Open Disclosure Policy & Procedure

Contents

Open Disclosure Policy

1. PURPOSE

1.1 This Policy outlines Dougherty Apartments Retirement Housing Project (Dougherty Apartments) commitment to a consistent open disclosure process, to ensure that residents, their families and/ or responsible person(s) and our staff are:

- Communicating effectively about a resident safety incident;
- Provided with an opportunity to recount their experiences, concerns and feelings and are listened to;
- Treated respectfully and provided with ongoing care and support for as long as is required.

1.2 We are committed to providing an organisational culture of safety and quality strengthened by:

- Creating a supportive environment in which resident safety incidents are identified and reported without attribution of blame;
- Encouraging staff to openly inform, listen to and support the resident, responsible persons and colleagues who may have been involved in a resident safety incident;
- Sharing lessons learned from resident safety incidents to identify and develop strategies to prevent potential incidents.

2. Overview

2.1 Dougherty Apartments recognises that effective incident management and open disclosure processes are attributes of high-quality aged care organisations, and important parts of quality improvement and a person-centred approach to care.

2.2 This policy should be read in conjunction with our Incident Management Policy.

2.3 A resident incident is any event or circumstance which could have (near miss) or did lead to unintended and/or unnecessary psychological or physical harm to a resident.

2.4 Open disclosure is the process of providing an open, consistent approach to communicating with residents, their family and/or responsible person(s) following an incident. This process includes expressing regret or saying sorry.

2.5 The open disclosure process forms part of an established system for safety and quality improvement that focuses on the timely reporting of all incidents and near misses, and prompt action to reduce resident harm.

2.6 This also includes regular review of our open disclosure processes and consideration of the resident experience from incidents.

2.7 This policy aims to ensure that relevant staff:

- Report and document the management and open disclosure of resident incidents;
- Provide appropriate feedback to, and engage with residents, their family, and/or responsible person(s), including open disclosure;

- Respond effectively to resident incidents, and promote safety and quality improvement through sharing lessons learned from single (or groups of) resident incidents;
- Take action, in collaboration with residents to improve the safety and quality of services; and
- Maintain compliance with relevant law and codes of conduct in relation to transparent and fair treatment, privacy and confidentiality of both residents and staff.

3. Understanding open disclosure

3.1 Open disclosure describes the way we communicate with residents and responsible person(s) when harm has been experienced during care. It involves open, effective and honest communication to acknowledge an adverse event.

3.2 The main elements of open disclosure are:

- an apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry';
- a timely and factual explanation of what happened;
- an opportunity for the resident or relevant stakeholders to relate their experience of the adverse event;
- 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.

3.3 Open disclosure is a discussion and an exchange of information that may take place in one conversation or over one or more meetings.

4. 'No blame' approach

4.1 Our open disclosure process incorporates a 'no-blame' approach.

4.2 Blaming individuals when adverse events occur is unproductive and may:

- create an environment of fear and distrust in which the reporting of adverse events is unlikely to occur;
- prevent understanding of the cause of the event such as:
  - a culture of taking short cuts;
  - failure to comply with Dougherty Apartments policy or procedures;
  - stress created through unplanned staffing events, inexperience and/or the complexity of resident care.

4.3 All workers have a right to fair treatment including the right to be heard, to be able to respond to any findings from an investigation and to have a support person present during any discussions.

5. When is open disclosure initiated?

5.1 Open disclosure is initiated when a resident has suffered unintended harm during care. This may be a recognised complication, unanticipated incident, or a result of human or systems error.

6. Risk management

6.1 Preparation for open disclosure of a resident safety incident requires careful consideration and assessment of risks - to Dougherty Apartments, the resident, their responsible person(s), and staff, including the risk of media exposure or litigation. Undertaking risk management processes should not delay appropriate and timely open disclosure.

6.2 Identifying and learning from the underlying causes of resident safety incidents, complaints and claims, with the aim of implementing solutions to prevent recurrence adds value to both risk management and quality improvement.

