include input from the multidisciplinary team.
Where to disclose?

The key contact person, in liaison with the service user, should organise the location of the disclosure meeting. Consideration should be given to the following:

- The meeting may have to be arranged off site, depending on the type of adverse event.
- If a meeting in the service user’s home is required a minimum of two staff should attend from the service and management should be informed that this meeting is happening.
- The key contact person should meet the service user on arrival.
- The room should be located away from the ward/unit/service and any out-patients clinic(s).
- The room temperature and ventilation should be considered according to season.
- Avoid barriers in the room between staff and the service user/family e.g. a desk. A round table is preferable.
- Place a “Do not disturb” notice on the door of the meeting room while the meeting is in progress.
- Select a quiet location.
- Consider if additional services are needed, such as wheelchair ramps, etc?
- Bleeps/mobiles to be turned off.
- Refreshments arranged.

What to disclose:

- Factually correct information in relation to the adverse event. It may be the case that not all of the information is available at that time and the service user should be advised of this.
- Factually correct information in relation to the service user’s clinical condition. It is important to note that disclosure of information to family members/support persons should only occur with the consent of the service user.
- Establish what the service user understands already and is experiencing in relation to their condition and also establish what they understand in relation to what has happened to them.
- An expression of regret or apology in relation to the service user’s condition and for what has happened to them, as appropriate. If it is established that an error has occurred an apology is called for and should be forthcoming.
- Information on the steps already taken and/or planned to try and prevent a recurrence of the adverse event.
- Information on the practical support mechanisms/services which are available for the service user and their family/support persons, as required.
- Plans for the patient’s on-going care. The service user should be involved in and understand the decisions made in relation to the plan for his/her continuing care.
- Answers to any questions the service user has based on the facts available at the time. Where answers are not available advise the service user as to when you may be in a position to address their queries. Follow through on any assurances given.
- Allow time for the service user to express their feelings/anxieties/emotions and manage this with consideration, respect and dignity.

Documentation:

Documenting the open disclosure process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user.

Documentation which has been produced in response to an adverse event may have to be disclosed later in legal proceedings or in response to a freedom of information application. 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 as 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.

It is imperative that documentation in the healthcare record captures the following aspects of the disclosure process:

- The date, time and details of the adverse event and any actions taken /treatment provided.
- The date and time of all disclosure meeting(s).
- The disclosure team present (name individuals and roles).
- The family members/support person(s) present (named).
- The salient points of the discussion – facts presented, plan of care, actions agreed, questions raised and answers provided.
- The details of the apology/expression of regret given – exact wording.
- The details of any reactions/queries raised by the service user and of the response provided.
- Copies of any correspondence sent to the service user in relation to the adverse event/open disclosure process.
- Copies of any correspondence sent to the service user or other healthcare providers in relation to the care of the service user/follow up actions.
6.9.2: Documentation which may be held separate to the Healthcare Record

An “open disclosure file”, separate to the healthcare record, should be opened to communicate other information not necessarily required for documentation in the healthcare record, e.g. minutes of the meetings, details of reviews undertaken, statements from staff etc. To allow for a comprehensive documented flow and structured file it may be advisable to separate the disclosure file into the following segments: pre, during and post disclosure. A checklist that can act as an aide memoire should be considered to ensure that a professional and standardised approach is taken. See Appendix A of this document for a sample checklist.

Common Pitfalls

- Talking too much/negative body language
- Too many people involved in the disclosure meeting
- Failure to recognise the elements of a grief reaction
- Arguing or trying to prove you are right and over use of the word “but” e.g. “I hear what you are saying but……..”
- Failure to express enough empathy for the patient/family situation
- Use of medical jargon
- Focusing on points of disagreements rather than on points of solutions
- Failure to follow through on actions agreed.
- Lack of situational awareness
- Punctuality

Actions that can assist the process

- VIP treatment for the patient
- Car park changes paid for the patient/family. (This should be discussed with the relevant personnel prior to discussion with the family)
- Keep communication channels open between the patient/family and the service
- Keep the patient/family up to date with the progress of investigations etc.
- Ensure that the patient is included in and contributes to decisions in relation to their ongoing care
- Always confirm the patient’s/family’s/support person’s understanding of what has been discussed/agreed
- Follow through on actions agreed
- More listening than talking!
Multiple Disclosures

