InterHealthCanada
Turks and Caicos Islands Hospital

PATIENT SAFETY BOOKLET

This handbook provides an overview of how to apply patient safety principals to your everyday work, the benefits of working together as a team to deliver patient care, communicating effectively and recognizing, responding to, reporting and disclosing incidents.

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Patient Safety

Patient safety is defined as the reduction and mitigation of unsafe acts within the healthcare system. When combined with the use of best practices which have been shown to lead to optimal patient outcomes, patient safety is a critical aspect of quality healthcare.

The Safety Competencies, as defined by the Canadian Patient Safety Institute[1], provide a framework of six core domains of abilities that are shared by all healthcare professionals. By contributing to the patient safety education of healthcare professionals, the Safety Competencies can support safer patient care.

This handbook is based around the six core domains which make up the Safety Competencies:

Domain 1: Contribute to a Culture of Patient Safety
A commitment to applying core patient safety knowledge, skills and attitudes to everyday work

Domain 2: Work in Teams for Patient Safety
Working within interprofessional teams to optimise both patient safety and quality of care

Domain 3: Communicate Effectively for Patient Safety
Promoting patient safety through effective healthcare communication

Domain 4: Manage Safety Risks
Anticipating, recognising and managing situations that place patients at risk

Domain 5: Optimise Human and Environmental Factors
Managing the relationship between individual and environmental characteristics in order to optimise patient safety

Domain 6: Recognise, Respond to and Disclose Adverse Events
Recognising the occurrence of an incident or near miss and responding effectively to mitigate harm to the patient, ensure disclosure, and prevent recurrence

This handbook uses extracts from The Canadian Patient Safety Institute's Safety Competencies[1] and the World Health Organisation's Patient Safety Curriculum Guide[2].

Quality Portal

The Quality Portal provides a collection of resources which can be accessed by all members of staff. It provides further information to support the Safety Competencies and includes:

- articles relating to quality;
- webinars and course materials;
- clinical audit guidance;
- National Confidential Enquiries into Patient Outcome and Death (NCEPOD) reports;
- Institute for Healthcare Improvement passport membership;
- links to related websites;
- incident reporting guidance;
- Information on risk management and patient safety;
- Accreditation Canada International resources

The Quality Portal can be accessed from the intranet home page by clicking on the "Departments" tab at the top left and selecting "Quality" from the drop-down list.

Domain 1: Contribute to a Culture of Patient Safety

Patients trust us with their lives; family members trust us with their loved ones. Nothing we do is more important than creating the safest environment possible for our patients, to show that their trust is well-placed.

Improving patient safety is about changing the culture in healthcare from one of blame to one where we examine our systems from beginning to end to reduce the opportunities for mistakes.

We trust each other, and we don't believe that people come to work to do a bad job or make an error but, given the right set of circumstances, any of us can make a mistake. That's why our culture of patient safety focuses on prevention, not punishment. We see incidents as opportunities to learn. We encourage staff to report incidents and near misses in a cooperative, open way, without fear of punishment.

We must always be seeking ways to improve our systems and processes. We must look past the easy answer that it was "someone's fault" to answer the tougher questions about why a mistake happened. The success of this effort depends on each member of the team's willingness to participate, to contribute, and to be open to sharing and receiving information about

incidents and near misses. At the Turks & Caicos Islands (TCI) Hospital all staff are expected and required to fully participate in building our culture of safety. Staff are advised to contact the Human Resources Department if they feel that an incident in which they have been involved is not managed in accordance with the Just Culture process.

Behaviours which are considered unacceptable

As you would expect, our patient safety culture does not excuse staff who:

- Choose to ignore or bypass policies and procedures;
- Fail to participate in the detection, reporting, and implementation of activities to prevent incidents or near misses;
- Intentionally contribute to or cause an incident or near miss;
- Attempt to hide, modify or withhold the reporting of an incident or near miss;
- Knowingly present false information in relation to the investigation or reporting of an incident or near miss.

Domain 2: Work in Teams for Patient Safety

Effective teamwork in healthcare delivery can have an immediate and positive impact on patient safety. The ways the team communicates with one another and with the patient will determine how effective the care and treatment is, as well as how the team members feel about their work.

