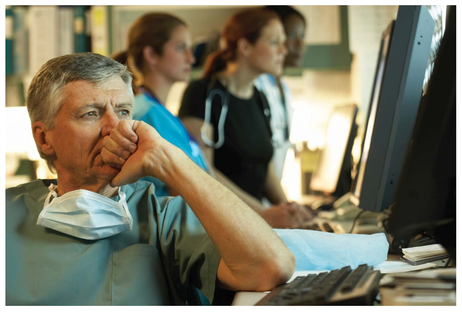
Disclosure Toolkit

Presented by the Department of Patient Relations & Risk Management

A culture of safety is one that discloses unanticipated outcomes to patients.

This culture is based on transparency, honesty and respect. Sharing of bad news is difficult. It is more difficult when the harm may have been caused by something we have inadvertently done.

Not only is disclosure of adverse events the right thing to do and what our patients expect, effective July 1, 2008 Regulation 965 of the Public Hospitals Act requires that the hospital have a system in place for disclosure of every critical incident.



The Ottawa Hospital Disclosure toolkit provides an overview of the steps that one should take in preparation for and when disclosing adverse events. The toolkit includes the following:

- Introduction and Quick Reference Tools
- Legal, Professional and Ethical Obligations
- Barriers & Benefits of Disclosure
- What Patients and Families Want
- Preparing for Successful Disclosure Conversation
- Apologizing – Doing the Right Thing the Right Way
- Definitions
- Documentation
- Frequently Asked Questions

Apologizing Doing the Right Thing the Right Way

An apology:

- is about the patient and his/her family
- must arise from a sense of humility, honour and ethics
- does not mean an admission of guilt. It is simply an expression of emotion, not a legal conclusion.

Done correctly, an apology may have the following benefits:

- Reestablish trust between the caregiver(s) and the patient/surrogate
- Reduce the risk of a college or media complaint and or litigation
- Reduce the discomfort the caregiver is feeling

What works	What does not work or help the situation
"I'm very sorry that you and your family have been through so much in the past few days."	"Sorry about what has happened."
"I am sorry that this incident has occurred. It is unclear at this point what caused it. Be assured we will look into this and will follow up with you."	"Things happen, we are all very busy you know."
"I'm sorry that this incident has occurred. I was not directly involved but am following up to better understand the circumstances of the incident. We will meet tomorrow when I have more information to provide to you."	"Sorry that this happened, I did what I was supposed to do, It is not my fault."
"I regret that these events have occurred and am sorry for the situation you are now experiencing. Let's talk about how we can help you right now."	"It is unfortunate that this has happened but it is time to move on."
"I realize now that there was a breakdown in communication between us and am sorry that I did not make sure you were fully understanding my instructions."	"I feel bad that this has happened, but if you had only told me how much medication you were taking I could have told you that was wrong."

Steps in Disclosure

1. Prepare yourself

- Review the disclosure policy
- Determine that disclosure is necessary
- Consider need for reporting to Risk Manager and Insurer
- Acquire the necessary communication skills to lead the disclosure discussion
- Consider the "W"s (when, where and with whom)
- Prepare what you are going to say
- Consider wording of apology/regret
- Anticipate questions (know the facts)
- Obtain a copy of the Disclosure documentation tool

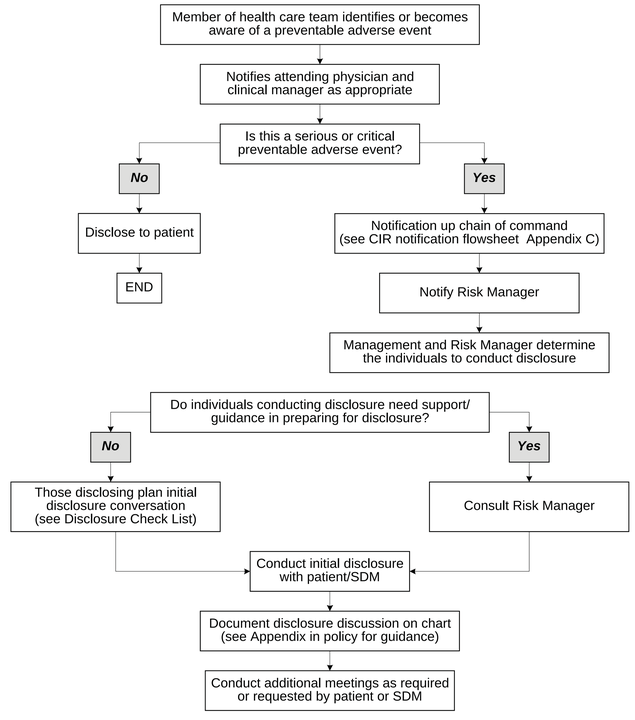
2. Meet with patient

- Ensure privacy
- Convey an expression of regret/apology
- Provide all known facts of the event
- Be mindful of your body language and the words you use
- Provide time for questions and listen
- Clearly outline next steps
- Summarize and confirm understanding
- Determine if an additional meeting is required

3. Document in the patient's health record using the Documentation Check off list as a guide.

4. Take care of yourself .

Procedural Flowchart for Disclosure of Preventable Adverse Events



Disclosure Documentation Check off List

- ❑ Date time and place of disclosure meeting
- ❑ Names of those present
- ❑ Facts of what occurred - " the material facts of what occurred with respect to the critical incident" Material facts are those facts that are considered important or essential.
- ❑ Actions taken (or to be taken to understand how the event occurred)
- ❑ The consequences for the patient of the critical incident, as they become known
- ❑ The actions taken and recommended to be taken to address the consequences to the patient of the critical incident, including any health care or treatment that is advisable
- ❑ Responses to questions answered
- ❑ Transfer of care to another physician/ Involvement of other health care professional
  - Considered
  - Discussed
  - Planned
  - Completed
- ❑ Offers of assistance made (as appropriate)
  - Social Work
  - Spiritual Care
  - Patient Relations

  (Indicate acceptance or rejection of offers)
- ❑ Name of individual who will follow up with patient/surrogate where appropriate
  - Contact number
- ❑ Other issues
- ❑ Patient/surrogate requested chart - Yes/No
- ❑ Signature of health care practitioner