ANAM CARA HOUSE GEELONG

TITLE: Open Disclosure – CORP 108
TYPE: Policy and Procedure

PURPOSE

This policy and procedure is to inform staff on how to manage an Open Disclosure process following an adverse event. Open Disclosure (OD) is an integral part of incident management. This policy reflects the intent of the Australian Open Disclosure Framework (2013). Open disclosure is a function of sound clinical governance and is an element of the Anam Cara House Geelong (ACHG) quality and safety program.

SCOPE

This procedure applies to all clinical staff of ACHG

POLICY

ACHG supports a philosophy of open discussion of an adverse event- an incident in which unintended harm occurs as a consequence of a person receiving healthcare. Harm may occur at the time of the event or later.

Communication on the part of ACHG and/or the treating doctor following an adverse event is conducted in an open, honest and consistent way with guests 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 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

The rights of all parties concerned are considered during the open disclosure process. Confidentiality of all discussions with those concerned is the responsibility of all parties.

Privacy issues are to be considered when decisions are made about the timing, location and participants in the process of open disclosure.

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 in consultation with and on the medical advice of the treating doctor.

Open disclosure is documented on the incident report and in the guest record.

Guests and staff who are involved in clinical incidents and/or consequent open disclosure, may require support.

PRINCIPLES OF OPEN DISCLOSURE

The Australian Open Disclosure Framework (2013) is intended to contribute to improving the safety and quality of health care and to promote a clear and concise framework. The framework enables health service organisations and clinicians to communicate openly with patients and their significant others when health care does not go to plan. ACHG follows the eight guiding principles of Open Disclosure as set out below:

1. Open and timely communication- If things go wrong, the guest, 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.
2. Acknowledgement- All adverse events should be acknowledged to the guest, their family and carers as soon as practicable. ACHG will acknowledge when an adverse event has occurred and initiate Open Disclosure
3. Apology or expression of regret- As early as possible, the guest, 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.
4. Supporting and meeting the needs and expectations of guests and their carers- The guest, 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 and supported in a manner appropriate to their needs.

5. Supporting and meeting the needs and expectations of those providing health care- ACHG has created an environment in which all relevant staff are encouraged and able to recognise and report adverse events, are prepared through training and education to participate in open disclosure and are 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 will be conducted through processes that focus on the management of clinical risk and quality improvement. Findings of these reviews focus on improving systems of care and are reviewed for their effectiveness. The information obtained about incidents from the open disclosure process will be incorporated into quality improvement activity.
7. Good governance- Open disclosure requires good governance frameworks and clinical risk and quality improvement processes. Through ACHG safety and quality systems, adverse events are investigated and analysed to prevent them recurring. Good governance by ACHG's senior management, leadership or Board of Directors ensures appropriate changes are implemented and their effectiveness is reviewed. Good governance includes internal performance monitoring and reporting.
8. Confidentiality- Policies and procedures are developed by ACHG with full consideration for guest and clinician privacy and confidentiality, in compliance with relevant laws (including Commonwealth, state and territory privacy and health records legislation).

PROCEDURE

Process Steps	Responsibilities
1. OD Procedure	
○ Where a guest has experienced harm ▪ as the result of care provided by staff at ACHG the Open Disclosure process is to commence. If harm has been experienced as the result of care provided by a credentialled health professional e.g., Medical Consultant or treating doctor, open disclosure is the responsibility of, and at the discretion of, that health professional. ▪ As notified via an incident, a complaint, a guest record review or from individual staff, volunteer, guest, carer or visitor	*Director of Clinical Services* *Clinical Staff*
○ Notify the Director of Clinical Services (DCS) of the incident. DCS will notify the CEO, who will in turn notify the Board. ○ Complete Incident and Near Miss Report Form- CORP 041 ○ In consultation with the Director of Clinical Services (and/or the Quality and Safety Manager) and the treating Doctor, follow the steps in the OD process utilising the flow charts below ○ Feedback on OD process outcome to Clinical Risk, Quality and Safety Committee and Doctors and Nurses Committee	*QM*

Figure 1

Flow chart outlining the key steps of open disclosure (S = Section in the *Australian Open Disclosure Framework*)

