SA Health

Guideline

How to Conduct Open Disclosure

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SA Health

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1. Name of guideline

How to Conduct Open Disclosure.

2. Relationship to parent policy

The Clinical Incident Management Policy is the parent policy to this How to Conduct Open Disclosure Guideline.

3. Guideline statement

Open disclosure with patients/families/carers when a patient incident occurs is foundational to organisational and professional integrity. This guideline provides information and resources to support the process of open disclosure and aligns with the requirements of Clinical Incident Management Policy.

4. Applicability

This guideline applies to all employees and contractors of SA Health; that is all employees and contractors of the Department for Health and Wellbeing (DHW), Local Health Networks (LHNs) including state-wide services aligned with those Networks and SA Ambulance Service (SAAS).

5. Guideline details

5.1 Principles of Open Disclosure

The Australian Open Disclosure Framework outlines eight principles of open disclosure to guide staff planning and actions during open disclosure. The SA Health process and guideline aligns with these principles.

1. Open and timely communication
2. Acknowledgement
3. Apology or expression of regret
4. Supporting, and meeting the needs/ expectations of the patient, their family or carers
5. Supporting, and meeting the needs and expectations of those providing health care
6. Integrated clinical risk management and systems improvement
7. Good governance
8. Confidentiality

5.2 What is Open Disclosure

- Open disclosure is an honest, transparent, and necessary conversation, where the health service says sorry to the patient/family/carer for unintended or possible harm. It aims to build trust and restore confidence in the health service, through one or multiple conversations over a period of time.
- There are four steps that staff should follow when conducting open disclosure.
    1. Identify patient/family/carer harm, or possible harm, and the need for escalation
    2. Plan to meet with the patient/family/carer and have a conversation about harm or possible harm.
    3. Meet with the patient/family/carer to have the open disclosure conversation
    4. Evaluate the open disclosure conversation.
- Open disclosure is not a legal process and does not imply health service or staff fault.
- Refer Appendix 1 Open Disclosure 4 Step Process Infographic
- An Open Disclosure Checklist is also available to support managers.

5.3 Step 1 Identify

- Patients/families/carers have a right to transparency, dignity and respect during every healthcare episode. Prompt organisational identification of harm or possible harm and the need to disclose a patient incident activates these rights.

5.3.1 When to conduct open disclosure

Incident managers should consider the following to inform open disclosure planning:

- Safety Learning System (SLS) manager Incident Severity Rating (ISR) 1, 2 and 3 clinical incidents involve patient harm and require open disclosure.
- For SLS manager ISR 4 no harm and near miss incidents, an adapted open disclosure using a low level response (Level 2) should be considered in accordance with the ACSQHC Australian Open Disclosure Framework.

5.3.2 Special circumstances and open disclosure

- In some instances open disclosure can be deferred. Due to the nature of incidents and the impact on individuals there may be instances where an open disclosure may be temporarily deferred in consideration of the patient's physical illness, family grief due to the death of their family member or some temporary level of impairment of decision-making due to these circumstances.
    - All deferred open disclosure should be documented clearly within the medical record and the SLS.
- Where an incident involves the death of a consumer by suicide additional open disclosure considerations are required.
    - Death by suicide is a tragic event where the full details may never be known. In this instance the open disclosure approach should be informed by a restorative and just culture; refer to the Office of the Chief Psychiatrist Towards Zero Suicide Initiative.
        - Communication with consumers should focus on offering condolences and providing opportunity for questions and support. This acknowledges the harm and impact of the incident, while promoting healing.
        - Where an incident review identifies learnings and recommendations these are disclosed.
        - Where the health service has not had an ongoing relationship with the patient, there has been significant time since contact and the incident review identifies no causal factors, communication with consumers may cause undue distress; clinical teams should determine if communication is beneficial.

