OPEN DISCLOSURE IN SPECIFIC CIRCUMSTANCES

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The approach to open disclosure can vary depending on the particular circumstances of the incident. Some of these are described below.

Death of a patient as a result of a patient safety incident, a known error or suspected suicide

When a patient dies as a result of a patient safety incident

When a patient safety incident has resulted in a patient's death, it is crucial that communication with people who were close to the patient is sensitive, empathic and open.

The health service's policies and practices should ensure that support persons receive information on the processes that will be followed to identify what happened, and on what care and support is available to them. Establishing open channels of communication enables people to indicate when it is appropriate to discuss what happened, and if counselling or other assistance is needed.

When a patient's death is to be investigated by the coroner

Open disclosure should not be delayed by waiting for completion of the coroner's investigation or inquiry. Where the coronial investigation has been initiated by the health facility, in addition to the usual open disclosure steps, the patient's support person(s) should be informed that the coroner's process has been initiated. They should be provided with contact details for the Coroner's office, who will liaise with the support person about the coronial process.

If a patient dies as a result of suspected suicide when they have received care for a mental illness

Although the full circumstances surrounding the person's death may not be known until after further investigation, the ensuing investigation process should not delay open disclosure.

Clinician disclosure should occur with the patient's nominated support person(s) as soon as possible.

According to the NSW Health Privacy Manual (Version 2)[36], a health service may disclose personal health information to an immediate family member for compassionate reasons. The following restrictions apply:

- disclosure must be limited to what is "reasonably necessary"
- disclosure must not be contrary to any wish the individual has expressed that the health care facility is aware of or could reasonably make itself aware of.

Where liaison with police is required to locate the support person(s), clinician disclosure should occur generally within 24 hours of the health care facility being notified of the name and contact details of that person.

Children and young people, people with a mental health condition, patients with cognitive impairment

Infants, children and young people

When a patient safety incident results in harm to an infant, child or young person (the child), the clinical team and the child's parents or guardian need to make informed and complex assessments of what the child should be told, with the child's best interests in mind.

The clinical team should assess the involvement of children and young people in open disclosure on a case-by-case basis, taking into account whether the child or young person is mature enough to receive the information and the wishes of the child or young person and his/her parents or guardian where appropriate.

When a young person has legal competence, the considerations are comparable to those for consent for treatment involving the young person. PD2005_406 Consent to Medical Treatment – Patient Information may be able to provide further guidance[37].

The clinical team will need to assess the young person's maturity and ability to understand the patient safety incident and deal with its physical and psychological impacts.

36. PD2005_593 NSW Health Privacy Manual version 2 Section 11.2.9
37. PD2005_406 NSW Health Consent to Medical Treatment – Patient Information Section 25 p19

Advice and guidance from specialist paediatric health professionals should be sought when caring for children and young people who have been involved in a patient safety incident and who may be involved in formal open disclosure. The open disclosure advisor may also be able to provide advice.

Patients with a mental health condition

The principles of disclosing information relating to treatment, including open disclosure of a patient safety incident, apply equally to patients with a mental health condition, irrespective of whether the patient is subject to mental health legislation, or whether the mental health condition was related to the reason the patient was being treated.

The timing of the disclosure discussion is informed by documented advice from the clinical team on how this information may affect the patient's health and his or her ability to understand what they are being told.

If the patient has not nominated a support person, it would be inappropriate to discuss patient safety incident information with a partner, carer or relative. In an emergency situation, the NSW Privacy Manual (Version 2) Section 11.2.9 allows for restricted disclosure to an immediate family member on compassionate grounds. The restrictions are as follows:

- the individual must be incapable of giving consent
- disclosure must be limited to what is "reasonably necessary"
- disclosure must not be contrary to any wish the individual has expressed that the health care facility is aware of or could reasonably make itself aware of.

If an open disclosure discussion is not able to be held with the patient, or is delayed or commenced with the patient's support person(s), the rationale must be clearly documented in the patient record and the IMS. Where possible, the decision should be independently verified by a colleague who was not involved in the incident and be documented in the patient record.

Patients with cognitive impairment

Patients with a temporary or permanent cognitive impairment who have been involved in a patient safety incident should be involved directly in communications about what has happened to them. The health care facility has a responsibility to work with the clinical team and relevant support people to determine the most accessible type and format of communication for the patient. A patient's capacity to understand what is being communicated to them may depend on whether the information is provided in a way that is appropriate to their abilities and usual methods of understanding[38].