6.3 A risk management plan needs to be developed to address identified risks. Any risk that is beyond a staff member's capacity or delegation of authority needs to be escalated to a higher level of management for acceptance and management of the risk.

7. Principles of open disclosure

Open and timely communication

7.1 If things go wrong, the resident and responsible person(s) should be 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.

Acknowledgement

7.2 All adverse events should be acknowledged to the resident and/or responsible person(s) as soon as practicable.

Apology or expression of regret

7.3 As early as possible, the resident and their responsible person(s) 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.

Supporting, and meeting the needs and expectations of residents, and/or responsible person(s)

7.4 The resident and their responsible person(s) can expect to be:

- fully informed of the facts surrounding an adverse event and its consequences;
- treated with empathy, respect and consideration; and
- supported in a manner appropriate to their needs.

Supporting, and meeting the needs and expectations of staff

7.5 Dougherty Apartments will 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.

Integrated clinical risk management and systems improvement

7.6 Thorough clinical review and investigation of adverse events and adverse outcomes should be conducted, focusing on the management of clinical risk and quality improvement.

7.7 The outcomes of reviews will concentrate on improving systems of care. The information obtained about incidents from the open disclosure process will be incorporated into our continuous improvement activity.

Good governance

7.8 An effective open disclosure system requires a good governance framework, and clinical risk and quality improvement processes. Through our governance systems, adverse events will be investigated and analysed to prevent them reoccurring.

7.9 At Dougherty Apartments we embrace a system of accountability from our Board of Directors through to the senior management team and all staff and care givers.

7.10 Good governance will include internal performance monitoring and reporting.

Confidentiality

7.11 This policy and associated procedures are developed with full consideration for resident and staff privacy and confidentiality, in compliance with relevant law (including federal, and state privacy and health records legislation).

PROCEDURE

8. What should happen after an adverse event?

8.1 After a resident incident, two separate but linked and related processes are initiated:

- open disclosure - that will assist the resident and responsible persons following the incident, and guide the workforce in supporting residents who have experienced harm
- incident reporting, investigation, analysis and action to change practices - these benefit staff, Dougherty Apartments and the resident through improvement to the safety and quality of services.

8.2 The linking of open disclosure and incident management is essential to ensure that:

- Residents and responsible person(s) can contribute to the investigation, and are informed of the recommendations arising and actions taken or planned to prevent recurrence and improve safety and quality;
- Dougherty Apartments learns from the investigation of incidents and from the resident / responsible person(s) perspectives.

Identification and immediate action after a resident incident

8.3 A resident incident might be identified:

- by a staff member, allied health worker, volunteer or student at the time of the incident, or when an unexpected outcome is detected;
- through established consumer feedback or complaints mechanisms;
- through other review systems, such as audit or review of medical records;
- by the resident and family/carer, other residents, visitors, students or other staff, at the time of the incident or later.

8.4 All Dougherty Apartments staff or those providing a service on behalf of Dougherty Apartments who observe or become aware that a resident incident or near miss has taken place are required to:

- ensure that any person affected by the incident is safe and all necessary steps are taken to support and treat the person/s and prevent further injury;
- inform a line manager;
- preserve evidence, within the constraints of providing safe clinical care in the situation;
- report the incident and document information in the medical record.

8.5 Residents and their family/responsible person(s) are encouraged to report incidents to the clinical team.

8.6 The Clinical Care Manager or Registered Nurse in charge may be responsible for the initial acknowledgement and completion of an open disclosure process.

8.7 Managers are required to provide or arrange support, team or individual de-briefing and/or counselling services to staff involved in a distressing resident incident.

Preservation of evidence surrounding incidents

8.8 If the matter has been referred to the Coroner, SafeWork, the Police or other external agencies, there are requirements for preservation of evidence that should be adhered to. If this cannot be done, use a digital camera to document the scene prior to the environment being disturbed.