Case Study 1: Step 1

Identify
Joan is an 84-year-old lady who falls in a SA Health residential aged care facility and has a history of frequent falls. On admission to hospital it is clear that Joan has fractured her neck of femur and requires surgery. On review of the patient incident, it is clear to the incident manager that multiple falls prevention practices were not in place. The incident manager alerts the director of nursing (DON). The incident manager and the DON agree that there is a need for open disclosure.

5.4 Step Two Plan

Open disclosure requires careful planning and coordination. This planning will support timely and sensitive conversations with the patient/family/carer.

5.4.1 Determine the planning level

The following should be considered when planning for open disclosure:

- There are two planning levels for open disclosure, level 1 requires significant planning in comparison to level 2.
    - Level 1 open disclosure is for serious harm incidents; mostly ISR 1 and 2 incidents.
        - Clinical leads and safety and quality (S&Q) teams should be involved in confirming the need for level 1 open disclosure.
        - Some open disclosure will be performed by senior members of the clinical team in the period following the incident. This will be less formal that the formation of an open disclosure team, however the principles apply.

        - Some open disclosure is more complex and will require the formation of an open disclosure team.
    - Level 2 open disclosure is for minor harm ISR 3 incidents and is encouraged and should be considered for no harm and near miss ISR 4 incidents.
    - Level 2 open disclosure often happens at the time of the incident and may not require any additional planning or a specific meeting.
    - **Level 2 open disclosure ISR 3 example**: Joan is administered an incorrect dose of antihypertensive. The senior nurse on duty informs Joan about the incident when it is discovered. Joan experiences lower than normal blood pressure with associated dizziness. The next day the Nurse Unit Manager meets with Joan and her family when they visit, to say sorry and explain what has been put in place to prevent the incident happening again.
    - **Level 2 open disclosure ISR 4 example**: Nurse Mark identifies the information on Shylee's arm band is incorrect while performing a patient identification check prior to administering her morning medications. He apologises to Shylee and fits a new arm band with the correct information.

5.4.2 Establish the facts

- Consider the available documentation and records to identify the incident facts and progress of the patient incident review.
- Only prepare information for the patient/family/carer that is based on the facts. Do not include information that is unsubstantiated or accusatorial in an open disclosure patient meeting.

5.4.3 Convene an open disclosure (level 1 open disclosure only)

- An open disclosure team plans the open disclosure patient/family/carer meeting.
- The incident manager should identify those staff who need to be included in the team meeting.
- The team members should include staff such as, the local manager, representatives from the treating team, and a staff member who is independent of the patient incident. Consider Aboriginal and Torres Strait Islander representation if the patient involved identifies as an Aboriginal or Torres Strait islander.
- The team meeting should have one member who is an experienced open disclosure facilitator.
- Incidents that involve a service with no direct patient relationship (e.g. SA Pathology), may choose to be a part of the team meeting but not attend the open disclosure meeting with the patient.

5.4.4 Conduct an Open Disclosure Team Meeting (level 1 open disclosure only)

- At the open disclosure team meeting the following should be discussed:
    - Identification of primary staff roles for the patient meeting such as, the open disclosure lead, clinician, scribe, and primary contact person for the patient/family/carer.
        - A minimum of two staff should be present at the patient meeting.
    - Confirmation of the facts to be shared at the patient meeting and any supporting documentation that is required at the patient meeting.
        - The patient/family/carer needs the following information in the open disclosure meeting:
            - what happened
            - immediate safety actions and any longer-term consequences
            - actions or plans to prevent the incident from happening again
            - they will be informed of further investigation findings and recommendations for system improvement
    - Discuss communication barriers and necessary supports. (e.g. hearing impairment devices, interpreter services or cultural considerations).
    - Refer to the Clinical Incident Management Policy (Appendix 3) if the patient/family/carer intends to have legal representation.
    - Security options should be organised prior to the meeting if staff have safety concerns.

5.4.5 Coordinate a day/ time (level 1 open disclosure)

- Confirm with the patient/family/carer, a suitable day/ time for the open disclosure meeting.

