Open Disclosure Procedure

1. Guiding Principles

The WA Country Health Service (WACHS) practises open disclosure in accordance with the Australian Open Disclosure Framework and the National Safety and Quality Health Service Standards – Clinical Governance Standard requirements.

If hyperlinks throughout this procedure fail to open in Microsoft Explorer, please use Microsoft Edge, Google Chrome or another browser.

2. Procedure

Once a clinical incident has become known, it is necessary to:

- minimise the risk of further harm and provide appropriate care
- notify a senior staff member or the unit manager who is to assess the level of open disclosure response required
- document the facts of the incident in the medical record
- report the incident in the Datix Clinical Incident Management System (CIMS).

The initial discussion is to occur as soon as possible after recognising harm, even if all the facts are not yet known.

Ensure consideration of communication aspects for culturally and linguistically diverse individuals (see section 4 of the Australian Open Disclosure Framework).

During the initial discussion:

- the adverse event is acknowledged to the patient, their family, carers or nominated support person (MH Act 2014 s273(1))
- an apology or expression of regret is given (see Sections 1.5 and 10.2 of the Australian Open Disclosure Framework)
- the effect of the incident, including all known facts and the consequences, are described.
- WACHS Open Disclosure Work Plan and Checklist may be used to plan open disclosure.

Nominate a contact person in the hospital/ health service who can provide any ongoing feedback and whom the patient, their family and carers can contact if they have any further queries to provide consistency.

3. Definitions

Open Disclosure	is defined in the Australian Open Disclosure Framework as the open discussion of adverse events that result in harm to a patient while receiving health care with the patient, their family and carers or nominated support person (MH Act 2014 s273(1)). 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 or more parties and an exchange of information that may take place in several meetings over a period of time.
A high level incident	refers to those events resulting in: • death • major permanent loss or considerable lessening of bodily 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 an intensive care unit • major psychological or emotional distress • All SAC 1 clinical incidents are regarded as high level A higher level response may also be instigated at the request of the patient even if the outcome of the incident is not as severe Refer to the WACHS Open Disclosure Process for High Level Incidents
A low level incident	refers to those events where there has been no permanent injury or increased level of care and resulting in no or minor psychological or emotional distress. Refer to the WACHS Open Disclosure Process for Low Level Incidents.

4. Roles and Responsibilities

Regional Medical and Nurse Directors are responsible for managing the open disclosure process for a high level incident.

A senior medical officer or senior nurse or midwife or senior mental health professional only, need be involved in the open disclosure process for low level incidents.

5. Compliance

All WACHS regions are required to comply with open disclosure in accordance with the Australian Open Disclosure Framework and to meet the National Safety and Quality Health Service Standards – Clinical Governance Standard requirements.

Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

The Open Disclosure process and discussion is to be recorded in the patient's medical record using the MR30L WACHS Open Disclosure Discussion Record.
Initiation of the Open Disclosure Process is to be recorded in Datix CIMS.
Where an Open Disclosure Process is not initiated a valid reason must be recorded.

7. Evaluation

Monitoring and evaluation of this Open Disclosure Procedure is to be ongoing based on need and resources, and risk management strategies and may include:

- the number of Severity Assessment Code (SAC) 1 events with a record that Open Disclosure has been commenced or undertaken as recorded in the clinical incident management system.
- the number of clinical incidents with a record that Open Disclosure has been commenced or undertaken as recorded in the clinical incident management system.
- audit of medical records.

8. Standards

National Safety and Quality Healthcare Standards 1.12

9. Legislation

Section 26 of the *Health Services Act 2016* (WA)

10. References

Australian Commission for Safety and Quality in Health Care. Open Disclosure Framework: The Open Disclosure Framework is designed to enable health service organisations and clinicians to communicate openly with patients when health care does not go to plan. It provides a nationally consistent basis for open disclosure in Australian health care.
Open Disclosure Resources

National Safety and Quality Health Service Standards – Clinical Governance Standard requirements

WACHS Open Disclosure Work Plan and Checklist

11. Appendices

Appendix 1 - WACHS Open Disclosure Process for High Level Incidents

Appendix 2 - WACHS Open Disclosure Process for Low Level Incidents

12. Related Forms

MR 30L WACHS Open Disclosure Discussion Record

13. Policy Framework

Clinical Governance, Safety and Quality Policy Framework

This document can be made available in alternative formats on request for a person with a disability

