

Open disclosure of things that don't go to plan in health care

A booklet for patients beginning an open disclosure process

A guide for patients



AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE



This guide was produced by the

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

If you have any comments or feedback on this guide, we would appreciate hearing from you.
Please email mail@safetyandquality.gov.au or call (02) 9216 3600.

We have tried our best to make sure that the information in this guide is correct. However, it is for guidance only and you should not rely on it as a full statement of the laws relating to open disclosure.



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About this guide

This guide has been designed to help you when things don't go to plan in your health care. It will also be useful if something hasn't gone to plan in the care of a relative, friend, or someone you care for.

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

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



Introduction to open disclosure

Every day many thousands of patients are treated by clinicians, healthcare providers and organisations in Australia. Occasionally things don't go to plan.

Australian health services are working to improve the way they handle when things don't go to plan. Part of improving the way health services manage these situations is being open with you about what happened. The process of communicating with you when things haven't gone to plan is called open disclosure.

What is open disclosure?

Open disclosure is open discussion about incidents that happened during care which caused harm to a patient, with the patient, their family, carers and other support persons.

If you are harmed during your treatment, your doctor, nurse or a health service representative should talk with you about it.

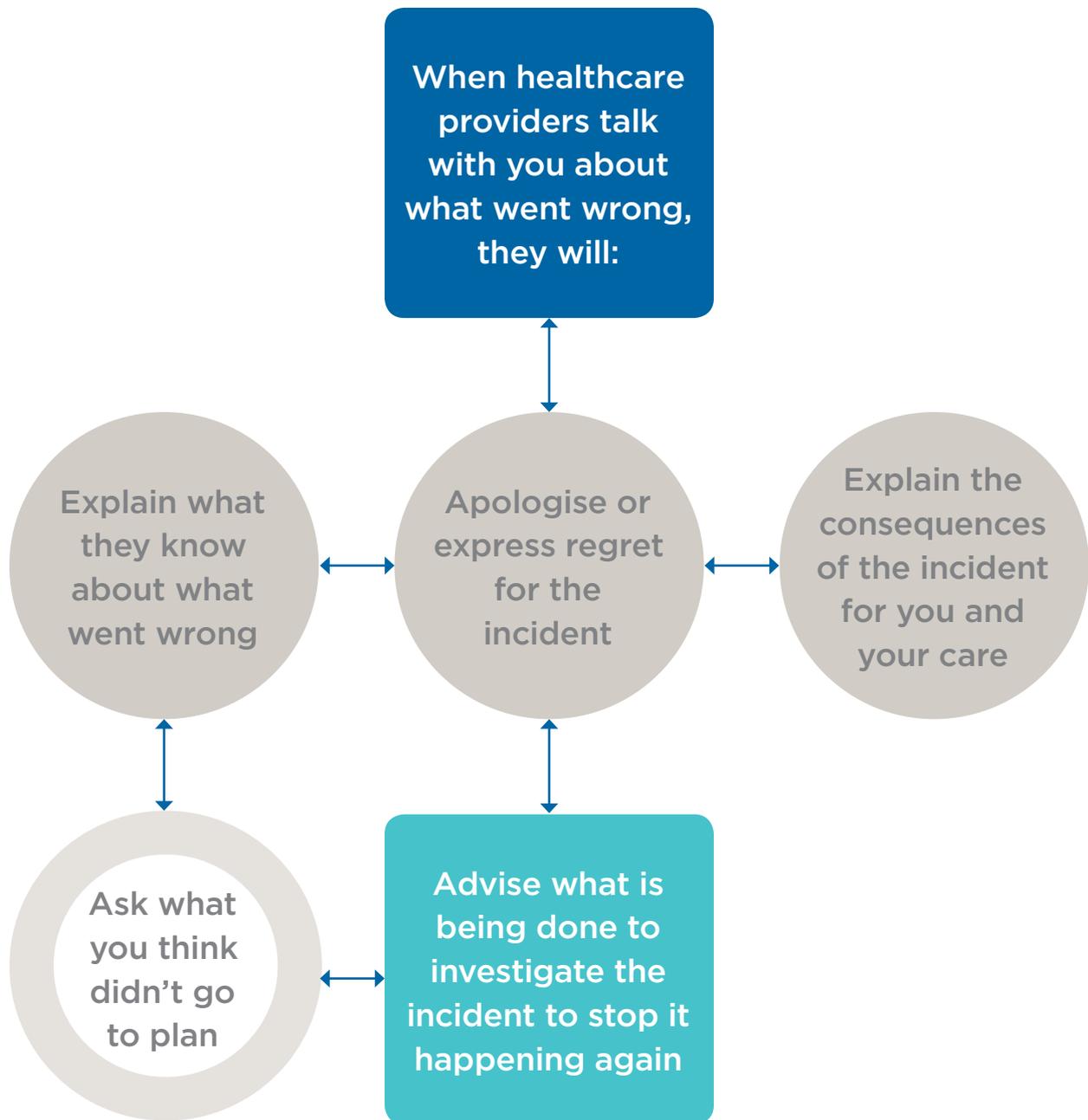
Open disclosure can:

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

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

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

1. Introduction to open disclosure





What to expect from open disclosure

If your care doesn't go to plan, it is important that someone with knowledge of what has occurred will talk with you.

For incidents which have resulted in harm, your doctor or nurse will talk with you about what went wrong in the same way they talk with you about other aspects of your treatment. They should talk with you as soon as they are aware of the incident.

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

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

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

2. What to expect from open disclosure

When will the meeting take place?

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

If the suggested time doesn't suit you, tell the person coordinating the meeting so they can arrange a more convenient time. If you are feeling too unwell or don't want to talk, you can ask for the meeting to happen when you feel ready for it.