Where the patient has a guardian or a carer with a power of attorney, the scope to which they can make decisions on behalf of the patient to decide whether or not they should be involved in open disclosure should be checked. Sometimes, a guardian may only have the power to make financial decisions for a patient and should therefore not be part of the open disclosure discussion, unless the patient wants them to be there.

Patients with complex care requirements and language or cultural diversity

Patients with complex care requirements involving multiple health care teams, wards and facilities

When a patient has been involved in a patient safety incident whilst receiving health care from multiple teams or health facilities, open disclosure requires consistent and coordinated communication:

- with the patient and/or their support person
- with each of the teams involved and
- between the teams/health facilities involved.

Patients and/or their support person(s) should receive unambiguous information, preferably from a single point of contact. Appointing a person to ensure that communications are timely and coordinated is recommended – for example, the open disclosure coordinator, complaints officer or patient safety manager. This person may also work with the clinical teams involved to ensure that the patient's complex care requirements are met in a timely and coordinated way.

A senior clinician from the primary treating team, or a senior manager should be nominated to lead the formal open disclosure discussions, with representation from other treating teams and other facilities if appropriate.

38. Health Records and Information Privacy Act 2002 (NSW) *Handbook to Health Privacy Section 1.4 p19. Privacy* NSW, 2004

When several teams or facilities are involved and wish to be represented at the formal open disclosure discussion, it is important to be aware of the potential for the number of health care staff to overwhelm the patient and/or their support person(s). It is important to liaise with the patient and/or their support person(s) about the people whom they would like to be present or prefer not to be present at the disclosure discussion.

Language and/or cultural diversity considerations

Ensuring appropriate and effective communication which conveys empathy and respect is an important consideration, especially when patients and/or their support person(s) come from a linguistic or cultural background different to that of the clinician. Clinicians and managers should seek assistance from appropriate services when planning open disclosure, especially formal open disclosure.

If a patient safety incident occurs, the physical and emotional impact of the patient safety incident may affect the patient's ability to communicate in English. Some patients who are proficient in English may have difficulty in understanding medical terms.

Awareness and consideration of special cultural needs must be taken into account when planning to discuss patient safety incidents – for example patients from cultures where it is difficult for a woman to speak with a man about intimate issues. If unsure about culturally appropriate communication with a patient, advice should be sought from a patient advocate or interpreter on the most sensitive way to discuss the information.

Interactions with the health system for people from culturally and linguistically diverse backgrounds, in particular Aboriginal people and refugees, may be influenced by previous personal or family experiences of racism, discrimination and mistrust.

Aboriginal people include a diversity of cultural and linguistic groups. Barriers to communication with clinicians for some Aboriginal people include language differences and differences in principles and beliefs regarding health and other matters. If available, an Aboriginal liaison officer should be involved from the outset to ensure open disclosure occurs in a culturally appropriate manner.

Professional health care interpreters are available for health care staff and patients in public hospitals and community health services. Most community languages are catered for. The service is free of charge and operates on an appointment basis. For further information, contact your nearest Health Care Interpreter Service. Avoid using 'unofficial translators' and/or the patient's family or friends as clarity of communication and the information being conveyed is essential during open disclosure discussions.

Every effort needs to be made to ensure that the appropriate people (in the context of the patient and/or their support person(s) and with their agreement) are included in discussions regarding patient safety incidents and their investigation and management.

A breakdown in the relationship between the patient and the health care team

Sometimes, despite the best efforts, the relationship between the patient, their support person(s) and the health care team can break down. The patient and/or their support person(s) may not accept the information provided or may not wish to participate in open disclosure.

The following actions may assist to rebuild the trust between the patient and/or their support person(s) and the health care team:

- address an issue/problem as soon as it arises
- do what you say you are going to do, and keep to timeframes wherever possible
- with the patient's agreement, ensure that their support person(s) and other relevant people are involved in discussions from the time when a patient safety incident is first identified
- ensure access to appropriate support services for the patient and/or their support person(s)
- ensure the appropriate staff member (most often the senior clinician) is aware of a potential relationship breakdown by notifying them of early warning signs such as a patient and/or their support person(s) expressing concern to members of the team.

