LEADING EDGE FAMILY MEDICINE AND SKIN CANCER CLINIC

Open Disclosure

Definition of open disclosure

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.

The purpose of this policy

The Australian Open Disclosure Framework (the Framework) is a national initiative of the Australian, and state and territory governments, in conjunction with private health services, through the Australian Commission on Safety and Quality in Health Care (the Commission). It is intended to contribute to improving the safety and quality of health care.

Open disclosure is an inherently complex and difficult process. This document provides a flexible framework designed to be used by health service organisations in all settings and sectors when developing or amending policies and procedures for open disclosure. Organisations should develop open disclosure policies and procedures that are tailored to local needs and resources, and the relevant legal, regulatory, institutional and cultural context. In particular, policies and procedures should include the following:

- Appropriate training and education for relevant staff to ensure a consistent and informed approach to open disclosure.
- Mechanisms for involving consumers and clinicians in developing policies and procedures.
- Insurer requirements of health service organisations and professionals, and procedures for involving them in policy development at an early stage. The Open Disclosure Standard Review Report contains information and references that can be of use in developing local open disclosure policy and practice.

Open Disclosure principles

- *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.

- *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.

- *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.

- *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.

- *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.

- *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.

- *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.

- *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.

Open disclosure procedure

- 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 a response, ranging from lower to higher levels

- 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
  - 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

- 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)

- Engaging in open disclosure discussions
  - 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