Teams can improve care at the level of the organisation, the team as a whole, the individual team member and the patient:

	How teams can improve patient care		
Organisational benefits	Team benefits	Patient benefits	Benefits to team members
Reduced hospitalisation time and costs	Improved coordination of care	Enhanced satisfaction with care	Enhanced job satisfaction
Reduced unanticipated admissions	Efficient use of healthcare services	Acceptance of treatment	Greater role clarity
Better accessibility for patients	Enhanced communication and professional diversity	Improved health outcomes and quality of care. Reduced medical errors	Enhanced well-being

Healthcare teams interact dynamically and have the common goal of delivering health services to patients.

Characteristics of successful teams

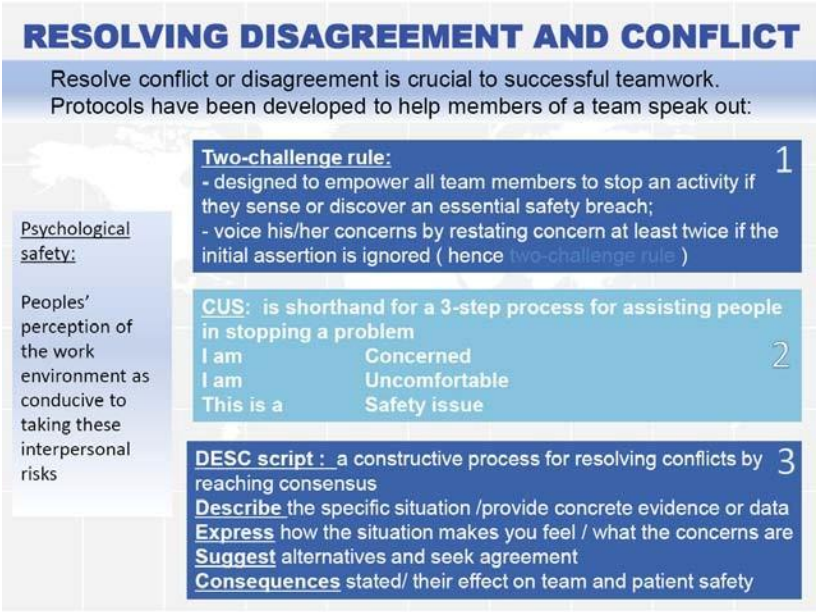
- **Common purpose:** Team members generate a common and clearly defined purpose that includes collective interests and demonstrates shared ownership.
- **Measurable goals:** Teams set goals that are measurable and focused on the team's task.
- **Effective leadership:** Teams require effective leadership to set and maintain structures, manage conflict, listen to members and trust and support members. It is also considered important that team members agree on and share leadership functions.
- **Effective communication:** Good healthcare teams share ideas and information quickly and regularly, keep written records and allow time for team reflection. Some of the most in-depth analysis of interprofessional team communication (across disciplines, and not just among medical specialties) has focused on high-stakes teams, such as those found in surgery.
- **Good cohesion:** Cohesive teams have a unique and identifiable team spirit and commitment and have greater longevity, as team members want to continue working together.
- **Mutual respect:** Effective teams have members who respect each others' talents and beliefs, in addition to their professional contributions. Effective teams also accept and encourage a diversity of opinions among members.

Additional requirements for effective teams include individual task proficiency (both in terms of personal technical skills and teamwork skills); task motivation; flexibility; the ability to monitor their own performance; effective resolution of and learning from conflict and engagement in situation monitoring.

Reviews of high-profile incidents, such as aviation disasters, have identified three main types of teamwork failings as contributing to accidents, namely, unclear definition of roles, lack of explicit coordination and other miscommunication.

Resolving disagreement and conflict

The ability to resolve conflict or disagreement in the team is crucial to successful teamwork. This can be especially challenging for junior members of the team, such as students, or in teams that are highly hierarchical in nature.



