West Gippsland Endoscopy Centre

Open Disclosure

1 . PURPOSE AND SCOPE:

To detail the responsibilities of West Gippsland Endoscopy staff when providing information to patients and their carer's or support person following a high-level adverse event.

The policy applies to all clinical staff, and is to be read in conjunction with the: - Incident reporting policy & Risk Management policy

2. DEFINITIONS:

Adverse Event

A serious incident in which major harm resulted to a person receiving healthcare. This could include:

- Death or major permanent loss of function
- Permanent or considerable lessening of body function
- Significant escalation of care/ change in clinical management
- Major psychological or emotional distress

An adverse event is rated as an Incident Severity Rating of either 1 or 2 in the Victorian Health Incident Management System (VHIMS). (An adverse event may be a sentinel event: one that is listed through endorsement by the Australian Health Ministers 2002)

Open Disclosure

Is the open discussion with the patient, their family and carer, of adverse events that result in harm to a patient while receiving healthcare. The elements of open disclosure are:

1. An apology or expression of regret.
2. A factual explanation of what happened
3. An opportunity for the patient, their family and carer to relate their experience
4. A discussion of the potential consequences of the adverse event.
5. An explanation of the steps being taken to manage the adverse event and prevent occurrence.

3. POLICY STATEMENT:

In the event of an adverse event, open disclosure is to be undertaken in a timely and honest manner. This is to happen as soon as the incident/event has been realised and must be left no later than 24 hours post that realisation of the incident occurring.

After the adverse event, the Director and Director of Nursing are to be informed as soon as practicable. For adverse events contributed to by Nursing Staff the DON and the Director are to be notified to arrange the open disclosure process. For adverse events contributed to by Medical Staff, the Director and the DON are to be notified. Open disclosure process and coordination is to be managed by the DON and the Director.

The Director will notify the Medical Advisory Committee and the Quality and Safety Committee Board of Directors of any ISR1 or ISR 2 adverse events and note that there has been open disclosure. A notification to WGEC's insurer and a medico legal file is to be initiated by the Director.

If a patient is transferred to another hospital for treatment after an adverse event, the receiving hospital must be notified about that event immediately it has been realised. The patient and family are to be contacted as soon as possible and no longer than 24 hours post event, to ensure the process of open disclosure has taken place and to explain the follow up process.

4. PROCESS:

The elements to be followed in the case of an adverse event are:

1. An apology or expression of regret which are to include the words "I am sorry" or "we are sorry"
2. A factual explanation with information about what happened in a timely, open and honest manner.
3. A discussion of the potential consequences of the adverse event
4. An opportunity for the patient, their family and/or carer to ask questions.
5. An explanation of the steps being taken to manage the adverse event and prevent occurrence.
6. Documentation of the open disclosure in the medical record.

The provision of information to the patient (and/or next of kin) may be ongoing.

Open disclosure discussion with the patient or the family is to be undertaken by a senior member of staff such as the Consultant or the Director of Clinical Operations.

Recognition of reasonable expectations - a patient is to be fully informed of the facts surrounding an adverse event and its consequences, treated with empathy, respect and consideration and provided with support in a manner appropriate to the patient's needs.

Staff support – WGEC will create an environment in which all staff are able and encouraged to recognise and report adverse events and are supported through the open disclosure process.

Integrated risk management and systems improvement – WGEC will investigate any adverse events and outcomes with a focus on risk management and on improving systems of care and reviewing their effectiveness.

Good governance – Accountability is expected (through the WGHG's chief executive officer) to implement clinical risk and quality improvement processes that prevent the recurrence of adverse events, and to ensure changes are reviewed for their effectiveness.

Confidentiality is to be maintained at all times.

5. REFERENCES:

Open Disclosure Framework Australian Commission for Safety and Quality in Healthcare- 2015