Policy Directive

Open Disclosure

Summary This Policy Directive sets out the minimum requirements for implementing open disclosure within NSW Health facilities and services.

Document type Policy Directive

Document number PD2023_034

Publication date 18 October 2023

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Replaces PD2014_028

Review date 18 October 2028

Policy manual Health Records and Information Manual for Community Health Facilities, Patient Matters Manual for Public Health Organisations

File number

Status Active

Functional group Clinical/Patient Services - Governance and Service Delivery, Incident Management
Corporate Administration - Governance
Personnel/Workforce - Conduct and ethics

Applies to Ministry of Health, Public Health Units, Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, NSW Health Pathology, Public Health System Support Division, Cancer Institute, Government Medical Officers, Community Health Centres, NSW Ambulance Service, Dental Schools and Clinics, Public Hospitals

Distributed to Ministry of Health, Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Environmental Health Officers of Local Councils, Private Hospitals and Day Procedure Centres, Health Associations Unions, Tertiary Education Institutes

Audience All Clinical Staff;Management and Executive Staff of Public Health Organisations in NSW

Secretary, NSW Health

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

NSW Health
POLICY DIRECTIVE

Open Disclosure

POLICY STATEMENT

NSW Health is committed to ensuring open and timely discussions occur between NSW Health Services and patients and support persons following an incident by implementing open disclosure processes.

SUMMARY OF POLICY REQUIREMENTS

Open disclosure must occur whenever a patient has been harmed. Open disclosure is an open discussion with the patient and/ or their support person(s) about a patient safety incident which could have resulted in or did result in harm to that patient while they were receiving health care.

Clinician disclosure is the first stage of open disclosure and must be undertaken within 24 hours of incident identification. Formal open disclosure is the second stage of open disclosure and is undertaken as required, however may be needed for any incident of any level of harm.

NSW Health Services must have appropriate governance and implementation frameworks to ensure that open disclosure roles, responsibilities and functions are met.

The practice of open disclosure involves:

- **Acknowledgement** of an incident to the patient and/ or support person within 24 hours of incident identification. This includes recognising the significance of the incident to the patient.
- **Truthful, clear and timely communications** on an ongoing basis as required.
- **An apology** to the patient and/ or support person, including the words “I am sorry” or “we are sorry”.
- **Ongoing care and support to patients** and/ or support persons that is responsive to their needs and expectations, for as long as is required.
- **Support to staff** which is responsive to their needs and expectations.
- An **integrated approach to improving patient safety** in which open disclosure is linked with clinical and corporate governance, incident reporting, risk management, consumer feedback/ complaints management and quality improvement policies and processes.

  This includes evaluation of the process by patients, carers and families, and staff, accountability for learning from incidents and evidence of systems improvement.
- **Multidisciplinary involvement** in the open disclosure process.

- Compliance with the legal requirements of **privacy and confidentiality** for the patient and/ or support person, and staff delivering health care.

REVISION HISTORY

Version	Approved By	Amendment Notes
PD2023_034 October 2023	Deputy Secretary, System Sustainability and Performance	Role of open disclosure coordinator removed. Revised to align with NSW Health Policy Directive *Incident Management* (PD2020_047).
PD2014_028 September 2014	Deputy Secretary, Governance, Workforce and Corporate	This revised policy contains changes to the open disclosure process and replaces PD2007_040 and GL2007_007.
GL2007_007	Director General	New guideline
PD2007_040	Director General	New policy