How to apply teamwork principles

Practical tips for healthcare professionals to practice at work:

- Always introduce yourself to the team;
- Read back/close the communication loop;
- State the obvious to avoid assumptions;
- Ask questions, check and clarify;
- Delegate tasks to specific people, not to the air;
- Clarify your role;
- Use objective (not subjective) language;
- Learn and use people's names;
- Be assertive when required;
- If something doesn't make sense, find out the other person's perspective;
- Always do a team briefing before starting a team activity and a debrief afterwards;

- When in conflict, concentrate on “what” is right for the patient, not “who” is right / wrong.

Domain 3: Communicate Effectively for Patient Safety

Effective communication is crucial to optimal patient outcomes, and poor communication can lead to patient harm. High-quality and safe care depends on the ability of healthcare providers to communicate well with patients and with other professionals. This domain centres on the processes by which healthcare professionals convey and receive information to foster positive interpersonal relationships within clinical situations, and within and across organisations, to ensure safe and effective patient care and to prevent adverse events. Effective communication is a dynamic, ongoing process.

One of the most important goals of effective communication is to optimise patient safety. Communication issues related to patient safety fall into two main categories: preventing adverse events and responding to adverse events. Communication designed to optimise the safety of patient care should include effective written, verbal and non-verbal formats. The appropriate use of electronic communication tools and channels is also essential.

Effective communication is beneficial to patients and healthcare providers, builds trust, and is a precondition of patient consent. Patients who receive information that is clear and consistent are better able to understand the risks, benefits and possible outcomes of investigations and treatments, and can thus participate as full partners in their own care.

Healthcare professionals who communicate effectively for patient safety:

- protect privacy and confidentiality;
- provide the correct type and amount of information;
- share understanding and decision-making with patients and family;

- use jargon-free language to convey complex information clearly;
- provide informed consent, including capacity assessment as required and informed discharge;
- support written or oral communication, when appropriate, with patient education materials;
- use appropriate communication techniques for high-risk situations;
- communicate with other providers to facilitate smooth transfer of care;
- use effective team communication techniques;
- effectively communicate delegated tasks and provide appropriate supervision;
- provide effective consultations, requests, reports and documentation;
- use communication tools and technologies;
- provide proper disclosure and reporting of adverse events.

SBAR

The safety attitudes questionnaire administered at Kaiser Permanente identified that physician and nurse perceptions of teamwork were significantly different. Physicians tended to view the care environment as fairly collaborative, whereas nurses saw it as much less so. To address the issue, Kaiser Permanente developed a communication tool that was adapted from the US Navy, called SBAR.[3]

SBAR (Situation, Background, Assessment, Recommendation) is an effective and efficient way to communicate important information. SBAR offers a simple way to help standardise communication and allows parties to have common expectations related to what is to be communicated and how the communication is structured.

S = Situation (a concise statement of the problem)

B = Background (pertinent and brief information related to the situation)

A = Assessment (analysis and considerations of options — what you found/think)

R = Recommendation (action requested/recommended — what you want)

SBAR has been adopted by TCI Hospital as a tool to promote effective communication and improve patient safety.

Item	Definition	Example
Situation	One sentence description of need	Patient arrived for appointment on wrong day
Background	Details that give information to make an assessment (can be from patient's view and from your clinical view as you inquire and research)	1. Patient arrived for appt today 2. Appointment is tomorrow 3. Pt has travelled 40 miles 4. Pt needed friend to give them a lift to the Hospital 5. Dr could see an extra patient at the end of the clinic or earlier if there is a DNA 6. It's not clear whether the mistake was with the pt or the Hospital
Assessment	Your position on the issue	We should see the patient today
Recommendation	Your specific method for solving the problem	I recommend that you see this pt as soon as possible today

Kaiser Permanente

Teach Back

Teach Back is a research-based health literacy intervention that improves patient-provider communication and patient health outcomes.[4]

Teach Back involves asking a patient (or family member) to explain, in their own words, what they need to know or do as a way to check for understanding and, if needed, re-explain and check again.

