

TOOL 8 - Safety Learning System topic guide

OPEN DISCLOSURE processes

July 2016

Introduction

Health services need systems that minimise the number of incidents; minimise the degree of harm resulting from incidents; provide routine open disclosure; and act to improve the safety and quality of services.

After an incident, two separate but integrated processes are initiated, both of which are essential to all people involved.

- > Open Disclosure (OD).
- > Incident reporting, investigation, analysis and then action to improve practices.

Definition of OD

OD is a process of providing an open, consistent approach to communicating with consumers/patients and their carer/support persons following a patient incident, including expressing regret.

OD is a patient/consumer right, a core professional requirement and a legal obligation.

Benefits of OD

OD will assist the patient and carers in their recovery from the incident. After an incident there is an expectation that the patient, their family and carers will be:

- > fully informed of the facts surrounding an incident, its consequences for them, and the steps being taken to manage the incident and prevent recurrence
- > treated with empathy, respect and consideration and supported in a manner appropriate to their needs
- > offered support in addition to the usual treatment and care provided by the clinical treating team
- > given the opportunity to ask questions or to make a complaint
- > assured of their privacy and confidentiality.

OD is a way of talking about bad news in a sensitive, respectful, informative way, and listening to the patient and their family.

Levels of OD

Level 1 - This is usually conducted by or with a trained OD Facilitator, that is, it is a more formal response. Level 1 OD is required for incidents that have had a more serious consequence or outcome for the patient, have generated significant patient or carer concern, or possible media interest (actual Safety Assessment Code (SAC) rating of 1 or 2 that is, a harmful incident).

Level 2 - This is a less formal local response to incidents that have not resulted in serious harm to the patient, including near misses, and that are rated with an actual SAC rating of 3 or 4. These OD processes are usually conducted by the clinician providing care, or a senior member of the clinical team.

Using Safety Learning System (SLS) to document OD

If you are the person reporting the incident into SLS (the notifier):

After you have described what happened, and the outcome of the incident, there is a mandatory question that asks whether or not an open disclosure discussion has already taken place, at the time the report was made.

If you are the Patient Incident Manager responsible for the review, investigation and analysis of the incident

On the Manager's page of SLS, the following question is asked.

Open disclosure

Has the incident been disclosed to the patient/family?

If Yes, the manager is asked to provide further information:

What level OD process was used? (Level 1 or Level 2)

If Level 1 is selected, a further question appears:

Was a Trained OD Facilitator present at OD meeting with patient/family? (Yes/No)

There is a link to Tool 14 which is a blank template for summarising OD meetings, particularly level 1. Once completed this should be uploaded into the Documents tab.

The outcome of a Level 1 or 2 open disclosure discussion can also be recorded in the Progress notes section.

If an open disclosure discussion has not already taken place for SAC1 or 2 incidents, the manager will need to make arrangements for that to occur. In unusual circumstance a manager can request approval from the Safety and Quality Manager for OD to be deferred for SAC1 or 2 incidents.

Document in the medical record that OD process is underway or has taken place, including the date(s) and any outcome(s) that are relevant to the care provided.

Incident Managers are reminded that information concerning the investigation and analysis of patient incidents that is recorded on the Managers page should be factual and objective.

References

- > SA Health Patient Incident Management and Open Disclosure Policy Directive.
 - Patient Incident Management and Open Disclosure tools and resources.
 - www.sahealth.sa.gov.au/SafetyLearningSystem.
- > National Safety and Quality Health Service Standards.
- > Australian Open Disclosure Framework.
- > Charter of Health and Community Services Rights (the HCSCC Charter).

For more information

SA Health
Safety and Quality Unit
Telephone: 08 8226 6539
Email: safetylearningsystem@sa.gov.au
www.sahealth.sa.gov.au/SafetyLearningSystem

For Public Use: I1-1A



www.ausgoal.gov.au/creative-commons

