RESOURCES

RESOURCES

EXAMPLES OF WORDING

Signalling formal open disclosure

Following on from the clinician disclosure discussion when the patient has suffered serious harm – for example a significant complication during surgery, an adverse drug reaction, a fall which results in a serious fracture, an incident of self-harm to a mental health inpatient, a post-partum bleed from retained placenta :

"Mr Chan, what has happened to your wife has resulted in serious harm to her. I would like to explain what happens now. If you would prefer that I come back at another time, please let me know. We have already covered quite a lot of information and this situation is very distressing".

An example of appropriate wording if the patient and/or their support person(s) agree to continue:

"Mr Chan, what happens from now on is that we will provide Mrs Chan with all the care that she requires. We will provide you with as much support as we can.

Because we want to find out how this terrible event occurred, **we will be investigating the incident** in detail. This is a formal process supervised by a group of experienced clinicians and managers. The investigation will start shortly and can take several months.

Part of this process **involves formal meetings with you** and other people that you may wish to be with you to offer support, for example family members or a close friend.

Do you have any questions about what I have said so far?

At these meetings **we will keep you informed** about the progress of the investigation. You can ask any questions that you may have over time, as you think about what we have told you and your experiences of the incident.

We would also welcome **anything that you are able to share with us** about your understanding of what happened to Mrs Chan. This will help us with finding the causes of what happened.

As the doctor in charge of Mrs Chan's care, I would usually be at these meetings along with the nurse in charge and one of the hospital managers. Would you prefer someone else to be present at the meeting?

Mr Chan I'm aware that I **have just provided a lot of information,** and that it is not easy to take all this in at this time. We have some written information for you that covers what I have just explained – you can keep this and read it when you wish.

We will **contact you to update you on the progress of the investigation** and to find a date to have a formal meeting at which we can **discuss your concerns, and our findings** of what happened and what needs to be done in the future.

When you have any questions or concerns, **please contact me,** the nurse manager, or my colleague the patient representative. I will leave our names and phone numbers with you, and please feel free to ask the staff as well.

Thank you Mr Chan and **may I say again how sorry I am that this has happened** to your wife Mrs Chan".

Apologies in different circumstances

These examples are provided as a guide only. The apology should be relevant to the circumstances of the patient safety incident, the harm caused to the patient and the responses of the patient and/or their support person(s) to both the incident and open disclosure.

An apology during the initial clinician disclosure discussion:

- "Mr Nguyen, I'm sorry that I've not been able to take a blood sample although I've had several attempts. I have not been able to access a vein. Is there anything that you can tell me about when you've had blood tests taken before? You may have some bruising and soreness around the site – we will keep a close eye on it. Please let us know if the soreness doesn't settle or gets worse. I will ask my colleague to take your blood sample so that there is no delay in getting the results."
- "Mrs Patel, when I was removing the tape over your wound dressing, some of the skin around the dressing was damaged. I'm really sorry that this happened. Can you tell me if you've had any skin sensitivity with the tape used for this dressing or others? We will apply a protective film to your skin, and change the tape that we use to one that is more suitable for sensitive skin. We'll monitor the response closely to ensure that this doesn't happen again."
- "Mr Kelly, you didn't receive your medication when it was due as you were off the ward having an x-ray, and we didn't remember to give it to you when you returned. I'm very sorry. Please tell us if this has caused you any concern or if there is something that we may have missed. We will need to keep a close eye on your blood sugar levels for the next few hours, and we may need to give you some extra medication this afternoon. Please let us know if you are feeling unwell or 'not quite right'."
- Young child: "Ms Tan, your daughter Julie didn't receive her medication when it was due as she was off the ward having an x-ray. We didn't remember to give it to her when she returned. I'm very sorry. We will need to keep a close eye on Julie for the next few hours. Please let us know if there is something that we have missed, or if you or Julie's other family members notice anything or have any concerns about Julie's condition while you are here."