10 Elements of Competence for Using Teach-back Effectively

1. Use a caring tone of voice and attitude;
2. Display comfortable body language and make eye contact;
3. Use plain language;
4. Ask the patient to explain back, using their own words;
5. Use non-shaming, open-ended questions;
6. Avoid asking questions that can be answered with a simple yes or no;
7. Emphasise that the responsibility to explain clearly is on you, the provider;
8. If the patient is not able to teach back correctly, explain again and re-check;
9. Use reader-friendly print materials to support learning;
10. Document use of and patient response to teach-back.

Asking for Teach Back - examples

- I teach this information a lot and sometimes forget to include everything. Please explain what we just discussed, so I can be sure I included everything and it was clear.
- What will you tell your husband about the changes we made to your medicine today?
- Let's review the main side effects of this new medicine. What are the two things that I asked you to watch out for and to let me know if you get them?
- Please show me how you would use this inhaler, so I can be sure my instructions were clear.

Domain 4: Manage Safety Risks

Effective risk management requires anticipating, recognising, and managing situations that place patients at risk and will:

- increase the likelihood of achieving objectives;
- improve the quality of care;
- protect patients, staff, assets, property and reputation;
- ensure that performance is consistent with values;
- support better business decision making;
- meet accreditation and TCIG requirements.

In healthcare, as in other high-risk endeavours (e.g., aviation and the nuclear industry), it is recognised that things can and will go wrong.

Therefore, it is necessary to design the healthcare work system, and to train individual healthcare professionals, in a manner that anticipates and recognises this potential and that facilitates the effective management of situations that place individuals and groups at risk. The defining competencies that enable healthcare professionals to recognise and manage risk in dynamic situations include task management, team work, and clinical and systems-based decision-making informed by situational awareness. By learning and applying these non-technical skills and competencies, healthcare providers can help to improve

outcomes for patients and their families by preventing or mitigating adverse events. Reducing the likelihood of harm requires integrating these non-technical skills with clinical knowledge and techniques.

Refer to TCI Hospital *Risk Management Strategy* (QRM 205) and *Risk Management Policy* (QRM 206) for further information.

Domain 5: Optimise Human and Environmental Factors

The processes by which we make decisions and perform our roles as individuals and as members of teams are complex.

When we're not functioning at our best physically or emotionally – and when we're in an environment that affects our thinking and decision-making processes – errors can result. Human factors that contribute to an error can be addressed by using strategies to minimise or prevent risk.

Healthcare professionals who optimise human and environmental factors for patient safety appreciate that individual performance is affected by behaviour within a system constructed by resources, culture and policy. An understanding of the human factors and the environmental factors that shape our decisions helps us to recognise and address unhelpful influences and improve our decision-making.

Human factors

Human performance is significantly shaped by knowledge, skill and experience, in addition to personality attributes and attitudes toward risk:

- individual characteristics, including gender, age, personality and risk tolerance or aversion;
- factors that affect their personal well-being, including work-life balance, sleep deprivation/sleep debt, and physical and emotional health;
- critical thinking, including situational awareness and an awareness of cognitive biases in decision-making.

Environmental factors

Systems-based thinking in healthcare can help us understand the relationships between the various elements of complex work environments.

- light and sound, surge conditions, work interruptions and technology;

- ergonomics, including human factors engineering, system design, technology and work flow;
- systems, including their policies and procedures, resource allocation and culture;
- the effect of the acceptance of deviance as the norm and the creation of unsafe work-arounds.

Domain 6: Recognise, Respond to and Disclose Adverse Events

Incident Reporting

Incident reporting is …

- ✓ A way of identifying and tracking incidents and near misses to find patterns and trends;
- ✓ A succinct, factual description of the event which will help us learn how we can improve our systems to prevent future mistakes.

Incident reporting is *not* …

- ✗ Your opinion of the event;
- ✗ A system for venting your frustration;
- ✗ An opportunity to discredit your colleagues;
- ✗ About reporting a person;
- ✗ An opportunity to retaliate or make yourself look superior;
- ✗ Included in staff personnel files, unless it relates to behaviours which are considered unacceptable (see page 3).

The information that you include in an incident report is seen by a number of people: those who are involved in the investigation of the incident, members of the Quality, Risk & Patient Safety Committee who review the incidents which have been reported and Board members via the monthly Board report. There is also the potential that, if the incident is the subject of a litigation case, it will be required by our legal representatives to inform their review. Therefore it is imperative that incidents are reported in a professional manner.