8.9 Any relevant equipment, disposables and the environment involved must be left as it was at the time the incident occurred, where practicable. Avoid altering equipment settings and connections. If, for safety reasons this is not possible:

- document any changes and attach this documentation to relevant equipment, and
- isolate and secure the relevant equipment, accessories, disposables and associated packaging.

8.10 If there is no feasible alternative to the continued use of the equipment or clinical environment, preservation of evidence will take second place to the provision of safe services to residents and the emotional well-being of those involved.

Summary of the key steps in the process

8.11 The key elements of the process (see Appendix A for full details) may be summarised as:

a) Detect and assess the incident;

b) Signal the need for open disclosure;

c) Prepare for open disclosure;

d) Engage in open disclosure;

e) Provide follow-up;

f) Complete the process and maintain documentation.

9. Governance

9.1 Open disclosure begins with the recognition that a resident has been harmed or will potentially be harmed by an ongoing safety risk as a result of receiving or not receiving treatment or care.

9.2 Open disclosure may be ongoing, involving multiple disclosure conversations over time. Open disclosure involves two-way communications. The input and perspective of the resident and their responsible person(s) should be actively sought and welcomed in

determining what happened, the impact on the resident and/or their responsible person(s) and in planning for any ongoing care requirements.

9.3 When it is time to participate in open disclosure, the key elements which need to be in place include:

- establishing the facts (clinical and other facts);
- identifying immediate support needs for everyone involved;
- assessing the event to determine the appropriate response;
- identifying who will take responsibility for discussion with the resident;
- considering the appropriateness of engaging resident support at this early stage, including the use of a facilitator or a resident advocate;
- ensuring everyone involved maintains a consistent approach in any discussions with the resident;
- considering legal and insurance issues and notify the relevant people;
- considering how to address issues regarding ongoing care;
- ensuring the resident record is up to date.

9.4 If participating with colleagues in open disclosure, preparatory meetings should be held to understand the issues and the individual responsibilities at the meeting.

9.5 It may be appropriate to rehearse some aspects of the conversation, such as the apology or expression of regret with the team. Often it is useful to go through the main elements of the information, including the apology or expression of regret.

9.6 Preparation should be balanced by responding appropriately to the resident and the way the meeting progresses. Residents may not feel that the discussion is sincere if it is stilted or otherwise perceived as insincere.

Legal and Legislative considerations

9.7 Open disclosure:

- Is a dialogue between two parties;
- Is not a legal process;
- Does not imply that an individual or service has blameworthy facts to disclose.

9.8 Open disclosure does not, of itself, create legal liability. Acknowledging an incident, and expressing regret that it has happened, is not an admission of liability. Liability is established by a court and is based on an evidentiary matrix which may, in part, be based on statements made either before or after the event.

9.9 However, staff must be aware of the risk of making an admission of liability during open disclosure. In any discussion with the resident during open disclosure, staff should take care not to:

- speculate on the cause of an incident;
- pre-empt the results of any investigations;
- attribute or apportion blame, or criticise individuals;
- state, imply or agree that they, other staff or health service organisations are liable for the harm caused to the resident.

9.10 Further information is available through the training that is available for staff who have a role in leading Open Disclosure processes (Open Disclosure facilitators) and the Australian Open Disclosure Framework (Australian Commission on Safety and Quality In Health Care). This resource also provides guidance on other legal issues such as freedom of information, privacy, defamation, and qualified privilege.

Investigation of a resident safety incident

9.11 When a resident has been harmed as the result of any resident safety incident, an investigation into the incident must commence as soon as practicable. The circumstances of the incident, including the severity of harm and/or distress experienced by the resident and their responsible persons, will determine the level and method of investigation. The findings from each investigation into a resident safety incident are an essential part of the information that is provided to a resident and their responsible persons during an open disclosure process.

