



Disclosure of Adverse Patient Events Procedure

Procedure Number

CHC-PG-0041

Version Nos:

2

1. Purpose

This Procedure is performed as a means of improving the quality of care delivered to West Coast District Health Board (WCDHB) patients/consumers and maximise patient/consumer safety, through the identification and analysis in a timely manner of those patient events that are adverse.

2. Application

This Procedure is to be followed by WCDHB clinical staff members.

3. Definitions

For the purposes of this Procedure:

Adverse Event is taken to mean an unexpected, unintended occurrence that results in injury to the patient or has the potential for causing injury. Examples include events that require additional treatment, increased monitoring, delay in discharge or transfer to another healthcare facility.

Serious Incident is defined as an incident which has an adverse outcome and includes client/patient suicide, deliberate self-harm/attempted suicide by a client/patient, physical violence resulting in injury to a client/patient/staff member, admission of a client/patient following unsuccessful treatment by another health provider, hospital-incurred trauma/injury of a client/patient, client/patient AWOL, sudden death of a client/patient, or accident/incident involving a staff member that resulted in serious harm or death, or any other accident/incident that in the opinion of the Chief Executive Officer or General Manager needs to be classified as a serious incident

4. Responsibilities

For the purposes of this Procedure:

the **Chief Executive Officer** is required to:

- oversee all aspects of this Procedure;

Staff Members are required to:

- ensure they abide by the requirements of this Procedure.

5. Resources Required

This Procedure requires no specific resources.

6. Process

1.00 Open disclosure of adverse events:

- i). contributes to the foundation of a successful health professional-patient relationship by ensuring that trust between the health professional and patient is not compromised;
- ii). is a right of a patient under the Code of Health and Disability Services Consumers' Rights;
- iii). is part of the move towards increased accountability from health professionals.;
- iv). is necessary for the informed consent process, especially when the harm results in the need for further treatment or care;
- v). contributes to public awareness, information, and education about the reality of medical treatment;



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- vi). provides an environment that enables health professionals to learn from others' mistakes in an educational manner because harm can be discussed openly;
 - vii). is not about attributing blame.
- 1.01 Disclosure to the patient and/or family/whanau/caregiver should generally be made when any adverse patient event has occurred. In some situations, consideration should be given to discussing adverse events that do not result in patient injury (i.e. "near misses"). The decision to disclose will depend on the specific circumstances of the event.
- 1.02 Disclosure should take place at the right time, when the patient is medically stable enough to absorb the information, and in the right setting. In situations where the patient has suffered permanent injury or death, information should be provided to the patient's family/whanau/caregiver or legal representative in a timely and considerate manner. Typically, disclosure should take place within 24 hours after the event has occurred or is discovered.
- 1.03 In most cases, the health professional with overall responsibility for the patient's care, i.e., the Senior Medical Officer (SMO), should handle the disclosure of information as well as subsequent discussions with the patient and/or family. In some situations, however, other health professionals may be more appropriate to disclose the event, such as relevant General Manager or other health professionals who has the most information about the event and/or has an existing relationship with the patient and family/whanau/caregiver
- 1.04 At least one other staff member (either clinical or management) should be present at the initial disclosure discussion or at subsequent planned discussions with the patient and/or family/whanau/caregiver.
- 1.05 When having the initial disclosure discussion with the patient and/or family/whanau/caregiver, it is important for staff members to acknowledge that the adverse event has occurred and to make some expression of personal regret and apology for the event. Patients and family/whanau/caregivers often appreciate an expression of regret and empathy. Saying "I'm sorry" will help to strengthen, rather than undermine, the health professional-patient relationship.
- 1.06 The next step is to describe in a truthful and compassionate manner the following:
- i). The nature of the event as it is understood at the time of the discussion;
 - ii). The time, place and circumstances of the event as it is understood at the time of the discussion;
 - iii). The known, definite consequences of the event for the patient, as well as any anticipated or potential consequences;
 - iv). The corrective actions taken in response to the event which may include ongoing communication with the patient and family/whanau/caregivers as is necessary;
 - v). Identify who will be managing ongoing care of the patient;
 - vi). Identify who will manage ongoing communication with the patient and/or family/whanau/caregiver, including names and phone numbers of individuals at the relevant WCDHB facility to whom the patient and family/whanau/caregiver may address questions, complaints or concerns.



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- 1.07 As soon as is practical after the adverse event has occurred, it is to be recorded using a WCDHB Accident/Incident Form (as per the requirements of the *WCDHB Accident/Incident Reporting System*).
- 1.08 The patient's clinical record should also contain a complete, accurate and factual record of pertinent clinical information related to the event and should be completed in a timely manner. The documentation should include:
- i). Objective details of the event, including date, time and place
 - ii). The patient's condition immediately before the time of the event
 - iii). Medical intervention and patient response
 - iv). Notification of other health professionals
 - v). Additionally, documentation outlining the disclosure discussion with the patient and/or family should include:
 - vi). Time, date and place of discussion
 - vii). Names and relationships of those present at the discussion
 - viii). Documentation of discussion of the event
 - ix). Documentation that additional information has been shared with the patient/family/whanau/caregiver or legal representative, if appropriate
 - x). Documentation of any follow-up conversations
- 1.09 When documenting the adverse event, staff members are not to assign blame, make assumptions or draw conclusions about the event. Staff members are also not to use the patient's clinical record to make complaints about staffing, facility or department issues. This information is to be recorded using a WCDHB Accident/Incident Form.
- 1.10 Harm to patients is rarely the result of deliberate negligence or incompetence and the health professionals involved may find the experience stressful and difficult. It is important that these health professionals have access to support, which is available via the internal WCDHB Peer Support Programme, and externally via the Employee Assistance Programme (EAPS). The WCDHB OSH Advisor should be contracted for information regarding these processes.

7. Precautions And Considerations

- Disclosure to the patient and/or family/whanau/caregiver should generally be made when any adverse patient event has occurred.
- When having the initial disclosure discussion with the patient and/or family/whanau/caregiver, it is important for staff members to acknowledge that the adverse event has occurred and to make some expression of personal regret and apology for the event.
- Disclosure should take place at the right time, when the patient is medically stable enough to absorb the information, and in the right setting.
- It is important that these health professionals have access to support, which is available via

8. References

Code of Health and Disability Services Consumers' Rights (1996)

9. Related Documents



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WCDHB Accident/Incident Reporting System

Revision History	Version:	2
	Developed By:	Risk Manager
	Authorised By:	Chief Executive Officer
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