

Open Disclosure Policy

Purpose

We are committed to the provision of safe quality health care to the residents. Despite best efforts, there are occasions when individuals are harmed by the health care they receive. While such harm is sometimes unavoidable, there are occasions when it results from preventable mistakes or errors in the provision of that care.

Consumers want a clear and consistent approach to open disclosure by health care and disability services providers.

Right 6 of the Code of Health and Disability Services Consumers' Rights gives all consumers the right to be fully informed. Consumers have a right to know what has happened to them.

Health care has a legal duty to take steps to ensure that open disclosure is practised by staff and supported by management.

Scope

Open disclosure applies to all staff involved in patient's care, and communication with patients and/or support person should reflect the fact that care is provided by a multi-disciplinary team.

Policy

There are a number of rights under the Code of Health and Disability Services Consumers' Rights (the Code) that are relevant to open disclosure.

- Open disclosure:
 - affirms patients' rights;
 - fosters open and honest professional relationships; and
 - it enables systems to change to improve service quality and consumer safety.
- Patients want to know when things go wrong and why. Providers and provider organisations are required to promote the disclosure of such information in accordance with their individual or organisational duty of care.
- Patients need to know what the consequences could be for them and their ongoing care.
- Patients are interested in any action taken as a result of the error or adverse event.

Open Disclosure Procedure

NOTE: The practice manager must be informed of any open disclosure undertaken by any staff

Who

- The individual provider with overall responsibility for the patient's care should disclose the incident.
- If the incident occurred in a team environment, the team will meet to discuss what happened, how it happened, the consequences for the patient (including arrangements for continuity of care), and what will be done to avoid a similar occurrence in the future and how the harm will be disclosed to the patient.
- The team will discuss the event to check systems and processes and discuss the appropriate actions concluded from the event.
- Document everything as is practicable

When/Where Should the Disclosure Take Place

1. **A patient should be informed about any adverse event/potential adverse event**, i.e. when the consumer has suffered any unintended harm while receiving health care or disability services, usually within 24 hours.
2. An error that affected the patient's care but does **not appear to have caused harm may also need to be disclosed**. Notification of an error may be relevant to future care decisions — whether or not to go ahead with the same procedure on another occasion. The effects of an error may not be immediately apparent.
3. **A disclosure should include** acknowledgement of the incident, an explanation of what happened, how it happened, why it happened and what actions have been taken to prevent it happening again. In some situations, specific actions will need to be taken straight away, whereas in other situations where the explanation is still unfolding, the actions that need to be taken may take longer to identify.
4. **A disclosure may include an apology**. It is the acknowledgment of the adverse event and the distress that it causes. Apologies may bring considerable comfort to the consumer and have the potential to assist with resolution. In some situations, an apology may be critical to the patient's decision to lay a formal complaint and pursue the matter further.
5. The patient should be given contact details and information about the local health and disability **consumer advocate services** as well as options for making a complaint.

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Consumers Rights Relevant to “Open Disclosure” and incidents

- Right 1** The right to be treated with respect – requires a truthful and sensitive discussion about any harm or incident.
- Right 2** The right to be free from discrimination, coercion, harassment and exploitation – requires us to ensure we look upon our patients with an equity lens and inclusiveness.
- Right 3** The right to be treated with dignity and independence – we will recognise that this is a core value of our team for all patients treating them equally.
- Right 4** Providers have an obligation to provide services with reasonable care and skill; we need to ensure that this is an ongoing care of duty, to do our best to prevent adverse events occurring.
- Right 5** Information must be provided in a form language and manner such that the patient understands where possible.
- Right 6** We have a duty of open disclosure according to legal, professional, ethical, and other standards – Consumers have a right to honest and accurate answers to questions relating to services, including the identity and qualifications of providers, and how to obtain an opinion from another provider. They have a right to receive on request a written summary of information provided
- Right 7** Recognising the need to explain all eventualities when consent is being given.
- Right 8** The right to have a support person, is important in distressing situations, or when receiving bad or unexpected news.
- Right 9** Openness when our practice is involved in a teaching scenario or any research may be undertaken – the patient should be informed and given the option to not be involved with it if preferred.
- Right 10** Requires providers to ensure that consumers are made aware of their right to complain and be provided with information about the complaint process and their options.

Resources:

- Guidance on open disclosure policy - <https://www.hdc.org.nz/media/5372/guidance-on-open-disclosure-policies.pdf>

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Due Date : 4th Nov 2024

Signed: *CRGoldsmith(PM)*