SESLHD GUIDELINE COVER SHEET

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KEY TERMS	Disclosure
SUMMARY	Describes the communication between patient and clinicians following a patient safety incident

SESLHD GUIDELINE COVER SHEET

Health
South Eastern Sydney
Local Health District

Open Disclosure

Section 1 – Background

SESLHD aims to foster a safe, just and transparent culture where patients, their families and carers, clinicians and managers all feel supported.

Open disclosure is a process for ensuring that open, honest, empathic and timely discussions occur between patients and/or their family and support persons after an incident that resulted in harm while they were receiving health care.

A disclosure discussion must occur whenever a patient has been harmed as a result of; an unplanned or unintended event or circumstance, the outcome has not met the patient's or clinician's expectations for improvement or cure, and situations where harm is caused because the patient did not receive their planned or expected treatment.

Patients should be informed whenever an error occurs, regardless of the outcome. However, disclosure of a near miss incident is discretionary.

Open disclosure may be ongoing, involving multiple disclosure conversations over time.

Section 2 - Principles

Open Disclosure is:

- A patient's and 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 communications
- An attribute of high-quality health services and an important part of health care quality improvement

The five essential elements of Open Disclosure are:

- An apology
- A factual explanation of what happened
- An opportunity for the patient /family / support person to relate his/her experience
- Discussion of potential consequences
- An explanation of the steps taken to manage the event and prevent reoccurrence.
  Ref: NSW Health Open Disclosure Policy PD2014_028

Effective Open Disclosure requires:

- Acknowledging to the patient /family / support person when things go wrong
- Listening and responding appropriately, being empathetic
- Allowing the patient/family/support person to ask questions, and answering openly and truthfully
- Ensuring support for patients/ family/support persons and the health care staff to cope with the physical and psychological consequences of the incident.

Open disclosure flow Chart – PD2014_028 page 13 (Appendix A)

Section 3 - Definitions

Definition: **Apology**

- An expression of regret/condolence is offered to the patient/family/support person at the beginning of each Open Disclosure conversation
- Must include the words "I am sorry" or " We are sorry"
- Under Section 69 of the NSW Civil Liability Act 2002, the effect of apology on liability:
  - (1) An apology made by, or on behalf of a person in connection with any matter alleged to have been caused by the person:
    - a. Does not constitute an express or implied admission of fault or liability by the person in connection with that matter
    - b. Is not relevant to the determination of fault or liability in connection with a matter.
  - (2) Evidence of an apology made by, or on behalf of a person in connection with any matter alleged to have been caused by the person is not admissible in any civil proceedings as evidence of the fault or liability of the person in connection with that matter (NSW Ministry of Health Open Disclosure Policy PD2014_028).

Definition: **Defamatory Statements apportioning blame to an individual, group or system**

- Must be avoided
- Rumours or material known to be false or irrelevant to be are excluded
- All statements made should be accurate and verifiable
- All conclusions must be based on the facts and follow logically and reasonably from the information obtained
- The manner and extent of disclosure should not exceed what is reasonably required for the purpose of Open Disclosure.

Definition: **Clinician Disclosure**

- Occurs as soon as practicable after the incident (within 24 hours)
- Performed by senior members of the clinical team

Definition: **Formal Disclosure**

- A formal meeting with patient /family / support person occurring when the final investigation report is to hand
- Patient /family/support person are provided with a written copy of any investigation report.

Definition: **Reimbursement for out of pocket expenses**

- Open Disclosure is most effective if it is coupled with restorative action as it sends a strong signal of sincerity
- Practical support offered through reimbursement for out-of-pocket expenses does not imply responsibility or liability
- Offers of reimbursement, up to $5,000 can be made at the discretion of the General Manager and can be funded through the facility's cost centre
- TMF notification should be made, in case a further claim is made, on the advice of the facility medical legal officer or hospital executive
- Reimbursement of any out of pocket expense must be documented in the Open Disclosure file note (NSW Ministry of Health Open Disclosure Policy PD2014_028 Section 4.6

Section 4 - Responsibilities

General Managers are responsible for:

- Circulating Open Disclosure policy and guidelines to all senior clinicians and managers
- Supporting training of Open Disclosure advisors and the completion of My Health Learning modules for clinical staff
- Appointing and supporting Dedicated Family Contacts in conjunction with the Director of Clinical Governance, as per NSW Health PD2020_047 Incident Management Policy
- Approval of reimbursements
- Informing NSW Health of significant events.

