KEILOR PRIVATE

February 2018 V1

Policy

Aim:
To ensure there is a 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.

Scope:
This policy is relevant to all staff employed by Gastro West Pty Ltd.

Procedure:
What is open disclosure?
Open disclosure is the process of open communication with a patient, and or their family support person, following an adverse or unexpected event that may or may not result in harm to the patient.

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.

The Open Disclosure Framework provides principles to address the interests of patients, support persons, staff and other key stakeholder groups.

These Include:
- Openness and timeliness of communication
- Acknowledgement of the incident
- Expression of regret/apology
- Recognition of the reasonable expectations of the patient and their support person
- Staff need for support
- Confidentiality

The open disclosure process
The Open Disclosure Process will commence after the detection of a clinical incident by:
- a member of staff at the time of the incident,
- when an unexpected outcome is first detected sometime after the incident
- a patient who expresses concern or dissatisfaction with their health care either at the time of the incident or at some time after the incident
- incident discovered at audit, such as clinical audit or medical records review.

Following the detection of a clinical incident, members of the clinical team must ensure that steps are taken to immediately prevent or reduce the occurrence of further suffering and harm to the patient. After any such steps have been initiated, the following measures should be implemented by the hospital:

1. Report the clinical incident to a relevant authority, in accordance with Department of Health policy
2. Notify the patient of the clinical incident and the facts that are known up to that point in time
3. Undertake an investigation of the clinical incident
4. Provide feedback to the patient
5. Develop an agreed plan for the ongoing care of the patient

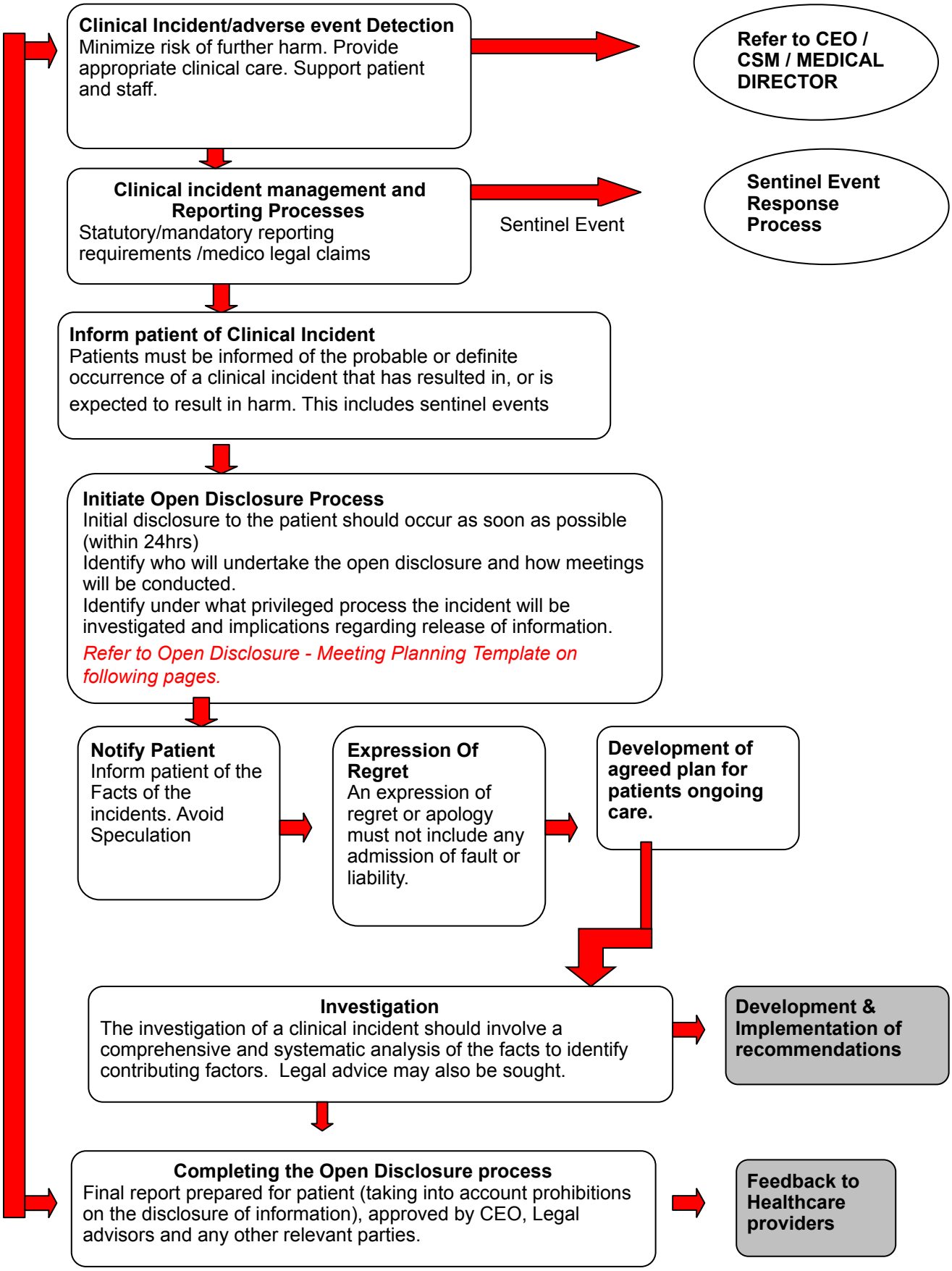
Investigation of a clinical incident

A clinical incident may signal a serious breakdown in health care systems and require thorough investigation and response. Any clinical incidents identified by must be appropriately investigated to determine what happened and, where possible, to reduce the risk of a similar clinical incident happening again. Members of the clinical team are required to participate in any investigation that may arise from a clinical incident.

