Scope of Policy:	To identify and work within the Australian Open Disclosure Framework.
Document Location:	LOGI**QC**
Area/Department:	Hospital Wide
Distributed to:	All clinical Staff

DEFINITIONS

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.

Australian Commission on Safety and Quality in Healthcare, 2014

RESPONSIBILITIES

Director of Nursing
Perioperative Services Manager
All clinical staff employed at Monash House Private Hospital

PROCEDURE

Open disclosure is the process of open communication with a patient and/or their family, carer or support person, following an adverse or unexpected event that may or may not result in harm to the patient.

The open disclosure process provides an ethical framework for ensuring that staff inform patients, and where applicable their support person, in an open, honest and empathetic manner about a patient related incident and its implications for the health care of those patients.

The Australian Open Disclosure Framework (2014) encompasses eight principles to address the interests of patients, support persons, staff and other key stakeholder groups. These Include:

1. **Openness and timeliness of communication:** Providing patients and their families in a timely, open and honest manner if something has gone wrong.
2. **Acknowledgement:** Staff and MHPH leadership must acknowledge to the patient if an incident or advent event has occurred.
3. **Apology/expression of regret:** An apology or expression of regret must be given as soon as possible to the patient such as saying "we are sorry" without admission of liability.

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4. **Supporting and meeting the needs and expectations of patients, their family and carers:** Patients, family and carers should be given facts of the incident, be provided with empathy and respect and individual support given as appropriate to the patient's needs.
5. **Supporting, and meeting the needs and expectations of those providing health care:** Ensuring the Hospital supports a reporting culture of adverse events, are provided with education and training surrounding Open Disclosure, and provided with guidance and support during the Open Disclosure process.
6. **Integrated clinical risk management and systems improvement:** Adverse events are investigated, and clinical review conducted, and findings integrated into quality improvement initiatives.
7. **Good governance:** Adverse events are properly investigated and managed using risk management processes to prevent re-occurrence.
8. **Confidentiality:** Ensuring patient and staff confidentiality is maintained in alignment with state and federal legislation.

THE OPEN DISCLOSURE PROCESS

Detection of a clinical incident

A clinical incident may be detected by:

- A member of staff at the time of the incident
- When an unexpected outcome is first detected sometime after the incident
- A patient who expresses concern or dissatisfaction with their health care either at the time of the incident or at some time after the incident
- Feedback, Compliment and Complaint processes
- Incident discovered at audit, such as clinical audit or medical records review
- Other sources/people such as family, carers, support person

Following the detection of a clinical incident, members of the clinical team must ensure that steps are taken to immediately prevent or reduce occurrence of further suffering and harm to the patient.

- Assess the incident for severity of harm and response which is assessed as low-level or high-level response (see table below)
- Support and advice for staff involved (refer to Employee Assistance Program policy doc_115) as necessary
- Report the clinical incident to a relevant authority, in accordance with Department of Health policy
- Maintain privacy and confidentiality of staff and patient/family, counsel staff as necessary

Examples of Incident response levels

Incident type	Examples of criteria
Lower-level response	1. Near misses and no-harm incidents 2. No permanent injury 3. No increased level of care (e.g. transfer to operating theatre or intensive care unit) required 4. No, or minor, psychological or emotional distress
Higher -level response	1. Death or major permanent loss of function 2. Permanent or considerable lessening of body function 3. Significant escalation of care or major change in clinical management

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	(e.g. admission to hospital, surgical intervention, a higher level of care, or transfer to intensive care unit) 4. Major psychological or emotional distress 5. At the request of the patient

Source: Australian Open Disclosure Framework (2014)

Initiating the open disclosure process

- Acknowledging to the patient and family, carers that an adverse event has occurred
- Discuss with the patient and set a date, time and location for formal open disclosure meeting, including who shall be present. Provide written confirmation
- Avoid speculation or blame, criticising or discussions of legal liability
- Ensure clear communication and avoid any mixed messages or conflicting information
- Maintain thorough and accurate documentation
- Provide patient with Open Disclosure Patient Information Brochure doc_1627 to read about what open disclosure is
- Consider cultural and linguistic diversity and ensure patient has support (friend, relative or interpreter) as appropriate.

