MARIE STOPES AUSTRALIA	**TITLE: Open Disclosure Policy**		
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1. TARGET AUDIENCE

All Marie Stopes Australia (MSA) staff.

2. POLICY STATEMENT

All clients have the right to open, honest, timely and empathic communication with us if something does not go to plan with the healthcare that we provide to them. This policy sets out our commitments to open disclosure and is underpinned by the Australian Open Disclosure Framework[i].

3. PRINCIPLES

If things go wrong, all clients have the right to open communications that are timely and empathic.

All adverse events should be acknowledged by MSA to the client and their family/ support person or carer**.**

An apology or expression of regret should be provided as soon as appropriate and practicable and should include the words "I am sorry" or "we are sorry". Note: using these words does not constitute an admission of guilt.

Clients and their families and support people should be supported and treated empathically in the process of open disclosure.

All staff should feel informed, empowered and supported to recognise and report adverts events. Note: open disclosure training is mandatory for all staff who are likely to be involved in the process.

Our open disclosure practices are integral to our clinical governance including our adverse event reporting and review process. Information obtained about incidents from the open disclosure process is vital to our quality improvement activities.

Our open disclosure processes are underpinned by good governance frameworks and are regularly reviewed to ensure they maintain integrity and accountability.

Confidentiality is a critical consideration in open disclosure and MSA has a responsibility to ensure the privacy of clients and clinicians at all times and in accordance with our legal obligations.

Definitions

Admission of liability refers to a statement made by a person that admits, or tends to admit, a person's or organisation's liability in negligence for harm or damage caused to another.[ii]

Clinical Adverse Event at MSA refers to a clinical adverse event is a complication of treatment or a procedure in which harm resulted to a client receiving healthcare

Apology is an expression of sorrow, sympathy and (where applicable) remorse by an individual, group or institution for a harm or grievance. It should include the words 'I

am sorry' or 'we are sorry'. Apology may also include an acknowledgment of responsibility, which is not an admission of liability.[iii]

Expression of regret is an expression of sorrow for a harm or grievance. It should include the words 'I am sorry' or 'we are sorry'. An expression of regret may be preferred over an apology in special circumstances (e.g. when harm is deemed unpreventable).[iv]

Harm refers to an impairment of structure or function of the body and/or any deleterious effect arising therefrom, including disease, injury, suffering, disability and death. Harm may be physical, social or psychological.

Healthcare refers to the prevention, treatment and management of illness and the preservation of mental and physical wellbeing through the services offered by the medical and allied health professions.[v]

Liability is the legal responsibility for an action.[vi]

Open disclosure is an open discussion with a client about an incident(s) that resulted in harm to that client while they were receiving healthcare. The elements of open disclosure are an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the client to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure is a discussion and an exchange of information that may take place over several meetings.

Quality refers to the continuous study and adaptation of a healthcare organisation's functions and processes to increase the probability of achieving desired outcomes and better meet the needs of clients and other users of services.

Risk refers to the effect of uncertainty on objectives. The effect that uncertainty has on the achievement of an agency's objective gives rise to risk.[vii]

Risk management refers to the design and implementation of a program to identify and avoid or minimise risks to clients, employees, volunteers, visitors and the organisation. At MSA we have two types of risk management:

- *Clinical risk management: c*linical, administrative and manufacturing activities that we undertake to identify, evaluate and reduce the risk of injury to clients and visitors, and the risk of loss to the organisation itself.
- *Corporate risk management: a*ctivities of an organisation or corporation to identify and reduce potential financial or reputational liabilities, exposures and dangers.[viii]

Support person refers to a person who has a relationship with the patient. This includes a family member/ next of kin, carers, friends, partners, guardians, social workers and trained patient advocates.[ix]

Key Elements of open disclosure[x]

1. Open and timely communication

   When things go wrong, the client and their support person are provided with information about what happened in an open and honest manner. The open

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disclosure process is fluid and will often involve providing ongoing information to the client.

2. Acknowledgement

   All adverse events should be acknowledged to the client, their support person, family or carer as soon as practicable. We acknowledge when an adverse event occurs and initiate open disclosure.

3. Apology or expression of regret

   As early as possible, the client, their family and carers should receive an apology or expression of regret for any harm that resulted from an adverse event. An apology or expression of regret should include the words 'I am sorry' or 'we are sorry', but must not contain speculative statements, admission of liability or apportioning of blame. Refer to Australian Commission on Safety and Quality in Health Care guide to saying sorry.

