Subject: Open Disclosure HW-055

Purpose:	The purpose of this policy and Procedure is to ensure a coordinated and consistent approach to Complaint and Incident management using the Open Disclosure process.
Responsible for Review:	Senior Management Committee
Approved by:	CEO/DON
Reference:	Risk Management Standard AS4360 : 2004 Australian Open Disclosure Framework Better communication: a better way to care 2013 NSQHSS 1.5, 1.6, 1.16.1, 1.16.2

1. Policy

Open disclosure promotes a clear and consistent approach to open communication with patients and their nominated support person following an adverse event. It includes guidelines for discussion about what has happened, why it happened, and what is being done to prevent it happening again.

Level of Response

Lower level responses can be conducted at the time of the incident, if a higher level response is necessary, it will be conducted as part of the RCA process, the CEO/DON is the only Open Disclosure Officer who works with RCA teams to formulate and authorise Open Disclosure communication and correspondence where warranted.
CEO/DON is the Official Open Disclosure Officer.

The criteria for determining the appropriate level of response is presented in Table 2

Table 2:

	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 (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

Maryvale Private Hospital follows the eight guiding principles of Open Disclosure as set out below:

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/complaints will be acknowledged to the patient and their support person as soon as practicable. Maryvale Private Hospital will acknowledge when an adverse event has occurred and initiate the open disclosure process.

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 carer(s)

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

Maryvale Private Hospital has created an environment in which all staff are:

- encouraged and able to recognise and report adverse events
- supported through the open disclosure process.

Integrated risk management and systems improvement

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

Good governance

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

Confidentiality

Maryvale Private Policies and procedures are developed with full consideration of the patient's, carer's and staff's privacy and confidentiality, in compliance with relevant law, including Commonwealth and state/territory privacy and health records legislation.

2. Procedure

Key Elements of Process

The key elements of an open disclosure process are presented in Table 1, if incident is a complaint this process needs to be in conjunction with the complaints process – see QM-005 Customer Complaints Policy

Table 1

1. Incident Detection	• Detect adverse event/complaint through a variety of mechanisms • If Adverse event/outcome provide prompt clinical care to the patient to prevent further harm • Assess the incident for severity of harm and level of response • Provide support for staff • Initiate a response, ranging from lower to higher levels • Notify relevant personnel and authorities • Ensure privacy and confidentiality of patients and clinicians are observed
2. Signalling the need for open disclosure	• Acknowledge the adverse event/outcome to the patient, their family and carers including an apology or expression of regret • A lower-level response can conclude at this stage • Signal the need for open disclosure (higher level response) o Negotiate with the patient, their family and carers or nominated contact person the formality of open disclosure required o the time and place for open disclosure o who should be there during open disclosure o Provide written confirmation o Provide a health service contact for the patient, their family and carers o Avoid speculation and blame o Maintain good verbal and written communication throughout the open disclosure process
3. Preparing for open disclosure	• Hold a multidisciplinary team discussion to prepare for open disclosure • Consider who will participate in open disclosure • Appoint an individual to lead the open disclosure based on previous discussion with the patient, their family and carers • Gather all the necessary information • Identify the health service contact for the patient, their family and carers (if this is not done already)
4. Engaging in open disclosure	• Provide the patient, their family and carers with the names and roles of all attendees • Provide a sincere and unprompted apology or expression of regret including the words 'I am sorry' or 'we are sorry' • Clearly explain the incident • Give the patient, their family and carers the opportunity to tell their story, exchange views and observations about the incident and ask questions • Encourage the patient, their family and carers to describe the personal effects of the adverse event • Agree on, record and sign an open disclosure plan • Assure the patient, their family and carers that they will be informed of further investigation findings and recommendations for system improvement • Offer practical and emotional support to the patient, their family and carers • Support staff members throughout the process • If the adverse event took place in another health service organisation, include relevant staff if possible. • If necessary, hold several meetings or discussions to achieve these aims

