

# OPEN DISCLOSURE POLICY

## 1. INTRODUCTION AND PURPOSE

Open disclosure is the process of communicating with a patient and their support person about a patient related incident. Open disclosure provides an ethical framework for staff and GenesisCare to fulfil their duty of care to patients and their support persons.

GenesisCare will provide an environment in which staff recognise and openly discuss incidents with patients and their support persons. Staff will be supported to acknowledge when an incident has occurred and to initiate the open disclosure process with the patient and their support person.

The purpose of this policy is to:

- Establish a framework for communicating with patients and their support persons and the other stakeholders after an incident
- Ensure that communication with and support for affected patients and their support persons occurs in an empathetic and timely manner
- Ensure that GenesisCare has an established open disclosure processes

The key principles of the open disclosure process are:

- Openness and timeliness of communication to patients and families who experience serious incidents
- Acknowledgement of error to patients and families who experience serious incidents
- Expression of regret
- Recognition of the reasonable expectations of patients and their support person
- Emotional support to patients, families, clinicians and others affected by such incidents.
- Establishing a clear plan for follow up care
- Communication about the system or institutional response to the incident
- Confidentiality.

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## 2. TERMS AND DEFINITIONS

*Open Disclosure* - The process of providing an open, consistent approach to communicating with the patient and their support person following a patient related incident. This includes expressing regret for what has happened, keeping the patient informed, and providing feedback on investigations, including the steps taken to prevent a similar incident occurring in the future. It is also about providing any information arising from the incident or its investigation relevant to changing systems of care in order to improve patient safety.

*Incident* - Any event resulting in, or with the potential for, injury, damage, outcome of care or other loss. For the purposes of the open disclosure process an incident will exclude a near miss.

*Incident Investigation* - The management process by which underlying causes of undesirable events are uncovered and steps are taken to prevent similar occurrences

*Incident Management* - A systematic process for identifying, prioritising, investigating and managing the outcomes of an incident.

*Apology* - A key aspect of open disclosure is saying sorry or offering an apology to the patient and their support person following an incident. An apology is an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter whether or not the apology admits or implies an admission of fault in connection with the matter. An apology does not constitute an admission of fault or liability and neither is it relevant to the determination of fault or liability in connection with a matter.

*Clinician* - A health practitioner or health service provider regardless of whether the person is registered under a health registration act.

*Support Person* - May be any individual identified by the patient as a nominated recipient of information regarding their care. This may include the patient's family members, partner, carer or friends. In cases of a dispute between the patient's family members, partner, carer and/or friends about who should receive information, the patient's wishes should be paramount. Where a patient is unable to give consent, the 'next person responsible' should be approached.

The open disclosure process provides an ethical framework for ensuring that staff inform patients, and where applicable their support person, in an open, honest and empathetic manner about a patient related incident and its implications for the health care of those patients.

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## 3. SCOPE

This Policy applies to employees, of Genesis Care and all its related entities, collectively referred to in this Policy as 'workplace participants.

## 4. RESPONSIBILITIES

It is the responsibility of all workplace participants to report incidents.

The Practice Manager / delegated manager has the responsibility to determine if Open Disclosure is required as a result of the incident in collaboration with the General Manager, the Medical Practitioner, Legal Counsel and the CMC.

## 5. POLICY

5.1 Where an adverse event has occurred and has the potential to / has resulted in harm to a patient and is designated as a major or critical outcomes the Open Disclosure procedure shall be enacted.

5.2 All steps involved in the open disclosure process are to be undertaken without prejudice in a manner consistent with the Mission and Values of GenesisCare.

5.3 In the event of the adverse event being caused by negligence, the investigation shall be ceased and medico-legal cover shall be sought.

## 6. PROCEDURE

6.1 As soon as practicable after the detection of an adverse event:

- Immediately minimise risk of further harm to patient.
- Provide appropriate clinical care and support to patients, family and staff members as indicated.
- Notify Practice Manager, General Manager, of incident.
- Report incident through RiskMan Incident Management System
- Report incident to governing bodies as per legislation and insurance requirements
- Ensure patient is informed of the incident within 12 hours or as soon as practicable.

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- Identify who will be responsible for undertaking the Open Disclosure process and how meetings with the patient and support people will be conducted. This will be determined by the severity of the event.
- Identify what privileged process if any the incident will be investigated under and what implications this will have for the release of information
- Identify and provide support resources for the patient and staff members involved
- Hold a discussion with the patient and their support person within 12 hours of incident.
  - Known facts
  - Expressions of regret
  - Care plan
  - Patient support
  - Staff support by person responsible for clinical risk management where needed to be incorporated at this time.

6.2 A Multidisciplinary team meeting to be carried out to establish facts, investigate incident (Refer to GenesisCare–Root Cause Analysis Policy and Procedure and develop recommendations

6.3 Disseminate information of investigation to Clinical team and other relevant committees i.e. GenesisCare Board

6.4 Implement recommendations and monitor for change and improvement within the required time frame

6.5 Develop final report and provide feedback for the patient/carer or family member, staff, legal (as appropriate) healthcare system (governing bodies) and relevant committees

## 7. EVALUATION

- All sentinel events and incidents where harm has occurred will be subject to the Open Disclosure process.
- All quality improvements arising from the RCA process will be disseminated to all appropriate committees and staff for shared learnings

## 8. ASSOCIATED DOCUMENTS

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GenesisCare Policy – Incident, Near Miss and Sentinel Event Management  
GenesisCare Policy – Root Cause Analysis

## 9. REFERENCES

National Safety and Quality Health Service Standards – Standard 1: Governance for Safety and Quality in Health Service Organisations 2019

Open Disclosure Standard; Australian Commission on Safety and Quality in Healthcare, April 2008

## 10 APPENDIX

Nil

## 11. KEY WORDS

Apology, Communication, Open Disclosure, Patient, Sentinel Management,