waverleyendoscopy

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 Framework's eight guiding principles are:

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. Health service organisations should 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 (see Section 1.5).

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

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.

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.

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.

8. CONFIDENTIALITY

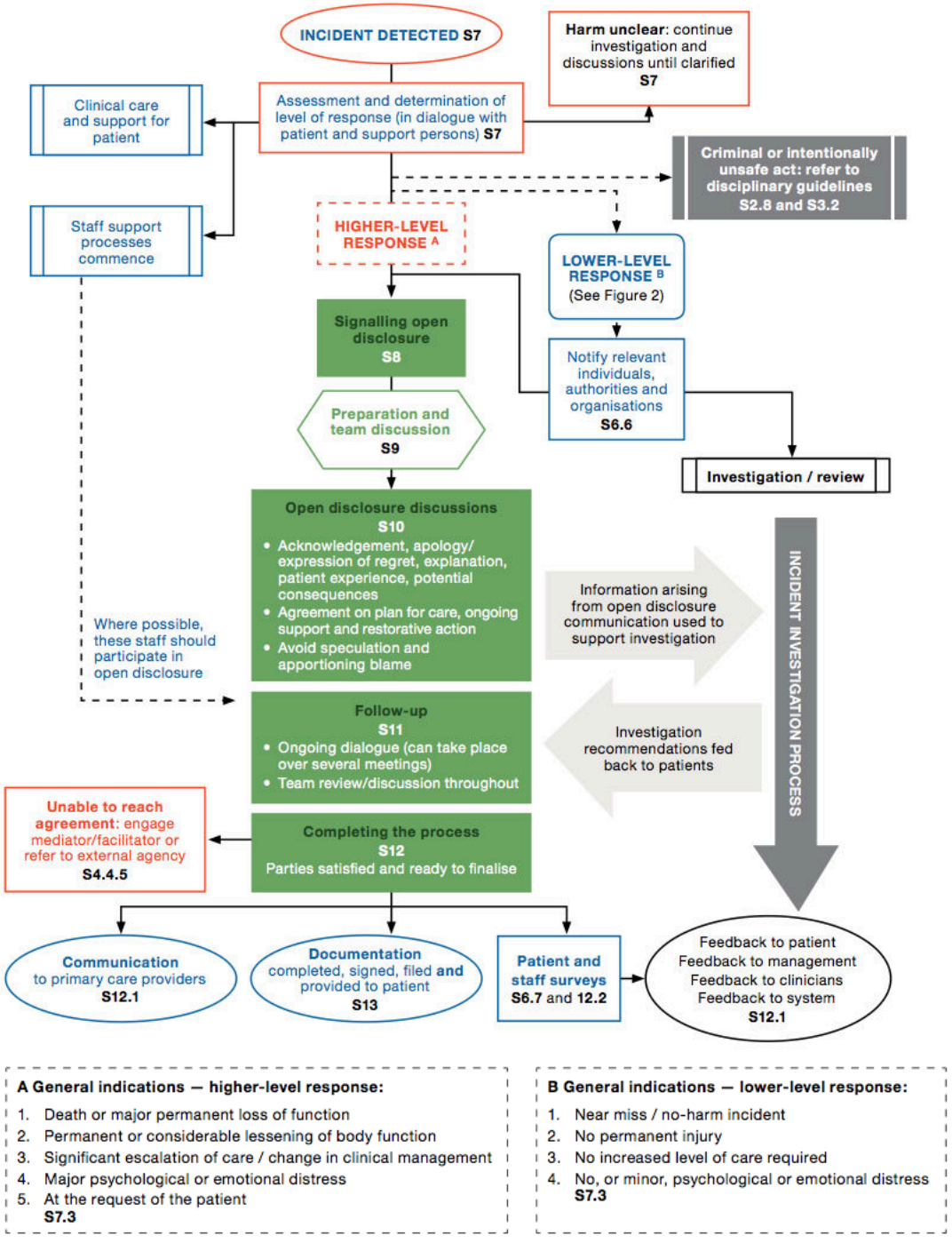
Policies and procedures should be developed by health service organisations with full consideration for patient and clinician privacy and confidentiality, in compliance with relevant law (including Commonwealth, state and territory privacy and health records legislation). However, this principle needs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

Waverley Endoscopy will follow all these recommendations and will follow the processes outlined in the flowcharts below.
Processes used will be

- Incident or complaint by patient
- Discussion with patient and or carer involved
- Action request raised
- Discussion of incident with Nursing staff and Medical staff involved with DON and Medical Directors
- Risk register audit results
- Written report by DON
- Management Review
- Open disclosure discussion
- Resolution or meditation
- Full documentation completed, signed and filed and a copy to the patient
- Staff nursing and Management meeting combined to discuss the results
- Counseling for staff if necessary

All staff will be educated in the process of open disclosure.

