Fronditha care

Open Disclosure Campaign

WEEK 5

FIND OUT AND EXPLAIN WHAT HAPPENED

We are in the fifth week of Open Disclosure Awareness.

Further to apologising and expressing regret it is equally important that when things have gone wrong that we **find out what happened and communicate** this to the consumer/representative. In our commitment to being transparent and our focus on learning and continuous improvement it is important to gather all necessary information. How we do this, might look different each time, dependent on the events that have occurred and the scale of harm.

To reiterate, this is not a process to apportion blame, instead it should be viewed as an opportunity for learning, with the aim to improve outcomes for consumers.

In aiming to understand the events/incident, information is sought from all key stakeholders, the consumer, representative, staff and others as applicable.

Some of the questions posed might include:

- **What happened? (this means gaining a detailed understanding of events)**
- **Why did it happen? (what were the chain of events or causes of the event) and**
- **How can it be prevented from occurring again? (this requires reflection, problem solving and implementing measures to avoid a recurrence).**

Following this, we share our findings with the consumer and provide a factual explanation of what happened, ensuring information is presented in a way the consumer will understand. The consumer is invited to re-tell their story, provide their views and ask questions about the insights into the events. Their views and concerns are listened to, understood, and considered.

There may be several discussions with the consumer and/or follow up meetings and support. Information continues to be provided along the way as we evaluate what has happened.

All conversations and outcomes are documented.

What we do at Fronditha Care:

- We work with individuals to understand what has occurred and why
- We undertake a thorough analysis of the information gathered
- We engage the consumer / representative along the process
- We strive to Do Better
- We put things in place to avoid a recurrence in future

FIND OUT AND EXPLAIN WHAT HAPPENED

Continuing from last week's case scenarios, below you will find how to apply Element 4 of Open Disclosure – Find out and explain what happened.

1 A personal support worker fails to attend a consumer's home for meal preparation

At the home visit the Care Advisor offered Chloe and Eva an opportunity to re-tell their story, the events as they occurred, and how this affected each of them respectively. The details of psychological harm that occurred and the concerns about what could have happened, were actively listened to and validated.

The Care Advisor reassured Chloe and Eva that the Service Manager along with the staff involved had promptly met following the incident, to investigate and understand what had happened and why, and had put plans into place to reduce the risk of this happening again. It became apparent that there had been an unintentional communication breakdown between the support worker, rostering team and consumer/family.

In addition, and despite the efforts of the rostering team, there was no other support worker available during the lunchtime slot preferred by the consumer. The communication to the consumer/family was overlooked so that options could be discussed and contingencies enacted.

The Care Advisor confirmed that communication and rostering processes, and roles and responsibilities had been reviewed to reduce the risk of reoccurrence. The Care Advisor also sought to discuss and document contingency options with Eva and Chloe if the situation presented itself again, where a support worker was on unexpected personal leave and a replacement could not be found at the last minute for the lunchtime service. Chloe and Eva appreciated the honesty and transparency of the process and the opportunity to contribute to the solutions. Chloe and Eva were able to identify other informal support people who could attend at short notice to assist, ensuring the care needs of Eva could be met and Chloe could be at work without the additional worry.

The discussion and outcome were documented in the consumers History notes and Care Plan and shared with consent, with the respective teams/people involved.

2 The case of personal belongings disposed of in the rubbish bin

The Manager spent time with Mr. G. giving him the opportunity to express his frustration and inconvenience in having to go and purchase new clothing for his Aunt's burial. He also expressed sadness over the loss of the pictures. He wanted to know how this has happened and why. The Manager understood his concerns and following an investigation she was able to provide an explanation to Mr. G.

Due to an oversight, the regular Tote bags used for packing consumers' belongings was not ordered in a timely fashion. This resulted in the RN on duty having to pack Mrs. G's belongings into an ordinary black rubbish bag without a name tag. Due to another oversight, this bag was removed as rubbish, into the basement area from where the Maintenance officer disposed of it into the larger rubbish bin.

The Manager provided opportunities for further clarification and explanation by each staff member involved. These details were also passed onto Mr. G who was reassured that the Manager and her team had already initiated actions to ensure that these mishaps will not happen again. An offer of compensation was made at this time to Mr. G to assist with the funeral arrangements. The Manager also offered a choice of several photographs of Mrs. G available at the facility.

The Manager documented all the details of the events and conversations as part of the record keeping requirement process.

** All names and scenarios are fictional. Any resemblance to real persons or cases is purely coincidental.*

For the full case scenario visit:
https://frondithacare.org.au/open-disclosure-awareness/