Before the meeting, you may want some time to:

- prepare questions to ask
- decide who you would like to bring to the meeting to support you
- decide if you would like to seek a second opinion about your ongoing care
- make a list of the help that you might need because of the incident, like childcare or help to bring your relatives to visit you.

Who from the health service comes to the meeting?

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

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

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

Who supports you during the meeting?

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

You will be asked to choose a specific person (a family member friend or carer) who you'd like to be a contact person during the process. You should choose:

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

Where will the meeting take place?

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

Why should I come to the meeting?

People who have been harmed by treatment often say that they cope much better once they understand what went wrong. By talking to health service staff in the meeting, you will help them better understand and respond to your needs. Also, the health service can learn from people who have been harmed whilst in their care. Sharing your experience may help to stop the same harm happening to someone else.

What if I need an interpreter or translator?

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



The open disclosure meeting

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

What will be said during the open disclosure meeting?

When the health service staff meet with you about the incident, they will:

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

Investigating what happened

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

However, you should be told who will be your main contact person during the investigation and also who will be at all the meetings, their role and why they are there (where possible). You should ask the main contact person how you will be kept informed of the investigation’s progress.



How will the health service investigate what went wrong?

Health services use many different methods to investigate the things that go wrong, but for serious incidents most health services use a comprehensive structured process. One example of this is root cause analysis, but your health service may use a different method.

Investigations could involve putting together a team of experienced healthcare providers and clinicians (with different specialties or from other health services) to investigate the incident. The investigation can take many weeks and will also look for ways to improve the health system.

You will then be kept aware of its progress and final decisions. The team has been trained to look not just for the obvious reasons why something went wrong, but also for the reasons behind the reasons. The 'reasons behind the reasons' are referred to as the 'root causes'.

What if I have ideas about what went wrong?

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



Getting the results from the investigation

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

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

Sometimes, the investigation may find a complex technical explanation or an explanation that was quite different to what you expected. If that happens, someone from the investigating team will explain and discuss this with you and your family.

What if the information cannot be freely discussed?

Each state and territory has laws about what the information discovered during incident investigations can be used for. This sometimes causes confusion about what the health service can tell you about the investigation. None of the laws stop you being told of the investigation's findings on the incident in which you were harmed.

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

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

Further meetings

Open disclosure may require more than one meeting.

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

Follow-up meetings may be arranged to:

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



Getting help, support or more information

When something has not gone to plan in your health care, it can be difficult and can affect you and your family in many aspects of your lives.

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

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

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

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

How do I find out more about open disclosure?

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

Some states and territories also have their own policies and guidelines about open disclosure. You can find these policies, as well as information about other safety and quality improvement programs, on the website of the health department in your State or Territory.

6. Getting help, support or more information

Australian Capital Territory
www.health.act.gov.au

New South Wales
www.health.nsw.gov.au

Northern Territory
www.health.nt.gov.au/

Queensland
www.health.qld.gov.au

South Australia
www.health.sa.gov.au/

Tasmania
www.dhhs.tas.gov.au/

Victoria
www.health.vic.gov.au/clinrisk/opendisc.htm

Western Australia
www.safetyandquality.health.wa.gov.au

Open disclosure does not affect your existing rights.

For example, you are still able to talk to a solicitor about making a claim for the harm you've experienced. You can also still contact the complaints agency in your State or Territory after open disclosure.

How do I make a complaint?

In the first instance, you can make a complaint to the health service. Ask your health service contact for assistance. If you wish to make a further complaint, you can contact the health complaints agency in your state or territory.

Australian Capital Territory

Community and Health Services Complaints Commissioner

Telephone: 02 6205 2222

Fax: 02 6207 1034

TTY: 02 6205 1666

Website: www.healthcomplaints.act.gov.au

Email: human.rights@act.gov.au

Northern Territory

Commissioner for Health and Community Services Complaints

Telephone: 08 8999 1969

Telephone: 1800 806 380 (free call)

Fax: 08 8999 1828

Website: www.hcsc.nt.gov.au

Email: hcsc.omb@nt.gov.au

6. Getting help, support or more information

New South Wales

Health Care Complaints Commission

Telephone: 02 9219 7444

Telephone: 1800 043 159 (free call)

Fax: 02 9281 4585

Website: www.hccc.nsw.gov.au/

Email: hccc@hccc.nsw.gov.au

Queensland

Health Quality and Complaints Commission

Telephone: 07 3120 5999

Telephone: 1800 077 308 (free call)

TTY: 07 3120 5997

Fax: 07 3120 5998

Website: www.hqcc.qld.gov.au/

Email: info@hqcc.qld.gov.au

South Australia

South Australia Health and Community Services Complaints Commissioner

Telephone: 08 8226 8666

Fax: 08 8226 8620

Toll free in SA: 1800 232 007

Website: www.hcsc.sa.gov.au/

Western Australia

Health and Disability Services Complaints Office

Telephone: 08 6551 7600

Country Free Call: 1800 813 583

Fax: 08 6551 7630

Website: www.healthreview.wa.gov.au/

Email: mail@hadsco.wa.gov.au

Victoria

Office of the Health Services Commissioner

Telephone: 03 8601 5200

Telephone: 1800 136 066 (Toll free)

TTY: 1300 550 275

Fax: 03 8601 5219

Website: www.health.vic.gov.au/hsc/

Email: hsc@dhs.vic.gov.au

Tasmania

Office of the Health Complaints Commissioner

Toll free in Tas: 1800 001 170

Telephone: 1300 766 725

Fax: 03 6233 8966

Website: www.healthcomplaints.tas.gov.au/

Email: healthcomplaints@ombudsman.tas.gov.au

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