- offer the patient and/or their support person(s) another health care facility contact with whom they may feel more comfortable. This could be another member of the clinical team or the health service's manager responsible for insurable risk
- use a mediation or conflict resolution service to help identify the issues between the health service and the patient and/or their support person(s), and to look for a mutually agreeable solution
- provide information about the local health care complaints office if the patient and/or their support person(s) wishes to lodge a formal complaint with the Local Health District/Specialty Network or with the Health Care Complaints Commission (HCCC)
- assess whether sufficient weight has been given to the patient's version of events and whether reasonable efforts have been made to seek information from all key witnesses, including witnesses identified by the patient and/or their support person(s).

When the patient doesn't want to meet with the clinician or other member of staff

Where the patient and/or their support person(s) express a preference for the health care staff involved in the patient safety incident not to be present, the health care staff may wish to provide a personal written apology that can be given to the patient and/or their support person(s) during the discussion.

When the clinician doesn't want to meet with the patient and/or their support person

There may be occasions following a patient safety incident when a key clinician who was involved in the incident is unable or unwilling to meet with the patient and/or their support person. It is important for the health service to ascertain the reasons and address them wherever possible, including asking the open disclosure advisor to speak with the clinician, referring him/her to their professional indemnity insurers for further advice and/or referring him/her to the appropriate support services.

If the clinician is unable or unwilling to attend, his/her department head, a senior manager or an open disclosure advisor should be available to attend the open disclosure discussion on his/her behalf.

The patient and/or their support person(s) should be informed that the clinician is unable to attend, provided with an explanation as to why he/she can't be there, and that the health service is able to offer a senior clinician to attend in his/her place, to enable them to make a decision about whether to proceed with the discussion.

Patient safety incidents occurring elsewhere or involving transfer of the patient

Patient safety incidents occurring elsewhere

A patient safety incident may have occurred in a different facility or health service from where the incident is identified. The person who first identified the incident should notify the patient safety manager in their health care facility.

The patient safety manager should establish whether:

- the patient safety incident has already been recognised in the health care facility in which it occurred
- open disclosure has already commenced in that health care facility
- reviews or investigations are underway in that health care facility
- the incident has been reported to Treasury Managed Funds (TMF).

If open disclosure has not already commenced, it should occur after consultation and collaboration with the other health service, and without undue delay. Respect for the patient's right to know about a patient safety incident that involves them is paramount.

A thorough clinical review and investigation of the patient safety incident should occur in the health care facility where the incident took place.

Transfer of the patient to another facility or Local Health District/Specialty Network with their support person(s) accompanying them

A patient safety incident may necessitate transfer of the patient who has been harmed to another health care facility in order to receive the care that they require. Clinician disclosure should occur before the patient is transferred, depending on the patient's condition and the availability of their support person(s).

It may be appropriate for the clinicians involved from both settings to be present and conduct the formal open disclosure discussions together.

Delayed detection of a recent patient safety incident

In any situation when there has been delayed detection of a patient safety incident, for example after a patient has been discharged, health services should:

- notify the patient and/or their support person(s) (clinician disclosure)
- with the agreement of the patient and/or their support person(s), notify other health care teams who have responsibility for ongoing care of the patient – for example, their general practitioner or community care provider
- commence an investigation of the incident
- proceed with formal open disclosure if indicated by the particular circumstances.

The needs of the patient and/or their support person(s), as well as the health care staff involved in the incident, may require flexibility with the location or delivery of the open disclosure discussion(s). Video or internet based conferencing may be an option to offer to the patient and/or their support person(s).

Incident identification following a death audit

When a serious patient safety incident is identified during a retrospective death audit, open disclosure may not have been initiated. In these situations, it may be preferable to undertake an incident investigation prior to initiating open disclosure. If the incident investigation confirms a patient safety incident has occurred, then open disclosure should be commenced.

Issues of accountability or suspected intentional unsafe acts

If during the investigation of the patient safety incident a performance issue relating to an individual member of health care staff is identified, the course of action is redirected to the health service's performance management system. See Complaint or Concern about a Clinician – Principles for Action PD2006_007 and Complaint or Concern about a Clinician – Management Guidelines GL2006_002.