5. Providing Follow up	• Reach an agreement between the patient, their family and carers and the clinician, or provide an alternative course of action • Provide the patient, their family and carers with final written and verbal communication, including investigation findings • Communicate the details of the adverse event, and outcomes of the open disclosure process, to other relevant clinicians • Complete the evaluation surveys
6. Completing the process	• Reach an agreement between the patient, their family and carers and the clinician, or provide an alternative course of action • Provide the patient, their family and carers with final written and verbal communication, including investigation findings • Communicate the details of the adverse event, and outcomes of the open disclosure process, to other relevant clinicians • Complete the evaluation surveys
7. Maintaining documentation	• Keep the patient record up to date • Maintain a record of the open disclosure process • File documents relating to the open disclosure process in the patient record • Provide the patient with documentation throughout the process

3. Training and Education

Open Disclosure Communication with Patient & Family following adverse events

Orientation – Open disclosure

4. Associated Documents

Incident Report

HW-017 Incident and non conformance management

RCA template

Maryvale Private Open Disclosure checklist-plan and documentation and discussion summary template – see attached

Maryvale Private Satisfaction Survey

Maryvale Compliment or Complaint Form

5. Monitoring and Evaluation

- Monthly Incident and Non conformance reporting – tabled at Senior Management, Departmental Heads Safe Practice & Environment & Clinical Committee, BOD receive Board Report with 3 monthly Incident and Non conformance reporting
- regular quality audits that focus on specific indicators for best practice

Maryvale Private Open Disclosure checklist and plan

- *All personnel involved in the first meeting with the patient must read and agree upon the contents of this document.*

It is important to note that open disclosure is not a one-way provision of information but an open exchange of information that may take place in several meetings over a period of time.

Data

Patient's full name (including title)	
UR and date of birth	

Admission diagnosis and comments about management etc.	
Patient admission date	

Names and relationships of relevant next of kin/family members/carers	
Date of incident triggering the open disclosure process	
Incident description *Known facts only*	
Incident outcome *Known facts only, avoid cause and effect statements*	
Plan for further incident management and investigation *(such as RCA, report to department, Coroner)*	
Health professionals involved in patient care *It is recommended that clinicians involved in adverse events be given the option to participate in the disclosure. (consultants, anaesthetist and others as appropriate.)*	

First meeting

Does the patient require an interpreter? *If yes, provide details of language and arrangements that have been or to be made*	
Has the patient (if able) consented to sharing information with family members/others? *Give details*	
Has the insurer been notified? *Include date of notification*	
Date of first meeting	
Location of first meeting *Other details such as room booking, arrangements to ensure confidentiality if shared ward etc.*	
Patient/family understanding of the incident prior to the first meeting	
Person to be responsible for note taking	

Planning the disclosure dialogue	**Notes**
Who will speak first, provide introductions and so on?	
Anticipated patient concerns at this time if known	
Apology or expression of regret *Avoid admissions of liability*	
Description of what happened *Known facts only, avoid blaming individuals and self*	
Listening to patient, family/carer concerns (ensure they are offered the opportunity to express/relate their experience and is listened to)	
Discussion of what will happen next *(such as OR, further treatment, investigation into the incident)*	
Information to be provided about short/long-term effects	
Assurance for patient/support person that they will be informed when further information comes to hand	

Information about further support available to the patent and family	
Information provided in relation to how to take the matter further at any time *(such as internal and external complaint process. Avoid discussion about compensation without insurer consent, do not give legal advice but suggest patient seeks legal advice if information about compensation sought.)*	
Next meeting date and location	

First meeting outcomes

Actual date and location of meeting	
Names of all present at first meeting *Include titles/position/relationship to patient etc.*	
Concerns expressed by patient/family including requests for further information to be supplied	
Further support personnel identified *(such as pastoral worker, social worker)*	
Responsibility for documentation of the meeting in the medical record	
Name(s) of personnel given to patient/family if they have further questions prior to subsequent meetings	