An apology during clinician disclosure when it is likely that formal open disclosure will be required and the facts may not be known yet:

- "Mr Suzuki, we are very sorry that this has happened. It is clear that something went wrong and we are investigating it right now. We will give you information as it comes to hand. It is very important for us to understand what happened from your point of view. We can go through this now if you like, or we can wait until you are ready to talk about it."
- "Mr Brown, there has been a problem with your medication and you have told me that the pain has been quite bad. I'm very sorry that this has happened and that your pain has not been controlled well. Please tell me about what happened from where you stand? We are not exactly sure what happened at present, but we will investigate to find out and will give you more information as it becomes available. For now, we have adjusted your medications and will ensure that you receive them when you need them. Please let us know if your pain increases or if you notice that anything else is not right."
- "Mr Malouf, shortly after your wife Mrs Malouf was given a medication through her IV drip, the nurse noticed that she experienced trouble breathing and developed a red rash over her body. The nurse called the senior nurse for help. The senior nurse made an emergency call and while she was doing this, Mrs Malouf stopped breathing. We resuscitated her and she is resting comfortably and being monitored closely. Something serious appears to have happened and we are investigating it now. I am sincerely sorry that this has happened. To help us find out what caused the incident, it would be helpful if you could tell us what you saw or perceived. We can go through this when you are ready to talk about it."

> **15 year old patient:** "Hello Sarah. We need to speak with you about the plaster cast on your right wrist. Is it OK with you if we include your parents in this discussion?"

(If Sarah agrees): "Sarah, when we were checking the x-ray of your right wrist after applying the plaster cast, we noticed that the cast had been applied to the wrong wrist. As you know it is your left wrist that you broke after falling off your skateboard. I'm so sorry about this. We're not sure how this happened and are trying to find out now. Is there anything that you or your parents noticed and can tell us that may help us to understand what happened?

We'll shortly apply the plaster cast to your left wrist and remove the cast from your right wrist. There should be no long term consequences and you should be able to go home in the next few hours. We'll continue your pain relief. Please let me know if you have any concerns or questions. After we've investigated how this happened, we'd like to meet with you and your parents again to discuss the results of the investigation. Once again, I'm very sorry that this has happened."

An apology when a patient has died as a result of a patient safety incident:

Initial clinician disclosure discussion – acute care setting

"Ms Lim, I am very sorry about the death of your father Neil. At this stage we are not sure exactly what happened that has resulted in his death. What we do know is that after his fall yesterday he was assessed by the medical and nursing staff and showed no apparent signs of injury.

Last evening he ate all his dinner and was talking to the other men in his room.

However, when the nursing staff went to wake him this morning for his breakfast, he did not respond to them. Despite urgent medical attention, he did not improve and died not long after you arrived. I am so sorry.

We will be investigating the matter extensively and will of course keep you informed throughout.

Is there anything that we should know about your father's condition over the past day – anything that you've noticed or were not sure about?

You may have some questions you would like to ask and I will try to answer them as best I can. If you would prefer to wait for your family or to meet later today please let me know. Here is my telephone number, or you can ask the nurse in charge to contact me."

Initial clinician disclosure discussion – Mental Health in-patient:

"I am so sorry Mr Napier about the death of your daughter Leanne. At this stage we are not sure exactly what happened that has resulted in her death. As you know, she has been receiving treatment for severe depression for several months. Over the last few weeks Leanne had seemed to improve.

This afternoon she didn't come to her appointment with me. When we looked for her, one of the nurses found her in the TV room. Leanne had a number of deep cuts to her arms and had lost a lot of blood. The nurses gave her emergency treatment and she was transferred by Ambulance to the teaching hospital.

Sadly, Leanne did not respond to the treatment and died shortly after arriving at Hospital X.

I am so very sorry.

We will be investigating the matter extensively and of course will keep you informed throughout.

Is there anything that we should know about your daughter's condition over the past few days – anything that you noticed or were not sure about? You may have some questions you would like to ask and I will try to answer them as best I can. If you would prefer to wait for your family or to meet later today please let me know. Here is my telephone number, or you can ask the nurse in charge to contact me."

Formal open disclosure – follow up discussion after the investigation has been completed:

"Ms Oakley, your husband, John, was given an injection of penicillin shortly before his death. We found notes in his medical records that he was allergic to penicillin, but the person who gave the injection did not see the notes. I am so sorry that this happened. I cannot imagine the distress that this has caused to you and your family. If you are able, I'd appreciate it if you could tell me about things from your point of view.

We have spoken several times since John's death. Now that we have the results of the investigation we can go through the findings if you wish, and you may have questions you would like to ask. I will try to answer them as best I can.

