HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Quality Management and Patient Safety		
Document:	Multidisciplinary Policy and Procedure		
Title:	Disclosure of Patient Safety Event		
Applies To:	Patients, Patient's Family, Staff, MOH, and Related Organizations		
Preparation Date:	January 05, 2025	**Index No:**	QM&PS-MPP-020
Approval Date:	January 19, 2025	**Version :**	2
Effective Date:	February 19, 2025	**Replacement No.:**	QPS-MPP-025(1)
Review Date:	February 19, 2028	**No. of Pages:**	05

1. PURPOSE:

1.1 To educate healthcare providers about the many aspects of patient safety.
1.2 To inform and support patients and their families about adverse/unanticipated events that may affect their wellbeing or health at the time of care or in the future.
1.3 To ensure an effective and consistent approach to informing patients and their families of an adverse/unanticipated event.

2. DEFINITONS:

2.1 **Disclosure** —the act of disclosing something: something (such as information) that is made known or revealed: something that is disclosed. In the context of healthcare disclosure is to inform the patient, or the patient's representative, of any adverse event or error in his treatment.
2.2 **Harm:** Any temporary or permanent physical or psychological injury.

3. POLICY:

3.1 To maintaine a system and a process for the disclosure of patient safety events to the patients and their families.

4. PROCEDURE:

4.1 MOH mandates to maintain a system and a process for the disclosure of patient safety events to the patients and their families.
- 4.1.1 Disclosure of patient safety events meeting must occur if there has been:
  - 4.1.1.1 Any harm related to a patient safety incident, or if there is a risk of potential future harm.
  - 4.1.1.2 In some case of near miss, disclosure is discretionary based on whether it is felt that the patient or family would benefit from knowing.
  - 4.1.1.3 Any harm resulting from disease process should be discussed with the patient or the patient family (in the case of paediatric; elderly patient).
  - 4.1.1.4 Harm that has resulted from the inherent risk of, an investigation should take place regardless of an investigation or treatment should always be communicated.
  - 4.1.1.5 The disclosure occurs over multi-stages starting by the initial disclosure and followed by a series of discussion depending on the case needs.

4.2 For the patient who is deceased, incapacitated, or otherwise unable to participate in the process of adverse event disclosure, any clinical or institutional disclosure must be communicated to the patient's personal representative and may involve others, as designated by the personal representative.
4.3 Informing the media:
- 4.3.1 Healthcare providers and patients should be notified before any media information release.
- 4.3.2 Any informing of the media should be sensitive the patient, patient family and providers/s involved.

4.3.3 Organizations are responsible for developing communication sharing plans to be released to the traditional Media (television, radio, and print media) or social Media (social networking websites and applications).

4.3.4 Organizations sholuld monitor incidentes unofficially reported through social media sites and evaluate the need for a response.

4.3.5 When responding on social media sites consideration of transparency, timeliness, tone, and citing resources must take place.

4.3.6 Patient confidentiality and providers' identity should be protected.

4.4 Training:

4.4.1 Healthcare providers and involved administrators should receive appropriate disclosure training during their employment orientation process and as a part of continues education.

4.5 Responsibility:

4.5.1 It is the responsibility of the leadership at the healthcare facility level to ensure the implementation of this policy.

4.5.1.1 Disclosure of patient safety events is part of the quality and patient safety organization committee meeting agenda.

4.5.1.2 Quality and Patient Safety department at the healthcare organizations is responsible for monitoring compliance with the provisions stipulated herein.

4.5.1.3 Quality and Patient Safety department at the directorate level is responsible for ensuring that this policy is implemented.

4.6 Step 1

4.6.1 Initial disclosure:

4.6.1.1 The discussion will often focus on the medical condition as it now exists. Only the agreed upon facts that are known are communicated during the initial disclosure.

4.6.2 Elements of initial disclosure include:

4.6.2.1 An applogy for what happened

4.6.2.2 The avoidance of blame and speculation.

4.6.2.3 A brief overview of the investigative process that will follow.

4.6.2.4 The provisional of emotional, clinical, and practical support to the patient.

4.6.2.5 An offer of future meetings.

4.6.2.6 Time for questions and answers.

4.6.3 An offer of apology or an expression of regret can be offered and is not an admission of guilt.

4.7 Step 2

4.7.1 The second stage of disclosure (Post analysis disclosure):

4.7.1.1 During the second stage of disclosure, additional facts and causes are identified. Organizations' Leadership and providers are involved in this stage.