NSW GOVERNMENT

NSW Health

Open Disclosure

CONTENTS

1. BACKGROUND 3
1.1. About this document 3
1.2. Key definitions 3
1.3. Legal and legislative framework 5
1.4. Other related policies and CEC resources 5
2. IMPLEMENTATION 6
2.1. Clinicians 6
2.2. Senior clinicians 6
2.3. Heads of department 6
2.4. Facility/ Operations/ Service Managers 7
2.5. Open Disclosure Advisors 7
2.6. Directors of Clinical Governance 7
2.7. Chief Executives or their delegates 7
2.8. The Clinical Excellence Commission 7
3. THE OPEN DISCLOSURE PROCESS 8
3.1. When to disclose 8
3.2. When to progress to formal open disclosure 8
3.3. Risk management 9
3.4. Relationship to incident management 9
3.4.1. Dedicated family contact 9
3.4.2. Privileged processes 9
3.4.3. When more than one organisation is involved 10
3.5. Where staff participating in open disclosure may seek advice or support 10
3.6. Key steps 10
3.6.1. Assess the level of open disclosure response required 10
3.6.2. Stage 1: Clinician disclosure 10
3.6.3. Stage 2: Progress to formal open disclosure as required 11
3.6.4. Follow up activities 12
3.6.5. Finalise formal open disclosure 12
3.7. Record management 12
3.8. Out of pocket expenses 13
3.9. Specific circumstances 13
3.10. Monitoring and evaluation 13

4. REFERENCES 14

NSW GOVERNMENT

1. BACKGROUND

Open disclosure is an open discussion with the patient (and/ or their support person(s)) about a patient safety incident; and aims to ensure that open, honest, empathic and timely discussions occur between the NSW Health Service and patients and their support person(s) following an incident. It is based on principles in the *Australian Open Disclosure Framework* and is integral to incident management in NSW Health.

This Policy Directive should be read in conjunction with the Clinical Excellence Commission's *Open Disclosure Handbook*.

1.1. About this document

This Policy Directive sets out open disclosure requirements for NSW Health Services. It defines when open disclosure is required, describes the open disclosure process and outlines the key steps involved. The Clinical Excellence Commission (CEC) Open Disclosure website has resources to support implementation.

The open disclosure process relates to patient safety incidents; however, this process can be used in other areas as applicable. It is a continuous process that commences with clinician disclosure and may progress to formal open disclosure.

1.2. Key definitions

Apology	An expression of sympathy or regret, or a general sense of benevolence or compassion. It must include the words "I am sorry" or "we are sorry".
	
	Under Section 69 of the *Civil Liability Act 2002* (NSW), the effect of apology on liability:
	
	1) An apology made by or on behalf of a person in connection with any matter alleged to have been caused by the person:
	   a) Does not constitute an express or implied admission of fault or liability by the person in connection with that matter, and
	   b) Is not relevant to the determination of fault or liability in connection with a matter.
	
	2) Evidence of an apology made by or on behalf of a person in connection with any matter alleged to have been caused by the person is not admissible in any civil proceedings as evidence of the fault or liability of the person in connection with that matter.

Clinician	A trained health care provider who provides patient care.
Clinician Disclosure	The treating clinician/ team discusses the incident with the

	patient and/ or their support person within 24 hours. The clinician/ team/ staff discusses the incident, listens and seeks feedback, and apologises for the incident occurrence. This is the first stage of the continuous open disclosure process, which can progress to formal open disclosure.
Dedicated Family Contact	The Dedicated Family Contact (DFC) is a staff member assigned to support a patient, carer or family during a serious adverse event review and beyond if needed. The DFC is the primary contact for the patient, carer and family. They maintain regular communication and help them to navigate the health system and understand the incident review process.
Formal Open Disclosure	A structured process which continues from clinician disclosure, to ensure effective and timely communications between the patient and/ or their support person, the senior clinician, and the organisation. Formal open disclosure may be required for any incident. During formal open disclosure the NSW Health Service provides further information as it comes to hand.
NSW Health Services	A local health district or a statutory health corporation, NSW Ambulance, HealthShare NSW, NSW Health Pathology, eHealth NSW, Health Protection NSW, Cancer Institute, and affiliated health organisations.
Incident	An unplanned event that results in or has the potential for injury, damage or loss, including near misses.
Open Disclosure	Open disclosure is defined in the *Australian Open Disclosure Framework* as “an open discussion with the patient (and/ or their support person(s)) about a patient safety incident which could have resulted in or did result in harm to that patient while they were receiving health care[1]. Essential elements of open disclosure are: • An apology • A factual explanation of what happened • An opportunity for the patient to relate their experience • A discussion of the potential consequences • An explanation of the steps being taken to manage the event and prevent recurrence. The open disclosure process is a discussion between two parties and may include a series of discussions and exchanges