Head of Department is responsible for:

- Ensuring ongoing care is provided to the patient for as long as is required
- Identifying and notifying incidents which are managed via IMS+
- Supporting clinical and other health staff following an incident which has caused harm
- Leading and participating in both Clinical and Formal Open Disclosure meetings, where appropriate
- Ensuring that timely Clinician Disclosure occurs
- Ensuring that findings of an incident investigation are presented at M&M
- Assist in facilitating the incident investigation report being provided to staff involved
- Inform facility and LHD executive of significant events which may result in media interest

Open Disclosure Advisors:

- Are trained in high level Open Disclosure methods; empathetic communication skills and Open Disclosure processes
- Participate in Open Disclosure meetings
- Provide advice and “just in time” training to clinicians and managers who participate in clinician and formal Open Disclosure meetings.
- Mentor colleagues as they gain skills in Open Disclosure
- Needs to have undertaken Respecting the Difference (RTD) training (at a minimum the on-line module) for a discussion involving Aboriginal patients, family and their support person This framework ensures that all health staff are empowered to deliver more respectful, responsive and culturally sensitive services to Aboriginal people, their families and their communities. Aboriginal Liaison staff can be members of the Open Disclosure team

Clinical Governance and Clinical Practice Improvement Unit Staff are responsible for:

- Providing Leadership support and advice on Open Disclosure
- Ensuring a Preliminary Risk Assessment (PRA) occurs where are Dedicated Family Contact (DFC) is appointed in compliance with NSW Health PD2020_047
- Providing oversight of Open Disclosure training for clinical staff
- Acting as Open Disclosure Coordinators – to coordinate and support clinician and formal Open Disclosure
- Monitoring and evaluating Open Disclosure processes and systems
- Becoming Open Disclosure Advisors.

Dedicated Family Contact:

- Are allocated at the PRA, being the person most appropriate to undertake this role for this family
- Maintain contact with the patient /family / support person, as guided by the family.
- Keep the family updated on progress of the investigation
- Facilitate a meeting with SAER team members so the patient's version of events are understood and their specific questions can be answered
- Assist in facilitating the formal Open Disclosure meeting

Clinical Staff are responsible for:

- Completing education about Open Disclosure – My Health Learning on-line modules (recommended requirement)
- Ensuring immediate care is provided to the patient
- Notifying immediate managers if an incident causing serious harm has occurred
- Entering the incident into the incident reporting system (IMS+)
- Participating in Clinician Disclosure meetings.

Section 5 - Procedure

Open Disclosure is required following any incident where a patient has been harmed.

Initial Steps

- Identify the incident
- Ensure personal safety and the safety of patients and others
- Provide clinical care for the patient; escalate care as required
- Provide support for clinicians and other health service staff.

Assess and determine the severity of the harm and level of Open Disclosure required.

The approach to Open Disclosure can vary depending on the patient's personal circumstances. Each situation should be addressed on a case by case basis.

Clinician Disclosure

- Should occur within 24 hours and at a time appropriate for patient/family/support persons. Clinicians should take the following steps. The STARS tool can be used to guide discussion **(Appendix B)**.

- Prepare for the discussion
- Consider cultural or special circumstances which may impact
- Begin conversation with an apology
- Acknowledge the incident
- Understand the clinical facts and be able to clearly describe them and answer questions
- Avoid speculation, attributing blame, denial of responsibility or providing conflicting information
- Allow patient/family/support persons to relate their experiences, concerns and feelings and ask questions
- Plan for ongoing care
- Describe the investigation that will be undertaken
- Provide contact details to the patient/family/support persons for follow-up meetings or queries
- Offer practical assistance such as reimbursement of out of pocket expenses, if relevant
- Document the meeting in the medical record and IMS+ notification/RIB.

During the Investigation:

- Ensure staff involved in the incident are provided with appropriate support
- Commence investigation of Harm Score 1 incidents as per NSW Health PD2020_047 and appointment of a Dedicated Family Contact
- Commence investigation of a Harm Score 2 incident by appointing clinical review team

- Consider inviting the patient/family/support person to contribute to the investigation by giving their version of events so their concerns are able to be addressed in the final report
- The DFC is to maintain contact with the patient/family/support persons
- The clinical team to continue treatment or refer to another clinical team, if the patient requests
- If there are any delays in the completion of the investigation, the DFC should notify the patient/family.

Formal Open Disclosure meeting

- The team will comprise of the relevant senior clinician and senior manager, the DFC will facilitate this meeting, provides support and may attend
- An agreed meeting time is to be arranged at an appropriate venue, noting the patient may not be willing to return to the hospital
- Patient encouraged to bring support person
- Staff attending the meeting must prepare by being familiar with the SAER or investigation report.
- At the meeting, the Open Disclosure Team should:
  - Reaffirm the apology and acknowledgement of the incident
  - Explain the formal open disclosure process
  - Provide the opportunity for the patient/family/support persons to relate their experiences, concerns and feelings
  - Listen and respond appropriately, answer questions truthfully
  - Talk through the investigation report, summary of incident and recommendations
  - Provide the written report
  - Avoid speculation, attributing blame, denial of responsibility or providing conflicting information
  - Agree on plan for any on-going care
  - Offer practical assistance such as reimbursement of out of pocket expenses, if relevant
  - Offer further meeting to discuss issues
  - Document meeting

Section 6

Documentation

Documentation of Open Disclosure conversations should be made in the:

- Patient's medical record
- IMS+ – notes section
- Open Disclosure file notes – file notes are to be maintained for significant cases in line with general retention and disposal schedules set out in the State Records Act.

