Management of Open Disclosure

Purpose

It is the Levant CS group's policy to support an open discussion of an adverse event that resulted in unintentional harm to a person while receiving care at a Levant CS facility.
The Levant CS group acknowledges the importance of open disclosure in sound clinical governance and the maintenance of safety, quality and clinical risk management.

Definition

Adverse events and patient harm can, and does occur. Open disclosure describes how clinicians should best communicate with patients, and their support persons, who have experienced harm during health care.

The World Health Organization defines harm as:

'Impairment of structure or function of the body and/or any deleterious effect arising there from, including disease, injury, suffering, disability and death. Harm may be physical, social or psychological'

The Levant CS group acknowledges that open disclosure is a patient right and is inclusive in good clinical practice. All staff at Levant Cosmetic Surgery are responsible for ensuring that patients are aware of their rights and responsibilities upon admission to the facility.

Responsibilities

All staff at Levant CS facilities are responsible for ensuring that open disclosure is practiced. The Practice Manager of each facility is to ensure all staff are provided with the appropriate documentation and training to aid in easy and effective open disclosure to patients as required.

Procedure

In the unlikely event of an adverse occurrence, staff and the treating Medical Practitioner at each facility have a responsibility to communicate with the patient, carer and their family in an open and honest way. This includes an explanation of what happened, reasons for the adverse event and advice regarding how the occurrence can be managed or resolved.
In the event of an adverse occurrence, each facility will follow open disclosure processes compliant with the Australian Open Disclosure Framework, including immediate actions to rectify the occurrence, an explanation of what has occurred including anticipated short and long-term consequences, acknowledgement of patient distress and provision of support, advice on any future management if required and the provision of information on how to make a complaint. The Medical Director of the facility is to inform the group Medical Director and Board of Directors that an open disclosure process has occurred.

The elements of open disclosure are:

- An apology or expression of regret, which should include "I am sorry"
- A factual account of the event
- An opportunity for the patient or their support persons to relate their experience of the event
- A discussion of potential consequences of the event
- An explanation of the steps being taken by Levant Cosmetic Surgery to manage the adverse event and the prevention of a recurrence.

During the expression of regret staff are to ensure only known facts are to be communicated to the patient and their support persons, to ensure that there is no direct or implied blame of employees or Levant Cosmetic Surgery, speculation is not to occur. While liability is not determined by what is said, it is prudent to discuss only facts with the patient and their support persons.

Detail of the event is to be recorded in the patient's medical record, including associated risks and likely consequences.
The treating Medical Practitioner will notify their indemnity insurer of the event. Apologizing or expressing regret is central to open disclosure. All Australian jurisdictions have enacted apology laws to protect statements of apology or regret made after 'incidents'. Generally, apology laws dissociate apology from liability and are designed to enable the natural 'humane response' of apologizing.

Related Documents

Medical records
Board/MAC meeting minutes

Resources

Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service (NSQHS) Standards 2nd Ed. 2021. Sydney.

Australian Council for Safety and Quality in Health Care. Open Disclosure Standard: A national standard for open communication in public and private hospitals, following an adverse event in health care 2003

Australian Council for Safety and Quality in Health Care. Open Disclosure Standard: Australian Open Disclosure Statement; Open disclosure: just in time information for clinicians 2013

Australian Council for Safety and Quality in Health Care. Australian Open Disclosure Framework 2014

World Health Organization. The International Classification for Patient Safety WHO, 2009

Amendment Record

Date	Amendment made	Approved by
01/18	Policy developed	CK
03/21	Scheduled policy review, updated references	CA
07/22	Routine policy review, no changes	CA
05/23	Updated to new logo, entity, responsibilities	Board
04/24	Updated to new branding	Board