POLICY	OPEN DISCLOSURE	
THE BAYS	Category:	Organisational
	Person responsible:	Director of Nursing
	Approved by:	Clinical Practice
	Scope:	Acute & Aged Care

1. INTRODUCTION

The purpose of this Policy & Procedure is to inform staff how to manage an Open Disclosure process following an adverse event. Open Disclosure is an integral part of incident management. This procedure should be read in conjunction with the Incident & Injury Reporting Policy & Procedure.

2. PURPOSE

All staff are able to perform an open disclosure in accordance with The Bays Open Disclosure Policy & Procedure.

3. DEFINITIONS

Open disclosure

An open discussion with a patient about an incident(s) that resulted in harm to that patient 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 and 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.

Adverse event

An incident in which harm resulted to a person receiving health care.

Apology

An expression of sorrow, sympathy and (where applicable) remorse by an individual, group or institution for a harm or grievance. It should include the words "I am sorry" or "we are sorry". Apology may also include an acknowledgement of responsibility, which is not an admission of liability.

Expression of regret

An expression of sorrow for a harm or grievance. It should include the words "I am sorry" or "we are sorry". An expression of regret may be preferred over an apology in special circumstances (e.g. when harm is deemed unpreventable).

Carer

A person who provides unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or general frailty. Carers include parents and guardians caring for children.

A person is not a carer if he or she provides this support and assistance under a contract of service or a contract for the provision of services, or in the course of doing voluntary work for a charitable, welfare or community organisation, or as part of the requirements of a course of education or training.

Near miss

Generally open disclosure is not required unless ongoing patient safety risk.

Support person

An individual who has a relationship with the patient. References to "support person" in this document can include:

- family members/next of kin
- carers
- friends, a partner or other person who cares for the patient
- guardians or substitute decision-makers
- social workers or religious representatives
- where available, trained patient advocates

References to support person should be read with the words "where appropriate"

Lower-level response

A briefer open disclosure process, usually in response to incidents resulting in no permanent injury, requiring no increased level of care (e.g. transfer to operating theatre or intensive care unit), and resulting in no, or minor, psychological or emotional distress (e.g. near misses and no-harm incidents). These criteria should be determined in consultation with patients, their family and carers.

Higher-level response

A comprehensive open disclosure process usually in response to an incident resulting in death or major permanent loss of function, permanent or considerable lessening of body function, 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 an intensive care unit), or major psychological or emotional distress. These criteria should be determined in consultation with patients, their family and carers.

A higher-level response may also be instigated at the request of the patient even if the outcome of the adverse event is not as severe.

4. POLICY

The Open Disclosure Standard was replaced with the Open Disclosure Framework in 2013. It is intended to contribute to improving the safety and quality of health care and promotes a clear and concise framework enabling health service organisations and clinicians to communicate openly with patients and their significant others when health care does not go to plan.

Supporting this policy is the Board of Directors as outlined in the Organisational Manual (Compliance to AS4269-1995; Complaints Handling) regarding release of medical information and rights on access to medical records.

The Bays Healthcare Group Inc. has taken into account and is aware of legal implications in regard to compliance to open disclosure standard principles, both Commonwealth and State, and general law principles.

The Bays Healthcare Group Inc. follows the eight guiding principles of Open Disclosure as set out below:

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.

2. Acknowledgement

All adverse events should be acknowledged to the patient, their family and carers as soon as practicable. The Bays Healthcare Group will acknowledge when an adverse event has occurred and initiate Open Disclosure.

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.

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.

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

The Bays Healthcare Group has created 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.

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 The Bays systems, adverse events are investigated and analysed to prevent them recurring. Good governance by The Bays Healthcare Group senior management, executive 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 The Bays Healthcare Group 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).

5. REFERENCES

AS/NZS ISO 9001:2015, "Quality Management Systems – Requirements", 5th edition, *International Standardisation Organisation Standards Australia/ Standards New Zealand,* standard:

5.1 Leadership and commitment
5.1.1 General.
5.1.2 Customer Focus
7.1 Resources
7.1.2 People
7.5 Documented Information
7.5.1 General
7.5.2 Creating and updating
7.5.3 Control of documented information
8.5 Production and Service Provision
8.5.1 Control of production and service provision
9.1 Monitoring, Measurement, analysis and evaluation

NSQHS National Safety and Quality Health Service Standards – Second edition
Standard 1: Clinical Governance
Standard 2: Partnering with Consumers

Australian Aged Care Quality Agency Accreditation Standards
Standard 1: Management Systems, Staffing & Organisational Development
1.6 Human Resources

Australian Open Disclosure Framework, Better communication a better way to care, Australian Commission on Safety and Quality in Health Care, Canberra: Commonwealth of Australia, 2014

Key differences and changes between the OD Framework and OD standard, Australian Commission on Safety and Quality in Health Care, Canberra: Commonwealth of Australia, 2013

Open Disclosure Standard: A National Standard for Open Disclosure in Public and Private Hospitals, following an adverse event in Health Care, Australian Council for Safety and Quality in Health Care, Canberra: Commonwealth of Australia, 2003

Open Disclosure for Victorian health services: a guide book, DHS, Melbourne, Victoria, 2008

Open Disclosure Flow Chart for Healthcare Consumers, Australian Commission on Safety and Quality in Health Care website http://www.safetyandquality.gov.au/wp-content/uploads/2013/05/A3-Open-Disclosure-Flow-Chart-Consumers-May-2013.pdf