Wyndham Clinic Private Hospital
Open Disclosure

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National Standards:  NDIS Practice Standards	**Personnel Affected:** **All personnel**

Purpose

Open disclosure describes the way clinicians communicate with patients, families and carers who have experienced harm during health care. It involves open, effective and honest communication with patients and families to acknowledge an adverse event.

The Australian Open Disclosure Framework defines open disclosure is an open discussion with the patient, and their family and carer(s) about adverse events that result in harm while receiving healthcare.

Open disclosure can be complex, challenging and difficult for all participants. However, its systematic practice can assist clinicians to manage adverse events compassionately and provide broader benefits through:

- re-establishing trust in patient and clinician relationships
- improving clinical communication
- centering health care on the person
- learning from error by improving care delivery systems and processes.

Compliance

Audits: As per internal surveillance schedule

Policy

A standardised approach is in place for all staff at Wyndham Clinic Private Hospital, to communicate with the patient and/or their nominated relatives/carers after a clinical incident.
Wyndham Clinic Private Hospital will ensure that communication with, and support for all affected patients and staff, occurs in a supportive and timely manner.
Wyndham Clinic Private Hospital takes the 'no-blame approach' and it is very important to ensure that our staff feel comfortable about speaking up about adverse events so we continually improve our systems and processes.
Wyndham Clinic Private Hospital encourages the involvement of the Consumer and Carer Consultants in any review processes and discussions with patients and carers.

Procedure

The Open Disclosure Process will commence after the detection of a clinical incident by:

1. Open and timely communication

If care doesn't go to plan, the patient 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 as soon as practicable, and open disclosure initiated. Indemnity insurers should be notified.

3. Apology or expression of regret

As early as possible, the patient 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

The patient 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

Clinicians and other practitioners should be:

- 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

Wyndham Clinic Private Hospital will review adverse events to prevent recurrence, enable lessons to be learnt and the quality of care to be improved. The information attained about incidents from open disclosure should be incorporated into these processes.

7. Good governance

Wyndham Clinic Private Hospital has appropriate governance and accountability in place which involves monitoring and feedback.

8. Confidentiality

Full consideration should be given to patient and clinician privacy and confidentiality in compliance with relevant law (including federal, state and territory privacy and health records legislation).

The individual who detected the incident should make an initial assessment of the incident, usually in consultation with a senior clinician. This process will consider the severity of harm and the level of response required. The level of response required will be determined by the effect, severity or consequence of the incident.

Potential responses to various situations and incidents

Low level response:

1. Near misses and no-harm incidents
2. No permanent injury
3. No increased level of care
4. No, or minor psychological or emotional distress

High level response:

1. Death or 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. admission to hospital, surgical intervention, a higher level of care, or transfer to intensive care unit
4. Major psychological or emotional stress
5. At the request of the patient

It is important to consider that patients, their families and carers can potentially suffer further emotional harm if post-incident communication is managed insensitively. A lower-level response should only be initiated if the risk of further harm (from not conducting higher-level open disclosure) is unlikely. Where uncertainty exists, a higher-level response should be initiated.

Clinicians (and other staff) involved in the adverse event should be monitored and supported as required.

As soon as harm is identified, the first priority is prompt and appropriate clinical care and prevention of further harm. Additional treatment should be provided if required and if reasonably practical, after discussion and with the agreement of the patient. Responsible management personnel should be advised and should gather any evidence that will assist in investigating the event.

The patient record must be up to date before the team discussion takes place.

Where appropriate and relevant, the multidisciplinary team and all other clinicians involved in the adverse event, including the most senior clinician, will communicate as soon as possible after the event to achieve the following.
Establish the basic facts (clinical and other facts).

Assess the event to determine the appropriate response.
Identify who will take responsibility for discussion with the patient, their family and carers.
Consider the appropriateness of engaging patient support at this early stage, including the use of a facilitator or a patient advocate.
Identify immediate support needs for everyone involved.
Ensure that all team members maintain a consistent approach in any discussions with the patient, their family and carers.
Consider legal and insurance issues, both for the organisation and the clinicians, and notify the relevant people.
Consider how to address issues regarding ongoing care such as billing and other costs, which should be addressed at the earliest opportunity.

The individual leading the disclosure should, where possible, be the most senior clinician who is responsible for the care of the patient. Ideally, the lead person should:

- be known to the patient, their family and carers
- be familiar with the facts of the adverse event and the care of the patient
- be of appropriate seniority to ensure credibility
- have received training in open disclosure
- have good interpersonal skills
- be able to communicate clearly in everyday language
- be able and willing to offer reassurance and feedback to the patient, their family and carers
- where possible and appropriate, be willing to maintain a medium to long-term relationship with the
- patient, their family and carers.

The decision about who will make the disclosure should, where possible, be made in consultation with the patient, their family and carers and senior management. If for any reason the senior clinician is unable to lead the open disclosure, a substitute will need to be selected but, ideally, the senior clinician should still be present at the discussion. The person leading the open disclosure may require the support of a senior staff member with appropriate skills.

In summary the key elements of the open disclosure process are:

- Incident detection
- Signalling the need for open disclosure
- Preparing for open disclosure
- Engaging in open disclosure
- Completing the process
- Maintaining documentation

The Open Disclosure Discussion Summary is to be completed and kept in the patient file.

Undertaking the investigation process under legal privilege

If an investigation into a clinical incident is carried out at the request of Wyndham Clinic Private Hospital legal advisers, the communications generated during the investigation, including the investigation report, may be

subject to legal professional privilege. If a document or record is subject to legal professional privilege, that document or record is protected from disclosure unless legal professional privilege is waived.

Staff Training and Competency in Incident, Risk and Complaints Management
Staff have regular training which incorporates incident, complaints and open disclosure management. Staff complete a yearly mandatory training module on Turrell on-line which also includes completion of an assessment. If it is identified that staff will benefit from additional training as a result of a reported incident, this will be organised as soon as possible. DON and CSM will liaise with the clinical educator to source appropriate training.

Once the open disclosure process is complete and the patient is still unsatisfied about the process, they have the right to take the matter further. Advise them to contact the Health Services Commissioner 30th floor 570 Bourke St, Melbourne Vic 3000. Toll-free 1800136066

References

Australian Commission on Safety and Quality in Health Care. Australian Open Disclosure Framework – better communication a better way to care. 2013

Australian Commission on Safety and Quality in Health Care. Implementing the Australian Open Disclosure Framework in small practices

Relevant Legislation and Guidelines

Health Services Act 1988

Coroners Act 2008

AS NZS ISO 9001:2016 Quality Management Systems - Requirements

Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013

NDIS Rules, 2018

National Standards

Standard 1: Governance and Safety

Standard 2: Partnering with Consumers

Standard 3: Healthcare associated infections

Standard 4: medication Safety

Standard 5: Comprehensive Care

Standard 6: Communicating for safety

Standard 7: Blood Management

Standard 8: Recognising and Responding to Clinical Deterioration in Acute Health Care

NDIS Practice Standards

Revision History

Version	Date	Committees and Persons Involved in Review	Authorised By
1	May 2015	BOM	DON
2	April 2016	BOM	DON
3	July 2017	BOM	DON/CSM
3 reviewed	July 2018	HOD Clinical Governance	DON
4	Nov 2019	HODS	DON
5	November 2020	MAC, HODs	DON