

Please note that the following document was created by the former Australian Council for Safety and Quality in Health Care. The former Council ceased its activities on 31 December 2005 and the Australian Commission on Safety and Quality in Health Care assumed responsibility for many of the former Council's documents and initiatives. Therefore contact details for the former Council listed within the attached document are no longer valid.

The Australian Commission on Safety and Quality in Health Care can be contacted through its website at <http://www.safetyandquality.gov.au/> or by email [mail@safetyandquality.gov.au](mailto:mail@safetyandquality.gov.au)

Note that the following document is copyright, details of which are provided on the next page.

The Australian Commission on Safety and Quality in Health Care was established in January 2006. It does not print, nor make available printed copies of, former Council publications. It does, however, encourage not for profit reproduction of former Council documents available on its website.

Apart from not for profit reproduction, and any other use as permitted under the Copyright Act 1968, no part of former Council documents may be reproduced by any process without prior written permission from the Commonwealth available from the Attorney General's Department. Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Attorney General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>

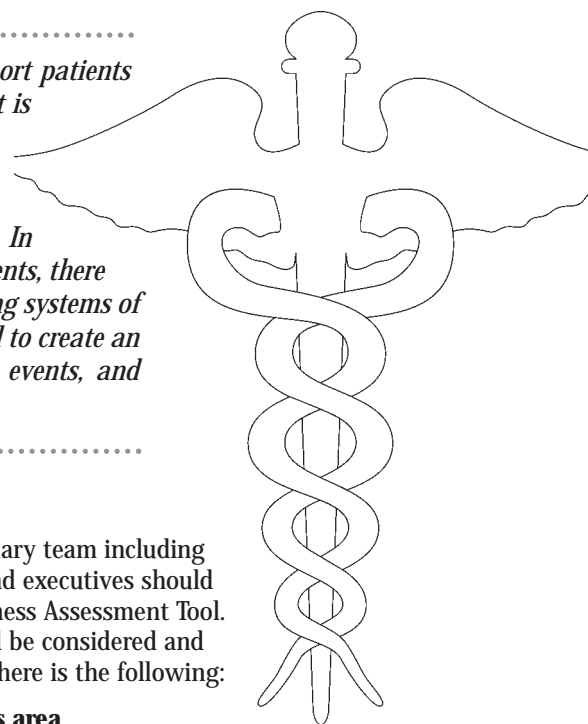
# Open Disclosure

## Organisational Readiness Assessment Tool

### What is Open Disclosure?

*Open Disclosure is about establishing a process to communicate and support patients and health care professionals when an adverse event occurs. Additionally, it is about investigating and correcting system failures to improve patient safety, which is a key imperative for health care organisations.*

*The Open Disclosure Standard defines an “adverse event” as an incident in which unintended harm has resulted to a person receiving health care. 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, health care organisations need to create an environment where staff are provided with the means to report adverse events, and identify and act on opportunities for systems improvements.*



#### KEY PRINCIPLES

The Open Disclosure Standard aims to foster commitment from health care organisations to:

- provide an environment where patients receive the information they need to understand what happened;
- create an environment where patients, health care professionals and managers all feel supported when things go wrong;
- build investigative processes to identify why adverse events occur rather than blame individuals; and
- to prevent adverse events from recurring by bringing about significant changes in clinical care delivery based on the lessons learnt.

For an organisation to be able to implement the Open Disclosure Standard a health care organisation is first required to have support systems and risk management frameworks in place. This assessment tool has been developed to assist hospitals to assess their level of readiness to implement the Open Disclosure Standard and to highlight areas where improvements would assist in implementation.

Each member of a multidisciplinary team including frontline clinical staff, managers and executives should complete the Organisational Readiness Assessment Tool.

Every element or activity should be considered and categorised according to whether there is the following:

#### **0 No awareness or activity in this area**

#### **1 Awareness and Discussion**

#### **2 Implementation in some areas**

#### **3 Implementation across Organisation**

#### **4 Implementation and Evaluation**

After you've completed the assessment tool, choose the lowest performing areas, i.e. those that scored 0, 1 or 2 and develop an action plan to move closer to organisation wide implementation and evaluation of services.

However, it should be noted that it is not necessary to score 4 in all areas. The assessment tool is just to provide guidance on the framework and processes that are needed to facilitate Open Disclosure.

The Open Disclosure Standard provides a flexible framework designed to be used by organisations, health care professionals and managers when developing or amending policies and procedures for open disclosure. Patients, consumer advocates, health care professionals and managers should be involved in local policy development.

For a more detailed discussion of the specific policies and guidelines required locally see the Appendix.