- A communications strategy needs to be in place for dealing comprehensively with large scale disclosure
- Large scale disclosures should pre-empt possible media and public attention
- Does the adverse event affect many patients within one healthcare facility
- Does the adverse event affect many patients within many healthcare facilities
- Risk assessment to identify patients ‘at risk’
- Where the likelihood of harm is high, the need to contact all patients is clear
- As the likelihood of harm decreases, a weighing of clinical probabilities and ethical obligations is required with the applicable healthcare professionals to make an informed decision
- The greater the risk of harm to patient(s) the more compressed the timeline should be.

Remember

- Open disclosure is a process - not a one-off event
- It may be necessary to meet with the patient/family on more than one occasion
- The frequency and number of meetings and the disclosure process will be determined by each individual case and level of harm
### Sample Language

<table>
<thead>
<tr>
<th>Stage of Process</th>
<th>Sample Phrases</th>
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</thead>
</table>
| **Acknowledgement** | “We are here to discuss the harm that you have experienced/the complications with your surgery/treatment”  
“I realise that this has caused you great pain/distress/anxiety/worry”  
“I can only imagine how upset you must be”  
“I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you”  
“I understand that you are angry/disappointed about what has happened”  
“I think I would feel the same way too” |
| **Sorry** | “I am so sorry this has happened to you”  
“I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation”  
“I truly regret that you have suffered xxx which is a recognised complication associated with the procedure/treatment”. “I am so sorry about the anxiety this has caused you”  
“A review of your care has indicated that an error occurred – I am/We are truly sorry about this”  
“A review of your care has demonstrated that there were failings in the care provided to you as follows: ……………… List  
“I am very sorry/We are very sorry about this” |
| **Story** | **Their Story**  
“Tell me about your understanding of your condition”  
“Can you tell me what has been happening to you”  
“What is your understanding of what has been happening to you” |
<table>
<thead>
<tr>
<th>Your understanding of their Story: (Summarising)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I understand from what you said that” xxx “and you are very upset and angry about this” Is this correct? (i.e. summarise their story and acknowledge any emotions/concerns demonstrated.)</td>
</tr>
<tr>
<td>“Am I right in saying that you ………………………………………</td>
</tr>
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<table>
<thead>
<tr>
<th>Your Story</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned?”</td>
</tr>
<tr>
<td>“Do you mind if I tell you what we have been able to establish at this stage?”</td>
</tr>
<tr>
<td>“We have been able/unable to determine at this stage that ………………………..”</td>
</tr>
<tr>
<td>“We are not sure at this stage about exactly what happened but we have established that …………………. We will remain in contact with you as information unfolds”</td>
</tr>
<tr>
<td>“You may at a later stage experience xx if this happens you should ………………….”</td>
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<table>
<thead>
<tr>
<th>Inquire</th>
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<tbody>
<tr>
<td>“Do you have any questions about what we just discussed?”</td>
</tr>
<tr>
<td>“How do you feel about this?”</td>
</tr>
<tr>
<td>“Is there anything we talked about that is not clear to you?”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Solutions</th>
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</thead>
<tbody>
<tr>
<td>“What do you think should happen now?”</td>
</tr>
<tr>
<td>“Do you mind if I tell you what I think we should do “</td>
</tr>
<tr>
<td>“I have reviewed your case and this is what I think we need to do next” ……….. What do you think about that?</td>
</tr>
<tr>
<td>“These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?”</td>
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<tr>
<td>“I have discussed your condition with my colleague Dr x and we both”</td>
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</tbody>
</table>
think that you would benefit from xx. What do you think about that?”

