Patient Incident and Management and Open Disclosure

Government of South Australia
SA Health

A guide to using the policy directive, guideline and toolkit

Patient Incident Management

Policy Directive SA Health Patient Incident Management and Open Disclosure	The Patient Incident Management and Open disclosure Policy Directive describes a standardised system for managing patient incidents that ensures all staff: > use the SA Health incident management reporting system called Safety Learning System (SLS) for reporting and documenting the management and open disclosure of patient incidents > providing appropriate feedback to, and engagement with patients/consumers, their family, carer and/or support person, including open disclosure > respond effectively to patient incidents, and promote safety and quality improvement through sharing lessons learned from single or groups of patient incidents > taking action, in collaboration with consumers, and service providers external to SA Health to improve the safety and quality of services; and > maintain compliance with relevant law and codes of conduct in relation to transparent and fair treatment, privacy and confidentiality of both patient and clinician. The policy relates to patient incidents, that is any events or circumstances which could have (near miss) or did lead to unintended and/or unnecessary psychological or physical harm to a patient during an episode of health care provided by, or on behalf of SA Health.
Policy Directive SA Health Lookback PolicyDirective	The Lookback Policy Directive ensures a consistent, coordinated and timely approach for notification and management of potentially/affected patients when necessary.
Tool 1 SLS Guide – How to report a patient incident	This is one of series of guides for users of SLS. It describes and illustrates the steps to report and classify a patient incident online into SLS. Key features of SLS are explained.
Tool 2 Safety Assessment Code (SAC) matrix	The SAC matrix assists readers to assign a SAC rating to a patient incident, based on the actual consequence, and the likelihood of a similar incident occurring. Additional explanatory information is included.
Tool 3 SLS Guide – How to manage a patient incident	This is one of series of guides for incident managers about SLS. It describes and illustrates the steps to classify and manage (review, investigate and analyse) a patient incident in SLS. Key features of SLS, SAC rating and legal considerations are explained.
Tool 4 Reporting and management requirements for SAC 1 notifiable patient incidents – flowchart	This flowchart illustrates the steps in the reporting and management of SAC 1 rated patient incidents. These harmful incidents have additional requirements for notification to senior managers, and may require additional investigation.
Tool 5 Diagram of incident management and open disclosure	This diagram illustrates all steps and components of patient incident management encircling the principles for open disclosure with patients and carers.
Tool 6 Glossary of terms	This document provides additional definitions and information about terms used in the Patient Incident Management and Open Disclosure Policy Directive and the accompanying policies and tools.

Open Disclosure (OD)

Tool 1 Reporting and management requirements for SAC 1 notifiable patient incidents – flowchart	This is a quick guide which provides information on the level 1 (SAC 1 and 2) and level 2 (SAC 3 and 4) responses to OD and the process.
Tool 2 Saying sorry – a guide to expressing regret during open disclosure	This is a guide which provides staff with information and examples on appropriate wording and phrasing for the open disclosure process, as an expression of regret.
Tool 3 Comprehensive guide to the open disclosure process	This is a comprehensive guide for clinical leads/facilitators with more detailed information on the formal open disclosure process, and tools.
Tool 4 An open disclosure guide for patients/consumers (brochure)	This is a patient/consumer information brochure on the open disclosure process. It outlines what is open disclosure, when should open disclosure occur, what the benefit of open disclosure is, and where to obtain additional information.
Tool 5 A booklet for patients/consumers beginning an open disclosure process	The booklet – a guide for patients/consumers beginning an open disclosure process is designed to help patients, consumers, families, carers and/or support person when an incident resulting in harm has occurred. The guide talks about health services (including hospitals), outlines what an incident is, what the open disclosure process is, what they can expect from the process, including how to prepare for the first open disclosure meeting.
Tool 6 Open disclosure flowchart for patients/consumers	This flowchart illustrates the steps in the reporting and management of an incident resulting in harm, and a near miss incident for patient/consumers, their families, carers and/or support persons.
Tool 7 Frequently asked questions about open disclosure for patients/consumers, families, carers and/or support persons	This information sheets provides patients/consumers, their families, carers and/or support persons with frequently asked questions about the open disclosure process, including what is open disclosure, what to expect in the process, what is an incident, what you can do, and how to find out more information on open disclosure.
Tool 8 SLS Guide – Open disclosure	This topic guide will assist managers and OD facilitators to record in Safety Learning System (SLS) the Level 1 or 2 OD process that occurs in response to a patient incident.
Tool 9 Open disclosure process checklist	This checklist is a tool to assist staff in the open disclosure process. It outlines key activities to be completed as part of the open disclosure process.
Tool 10 Patient considerations	The tool provides staff with information on what to consider when communicating with patients, including the patient needs for children, mental health conditions, culturally and linguistically diverse, aboriginal and torres strait islander, hearing or vision impaired, people with a disability; cognitive impairment. Information on the importance of communicating early, advocacy and support requirements, reimbursement, and ongoing care, and other considerations. It also outlines the patient/consumer resources available, refers to the saying sorry guide, and patient evaluation process of the OD process.