- Provide the patient/family/carer with information about the meeting purpose and members.
- Where possible provide the patient/family/carer with a Commission's Open Disclosure Fact Sheet.
- Identify an appropriate setting for face to face meetings, that is private, quiet and sensitevly appropriate.
- Consider patient/family/carer requests for financial reimbursement of expenses to attend the open disclosure meeting.
- Inform patients that they may bring support people. In particular, Aboriginal and Torres Strait Islander people should bring or be provided with a cultural support person.

Case Study 2: Step 2

Plan
Frank is admitted with high blood sugar levels. An insulin infusion is commenced but it is administered at the incorrect rate and Frank has a hypoglycaemic episode needing an intensive care unit (ICU) admission. Frank and his family are made aware of the incident and the reason for transfer to ICU, however level 1 open disclosure is also required. The medical lead brings together clinicians to be involved in the open disclosure discussion including the resident medical officer (RMO) and nurse unit manager (NUM). Prior to the open disclosure discussion, the clinicians establish the incident facts, treatment initiated and immediate safety actions that have occurred for discussion with the Frank and the family. The medical lead is appointed as the lead, the RMO as the scribe, and NUM the primary contact for the family. The medical lead contacts Frank and the family to request a meeting and organises a convenient day/ time and informs themy about the meeting purpose and who will be present. The meeting occurs the following day on the ward. At the meeting, the NUM provides Frank the Commissions fact sheet about open disclosure for consumers.

Case Study 3: Step 2

Plan
Cindy is admitted for the plannned birth of her baby after an uneventful pregrancy. Baby Jack is born with low APGARS and dies 3 days later in the neonatal intensive care unit. At the patient safety huddle it is identified the CTG was applied incorrectly and was measuring Cindys heart rate, not baby Jacks, and that he experienced a period of fetal distress. It is identified level 1 open disclosure is required. The obstretrician brings together clinicians to be involved in an meeting including the midwife, resident medical officer (RMO), nursing director (ND), midwifery unit manager (MUM), and patient safety officer (PSO) who is an open disclosure facilitator. At the meeting incident facts are established, and staff required at the open disclosure patient meeting are identified. The obstetrician is appointed as the lead, the PSO as the scribe and the primary contact for the family, and the MUM as an attendee. The PSO contacts the family to request a meeting and organises a convenient day/ time. The PSO informs the family about the meeting purpose and who will be present. The PSO sends an electronic invitation and attaches the Commission fact sheet about open disclosure for Cindy.

5.5 Step 3 The Meeting

The open disclosure patient meeting is about saying sorry, it is not about blame. Saying sorry can be empowering for staff and the patient/family/carer. Throughout the meeting it is important to provide a genuine apology and hear the patient/family/carer perspective. Consider the How to Say Sorry Topic Guide and below before the open disclosure meeting.

5.5.1 Be genuine in your apology

> Conversations should be honest, open and sincere.
  - Clearly explain the incident facts, express regret and provide an apology.(e.g. we are sorry for what has happened).
  - Describe the immediate and planned actions to prevent the incident happening again.

5.5.2 Appreciate the patient perspective

- Ask the patient/family/carer to share their experience and the impact of the incident.
- Use reflective listening skills to acknowledge the personal impact of the incident.
- Offer practical or emotional support about the incident.
- Ask the patient/family/carer if they are satisfied with the information received.
- Unresolved patient/family/carer questions or issues may require additional meetings.

5.5.3 Complaint pathways

- Explain patient/family/carer options for making a complaint.
- Provide the contact details of the complaints contact person in the LHN or SAAS and a HCSCC brochure.
- If financial renumeration for injury or distress from the incident is raised, refer the patient/family/carer to the local Consumer Advisory Service or complaints contact person in the LHN or SAAS.
    - Staff can provide financial renumeration for travel expenses required to attend the open disclosure meeting.

