

## TOOL 15 Patient/consumer, family, carer and/or support person evaluation survey

July 2016

This survey has been developed to enable feedback from patients, families their carers about the open disclosure process. The aim of this survey is to improve the open disclosure experience for people involved in an incident that resulted in harm to a patient while receiving health care – this includes patients, their family and carers as well as health service staff.

This survey is about your experience with open disclosure. When completing the survey, please reflect on your experience either as a patient or as a family member, friend or carer.

You can request that this survey be conducted as a face-to-face interview.

**Terms used in the survey:** To help you complete the survey, the following terms are used:

Harmful incident	An incident that led to patient harm. Such incidents can either be part of the healthcare process, or occur in the healthcare setting (i.e. while the patient is admitted to, or in the care of, a health service organisation).					
	Note: This term is used interchangeably with 'adverse event'.					
Staff	Anyone working within a health service organisation, including self-employed professionals such as visiting medical officers.					
Open disclosure	An open discussion with a patient about an incident(s) that occurred to that patient while they were receiving health care. The elements of open disclosure are an expression of regret (including the word sorry), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence.					
	Open disclosure is a discussion and an exchange of information that may take place over several meetings.					
	An individual who has a relationship with the patient. References to 'support person' in this document can include:					
	> family members/next of kin					
	> carers					
Support person	> friends, a partner or other person who cares for the patient					
	> guardians or substitute decision makers					
	> social workers or religious representatives					
	> where available, trained patient advocates.					
	References to support person should be read with the words, 'where appropriate'.					

All responses will remain confidential.

Surv	ey Que	estions								
<b>1.</b> I ar	m a (ple	ase tick <b>all re</b>	elevant answ	vers)						
	Patient									
	Relative	e of the patie	nt							
	Friend	of the patien	t							
	Carer o	of the patient								
	Suppor	t person								
	Other									
<b>2.</b> Da	ate of th	e incident th	at resulted in	harm						
3. W	here did	d the incident	occur?							
	Hospit	al/Health Ser	vice							
		e from 1-10 (' ncident?	<b>1</b> being <b>least</b>	serious and	10 the most	serious) ho	w serious we	re the effects	of the	
_	effects	icident?	Mild	effects		Moderate e	ffocts	Sovo	re effects	
1	enects	2	3	4	5	6	7	8	9	10
				-			<u> </u>			
	1-2 we Within More I was resthis ti Yes No – it Unsure	1 1 month than 1 month not told abou meframe acco was too earl was too late	it the unexpe eptable for in	itial contact?			ident (please	tick <b>one</b> )		
	Yes No									
If y	ou did <b>r</b>	not have any	open disclosi	ure meetings,	do not answ	er the other	questions. Th	nank you for y	our time.	
If y	ou <b>did</b>	participate i	n open disclo	sure meeting	s, please con	tinue to the r	next question			
8. We	ere you Yes No	informed abo	out the plan t	o commence	open disclosi	ure? (Please t	ick <b>one</b> )			

<b>9.</b> How long after the harmful incident did the	first planned open disclosure meeting occur? (Please tick <b>one</b> )
Within 48 hours	
1-2 weeks	
Within 1 month	
More than 1 month	
More than 6 months	
<b>10. Who</b> initiated the open disclosure meetings	s? (Please tick <b>one</b> )
Health service organisation/ staff	
Patient/support person	
<b>11.</b> If the open disclosure meeting was <b>initiate</b>	<b>d</b> by the <b>patient or support person</b> , when did this occur? (Please tick <b>one</b> )
After a request for information from the	e health service organisation
After a formal complaint to the health s	ervice organisation
Other (please specify)	
<b>12.</b> Who attended the open disclosure meeting	? (Please tick all relevant answers in <b>each column</b> )  This person was previously involved in the
	care of the patient
	Yes
Doctor	No
	Unsure
	Yes
Surgeon	No No
	Unsure
C D	Yes No.
☐ GP	Unsure
	Yes
Nurse	No
	Unsure
	Yes
Midwife	No
	Unsure
	Yes
Another healthcare provider	No
	Unsure
Health service administrator	Yes No
Treatur service duffillistidioi	Unsure
Other (please specify)	Yes
	No
	Lincuro