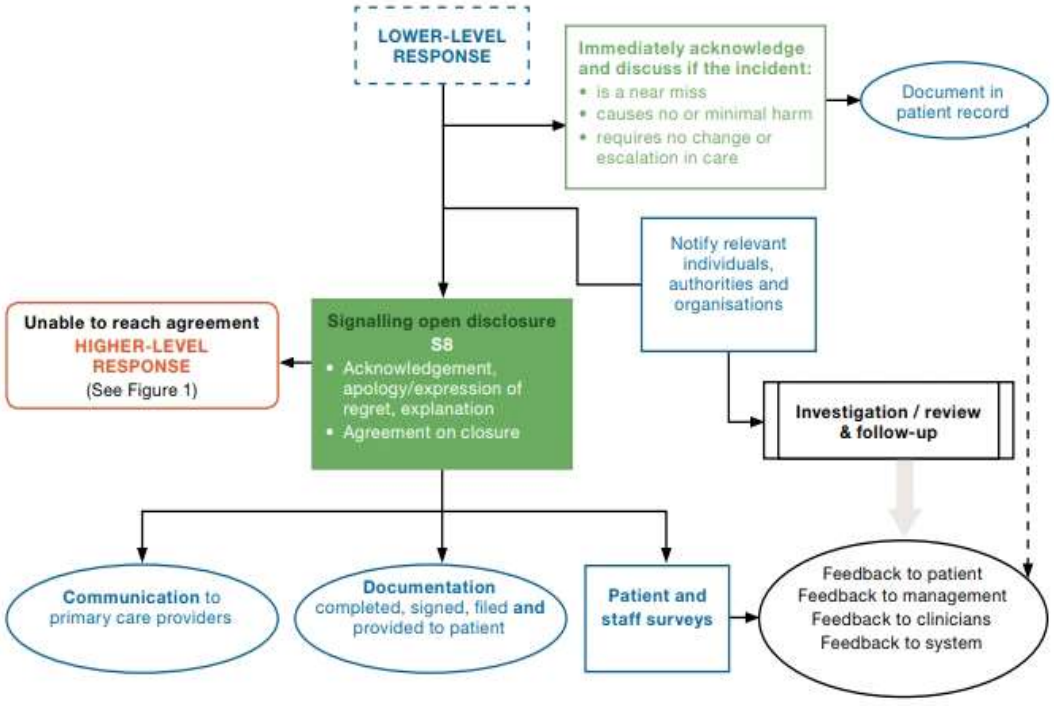
- Providing follow-up

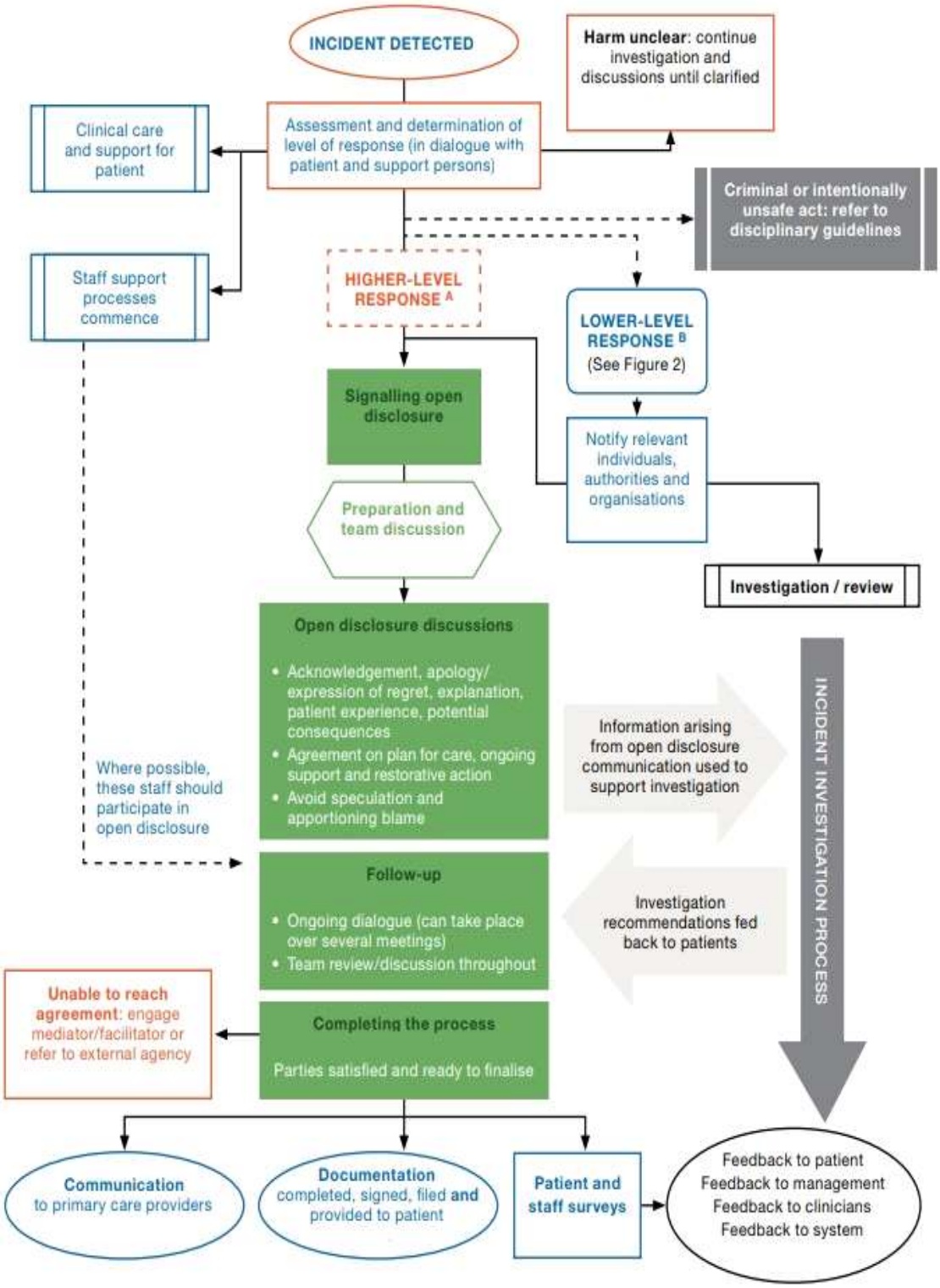
- Ensure follow-up by senior clinicians or management, where appropriate
- Agree on future care
- Share the findings of investigations and the resulting practice changes
- Offer the patient, their family and carers the opportunity to discuss the process with another clinician (e.g. a general practitioner).

- 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

- 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

Flow chart outlining the key steps of open disclosure





Conclusion

Leading Edge Family Medicine and Skin Cancer Clinic will document all incidents within the Open Disclosure framework in a separate template. This template would be called Leading Edge Family Medicine and Skin Cancer Clinic, Open Disclosure Documentation and Discussion Summary.

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