What should I report?

Staff should feel comfortable to report anything that harms, or has the potential to harm, the patient, staff, visitors or the Hospital. "Harm" does not necessarily refer only to physical injury; it also encompasses the emotional impact, reputational damage and financial cost.

The following list of examples of incidents which must be reported is merely a guide and is not exhaustive.

Patient Safety Incidents

An event that results in hazardous healthcare conditions or unintended harm to a patient

Incorrect diagnosis
Incomplete clinical assessment
Diagnostic report delayed
Diagnostic result not reported
Diagnostic report incorrect
Specimen missing
Specimen labelling error
Reaction to blood transfusion
Incorrect blood group
Blood administration errors
Any readmission
All Code alerts
Secondary PPH / Sepsis
Inadequate handover of care
Unlabelled baby
Incorrect medication prescription
Incorrect medication preparation
Unsafe handling of medication
Extravasation
Patient fall
Dehiscence of surgical wound
Laceration/skin tear/abrasion/burn
Clostridium difficile / MRSA
Infectious disease outbreaks
Difficult intubation

Failure / delay in diagnosis
Delay in medical review affecting care
Complication following diagnostic procedure
Diagnostics / treatment of wrong patient
Diagnostics / treatment of wrong site
Diagnostic report not acted on appropriately
Incorrect details on lab or imaging request
Self harm whilst on hospital premises
Storage/transportation of blood products
Delay in receiving blood product/unavailable
Communication failure patient/ team/ others
Neonatal collapse requiring transfer to NICU
Third and fourth degree tears post delivery
Baby with low/high temp, low blood glucose
Birth injury e.g. Erb's palsy
Medication administration without prescription
Inappropriate verbal order for medication
Delay in availability/admin of medication
Med admin not in accordance with prescription
Incorrect medication advice given by staff
Pressure ulcer developed during inpatient stay
Devpt of deep vein thrombosis whilst inpatient
Inappropriate placement of infectious patients
Devpt of pulmonary embolism whilst inpatient
Infection diagnosed >48 hrs after admission *

Unexpected transfer to HDU
Unexpected transfer to SCBU
Failure to follow policy
Failure of follow up arrangements
Theatre list details incorrect
Absconder / missing patient
Self discharge
Unexpected death
Excessive blood loss within 24 hrs of surgery
A complication resulting from any procedure
Failure to provide clinical care/observations
Surgery not performed according to consent
Inadequate or no consent obtained
Patient records missing vital information
Patient identification band incorrect

* includes bloodstream line infections, sepsis from other device infections (e.g., catheter-associated urinary tract infection), or any healthcare-associated infection.

Employee or Non-Employee

An event related to an employee or visitor, including injuries and personal conduct issues

Injury to staff whilst at work
Staff / visitor slip, trip or fall
Staff / visitor collapse
Failure to follow policy (if not a Patient Safety-related failure).
Sharps injuries
Splash injuries
Staff training issues
Exposure of staff or visitors to hazardous substances

Security, Operations and Environment

An event involving a security issue, a problem with day-to-day operations, or the organisation's physical environment

Verbal abuse
Physical abuse
Leaks/flooding
Two patients in single room
Breach of security
Extreme temperature of wards/rooms
Inappropriate admission or transfer
Discharge delays / poor discharge planning
Inadequate staffing compromising patient care

Patient Confidentiality

An event involving Protected Health Information (PHI) for a patient. This includes issues regarding access to PHI and any breach of PHI defined by Patient Confidentiality.

Patient information disclosed inappropriately
Accessing information not necessary to undertake role
Removal of patient information from the hospital

Adverse Drug Reaction

An event involving a patient having an adverse reaction to a medication or substance without any apparent incorrect action taking place. If the reaction was the result of an incorrect action, the event should be reported under the Patient Safety taxonomy.

Refer to TCI Hospital Incident Reporting and Management Policy (QRM 204) for further information.