Undertaking the investigation process under legal privilege
If an investigation into a clinical incident is carried out at the request of legal advisers, the communications generated during the investigation, including the investigation report, may be subject to legal professional privilege. If a document or record is subject to legal professional privilege, that document or record is protected from disclosure unless legal professional privilege is waived.

Critical Incident Debriefing
In the event of a critical incident debrief will be organised by the clinical services manager and follow up support offered on an individual basis

Staff Training and Competency in Incident and Complaints Management
Staff have regular training at orientation which incorporates incident, complaints and open disclosure management. Part of the education program includes assessing staff with competencies based on the training received.


Clinical Incident/adverse event Detection
Minimize risk of further harm. Provide appropriate clinical care. Support patient and staff.
Refer to CEO / CSM / MEDICAL DIRECTOR
Clinical incident management and Reporting Processes
Statutory/mandatory reporting requirements /medico legal claims
Sentinel Event
Sentinel Event Response Process
Inform patient of Clinical Incident
Patients must be informed of the probable or definite occurrence of a clinical incident that has resulted in, or is expected to result in harm. This includes sentinel events
Initiate Open Disclosure Process
Initial disclosure to the patient should occur as soon as possible (within 24hrs)
Identify who will undertake the open disclosure and how meetings will be conducted.
Identify under what privileged process the incident will be investigated and implications regarding release of information.
Refer to Open Disclosure - Meeting Planning Template on following pages.
Notify Patient
Inform patient of the Facts of the incidents. Avoid Speculation
Expression Of Regret
An expression of regret or apology must not include any admission of fault or liability.
Development of agreed plan for patients ongoing care.
Investigation
The investigation of a clinical incident should involve a comprehensive and systematic analysis of the facts to identify contributing factors. Legal advice may also be sought.
Development & Implementation of recommendations
Completing the Open Disclosure process
Final report prepared for patient (taking into account prohibitions on the disclosure of information), approved by CEO, Legal advisors and any other relevant parties.
Feedback to Healthcare providers

This template is designed to assist staff planning and preparing for the first open disclosure meeting. It is also intended to facilitate communication and information sharing among the healthcare team and other relevant personnel at before and during the first open disclosure meeting and throughout the subsequent open disclosure process.

Using the template
All relevant information should be entered in the template and placed in the patient record or other suitable place so that it is accessible to the healthcare team. It is important that all personnel involved in the first meeting with the patient read and agree upon the contents of this document.
Once the need for an open disclosure process has been recognised, the first meeting with the patient, family and carers should occur as soon as possible. Using this template will assist that process.

1. Data & information

Patient's full name (including title)	
URN and date of birth	
Admission diagnosis and comments about management etc.	
Patient admission date	
Names and relationships of relevant next of kin/family/carers	
Date of incident triggering the open disclosure process	
Incident description *Known facts only*	
Incident outcome *Known facts only, avoid cause and effect statements*	
Plan for further incident management and investigation *(such as report to DHS Vic, Coroner)*	
Healthcare providers/clinicians involved in patient care *Include consultants, anaesthetists and others as appropriate*	

2. First meeting

Interpreter required for patient *If so, provide details of language and arrangements that have been or to be made*	
Has the patient (if able) consented to sharing information with family members/ others? *Give details*	
Has the insurer been notified? *Include date of notification*	
Date of first meeting	
Location of first meeting *Other details such as room booking, arrangements to ensure confidentiality if shared ward etc.*	
Patient/family/carers understanding of the incident prior to the first meeting	
Person to be responsible for note taking	
Who will be the health service contact for the patient/family/carers?	

3. Planning the disclosure dialogue

Nominated individual to lead the discussion	
Expected patient concerns	
Apology or expression of regret *Avoid speculation and apportioning of blame*	
Description of what happened *Known facts only, avoid blaming individuals and self*	
Listening to patient/family/carers concerns (ensure they feel listened to)	

Discussion of what will happen next *(such as OR, further treatment investigation into the incident)*	
Information to be provided about short/long-term effects	

Information on out-of-pocket expenses and costs of ongoing care prepared with relevant parties e.g. indemnity insurer; see Australian Open Disclosure Framework Section 4.3	
Assurance for patient/family/carers that they will be informed when further information comes to hand	
Information about further support available to the patient/family/carers	
Information provided in relation on how to take the matter further at any time (such as internal and external complaint process. Avoid discussion about compensation without insurer consent, do not give legal advice but suggest patient seeks legal advice if information about compensation sought.)	
Next meeting date and location	

4. First meeting outcomes

Actual date and location of meeting	
Names of all present at first meeting *Include titles/position/relationship to patient etc.*	
Concerns expressed by patient/family/ carers including requests for further information to be supplied	
Further support personnel identified (such as pastoral worker or social worker)	

5. Outcomes of subsequent meetings (if required)

Date and location of meeting(s)	

Names of all present *Include titles/position/relationship to patient etc.*	
Concerns expressed by patient/family/ carers	
Further support personnel identified	
Responsibility for documentation of the meeting in the medical record	
Responsibility for providing documentation to the patient/family/ carers	
Name(s) of personnel given to patient/ family/carers if they have further questions prior to subsequent meetings	

6. Evaluation

Open disclosure survey forms provided to clinical staff	
Open disclosure process evaluated	

The template has been adapted to suit Keilor Private requirements and will be applied in conjunction with the *Australian Open Disclosure Framework* and other resources.

All national open disclosure resources can be accessed at www.safetyandquality.gov.au/opendisclosure

Timeframe for review
Five years from approval date or when evaluation indicates that significant non-compliance exists.

Supporting documents/Documents of interest
Open Disclosure Framework http://www.safetyandquality.gov.au/wp-content/uploads/2013/03/Australian-Open-Disclosure-Framework-Feb-2014.pdf