1. POLICY STATEMENT

Purpose

To inform staff of the Heidelberg Endoscopy and Day Surgery Centre corporate policy on Open Disclosure. It is the policy of Heidelberg Endoscopy and Day Surgery Centre to support a philosophy of open discussion of an adverse event that results in unintended harm to a patient whilst receiving health care at any of its Facilities. Harm may occur at the time or later. This Policy reflects the intent of the National Open Disclosure Standard: Australian Commission on Safety and Quality in Healthcare 2003 and as reprinted in 2008, and of the Australian Open Disclosure Framework 2013 (ACSQHC).

2. POLICY

The Heidelberg Endoscopy and Day Surgery Centre Policy on Open Disclosure:

- Heidelberg Endoscopy and Day Surgery Centre supports a philosophy of open discussion of an adverse event – an incident in which unintended harm resulted to a person receiving heath care; reflecting the intent of the National Open Disclosure Standard (Australian Commission on Safety and Quality in Healthcare).
- Medical practitioners and staff function in accordance with the Heidelberg Endoscopy and Day Surgery Centre philosophy open disclosure whilst taking account of the rights of all parties concerned, including patients.
- Communication on the part of the facility and/or the private treating doctor following an adverse event is conducted in an open, honest and consistent way with patents and their carers.
- Open disclosure and an apology ("I'm sorry" or "we are sorry") is not an admission of liability.
- The timing of the disclosure is a matter for the facility and/or the private treating doctor, based on several factors, including:
    - the extent to which the facts of the event are known
    - when the facts of the event are known
    - the availability of expert advice, if required
    - the availability of, and if the private treating doctor is to disclose or be involved jointly with the facility in the disclosure
- Privacy issues are to be considered when decisions are made about the timing, location and participants in the process of open disclosure. These are matters for resolution on a case by case basis.
- Confidentiality and regard for the privacy of all concerned with an adverse event is the responsibility of all parties and is to be maintained.

- There are circumstances that exist where the risk of disclosure outweighs the benefit to the patient. Any decision not to disclose in these circumstances is taken into consultation with and on the medical advice of the private treating doctor.
- Open disclosure is to be documented on the patient incident report and the patient medical record (if an inpatient at the tie of disclosure).
- Patients and staff, who are involved in clinical incidents and/or consequent open disclosure, may require support.

PRINCIPLES OF OPEN DISCLOSURE

Australian Open Disclosure Framework:

1. 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 on ongoing information.

2. Acknowledgement

Adverse events should be acknowledged to the patient, their family and carers a soon as practicable.

3. 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. And apology is not an admission of liability.

4. 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

5. Supporting, and meeting the needs and expectations of those providing health care

An environment should be created in which all staff are:

- Encouraged and able to recognise and report adverse events
- Prepared through training and education to participate in open disclosure
- Supported through the open disclosure process.

6. Integrated clinical risk management and systems improvement

Thorough clinical review and investigation of adverse events and adverse outcomes should be conducted through processes that focus on the management of clinical 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 incidents from the open disclosure process should be incorporated into quality improvement activity.

7. Confidentiality

Policies and procedures should be developed with full consideration for patient and clinician privacy and confidentiality, in compliance with relevant law (including federal, state and territory privacy and health records legislation).

3. RISK RATING LOW

4. PROCEDURE

1. Incident Detection and Notification

Adverse Events may be identified via a variety of mechanisms:

- Staff or a doctor at the time or retrospectively
- Patient of family/carer feedback
- Incident Management System
- Compliant mechanism
- Clinical Audit
- Clinical review systems and processes

The management of the incident is accordance with policy 2.13 Incident Management, and will include:

- Providing prompt clinical care to the patient to prevent further harm
- Asses the incident for severity of harm
- Notifying relevant personnel, e.g. the treating medical office, next of kin, carer, and internal notifications e.g. department manager, GM/DON
- Initiation of an appropriate response/investigation
- Providing support for staff
- Ensuring privacy and confidentiality of patients and clinicians is observed
- Entry of the incident into the Incident Management System

2. Signalling the need for open disclosure

The process of determining whether to proceed with open disclosure is to consider:

- The consequences of the event
- Circumstances where the where the harm to the patient outweighs the benefit of disclosure. Any decision not to disclose in these circumstances is taken in consultation with and on the medical advice of the private treating doctor.
- The timing of the disclosure, which is a matter for the facility and/or the private treating doctor, based on a number of factors, including:
    - the extent to which the facts of the event are known
    - when the facts of the event are known
    - the availability of expert advice, if required
    - the availability of, and if the private treating doctor is to disclose or be involved jointly with the facility in the disclosure
- Whether or not, in circumstance where the patient has been discharged, disclosure can wait until next review by the private treating doctor.
- The most appropriate location for the disclosure to occur.