Comments, Compliments and Complaints

TCI Hospital welcomes feedback from patients and the public about the services it provides. A range of methods are used to encourage service users to share their experiences and these include feedback from comments, compliments and complaints. All three elements of feedback should be recorded on the 'Guest Relations" module of the incident management system.

TCI Hospital is committed to providing safe, effective and high quality services. However, it is recognised that at times things could be done better. When comments or complaints are raised, the Hospital has a responsibility to acknowledge them, put things right as quickly as possible, and to learn lessons to make service improvements that prevent recurrence.

Do all complaints have to be put in writing?

No. Patients can register a complaint with any member of staff verbally, using the complaint form (which can also be found on the intranet under "Forms" / "Quality"), in writing or by email; whichever they find convenient.

What should I do when a patient or visitor complains?

You should respond to any complaint raised by patients or visitors in an open, constructive and non-judgmental manner and try to resolve the matter within 24 hours if possible. If a complaint can be resolved within 24 hours it is classed as an informal complaint and doesn't have to be provided with a written response. You may need to refer the matter to a more senior member of staff. Either way, you must make your Line Manager aware of the complaint. Informal complaints should be logged on the "Guest Relations" module on the incident management system to provide a record and allow analysis of what is reported over time.

In circumstances where resolution of misunderstandings is rendered difficult to impossible and a second party is required, the Patient Advocate should be contacted and consulted to avoid escalation of the situation. The position of Patient Advocate is meant to supplement staff efforts in order to ensure patient satisfaction and the overall excellent patient care experience. It is not intended as a replacement. It is critical that staff recognise their role in communicating effectively with our patients and relatives and to understand

and resolve as much as possible their anxiety, concerns and complaints with caring and compassion.

If a formal complaint (i.e. one that cannot be resolved to the complainant's satisfaction within 24 hours) is made verbally it should be recorded by the person to whom the complaint is made on the incident management system as soon as possible and within 24 hours maximum.

Formal complaints provided in writing (either as a letter, email or on a complaint form) must also be reported on the incident management system in the same way. The letter or form should be scanned and attached to the incident management system in the "documents" section. Emails can also be attached if they are saved as a ".txt" document. Contact the Quality, Risk & Patient Safety Manager if you need any support or advice.

What happens next?

The Quality, Risk and Patient Safety Manager will contact the complainant to acknowledge receipt of the complaint within three working days, discuss the nature of the complaint and explain how the complaint will be handled.

The Hospital aims to provide complainants with a full explanation and response to all complaints within twenty working days. Complaints will be thoroughly investigated with the aim of resolving the issues speedily and efficiently and within the agreed timeframe. The Quality, Risk and Patient Safety Manager will oversee the quality and timeliness of the investigation and validate the conclusions, outcome and actions agreed for inclusion in the complaint response.

The Quality, Risk and Patient Safety Manager will compile the response letter to the complainant and this will be reviewed by the Chief Executive Officer. If the complainant is not satisfied with the response provided following investigation by the Hospital, he/she has the right to request independent review of the complaint by the TCI Government.

Can a relative complain on behalf of a patient?

Yes. If a relative or friend is making a complaint on behalf of a patient it may be necessary to seek the signed consent of the patient in order to protect patient confidentiality.

Refer to TCI Hospital Complaint Reporting and Management Policy (QRM 201) for further information.

Incident and Complaint Investigation

Incident notifications

When an incident is reported on the incident management system, notifications will be emailed to the person who reported the incident, those people who need to be made aware of the incident ("trackers") and the person who is responsible for undertaking the investigation ("investigators"). If you feel that there are other people who need to be notified then you can add them by clicking on the "actions" drop- down and selecting "notify another".

If you are identified as the person responsible for undertaking the investigation, you can delegate this responsibility to a member of your team, but you will still be accountable for ensuring that the investigation is completed. If you delegate the responsibility, add a "comment" in which you can record to whom you have delegated the role and add them to the notifications if they are not already included.

How long do I have to complete the investigation?

