AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Frequently asked questions about open disclosure

NOTE FAQs for clinicians and for health service managers are also available at
www.safetyandquality.gov.au/opendisclosure

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,[1] the clinical workforce[2] 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 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 carer(s) to relate their experience of the adverse event

- 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.

Open disclosure is a discussion and an exchange of information that may take place in one conversation or over one or more meetings.

What is the *Australian Open Disclosure Framework*?

The *Australian Open Disclosure Framework* (the Framework) was released in 2013 by the Australian Commission on Safety and Quality in Health Care. The Framework is an updated and revised version of the national *Open Disclosure Standard,* which was released in 2003.

The Framework was developed with input from consumers, clinicians, indemnity insurers, health departments and health service organisations from across the country.

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[1] Clinician is defined as "a healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or a team of health professionals providing health care who spend the majority of their time providing direct clinical care".

[2] Clinical workforce is defined as "the nursing, medical and allied health staff who provide patient care and students who provide patient care under supervision. This may also include laboratory scientists".

The Framework reflects the latest international and Australian evidence and practice of open disclosure. It provides a framework for clear and consistent communication by health service organisation staff with patients when health care does not go to plan. It includes guidance on discussing what has happened, why the incident occurred, and what is being done to minimise the risk of it happening again.

Why was the *Australian Open Disclosure Framework* developed?

The Framework is designed to assist clinicians and health service organisations implementing and practising open disclosure. It provides a nationally consistent basis for open disclosure in Australia. The Framework encourages greater openness about adverse events in health care so that the causes of events can be understood and changes made to minimise the risk of similar events occurring again. It also means that, whenever and wherever their health care does not go to plan, consumers can expect:

- a full explanation of what occurred
- to be treated with respect and consideration.

When health care does not go to plan, patients and their carers 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. The Framework is designed to assist health service organisations meet these expectations and to communicate them openly and fully with patients following adverse events.

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 both for patients, and their family and carers, to recover. It is also important for clinicians to manage their involvement in, and recovery from, adverse events.

Finally, openly discussing adverse events is important for improving the safety and quality of care provided. A key step in this process is health service organisations encouraging greater openness in response to adverse events.

Who is the *Australian Open Disclosure Framework* intended for?

The Framework is principally a resource for organisations improving patient care by implementing open disclosure.

Open disclosure by health service organisations is an accreditation requirement of the *National Safety and Quality Health Service Standards* (the NSQHS Standards).

Health service organisations are accredited to the NSQHS Standards which provide a clear statement about the level of care consumers can expect. NSQHS Standard 1, Criterion 1.16, requires health services to have open disclosure policy and practice in place to be fully accredited.

More information on the NSQHS Standards and accreditation is available at www.safetyandquality.gov.au

Where can patients and consumers find out more about the *Australian Open Disclosure Framework?*

An open disclosure patient information brochure and booklet are available at www.safetyandquality.gov.au/opendisclosure

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 and other staff must be aware of the risk of making an admission of liability during open disclosure. In any discussion with the patient, their family and carers during open disclosure, clinicians and other staff 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.

The *Australian Open Disclosure Framework* provides guidance on what, and what not, to say when conducting open disclosure discussions, and highlights legal issues which should be considered, such as freedom of information, privacy, defamation, and qualified privilege.

There is not much evidence to suggest either an increase or decrease of medico-legal risk due to open disclosure. Anecdotally, patients and their families are motivated to litigate by a sense that information is being withheld, or that communication has been insufficient, or inappropriate, after adverse events.

Will open disclosure increase litigation?

There is not much evidence to suggest that practicing open disclosure either increases or decreases medico-legal risk.

Anecdotally, patients and their families are motivated to litigate by a sense that information is being withheld, or that communication has been insufficient, or inappropriate, after adverse events. The Framework encourages health services to communicate promptly and openly with patients following adverse events.

How is the Australian Commission on Safety and Quality in Health Care assisting with implementation of the *Australian Open Disclosure Framework*?

The Commission ensures that the Framework reflects the latest evidence, practice and advice on conducting, and participating in, open disclosure.

It makes available a range of resources and materials for public and private facilities that implement and practice open disclosure.

The Framework and support materials are available at
www.safetyandquality.gov.au/opendisclosure

Further open disclosure information

Further information is available from:

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