	of information that take place over several meetings.” [1]
Open Disclosure Advisor	A member of staff who has superior knowledge of the Open Disclosure process and may support the formal open disclosure team, assist planning for and attending meetings, leading debriefing sessions, mentor colleagues preparing for and participating open disclosure, and act as a source of expert advice.
Patient	For the purposes of this Policy Directive, the term ‘patient’ is any person receiving health care, and may include the terms ‘consumer’, ‘resident’ and ‘client’
Support person	A person who the patient would like present during open disclosure to provide assistance, comfort and support. This person may be a partner, carer, family member, friend or other person. The patient may identify more than one support person.

1.3. Legal and legislative framework

This policy operates within the following legal context:

- Apology: *Civil Liability Act 2002, s 67 – 69.*
- Protection for quality assurance activities: *Health Administration Act 1982* (NSW), Part 2 Divisions 6B and the *Health Administration Regulation 2020, Part 3* (NSW).
- Public access to information: *Government Information (Public Access) Act 2009* (NSW).
- Privacy: *Health Records and Information Privacy Act 2002* (NSW) and the *Privacy and Personal Information Act 1998* (NSW).
- Coronial investigations: *Coroners Act 2009* (NSW).

1.4. Other related policies and CEC resources

Reference	Title
National Framework	*Australian Open Disclosure Framework*
National Standards	*National Safety and Quality Health Service Standards – Clinical Governance Standard*
CEC resource	*Open Disclosure Handbook*
PD2020_013	*Complaints Management*
GL2020_008	*Complaint Management Guidelines*
PD2020_047	*Incident Management*
PD2018_032	*Managing Complaints and Concerns about Clinicians*
IB2023_032	*Healthcare Rights*

2. IMPLEMENTATION

2.1. Clinicians

Clinicians must:

- complete the mandatory eLearning module Open Disclosure (course code 47311513) via My Health Learning at the time of orientation
- undertake clinician disclosure following an incident, including an apology to the patient and/ or their support person
- notify their manager of the results of any initial clinician disclosure and any requirement to proceed to formal open disclosure
- participate in formal open disclosure as required
- ensure open disclosure is recorded in the patient's health care record and the incident management system.

2.2. Senior clinicians

Senior clinicians must:

- lead and undertake clinician disclosure following an incident, including an apology to the patient and/ or their support person
- participate in formal open disclosure as required
- notify their manager of the results of any initial clinician disclosure and any requirement to proceed to formal open disclosure
- ensure open disclosure is recorded in the patient's health care record and the incident management system
- review open disclosure practices for relevant cases within local clinical review and morbidity and mortality meetings.

2.3. Heads of department

Heads of department must:

- participate in open disclosure if the senior clinician is unable to do so
- ensure all clinicians complete mandatory open disclosure training
- support staff participating in the open disclosure process and promote access to staff support services
- notify the requirement for formal open disclosure to their direct manager and/ or the Director of Clinical Governance according to local procedure
- ensure the review of open disclosure practices within local clinical review and morbidity and mortality meetings.

Note: "Senior clinician" and "Heads of Department" may be the same person in some services.

2.4. Facility/ Operations/ Service Managers

Facility/ Operations/ Service Managers must:

- actively promote the practice of open disclosure
- ensure the coordination of the open disclosure process
- monitor and evaluate open disclosure processes.

2.5. Open Disclosure Advisors

Open disclosure advisors must:

- undertake training in communication skills and the open disclosure process
- support formal open disclosure teams throughout formal open disclosure and provide de-briefing as required
- provide expert advice within the NSW Health Service on open disclosure.

2.6. Directors of Clinical Governance

Directors of Clinical Governance must:

- lead and oversee the implementation of this Policy Directive
- provide leadership and advice on open disclosure
- assign trained Open Disclosure Advisors
- oversee and facilitate access to training for Open Disclosure Advisors
- oversee and facilitate access to and uptake of staff support services
- monitor and evaluate open disclosure processes and training.

