Purpose

To ensure patients, families/ consumers receive timely, factual, open and honest communication about any incident that resulted in harm to the patient whilst an admitted at Western Private Hospital.
A process will be formalised for reporting of and monitoring of adverse events.

Target Audience

Executive and Clinicians Western at Private Hospital

Definition

Open Disclosure is an open discussion with a patient/consumer about an incident that resulted in harm or could have resulted in harm to the patient while they were admitted to Western Private Hospital.
Adverse Event An incident that results or could have resulted in harm to a patient or consumer

Consumer a person who has or may potentially use health services or is a carer for a person using health services

POLICY OUTCOME
Patients, consumers, families and carers of Western Private Hospital (WPH) will receive appropriate information regarding any significant adverse event in which they are involved.

POLICY:
Western Private Hospital embraces the practice of Open Disclosure as outlined in the Australian Open Disclosure Framework 2013.

Although the majority of procedures that take place in the healthcare industry results in a positive outcome for patients, modern health care carries a significant risks and, at times, things do not go to plan. Adverse events and patient harm can and do occur

Open disclosure describes the way clinicians communicate with and support patients, their families and carers when they have experienced harm during a health care episode.

The Australian Open Disclosure Framework 2013 defines the Open Disclosure process as,

> ***'An open discussion with a patient about an incident(s) that resulted in harm to them 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,*
- *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.
Open disclosure is a patient right, is anchored in professional ethics, considered good clinical practice, and is part of the care continuum
<u>There are 8 Open Disclosure Principles.</u>

1. Openness and timeliness of communication –providing information to patients, their family and carers in a timely, open and honest manner.

2. Acknowledgement – Any adverse event should be acknowledged as soon as is practicable.

3. Apology or expression of regret – the patient and/or family/carer should receive and apology or expression of regret for any harm resulting from the adverse event as soon as possible. The use of the words "I'm sorry' or 'we are sorry' is recommended however there should not be speculative statements, liability of blame or apportioning of blame.

4. Supporting and meeting the needs and expectations of patients, their families and carers – should expect to be fully informed of facts surrounding incident, treated with empathy, respect and consideration, be supported in a manner appropriate to their needs.

5. Supporting and meeting the needs and expectations of those providing health care – staff should be encouraged to recognise and report adverse events, be trained and educated to participate in open disclosure, be supported through the open disclosure process.

6. Integrated clinical risk management and systems improvement – adverse events and outcomes shall be thoroughly reviewed, investigated and reported identifying opportunities for improvement

7. Good governance – effective open disclosure requires good governance frameworks where clinical risk management and quality improvement process exist...

8. Confidentiality – policies and procedures should exist within the healthcare facility that relate to the patient and clinician privacy and confidentiality during an open disclosure process.

9. Notification to the hospital insurer of all incidents of adverse events where Open Disclosure has taken place

Theses 8 principles shall be adopted into the routine management of incidents and adverse events at WPH.

PROCEDURE
Guidelines for holding an open disclosure discussion

1. The patient, their family and carers are told the name and role of everyone attending the meeting, and this information is also provided in writing.

2. A sincere and unprompted apology or expression of regret is given on behalf of the health service organisation and clinicians, including the words 'I am' or 'we are sorry'

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Examples of appropriate phrases during an apology

- *'I am/we are sorry for what has occurred'*
- *Factual statements explaining how the incident occurred ('this incident occurred because the wrong label was mistakenly placed on your specimen sample')*
- *Explaining what is being done to ensure it does not happen again ('we are currently investigating exactly what caused this breakdown in the process and will inform you of the findings, and steps taken to try to prevent recurrence, as soon as we know')*

Examples of phrases to avoid during an apology

- *'It's all my/our/his/her fault … I am liable'*
- *'I was/we were negligent …'*
- *Any speculative statements.*

3. A factual explanation of the adverse event is provided, including the known facts and consequences of the adverse event, in a way that ensures the patient, their family and carer

understand the information, and considers any relevant information related earlier by the patient, family and carers. Speculation should be avoided.