- 0** No awareness or activity in this area

---

- 1** Awareness and Discussion

---

- 2** Implementation in some areas

---

- 3** Implementation across Organisation

---

- 4** Implementation and Evaluation

## Does your health care organisation have?

### OPEN DISCLOSURE AS A PRIORITY WITHIN YOUR ORGANISATION:

	0	1	2	3	4
Open disclosure is part of organisational strategic direction within the quality framework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open disclosure education is provided for all staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open disclosure policy is in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open Disclosure processes are in place – eg. reporting system, access to support services, and attendance at multidisciplinary meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### AN INTEGRATED RISK MANAGEMENT PROCESS:

	0	1	2	3	4
Integrated risk management policy implemented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other risk management standard/ protocols implemented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff who are responsible for clinical risk management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff who are responsible for corporate risk management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clear policy for response to adverse events (major/sentinel/catastrophic; minor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sufficient resources are allocated to investigate adverse events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### QUALITY IMPROVEMENT PROCESSES:

	0	1	2	3	4
Staff who are responsible for quality improvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accreditation by an appropriate accreditation agency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Response to complaints process includes investigation and recommendations to management for improvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
System for credentialling new procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### SYSTEMS TO IDENTIFY ADVERSE EVENTS (INCIDENT REPORTING/MONITORING):

	0	1	2	3	4
Frontline staff have policy for immediate incident notification for major/sentinel/catastrophic adverse events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incident reporting in writing or electronically through an incident form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facility for the anonymous reporting of adverse events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
System that can measure trends in incidents reported/ separations and processes are in place for review and action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical and nursing staff use the same reporting systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



- 0** No awareness or activity in this area
- 1** Awareness and Discussion
- 2** Implementation in some areas
- 3** Implementation across Organisation
- 4** Implementation and Evaluation

**SUPPORT SYSTEMS FOR PATIENTS WHO HAVE HAD AN ADVERSE EVENTS:**

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Communication with General Practitioners residential facilities and other community care providers to facilitate continuity of care following an adverse event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mechanism for providing information to the patient or their family/carer on support services provided by social workers, religious representatives or patient advocates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication strategy for ensuring confidential information is provided to those family/carers nominated by the patient to receive information regarding their care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education of ward staff on providing support for patients following adverse events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SUPPORT SYSTEMS FOR STAFF WHO HAVE BEEN INVOLVED IN ADVERSE EVENTS:**

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Ward policy for team debrief after major/sentinel events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to a staff counsellor or employee assistance program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strategy for replacing/backfilling staff during shift following an adverse event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education of ward/departmental managers on support following adverse events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proactive beyond blame culture at all levels of management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MECHANISMS FOR INVESTIGATION OF ADVERSE EVENTS AND ANALYSIS OF FACTORS CAUSING ADVERSE EVENTS:**

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Staff who are responsible for investigation of adverse events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systematic process of investigation that includes development of recommendations to prevent recurrence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CLINICAL AUDIT AND PERFORMANCE REVIEW:**

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Multidisciplinary forum for discussion of Adverse Events and ways to prevent them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transparent decision making process for selecting recommendations to implement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
System of accountability for implementing recommendations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



- 0** No awareness or activity in this area
- 1** Awareness and Discussion
- 2** Implementation in some areas
- 3** Implementation across Organisation
- 4** Implementation and Evaluation

**MECHANISMS TO PROVIDE FEEDBACK TO STAFF ON ANALYSIS OF ADVERSE EVENTS:**

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Hospital email or similar timely communication system for all department and ward managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newsletter/staff publication containing clinical information/ successful interventions (near misses) / number of adverse events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Publication of aggregated data on patient complaints and responses to patient complaints via Intranet or similar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**A PUBLIC PARTICIPATION AND FEEDBACK PROGRAM:**

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Consumer/public participation strategy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer participation in quality control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Publication of performance to benchmark clinical indicators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Publication of performance to benchmark quality standards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**LOCAL POLICIES AND GUIDELINES AS DESCRIBED IN APPENDIX A:**

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Guidelines for referral to disciplinary processes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer participation in local policy development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Procedures for identifying and recording patients support person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guidelines for notifying local management and external agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## APPENDIX

**IT IS ESSENTIAL** that each health care organisation's policy and procedure meets its own unique needs and resource availability, while reflecting the specific legal, regulatory, institutional and cultural considerations relevant to them.

In particular, policies need to take into account the following:

- The requirements of those who provide insurance to health care organisations and professionals. Insurers should be involved in policy development at an early stage and pro-actively educate their constituents involved in open disclosure.
- The necessity of appropriate training and education for relevant staff to ensure a coordinated and informed approach to open disclosure and to avoid admissions of liability (in either verbal or documentary form).
- The need for involvement by consumer advocates and health care professionals in developing policies and processes.

The standard specifies that local guidelines are required particularly, in the following areas:

### **SCOPE - STANDARD CLAUSE 2**

Organisations should have guidelines in place on how and when to make a referral to a disciplinary process. In developing and amending these guidelines, care should be taken to avoid potential conflict between disciplinary and open disclosure investigations. This includes ensuring that the rights of the person subject to the disciplinary process are recognised and respected, such as the right to be given an opportunity to respond to findings by the open disclosure investigation and to have legal, union or other representation.

