Open Disclosure Policy

This Policy

- sets out the minimum requirements for implementing open disclosure within CheckUP
- outlines minimum requirements expected from contracted service providers
- describes when open disclosure is required
- defines the two stages of the open disclosure process
- outlines the roles and responsibilities for CheckUP staff in relation to open disclosure
- includes open disclosure as a key element of the early response to a patient safety incident.

Purpose and Background

This policy sets out the minimum requirements for a consistent open disclosure process within CheckUP, to ensure that consumers and staff are:

- communicating effectively about a patient safety incident
- provided with an opportunity to recount their experiences, concerns and feelings, and are listened to
- treated respectfully and provided with ongoing care and support for as long as is required.

What is Open Disclosure?

Open disclosure is a process for ensuring that open, honest, empathic and timely discussions occur between patients and/or their support person(s) and health service staff following a patient safety incident (1).

Open disclosure is:

- a consumer's right
- a core professional requirement of ethical practice and an institutional obligation
- a normal part of an episode of care should the unexpected occur
- a critical element of clinical communication and
- an attribute of high-quality health services and an important part of healthcare quality improvement.

Related Documents

- CheckUP Risk Management Framework (0034)
- CheckUP Clinical Governance Policy (B008)
- CheckUP Clinical Governance Framework (B024)
- CheckUP Clinical Incident Policy and Procedure (O151)
- CheckUP Clinical Incident Report Form (F034)
- CheckUP Clinical Incident Register
- CheckUP Feedback Policy and Procedure (O132)
- CheckUP Health Information Management Policy (O110)
- CheckUP Privacy Policy (B026)
- The Australian Charter of Health Care Rights (2nd edition, 2020)
- Australian Commission on Safety and Quality in Health Care (ACSQHC) Australian Open Disclosure Framework
- Australian Commission on Safety and Quality in Health Care (ACSQHC) Open Disclosure Standard

Definitions

Adverse event – an incident in which unintended harm resulted to a person receiving healthcare.

Expression of regret – an expression of sorrow for the harm experienced by the patient that will occur in accordance with the Civil Liability Act.

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 intensive care unit), or major psychological or emotional distress.

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.

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).

Open Disclosure - the open discussion of incidents that result in harm to a patient while receiving healthcare.

Requirements

The requirements for health services in the implementation of the open disclosure policy following a patient safety incident are based on the principles outlined in the *Australian Open Disclosure Framework*[1]. These principles address the complex interests of patients, clinicians, managers, health services and other key stakeholder groups such as healthcare consumers, medical indemnity insurers and professional organisations. The requirements are as follows:

1. acknowledgement of a patient safety incident to the patient and/or their support person(s), as soon as possible, generally within 24 hours of the incident. This includes recognising the significance of the incident to the patient.
2. truthful, clear and timely communication on an ongoing basis as required.
3. providing an apology to the patient and/or their support person(s) as early as possible, including the words “I am sorry” or “we are sorry”.
4. providing care and support to patients and/or their support person(s) which is responsive to their needs and expectations, for as long as is required.
5. providing support to those providing healthcare which is responsive to their needs and expectations.
6. an integrated approach to improving patient safety, in which open disclosure is linked with clinical and corporate governance, incident reporting, risk management, complaints management and quality improvement policies and processes. This includes evaluation of the process by patients and their support person(s) and staff, accountability for learning from patient safety incidents and evidence of systems improvement.
7. multidisciplinary involvement in the open disclosure process.

[1] Australian Commission on Safety and Quality in Health Care (2013), *Australian Open Disclosure Framework,* ACSQHC, Sydney. https://www.safetyandquality.gov.au/sites/default/files/migrated/Australian-Open-Disclosure-Framework-Feb-2014.pdf

Implementation

Role of CheckUP

To build a positive culture by learning from all patient safety incidents so that staff understand the requirements of open disclosure and can identify and report when a patient safety incident has occurred as per CheckUP's *Clinical Incident Policy and Procedure (O151).*

Ensure that contracted health services are aware of the requirements of the *Australian Open Disclosure Framework*[2] and implement accordingly within their service.

Role of contracted health services

Actively commit to open disclosure for all patient safety incidents and create and support an environment where the focus is on patient-based care.

Enable timely open disclosure through actively promoting a just and fair culture that ensures all staff in the health service are supported and encouraged to identify and report when a patient safety incident has occurred.

Build a positive culture by learning from all patient safety incidents.

Ensure an open disclosure program is in place and is consistent with the national *Open Disclosure Standard*[3]; and that the clinical workforce are trained in open disclosure processes.

Ensure that a record of the patient safety incident or complaint and the open disclosure is made in the patient's healthcare record, the incident management system and relevant authorities depending on the severity of the incident.

[2] Australian Commission on Safety and Quality in Health Care (2013), *Australian Open Disclosure Framework,* ACSQHC, Sydney. https://www.safetyandquality.gov.au/sites/default/files/migrated/Australian-Open-Disclosure-Framework-Feb-2014.pdf

[3] Australian Commission on Safety and Quality in Health Care, *Open Disclosure Standard,* ACSQHC, 2008. https://www.safetyandquality.gov.au/sites/default/files/migrated/OD-Standard-2008.pdf

Role of the State, Federal Authorities, Peak Bodies

- collaborate with health services to provide advice and support for clinicians and health managers on open disclosure issues and scenarios
- provide information to support open disclosure for clinicians
- provide information about open disclosure for patients and their support person(s)
- provide information about open disclosure for health service boards, clinical councils and peak quality committees.

Response

Table 2 describes lower-level and higher-level responses linked to criteria for harm that may be used to delineate lower-level and higher-level responses.

The investigation and management of clinical incidents should be managed as per CheckUP's *Clinical Incident Policy and Procedure (O151).* Incidents should be handled internally by all contracted health service providers however, any incident reported directly by a consumer to CheckUP should be assessed by the following criteria to determine CheckUP's appropriate level of response.

Table 2: Criteria for determining the appropriate level of response to an incident

	Criteria
Higher-level response (SAC 1,2)	1.death or major permanent loss of function 2.permanent or considerable lessening of body function 3.significant escalation of care or major change in clinical management (e.g. present to emergency department, surgical intervention, other higher level of care) 4.major psychological or emotional distress 5.at the request of the patient
Lower-level response (SAC 3,4, and consumer complaint - other)	1.near misses and no-harm incidents 2.no permanent injury 3.no increased level of care (e.g. need for domiciliary care) required

	4. no, or minor, psychological or emotional distress

Low level responses will be handled internally at the discretion of the CEO's delegate, including the implementation of CheckUP's *Clinical Incident Policy and Procedure (O151).*

High level responses will occur with assistance from the CEO/FO/Board of Directors. May require referral to Media and Communications team, and/or legal advice, and/or insurer.