4. Supporting and meeting the needs and expectations of clients and their support people, family and carers

   The client, their family and carers can expect to be; fully informed of the facts surrounding an adverse event and its consequences; treated with empathy, respect and consideration; and supported in a manner appropriate to their needs.

5. Supporting and meeting the needs and expectations of staff providing healthcare

   We are responsible for creating an environment in which all staff are; encouraged and able to recognise and report adverse events; prepared through training and education to participate in open disclosure; and supported through the open disclosure process. Note: open disclosure training is mandatory for all staff.

6. Integrated clinical risk management and systems improvement

   Thorough clinical review and investigation of adverse events and adverse outcomes is conducted In accordance with our Risk Management Framework. The information obtained about incidents from the open disclosure process is incorporated into quality improvement activity.

7. Good governance

   To prevent reoccurrence, open disclosure requires that clinical risk and quality improvement processes are created through governance frameworks. This ensures that changes are implemented and their effectiveness is reviewed.

8. Confidentiality

   Open disclosure occurs with full consideration for client and clinician privacy and confidentiality in compliance with relevant State and Territory laws and in accordance with our Privacy Policy. This element should also be considered in the context of the first element, *open and timely communication.*

4. OBJECTIVES

This policy supports MSA staff to:

- understand the principles of open disclosure;

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- practice open disclosure when things go wrong;
- be empowered to raise recognise and report adverse events and incidents;
- be confident that they will be supported during the process of open disclosure.

5. RESPONSIBILITIES

Managing Director and Executive

- Embed client centred care at the organisational level within the governance and leadership of MSA.
- Champion open disclosure at the highest level of the organisation and ensures appropriate delegation in place to oversee the open disclosure process.
- Ensure that MSA has effective systems for consumer complaints and open disclosure, and monitor performance of these systems

Medical Director

- Ensures that open disclosure system is in place and in accordance with National and State DHS policies (including Sentinel and Reportable Event Reporting), involves all members of the clinical workforce and are subject to periodic review of performance.

Managers

- Ensure staff effectively use the open disclosure process in accordance with this policy.

Frontline staff including Doctors, Registered Nurses, Enrolled Nurse:

- Take part in the design and implementation of open disclosure process.
- Practice open disclosure in accordance with this policy.
- Take part in mandatory training.

Clients and Consumers

- Take part in open disclosure when relevant and appropriate.
- Provide feedback from open disclosure events to assist MSA with quality improvement activities.

6. EVALUATION

We evaluate our open disclosure processes using the following methods:

- An audit of the practice of Open Disclosure following a Critical Incident is conducted each year and reported to the Clinical Governance Committee and the MSA Executive Team.
- A biennial staff safety climate survey is conducted to measure the strength of our safety climate culture
- An audit of open disclosure training is conducted each year to ensure 100% of staff who are likely to be involved in open disclosure processes have the adequate skills.

7. KEY ALIGNED DOCUMENTS

Critical Incident Screening Tool

Critical Incident Panel Terms of Reference

Mandatory Training Policy

Patient Feedback and Complaint Management

Patient Rights Policy Statement

Risk Management Procedure

Unexpected Death During or After a Procedure

8. KEY LEGISLATION, ACTS & STANDARDS

National Safety and Quality Health Service Standards Australian Charter of Healthcare Rights Standards 1.11, 1.12
Australian Open Disclosure Framework

9. REFERENCES

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- State of Victoria through the Victorian Managed Insurance Authority 2016. *Victorian Government Risk Management Framework Practice Guide*, https://www.vmia.vic.gov.au/tools-and-insights/tools-guides-and-kits/victorian-government-risk-management-framework retrieved January 2020

[i] Australian Commission on Safety and Quality in Health Care (2013), *Australian Open Disclosure Framework*. ACSQHC, Sydney.
[ii] IBID
[iii] IBID
[iv] IBID
[v] IBID
[vi] IBID
[vii] State of Victoria through the Victorian Managed Insurance Authority 2016. *Victorian Government Risk Management Framework Practice Guide*, https://www.vmia.vic.gov.au/tools-and-insights/tools-guides-and-kits/victorian-government-risk-management-framework retrieved January 2020
[viii] ACSQH 2013.
[ix] IBID
[x] Australian Commission on Safety and Quality in Health Care (2013) *Open disclosure principles, elements and processes.* ACSQHC, Sydney.