1.7 Open Disclosure

Purpose

To ensure Clinicians communicate with and support patients, their family and carers who have experienced harm during healthcare.

Process

What is Open Disclosure?

Open disclosure is the open discussion of adverse events that result in harm to a patient while receiving health care with the patient, their family and carers. The elements of open disclosure are:

- an apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry'

- a factual explanation of what happened

- an opportunity for the patient, their family and carers to relate their experience

- a discussion of the potential consequences of the adverse event

- an explanation of the steps being taken to manage the adverse event and prevent recurrence.

It is important to note that open disclosure is not a one-way provision of information. Open disclosure is a discussion between two parties and an exchange of information that may

Open Disclosure Principles

Open and timely communication

If things go wrong, the patient, their family and carers should be provided with information about what happened in a timely, open and honest manner.

Acknowledgement

All adverse events should be acknowledged to the patient, their family and carers as soon as practicable. Health service organisations should acknowledge when an adverse event has occurred and initiate open disclosure.

Apology or expression of regret

As early as possible, the patient, their family and carers should receive an apology or expression of regret for any harm that resulted from an adverse event. An apology or expression of regret should include the words 'I am sorry' or 'we are sorry', but must not contain speculative statements, admission of liability or apportioning of blame

Supporting, and meeting the needs and expectations of patients, their family and carers

The patient, their family and carers can expect to be:

- fully informed of the facts surrounding an adverse event and its consequences
- treated with empathy, respect and consideration
- supported in a manner appropriate to their needs.

Supporting, and meeting the needs and expectations of those providing health care

Health service organisations should create an environment in which all staff are:

- encouraged and able to recognise and report adverse events
- prepared through training and education to participate in open disclosure
- supported through the open disclosure process

Integrated clinical risk management and systems improvement

Thorough clinical review and investigation of adverse events and adverse outcomes should be conducted through processes that focus on the management of clinical risk and quality improvement. Findings of these reviews should focus on improving systems of care and be reviewed for their effectiveness. The information obtained about incidents from the open disclosure process should be incorporated into quality improvement activity

Good governance

Open disclosure requires good governance frameworks, and clinical risk and quality improvement processes. Through these systems, adverse events should be investigated and analysed to prevent them recurring. Good governance involves a system of accountability through a health service organisation's senior management, executive or governing body to ensure that appropriate changes are implemented and their effectiveness is reviewed. Good governance should include internal performance monitoring and reporting.

Confidentiality

Policies and procedures should be developed by health service organisations with full consideration for patient and clinician privacy and confidentiality, in compliance with relevant law (including Commonwealth, state and territory privacy and health records legislation).

When does the Open Disclosure Process begin?

Open Disclosure is part of Incident Reporting. As soon as an incident is identified and the risk level identified, the open disclosure response is graded as a **general level response** (usually low to medium risk) or a **high-level response** (usually high to very high risk).

General indications of a lower-level response are:

- Near Miss/ no-harm incident
- No permanent injury
- No increased level of care required
- No, or minor, psychological or emotional distress

General indications of a higher-level response are:

- Death or major permanent loss of function
- Permanent or considerable lessening of body function
- Significant escalation of care/ change in clinical management
- Major psychological or emotional distress
- At the request of the patient

See Open Disclosure Flowchart (Australian Commission on Safety and Quality in Health Care)

The Open Disclosure Checklist F-1.12 should be started.

The Open Disclosure Documentation and Discussion Summary F-1.13 should be completed for any discussions.

General Level Response

The purpose of the first meeting is to support and inform the patient. If direct communication with the patient is hindered because of the patient's clinical condition or language/cultural/disability difficulties or his/her emotional state, consideration should be given to initiating communication with the support person.

IN GENERAL LEVEL RESPONSES, the clinician directly involved in the incident is the most appropriate person to communicate with the patient and their support person. This may be a nurse, allied health professional or junior medical staff.

The general response involves:

- a meeting with the patient and their support person, where practicable
- an explanation of what happened, the immediate effects, and prognosis
- an apology

- The contact names and phone numbers of people in Melbourne Day Surgery who are available to address concerns and complaints, including psychological and social support contacts

- For a general level response, this first meeting with the patient and their support person may be the only meeting about the incident.
- This meeting may simply be a conversation between the clinician and the patient at the bedside or a telephone conversation with the patient if discharged. It is up to the clinician to initiate a follow-up, if necessary.
- Regardless of the level of response, the patient and their support person must be advised of the known facts of the incident within 24 hours of identification of the incident by Melbourne Day Surgery.
- See Open Disclosure Framework Flow Chart
- The incident must be recorded in the patient's health care record and on the IIIR Form F1.3 and IIIR Register
- If the incident escalates to a high or very high- risk incident, a high- level response should be initiated. A general level response can also be escalated to a high -level response at the discretion of the senior clinician and the senior manager.

