Title:	**Open Disclosure**
Document Type	**Procedure**
Approved by	**Chief Executive Officer**
Reviewer	**Director of Nursing and Clinical Support Services**

TARGET AUDIENCE
Organisational
PROCEDURE:

BACKGROUND INFORMATION:

Central Gippsland Health (CGH) supports and endorses the principles of Open Disclosure as set out in the Australian Open Disclosure Framework 2013
Open disclosure is the process of listening to and acknowledging patient/client/resident/carer experience, concerns and emotions when an adverse event has occurred, it also involves an expression of regret, including the word sorry.
Open disclosure involves providing honest and factual information to the patient/client/resident/carer and generating ideas as to how the patient's needs can be managed and how future care can be best provided. The process will facilitate re-building a relationship of trust between affected patient/client/resident/carers and clinicians.

Central Gippsland Health (CGH) attempts to be as free as possible from adverse events, and supports an environment where people feel supported and are encouraged to identify and report adverse events so that systematic improvements can be identified and acted on. Open and honest communication incorporating wishes and experiences of the patient/client/resident/carer to ensure a patient centred approach is vital to this process. Where the patient/client/resident/carer has low English proficiency, a profession interpreter should be involved

Open Disclosure is a requirement under the Aged Care Quality Standards. There are two specific references to open disclosure in the new standards. Standard 6: Feedback and Complaints, requires providers to use open disclosure process when things go wrong. Standard 8: Organisational Governance, where clinical care is provided, organisations are required to have a Clinical Governance Framework which includes open disclosure.

Identification of the event
An adverse event is an incident in which unintended harm resulted in a person receiving healthcare.
Adverse events requiring open disclosure may be first identified by any of the following mechanisms

- A staff member at the time of the event
- A staff member retrospectively, when unexpected put come is identified
- A patient/client/resident/ carer, visitor or student
- Through CGH Consumer feedback processes
- Through CGH incident reporting or Limited Adverse Occurrence Screening (LAOS) reporting systems

Initial Actions Figure 1 Initial Decision Making flow chart

When an adverse event has been identified the first priority is prompt and appropriate clinical care and prevention of further harm.
Staff who suspect that an adverse event has occurred shall immediately inform their immediate supervisor so that appropriate actions after identification of the event can be taken by the most senior staff member on duty at the time.
This may be the Director of Nursing and Clinical Support Services, Chief Medical Officer, Director of Community Services, Chief Executive Officer, senior Medical Officer or senior nurse (ie Nurse Unit Manager or Hospital Coordinator). They will assist in identifying additional support required for patient/staff.
The event shall be reported through the CGH Incident reporting system or the CGH Limited Adverse Occurrence Screening (LAOS) system in the Riskman program

Consideration needs to be given to the level of response required: Lower level or Higher level. Higher level responses require a more formal approach, led by senior clinician (medical, nursing and /or allied health) trained in the Open Disclosure process and other health service staff as appropriate

Level of response	Consequence of adverse event	Action and level of staff involvement
Low level response	• Near miss/no – harm incident • No permanent injury • No increased level of care required • No or minor psychological or emotional distress	Incident report Local management Disclosure by senior health care professional – Nurse Unit Manager, Registrar, Resident Medical Officer or Allied Health Team Leader, Hospital Coordinator Completion of Open Disclosure Initial Checklist for Clinicians and send to Medical Executive Administration
High level of response	• Death or major permanent loss of function • Permanent or considerable lessening of body function • Significant escalation of care or major change in clinical management (eg admission to hospital, surgical intervention, a higher level of care or transfer to intensive care unit • Major psychological or emotional distress • At the request of patient/client/resident/carer	**This requires Formal Open disclosure response** Incident report Immediate notification of most senior staff member on duty at time Disclosure by senior medical practitioner, DoN &CSS, CEO, DCS or CMO Completion of Open Disclosure Initial Checklist for Clinicians and send to Medical Executive Administration

Important issues to remember:
Do not speculate, attribute blame, criticise other individuals or admit liability

Do not argue with the patient/client/resident, resist the urge to prove you were right, avoid "**But….**"
Understand the issue from the patient/client/resident perspective

It is not always known immediately what the contributing factors are; don't try to speculate

Management of Low Level Open Disclosure Response (Figure 2 Lower level response flow chart)
If the event meets the low level open disclosure requirements:

- The health professional detecting the incident or adverse event and the appropriate Manager will discuss/review the incident/event and decide who will manage the open disclosure with the patient/client/resident/carer. Open disclosure is to take place within 24 hours of the incident/event occurrence if possible.
- A meeting time shall be arranged with the patient/client/resident/carer and or their support team. An interpreter shall be organised if required.
- Discussion with patient/client/resident/carer and or their support person will include:
  - Introduction of persons present and their roles
  - Acknowledgement of what has occurred and how the patient/client/resident/carer has been affected
  - An apology or expression of regret including the words "I am sorry "or "we are sorry"