Figure 1 Flow chart outlining the key steps of open disclosure (Note: S = Section)



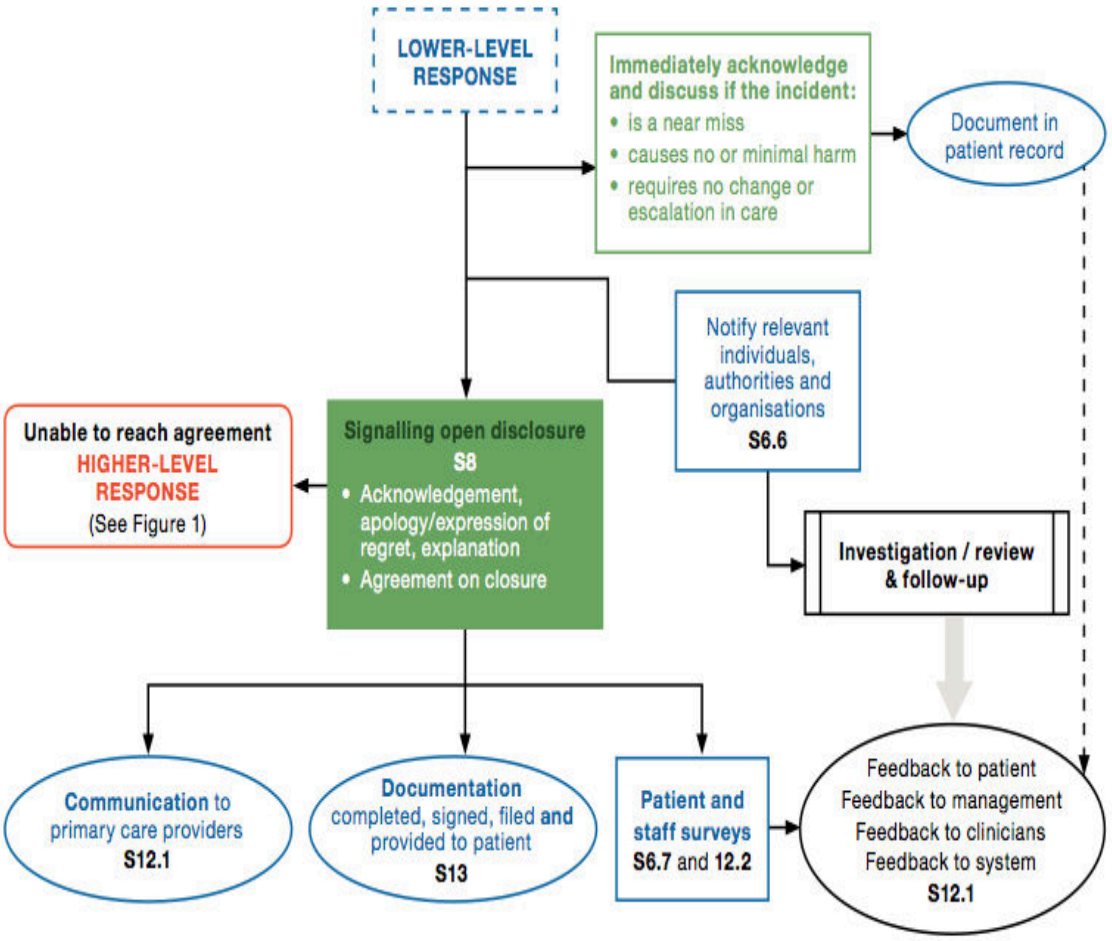
A General indications — higher-level response:

1. Death or major permanent loss of function
2. Permanent or considerable lessening of body function
3. Significant escalation of care / change in clinical management
4. Major psychological or emotional distress
5. At the request of the patient
   S7.3

B General indications — lower-level response:

1. Near miss / no-harm incident
2. No permanent injury
3. No increased level of care required
4. No, or minor, psychological or emotional distress
   S7.3

Figure 2 Lower-level response



For further information see Incident reporting M 098

For more information see

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References

- Australian Commission on Safety and Quality in Health Care (ACSQHC) (2013), Australian Open Disclosure Framework, ACSQHC, Sydney.
- Australian Commission on Safety and Quality in Health Care (ACSQHC) (2020), Australian Charter of Healthcare Rights 2nd Edition
- Australian Commission on Safety and Quality in Health Care (September 2011), National Safety and Quality Health Service Standards, ACSQHC, Sydney.
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