OPEN DISCLOSURE POLICY

Policy

FCC is committed to a process of open communication with a patient, and or their family/support person, following an adverse or unexpected event that may or may not result in harm to the patient.
FCC uses an open disclosure program that is consistent with the Australian Open Disclosure Framework and monitors and acts to improve the effectiveness of open disclosure processes.

Procedure

FCC aligns itself with National Open Disclosure standards and replicates these in our service. Open disclosure involves discussing incidents that have occurred affecting patient safety with staff and patients.

Open disclosure is described within the Australian Open Disclosure Framework as:
An open discussion with a patient about an incident(s) that resulted in harm to that patient while they were receiving health care. The elements of open disclosure are an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence.

Open disclosure is:

- A patient and consumer right
- An essential professional requirement and institutional obligation
- A normal part of an episode of care should the unexpected occur
- An attribute of a high-quality service organisation and an important part of healthcare quality
- improvement.

FCC encourages our entire workforce to adopt open disclosure standards by supporting them through training in open disclosure and encouraging reporting of incidents which effect patient safety.

FCC also ensures all clinical staff have access to open disclosure frameworks at the point of care in electronic and hardcopy.

Our open disclosure program is supported by the Governance group through:

- Adopting the Australian Open Disclosure Framework
- Ensuring that enough resources are allocated to support implementation of the framework
- Ensuring that the responsibility for implementing the framework is allocated to an individual
- or committee
- Ensuring that there is a system in place for monitoring compliance with the framework; all variations from the framework should be investigated and addressed
- Reviewing regular reports on open disclosure to ensure that the principles and processes of
- the framework are met
- Leading a 'just culture' marked by openness and constructive learning from mistakes

All staff have access to reporting patient harm events through our quality management system which are reviewed, investigated by trained staff incorporating staff involved in the incident and outcomes discussed with staff at meetings and the patient.

FCC is committed to quality improvement and change management when needed including change to policy, procedure or protocols which are reviewed when implemented.

THE OPEN DISCLOSURE FRAMEWORK

The Framework has eight guiding principles:

1. Open and timely communication
If things go wrong, the patient, their family and carers are 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 are 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 of the Australian Open Disclosure Framework).

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 Committee 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. (Australian Commission on Safety and Quality in Health Care (2013), Australian Open Disclosure Framework. ACSQHC, Sydney)

The Clinical Workforce are Trained in Open Disclosure Processes
FCC ensures all staff are aware of open disclosure frameworks through our orientation/induction process of all new staff and returning staff. Open disclosure is a mandatory training element within FCC which is completed on a yearly basis.
All staff training is recorded within the training register of the quality management system ensuring all staff and trainers are notified when staff are due specific mandatory and work place training.
Staff with the responsibility to review incidents where patient safety has been affected are trained to encourage the best possible staff and patient outcome.

FCC follows the Australian Open Disclosure Framework process for reviewing an adverse event:

1. 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
- notify relevant personnel and authorities
- ensure privacy and confidentiality of patients and clinicians are observed

2. 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
- avoid speculation and blame
- maintain good verbal and written communication throughout the open disclosure process

3. 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)

4. 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

5. 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)

6. 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

7. 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 (Australian Commission on Safety and Quality in Health Care (2013), Australian Open Disclosure Framework. ACSQHC, Sydney.)

Key Principles of Open Disclosure for FCC

- openness and timeliness of communication
- acknowledgement of the incident
- expression of regret/apology
- recognition of the reasonable expectations of the patient and their support person
- support for staff
- Confidentiality

Open Disclosure Discussion

FCC ensures the word "sorry" is effectively utilised within all discussions with clients when issues arise in their care, together with a factual explanation of what has happened, the ongoing effects (if any) and the provision of information supporting our discussion.

All clients are treated with empathy, honesty and transparency in a timely manner.

FCC clients also have the opportunity to convey their experiences ensuring they have input into finding a resolution to the issue. Similarly, our workforce is also supported through related client incidents and FCC are committed to providing the right environment, resources and culture to guide our workforce through any issue when it arises.

We recognise open disclosure as the right thing to do, as it strengthens the relationships and confidence between the client and FCC to continue being involved in their care.

FCC allocates all open disclosure issues to the Governance meeting. The Governance meeting has the role and responsibility to implement the open disclosure process when incidents occur.

FCC follows the Australian open disclosure process to guide our Governance group at times when needed from implementing the process to reviewing the process.

FCC audits clinical incidents to determine if the open disclosure process should have been implemented, ensuring all clinical incidents are thoroughly acknowledged.