5.5.4 Document the conversation

- A level 1 open disclosure meeting requires the scribe to document the meeting in Open Disclosure Meeting Summary. The completed meeting summary should be provided to the patient and saved in the SLS documents tab.
- Level 1 and 2 open disclosure meetings both require brief documentation in the medical record and the SLS.
- A copy of the meeting summary should be made available to the patient/family/carer.

Case Study 4 : Step 3

Meet
Shivay is a 34-year-old gentleman from Bangladesh, who while on holiday required surgery in Adelaide. During surgery, surgical sponges are left in his abdominal wound, necessitating a return to theatre and ongoing antibiotics. A level 1 open disclosure meeting was held with Shivay, clinical staff, an interpreter and a support person on the ward after Shivay had recovered from the operation and anaesthetic. In the meeting, the surgeon involved in the incident apologised and expressed regret for the incident. He explained the process in place to minimise the likelihood of retained sponges. Shivay was very understanding but had significant financial challenges because of the extended hospital stay. The surgeon used reflective listening skills to empathise with Shivay and offered social work services to facilitate travel arrangements. Shivay was provided with information about the various complaint pathways open to him as a patient. The surgeon asked Shivay if he was satisfied with the meeting and if there were any other supports he needed. No additional meetings were required but a referral was made to social work. The NUM documented the meeting in the medical record and the SLS, saved the completed meeting summary in the SLS and provided this to Shivay.

Case Study 5 : Step 3

Meet
A level 1 open disclosure meeting was held with the Cindy and her husband Pete following the death of baby Jack. In the meeting, the obstetrician involved in the incident apologised and expressed deep regret for the incident. She explained the process in place to manage labour and the monitoring of fetal progress during labour and delivery. Cindy and Pete are deeply upset over the loss of baby Jack and angry at the health service. The obstetrician used reflective listening skills to empathise. Cindy and Pete were informed the health service is conducting a root cause analysis (RCA) investigation to understand the incident and identify recommendations to prevent further incidents and were provided with information about the various complaint pathways open to them. The PSO asked Cindy and Pete if they would like to contribute to the RCA and asked if there were any other supports they needed. Cindy and Pete advised they were struggling with grief so an offer for financial support for counselling services was made. A further meeting was planned at the conclusion of the RCA to be facilitated by the PSO. Cindy and Pete were provided the contact

Meet
details for the PSO as the primary contact. The obstetrician documents the meeting in the medical record. The PSO saves the completed meeting summary in the SLS and sends a copy to Cindy and Pete.

5.6 Step 4 Evaluate

5.6.1 Following a level 1 open disclosure meeting

- An open disclosure evaluation meeting is valuable. This meeting provides opportunity for discussion about open disclosure effectiveness, follow up actions and debrief.
    - Refer to Section 5.8 for effectiveness measures and the Commission's consumer/ staff open disclosure surveys.

5.6.2 Following a level 2 open disclosure meeting

- Evaluation involves an informal conversation between those staff present and feedback to the local manager/ staff involved in the incident if appropriate.

Case Study 6 : Step 4

Evaluate
Following a level 1 open disclosure patient meeting, the open disclosure team had an evaluation meeting. Staff had opportunity to debrief and talk through the meeting. One staff member was particularly concerned about the meeting and these concerns were openly discussed. Employee assistance programs and manager support were offered to the staff member. The facts shared with the patient/family/carer were confirmed as appropriate, and the meeting approach was aligned with the How to Conduct Open Disclosure Guideline. Following considerable discussion the team determined that the open disclosure meeting was successful and follow up actions were allocated.