4.7.1.2 The review process that will be conducted should be provided to the patient/ and family. In most cases involving a critical incident, a multidisciplinary review will occur. Quality improvement recommendations from the review can be shared with the patient and family if so desired.

4.8 Step 3

4.8.1 The healthcare providers most involved in the care should be present during the initial disclosure with the patient / patient representative.

4.8.1.1 Communication of an adverse/unanticipated event ideally will be provided by a team. The team will likely include the most responsible physician (at the time of the event), a representative for the region (a manager/ director for the area) and in some cases depending on the severity of harm and circumstances, a representative from Risk Management. Lead for the discussions should rest with those who have the most knowledge of the event.

4.8.1.2 The most responsible provider or the person most directly involved in the care during the incident time is usually the one to take the leadership role.

4.8.1.3 The decision about who will take the lead in the disclosure should consider the following:

4.8.1.3.1 The patient/family preferences.

4.8.1.3.2 The provider knowledge about the incident.
4.8.1.3.3 The provider preference.
4.8.1.3.4 The provider skills in disclosure

4.8.2 The patient or family will be the recipients of the adverse/ unanticipated event information.

4.8.3 Other support resources such as the patient Representative or Social Worker (with appropriate permission) may be included in the discussion to assist patients families by providing support during and after the discussion.

4.8.4 The discussion setting should be in a private, quiet location.

4.8.5 Information should be provided professionally, compassionately, truthfully and in the absence of blaming statements. Opinions should not be discussed. Disclosure of the circumstances should not be delayed because all facts are not known. The recipient of the information should be made aware that all facts may not yet be known, and a follow-up discussion should be planned to disclose new facts.

4.8.6 Disclosure should be conducted using terminology understood by the patient.

4.8.7 All members of the health care team involved in the care should be aware that communication with the patient or family has occurred.

4.8.8 Pertinent health record documentation will be available for the discussion and patients and families will be provided with information about how to access their health information.

4.8.9 The initiator of the discussion must document the content of the meeting in the patient's health record including date and time of meeting; participants-including names and relationship to the patient and factual account of the information shared.

4.8.10 The occurrence of an adverse event can have significant emotional and psychological impact on the involved providers of care for the patient. Support for the providers involved in an adverse/unanticipated event will be provided/facilitated by the organization.

4.9 Step 4

4.9.1 Multi- person disclosure:

4.9.1.1 There may be disclosures that involve more than one patient. Initial contact may include a registered letter, telephone call, or an invitation to an in-person meeting. Appropriate clinicians should be involved and/or advised of the disclosure.

4.10 Step 5

4.10.1 Multi- jurisdictional:

4.10.1.1 In case the harm event was discovered in another facility, different from where the event happened. If possible, healthcare provider or organization involved must be present and lead the initial disclosure.

4.10.1.2 A Representative from both organizations should collaborate in the process.

4.11 Step 6

4.11.1 Details of adverse event/s should be reported in medical records by the care providing team members involved in the incident.

4.11.2 All discussions follow up conversations and responses between the provider/s and the affected patient/family should be documented.

4.11.3 Required documentation in the medical report/case file:

4.11.3.1 Details of the Adverse Event (date, time, and location).

4.11.4.2 Patients' condition before, during, and after medical interventions.

4.11.4.3 Names and positions of all involved personal.

4.11.4.4 Presented facts, investigation results and analysis of the event.

5. MATERIALS AND EQUIPMENT:

5.1 N/A

6. RESPONSIBILITIES:

6.1 Quality and Patient Safety Committee
6.2 Quality and Patient Safety Department
6.3 Quality and Patient Safety Director

7. APPENDICES:

7.1 Flowchart: The Disclosure Process

8. REFERENCES:

8.1 MOH Patients and Family Rights document.
8.2 Administrative Policy and Procedure: Reporting, and Management of Occurrence Variance Accidents.
8.3 Administrative Policy and Procedure: Reporting, Investigation of Sentinel Events and Action Plan.
8.4 Administrative Policy and Procedure: Review of Mortality and Morbidity.
8.5 Saudi Patient Safety Taxonomy,
8.6 MOH disclosure Policy
8.7 Amelican Society for Heathcare Risk Management, 2013. Disclosure of unanticipated events: the next step in better communication. Retrived from: https://www betahg.com/services/advese/ASHRM .pdf
8.8 Canadian Institure of Patient Safety, (2008) Canadian Disclosure Guidelines. Retrived from http://www.chirofed.ca/english/pdf/CPSI_Canadian Dislosure_Guidelines_EN.pdf

9. APPROVALS:

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APPENDIX 7.1 Flowchart: The Disclosure Process