2.7. Chief Executives or their delegates

Chief Executives or their delegates must:

- ensure open disclosure occurs within an integrated risk management framework
- ensure mandatory open disclosure training is undertaken by all clinicians
- ensure access to role-relevant training for Open Disclosure Advisors
- allocate resources to maintain effective open disclosure processes
- ensuring staff support services are available.

2.8. The Clinical Excellence Commission

The Clinical Excellence Commission will:

- support the availability of open disclosure education
- advise NSW Health Services on open disclosure matters as required
- provide resources to support the practice and evaluation of open disclosure.

3. THE OPEN DISCLOSURE PROCESS

Open disclosure is an open discussion with the patient (and/ or their support person(s)) about a patient safety incident which could have resulted in or did result in harm to that patient while they were receiving health care. It is a continuous process that consists of clinician disclosure and, if required, formal open disclosure. The essential elements of open disclosure are:

- an apology
- a factual explanation of what happened
- an opportunity for the patient to relate their experience
- a discussion of the potential consequences
- an explanation of the steps being taken to manage the event and prevent recurrence.

Open disclosure must be managed to completion irrespective of other circumstances occurring at the same time, such as the commencement of Health Care Complaints Commission, coronial or legal proceedings. If needed, NSW Health Services may seek advice from the NSW Ministry of Health, Legal and Regulatory Services Branch (mailto:nswh-legalmail@health.nsw.gov.au) or facility lawyers.

3.1. When to disclose

Open disclosure must occur whenever a patient has been harmed.

Disclosure is discretionary in the case of a near miss, being an incident that did not reach the patient and/ or in which there is a potential for harm from ongoing risk. Factors to consider are timeliness and/ or whether it is felt the patient would benefit from knowing.

3.2. When to progress to formal open disclosure

Formal open disclosure involves multidisciplinary discussions with the patient and their support person and the senior clinical leaders and/ or hospital executive. The open disclosure process may progress to formal open disclosure for any incident as determined by the Director of Clinical Governance and/ or the Facility/ Operations/ Service Manager and/ or the patient and/ or their support person. Formal open disclosure must be coordinated by the NSW Health Service in a manner that ensures clarity and reduces the risk of confusion for patients and/ or their support persons.

The NSW Health Policy Directive *Incident Management* (PD2020_047) describes formal open disclosure for Harm Score 1 incidents and recommends formal open disclosure for Harm Score 2 incidents.

The NSW Health Service is to inform patients and/ or their families they should be aware that formal open disclosure can progress at a future date if there is a change in circumstances.

Formal open disclosure may be considered inappropriate when:

- the patient and/ or their support person declines the offer to meet
- the patient is incapacitated or has died and there is no chosen support person
- the chosen support person is unavailable (in which case, rescheduling should be offered).

3.3. Risk management

NSW Health Services must operate within a risk management framework. In preparation for an open disclosure, risks are to be assessed in relation to the patient and their support person, NSW Health staff and the NSW Health Service, including risk of media exposure or litigation. For some incidents, risk management is undertaken as part of a preliminary risk assessment as per the NSW Health Policy Directive *Incident Management* (PD2020_047).

3.4. Relationship to incident management

The practice of open disclosure is integral to managing an incident. The NSW Health Policy Directive *Incident Management* (PD2020_047) describes the type of review to be undertaken based on incident rating (Harm Score) and outlines when to share information with the patient, carer and/ or family via open disclosure. The open disclosure process can be used regardless of the Harm Score.

3.4.1. Dedicated family contact

The dedicated family contact is a staff member assigned as the primary contact for the patient, carer and/ or family for a serious adverse event review and beyond. The dedicated family contact has a critical role in establishing rapport, credibility and trust with the family.

A dedicated family contact may also be assigned to assist in response to consumer feedback, or for all formal open disclosure processes regardless of the incident Harm Score. They liaise between the patient, carer and/ or family, review team and open disclosure team.

The NSW Health Policy Directive *Incident Management* (PD2020_047) describes the dedicated family contact role in more detail.