9.12 Residents and/or their responsible person(s) are encouraged to participate in the ongoing investigation process.

Restrictions on the release of information

9.13 There are some restrictions on the information that can be released during open disclosure discussions. Legal privilege can protect certain documents from being disclosed, specifically documents created, or communications made, in confidence for the dominant purpose of obtaining legal advice in relation to the incident, or for use in legal proceedings (including civil claims for compensation; coronial inquest hearings; and prosecutions before a disciplinary body).

Records management

9.14 If open disclosure is initiated with the resident and/or their responsible person(s) following any resident safety incident, including near misses and no harm incidents, the clinician responsible for the care of the resident must record that fact in the resident's health care record.

10. Open Disclosure Meetings

Introductions

10.1 The resident, their family and/or responsible person/s should be told the name and role of everyone attending the meeting.

Saying sorry

10.2 A sincere and unprompted apology or expression of regret should be given on behalf of Dougherty Apartments, including the words 'I am' or 'we are sorry'. Examples of suitable and unsuitable phrasing of an apology are provided in the resource titled Saying Sorry: a guide to apologising and expressing regret in open disclosure available at www.safetyandquality.gov.au/opendisclosure.

Factual explanation

10.3 A factual explanation of the adverse event should be provided, including the known facts and consequences of the adverse event, in a way that ensures the resident and other stakeholders understand the information, and should also consider any relevant information

related earlier by the resident, their family and/or other stakeholders. Speculation should be avoided.

10.4 The resident, family and other stakeholders should have the opportunity to explain their views on what happened, contribute their knowledge and ask questions. It will be important for the resident, their family and stakeholders that their views and concerns are listened to, understood and considered.

Personal effect of the adverse event

10.5 The resident, family and stakeholders is/are encouraged to talk about the personal effect of the adverse event on their life.

Plan agreed and recorded

10.6 An open disclosure plan is agreed on and recorded, in which the resident, their family and carer(s) outline what they hope to achieve from the process and any questions they would like answered. This is to be documented and filed in the appropriate place and a copy provided to the resident, their family or other stakeholders as appropriate.

Pledge to feed back

10.7 The resident, their family and other stakeholders should be assured that they will be informed of any further reviews or investigations to determine why the adverse event occurred, the nature of the proposed process and the expected time frame. They should be given information about how feedback will be provided on the investigation findings, by whom and in what timeframe, including any changes made to minimise the risk of recurrence.

Offer of support

10.8 An offer of support to the resident, their family / responsible person(s) should include:

a) ongoing support (including consideration of reimbursement of out-of-pocket expenses incurred as a result of the adverse event);

b) assurance that any necessary follow-up care or investigation will be provided promptly and efficiently;

c) clarity on who will be responsible for providing ongoing care resulting from the adverse event;

d) contact details for any relevant service they wish to access;

e) information about how to take the matter further, including any complaint processes available to them.

Support for staff

10.9 Staff are supported by their colleagues, managers and Dougherty Apartments both personally (emotionally) and professionally, including through appropriate training, preparation and debrief.

Other considerations

10.10 It is not necessary to cover every component in the first disclosure meeting. For instance, a full explanation of why an adverse event occurred may not be possible until associated investigations are completed and the causative factors are known.

10.11 A written account of the open disclosure meeting should be provided to the resident, their family and relevant stakeholders, with a copy filed in the resident record.

If necessary, hold several meetings or discussions to achieve these components.

11. Completing and documenting the open disclosure process

11.1 Completing the open disclosure process with residents and responsible person(s) includes:

- reaching an agreement regarding future care, ongoing support and restorative action between the resident, their family/responsible person and Dougherty Apartments
- offering the resident, their family/responsible person(s) final written and verbal communication, including recommendations arising from the investigation findings.