As a result of the investigation and the recommendations, our hospital is reviewing the ways in which we signal that a patient has an allergy. We are examining how leading hospitals from across Australia and internationally highlight allergies that a patient may have. If you wish, we will keep you and your family informed about our progress and the changes that result to our system so that this terrible incident does not happen to anyone else.

We understand that this does not bring your husband back. The changes to our system will serve to prevent this from happening to any patients in the future."

GENERAL PRINCIPLES AND REQUIREMENTS FOR OPEN DISCLOSURE

The NSW Health Open Disclosure Policy PD2014_028 determines that the roles and responsibilities of all clinicians include:

- completing education about open disclosure
- ensuring that the patient is safeguarded from further harm following a patient safety incident
- apologising to a patient and/or their support person(s) following a patient safety incident, without attribution of blame or speculation about the course of events
- participating in open disclosure as required
- ensuring that a patient safety incident and associated open disclosure is recorded in the patient's health care record and the incident management system.

The Policy also sets out the specific responsibilities of senior clinicians, directors of clinical governance, managers with operational responsibility at facility/service level, department heads, open disclosure coordinators and open disclosure advisors.

The mandatory requirements outlined in the NSW Health Open Disclosure Policy are derived from the Australian Open Disclosure Framework[41] and are as follows:

1. **Acknowledgement of a patient safety incident to the patient and/or their support person(s),** as soon as possible after the incident has occurred and any immediate action needed to support the patient's care has been taken, generally within 24 hours. This includes recognising the significance of the incident to the patient, even if there has been no or minimal clinical impact arising from the incident.

2. **Truthful, clear and timely communications** on an ongoing basis, for as long as required, to appropriately support the patient and their support person(s) and health care staff involved in the patient safety incident. This involves (a) providing information to the patient and their support person(s), (b) providing an opportunity for the patient and their support person(s) to recount their experiences, concerns and feelings, and (c) listening and responding appropriately to the patient and their support person(s).

3. **Providing an apology to the patient and/or their support person(s)** – as early as possible, including using the words "I am sorry" or "we are sorry".

   Communications that go towards meeting the essential elements of an apology and which may be appropriate in some circumstances – for example, at clinician disclosure before the incident investigation process has been completed and where all relevant facts are not known yet – include one of the following[42]:
   - expressions of sympathy or empathy, for example "I'm sorry this happened to you"
   - expressions of regret for the act or its outcome, for example "I regret that this happened"
   - expressions of sorrow – for example, "I'm very sorry for what has happened".

4. **Providing ongoing care and support to patients and/or their support person(s)** which respects and is responsive to their needs and expectations, for as long as is required, so that they:
   - are fully informed of the facts surrounding a patient safety incident and its consequences
   - are treated with empathy, respect and consideration
   - are supported in a manner appropriate to their needs
   - continue to receive appropriate treatment, including if the patient and/or their support person(s) request that the patient's health care needs are taken over by another health care team where feasible.

5. **Providing support to health care staff** when they have been involved in a patient safety incident which respects and is responsive to their needs and expectations, in an environment in which all staff are:
   - encouraged and able to recognise and report patient safety incidents
   - prepared through training and education to participate in open disclosure

41 Australian Commission on Safety and Quality in Health Care (ACSQHC) Australian Open Disclosure Framework, Sydney, 2013
42. NSW Ombudsman Apologies – A practical guide 2nd edition, Sydney, 2009

6. **An integrated approach to improving patient safety,** in which open disclosure is linked with clinical and corporate governance, incident reporting, risk management and quality improvement policies and processes. This includes evaluation of the process by patients and their support person(s) and staff, accountability for learning from patient safety incidents and evidence of systems improvement.
7. **Multidisciplinary involvement in open disclosure** reflecting that health care is provided by multidisciplinary teams.
8. **Compliance with legal and ethical requirements for privacy and confidentiality** for the patient and/or their support person(s), and health care facility staff.

