COMPANY PROCEDURES **PROCEDURE GP 29**

OPEN DISCLOSURE

Quality System Control	**Open Disclosure**
Issued to	Signed (QM)
1. Nurses Station (Main Folder)	
2. Reception	

AIM OF THIS PROCEDURE

To create an environment at Bendigo Day Surgery that encourages identifying and reporting adverse events so that opportunities for learning can be identified and acted on. In working towards an environment that is as free as possible from adverse events, there is a need to move away from blaming individuals to focusing on establishing systems of organisational responsibility.

In this context open disclosure can:

- improve patient safety and quality of care through organisational learning
- increase trust between patients and their clinicians
- assist patients and their families and carers recover from healthcare harm
- support staff through understanding and managing unintended patient harm.

WHEN IS THIS PROCEDURE USED?

This procedure is implemented following an adverse event which may or may not result in significant harm to a patient.

WHO USES THIS PROCEDURE?

The Director of Nursing is responsible for implementing this procedure.

USING THIS PROCEDURE

- The Open Disclosure Policy has been developed in accordance with the requirements of the NSQHS Standards, particularly the first standard, the Clinical Governance standard.
- Open Disclosure is the open discussion of incidents that have resulted in harm to a patient while receiving care at Bendigo Day Surgery
- In the event of a near miss or less serious incident, an informal process may be implemented; where the treating doctor or DON informs the patient of what has occurred and expresses their regret for the harm caused or adverse outcome. This may occur at the discretion of the treating doctor and/or the DON

- Where a serious adverse event has occurred, a formal meeting should be arranged between the treating doctor, the Director of Nursing, the patient and/or their carer.

- An interpreter should be arranged if required. In these instances, it is not appropriate for family members to act as an interpreter.

- Discussion should include, but is not limited to:

    - An apology or expression of regret

    - An explanation of what happened (the facts known at the time)

    - A discussion about what will happen next and the anticipated impact upon the patient

    - Advice on how and when they will be provided with further information

    - Health professionals should listen to any concerns and respond to questions

    - Any additional support or referrals identified and the patient and/or carer given advice on how to access appropriate services

- Information provided and meeting outcomes should be thoroughly documented

- Bendigo Day Surgery Insurer should be notified where harm has occurred

- Provide the patient and/or their carer with contact details should they have further questions

- The process should be evaluated and communicated with staff directly involved in the incident, the Management team, MAC and Board of directors as deemed necessary

- Staff involved should be informed and supported throughout the Open Disclosure process. Placing blame on individuals should be avoided, with the focus being on organisational and system improvements to reduce future incidents

- Patient, carer and staff privacy should be fully considered throughout the process

- In extreme cases, the Director of Nursing or treating doctor may employ the services of an independent practitioner, trained in the process of Open Disclosure to help facilitate and enable open communication between the patient, their family, the treating doctor, Bendigo Day Surgery staff and management representatives

- All Bendigo Day Surgery staff are required to undertake Open Disclosure training annually
- All incidents where Open Disclosure occurs are to be reported on a IIIR form

CONTROLLED DOCUMENTS RELATED TO THIS PROCEDURE

Issue, Incident & Improvement Request (IIIR) Form	ICF 1
Request for New or Updated Document	ICF 4

REFERENCES TO THIS PROCEDURE

National Safety and Quality Health Service Standards (second edition): 2017

www.safetyandquality.gov.au/standards/nsqhs-standards

The Australian Open Disclosure Framework (2014)

www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework

Open Disclosure Flowchart for healthcare consumers (ACSQHC 2013)

www.safetyandquality.gov.au/publications-and-resources/resource-library/open-disclosure-flow-chart-healthcare-consumers-poster

Department of Health (Victoria) Open Disclosure short course

WWW.vhimsedu.health.vic.gov.au/opendisclosure/topics/topic1/page1.php