11.2 Additional steps that may be required include:

- offering the resident, their family/responsible person(s) the opportunity to discuss the process with another clinician (e.g. a general practitioner);
- additional meetings and following up any outstanding concerns that the resident or family/responsible person(s) have;
- providing information to support the resident and family/responsible person(s) to take an alternative course of action if an agreement cannot be reached

11.3 Completing the open disclosure process includes communicating the recommendations for minimising recurrence that have arisen from the incident investigation and outcomes of the open disclosure process to resident, responsible person(s) and staff.

11.4 Communicating with staff is achieved through documentation of the incident management and open disclosure process in the resident record

12. RELATED LEGISLATION AND DOCUMENTS

Aged Care Act 1997

Clinical Governance Framework

Compulsory Reporting Management & Policy

Complaints & Compliments Handling Policy and Procedure

Incident Management Policy

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

13. FEEDBACK

13.1 Dougherty staff may provide feedback about this document by emailing the General Manager.

14. APPROVAL AND REVIEW DETAILS

APPROVAL & REVIEW DETAILS	
Approval Authority	General Manager
Administrator	Clinical Care Manager
Last Review Date	Reviewed and updated February 2019
Next Review Date	February 2021

APPENDIX A
Key elements of the open disclosure process

Detecting and assessing incidents	▪ Detect adverse event through a variety of mechanisms ▪ Provide prompt clinical care to the resident 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 residents and clinicians are observed
Signalling the need for open disclosure	▪ Acknowledge the adverse event to the resident, their family / responsible person(s) 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 resident, their family/ responsible person(s) or nominated contact person o the formality of open disclosure required o the time and place for open disclosure o who should be there during open disclosure ▪ Provide written confirmation ▪ Provide a Dougherty Apartments contact for the resident, their family / responsible person(s) ▪ Avoid speculation and blame ▪ Maintain good verbal and written communication throughout the open disclosure process
Preparing for open disclosure	▪ Hold a 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 resident, their family / responsible (person) ▪ Gather all the necessary information ▪ Identify the Dougherty Apartments contact for the resident, their family / Responsible person(s) (if this is not done already)
Engaging in open disclosure	▪ Provide the resident, their family / Responsible person(s) with the names and roles of all attendees ▪ Provide a sincere and unprompted apology or expression of regret including the words I am or we are sorry ▪ Clearly explain the incident ▪ Give the resident, their family / Responsible person the opportunity to tell their story, exchange views and observations about the incident and ask questions ▪ Encourage the resident, their family / responsible person(s) to describe

	the personal effects of the adverse event ▪ Agree on, record and sign an open disclosure plan ▪ Assure the resident, their family / Responsible person(s) that they will be informed of further investigation findings and recommendations for system improvement ▪ Offer practical and emotional support to the resident, their family / responsible person(s) ▪ Support staff members throughout the process ▪ If necessary, hold several meetings or discussions to achieve these aims
Providing follow-up	▪ Ensure follow-up by senior management, where appropriate ▪ Agree on future care ▪ Share the findings of investigations and the resulting practice changes ▪ Offer the resident, their family / responsible person the opportunity to discuss the process with another clinician (e.g. a general practitioner)
Completing the process	▪ Reach an agreement between the resident, their family / responsible person(s) and Dougherty Apartments, or provide an alternative course of action ▪ Provide the resident, their family / responsible persons with final written and verbal communication, including investigation findings ▪ Communicate the details of the adverse event, and outcomes of the open disclosure process, to all relevant staff
Maintaining documentation	▪ Keep the resident record up to date ▪ Maintain a record of the open disclosure process ▪ File documents relating to the open disclosure process in the resident record ▪ Provide the resident with documentation throughout the process