Preparing for open disclosure

- A meeting should be conducted with the DON, POSM, and/or Departmental managers and necessary staff to discuss the plan for proceeding with open disclosure
- Obtain open disclosure documents- Open Disclosure Meeting form (doc_235) and Open Disclosure Documentation and Discussion form (doc_1628)
- The adverse event should be assessed and considered to ensure adequate planning and response
- Determine who shall lead the open disclosure and be involved. The staff member leading the open disclosure should ideally be:
    - be known to the patient, their family and carers
    - be familiar with the facts of the adverse event and the care of the patient
    - be of appropriate seniority to ensure credibility
    - have received training in open disclosure
    - have good interpersonal skills
    - be able to communicate clearly in everyday language
    - be able and willing to offer reassurance and feedback to the patient, their family and carers
    - where possible and appropriate, be willing to maintain a medium to long-term relationship with the patient, their family and carers.
- Obtain all necessary information about the adverse event, being aware of information that may not be available at the time of the open disclosure meeting and discuss and arrange additional meeting when all information is available
- Ensure all staff who will be involved in the open disclosure process have a thorough understanding of the adverse event that took place and the implications and impact that the event has had on the patient
- Consider legal implications and initiate contact with appropriate personnel
- Consider and address billing costs of ongoing care as a result of the adverse event

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- Be mindful that immediate response via open disclosure may not be appropriate given the nature of the event e.g. if the patient suffered significate psychological, emotional or physical harm, open disclosure processes should be deferred (ensure the reason for deferring open disclosure is clearly documented in patient notes).

Conducting open disclosure

- Conduct the open disclosure meeting at the agreed time
- Introduce the staff (including position/roles within the Hospital) to the patient and family/carers
- Give the patient a sincere apology or expression of regret "we are sorry"
- Clearly explain the incident, stick to the facts
- Apply principles of health literacy and appropriate use of communication (written and verbal), in a way that the patient can understand
- Allow the patient and family time to speak, to express their perspective and ask questions
- Support patient expression- encourage the patient to explain how the adverse event has impacted them
- Discuss an open disclosure plan (you may need to hold several meetings). Once agreed, ensure signed by both parties
- Discuss practical support such as re-imbursement of out-of-pocket expenses as a result of the adverse event, who will be taking over care of the patient following the adverse event, how to initiate complaint processes
- Reassure the patient that they will be informed and communicated with, any findings or quality system improvements. Provide emotional and practical support.

Open disclosure follow-up

- Follow up management is lead by DON, POSM or Departmental Manager and is discussed with appropriate staff
- Care planning of the patient reviewed and implemented
- Any organisational changes to practices as a result of quality improve response to the adverse event is shared with the patient

Completing open disclosure

- Provide the patient and family, carers with final written findings and responses to the adverse event
- Discuss the outcomes of the open disclosure process and findings and quality improvement responses at Departmental meeting, SMM, MAC or Board as appropriate
- Request that the patient completes the "Open Disclosure Questionnaire for Patients" (doc_960) to determine and evaluate effectiveness of open disclosure process
- Request that the staff members involved complete the "Open Disclosure Questionnaire for Staff" (doc_959) to determine and evaluate how effective the staff believe the open disclosure process was, their understanding of the process and any possible areas where improvements may be required
- Make appropriate planning and discharge planning for ongoing and continuity of care. Discharge letters and transfer letters should describe the adverse events and clinical outcomes and treatment given, clinical investigations and results.

Documentation

- Ensure all communications are continuously documented in the patients Medical Record, ensure factual with no delays

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- Ensure all documentation thorough and accurate- utilise Open Disclosure Meeting form (doc_235) and Open Disclosure Documentation and Discussion form (doc_1628)
- Ensure all documentation properly dated, timed and signed with person making entry documenting name and designation
- Provide the patient with a copy of the open disclosure documentation
- Additional request for information beyond open disclosure documentation should be managed as per Release of Medical Record Information policy (doc_193).