CHECKLISTS AND OTHER RESOURCES

CLINICAL EXCELLENCE COMMISSION

The following Checklists to support open disclosure practice are included in this section and can be downloaded from the Open Disclosure page on the CEC website:
www.cec.health.nsw.gov.au/programs/open-disclosure

- **CHECKLIST A: CLINICIAN DISCLOSURE** – this checklist may be useful for identifying the steps to be completed for the initial clinician disclosure discussion with a patient and/or his/her support person(s).
- **CHECKLIST B: PREPARATION FOR FORMAL OPEN DISCLOSURE** – this checklist may be helpful for identifying tasks to be completed or delegated when preparing for a formal open disclosure discussion with a patient and/or his or her support person(s).
- **CHECKLIST C: THE OPEN DISCLOSURE TEAM MEETING** – this checklist may be useful for identifying tasks to be completed or delegated during a meeting of the open disclosure team in preparation for a formal open disclosure discussion.
- **CHECKLIST D: FORMAL OPEN DISCLOSURE – DURING THE DISCUSSION** – this checklist may be useful for identifying important points to address in a formal open disclosure discussion with the patient and/or his or her support person(s).
- **CHECKLIST E: FORMAL OPEN DISCLOSURE – COMPLETION** – this checklist may be useful for identifying important points to consider when completing formal open disclosure.

Additional resources available from the Open Disclosure page on the CEC website include:

- **CHECKLIST: ORGANISATIONAL READINESS FOR OPEN DISCLOSURE**
- **GUIDE TO OPEN DISCLOSURE FOR MANAGERS RESPONSIBLE FOR INSURABLE RISK**
- **OPEN DISCLOSURE POLICY PD2014-028 – DIFFERENCES BETWEEN FORMER AND CURRENT POLICIES**

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE (ACSQHC)

www.safetyandquality.gov.au/our-work/open-disclosure/

To support the Australian Open Disclosure Framework, the ACSQHC has developed a range of resources for clinicians and health care providers, health service organisations and consumers.

CLINICIAN DISCLOSURE
CHECKLIST 'A' – STEPS FOR THE INITIAL DISCUSSION

This checklist may be useful for identifying the steps to be completed for the initial clinician disclosure discussion with a patient and/or his or her support person(s).

☐	Health professional (s) to speak with the patient and/or their support person as soon as possible, at the latest within 24 hours of the patient safety incident
☐	Assess the need for and arrange support for the patient and/or their support person e.g. social worker, patient safety representative, health care interpreter
☐	Hold the initial discussion with the patient and/or their support person(s)   **SORRY** • **Acknowledge what happened,** explain known facts of the incident • **Apologise for the incident** "I'm sorry that this has happened" • **Acknowledge the consequences** for the patient and/or their support person  **TELL ME ABOUT IT:** encourage the patient and/or their support person to relate their experience of the patient safety incident, its impact and what is needed from their perspective. Listen and respond appropriately.  **ANSWER QUESTIONS:** honestly, without speculation or blame  **RESPONSE:** Discuss what happens next with the patient and/or their support person • The **plan for ongoing care** (if required) • **Follow up** (if required) • Lessons learned – how the incident will be investigated and managed, to prevent recurrences  **SUMMARISE:** the key points of the discussion and the next steps
☐	**Provide the patient** and/or their support person with the relevant person's name and contact details should they have any concerns or questions
☐	**Document in the patient's health record that clinician disclosure has occurred,** including • a confirmation that an apology was provided • a brief outline of the information provided to the patient and/or their support person • future steps to be taken (if required)
☐	**Record** that clinician disclosure has occurred in the incident management system
☐	**Notify insurers, if appropriate, via managers responsible for insurable risk** (e.g. TMF, professional indemnity insurers)
☐	Assess whether a **formal open disclosure response** is required
☐	Provide the patient and/or their support person with information about how to provide feedback or make a complaint should they wish
☐	If required, provide the patient and/or their support person with further information about the formal open disclosure process
☐	If required, document activation of formal open disclosure in the incident management system and the patient's health record

For more detailed information please refer to the Clinician Disclosure section of the CEC Open Disclosure Handbook *www.cec.health.nsw.gov.au/programs/open-disclosure*

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CLINICAL EXCELLENCE COMMISSION

FORMAL OPEN DISCLOSURE
CHECKLIST 'B' – PREPARATION

This checklist may be useful for identifying tasks to be completed or delegated when preparing for a formal open disclosure discussion with the patient and/or his or her support person(s)