5.7 Other considerations

5.7.1 Patient

- When an incident involves a child (less than 18 years), an agreement on whether the child is informed about the incident should be reached. This agreement should involve both clinicians and the parents/ guardian.
- Where the patient is very unwell, timing and/or the appropriateness of open disclosure should be considered.
- If the patient does not have decision making capacity the incident must be communicated with their substitute decision maker or Person Responsible.
- Planning and delivery of open disclosure to patient/family/carers from diverse cultural or linguistic groups may require additional sensitivity (e.g. burial plans, cultural communication, language).
- Where the patient/family/carer does not want communication with specific staff, this should be accommodated.

5.7.2 Staff

- Where staff are impacted by the incident and do not wish to be involved in the open disclosure patient meeting, this should be acknowledged and respected.
- Saying sorry is not an admission of staff fault or liability. The *Civil Liability Act 1936:Division 12 section 75* comments that an apology is not "admissible in any civil proceedings as evidence." (pg53) Public sector protections are also noted in the *Public Sector Act 2009; Division 4 section 74*.
- In the rare instance where staff deliberately cause patient/family/carer harm, the incident is a criminal act. Refer to the Clinical Incident Management Policy (Appendix 5) in relation to reporting requirements.
- Legal services are not involved in open disclosure meetings, but advice from legal services may be sought prior to the meeting.

5.7.3 Education and training

- Staff should undertake open disclosure training at the commencement of employment to ensure they have a basic understanding about open disclosure.
- Key individuals in the organisation should be trained as Open Disclosure Facilitators to provide expert leadership in level 1 open disclosure meetings.

5.8 Measurement and evaluation

- Effectiveness measures should be outlined in local open disclosure procedures. The Commission webpage has both consumer and staff surveys to evaluate the effectiveness of open disclosure.

6. Supporting information

- Australian Open Disclosure Framework, Australian Commission on Safety and Quality in Healthcare 2014
- Canadian Open Disclosure Guidelines: Being Open with Patients and Families 2011
- Charter of Health Community Services Rights, Health and Community Services Complaints Commissioner
- Clinical Incident Management Policy
- Engaging and involving patients, families, and staff following a patient safety incident, NHS 2022
- *Garrubba M & Joseph C. 2016. Open Discussion: A Rapid Review. Centre for Clinical Effectiveness, Monash Health, Melbourne, Australia*
- National Redress Scheme for people who have experienced child sexual abuse
- Open Disclosure Resources, NSW Clinical Excellence Commission
- Open Disclosure Resources for Consumers, Australian Commission on Safety and Quality in Healthcare webpage
- Preparing and participating in open disclosure Fact Sheet; Information for consumers and carers. Australian Commission on Safety and Quality in Healthcare.
- SA Health How to Say Sorry Topic Guide
- SA Health Open Disclosure Checklist
- SA Health Open Disclosure Meeting Summary
- SA Health 'Your Rights and Responsibilities' Brochure and Webpage
- South Australian Public Sector Code of Ethics 2009

7. Definitions

- **Clinical incident:** means an event or circumstance that occurs during SA Health Care that could have or did result in patient harm to a patient, client or consumer of SA health services.
- **Consumer:** means the patient, family, carer, substitute decision maker (SDM) or guardian.
- **Decision making capacity:** means a person is capable of agreeing to an action or arrangement. This capacity involves the person being able to (1) understand the information and nature of the decision (2) retaining the information provided even if only for a short time (3) use the information to make the decision and (4) communicate the decision.
- **Financial reimbursement:** means moneys required for travel to and from the open disclosure meeting. In some instances it may be required to pay for lost work hours of the patient to attend the open disclosure meeting, but this is negotiated outside of the open disclosure meeting with executive staff.
- **Guardian:** means a person acting or appointed under any Act or law as a guardian of another

