

1. Purpose

The purpose of this policy is to inform staff of the requirements of open disclosure processes following an adverse event or incident that has affected a patient. It places emphasis on an appropriate and consistent approach for transparent communication with patients and their support person/family following an incident.

2. Scope

This policy applies to all Icon Cancer Centre division sites, staff and support services.

3. Overview

Icon Cancer Centre is committed to establishing safe systems and processes in an effort to provide an environment where the incidence of adverse events is minimised. Modern healthcare however, can carry risks and the possibility of adverse events. Icon fosters a culture where staff feel supported and are encouraged to identify and report adverse events so that opportunities for system improvements can be identified and acted upon.

All clinical staff complete online Open Disclosure training.

The focus of the Open Disclosure process is on ensuring that the patient affected by an incident, and their family/support person knows and understands what happened and that actions will be taken to prevent such incidents from happening again. Communication and support for the patient is honest, consistent and occurs in an empathetic and timely manner.

4. Definitions

Term	Definition
Admission of liability	A statement 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.
Apology	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 acknowledgement of responsibility, which is not an admission of liability.
Open Disclosure	An open discussion with a patient about an incident(s) that resulted in harm to that patient while they were receiving health care. Open disclosure is a discussion and an exchange of information that may take place over several meetings.
Adverse event	An incident in which harm resulted to a person receiving health care.
Harm	Impairment of structure or function of the body and/or any deleterious effect arising there from, including disease, injury, suffering, disability and death Harm may be physical, social or psychological
Lower level response	A briefer Open Disclosure process usually in response to incidents resulting in no permanent injury, requiring no increased level of care and resulting in no, or minor psychological or emotional distress (e.g. near misses and no harm incidents) These criteria should be determined following consultation with patients, their family and carers

Higher level response	A comprehensive Open Disclosure process usually in response to an incident resulting in death or major permanent loss of function, permanent or considerable lessening of body function, significant escalation of care or major change in clinical management (e.g. admission to hospital, surgical intervention) or major psychological or emotional distress These criteria should be determined following consultation with patients, their family and carer
RiskMan	Electronic incident reporting management, reporting and analysis tool

5. Guidelines

Icon Cancer Centre is required by legislation to protect the privacy of patients, doctors and others when conducting investigations, creating reports and making any disclosures during the Open Disclosure process. Patients, their family and carers should be informed of these requirements

Information obtained as part of the open disclosure investigation should be recorded and stored in accordance with the legislation. All adverse events are reported as per the Patient Incident Management policy (refer to GOVR 003)

When an adverse event is identified, the first priority is prompt and appropriate clinical care and prevention of further harm. This is then followed by assessment and determination of the level of response required.

The delegate should be advised and gather evidence in consultation with the Quality team and Executive.

The initial discussion should occur as soon as possible after recognising harm.

The elements of Open Disclosure include the following:

- an apology or expression of regret, which should include the words "I am sorry" or "we are sorry"
- a factual explanation of what happened
- an opportunity for the patient to relate their experience
- a discussion of the potential consequences of the adverse event
- an explanation of the steps being taken to manage the adverse event and prevent re-occurrence

Staff involved in the adverse event should be monitored and supported as required including the offer of counselling and relief from duty where appropriate.

Following any injury, accident or adverse event requiring medical attention, an immediate documented investigation is initiated of what occurred, why it occurred and identification of systems and processes to prevent it happening again.

6. Supporting External Documentation / Legislation

Doc No.	Name of Document	Version No.	Source
	Australian Open Disclosure Framework		https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework/

NSQHS Standard(s)
1. Clinical Governance

7. Related Policies & Procedures

Related Policies & Procedures		
Document Code	Name	Division
GOVR 003	Patient Incident Management	Icon Cancer Centre
GOVR 005-01	Open Disclosure Procedure	Icon Cancer Centre

8. Version Control & Authorisation

Document Owner.	Group Medical Director
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Version History					
Version No.	Author	Approver	Date Approved	Change History	Review Date
1	Kyla Snelling	Dr Ian Irving	14/08/2018	Integration medical/radiation oncology documents. Approved by MAC 14/8/18	14/08/2021
1.1	Justine Morrow	Dr Ian Irving	17/09/2019	Updated to reflect Icon Cancer Centre template change	14/08/2021