3.4.2. Privileged processes

Incident review findings are essential to the information provided to the patient and their support person during formal open disclosure. For all reportable incidents (clinical Harm Score 1 incidents), the NSW Health Service undertakes a preliminary risk assessment and serious adverse event review. These processes are privileged under Part 2A of the *Health Administration Act 1982* (NSW). The NSW Health Policy Directive *Incident Management* (PD2020_047) describes restrictions on information that can be released during open disclosure discussions.

In addition to the statutory privilege above (in relation to serious adverse event reviews [SAERs]), client legal privilege can protect certain documents or communications from disclosure. Documents specifically created or communications made, in confidence for the dominant purpose of obtaining legal advice regarding an incident, or for use in legal

proceedings (including civil claims for compensation; coronial inquest hearings; and prosecutions before a disciplinary body) cannot be disclosed.

Any minutes taken during open disclosure discussions are not privileged.

3.4.3. When more than one organisation is involved

When an incident occurs across NSW Health Service boundaries (such as a local health district and a state-wide service) or sectors (such as public and private healthcare facilities), open disclosure is managed through:

- the involvement of each organisation, as appropriate
- the assignment of a lead organisation, as appropriate
- the resolution of issues via Directors of Clinical Governance and/ or a senior representative from another sector
- the escalation of issues that cannot be resolved to the Director Patient Safety, Clinical Excellence Commission.

3.5. Where staff participating in open disclosure may seek advice or support

Staff who are participating in or who are leading clinician or formal open disclosure processes may seek individual or process guidance from the following sources:

- a NSW Health Service Open Disclosure Advisor (contact your local Clinical Governance Unit)
- Employee Assistance Program
- medical defence organisations or professional indemnity insurers
- professional associations and/ or unions
- the local Clinical Governance Unit.

3.6. Key steps

3.6.1. Assess the level of open disclosure response required

The open disclosure process may conclude with clinician disclosure progress to formal open disclosure, in agreement with the patient and/ or support person.

3.6.2. Stage 1: Clinician disclosure

Inform the patient and/ or support person as soon as possible following an incident. Clinician disclosure is to take place within 24 hours of incident identification.

Prepare for the discussion with the patient and/ or support person. Consider the preferences of the patient/ family/ carer, culture, language and the needs of people with a disability.

Undertake clinician disclosure with the patient and/ or support person by:

- acknowledging the incident and its impact on the patient
- explaining the cause of the incident if it is known
- apologising, including the words “I am sorry” or “we are sorry”
- listening to the patient and/ or support person
- documenting that open disclosure has occurred in the patient’s health care record
- agreeing on a plan for care which may include ongoing support or discussions such as formal open disclosure. Reimbursement of out-of-pocket expenses incurred as a direct result of an incident may be offered at this time (see Section 3.8 Out of pocket expenses).

3.6.3. Stage 2: Progress to formal open disclosure as required

Refer also to Section 3.2 When to progress to formal open disclosure.

Prepare for the formal open disclosure discussion by:

- assigning a staff member to coordinate open disclosure
- forming an open disclosure team including a senior staff member experienced in open disclosure to lead the discussions with the patient and/ or support person.
- preparing for specific circumstances. Consider culture (such as the NSW Health Guideline *Communicating Positively: A Guide to Appropriate Aboriginal Terminology* (GL2019_008)), language, the needs of people with a disability, and access such as using a virtual meeting platform
- contacting an Open Disclosure Advisor to provide support (if they are not a member of the open disclosure team)
- gathering information to date about the incident and previous discussions with the patient and/ or support person
- contacting the patient and/ or support person (this can be via the staff member assigned as the dedicated family contact if there is one) to arrange a meeting
- ensuring access needs. For a virtual meeting, refer to the NSW Health *NSW Virtual Care Strategy* or the Agency for Clinical Innovation *Virtual care in practice* guide
- preparing information for the patient and/ or support person in a suitable format.

