Open Disclosure Practices in Healthcare

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What is open disclosure?

"...the discussion of incidents that result in harm to a patient receiving healthcare..."

The failure to promptly and honestly advise patients of an adverse clinical outcome and provide an explanation of what occurred as well as a patient management plan moving forward has often been the catalyst for a complaint or claim against the practitioner involved. Being deserted after an adverse event is a major contributor to a complaint and or legal intent.

Why open disclosure?

If patients are quickly told about an adverse event and further harm prevented or minimised, the less likely the patient will get angry and complain or seek legal advice. For those incidents where there clearly has been medical negligent, open disclosure should assist with early resolution of the matter as well as a more cost-effective outcome potentially through an alternative to the standard stressful litigation model.

The 8 open disclosure standard key principles

1. Openness and timeliness of communication

When things go wrong, the patient and their support person should be provided with information about what happened, in an open and honest manner at all times. The open disclosure process is fluid and may involve the provision of ongoing information.

2. Acknowledgement

All adverse events should be acknowledged to the patient and their support person as soon as practicable. Health care organisations should acknowledge when an adverse event has occurred and initiate the open disclosure process.

3. Expression of regret

As early as possible, the patient and their support person should receive an expression of regret for any harm that resulted from the adverse event.

4. Recognition of the reasonable expectations of patients and their support person.

The patient and their support person may reasonably be expected to be fully informed of the facts surrounding the adverse event and its consequences, treated with empathy, respect and consideration and provided with support in a manner appropriate for their needs.

5. Staff support

Healthcare organisations should create an environment in which all staff are able and encouraged to recognize and report adverse events and are supported through the open disclosure process.

6. Integrated risk management and systems improvement

Investigation of adverse events and outcomes are to be conducted through processes that focus on the management of risk (see AS/NZS 4360). Outcomes of investigations are to focus on improving systems of care and will be reviewed for their effectiveness.

7. Good governance

Open disclosure requires the creation of clinical risk and quality improvement processes through governance frameworks where adverse events are investigated and analysed to find out what can be done to prevent their recurrence.

8. Confidentiality

Policies and procedures are to be developed by health care organisations with full consideration of the patient's, carer's, and staff's privacy and confidentiality, in compliance with relevant law, including Commonwealth and State/Territory Privacy and health records legislation.

Fact finding not fault finding

It is essential that the open disclosure process should focus on fact finding not fault finding. In any discussion with the patient and/or their support person during the open disclosure process, the healthcare professional should take care to avoid the following:

- State or agree that they are liable for the harm caused to the patient
- State or agree that another healthcare professional is liable for the harm caused to the patient, or
- State or agree that the healthcare organisation is liable for the harm caused to the patient.

Prepare & how to do it

1. Once it has been identified that harm has occurred, it is important to ensure that no further harm occurs.
2. The level of response need to be determined. This will depend of the seriousness of the incident and prognosis.
3. You will need to be very well researched about the medicine and cognisant of all the known facts, the reasons for the adverse outcomes and subsequent possible medical outcomes.
4. You will need to have developed a treatment plan to manage the situation.

As per the standards key elements, you will need to:

- Express regret
- Provide a factual explanation of what happened
- Detailed steps to be taken to manage the event
- Details of how a recurrence might be prevented

When in doubt

Contact MIPS 24 hour Clinico-Legal Support 1800 061 113

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