If you have been nominated as the person responsible for the investigation you have 30 days within which to complete your investigation. This might seem like a long time but you need to take into account that the investigation will possibly include review of healthcare records and other documentation and discussion with members of staff. It is advisable to seek witness input as soon as possible after the event as there is the potential that they will be unable to recall all of the necessary details at a later date. Also bear in mind that complaints will require a written response letter to the complainant once you have completed your investigation and there is a deadline of 20 working days from receipt of the complaint for this. Consequently you will need to complete your complaint investigations as soon as possible.

Recording the investigation

The findings should be recorded by the person assigned investigation in the "review/interview" section of the incident reporting system. These must include the root cause of the incident and the corrective action that has been taken to prevent the risk of a similar incident happening in the future as this is the fundamental purpose of incident reporting.

Recommendations Hierarchy

The following table identifies the strength of corrective actions according to the recommendations hierarchy:

Stronger actions	Intermediate actions	Weaker actions
• Remove a physical barrier that is preventing access; • Architectural / physical changes; • New device with usability testing before purchasing; • Engineering control or interlock (forcing functions); • Simplify process and remove unnecessary steps: • Standardise to minimise variation in equipment, process, care pathways, drugs and rules; • Involvement and leadership in support of patient safety improvement.	• Use checklists, protocols and reminders (cognitive aids) to reduce reliance on memory; • Eliminate the use of sound-alike or look-alike names; • Increase in staffing / decrease in workload; • Software enhancements / modifications; • Improved documentation / communication / handover; • Eliminate / reduce distractions.	• A new policy or procedure or guideline; • Staff training and education; • Additional study and analysis; • Double checks; • Warnings and labels.

Recommendations to reduce the risk of recurrence fall into three categories – strong, intermediate and weak actions. You should be seeking to implement examples of those in the strongest possible category as these will be the most effective.

What is my role as "tracker"?

People are assigned the tracker role to enable them to monitor progress with the investigation and add any relevant details. Contributions to the investigation by trackers should be recorded as a "comment", unless they relate to additional details about the event which are discovered after the report has been submitted, in which they should be added to the relevant section of the review/interview.

If they have nothing to add to the investigation it is not necessary for the trackers to add comments. However it is imperative that all of those who are assigned a task add their review of the incident, even if that is just to record that they have acknowledged the incident. To add a review, right click on your name in the "tasks/notifications" section, select "review task" and then add your review. It is not possible for the Quality, Risk and Patient Safety Manager to close incidents without everyone who has been notified adding their review.

A spreadsheet detailing the responsibility for investigating all incidents which are open is located in the "incident reporting" folder of the Quality portal for reference purposes.

What happens next?

Once you have completed your investigation you must notify the Quality, Risk & Patient Safety Manager to enable the incident or complaint to be closed. Those which exceed the deadline will be reported to the Quality, Risk & Patient Safety Committee.

Being Open (Disclosure)

If an adverse event has occurred where we have not met our own expectations or the patient's, we will tell them openly and honestly. We will share with the patient our understanding of what happened and why it happened, and we will invite them to be involved in identifying how we can make improvements.

This open communication process is known as Being Open or Disclosure.

What does Being Open involve?

- Acknowledging, apologising and explaining to patients when things could have been done better;
- Conducting a thorough investigation into the situation and reassuring the patient, their family and carers that lessons learnt will help prevent recurrence;
- Providing support to all those involved or affected.

Refer to TCI Hospital Disclosure Policy – Being Open (QRM 202) for further information.

References

1. The Canadian Quality and Patient Safety Framework for Healthcare Services, Health Standards Organization, Canadian Patient Safety Institute, and their respective licensors; 2020

2. The Canadian Quality and Patient Safety Framework for Healthcare Services; 2018

2. Frank JR, Brien S, (Editors) on behalf of The Safety Competencies Steering Committee. The Safety Competencies: Enhancing Patient Safety Across the Health Professions. Ottawa, ON: Canadian Patient Safety Institute; 2008.

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5. Schillinger D, Piette J, Grumbach K, Wang F, Wilson C, Daher C, Leong-Grotz K, Castro C, Bindman A. Closing the Loop Physician Communication With Diabetic Patients Who Have Low Health Literacy. Arch Intern Med/Vol 163, Jan 13, 2003