Privacy legislation prevents the sharing of information about investigations into the performance of individual clinicians, unless that clinician provides consent. The patient and/or their support person(s) can be informed that incident review processes routinely consider whether or not further investigations into individual performance are needed. Further assessment may be made at the local level or through referral to the Health Care Complaints Commission (HCCC) or the Australian Health Practitioners Regulation Agency (AHPRA). It is important to emphasise that performance assessment processes are confidential to enable proper and fair processes to be followed. The hospital is legally unable to provide a copy of the investigation report or any specific details of the investigation to the patient and/or their support person(s). However, where a person made a complaint to the HCCC or AHPRA, he/she will be advised of the outcomes directly by these bodies.

Criminal or intentional unsafe acts

Patient safety incidents are almost always unintentional. If, at any stage following an incident, it is determined that harm may have been the result of a criminal or intentional unsafe act, the health service chief executive and the manager responsible for insurable risk should be notified immediately. This applies to any person working in any capacity within a NSW Health facility, including contractors, students and volunteers.

The person who is the subject of the process should not be involved in the open disclosure discussion.

Health service management should follow the pathway outlined in the Complaint or Concern about a Clinician – Management Guidelines GL2006_002, which includes referring the matter to the appropriate authority.

Obligation to report to Police

All suspected criminal acts (whether instigated by a staff member or a patient) must be reported to the NSW Police Service as soon as they are identified. Investigations by the health service must be conducted in accordance with the NSW Health Policy Directive concerning the allegation of criminal and child related conduct PD2006_026 Criminal Allegations, Charges and Convictions against Employees. Examples of criminal acts include suspected homicide, and sexual or physical assault.

In these situations, open disclosure will be modified to accommodate the context and particular circumstances. The Police Service will advise on what information is able to be provided to the patient and/or their support person(s). At a minimum, the health service should disclose that there are concerns about a patient safety incident, that police have been informed and then provide the contact details for the police officer in charge.

Exceptions to the timeframes for initial clinician disclosure discussion

After a patient safety incident is identified, the initial clinician disclosure discussion should occur at a time which meets the needs of the patient and/or their support person(s), and be generally within 24 hours of the incident.

In some settings such as mental health patients in the community or patients of Justice Health and Forensic Mental Heatlh, conditions or events surrounding a patient safety incident may delay the initial clinician disclosure discussion.

The rationale for any delay must be clearly documented in the patient record and the IMS.

Deferring open disclosure

Occasionally open disclosure may need to be deferred – for example on the advice of the treating clinician that the patient is not able to participate due to the state of their physical or mental health.

The decision and rationale for delaying open disclosure must be clearly documented in the patient record and the incident management system (IMS). Where possible, the decision should be independently verified by a colleague who was not involved in the patient safety incident and documented in the patient record.

The patient and/or their support person(s) may also request deferral. They must be provided with the name and contact details for a liaison person at the health care facility and informed that at any time, they can request that open disclosure proceeds.

Open disclosure may be deferred with the patient and held with their support person(s) either instead or as a temporary measure. Where possible, the process should recommence with the patient at a later date.

Large scale open disclosure

When there is potential for a number of people to be harmed by a common patient safety incident or series of incidents, each situation should be assessed promptly with legal counsel and public relations departments.

The NSW Health Lookback Policy PD2007_075 provides guidance to ensure a consistent, coordinated and timely approach for notification and management of potentially/ affected patients when necessary. Initial communication should be direct, either face-to-face or via telephone, where the patient must be given the opportunity to ask questions. Where appropriate, the timing of the disclosure to individuals who may have been affected needs to be considered so that a person is contacted (where possible), before learning about the event from other sources e.g. media. Affected patients are offered a written apology by the health service.

All information should be given in accordance with the Open Disclosure Policy PD2014_028 and privacy principles detailed within the NSW Health PD2005_593 Privacy Manual (Version 2). Clinicians are responsible for applying open disclosure principles when communicating with patients and/or their support person(s).

Proactive disclosure is recommended. This may include a public announcement (e.g. a press conference) and description of what has occurred using various media; an apology for distress that the announcement may cause, details of the investigation underway and what would happen if it is identified that a person has been affected, and details of a dedicated toll-free contact number staffed by clinical members of the team and an email address[39].

39. Aldrich R, Finlayson P, Hill K, Sullivan M (2012). Look back and talk openly: responding to and communicating about the risk of large-scale error in pathology diagnoses. International Journal for Quality in Health Care 2012;24(2)135-143