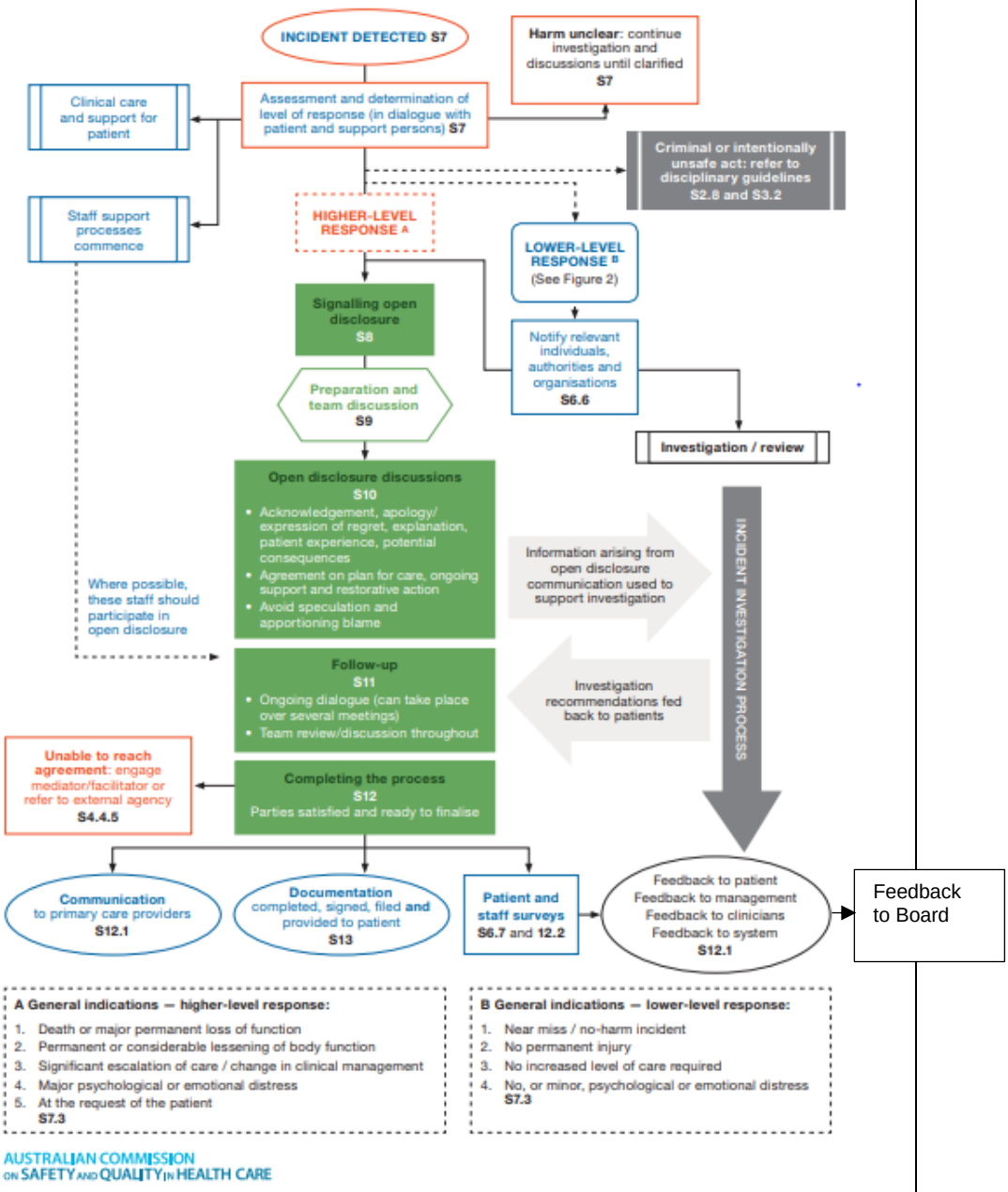

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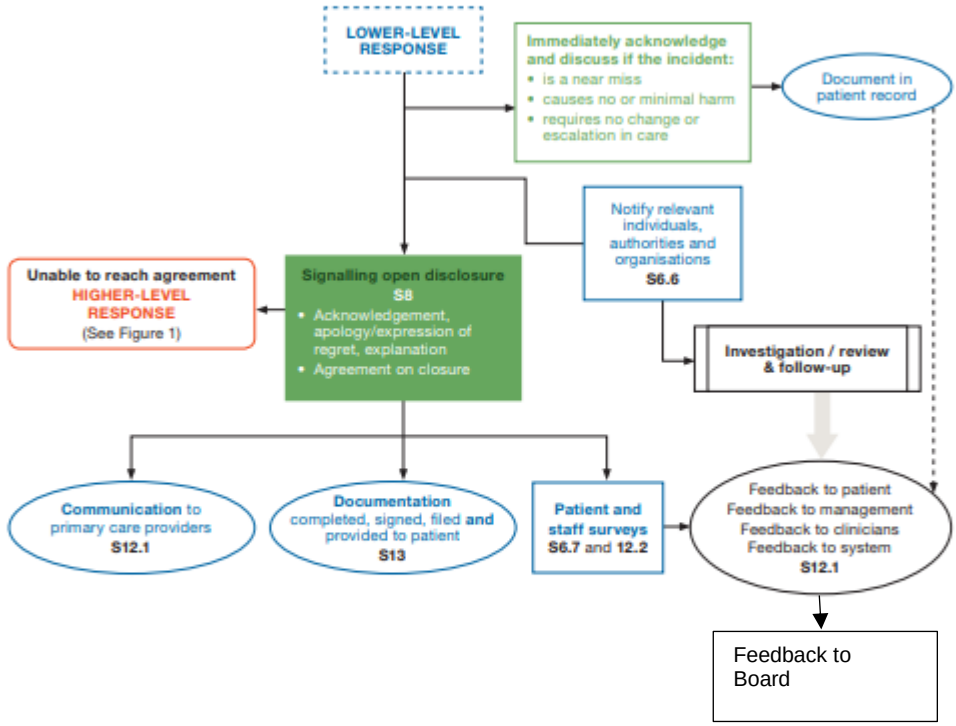
Figure 2

Flow chart outlining lower-level response

(S = Section in the *Australian Open Disclosure Framework*)



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2. Resources

The Australian Open Disclosure Framework authored by the Australian Commission for Safety and Quality in Health Care provides a number of useful resources to aid the OD process. Suggested resources: -

- OD Framework Guide for Managers
- OD Process checklist
- OD Documentation template
- OD Flow chart for consumers
- OD Guide for patients
- OD Just-in-time information

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DEFINITIONS
ACHG – Anam Cara House Geelong OD – Open Disclosure
RELATED POLICY, PROCEDURE and FORMS
Incident and Near Miss Report Form- CORP 041 Clinical Near Miss Incident Flow Chart- CLIN 594 Incident and Near Miss Reporting- CORP 174 Compulsory reporting- CORP 143
REFERENCES
The Australian Open Disclosure Framework (2013) authored by the Australian Commission for Safety and Quality in Health Care Healthscope Open Disclosure Policy and Procedure 2.30 August 2020

AUTHORISED BY	**Chief Executive Officer**