References

NSW Health Policy Directive PD2014_028 Open Disclosure Policy

NSW Health Policy Directive PD2020_047 Incident Management

Clinical Excellence Commission - Open Disclosure Handbook

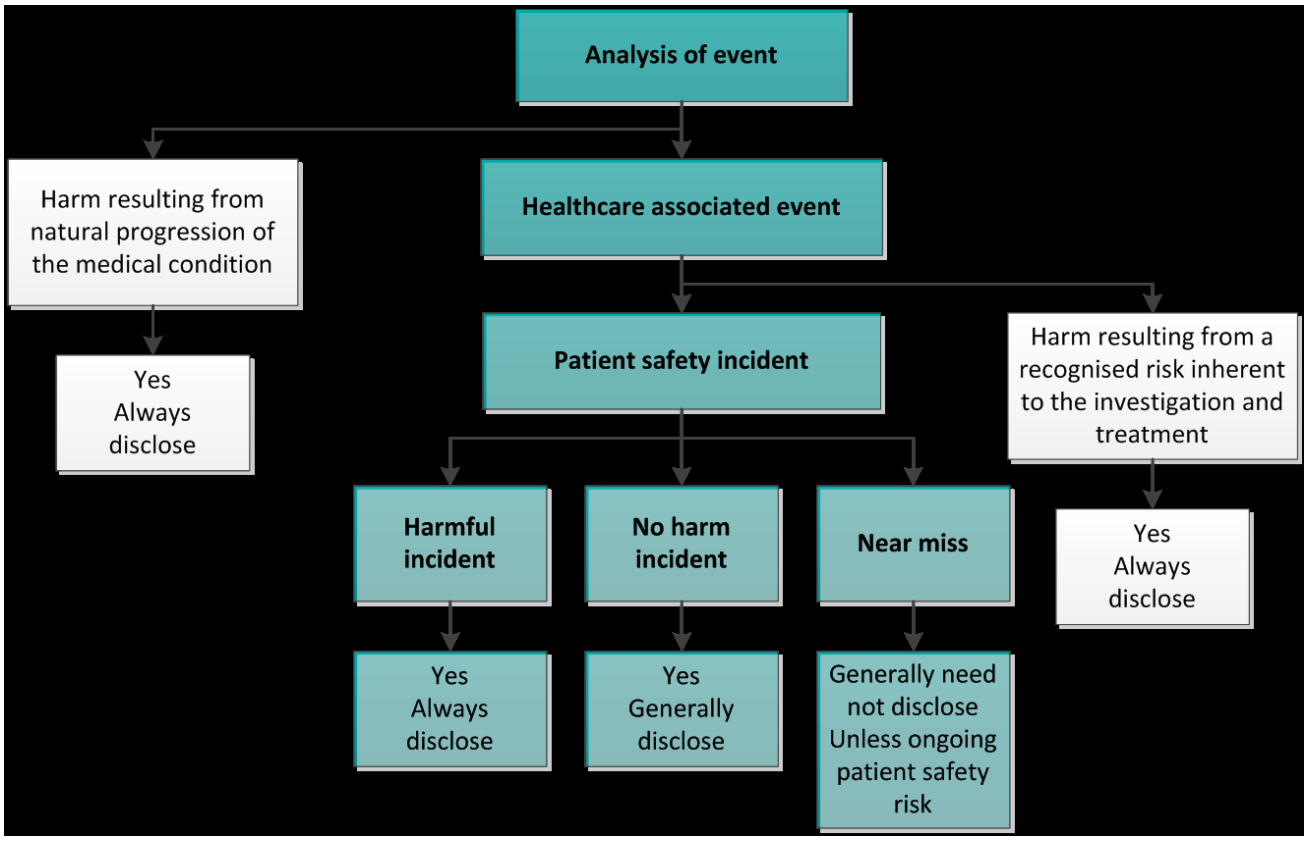
National Commission on Safety and Quality in Health Care - Australian Open Disclosure Framework

Revision and Approval History

Date	Revision no:	Author and approval
November 2017	Draft	Executive Sponsor approved for Draft for Comment
December 2017	Draft	Endorsed by SESLHD Clinical and Quality Council
March 2022	2	Minor review: addition of reference to PD2020_047 and incident management requirements. Approved by Executive Sponsor.

Appendix A:

Open disclosure flow Chart – PD2014_028 page 13



Appendix B:

STARS tool - CEC Open Disclosure Handbook page 87

An example of appropriate wording for clinician disclosure