Every patient has the right to be treated with care, consideration and dignity.

At South Perth Hospital, we are committed to improving the safety and quality of the care we deliver, which is why we support the principles of Open Disclosure.

This leaflet seeks to inform you, your family or carer about the open disclosure process.

References:

Australian Commission on Safety and Quality in Healthcare, Open Disclosure of things that don't go to plan".

Women's and Newborn Health Service, King Edward Hospital, "Open Disclosure". June 2012.

Department of Health, Victoria, "Information for patient, family/carer about adverse events and open disclosure".

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Disclaimer

South Perth Hospital

Open Disclosure

Patient information for when things don't go to plan

Background

In Australia, we can expect to receive the safest care possible when we visit a healthcare professional or facility. However, sometimes things don't always go to plan.

Of the estimated 200,000 people treated each day in an Australian hospital, occasionally patients can experience an adverse event during the delivery of healthcare.

What is Open Disclosure?

Patients have the right to know what happens to them and why. South Perth Hospital has a policy on Open Disclosure, the guiding principles of which are:

- That patients receive open, supportive and timely communication after an incident.
- That there is an acknowledgement that an incident has occurred.
- That an expression of sorrow is made for any harm resulting from the incident. This expression of sorrow does not constitute an admission of liability.

South Perth Hospital encourages its staff as well as patients (including their families/carers) and visitors to report when things go wrong so that the quality of care provided can be improved.

Why do things go wrong?

Things go wrong because someone has made a mistake or a unique flaw has appeared in a process or system that had not been evident before.

Most incidents in healthcare are minor or are identified before they can affect patients. For things that do not result in harm your doctor or your nurse will talk to you about what went wrong in the same way they talk to you about other aspects of your treatment. They should explain things to you as soon as they are aware of the incident.

If you have been seriously harmed, a more formal meeting will be arranged.

If you think that a serious incident has occurred which has not been acknowledged, you should alert your doctor, nurse or other hospital staff.

What is an adverse event?

Providing healthcare can be a very complicated process. While everything is done to ensure that safe, high quality care is delivered to all patients, sometimes things go wrong and unanticipated outcomes might occur.

At South Perth Hospital, we refer to these incidents as ***adverse events*** and we take them very seriously. An adverse event means that the incident has resulted in harm to a patient receiving healthcare.

What happens next?

All incidents minor or serious, are investigated and reviewed by the highest appropriate level of governance. We do this to identify what went wrong and to develop strategies to prevent similar incidents happening again.

People who have experienced serious harm often report that they cope better once they understand what went wrong. During the formal meeting you will be able to bring a family member or carer with you to provide support and you will be able to ask questions.

During the open disclosure process, you will be :

- Told what is known about the incident.
- Told what went wrong and where possible, why things went wrong.
- Provided with an expression of sorrow by staff involved.
- Provided with the support appropriate to your needs.
- Involved in the development of a plan which outlines how we plan to avoid incidents like this occurring in the future.

How can you find out more?

Australian Commission of Safety and Quality in Healthcare
www.safetyandquality.gov.au

Health and Disability Services Complaints Office
www.hadso.wa.gov.au