OPEN DISCLOSURE

Purpose

- To provide appropriate guidance for clinical staff in keeping the Client and family informed when the Client has suffered unintentional harm during health or disability service delivery. [1]
- To fulfil legal obligations to take steps to ensure that open disclosure is practised by staff and supported by management.[2]
- To maintain a focus on systems improvement, rather than the assignment of blame to individuals or groups.

1. Scope

a. Applies to all employees and managers who have responsibility for support services provided to Access and TCH clients.

b. Applicable throughout Access, TCH and Access Delivery Partners.

c. Open disclosure is a process required by law to be practised by the staff and supported by the management of Access Delivery Partners.[3]

2. Definitions

a. Open Disclosure (OD): "A transparent approach to responding to an incident/adverse event that places the consumer/resident central to the response. This includes the process of open discussion and on-going communication with the consumer/resident and their support person(s). An OD approach also includes support for staff and the development of an OD culture where staff are confident that the associated investigations will have a quality improvement rather than a punitive focus".[4]

b. Serious adverse event: One that requires significant additional treatment, but is not life threatening and has not resulted in a major loss of function.

c. Sentinel adverse event: Is life threatening, or has led to an unexpected death or major loss of function.[5]

d. Notifiable event: Refer to Health and Safety at Work Act 2015.

3. Responsibilities

a. National Clinical Group (NCG)

i. Commissioning Root Cause Analysis Teams following a serious or sentinel event.

ii. Identifying the need to provide incident information to the Access insurer prior to disclosure taking place and the level of disclosure required.

iii. Supporting Clinical staff with open disclosure and on-going communication when adverse events occur.

[1] Refer NZS 8158:2012 Standard 2.4.3 Adverse, unplanned and untoward events are addressed in an open manner.
[2] Guidance on Open Disclosure Policies p.1 Health and Disability Commissioner December 2009
[3] Refer Health and Disability Commission Guidance on Open disclosure Policies p.1, December 2009.
[4] Health Quality and Safety Commission Root Cause Analysis For Clinical Incidents #7 Communication with the patient and patient's family. February 2012.
[5] Refer for b, and c to Health quality and Safety Commission Factsheet 3 Feb. 2012 2010/2011.

iv. Managing the National Reportable Adverse Events process for Access.

b. Regional Managers (RM) and TCH Operations Manager

i. Immediately reporting to the COO all serious and sentinel events occurring as a result of the care/support delivered or not delivered by Access or TCH within own regions.

ii. Providing support to the Client/family and Access/TCH employees in a timely manner.

iii. Immediately advising the National Clinical Leaders Group of all adverse events occurring as a result of the healthcare or support services provided, if a change to process is identified as part of the investigation.

iv. Resourcing training requirements for open disclosure.

c. Clinical Managers (CM)/Community Nurse Team Leaders (CNTL)

i. Providing support and oversight during the open disclosure process.

ii. Providing input and assistance to the National Clinical Leaders Group for the completion of SAC reports within appropriate time frames as required by the NZ Health & Disabilities Services National Reportable Adverse Events Policy 2017.

d. Registered Health Professionals (CN/CRN/PT/OT)

i. Ensuring the Client is fully informed and, as required, reminded of their rights especially Right 6 which give all consumers the right to be fully informed.

ii. Assessing the Client to ensure that information provided is in a language, form and manner that the Client can understand and is practicable, enlisting the aid of appropriate interpreting services[6] if required.

iii. Confirming the Client /support person/s is aware of their right to complain, take the issue to the HDC, and possible entitlement under ACC.

iv. Fully document details about the incident, any harm, the disclosure and subsequent action in the Client's healthcare record.

e. Care Coordinator Team Leaders (CCTL)/ Support Worker Coordinator (SWC)

i. Investigating reports of harm

f. Care Coordinators (CC)

i. Immediately escalating any reports of harm occurring to the Client made by SWs, to the RHP principally responsible for the care of the Client.

ii. Inputting incident details into HGov.

iii. Making comprehensive concurrent diary notes of any reports of harm.

g. Support Workers (SW)

i. Immediately reporting to the NCC any incidents or accidents occurring to the Client during or soon after the delivery of care/support.

ii. Participating in open disclosure activities as and when required by the CNTL/RHP.

4. Procedure

a. As soon as the SW or RHP becomes aware of any harm occurring to a Client as a result of support services the following must occur:

i. Ensure the immediate safety and comfort of the Client, including calling for emergency assistance if that is required.

[6] Right 5 of the Health and Disability Commissioner Code of Rights.

ii. After the immediate care of the Client has been provided, the SW is to provide a comprehensive report of the event to the CC for diarising in Barista and recording in HGov.
iii. CC will seek advice from an RHP.
iv. In the event that harm occurs as the result of care provided by the RHP, follow step 4.a.i and then report the incident to the CM/CNTL and RM/TCH Ops Manager.

b. The RHP is to contact the SW for a report, and do a preliminary assessment of the harm to the Client which may include an immediate visit to the Client.

c. After discussion with the SW, if the harm is not significant, the RHP should, if possible, contact the Client/support person/family and arrange a meeting with the Client/ support person/family and the SW. This meeting should occur within 24 hours of the incident happening.

d. Open disclosure takes the following form:
i. The RHP reviews the Clients first language, cultural and ethnic identity to confirm the appropriate support is available.
ii. A sincere apology eg "We are sorry [this event] has occurred to you, and the distress it has caused to you and your family." **Note** – the purpose of the apology is not to allocate blame or admit liability.
iii. A factual explanation of what happened.
iv. The consequences of the event as far as they are known.
v. Describe the actions that have been taken or that are proposed to be taken, to prevent the occurrence from happening again.
vi. Acknowledge the limits of what is known of the incident.
vii. Listen to the Client or support person's understanding of what has happened and address any concerns they may have.
viii. Commit to sharing further information as it becomes available.

e. Confirm that the Client is aware of their right to complain, and ensure the information on the complaint process and their options is readily available.

5. Exceptions

a. It is not appropriate for a SW to disclose information relating to the health status of a Client that a colleague or team leader has provided, and which the SW knows or suspects is not known by the Client. In this instance the information ***must be*** discussed with the Registered Health Professional (RHP) who will advise what action, if any, is required.

b. Note also that an error which has affected the Client's care, but does not appear to have caused harm may also need to be disclosed to the Client/support person.

c. Where performance or conduct issues have arisen, standards of confidentiality prevent Access/TCH disclosing particular outcomes with a Client or their representative. A possible response will be; "A full investigation has been undertaken and we have taken appropriate action with the Access/TCH staff involved."

6. Associated Documents

- **a.** QD 3.5 Complaints and Comments Form
- **b.** QD 1.5 Complaints Management
- **c.** QD 2.1 Client Accident and Incident Procedure
- **d.** HGov Register

7. References

- **a.** NZS 8158:2012 Standards 1.6 Communication in a manner the consumer can understand and 2.4 Adverse Event Reporting
- **b.** NZS 8.1.3.4.1.2.4 Health & Disability Services Standards, Organisational Management: Adverse Event Reporting.
- **c.** Health Quality and Safety Commission Root Cause Analysis for Clinical Incidents. 12 June 2012
- **d.** Health and Disability Commissioner Guidance on Open Disclosure Policies.
- **e.** Australian Commission for Safety and Quality in Healthcare (NCSQHC) National Open Disclosure Standard.