☐	**Notify all relevant people about the patient safety incident:** health care staff involved in the patient safety incident, Clinical Governance Unit, Senior Executive
☐	Consider **legal and insurance issues** for the organisation and the clinicians – notify the relevant people
☐	Appoint an **open disclosure coordinator**
☐	Contact an **open disclosure advisor**
☐	**Establish a formal open disclosure team** – multidisciplinary: senior clinicians and executive, open disclosure advisor. Determine who will lead the discussion with the patient and/or support person
☐	**Hold the team discussion:** consider using *Checklist C* to guide preparation for the team meeting
☐	Be aware of your emotions and those of other health care staff participating in the discussion – seek support or advice from the open disclosure advisor/experienced colleagues if necessary
☐	Anticipate the patient's and/or their support person's concerns and questions about the formal open disclosure discussion, and prepare appropriate responses
☐	**Liaise with patient** and/or their support person to arrange: ☐ **the date, time and location for discussion** ☐ **who** they would **like to be present** ☐ any **additional support required** e.g. interpreter, aboriginal liaison officer, social worker, spiritual support
☐	Follow local processes for **early reimbursement of out of pocket expenses** to the patient and/or support person
☐	**Review the clinician disclosure** discussion STARS
☐	If possible, establish the patient's and/or support person's **understanding of the incident** before the formal open disclosure discussion
☐	Check if the **patient (if able) has consented/agreed to sharing information** with their support person(s), family members, others
☐	Locate a **quiet, private area** to hold the discussion, free from interruptions
☐	Prepare any **information for the patient** and/or their support person in an appropriate format
☐	Establish whether there has been any involvement of the media, and if so, what actions are required
☐	Document activation of formal open disclosure in the patient's health record and the incident management system

For more detailed information please refer to the Formal Open Disclosure section of the CEC Open Disclosure Handbook *www.cec.health.nsw.gov.au/programs/open-disclosure*

FORMAL OPEN DISCLOSURE
CHECKLIST 'C' – OPEN DISCLOSURE TEAM MEETING

This checklist may be useful for identifying tasks to be completed or delegated during a meeting of the open disclosure team to prepare for a formal open disclosure discussion with the patient and/or support person(s)

Please notify the Clinical Governance Unit when planning a formal open disclosure discussion.	
☐	All relevant health care staff involved in the patient safety incident have been notified/consulted
☐	Notify and invite the open disclosure advisor to the disclosure team meeting
☐	Identify the person(s) responsible for the disclosure conversation with the patient and/or their support person(s). Where possible, this person will: • be known to the patient • be familiar with the incident and care of the patient • have good interpersonal and communication skills • be willing to offer an apology to the patient and/or support person(s) • be willing to maintain a close relationship with the patient • have received open disclosure training
☐	Team discussion to include: ☐ Which team members will attend the discussion with the patient and/or support person ☐ Who will take notes to record the discussion and outcomes ☐ Determining who will be the liaison/contact person for the patient/support person(s) ☐ Establishing and agreeing on known facts and sequence of events: avoid opinion, speculation or blame ☐ The known impact/s for the patient and/or support person(s) ☐ Steps being taken to manage the impact and consequences of the incident ☐ What to include in the apology and who will provide it ☐ Encouraging/inviting the patient and/or support person to give their perspective of the incident ☐ An early offer of reimbursement of out of pocket expenses, and who will raise this with the patient/support person ☐ Anticipating potential questions from the patient and/or support person and considering answers ☐ What key messages need to be conveyed to the patient and/or support person ☐ Advice to provide on the review/investigation process ☐ What practical/emotional support will be offered to the patient/support person(s) and health care staff involved in the incident and/or the formal open disclosure discussion ☐ Advice to provide on complaints process or legal action if indicated

For more detailed information please refer to the Formal Open Disclosure section of the CEC Open Disclosure Handbook *www.cec.health.nsw.gov.au/programs/open-disclosure*

FORMAL OPEN DISCLOSURE
CHECKLIST 'D' – DURING THE DISCUSSION

This checklist may be useful for identifying important points to address in a formal open disclosure discussion with the patient and/or support person(s). If there is more than one discussion, not all steps may be required for follow up.