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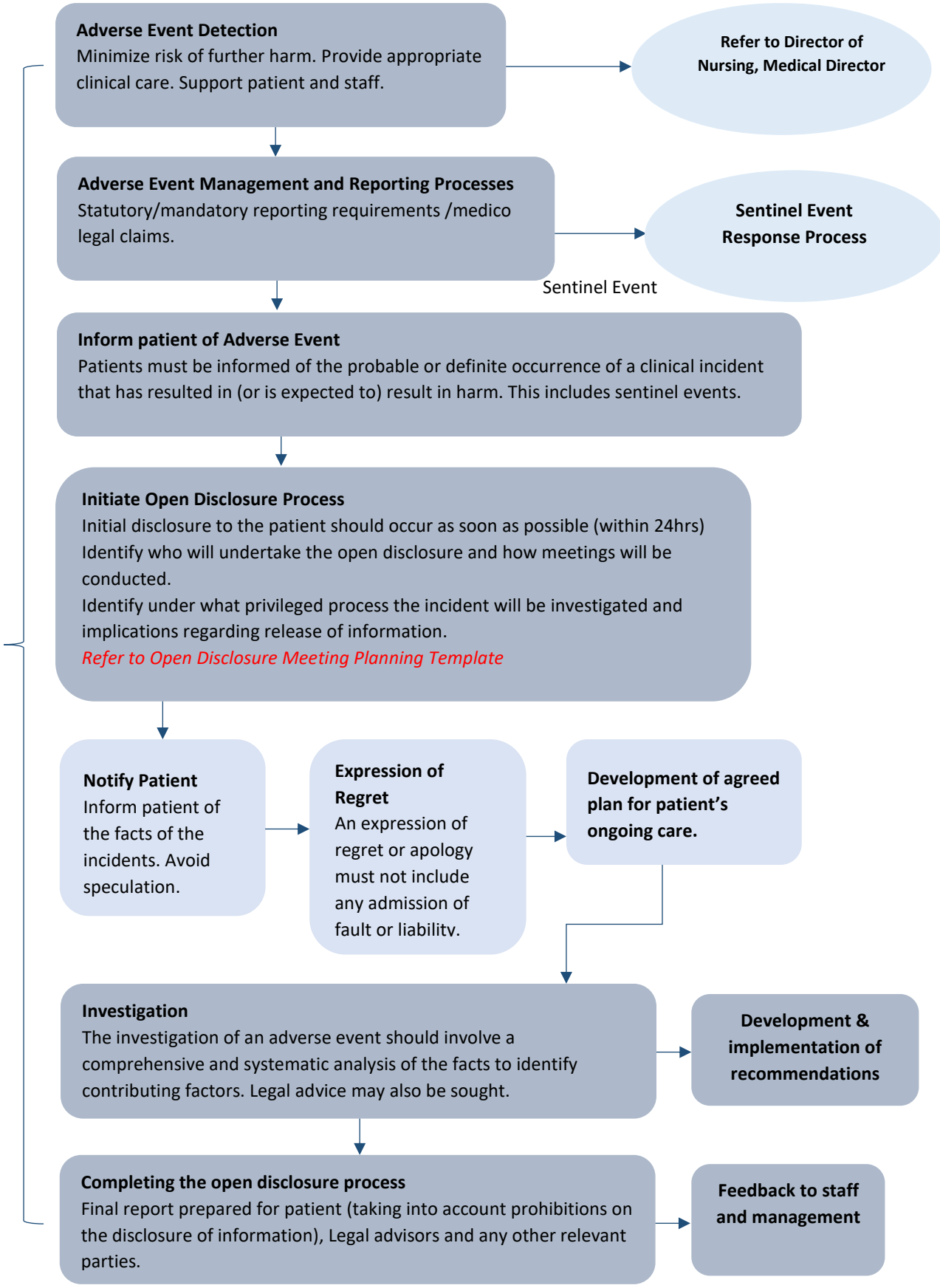

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Saying sorry

It is preferable that the people involved in the incident are involved in saying sorry. The words "we are sorry" or "I am sorry" should be used. Apologies must be sincere. Consider tone of voice, body language, gestures and body language. Staff should understand that an apology is not enough to rectify an adverse event. Acknowledgement of harm must be recognised and communicated, followed by an apology. The following example on how to make an apology was taken from the Australian Open Disclosure Framework (2014):