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<tr>
<th>Travel</th>
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<tr>
<td>“Our service takes this very seriously and we have already started an investigation/review into the incident to see if we can find out what caused it to happen”</td>
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<tr>
<td>“We will be taking steps to learn from this event so that we can try to prevent it happening again in the future”</td>
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<tr>
<td>“I will be with you every step of the way as we get through this and this is what I think we need to do now”</td>
</tr>
<tr>
<td>“We will keep you up to date in relation to our progress with the investigation and you will receive a report in relation to the findings and recommendations of the investigation team”.</td>
</tr>
<tr>
<td>“Would you like us to contact you to set up another meeting to discuss our progress with the investigation?”</td>
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<tr>
<td>“I will be seeing you regularly and will see you next in … days/weeks.”</td>
</tr>
<tr>
<td>“You will see me at each appointment”</td>
</tr>
<tr>
<td>“Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by …………………..”</td>
</tr>
<tr>
<td>“If you think of any questions write them down and bring them with you to your next appointment”.</td>
</tr>
<tr>
<td>“Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services”</td>
</tr>
</tbody>
</table>
Section 8: Practicing Open Disclosure

Exercise 3

We have demonstrated the importance of effective communication with patients and their families following an adverse event. This exercise will provide you with an opportunity to practice these skills using the A.S.S.I.S.T model.

- Read Scenario A, B, C, or D as allocated.
- In groups of three you will take it in turn to act as (a) the doctor, (b) the patient and (c) the observer.
- The doctor will be allocated 5 minutes to work through your consultation using the A.S.S.I.S.T model.
- The patient should communicate your disappointment to the doctor in relation to your experience and how you have suffered because of this.
- At the end of 5 minutes the observer will be allocated 2 minutes to provide feedback on his/her observations in relation to how the A.S.S.I.S.T model was used.
- The group should then switch roles and continue until all 3 members have undertaken the 3 roles.
- Don’t worry if you have not completed the full process.
Scenario A

Acute Hospital

Wrong Site Surgery

The Patient

Jim, a 65 year old patient presented with a left detached retina which required urgent surgical repair. In preparation for the surgery the left eye was inadvertently taped. Surgery commenced on the right eye. It became apparent following surgical examination that there was no problem with the right eye. The surgeon then realized the error and commenced surgery on the correct eye i.e. the left eye.

Post Surgery

Following surgery the patient woke up to discover that both eyes had protective bandaging and eye shields applied. Prior to going on holidays that evening, the consultant surgeon met briefly with the patient in recovery and informed him that the ‘right’ eye had been ‘examined’.

24hours later the patient met with the surgeon’s registrar who explained that the wrong eye had been operated on. He informed the patient he was not told of the error immediately as the consultant did not want to cause him undue stress at that time. The patient met his consultant at an out-patient appointment some 38days later, he was then informed by the consultant that an error had been made. The patient felt he had been misled.

The Hospital

Following discharge the patient requested a meeting with the hospital to establish how the error occurred. No one in authority would meet with him. He subsequently requested his consent form, following which he was told he would have to write in for it. He was now angry with the hospital as he felt there was a cover up, a significant delay of informing him of the error and an inability to communicate with him in a timely and honest manner.

He proceeded to take a case against the hospital, which was subsequently settled out of court.

Role Play

The disclosure meeting:

Open disclosure meeting 38 days later between the patient’s consultant and the patient

Lead discloser: Patient’s Consultant

Present: Jim (the patient)

Observer: Observe the disclosure process using the A.S.S.I.S.T model.
Scenario B

PCCC

**Setting:** Community Hospital

**Scenario:** Mary Daly is an 84 year old lady with severe cognitive impairment. She was transferred from the acute hospital to her local community hospital for rehabilitation and convalescence following a right total hip replacement. Mary has complex health problems and was discharged from the acute hospital on several medications including Zantac for acid reflux.

The discharge letter which included a list of Mary’s current medications was handwritten and was difficult to read.

Dr A who is a locum GP working in the GP out of hours service, was asked, while attending another patient in the unit, to write up Mary’s prescription chart. After reviewing the discharge letter he prescribed Xanax (a drug used to treat anxiety and panic disorders) for Mary instead of Zantac.

Nurse B, a staff nurse on the unit, administered Xanax to Mary as prescribed.