	as there <b>anyone else</b> you would have liked to attend the open dis	sclosure r	meeting/s	s? (Please	tick <b>one</b>	e)	
	No						
	Yes (please specify)						
Please	indicate <b>your level of agreement</b> by circling the relevant answe	r:					
		Strongly DISAGREE	Slightly DISAGREE	Neutral	Slightly AGREE	Strongly AGREE	NA or unknown
Open	Disclosure Process						
14.	I was given the name of a health service staff member who would act as an ongoing point of contact throughout the open disclosure process	1	2	3	4	5	NA
15.	I was given options about the time and place of the open disclosure meeting/s	1	2	3	4	5	NA
16.	I was given options about the staff participants attending the open disclosure meeting/s	1	2	3	4	5	NA
17.	I was given the opportunity to have a support person(s) present who was not a health service organisation staff member	1	2	3	4	5	NA
18.	I was given enough information about what to expect during the open disclosure process	1	2	3	4	5	NA
19.	I was given an expression of regret including the words I am/ we are sorry	1	2	3	4	5	NA
20.	I was given an explanation about the harmful incident	1	2	3	4	5	NA
21.	This explanation was clear	1	2	3	4	5	NA
22.	I was given adequate time to talk about my experience of the harmful incident	1	2	3	4	5	NA
23.	I had opportunity to ask questions about the harmful incident	1	2	3	4	5	NA
24.	Clear information was given about the consequences of the harmful incident	1	2	3	4	5	NA
25.	After the open disclosure, it was clear to me how the health service organisation was investigating the harmful incident	1	2	3	4	5	NA
26.	I was given the opportunity to contribute to the health service organisation investigation of the harmful incident	1	2	3	4	5	NA
27.	Staff were willing to share further information as it became available	1	2	3	4	5	NA
28.	I was give information about how the health service will prevent similar harmful incidents in the future	1	2	3	4	5	NA
29.	The information given to me about how the health service will aim to prevent similar harmful incidents in the future was clear	1	2	3	4	5	NA
30.	Health service staff also gave written information about what we discussed in the open disclosure meeting(s)	1	2	3	4	5	NA
31.	Written information given to me about what we discussed in	1	2	3	4	5	NA

32.

the open disclosure meeting(s) was clear

Health service staff did not try to avoid the open disclosure

2

1

3

5

NA

	Strongly DISAGREE	Slightly DISAGREE	Neutral	Slightly AGREE	Strongly AGREE	NA or
omes						
Health service staff involved in the patient's care recognised and acknowledged the healthcare incident	1	2	3	4	5	NA
Health service staff were regretful	1	2	3	4	5	NA
Health service staff treated me with respect	1	2	3	4	5	NA
Health service staff were good at listening to me	1	2	3	4	5	NA
I was offered appropriate support to deal with the harmful incident immediately after it	1	2	3	4	5	NA
I was offered appropriate support to deal with the harmful incident on an ongoing basis	1	2	3	4	5	NA
Health service staff offered support for any future problems caused by the incident	1	2	3	4	5	NA
I was given the option of arranging additional meetings if I have further questions in the future	1	2	3	4	5	NA
The conclusion of the open disclosure process was mutually agreed between myself and the staff	1	2	3	4	5	NA
The health service met its responsibility to me	1	2	3	4	5	NA
I found open disclosure helpful	1	2	3	4	5	NA
I would be willing to return to this health service for future care	1	2	3	4	5	NA
I am satisfied with the open disclosure process	1	2	3	4	5	NA
ease tell us how the open disclosure process could be improved for	· patients	s/support	persons	?		
	and acknowledged the healthcare incident  Health service staff were regretful  Health service staff treated me with respect  Health service staff were good at listening to me  I was offered appropriate support to deal with the harmful incident immediately after it  I was offered appropriate support to deal with the harmful incident on an ongoing basis  Health service staff offered support for any future problems caused by the incident  I was given the option of arranging additional meetings if I have further questions in the future  The conclusion of the open disclosure process was mutually agreed between myself and the staff  The health service met its responsibility to me  I found open disclosure helpful  I would be willing to return to this health service for future care  I am satisfied with the open disclosure process	and acknowledged the healthcare incident  Health service staff were regretful  Health service staff treated me with respect  1  Health service staff treated me with 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satisfied with the open disclosure process  I am satisfied with the open disclosure process

Thank you for completing this survey.

## For more information

**SA Health** Safety and Quality Unit Telephone: 08 8226 6539

www.sahealth.sa.gov.au/safetyandquality

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July 2016.