Please notify the Clinical Governance Unit when planning a formal open disclosure discussion.	
☐	Use language and terminology that is appropriate for the patient – avoid jargon. If using this checklist during the discussion, explain the reason to the patient/support person
☐	Assess the need for and as required, arrange support for the patient and/or their support person e.g. social worker, patient safety representative, health care interpreter
☐	**Introduce the participants to the patient** and/or their support person(s), their roles and reasons for attending
☐	**Acknowledge and apologise:** ☐ **Acknowledge what happened** – known facts ☐ **Apologise for the patient safety incident** "I am/we are sorry that this has happened" ☐ **Acknowledge the consequences** for the patient and/or their support person
☐	**Explain the formal open disclosure process,** including: ☐ The process for investigating the incident and timelines ☐ The patient and/or support person will be able to contribute to the investigation ☐ How the patient and/or support person will be kept informed ☐ What the formal open disclosure process does not include ☐ Any restrictions on information that is able to be provided and the reasons
☐	**Invite the patient and/or support person to tell of his/her experience** *of* the incident, its impact and what is needed from their perspective.
☐	**Listen and respond** appropriately
☐	**Describe the facts of the patient safety incident** and any outcomes known at the time
☐	**Provide the findings of any review or investigation** that are able to be shared
☐	Discuss and agree on a **plan for care** for the patient and/or his/her support person: ☐ Ongoing care and support (if required) addressing short and long term consequences ☐ Names and contact details for people/services who will be providing care ☐ Information on the patient's right to continue his/her care elsewhere if preferred ☐ Information on how to take the matter further, including complaint or legal processes available to him/her ☐ Offers of practical and emotional support as needed ☐ An offer to reimburse out of pocket expenses
☐	**Review** with the patient and/or support person(s) and health care staff present what was discussed and any decisions made
☐	**Provide the patient** and/or support person(s), and health care staff involved in the incident and/or the open disclosure discussion, with a **written record of the discussion** and outcomes, including the plan for care
☐	Offer to arrange **follow up discussions** as required
☐	**Provide the patient** and/or their support person with the relevant name and contact details should they have any concerns or questions
☐	**Document in the patient's health record** that formal open disclosure has occurred and the date

For more detailed information please refer to the Formal Open Disclosure section of the CEC Open Disclosure Handbook *www.cec.health.nsw.gov.au/programs/open-disclosure*

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CLINICAL EXCELLENCE COMMISSION

FORMAL OPEN DISCLOSURE
CHECKLIST 'E' – COMPLETION

This checklist may be useful for identifying important points to consider when completing formal open disclosure.

☐	The open disclosure team meet to review the formal open disclosure discussion with the patient and/or support person(s).
☐	Prepare a summary of the formal open disclosure discussion. Consider the following points for inclusion: ☐ Date and location of the discussion ☐ Name of the patient and any support person/people present ☐ Members of the open disclosure team present: names and role ☐ Whether an apology was offered ☐ Response to the apology by the patient and/or support person(s) ☐ Information about the patient safety incident provided, including the investigation/review process ☐ Questions asked by the patient/support person and responses and explanations provided ☐ Offers of practical and emotional support and response from the patient/support person ☐ Offer to reimburse out of pocket expenses and response from patient/support person ☐ Information provided about how to take the matter further, including complaint or legal processes available ☐ Relevant person's name and contact details for the patient and/or support person should they have any concerns or questions ☐ Outstanding issues to be resolved ☐ Undertakings given that need to be followed through by the open disclosure team, such as • Follow up discussions • Providing a written record of the discussion to the patient and/or support person, and to health care staff who were present and/or involved in the incident ☐ Other issues raised that need addressing ☐ Final recommendations to the open disclosure team about further management of this incident
☐	If resolution for the patient and/or support person has not been reached, provide information on alternative courses of action e.g. making a complaint via internal processes or HCCC
☐	Notify the manager responsible for insurable risk if an offer has been made to the patient/support person to reimburse out of pocket expenses and the response from the patient/support person
☐	Offer clinicians and others involved in the incident and/or the formal open disclosure discussion the opportunity to debrief with the open disclosure advisor or other support services
☐	Offer to provide the patient /support person with a copy of the report of any investigation or review and to discuss/explain the findings
☐	Offer patients, support people and clinicians/managers involved in open disclosure the opportunity to evaluate their experience of the process
☐	Complete any documentation about the incident and open disclosure, in the incident management system, the patient's health record and the open disclosure records in the Clinical Governance Unit
☐	Monitor and record the implementation of any changes recommended as a result of the review of the patient safety incident, and the effectiveness of those measures
☐	Share any lessons learned from investigation of the patient safety incident at appropriate forums e.g. clinical grand rounds, morbidity and mortality meetings, executive and board meetings

For more detailed information please refer to the Formal Open Disclosure section of the CEC Open Disclosure Handbook *www.cec.health.nsw.gov.au/programs/open-disclosure*