



4. CLINICIAN DISCLOSURE

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Open Disclosure begins with clinician disclosure – the initial discussion with a patient and/or their support person(s) following a patient safety incident. The purpose of this discussion is to inform and support the patient and/or their support person(s) and to offer an apology for what has happened.

Clinician disclosure is an informal process involving:

- **meeting with the patient** and/or their support person(s) once the patient is removed from any harmful situation and has received treatment and support for the harm that may have occurred
- **acknowledging the patient safety incident** to the patient and/or their support person(s)
- **explaining** all known facts relevant to the incident, to provide context for the apology
- **apologising** for the occurrence of the event
- **actively seeking input and feedback** from and **listening** to the patient and/or their support person(s)
- consulting with the patient and/or their support person(s) on **a plan for ongoing care** if required, including the possible need for formal open disclosure
- **providing contact names** and phone numbers of people in the health service who are available to address concerns and complaints, including psychological and social support contacts.

During these discussions, it is important not to speculate, attribute blame to yourself or others, criticise individuals or imply legal liability.

If you don't know the cause of the patient safety incident, say so, and explain what is being done to investigate the cause/s of the incident.

Are there any exceptions to initiating clinician disclosure?

The only exception is if the patient safety incident is recognised as a '**near miss incident**'. In this case disclosure is discretionary, based on whether it is felt the patient would benefit from knowing, for example, if there is an ongoing safety risk to the patient.

To guide decisions about open disclosure, advice from the senior treating clinician and/or open disclosure advisor may be required to assist with determining the level of risk. The timeliness of informing patients must always be considered. Near miss incidents must be entered into the incident management system.

Who should initiate clinician disclosure with the patient and/or their support person?

For patient safety incidents where the patient has suffered minor or no perceived harm, the clinician most directly involved in the incident or the person who first recognises the incident – generally a nurse, midwife, allied health professional or medical officer – is usually the most appropriate person to speak with the patient and/or their support person(s). Ideally other members of the clinical team are present so that they are aware that the incident has been discussed with the patient and/or their support person. If that person is not able to speak with the patient and/or their support person(s), they must notify their manager or senior treating clinician who will facilitate clinician disclosure.

For patient safety incidents where the patient has suffered anything more than minor harm, the senior treating clinician or manager should be engaged as promptly as possible and participate in clinician disclosure, unless the patient and/or their support person(s) requests otherwise. A serious patient safety incident represents a major threat to the patient's sense of control and trust in the health care team. It is essential that the initial communication be with a person with whom the patient has a trusting relationship, and that it convey care, concern and respect for the patient.

Irrespective of the degree of harm caused to the patient, a clinician disclosure discussion with the patient and/or their support person(s) should commence as soon as possible, and at the latest generally within 24 hours of identification of the patient safety incident by the health service.

If a patient does not have the physical or mental ability ('capacity') to participate in the disclosure discussion, their support person(s) must be notified and involved until the patient is able to fully participate and make his or her own decisions. If the patient has died (as a result of the patient safety incident or otherwise), the support person is the lead contact for open disclosure about the incident.

Completing Clinician Disclosure

The clinician disclosure discussion may be the only discussion that the patient and/or their support person(s) require following a patient safety incident. With their agreement, open disclosure may be concluded after this discussion.

However, clinician disclosure may progress to formal open disclosure for any patient safety incident, as determined by the director of clinical governance (DCG), and/or the appropriate senior manager (for example, the health service manager, or operations manager), and the patient and/or their support person(s).

Tools for Clinician Disclosure

Tools to assist Clinician Disclosure are available to download and print from the Open Disclosure page of the CEC website: www.cec.health.nsw.gov.au

- CHECKLIST A – CLINICIAN DISCLOSURE** identifies the steps to be completed for the initial clinician disclosure discussion with a patient and/or his or her support person(s).
- The **STARS® Tool**, developed by the Patient Safety Unit at Queensland Health¹⁹, is a practical tool to assist clinicians to confidently and competently communicate with patients and families about patient safety incidents. It has been designed to be easily recalled to guide clinicians through a logical communication pathway.

See Chapter 7 of this Handbook for practical considerations for open disclosure, such as privacy and confidentiality and establishing the right environment for clinician disclosure.

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19. The State of Queensland (Queensland Health) iLearn @ Health *Clinician Disclosure Lesson 6 Communicating with patients following an adverse event*, 2011

An example of appropriate wording for clinician disclosure



Sorry: Acknowledge, Apologise, Acknowledge

Acknowledge what happened:

"Mrs Smith, the staff have let me know that you didn't receive your insulin when it was due this morning".

Apologise:

"I am sorry that this has happened".

Acknowledge the impact of the patient safety incident:

"We will need to check your blood sugar more often today. I agree that things didn't go to plan. I can see that you are upset. I am really sorry".



Tell me about it

"To find out exactly what happened, I'd like to understand what you saw or experienced. This may help us to understand how this could have happened and how to prevent things like it happening in future".



Answer Questions

"You may have some questions that you need answered – you can ask questions at any time. What would you like to know?"



Response/Plan for care

"The problem was recognised quickly and we are now back on schedule with your insulin injections. With your permission, we will continue your treatment as planned. If you feel or notice anything unusual please let us know. We don't expect that you will need to stay here any longer than originally planned".



Summarise

"We still need to find out how this happened, and we will let you know as soon as possible what we find out. I will be here today until 5pm. If you have any questions or concerns, please contact me or the nurse in charge. Please feel free to ask the staff as well if there is anything you need or want to discuss.

Is there anyone that you would like us to contact for you? From your admission notes I can see you have nominated your son. Would you like me to explain to him what has happened?"

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