Open Disclosure MSP-35

National Safety and Quality Health Standards
Links to Standard 1 Criterion 1.11, 1.12

Part 1: Why do we have this procedure?

- To ensure that everyone understands the principles Open Disclosure and its applications at Corymbia Day Hospital

Definitions

What is open disclosure?

Open disclosure describes the way clinicians communicate with patients who have experienced harm during health care. Open disclosure is intended to:

- assist patients that have experienced harm
- guide clinicians, the clinical workforce and health service organisations in supporting patients that have experienced harm
- ensure that health service organisations learn from adverse events.

The main elements of open disclosure for the patient and their carer are:

- an apology or expression of regret
- A discussion with the patient of what happened and any treatment that may be required as a result.
- an opportunity for the patient to relate their experience of the adverse event
- a discussion of the potential consequences of the adverse event
- Information will be given on how the Corymbia Day Hospital is investigating what happened and what steps are being taken to manage the adverse event and prevent recurrence.

When health care does not go to plan, evidence suggests that patients want to know and understand what happened and why. They want to feel there is genuine regret that the event occurred and they want to know that steps will be taken to minimise the risk of similar events occurring again.

Why is open disclosure important?

For clinicians there is often uncertainty and confusion about disclosing information when health care does not go to plan. Actively and openly managing such incidents, including through the exchange of timely and appropriate information, is important for:

- the recovery process of patients
- clinicians to manage their involvement in, and recovery from, adverse events
- health service organisations to learn from errors.

Ideally health service organisations should create environments that encourage identifying and reporting of adverse events. Part of this process requires moving away from blaming individuals to focusing on systems that reduce the possibility of human error.

When is open disclosure required?

Open disclosure is required when a patient has suffered unintended harm during health care. This may be a recognised complication, unanticipated incident, or a result of human or systems error.

Does open disclosure create legal liability?

Open disclosure encourages clinicians to acknowledge that an adverse event has happened and to apologise or express regret for what has occurred.

Open disclosure does not, of itself, create legal liability. Acknowledging an adverse event, apologising or expressing regret, is not an admission of liability. Liability is established by a court and is based on an evidentiary matrix which may, in part, be based on statements made either before or after the event.

Clinicians must be aware of the risk of making an admission of liability during open disclosure. In any discussion with the patient during open disclosure, clinicians should take care not to speculate on the cause of an incident or pre-empt the results of any investigations. They must not apportion blame, or state or agree that they, other clinicians or health service organisations are liable for the harm caused to the patient.

What contributes to successful open disclosure?

Following are some key actions by providers that can contribute to successful open disclosure:

- Establishing the facts (clinical or other)
- Identifying immediate support needs for everyone involved
- Identifying who will take responsibility for discussion with the patient.
- Ensuring the patient medical record is updated.
- Establishing a good rapport and relationship with patients (and their support persons) from the very start of the episode of care.
- Ensuring informed consent is obtained and that the patient has reasonable expectations prior to undergoing the care, treatment or procedure.
- Accurately conveying the risks involved in the procedure and in health care generally.
- Ensuring that patient's support persons are identified formally.
- Acknowledging an unexpected event as soon as possible even if further investigation is required.
- Not speculating on the causes of an incident, making unrealistic promises or blaming yourself or others
- Being respectful to the patient, their support person and your colleagues at all times.
- Demonstrating empathy, and genuine remorse and compassion as appropriate, when talking to patients.
- Listening actively to the patient during disclosure discussions and being aware of your body language.
- Supporting your colleagues.
- Preparing for participation in open disclosure.

Policy

Corymbia Day Hospital Board of Management acknowledges The Australian Open Disclosure Framework endorsed by the Australian Commission on Safety and Quality in Health Care.

Part 2: Who is involved in this procedure?

- All staff

Part 3: What are the steps of the process?

Clinical staff need to report an adverse clinical event as soon as it occurs. The report needs to be verbal to the Director of Nursing or deputy in her absence, then an incident report completed. Clinical notes should reflect all clinical actions taken.

The DON, or deputy, and the CEO will determine what patient and carer follow up will occur following these 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. The open disclosure process is fluid and will often involve the provision of ongoing information.
- **Acknowledgement** All adverse events should be acknowledged to the patient, their family and carers as soon as practicable.
- **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.
- **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.
- **Risk management and systems improvement** The Corymbia Day Hospital Board of Management reviews adverse events and relating processes. System improvements may be identified and implemented.

Clinicians have rights that should be considered during the open disclosure process. The most relevant rights are:

- The right to seek appropriate legal advice and to disclose information to legal advisers in a manner that ensures that it attracts legal professional privilege
- The right to be treated fairly by the institution and to receive natural justice and procedural fairness
- The right not to be defamed
- The right – and on some occasions, the contractual obligation – to seek appropriate advice and guidance from their indemnity insurers or medical defence organisations.

Part 4: Documents and records needed for this procedure, and how are they stored.

Document Title/Form Number	Paper or Electronic	Where are they kept	How long form (years)	Access restrictions	Comments
	P/E		10 years	All staff	
	P/E		10 year		

Part 5: References

Australian Open Disclosure Framework – Better communication, a better way to care | 13
https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework

Open disclosure FAQs: clinicians and healthcare providers
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/open-disclosure-frequently-asked-questions

Further information is available from:

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