TOOL 6 - Open disclosure flowchart for patients/consumers

Incident resulting in harm

Incident investigation process

An incident resulting in harm occurs.

Health care services will talk to you, your family, carer and/or support persons about what went wrong.

Open disclosure discussions

Staff will:
- Explain what they know about what went wrong
- Express regret for the incident
- Explain the consequences of the incident for you and your family and/or carer

Ask what you think happened and how you feel.
- Opportunity for the patient/consumer, family, carer and/or support person to relate their experience.

Agreement on your plan for care, ongoing support and restorative action.

Information arising from open disclosure may be used to support investigation.

Advise you what is being done to investigate the incident to stop it happening again.

Provide you with the guide support appropriate to your needs and contact details of staff member.

Follow up
- Ongoing dialogue (can take place over several meetings)
- Team review / discussion throughout
- Actions taken for improvements are fed back to patient/consumer, family, carers and/or support persons.

Complete the process
Everyone involved are satisfied with the process and ready to finalise.

You complete a survey about your experience with open disclosure (in writing or face to face)

Unable to reach agreement: Facilitator engaged to refer to external agency.

Health service writes and telephones other provider(s) eg GP

Documentation completed, signed and copy provided to patient.

Feedback to the patient/consumer, family, carer and/or support person on how the service will be/has been improved due to the investigation or review findings.

Open disclosure discussions

Incident resulting in harm
1. Death or major permanent loss of function
2. Permanent or considerable lessening of body function
3. Significant escalation of care/change in clinical management
4. Major psychological or emotional distress
5. Significant patient/consumer, family or carer concern arising from incident
6. Incidents which may involve media interest
7. Cluster incidents
8. Extreme and unexpected poor outcome or avoidable complication of care

Incident with no harm
1. Near miss / no harm incident
2. No permanent injury
3. No increased level of care required (eg transfer to operating theatre or intensive care unit)
4. No, or minor, psychological or emotional distress.

continued
You complete a survey about your experience with open disclosure (in writing or face to face)

Feedback to you on how the service will be/has been improved due to the investigation or review findings.

You complete a survey about your experience with open disclosure (in writing or face to face)

Open disclosure

> Acknowledgement, expression of regret, explanation
  > Discussion and exchange of view
  > Agreement on closure

Health care services will talk to you, your family and/or carer about what went wrong.

Incident investigation process

An incident occurs

> Near miss
> Causes no or minimal harm
> Requires no change or escalation in care.

Health service writes and telephones other provider(s) eg GP

Documentation completed, signed and copy provided to patient.

Incident resulting in a near miss or no harm

For more information
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