Evaluation

Evaluation of this open disclosure process	

Follow Up meeting

Has the insurer been notified? *Include date of notification*	
Date of meeting	
Location of meeting *Other details such as room booking, arrangements to ensure confidentiality if shared ward etc.*	
Person to be responsible for note taking	

Planning the disclosure dialogue	**Notes**
Who will speak first, provide introductions and so on?	
Anticipated patient concerns at this time if known	
Update of what has happened since first meeting *Known facts only*	
Listening to patient, family/carer concerns (ensure they are offered the opportunity to express/relate their experience and is listened to)	
Discussion of what will happen next *(such as OR, further treatment, investigation into the incident)*	
Assurance for patient/support person that they will be informed when further information comes to hand	
Information about further support available to the patent and family	
Information provided in relation to how to take the matter further at any time *(e.g. internal and external complaint process. Avoid discussion about compensation without insurer consent, do not give legal advice but suggest patient seeks legal advice if information about compensation sought.)*	
Next meeting date and location	

Meeting outcomes

Names of all present at meeting *Include titles/position/relationship to patient etc.*	
Concerns expressed by patient/family including requests for further information to be supplied	
Further support personnel identified *(such as pastoral worker, social worker)*	
Responsibility for documentation of the meeting in the medical record	

Evaluation

Evaluation of this open disclosure process	

Maryvale Private Hospital Open Disclosure documentation and discussion summary template

Open disclosure discussion - summary *complete this form following each open disclosure discussion with patient, family, carer(s) or other support persons, and file in the appropriate section of the medical record*

Affix patient ID sticker or clearly enter details below

Patient's full name	
URN or ID (if applicable)	
Date of birth	

Date of incident:

Date of discussion:

Mode of communication (face-face, telephone,):

Staff member who led open disclosure discussion

Name:

Position:

Other staff present (list names and positions)

1. Name:
Position:

2. Name:
Position:

3. Name:
Position:

4. Name:
Position:

Name of patient's support persons who attended the meeting

Name:_____

Relationship to patient: _____

Brief factual summary of incident

Summary of all points explained to patient and support persons

Was an **apology** or **expression of regret** offered? (please circle) Yes No

If not, why?

Summary of support offered to patient and support persons and responses to offers:

Health service contact (staff member assigned as point of contact for patient and support persons)

Name:

Position:

Telephone:

Email:

Plans for follow-up:

Date of next meeting (if arranged): N/A

We hereby confirm that this is an accurate reflection of the discussion:

Staff signature: Date:

Print name:

Patient / support signature: Date:

Print name:

Open Disclosure Patient Questionnaire

Please tick appropriate box.

No.	Question	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	I understand what happened to me or my relative during the hospital stay	☐	☐	☐	☐	☐
2	I received enough information after the event to understand what happened	☐	☐	☐	☐	☐
3	I understand what the organisation will do to prevent this happening to someone else	☐	☐	☐	☐	☐
4	I could have the people I wanted present during discussions	☐	☐	☐	☐	☐
5	The doctors and nurses involved in discussions with me were helpful and supportive	☐	☐	☐	☐	☐
6	Telling me what went wrong could have been done better	☐	☐	☐	☐	☐
7	I was given the opportunity to express/relate my experience in relation to the incident	☐	☐	☐	☐	☐
8	My questions were answered to my satisfaction	☐	☐	☐	☐	☐
9	I understand how the health organisations investigate a serious incident and tell families about them.	☐	☐	☐	☐	☐
10	I am satisfied with the outcome of the open disclosure meetings	☐	☐	☐	☐	☐
11	I know who to contact if I have any further questions	☐	☐	☐	☐	☐
12	I would rather not have known about what happened	☐	☐	☐	☐	☐

Please add any comments you would like to make about your experience of open