Contact:	Program Manager Clinical Risk		
Directorate:	Medical Services	**TRIM Record #**	ED-CO-14-34245
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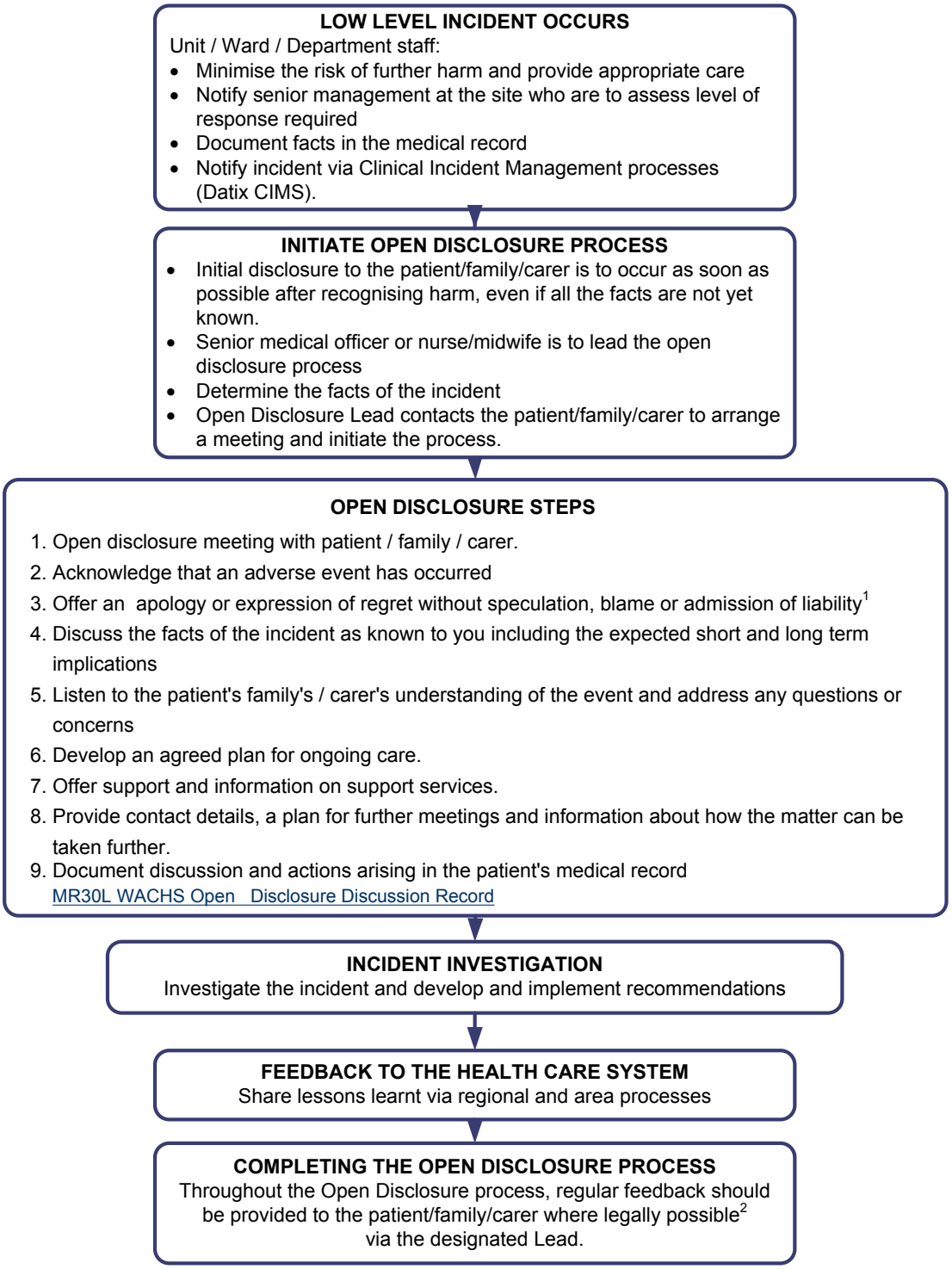
Appendix 1

OPEN DISCLOSURE PROCESS FOR LOW LEVEL INCIDENTS



1: Refer to Australian Open Disclosure Framework Appendix 1, 1. Apology, expression of regret and open disclosure
2. Refer to Australian Open Disclosure Framework Appendix 1, 1. Protection of communications and documents

Appendix 2

OPEN DISCLOSURE PROCESS FOR HIGH LEVEL INCIDENTS

HIGH LEVEL INCIDENT OCCURS

Unit / Ward / Department staff:

- Minimise the risk of further harm and provide appropriate care
- Ensure senior management at the site are aware of the event
- Document facts in the medical record
- Notify incident to the regional Safety and Quality team via Clinical Incident Management processes (Datix CIMS).

NOTIFICATION

- Regional Safety and Quality team ensure RD, RMD and RNMD are aware of the incident, notify incident following SAC 1 business rules.
- RMD/RNMD ensure Legal and Legislative Services and Risk Cover are notified and that support resources are available for staff involved in the incident.

INITIATE OPEN DISCLOSURE PROCESS

- Initial disclosure to the patient/family/carer is to occur as soon as possible after recognising harm, even if all the facts are not yet known.
- RD to liaise with RMD and RNMD to determine who will lead the Open Disclosure process.
- RD, RMD, RNMD and Open Disclosure Lead meet to prepare and agree on Open Disclosure plan.
- Open Disclosure Lead contacts the patient/family/carer to arrange a meeting and initiate the process.

OPEN DISCLOSURE STEPS

1. Open disclosure meeting with patient / family / carer.
2. Acknowledge that an adverse event has occurred
3. Offer an apology or expression of regret without speculation, blame or admission of liability[1]
4. Discuss the facts of the incident as known to you including the expected short and long term implications
5. Listen to the patient's family's / carer's understanding of the event and address any questions or concerns
6. Develop an agreed plan for ongoing care.
7. Offer support and information on support services.
8. Provide contact details, a plan for further meetings and information about how the matter can be taken further.
9. Document discussion and actions arising in the patient's medical record.
   MR30L WACHS Open Disclosure Discussion Record

INCIDENT INVESTIGATION
Investigate the incident and develop and implement recommendations

FEEDBACK TO THE HEALTH CARE SYSTEM
Share lessons learnt via regional and area processes

COMPLETING THE OPEN DISCLOSURE PROCESS
Throughout the Open Disclosure process, regular feedback should be provided to the patient/family/carer where legally possible[2] via the designated Lead.

1: Refer to Australian Open Disclosure Framework Appendix 1, 1. Apology, expression of regret and open disclosure
2. Refer to Australian Open Disclosure Framework Appendix 1, 1. Protection of communications and documents