High Level Response

The High -level response involves the full open disclosure process as follows:

Establish the open disclosure team. Senior Management forms an open disclosure team as soon as the severity of the incident has been established. The teams role is to support and assist with managing the open disclosure process and develop a robust plan to ensure that communication is consistent and accurate.

Team members may include the following:

- Patients senior clinician
- Director of Nursing/ Senior Manager or equivalent
- Another involved clinician
- A patient advocate
- If required, CEO

The team meets as soon as possible after the incident to discuss the following:

- Nominating the team leader who communicates with the patient and their support person
- Immediate patient care
- Ongoing patient care and support
- Basic clinical and other facts relevant to the incident
- Level of support for the patient's family and support person
- Level of support for staff and responsibility for providing that support

- How to maintain a consistent approach in discussions with the patient and their support person.

Reporting of very high- level risk to Department of Health.

The Department of Health has a schedule of Sentinel Events that require reporting. The Sentinel Event form must be completed via https://www.bettersafercare.vic.gov.au/our-work/incident-response/sentinel-events/how-to-report

Notifying the Medical Defence Organisation

It the incident is significant or involves the high level open disclosure response, it is recommended that Medical Practitioners contact their Medical Defence Organisation at the earliest practical opportunity for advice and support, at the same time meeting any insurance notification obligations.

Notifying other people/ groups

Other notifications may include (subject to observing applicable privacy requirements):

- The patient's General Practitioner
- The Coroner (note that the patients family and support person must be notified if the Coroner is notified)

Meeting with the patient

The initial disclosure meeting with the patient and their support person may involve the team leader, the person(s) directly involved with the treatment that resulted in the incident and the responsible Senior Clinician.

The discussion should include:

- An explanation of what happened and the known facts
- An apology
- The contact names and phone numbers of people in the health facility who are available to address concerns and complaints, including psychological and social support contacts
- Names of people on the open disclosure team
- How the incident will be investigated, what tools will be used
- Steps for ongoing feedback
- Anticipated timelines for investigating the incident
- A statement that an explanation of how or why the incident occurred may be delayed until investigations are complete.

If there is a breakdown in communication between the patient/support person and the team leader, the patient should be offered another person as the team leader.

Follow-up with the patient

The purpose of follow-ups with the patient and their support person is to inform them of the progress of any investigations. Follow-ups must be undertaken either in face-to-face interviews or by letter or both. If there are delays in the investigation, frequent updates should be supplied, together with an explanation of the reason for delays. Following discharge of the patient, a series of follow-up arrangements with the patient and their support person may need to be established to provide updates on findings of investigations.

Final follow-up interview and letter

Issues covered in the final follow-up interview and letter are:

- An apology and expression of regret for the harm suffered
- Acknowledgement of the concerns or complaints of the patient and their support person
- Details of the Root Cause Analysis Final Report and explanation of the report in plain English.
- A summary of the factors contributing to the incident and information on measures being implemented to prevent a similar incident from occuring.
- How improvements will be monitored.

See ACSQHC Open Disclosure Flowchart

Record Keeping

The Senior Clinician responsible for the care of the patient must record a summary of communication with the patient and their support person in the patient's healthcare record.

All ongoing developments and communication during and at the completion of the open disclosure process must be recorded.

The recordings include the date and time of each entry, what the patient was told and a summary of agreed actions. Confirmation that an apology was given must also be recorded.

The recording should include only known facts, be objective and not apportion blame.

The Open Disclosure Checklist F-1.12 and Open Disclosure Discussion F-1.13 should be used and kept with patient healthcare record.

Supporting the Clinician

When an incident occurs, the clinicians involved may require emotional and psychological support and advice on how to deal with their response to the incident. Each health facility should have systems in place to ensure that staff are aware and can access adequate support. Opportunities for staff debriefing should be provided as required. Staff involved in the incident should also be advised of the outcomes of the open disclosure process, including recommendations and implementation strategies.

Related Policies and Forms

ACSQHC Open Disclosure Flowchart

Open Disclosure Checklist

Open Disclosure discussion and summary

Legislation, Standards and References:

Australian Commission for Quality & Safety Open Disclosure Framework

National Safety and Quality Health Services Standards Version 2

Australian Commission for Quality & Safety Open Disclosure Flowchart