Open Disclosure Policy

It is a legal obligation under the Victorian Charter of Human Rights & Responsibilities Act 2006 (Vic) for public entities (including health services) to discuss adverse events with the affected patient and/or their family/carer.
In March 2013 the Australian Commission on Safety and Quality in Health Care published the Australian Open Disclosure Framework to provide a nationally consistent basis for communication following unexpected healthcare outcomes and harm. The framework replaces the former Open Disclosure Standard endorsed at the Australian Health Ministers Conference in July 2003.

Purpose

All Staff at The Digestive Health Centre will be educated in and will practice in accordance with the Australian Open Disclosure Framework. The Open Disclosure Frameworks Short Course available from the Department of Health will form part of the DHC's Yearly Education Schedule HR-001-F011.

Definition

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.

It is important to note that open disclosure is not a one-way provision of information. Open disclosure is a discussion between two parties and an exchange of information that may take place in several meetings over a period of time. (AODF 2013 11)

The Eight Principals of the 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 of ongoing information. (AODF 2013 12-13)

2. Acknowledgement
   - All adverse events should be acknowledged to the patient, their family and carers as soon as practicable. Health service organisations should acknowledge when an adverse event has occurred and initiate open disclosure. (AODF 2013 12-13)

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. (AODF 2013 12-13)

4. Supporting, and meeting the needs and expectations of patients, their family and carers
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. (AODF 2013 12-13)

5. Supporting, and meeting the needs and expectations of those providing health care
Health service organisations should create an environment 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 (AODF 2013 12-13)

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. Findings 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. (AODF 2013 12-13)

7. Good governance
    - Open disclosure requires good governance frameworks, and clinical risk and quality improvement processes. Through these systems, adverse events should be investigated and analysed to prevent them recurring. Good governance involves a system of accountability through a health service organisation's senior management, executive or governing body to ensure that appropriate changes are implemented and their effectiveness is reviewed. Good governance should include internal performance monitoring and reporting. (AODF 2013 12-13)

8. Confidentiality
    - Policies and procedures should be developed by health service organisations with full consideration for patient and clinician privacy and confidentiality, in compliance with relevant law (including Commonwealth, state and territory privacy and health records legislation). However, this principle needs to be considered in the context of Principle 1: Open and timely communication. (AODF 2013 12-13)

Just Culture

Blaming individuals when an adverse event occurs is unproductive and may have the effect of:
- Creating an environment of fear and distrusting which the reporting of adverse events in unlikely to occur
- Obscuring the underlying or root cause of the incident which must be addressed if a recurrence of the incident is to be prevented
- Disregarding the implication of organisational and system issues which contribute to adverse events.

Instead of a culture that assigns blame DHC will actively promote "Just Culture"
It is a term that refers to a culture that is both fair to staff who make errors and effective in reducing safety risks. In a Just Culture staff know that safety is valued in the organisation, and they look for risks that pose a threat to that safety.

The Open Disclosure Procedure

1. Detecting and assessing incidents
    - Detect adverse event through a variety of mechanisms
    - 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 an appropriate response, ranging from lower to higher levels
    - Notify relevant personnel and authorities
    - Ensure privacy and confidentiality of patients and clinicians are observed (AODF 2013 14-15)

2. Signalling the need for open disclosure
    - Acknowledge the adverse event 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 - LOW RM-003-F003 or HIGH - RM-003-F004
    - Negotiate with the patient, their family and carers or nominated contact person
        - the formality of open disclosure required
        - the time and place for open disclosure
        - who should be there during open disclosure
    - Provide written confirmation
    - Provide a health service contact for the patient, their family and carers
    - Avoid speculation and blame
    - Maintain good verbal and written communication throughout the open disclosure process (AODF 2013 14-15)

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) (AODF 2013 14-15)

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 (AODF 2013 14-15)

5. Providing follow-up
   - Ensure follow-up by senior clinicians or management, where appropriate
   - Agree on future care
   - Share the findings of investigations and the resulting practice changes
   - Offer the patient, their family and carers the opportunity to discuss the process with another clinician (e.g. a general practitioner) (AODF 2013 14-15)

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 (AODF 2013 14-15)

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 (AODF 2013 14-15)

Particular Patient Circumstances

Differing patient circumstances and situation can affect the process of Open Disclosure. Circumstances to be considered include but are not limited to:

- Children and young people. Their involvement in open disclosure will need to be assessed on a case by case basis and will take into account the maturity or the child and the appropriateness sand desire of the child to include their parents or guardians in the open disclosure process.
- Patients with a Mental Illness. The timing and content of the disclosure should be subject to the clinical team's assessment of how the information will affect the patient and also the patient's ability to understand the information.
- Patients with Cognitive Impairment. In the absence of a patient's informed consent, guardianship orders or power of attorney must be carefully considered when assessing disclosure of an adverse event.
- Diverse Communities. Where someone has difficulty with communicating in English then a professional interpreter should be used. Using family members as an interpreter should be discouraged. Consideration and sensitivity will be given to issues relating to sexual orientation, gender identity and intersex conditions.

Records

Open Disclosure Framework – Located in the boardroom
Yearly Education Plan HR-001-F011
Staff Register

References

State Government of Victoria, Australia, Department of Health
http://vhimsedu.health.vic.gov.au/opendisclosure/menu.php

Australian Open Disclosure Framework – Better communication, a better way to care. Australian Commission on Safety and Quality in Health Care.
http://www.safetyandquality.gov.au/Australian-Open-Disclosure-Framework

Version	Date	Author	Description
1	15/04/2014	DON	Initial policy
2	18/10/2017	CEO	Reviewed no changes
3	05/02/2020	DON	Checked references and updated
4	04/03/2022	DON/BOM	Updated Signal the need for open disclosure - LOW RM-003-F003 or HIGH - RM-003-F004