- **Harm:** means impairment of structure or function of the body and/ or psychological distress. Harm includes disease, injury, suffering, disability, and death.
  - Harmful incidents can occur because an unplanned or unintended variation in care has occurred, the patients or medical team's expectations of care were not met, or a complication of investigation, (e.g. colonoscopy) or treatment, (e.g. surgery) resulted in patient harm. (e.g. bowel perforation or pneumothorax).
  - Harm may also be self-inflicted or as a result of violence and aggression.
- **Incident severity rating:** means a numerical score applied to a clinical incident based on the patient outcome and follow up treatment after an incident; Incident Severity Rating Topic Guide, Tool 2.
- **Liability:** means being legally responsible for an incident.
- **Medical record**: means both the electronic and hard copy patient record.
- **Near miss incident:** means an incident which could have, but did not occur or result in harm, either by chance or through timely intervention
- **No harm incident:** means an event or circumstance took place, but this did not result in harm.
- **Open disclosure:** means an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient/family/carer to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure is a discussion and an exchange of information that may take place over several meetings.
- **Open disclosure facilitators:** means those staff who have completed a course that includes open disclosure facilitation.
- **Open disclosure meeting:** means a meeting with the patient/family/carer to say sorry, explain the incident facts, implications and actions to prevent the incident from reoccurring.
- **Open disclosure team:** means a group of clinicians and/ or professionals who plan how the organisation will say sorry for patient/family/carer harm; they may have direct or indirect involvement with the patient/family/carer or have expertise in open disclosure meetings.
- **Patient:** means a person receiving services from a SA Health service or a service funded by SA Health. For the purpose of this document, patients, consumers, clients and residents are equivalent terms.
- **Person Responsible**: means a person responsible for a patient as defined under section 14 of the *Consent to Medical Treatment and Palliative Care Act 1995* and in the following legal hierarchy:
  - a guardian
  - a prescribed relative (being a person who is legally married to the patient, an adult domestic partner, an adult related by blood or marriage, a relation by adoption, an adult of aboriginal or Torres Strait Islander descent who is related to the patient according to kinship rules)
  - an adult friend with a close and continuing relationship with the patient
  - an adult who is charged with overseeing the ongoing day-to-day supervision care and wellbeing of the patient
  - the South Australian Civil and Administrative Tribunal on application of a prescribed relative, the medical practitioner proposing to provide treatment or any other person who the Tribunal is satisfied has a proper interest in the matter.
- **Regret:** means an expression of sorrow for a harm or grievance. It should include the words 'I am sorry' or 'we are sorry'. An expression of regret may be preferred over an apology in special circumstances (e.g. when harm is deemed unpreventable).
- **Restorative Just and Learning Culture:** means a way to avoids retributive, backward-looking accountability (which tends to blame individuals for things that went wrong) and instead focuses on the hurts, needs and obligations of all who are affected by the event. All stakeholders (staff,

consumers, carers, the service and the community) should be engaged in collaboratively identifying responsibilities for changes and improvements. Processes in place for reviewing events need to facilitate this forwarding looking accountability to learn, improve and heal.

- **Safety Learning System:** means the SA Health Incident Management System for reporting patient incidents. It aims to support comprehensive clinical governance, embed a culture of patient safety and quality, provide opportunity for trending of patients incidents, and shared learning across SA Health to improve patient safety and quality.
- **Serious harm:** means an outcome that involves a patient death or where a patient requires life-saving surgical or medical intervention, has shortened life expectancy, experiences permanent or long-term physical harm, or permanent or long-term loss of function.
- **State-wide services**: means State-wide Clinical Support Services, Prison Health, SA Dental Service, BreastScreen SA and any other state-wide services that fall under the governance of the Local Health Networks and DHW.
- **Substitute Decision Maker (SDM):** means a person appointed under an Advance Care Directive to make health, accommodation and lifestyle decisions when the appointee has impaired decision making capacity. SDMs cannot make decisions about finances, property or legal affairs.

8. Document ownership

Guideline owner: Domain Custodian for the Clinical Governance, Safety, and Quality Policy Domain.

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9. Document history

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1.0	15/04/2024	A/Chief Executive, DHW	Original Version

10. Appendix

1: Open Disclosure 4 Step Process

Appendix 1 Open Disclosure 4 Step Process