- Explanation of the facts as they are known at time of discussion, opportunity for questions and clarification
- Inform patient/client/resident/carer and or their support team what will happen – investigations, ongoing communication strategies, including provision of a contact person for patient/client/resident/carer and or support team to contact if they have any further questions
- Sharing of an agreement upon options for follow-up care
- Provide information about complaints/adverse event processed so patient/client/resident/carer and or support team can take further if they wish
- Provide the patient/client/resident/carer and or support team with the following documents:
    - Open disclosure - what to expect if you are experiencing harm during health care?
    - Preparing and participating in open disclosure discussions

- Outcomes of the meeting are to be documented in the patient/client/resident medical/client/resident record and in the incident report
- Complete Open Disclosure Initial Checklist for Clinicians and send to Medical Executive Administration

Management of High Level Open Disclosure Response (Figure 3 Higher Level Response flow chart)

If event meets the high level response requirements:

Notify the Director of Nursing & Clinical Support Services/Chief Medical Officer or Hospital Coordinator (if out of hours) of the event and plan for a Formal Open disclosure process.

- Open disclosure is to take place within 24 hours of the incident/event occurrence if possible.
- Health professional(s) involved in the patient/client/resident/carer adverse event will meet as soon as possible to assess the event, establish basic facts and identify who will be responsible for the open disclosure process and identify any supports this clinician may require
- Establish a consistent approach to discussion with patient/client/resident/carer and or support team
- Determine appropriate timing and location for the open disclosure meeting and if identify who should attend, including interpreter where relevant
- Prepare for meeting and process including completion of the Formal Open Disclosure checklist and plan
- Consider legal and insurance issues
- Consider notification requirements eg coroner and other authorities and ensure that they are notified

As part of the Formal Open Disclosure process discussion with patient/client/resident/carer and or their support person will include:

- Introduction of persons present and their roles
- Acknowledgement of what has occurred and how the patient/client/resident/carer has been affected
- An apology or expression of regret including the words “I am sorry “or “we are sorry”
- Explanation of the facts as they are known at time of discussion, opportunity for questions and clarification
- Inform patient/client/resident/carer and or their support team what will happen – investigations, ongoing communication strategies, including provision of a contact person for patient/client/resident/carer and or support team to contact if they have any further questions
- Sharing of an agreement upon options for follow-up care
- Provide the patient/client/resident/carer and or support team with the following documents:
    - Open disclosure - what to expect if you experience harm during health care?
    - Preparing and participating in open disclosure discussions

- Provide information about complaints/adverse event processed so patient/client/resident/carer and or support team can take further if they wish
- Ongoing communication may be required in many cases and may take place over several meetings as investigation of the event progresses and the clinical consequences become defined

The patient/client/resident/carer will be informed of:

- What will happen in follow-up of the event including further investigation and feedback
- Ongoing contact person details if they have any further questions
- Options for ongoing clinical care
- Options for practical and emotional support

Outcomes of the meeting(s) are to be documented in the patient/client/resident medical/client/resident record and in the incident report

A written account of formal open disclosure meeting(s) should be provided to the patient/client/resident/carer.

Insurer may need to be notified

Particular patient circumstances.

When considering open disclosure, the approach may need to be modified following consideration of the patient's unique circumstances including the following:

- When a patient dies
- **Patients who are children** – their involvement in the disclose process will depend on their age and the wishes of their parent and or guardian
- **Patients with mental health issues** – timing of the disclosure should take into consideration how this will affect the patient/client/resident/carer's health and ability to understand what is being said
- **Patients with cognitive impairment** – power of attorney and or guardianship orders must be taken into consideration when planning open disclosure
- **Patients with a Cultural and Linguistic Diversity** – professional interpreters should be used during open disclosure processes
- **Patients with Aboriginal and Torres Strait Islander background** – every effort should be made to ensure communication is appropriate not only in respect to use of language but also of underlying principle and beliefs regarding health matters
- Patients who disagree with the information provided
- Patients with other communication needs, eg breakdown in relationship between patient/client/resident/carer and or their support person and the health service – offer the patient/client/resident/carer and or their support person another contact whom they may feel more comfortable talking with. This may include complaints or conflict resolution services or mediation

Other factors to consider

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

Staff who are involved in an adverse event may also require emotional support and advice.

Staff involved in open disclosure process should be provided with access to assistance support and information they may need for fulfilling their role on the process.

Staff at CGH may access this support through their Manager and/or Director. There may be a need for formal or informal debriefing to be provided.

The interests and circumstances that individual staff may find themselves in, may not be the same as the organisations expectations and the adverse event may lead to disciplinary procedures or legal liability.

In this instance the correct procedures for these issues will need to be instigated by management however this is not part of the open disclosure process.
All staff have a right to equitable and fair treatment.
Staff have the right to seek advice and guidance from their professional bodies and their indemnifiers and other relevant advisors and to act in accordance with this advice

Privacy and Confidentiality
Staff at CGH will need to take into account the organisations obligation to maintain privacy and confidentiality under the legislation. Consent can be obtained from the patient/client/resident to disclose relevant information to nominated persons.