APPENDIX B

Organisational readiness for open disclosure: Checklist

	YES	NO	NOTES	Review Date
Senior management commitment				
Senior management is committed to open disclosure	☐	☐		
Appropriate resources are allocated to support open disclosure	☐	☐		
Senior management has established a governance reporting and monitoring requirement on the application of open disclosure	☐	☐		
The organisation consults with and provides advice to consumers about the open disclosure policy	☐	☐		
Training requirements are determined and scheduled	☐	☐		
Open Disclosure Policy				
An open disclosure implementation plan has been developed by management and staff and signed by the chief executive officer	☐	☐		
Local open disclosure protocols and procedures have been developed based on the framework outlined in the Policy	☐	☐		
The implementation plan aligns with other operational policies and the organisation's strategic objectives	☐	☐		
The Policy has been communicated to all staff	☐	☐		
The implementation plan is reviewed at least yearly	☐	☐		
Open disclosure - operational management				
Responsibility for open disclosure has been assigned	☐	☐		
The roles and responsibilities of staff involved in open disclosure are clearly documented and communicated within the organisation	☐	☐		
The organisation has developed a performance monitoring tool to assess its requirements against the policy	☐	☐		

Open disclosure issues are discussed at safety and quality committees at least quarterly	☐	☐		
Open disclosure issues are discussed at morbidity and mortality meetings	☐	☐		
The clinical workforce are trained in open disclosure processes (NSQHSS 1.16.2)	☐	☐		
Open disclosure monitoring				
There are appropriate audit and monitoring systems in place to measure and evaluate open disclosure within the organisation	☐	☐		
Other considerations				
A process is in place to guide the early response to a resident safety incident, including what and how information is gathered and communicated as part of the open disclosure process	☐	☐		

APPENDIX C
KEY DEFINITIONS

Term	Meaning
Adverse Event	An incident in which harm resulted to a person receiving care Note: This term is used interchangeably with 'harmful incident'.
Apology	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. It should also acknowledge the consequences of the situation to the recipient. It must include the words "I am sorry" or "we are sorry".
Care Worker	All staff engaged to provide aged care services and support to our residents.
Harm	Impairment of structure or function of the body and/or any deleterious effect arising there from, including disease, injury, suffering, disability and death. Harm may be physical, social or psychological.
Incident	An event or circumstance which could have resulted, or did result, in unintended or unnecessary harm to a person and /or a complaint, loss or damage.
Near Miss	An incident that did not cause harm but had the potential to do so.
No Harm incident	An error or system failure that reaches the resident but does not result in resident harm
Open Disclosure	Open disclosure is defined in the *Australian Open Disclosure Framework* as "an open discussion with a resident (and/or their responsible person(s)) about a resident safety incident which could have resulted, or did result in harm to that resident while they were receiving health care. Essential elements of open disclosure are: ▪ an apology ▪ a factual explanation of what happened ▪ an opportunity for the resident to relate their experience ▪ a discussion of the potential consequences ▪ an explanation of the steps being taken to manage the event and prevent recurrence. The open disclosure process is a discussion between two parties and may include a series of discussions and exchanges of information that take place over several meetings."

Resident safety incident	Any unplanned or unintended event or circumstance which could have resulted, or did result in harm to a resident. This includes harm from an outcome of an illness or its treatment that did not meet the resident's or the clinician's expectation for improvement or cure. ***Harmful incident*:** a resident safety incident that resulted in harm to the resident, including harm resulting when a resident did not receive their planned/expected treatment (replaces 'adverse event' and 'sentinel event'). ***No harm incident*:** a resident safety incident which reached a resident but no discernible harm resulted. ***Near miss*:** a resident safety incident that did not reach the resident, and/or in which a potential for harm from ongoing risk may result.
Responsible person	A person who has been identified by the resident as someone whom they would like to be present to provide assistance, comfort and support during the open disclosure process and to whom information about their health care can be given. A responsible person may be (but is not limited to) a family member, partner, carer or friend. Only the resident can determine who will be their responsible person. In cases of a dispute about who should receive information, the resident's wishes should be paramount. Where a resident does not have capacity to decide for themselves or is deceased an "authorised representative" can decide on their behalf. A nominated next of kin is not necessarily an authorised representative.
Staff	Any person working in any capacity within Dougherty Apartments, including contractors, students and volunteers.