Open Disclosure

Procedure

Policy supported

Risk and Incident Management

Purpose and Rationale

This procedure outlines a systematic and transparent organisation-wide approach to managing

Target Audience

This procedure applies to all Jessie McPherson Private Hospital staff, Accredited Health Practitioners, students undertaking placement and external parties contracted to Jessie McPherson Private Hospital.

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Communication about the incident to the patient/carer will occur in the following sequence:

Type	Timeframe	Action
Patient Notification	Within 6 hours of identification of the incident.	The most senior clinician at the site of the incident will: • For ISR 1 & 2 incidents, discuss the information to be given with the Consultant. • Inform the patient/family/carers of the incident. • Ensure the patient/family/carer understand what has happened and the ongoing plan for management. • Provide a contact for further questions. Document the date, time and occurrence of patient notification in the health record and on Riskman in the green 'Open Disclosure' section.
Open Disclosure	Within 48 hours of identification of the incident.	Treating team to assess the incident within 48 hours or before the next ward round. On weekends it will be the Registrar in charge of the care, in consultation with the Consultant on call. If the Registrar has been directly involved in the error, the Consultant on call will be required to come in for the open disclosure. Treating team to meet with the patient/family/carer to: • Confirm the seriousness and impact of the incident. • Agree on clinical management plan and an incident investigation plan. • Arrange a meeting with the patient/carer. • Express regret and apologise for what has occurred. • Disclose key known facts regarding the incident. • Listen to the patient/family/carer as to what happened and acknowledge their views and concerns. • Address their questions and concerns. • Allow them to present suggestions as to how the situation will be managed and offer positive suggestions

		to assist them. • Advise that investigations are continuing. • Provide details of measures already taken to prevent recurrence. • Where appropriate, explain complaints process, referring to Complaints and compliment feedback procedure. • Provide name of contact for any further questions. • Arrange any additional support identified in the meeting as needed; e.g. social work and/or pastoral care. • Document the date, time and occurrence of clinical team disclosure in the health record and on Riskman in the green 'Open Disclosure' section. **For most incidents this will conclude the disclosure process.**
Formal Open Disclosure	On closure of incident investigation.	Following sentinel events and ISR 1 incidents leading to death or permanent harm, a formal open disclosure is conducted by trained and/or experienced personnel. Refer below.

Formal Open disclosure

Incidents requiring formal open disclosure:

- All sentinel events
- ISR 1 incidents leading to death
- ISR 1 incidents leading to permanent harm.
- Other complex incidents, as per treating team, Quality and Safety Unit or Legal Counsel.

Planning for open disclosure

Senior member of the treating team to lead the process by liaising with the Program Director or General Manager who may choose to seek assistance from their Executive Director, Chief Medical Officer or Legal Counsel in determining:

- Who will undertake the open disclosure with the patient/carer?
- Who will be present at the meeting?
- The support is required for the patient.

Further disclosures

- Further disclosures with the patient/family/carer are held as appropriate, particularly after initial investigation has been completed and higher level investigations are pending. . Such disclosures, held at the earliest opportunity, will include:
    - Information about the progress of the investigation.
    - A response to any issues raised by the patient/family/carer
    - Information about what is being done to minimise the chance of recurrence
- The senior health care professional, involved in initial disclosures, is to be involved in the further disclosures. Continuity of involvement is vital.
- A record of the disclosure is documented in the health record.

Conduct open disclosure meeting on closure of the incident investigation

- Introduce everyone present and the role of each person.
- Express regret and apologise for what has occurred.
- Disclose key known facts regarding the incident, including findings, actions and recommendations resulting from investigation.
- Provide details of measures already taken to prevent recurrence.
- Listen to patient/family/carer about what happened and acknowledge their views and concerns
- Address their questions and concerns
- Where appropriate, arefer to Complaints and compliment feedback procedure
- Provide name of contact to patient/family/carer for any further questions
- Arrange any additional support identified in the meeting as needed; eg. social work and/or pastoral care.
- Document the date, time and occurrence of open disclosure in the health record, and on Riskman in the green 'Open Disclosure' section.

Feedback

- Feedback to patient/family/carer may be provided during face to face disclosure, by letter or both. Information is given as soon as possible, and in a style that is readily understood by the patient/family/carer.
- For all ISR1 and some ISR 2 incidents, formal written feedback, outlining the findings and outcomes from investigation, will be provided to the patient/family/carer. This will be approved by the Program Director and Director of Patient Safety, Strategy and Innovation.
- Feedback to staff requires an effective communication strategy to ensure that recommended changes are fully implemented and monitored.

Open disclosure evaluation

Key Performance Indicators:

- % of ISR 1 and 2 incidents where clinical team disclosure has occurred within 48 hours is reported in the monthly Jessie McPherson Private Hospital Quality and Safety Performance report.

Keywords or tags

Open Discussion, OD, family meeting

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