### **PATIENT ISSUES - STANDARD CLAUSE 4**

Health care organisation need to create an environment that facilitates open and effective communication. Policies and practices should address the following:

- a) They should ensure early identification of the patient's needs including, but not limited to, documentation at the time of admission of –
  - the names of particular individuals to provide assistance and support to the patient;
  - the names of those individuals (who may be different to the patient's next of kin or those identified above) that the patient has chosen to receive information about their health care, and any restrictions on disclosure; and
  - whether an interpreter service may be required for the patient. (See Appendix C.7 and C.9) [not reproduced here].
- b) They should encourage patients to notify the clinical team of any issues or conditions that may affect their care.
- c) Where an adverse event has occurred, policies and practices should provide assurance that an ongoing care plan will be developed in consultation with the patient and their support person, and that the plan will be followed through; facilitate inclusion of the patient's support person in discussions about an adverse event where the patient agrees.

- d) Policies, processes and practices should provide appropriate opportunities for the patient and their support person to obtain information about the adverse event.
- f) They should provide information about the open disclosure process to patients and their support person in verbal and written format. For low level response events where requested and for high level response events as a matter of course.
- g) Where a patient has died as a result of an adverse event, subject to the requirements of the coroner and legislation, policies and practices should ensure that the support person is provided with known information, care and support. The support person should also be referred to the coroner for more detailed information.

### **STAFF ISSUES – STANDARD CLAUSE 5**

Organisations must also take into account in their policies and practices the rights of health care professionals. This should include ensuring in policies and practices that –

- a) the open disclosure process focuses on safety and not attributing blame, leaving issues relating to individuals to disciplinary processes, if this is considered appropriate;
- b) criticism and adverse findings against individual professionals is avoided. If adverse findings do have to be made, treat the professional fairly and afford natural justice, including giving the person the opportunity to comment on any adverse findings and taking those comments into account. This will also help to avoid defamatory statements (both verbal and written); and
- c) recognise the obligation and/or right of professionals to seek appropriate advice and guidance from their indemnifiers and other relevant advisers and to act in accordance with such advice.

## **ORGANISATIONAL ISSUES – STANDARD CLAUSE 6**

The organisation will need to determine whether the open disclosure process is to be implemented into existing systems and policies, such as risk management and identification of adverse events, or whether those systems need to be amended to take account of the open disclosure process.

## **LEGAL AND INSURANCE CONSIDERATIONS – STANDARD CLAUSE 7**

Organisations and individuals disclosing information to patients and their support person after an adverse event should do so in the context of the local legal and insurance environment. Legal issues that require consideration in relation to patients, staff and organisations are:

- Confidentiality;
- Privacy requirements;
- Insurance and other contractual obligations;
- Legal professional privilege; and
- Qualified privilege.

Organisations should develop their own guidelines to ensure that the relevant privacy principles and other obligations of confidentiality are adhered to during the open disclosure process. It is important to note that this legislation also provides patients with the right to access information about their care such as their medical record.

## **NOTIFICATION OF MANAGEMENT - STANDARD CLAUSE 10.6.3**

Notification of management will usually occur via the individual responsible for clinical risk. However, when a major incident occurs that may attract media attention or where a criminal act is suspected, the CEO should be notified immediately, in accordance with the organisation's incident policy.

## **NOTIFICATION TO RELEVANT STATUTORY AND OTHER APPROPRIATE AUTHORITIES - STANDARD CLAUSE 10.6.6**

Where there are adverse outcomes health care organisations may need to respond to a variety of external requirements, reviews or queries, including requirements of State, Territory and Commonwealth regulatory bodies. The organisation's policy on adverse events and open disclosure should clearly state these requirements to ensure that an organisation's legal and insurance needs are met.

## **INCIDENT REPORT - STANDARD CLAUSE 11.3**

Clinical or other staff should submit an initial incident report in accordance with the organisation's policy on adverse events or incident reporting.

## **INVESTIGATION AND ANALYSIS - STANDARD CLAUSE 13.1**

In serious adverse events (major or sentinel health event), a root cause analysis, or another investigation method of similar intensity, should be considered. In these circumstances, the services of outside experts may also be used. Cases of moderate severity may be investigated by a small number of designated people. Low-risk cases may be investigated by a small team or subjected only to aggregate review (data trending). The decision about the level of investigation should be determined by grading the event to determine the level of investigation (see clause 12) [not reproduced here] and be in accordance with the organisation's policy.

## **PERSONNEL TO BE INVOLVED IN THE INVESTIGATION – STANDARD CLAUSE 13.2.1**

An individual who has the knowledge and status to make authoritative recommendations should conduct the investigation in association with appropriate clinical advisers. This will usually be a senior health care professional or manager (as designated in the organisation's policy). All health care professionals involved in the incident should be given the opportunity to have input into the investigation.

## **PRELIMINARY FOLLOW-UP WITH THE PATIENT AND THEIR SUPPORT PERSON – STANDARD CLAUSE 14.1**

A written record of the discussion should be made and filed, according to internal policy and legal requirements.

## **FINANCIAL SUPPORT – STANDARD APPENDIX B**

Health care organisations should develop guidelines in consultation with insurers and other relevant agencies for providing assistance to patients who have experienced adverse events.

## **PARTICULAR PATIENT CIRCUMSTANCES - STANDARD APPENDIX C**

Occasions may arise where an individual coroner requests that discussion of the case between hospital staff and family should not take place until he or she has considered the evidence. Directions for disclosure of information should be included in local guidelines.