Always disclose	Generally, disclose	Disclose if ongoing safety risk
Harmful incident	No harm incident	Near miss

3. Preparing for Open Disclosure

The decision to disclose an incident must consider the following:

- Whether a decision between parties (GM/DON, medical practitioner) is required to prepare for open disclosure
- Who should disclose to the patient/carer is determined by the circumstances under which the need to make the disclosure arise and the respective roles and responsibilities of the private doctor and Heidelberg Endoscopy and Day Surgery Centre under these circumstances.
- For formal open disclosure processes, no other Heidelberg Endoscopy and Day Surgery Centre staff member (other than the facility nominated representative) is permitted to discuss the adverse event with the patient or any person representing the patient.
- It is encouraged that the disclosure be completed in a collaborative way and be led by the most appropriate person in a senior leadership role, with the knowledge and skills to facilitate the disclosure discussion.
- Whether the disclosure be a joint process involving the treating doctor and facility.
- If the circumstances giving rise to the disclosure relates to medical care and treatment, then the treating specialist should lead the disclosure.
- If the circumstances giving rise to the disclosure relates to services provided by the hospital, then the Facility should lead the disclosure.

- The gathering of all the necessary information.
- Identification of a contact person for the patient, their family and carers – if required.

4. Open Disclosure Discussion

The elements of open disclosure discussion are:

- An apology or expression of regret
- A factual explanation of what happened
- An opportunity for the patient to relate their experience, views and recollection of the incident, including providing the opportunity for the patient, their family and carers to describe the personal effects of the adverse event, and to share what matters there are of significance to them or specific questions they would like answered
- A notation of the patient/carer involvement in the process made in the investigation report
- The potential consequences
- The steps being taken to manage the event and to prevent recurrence
- When an investigation is being conducted
- The nature of the investigation (e.g. RCA, CSR, M&M review)
- The timing of the investigation and how long it will take
- What the patient/carer can expect to be advise of during and following the investigation
- Offer of ongoing support

5. Follow Up

Follow up may include:

- During the investigation, it is encouraged that the hospital keeps in regular contact with the patient/carer – even if there is nothing to be told
- Ensuring follow-up with the patient, where appropriate
- Agreeing on future care, where applicable
- Sharing the findings of investigations and the resulting practise changes, e.g. via the Shared Learnings Report, clinical governance meetings

6. Completing the Process

Following open disclosure, it may be necessary for the person undertaking the disclosure to:

- Provide the patient, their family and carers with final written and/or verbal communication, including investigation findings (whichever is preferred by the patient)
- Communicate the details of the adverse event and outcomes of the open disclosure process to other relevant clinicians

7. Maintaining Documentation

Recoding of disclosure is to be recorded in the Patient Incident form and clinical record.

Documentation is to include the following:

- Date and time of disclosure
- The full name and position of the person/s who made the disclosure
- To whom the disclosure was made (full name/s) and their relationship to the patient
- A brief outline of the discussion
- The agreed outcomes
- Further follow up

TRAINING

Open disclosure training is required to be completed by managers on commencement of employment/orientation.

5. LOCATION OF ADDITIONAL INFORMATION

6. REFERENCES / RELEVANT ACTS

Author: National Director – Clinical Risk and Patient Safety

- Australian Open Disclosure Framework: Australian Commission on Safety and Quality in Healthcare (2013)
- Key Differences Between the Australian Open Disclosure Framework and the Open Disclosure Standard: Australian Commission on Safety and Quality in Healthcare (2013)
- Open Disclosure Principles, Elements and Process: Australian Commission on Safety and Quality in Healthcare (2013)
- Saying Sorry, A guide to apologising and expressing regret during open disclosure: Australian Commission on Safety and Quality in Healthcare (2013)
- National Open Disclosure Standard: Australian Commission on Safety and Quality in Healthcare (2013)
- Australian Private Hospitals Association Position on Open Disclosure
- Corporate Governance – Good Principles: AS 8000, Standards Australia, 2003

Approved by:	***Loretta Gya***
Original Date Approved:	04/12/2014
Date Reviewed:	01/12/2014
Date Reviewed:	01/07/2018
Date Reviewed:	21/02/2021
Review Date Due:	15/02/2024

Version Number	***Version Date Issued***	***Authorised Person***	***Amendment Details***	***Reason***
1.0	06/11/2014	L.B. Gya	New Policy	
2.0	16/12/2014	L.B. Gya	Addition to procedure	
3.0	15/02/2021	L.B. Gya	Revised Policy	