**ORGANISATIONAL POLICY:**

# OPEN COMMUNICATION / DISCLOSURE OF HARM

## AUTHORITATIVE SOURCE:

Health and Disability Commission code of Rights
Health and Disability Sector Safety Act
Health Quality Safety Commission – National Incident Policy

## AUTHOR:

Director of Nursing, Quality & Patient Safety

## PURPOSE:

*When a patient is harmed while receiving treatment, Hauora Tairāwhiti expects that the patient's health professional will advise the patient, (or the patient's family), of the facts of the harm in the interests of an open, honest and accountable professional relationship.*

## SCOPE:

This policy applies to all Hauora Tairāwhiti employees and Lead Midwifery Carers when using their access agreement.

**Definition - Disclosure of Harm**

1. "Disclosure of harm" means explaining when a patient has been harmed as a direct result of receiving treatment in a clinical situation. This includes a situation where the harm maybe a recognised risk of the treatment but further intervention has been required to augment recovery.

**Policy Statements:**

1. Hauora Tairāwhiti believes that open disclosure of harm will benefit the health and safety of the public and strengthen the relationship between patient and their health professional.
2. All patients should be made aware through the informed consent process that all treatment carries some risk and that they may experience an undesired side effect. However everything will be done to minimise these risks.
3. Harm is often the result of a combination of factors that are attributable to more than one single cause.
4. Open disclosure of harm is not about attributing blame.
5. Open communication contributes to a successful health provider relationship by ensuring that trust between the health provider and the patient is not compromised
6. A disclosure should include a sincere apology. This is the provider's opportunity to say, "We are sorry this happened to you".

7. Open communication is a right of a patient under the Code of Health and Disability Services Consumers' Rights
8. Open communication is a requirement of the Health and Disability Services Standard 2008
9. Open communication is a step towards ensuring patients are advised that they may be entitled to compensation through the ACC
10. Open communication provides an environment that enables the health team to learn in an educational manner because harm can be discussed openly
11. Open communication demonstrates acknowledgement of a near miss and can lead to a review of processes and contribute to quality improvement and a culture of safety.

**Accepted risks of treatment**

1. All forms of treatment have recognised risks – a recognised possible outcome of the treatment that is not intended but acknowledged as a risk.
2. It is important that recognised risks are discussed with the patient as part of the informed consent process prior to starting any treatment. This means identifying the risk, explaining what the possible implications are for the patient if harm results and providing the patient with information about the implications of consenting to, or declining, the treatment.

**What should happen before disclosure of harm?**

The health provider must complete an incident report and log as per the datix incident reporting procedure.

**Communicating harm**

1. Communication should be made in a timely manner, usually within 24 hours of the event occurring, or of the error being recognised.
2. Although disclosure to the consumer concerned should not occur until he or she is medically stable enough to absorb the information and is in an appropriate setting, there is likely to be a suitable person (ie, someone who is interested in the welfare of the patient and is available) who should be informed. This may include an enduring power of attorney or legal guardian.
3. The appropriate health professional responsible for the patient's care should disclose the harm to the patient and any family/whanau/key support people the patient wishes to have present.
4. When preparing to disclose harm, you must consider the patient's cultural and ethnic identity, the patient's first language and what support the patient may need. When appropriate, you must advise the patient where and from whom the patient or the patient's family can get support.
5. You should document in the patient record details about the nature of the harm, and any subsequent action, including disclosure to the patient. It is recommended that the patient notes include who was present, what was disclosed, the patient's reaction and any issues regarding continuity of care. If the harm occurred in secondary or tertiary care you must inform the patient's general practitioner.

6. In some situations where the patient has died, has been significantly compromised, has long-term diminished competence, or is incompetent, it will be necessary to escalate the incident as per the Hauora Tairāwhiti Incident Management Policy.

**Training staff**

1. Ongoing staff training on open disclosure needs to take place so that staff are able to respond promptly and confidently when things go wrong. All personnel, including providers with independent access agreements and relevant contractors such as relief providers, also need to be aware of the policy, and adequately trained and supported in its implementation.
2. Although harm to patients is rarely the result of negligence or incompetence, staff may find the experience stressful and difficult. It is important that staff, as well as the patient have access to support.
3. Health professionals need the opportunity to discuss such incidents and for there to be systems put in place to prevent a recurrence of the problem.

## ASSOCIATED DOCUMENTS:

- The HDC's *Guidance on open disclosure policies*
- The New Zealand Medical Association Code of Ethics
- The National Health Service booklet on *Being Open*
- Hauora Tairāwhiti Incident Management policy

## REFERENCES:

HDC (2009) Guidance on open disclosure policies http://www.hdc.org.nz/decisions--case-notes/open-disclosure

New Zealand medical Council (2004), Disclosure of Harm "Good Medical practice"

Sally Hargreaves (2003) "Weak" safety culture behind errors, says chief medical officer – BMJ, VOL.326

Louise Kershaw (2002) When things go wrong: An open approach to adverse events – Australian Council for Safety and Quality in Health Care; Sydney, Australia, page 5.

PC Herbert, AV Levin & G Robertson (2001) Bioethics for clinicians: Disclosure of medical error – Canadian Medical Journal; Vol. 164, No. 4.

Peter Davis (2001) Adverse Events in New Zealand Public Hospitals; Principle findings from a national survey – Ministry of Health, Wellington, page 15.

TH Gallagher, AD Waterman, AC Ebers, WJ Fraser & W Levinson (2003) Patients' and physicians attitudes regarding the disclosure of medical errors – JAMA; Vol. 289, No. 8, page 1001.

Louise Kershaw (2002) When things go wrong: An open approach to adverse events – Australian Council for Safety and Quality in health Care; Sydney, Australia, Page 6.

Louise Kershaw (2002) When things go wrong: An open approach to adverse events – Australian Council for Safety and Quality in health Care; Sydney, Australia, Page 6. The health and Disability Commissioner's Guidance on open disclosure policies contains advice on how to apologise.

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