I. Hospital Philosophy:

II. Policy Statement:

III. Definitions of Terms: [examples]

Unanticipated outcome
Adverse event
Types of adverse events:
   Adverse drug event
   Unintended significant procedural event
   Preventable adverse event
   Unpreventable adverse event
Medical error
Minor error
Serious error
Near miss
Root cause analysis (RCA)
Sentinel event
Significant harm
Disclosure
Informed consent
IV. Criteria for Disclosure

V. Defining Personnel Roles

A. Disclosure Response Team:

Administrators, Risk Manager, Quality Improvement Manager, Medical Director, Physician(s), Pharmacists, Direct Care Givers

VI. Patient Contact Algorithm

A. Initial patient contact

B. Directing the patient to the appropriate individual(s)

Importance of Maintaining Confidentiality

VII. Investigate Unanticipated Outcome

A. Complete root cause analysis if needed

B. Review and communicate details of investigation with appropriate staff members

VIII. Planning the Disclosure Discussion

Who

When

Setting

Special needs/accommodations

IX. Disclosure Communication Content
Description of factors contributing to outcome if known. If not known, share with patient that you will look into what happened.

Expression of regrets

Apology - if warranted

Affects on current patient treatment plan

Address concerns

Review actions taken to prevent recurrence

Review next steps

X. Documentation

Who

When

Description of factors contributing to outcome

Information was provided

Patient

Responses to patient questions

Patient’s level of understanding

Planned follow-up

Who the patient should contact with questions

XI. Follow-Up

Attachments:  Templates or Forms

Coordinating Policies [Patient Communication;
Patient Informed Consent; Patient Confidentiality]