Undertake the formal open disclosure discussion with the patient and/ or support person and the open disclosure team by:

- reacknowledging the incident and its impact on the patient
- reaffirming an apology, including the words “I am sorry” or “we are sorry”
- explaining the formal open disclosure process
- reaffirming or expanding on previous explanations of the incident

- sharing findings available to date and ensuring privilege is maintained (if information is from a privileged process such as preliminary risk assessment or serious adverse event review)
- acknowledging the limitations (if any) on information that can be provided
- listening to the patient and/ or support person's experiences and concerns
- ensuring the discussion is based on known facts and avoids speculation, attribution of blame or denial of responsibility
- agreeing on a plan for care which may include ongoing support or discussions. Reimbursement of out-of-pocket expenses may be offered at this time if this has not been done previously.

3.6.4. Follow up activities

After the formal open disclosure discussion, the NSW Health Service must:

- Coordinate any ongoing discussions between the patient and/ or support person and the open disclosure team leader (via the dedicated family contact, if there is one).
- Ensure all agreed actions are completed.
- Arrange any meeting(s) for open disclosure team review and discussion.
- Share the review findings as appropriate when they are available with a summary of factors that caused or contributed to the incident and any recommended actions.
- Liaise, as needed, with the manager responsible for insurable risk to coordinate an offer of reimbursement for out-of-pocket expenses.

3.6.5. Finalise formal open disclosure

After completion of formal open disclosure, the NSW Health Service must:

- Provide the patient and/ or support person with contact details for follow-up including progress of recommendations.
- Provide a summary of the open disclosure meetings and agreed outcomes to the patient and/ or their support person.
- Complete documentation of the open disclosure. This is to include a progress note in the patient's health records that open disclosure has taken place and the related identification number from the incident management system and/ or a reference to the secure open disclosure file, if kept separately.

3.7. Record management

If open disclosure is initiated, the clinician responsible for the patient's care must record that clinician disclosure has occurred in the patient's health care record. When the incident is notified in the incident management system, the notifier must document the unique identification number in the health record.

Open disclosure meetings with the patient and/ or support person are to be noted in the incident management system.

Formal open disclosure records (such as meeting records, outcomes, reimbursement of out-of-pocket expenses) are to be kept together in a secure location.

3.8. Out of pocket expenses

Open disclosure is most effective if coupled with restorative action where appropriate. Offering to reimburse out-of-pocket expenses sends a strong signal of sincerity, however such an offer does not imply responsibility or liability. They are made at the discretion of the NSW Health Service on a case-by-case basis.

Expenses must be incurred as a direct result of an incident, for example accommodation, meals, travel and childcare. The NSW Health Service can claim some expenses back from the Treasury Managed Fund (TMF). If the amount is likely to exceed $5000, the NSW Health Service must contact its manager responsible for insurable risk who is to liaise with TMF prior to any agreement for reimbursement with the patient, carer and/ or family.

For significant reimbursement requests by the patient, carer or family, the NSW Health Service is to ask for a written request to refer on to TMF.

3.9. Specific circumstances

Advice must be sought from the Director of Clinical Governance and/ or an Open Disclosure Advisor when open disclosure involves:

- children and young people, patients with a mental health condition, patients with cognitive impairment
- patients with complex care requirements and/ or access and/ or language and/ or cultural diversity, such as Aboriginal patients
- a breakdown in the relationship between the patient and/ or support person and the NSW Health Service
- incidents which occurred elsewhere or patient transfer to another facility or NSW Health Service
- delayed identification of an incident
- issues of clinician accountability or suspected intentional unsafe acts.

3.10. Monitoring and evaluation

NSW Health Services must:

- monitor that clinician disclosure occurs within 24 hours of incident notification and progresses to formal open disclosure as required
- undertake periodic internal auditing of a sample of open disclosure processes, including outcomes of open disclosure

- review cases requiring open disclosure at local clinical review and morbidity and mortality meetings to identify and provide advice on improvements to open disclosure practice
- support and enable patients and/ or support persons and staff to provide feedback on their experience of open disclosure and contribute to improvement of open disclosure.

4. REFERENCES

1. Australian Commission on Safety and Quality in Health Care. (2013). *Australian Open Disclosure Framework.* ACSQHC, Sydney. https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework