Open Disclosure Policy

TITLE	Open Disclosure
DOCUMENT NUMBER	36
DOCUMENT TYPE	Policy
SCOPE	All staff at Dr Scope and Coburg Endoscopy Centre
RISK RELATED TO PROCEDURE	LOW MEDIUM HIGH
ORIGINAL AUTHOR	Olga Tomic / Victoria Lawal
ORIGINAL PUBLICATION DATE	October 2018
REVIEW	Wendy Davis February 2019, Victoria Lawal 19th February, 2023
NEXT REVIEW DATE	**January 2026**
APPROVED BY/DATE	Clinical Governance – February 2022, February 29th, 2024
PURPOSE	The purpose of this policy is to give guidance to staff on protocols to follow in the case of an unexpected clinical event.
POLICY/PROCEDURE	**The guiding principles of Open Disclosure are** • Openness and timeliness of communication • Acknowledgement of the incident • Apology or expression of regret • Supporting, and meeting the needs and expectations of patients, their family and carers • Supporting, and meeting the needs and expectations of those providing health care • Integrated clinical risk management • Good governance • Confidentiality Detailed information on Open Disclosure is available at https://www.safetyandquality.gov.au/our-work/clinical-governance/open-disclosure Further resources/checklists are available at https://www.health.vic.gov.au/quality-safety-service/open-disclosure-following-adverse-events-in-health-services **What is a statutory duty of candour?** The Victorian Government define it as "a legal obligation to ensure that consumers of healthcare and their families are apologised to, and communicated with, openly and honestly when things have gone wrong in their care." It adds to the practice of open disclosure required by health services under the existing Australian Open Disclosure Framework, rather than replacing it. **Statutory Duty of Candour (SDC) for serious adverse patient safety event (SAPSE)** When a patient has suffered a SAPSE, the health service entity will be legally required to provide the patient, and/or their next-of-kin (NOK)/carer, with: a written account of the facts regarding the SAPSE an apology for the harm suffered by the patient a description of the health service entity's response to the event

	the steps that the health service entity has taken to prevent re-occurrence of the event. They will also be required to comply with any timelines and requirements set out in the Victorian Duty of Candour Guidelines. **Duty of Candour Resources** Find out more how this could impact your health operations with these useful resources. Using the Victorian Government's website guidance as per https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour **Summary of Process** • Patients, family members or carer given name and role of everyone involved in open disclosure meetings • A sincere and unprompted apology or expression of regret is given • A factual explanation of the adverse event • Allow patient, family members or carer the opportunity to tell their story • The patient, family members or carer are encouraged to talk about their personal effect of the adverse event • An open disclosure plan is agreed and recorded based on what the patient, family member or carer would hope to achieve • The patient, family member or carer are assured that they will be informed of any further reviews • Offer support (as per 10.1 of the ACSQHC Australian open disclosure framework Policy) • Have open dialogue between clinicians and patient, family members or carer and offer support to both patient and staff • Involve other clinicians from other facilities if the adverse event occurred in a different location
MONITORING	The process will be monitored as part of incident reporting and major incident review
RELATED DOCUMENTS	See links within policy
REFERENCES	National Safety and Quality Health Service Standards Australian Commission on Safety and Quality in Healthcare- Open Disclosure Framework Statutory duty of candour https://www.health.vic.gov.au/quality-safety-service/open-disclosure-following-adverse-events-in-health-services https://www.safetyandquality.gov.au/sites/default/files/migrated/Australian-Open-Disclosure-Framework-Feb-2014.pdf

	https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour
FOOTNOTE – where relevant	

Version History

RV No	Date	Change Details
Created	Oct 2018	
Reviewed Version 2	Feb 2019	Document reduced to policy and procedure to include links to relevant sites
Reviewed Version 3	Jan 2022	Reviewed and links updated
Reviewed Version 4	Feb 2024	Reviewed and links updated