

NSW HEALTH OPEN DISCLOSURE POLICY PD2014_028

DIFFERENCES BETWEEN THE FORMER AND CURRENT POLICIES

| OLD POLICY PD2007_040 | NEW POLICY PD2014_028 |
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| <p>Definition of Open Disclosure</p> <p>The 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.</p> | <p>Definition of Open Disclosure</p> <p>Open disclosure is defined in the <i>Australian Open Disclosure Framework</i> as “an open discussion with a patient (and/or their support person(s)) about a patient safety incident which could have resulted, or did result in harm to that patient while they were receiving health care.</p> <p>Essential elements of open disclosure are:</p> <ul style="list-style-type: none"> • an apology which includes the words “I am sorry” or “we are sorry” • a factual explanation of what happened • an opportunity for the patient to relate their experience • a discussion of the potential consequences • an explanation of the steps being taken to manage the event and prevent recurrence. <p>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.”</p> |
| <p>Incident</p> <p>Any event resulting in, or with the potential for, injury damage or other loss. For the purposes of the open disclosure process an incident will exclude a near miss.</p> | <p>Patient safety incident</p> <p>Any unplanned or unintended event or circumstance which could have resulted, or did result in harm to a patient. This includes harm from an outcome of an illness or its treatment that did not meet the patient’s or the clinician’s expectation for improvement or cure.</p> <p><i>Harmful incident:</i> a patient safety incident that resulted in harm to the patient, including harm resulting when a patient did not receive their planned/expected treatment (replaces ‘adverse event’ and ‘sentinel event’).</p> <p><i>No harm incident:</i> a patient safety incident which reached a patient but no discernible harm resulted.</p> <p><i>Near miss:</i> a patient safety incident that did not reach the patient, and/or in which a potential for harm from ongoing risk may result.</p> |

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| OPEN DISCLOSURE RESPONSE | |
| <p>General level response</p> <p>Does not involve all the steps in the open disclosure process. Usually, it involves meeting with the patient, documentation of the incident, and notification to the line manager.</p> | <p>Clinician Disclosure</p> <p>An informal process where the treating clinician discusses with a patient and/or their support person(s) the occurrence of a patient safety incident; actively seeks input and feedback from, and listens to, the patient and/or their support person(s); and provides an apology for the occurrence of the event.</p> <p>Clinician disclosure is required whenever a patient has been harmed as a result of receiving treatment or care, and may be required if there is a potential for harm to result from ongoing risk.</p> <p>In the case of a near miss disclosure is discretionary, based on whether it is felt the patient would benefit from knowing, for example, if there is a residual safety risk.</p> |
| <p>High level response</p> <p>Involves all the steps in the open disclosure process</p> | <p>Formal Open Disclosure</p> <p>A structured process which follows on from clinician disclosure, to ensure effective communications between the patient and/or their support person(s), the senior clinician and the organisation occur in a timely manner⁵.</p> <p>Formal open disclosure may be required for any patient safety incident, as determined by the Director of Clinical Governance and/or the Facility/Operations/Service Manager, the patient and /or their support person(s).</p> |
| <p>Level of the Open Disclosure Response</p> <p>The level of the open disclosure response is based on the Severity Assessment Code (SAC). A SAC 1 and SAC 2 incident is usually graded as a high level response. A SAC 3 or SAC 4 incident is usually graded as a general level response. However, some of these incidents may be escalated to a high level response and this should be considered on a case-by-case basis at the discretion of the senior clinician and the senior manager.</p> | <p>Level of the Open Disclosure Response</p> <p>A disclosure discussion must occur whenever a patient has been harmed, whether that harm is a result of an unplanned or unintended event or circumstance, or is an outcome of an illness or its treatment that has not met the patient's or the clinician's expectation for improvement or cure. This includes disclosure when a patient has been harmed because they did not receive their planned/expected treatment.</p> <p>The open disclosure process begins with clinician disclosure. The process may progress to formal open disclosure for any patient safety incident, as determined by the Director of Clinical Governance (DCG) and/or the Facility/Operations/Service Manager, the patient and/or their support person(s).</p> |

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| ROLES AND RESPONSIBILITIES | |
| | <p>Open Disclosure Advisor A senior staff member specially trained in advanced empathic communications skills, who is available to support formal open disclosure in a health facility or service.</p> <p>Open Disclosure Coordinator A staff member who has responsibility for coordinating and supporting clinician and formal open disclosure in a health facility or service. This person may also have other roles and responsibilities for example, as a patient safety or patient liaison officer.</p> |
| PROCESSES | |
| | <p>Reimbursement of out-of-pocket expenses See section 4.6 in the Open Disclosure Policy</p> |
| NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARDS | |
| | <p>Standard 1.16 Implementing an open disclosure process based on the national open disclosure standard</p> <p>Actions required:</p> <p>1.16.1 An open disclosure program is in place and is consistent with the national open disclosure standard</p> <p>1.16.2 The clinical workforce are trained in open disclosure processes</p> |

For more detailed information please refer to the Open Disclosure page on the CEC website:

www.cec.health.nsw.gov.au/programs/open-disclosure