4.The patient, family and carers have the opportunity to tell the clinicians their story about the adverse event to explain their views on what happened contribute their knowledge and ask questions (the patient's factual explanation of the adverse event). It will be important for the patient, their family and carers that their views and concerns are listened to, understood and considered.

5.The patient, family and carers are encouraged to talk about the personal effect of the adverse event on their life.

6. An open disclosure plan is agreed and recorded in which the patient, their family and carers outline what they hope to achieve from the process and any questions they would like answered. This shall be documented and a copy provided to the patient, family or career.

7.The patient, their family and carers are assured that they will be informed of any further reviews to determine why the adverse event occurred, the nature of the proposed process and the expected time frame. The patient, their family and carers are given information about how feedback will be provided on the investigation findings, by whom and in what timeframe, including any changes made to prevent recurrence.

8. An offer of support to the patient, their family and carers should include:

a. ongoing support including reimbursement of out-of-pocket expenses incurred as a result of the adverse event
b. assurance that any necessary follow-up care or investigation will be provided promptly and efficiently
c. in relevant settings, clarity on who will be responsible for providing ongoing care resulting from the adverse event
d. contact details for services they may need to access
e. information about how to take the matter further, including any complaint processes available to them.

9.The patient, their family and carers engage in open disclosure with staff. Staff are supported by their colleagues, managers and health service organisation, both personally (emotionally) and professionally (including through appropriate training, preparation and debrief;

10.In cases where the adverse event spans more than one location or service, health service staff will ensure that, where possible, all relevant individuals from these additional institutions are involved in the open disclosure process

It is not necessary to cover every component in the first disclosure meeting. For instance, a full explanation of why an adverse event occurred may not be possible until the causative factors are known.

Information for patients, families, clinicians and managers shall be kept in the Sentinel Event/ Open Disclosure folder located in the Peri Operative Services Unit, Surgical Ward nurses station and the Cardiac Services Nurses' station

A written account of the open disclosure meeting should be provided to the patient, their family and carers.

RESPONSABILITIES

Open Disclosure is primarily the responsibility of the Consultant, the Chief Executive Officer and Director of Nursing. All managers need to be aware of the principles and processes of open disclosure.

EDUCATION and TRAINING

Training shall be provided to the Executive Management of Western Private Hospital and information regarding Open Disclosure obligations shall be communicated to all consultants credentialed at WPH in the WPH By Laws.

Staff will be given the opportunity to attend education sessions on the open disclosure process.

INCIDENT REPORTING

Open disclosure conversations shall be documented in the relevant Riskman incident.

MONITORING

Open Disclosure processes shall be audited 2nd yearly through a scheduled audit on the WPH Quality Plan. Monitoring of executive education shall be managed by the executive PA and the clinical educator.

Evaluation

Regular document revision and review of relevant RiskMan reports
Notification to Safer Care Victoria of Sentinel Events

Key Aligned Documents

Near Miss, Incident, Accident Policy
Privacy Policy
Sentinel Events Resource Folder – surgical ward, peri operative services, cardiology services

Key Legislation, Acts & Standards

National Safety and Quality Health Services Standards Second Edition 2017 Standard 1 Action 1.11

References

Australian Commission on Safety and Quality in Healthcare National Standards – Governance 2012
Australian Open Disclosure Framework 2013

DOHH, Victoria, Open Disclosure self-learning package 2015
Information Brochures – Australian Commission on Safety and Quality in Health Care

Version History & Author

Date Created / Reviewed *(Mmm/YYYY format)*	**Section(s) Changed** ***(eg procedure / definitions / references)***	**Created/Amended by** ***(position title)***
Aug. 2015	Created	Quality Manager & CEO
Nov. 2019	Reviewed	Quality Manager
Feb 2021	Reviewed	Quality Manager & DON