Box 3:
Examples of appropriate phrases during an apology

- *'I am/we are sorry for what has occurred'*
- Factual statements explaining how the incident occurred (*'this incident occurred because the wrong label was mistakenly placed on your specimen sample'*)
- Explaining what is being done to ensure it does not happen again (*'we are currently investigating exactly what caused this breakdown in the process and will inform you of the findings, and steps taken to try to prevent recurrence, as soon as we know'*)

Examples of phrases to avoid during an apology

- *'It's all my/our/his/her fault … I am liable'*
- *'I was/we were negligent …'*
- Any speculative statements.

Open disclosure needs to assist the patient and families in restoring broken trust in clinicians and the healthcare setting as a whole. Factual explanations can then be provided, which serves to explain the facts surrounding the adverse event.

When preparing for open disclosure, please consider the following:

- Harm should be acknowledged, and an apology or expression of regret provided as appropriate
- There should be no speculation on the causes of an incident
- Blame must not be apportioned to any individual, group or system
- The results of reviews and investigations must not be pre-empted.

Investigation of a Near-miss and "no harm" incidents

Near-miss events should still be managed however at a lower level of response. Near-miss incidents still indicate that there is the potential and risk of reoccurrence, therefore Clinical Governance is still required, and quality improvement responses implemented as appropriate to findings.

Furthermore, "no-harm" incidents clinical incident may still signal a potential and serious breakdown within Hospital's clinical processes that require thorough investigation and response. Any clinical incidents identified must be appropriately investigated to determine what happened to reduce the risk of a similar clinical incident happening again. Staff are required to participate in any investigation that may arise from near-miss or "no harm" incident.

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Undertaking the investigation process under legal privilege

If an investigation into an adverse event is conducted at the request of legal advisers, the communications generated during the investigation, including the investigation report, may be subject to legal professional privilege. If a document or record is subject to legal professional privilege, that document or record is protected from disclosure unless legal professional privilege is waived.

Critical incident debriefing
In the event of a critical incident, a debriefing meeting will be organised by the Departmental Manager and follow up support offered on an individual basis. Staff are also encouraged and supported to engage MHPH's Employee Assistance Program for confidential counselling (Converge). See MHPH's Sentinel Events policy (doc_1056) for management of sentinel events if applicable.

Staff Training and Competency in Incident and Complaints Management
Open disclosure training and education is a mandatory requirement on commencement of employment at MHPH and annually thereafter. Staff can also access education surrounding open disclosure via MHPH's online portal (Ausmed) at any time. Additionally, staff can contact MHPH's Educator any additional education requirements or complete an Education Request form (doc_1196). MHPH is able to monitor staff understanding and knowledge of open disclosure processes through conducting of annual Clinical Staff Survey (doc_842) where staff are questioned about their understanding of open disclosure, triggering opportunity to initiate further training. Likewise, education/training requirements can be discussed during annual performance appraisals.

ASSOCIATED DOCUMENTS

doc_235 Open Disclosure Meeting
doc_1628 Open Disclosure Documentation and Discussion
doc_159 Compliments and Complaints policy
doc_842 Clinical Staff Survey
doc_1196 Education Request form
doc_1626 Australian Open Disclosure Framework
doc_960 Open Disclosure Questionnaire for Patients
doc_959 Open Disclosure Questionnaire for Staff
doc_1627 Open Disclosure Patient Information Brochure

REFERENCES

Open Disclosure Framework http://www.safetyandquality.gov.au/wp-content/uploads/2013/03/Australian-Open-Disclosure-Framework-Feb-2014.pdf
Open Disclosure Training http://vhimsedu.health.vic.gov.au/opendisclosure/welcome.php
Open Disclosure and Management of Adverse Events Learning Package (Dept. of Health)
NSQHS standard 1. Clinical Governance
NSQHS standard 2. Partnering with Consumers
NSQHS standard 6. Communicating for Safety

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