Patient Incident and Management and Open Disclosure

Open Disclosure (OD) continued

Tool 11 Staff considerations	The tool provides staff with information on key considerations such as providing advice and training on incidents, communication skills, and the need for support. It outlines the staff rights and responsibilities, use of substitute clinicians, and assistance with initial open disclosure discussions. It also provides staff with information on legal counsel, what junior clinicians can benefit in observing and participating in open disclosure.
Tool 12 Open disclosure meeting checklist	This checklist is a tool to assist staff in the open disclosure process for beginning the meeting, what to do during the meeting ie explaining the facts, identifying patient's key concerns and expressing regret. It also provides information on closing the discussion and subsequent follow up.
Tool 13 Open disclosure meeting plan and prepare checklist	This meeting planning and preparation tool is designed to assist in planning for the first OD meeting, and provides a guide on the information to source for the meeting.
Tool 14 Open disclosure documentation and discussion	The open disclosure documentation and discussion summary is to be completed with the patient/consumer, their family, carer and/or support person. The summary provides a brief factual summary of incident, staff member who led the open disclosure discussions, summary of all points explained and plans for follow up.
Tool 15 Open disclosure patient / consumer evaluation survey	The patient/consumer evaluation survey has been developed to enable feedback from patients/consumers, their families, their carers and/or support person about the OD process. The aim of the 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.
Tool 16 Open disclosure staff evaluation survey	The staff evaluation survey has been developed to enable feedback from staff 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.
Tool 17 Level 1 open disclosure flowchart	This flowchart illustrates the steps in the reporting and management of an incident resulting in harm for level 1 (SAC 1 or SAC 2) OD response.
Tool 18 Level 2 open disclosure response flowchart	This flowchart illustrates the steps in the reporting and management of a near miss for level 2 (SAC 3 or SAC 4) OD response.

Root Cause Analysis (RCA)

Policy Directive SA Health Root Cause Analysis Policy Directive	The Root Cause Analysis Policy describes what conditions need to be satisfied during the commissioning and conduct of a RCA to ensure that protection under Part 8 of the Health Care Act 2008 (SA) is not lost because a legislative requirement has not been met. It also describes under what circumstance information can be released.
Tool 1 Root Cause Analysis report and documentation requirement	This document provides clear guidance on RCA Reports and documentation requirements. It includes completion, endorsement, delivery, amendment and protection of reports and documenting in SLS.
Tool 2 Contributing factors classification	This document provides guidance on classifying factors that contributed to an incident. It covers nine broad categories of patient assessment, staff factors, patient factors, equipment, work environment, information, communication, policies/procedures and coordination.

Root Cause Analysis (RCA) continued

Tool 3 Root Cause Analysis flip chart	The flip chart provides a quick easy to use reference that assists the RCA team to follow the recommended framework for conducting a RCA.
Tool 4 Letter to appoint a Root Cause Analysis Agreement (Team Leader)	A template letter for the appointment of a RCA Team Leader.
Tool 5 Letter to appoint a Root Cause Analysis Agreement Team	A template for the agreement of a person to participate in a RCA as the RCA Team Member.
Tool 6 Root Cause Analysis (RCA) Agreement (Team Leader)	A template for the agreement of a person to participate in an RCA as the RCA Team Leader.
Tool 7 Root Cause Analysis (RCA) Agreement (Team Member)	A template for the agreement of a person to participate in an RCA as the RCA Team Member.
Tool 8 Information for interviewees	This document provides information for people being interviewed by an RCA team. It includes information about why we do an RCA, the RCA process, protection of information and victimisation.
Tool 9 Report 1 – Public Report template	A template to be used, by a RCA team, for the provision of Report 1, the report that may be released.
Tool 10 Report 2 – Protected Report template	A template to be used, by a RCA team, for the provision of Report 2, the report that is protected from disclosure if the RCA was conducted under Part 8 of the *Health Care Act 2008* (SA).
Tool 11 RCA - Checklist	This checklist can be used by RCA teams to ensure that they have appropriately completed all investigation, recommendation and documentations steps in the RCA process.
Tool 12 Information for consumers	This information sheets provides patients/consumers, their families, carers and/or support persons with frequently asked questions about the RCA process, including what is a RCA, can you be involved in the process, what information will you receive, when can you expect to receive this information, and how to find out more information about the RCA process.

For more information

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