Mary was cared for at home by her daughter Margaret and family prior to her admission to the acute hospital for her surgery. Mary’s husband is deceased for 8 years. While visiting her Mum that evening, Margaret observes her Mum to be drowsy and questions the staff nurse as to whether her Mum has been sedated. She is angry that her Mum may have been sedated without her knowledge. Nurse B advises Margaret that her Mum has not been sedated and reports the concerns raised to the sister in charge. Margaret is unhappy with the response from Nurse B and she feels that there is a cover up as she has never witnessed her Mum to be drowsy prior to this.

Following a review of Mary’s medications as prescribed by the locum GP and the discharge letter from the acute hospital Nurse B and the sister in charge established that an error occurred and that Mary had been prescribed and was administered Xanax instead of Zantac. Visiting time was over and Margaret had left the building when the error was realised.

The director of nursing was informed and Margaret was contacted and asked to come in to meet with her to discuss Mary’s medications.

**Role Play**

**The disclosure meeting:**

Lead discloser: Director of Nursing, Community Hospital

Present: Margaret (Mary’s daughter)

Observer: Observe the disclosure process using the A.S.S.I.S.T model.
Scenario C
Acute Hospital

Scenario
Margaret, a 56 year old lady is found to have a retained swab after a life-saving laparotomy. It is discovered 3 weeks after the initial surgery when she is re-admitted for investigation of ongoing abdominal pain and fever.

She needs to return to theatre for removal of the swab. A different surgical unit is now looking after Margaret. Margaret is advised by this team that a swab had been retained during her previous surgery i.e the surgical laparotomy and a meeting is arranged for her to discuss this with her previous consultant who has been informed of the findings. Margaret has had no other abdominal surgery prior to the abdominal laparotomy.

Role Play

The disclosure meeting:
Lead discloser: Patient's Consultant at time of initial surgery i.e. laparotomy
Present: Margaret (the patient)
Observer: Observe the disclosure process using the A.S.S.I.S.T model.

Scenario D
PCCC

Scenario
John is an 87 year old man who suffers from Alzheimers disease. He is an in-patient in the Alzheimers Unit in a community hospital awaiting a bed in a nursing home as his wife is no longer able to care for him at home. John absconds from the community hospital during the third week of his stay there.

The Director of Nursing informed the Gardai, senior management, John's GP and John's next of kin immediately when he was noticed to be missing and he organised a search of the local area.

John was found by a passer by 23 hours later. He was lying in a wood and suffering from severe hypothermia. He was admitted as an emergency admission to the acute hospital and died later the same day. The Director of Nursing initiated a review of the incident and established that a care assistant had failed to close the door of the unit when escorting another patient off the unit.

Role Play: The disclosure meeting:
Lead discloser: General Manager PCCC
Present: John's son James. (John's wife is elderly and too upset to attend)
Observer: Observe the disclosure process using the A.S.S.I.S.T model.
## Section 9: Summary

**Exercise 4**

Watch the DVD. This is the same scenario as earlier but on this occasion the doctor manages the consultation using the A.S.S.I.S.T model.

Record the terminology used by the doctor which applies to the various components of the A.S.S.I.S.T model as listed below. Reflect on what was different about this consultation.

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“We were heartened by the efforts made by administrators and clinicians in the Mater to accept responsibility and embrace the need for change. We are grateful for those people in the Mater who helped us along the way, those people who admitted that failings had occurred and agreed to right them in the future, those who showed us compassion and treated us as human beings rather than potential litigants.

Financial compensation was never on our agenda. Money would never have compensated us for losing our wonderful and precious son. Instead we simply wanted answers, information, explanations, solid reassurances that what went wrong would never happen again. We wanted a proper and meaningful apology.”
Section 10: Glossary of Terms

- **Adverse Event**
  An undesired patient outcome that may or may not be the result of an error.
  or
  An incident which caused harm
  (WHO 2009)

- **Apology**
  An apology is a genuine expression of being sorry for what has happened. (Canadian disclosure guidelines: Being Open with service users and Families 2011)

- **Error**
  The failure of a planned action to be completed as intended or use of a wrong, inappropriate, or incorrect plan to achieve an aim. (WHO 2009)

- **Liability**
  Legal responsibility for an action or event.