Defamation
In the context of open disclosure it is possible for a health care professional to be defamed by virtue of a statement either verbal or written, for example that alleges another health care professional is incompetent. It is only necessary under law for the communication to be made to one other person for defamation to occur. It is not even necessary for that person to be referred to by name if it can be shown that the person can be readily identified.
It is critical that all heath care professionals employed at CGH ensure that they are careful in the information that is communicated, either verbal or written and what is said about others during the open disclosure process.

Consideration of Liability
In discussion with patients and their support person/s under open disclosure process, health care professionals shall:

- Acknowledge to patient, their family/carer (if applicable) as soon as possible that an adverse event has occurred
- Acknowledge that the patient/client/resident is unhappy with the outcome
- Provide an expression of sorrow, regret or sympathy (According to the Wrongs Act 1958 (Vic) an expression of sorrow, regret or sympathy which does not include a clear acknowledgement of fault, does not constitute an admission of liability in c civil proceeding)
- Provide known clinical facts and discuss ongoing care
- Indicate that an investigation is being or will be undertaken to determine what has happened and prevent such and adverse event from happening again
- Agree to provide feedback information from the investigation when available
- Provide contact details of a person or person's within CGH that can discuss any ongoing issues

Insurance considerations
An adverse event may involve more than one type of health care professional as care is usually undertaken by multidisciplinary teams. The interest of these parties may be in conflict and it is important that all parties are aware of their own responsibilities in relation to their own relevant insurance requirements. Medical defence organisations and other indemnifiers may provide medico-legal advice to their members and may wish to discuss the member's involvement in the open disclosure process.
Many insurance companies may also have a policy about reporting of an adverse event within a specified time frame and may also impose other restrictions following notification about an adverse event, such as what can and can't be said by staff. The person responsible for overseeing notification for adverse events to the insurance agents for the health service is the Chief Executive Officer (or delegate) and all enquiries should be processed through this department.

Training requirements
All CGH clinical staff are required to complete the CGH Competency "Open Disclosure" three yearly.
Compliance with mandatory competency completion is monitored by department heads and reported monthly into the Accountability Framework

Reporting
Open disclosure events shall be reported to the Clinical Governance group on a 3 monthly basis by medical Administration. Reporting shall include
The number of Open Disclosure processes commenced in a reporting period

- The number of Open Disclosure processes concluded in a reporting period
- The number and percentage of Open Disclosures triggered by;
  - Complaints to CGH
  - Clinical incident notification
  - LAOS notification
  - Patient request.

OUTCOME:
CGH shall provide timely and appropriate disclosure of incidents/events occurring at the Health Service

DEFINITIONS:
Shall: Indicates that the statement is mandatory

Open disclosure
An open discussion with a patient about an incident(s) that resulted in harm to that patient while they were receiving health care. The elements of open disclosure are an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure is a discussion and an exchange of information that may take place over several meetings

Apology
An expression of sorrow, sympathy and (where applicable) remorse by an individual, group or institution for a harm or grievance. It should include the words 'I am sorry' or 'we are sorry'. Apology may also include an acknowledgment of responsibility, which is not an admission of liability.

Adverse Event: An incident in which unintended harm resulted in a person receiving healthcare

Support Person: May be any individual, identified by the patient/client/resident as a nominated recipient of information regarding their care. This may include family, friend(s) partner or carer

References to 'support person' in this document can include:

- family members / next of kin
- carers friends, a partner or other person who cares for the patient guardians or substitute decision-makers
- social workers or religious representatives where available, trained patient advocates.

References to support person should be read with the words, 'where appropriate'.

Legislation
Victorian Health Services Acts 1988
Freedom of Information Act 1982 (Commonwealth)
Victorian Freedom of Information Act 1982
Victorian Wrongs Act 1958
Victorian Charter of Human Rights and Responsibilities Act 2008

Linked documents
Open Disclosure Initial check list for Clinicians
Formal Open disclosure Checklist and Plan
Open disclosure - what to expect if you experience harm during health care?
Preparing and participating in open disclosure discussions
Aged Care Open Disclosure Framework and Guidance

Consumer Feedback (Complaints & Compliments)
Organisational Structure

References:

Maryborough Hospital Open Disclosure procedure

Department of Health website http://www.health.vic.gov.au/clinrisk/opendisc.htm accessed 21/8/2014

Australian Open Disclosure Framework. Australian Commission on Safety and Quality in Health Care December 2013

http://www.safetyandquality.gov.au/wp-content/uploads/2013/03/Australian-Open-Disclosure-Framework-Feb-2014.pdf

Open Disclosure Northern Health 10/3/2014

Focus Area(s):
National Safety and Quality Health Service Standards – Standard 1
Aged Care/Home Care Standards –Standard 1, 2,3,6,8

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