- **Open Disclosure**
  The Australian Commission on Safety and Quality in Healthcare describes open disclosure as “an open discussion of incidents that result in harm to a patient while receiving healthcare”. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to manage the event and prevent a recurrence”.

- **Patient Safety**
  The reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes. (WHO 2009)

- **Patient Safety Incident**
  An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient. (WHO 2009)

- **Safety Culture**
  The safety culture of an organisation is the product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation’s health and safety management. (WHO 2009)

- **Systems Failure**
  The common categories of systems failure, include failures of design (process design, task design and equipment design) and failures of organisation and environment (presence of psychological precursors such as conditions of the workplace, schedules, etc; inadequate team building and training failures) (WHO 2009)
Appendix

A. Pre, During and Post Disclosure Checklist
## Appendix A

### Open Disclosure Checklist – Before – During – After

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>Note Taking</th>
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<tbody>
<tr>
<td>Patient's full name</td>
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<tr>
<td>Healthcare Record No.</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Date of Admission</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Key Healthcare Professional(s) in patient’s care</td>
<td></td>
</tr>
<tr>
<td>Date of Discharge (if applicable)</td>
<td>Date of Adverse Event</td>
</tr>
<tr>
<td>Description of Adverse Event</td>
<td></td>
</tr>
<tr>
<td>Outcome of Adverse Event</td>
<td></td>
</tr>
<tr>
<td>Agreed plan for management of Adverse Event</td>
<td></td>
</tr>
<tr>
<td>Agreed professional to act as Key Contact Person with patient</td>
<td></td>
</tr>
<tr>
<td>Date of First Meeting with patient</td>
<td></td>
</tr>
<tr>
<td>Location of first meeting (Other details such as roombookings, arrangements to ensure confidentiality if shared ward etc.)</td>
<td></td>
</tr>
<tr>
<td>Person to be responsible for note taking identified</td>
<td></td>
</tr>
<tr>
<td>Chairperson for meeting identified</td>
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<tr>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td>Anticipated patient concerns/queries</td>
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<tr>
<td>Meeting Agenda agreed and circulated</td>
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</tbody>
</table>

### PATIENT

<table>
<thead>
<tr>
<th>Note Taking</th>
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</thead>
<tbody>
<tr>
<td>Additional supports required, if any.</td>
</tr>
<tr>
<td>Has the patient consented to sharing information with others such as family members/support person</td>
</tr>
<tr>
<td>Does the patient require an interpreter? If yes, provide details of language and arrangements that have been or to be made</td>
</tr>
</tbody>
</table>

### DURING

<table>
<thead>
<tr>
<th>Note Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgement of the adverse event in relation to the patient’s experience</td>
</tr>
<tr>
<td>Apology/expression of regret provided.</td>
</tr>
<tr>
<td>Provide factual information regarding the adverse event.</td>
</tr>
<tr>
<td>Establish patients understanding of the adverse event</td>
</tr>
<tr>
<td>Ensure the patient is provided with the opportunity to voice concerns</td>
</tr>
<tr>
<td>Convey empathy and understanding</td>
</tr>
<tr>
<td>Agree the next steps and ongoing care – involve the patient in decisions made.</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Provide information on supports available:</td>
</tr>
<tr>
<td>Provide reassurance to the patient that they will be informed when further information is available - <strong>continuity provided</strong></td>
</tr>
<tr>
<td>Next meeting date and location</td>
</tr>
</tbody>
</table>

**AFTER**

- Circulate minutes of the meeting to all relevant parties for timely verification
- Follow through on action points agreed
- Continue with the incident review.
- Keep the patient included and informed on any progress made. – organise further disclosure meetings.
- Draft report to be provided to the patient in advance of the final report
- Offer a meeting with the patient to discuss the review report and allow for amendments if required.
- Follow through on any recommendations made by incident review team.

| Note Taking |  |
Section 11: Bibliography


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