Open Disclosure Procedure

Australia

Contents

1. Introduction

Open disclosure is the open discussion of an adverse event that results in harm to a patient while receiving health care.

This procedure outlines the process of open disclosure to be followed at GenesisCare in line with the GenesisCare Incident, Near Miss and Sentinel Event Management Policy and the Australian Open Disclosure Framework.

2. Terms and Definitions

Adverse event: an incident in which unintended harm resulted to a person receiving health care.

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.

Expression of regret: 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).

Support person(s): an individual, or individuals, who has a relationship with the patient and have been chosen by the patient to support them. References to "support person" in this document can include family members/next of kin, carers, friends, a partner, guardian or substitute or decision-makers.

Near miss: Generally open disclosure is not required in near miss events unless an ongoing patient safety risk is identified.

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. 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 patient 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.

Effective open disclosure improves patient, staff and community confidence in how the system responds to patient safety incidents and is fundamental to maintaining or re-building the trust between health care staff and patients.

Open Disclosure - Lower-level response: A briefer open disclosure process, usually in response to an incident which results in no permanent injury, requires no increased level of care and results in no, or minor, psychological or emotional distress. This criterion should be determined in consultation with the patient and their support persons.

Open Disclosure - 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. A higher-level response may also be instigated at the request of the patient even if the outcome of the adverse event is not as severe

Open Disclosure Team: a team established at the planning meeting to participate in the open disclosure (usually for a higher-level response). This team will include the treating doctor, senior clinicians as appropriate and an open disclosure coordinator.

Open Disclosure Coordinator: the staff member who will coordinate meetings where necessary, usually the Centre Leader/Practice Manager.

Sentinel Event: Sentinel events are a defined subset of adverse events in health care that result in serious harm to, or death of, a patient and must be reported to the state health jurisdiction.

Staff: in this document staff refers to all workplace participants at GenesisCare including contractors such as Visiting Medical Officers.

3. Scope

This procedure applies to all GenesisCare services and staff providing care to patients in Australia.

4. Responsibilities

GenesisCare is responsible for providing an environment and culture that minimises patient harm in line with GenesisCare values. GenesisCare is also responsible to provide resources to support the investigation of adverse events and the implementation of improvements so that adverse events do not recur.

Senior managers are responsible to facilitate the process of open disclosure and to ensure staff have access to training and support to participate in open disclosure.

All staff are responsible to report incidents, to provide patients with open communication when things go wrong and to escalate incidents of harm to their supervisor immediately.

The treating doctor is responsible for leading the open disclosure discussion with the patient. The Centre Leader/Practice Manager is responsible for coordinate open disclosure meetings when required, in consultation with the treating doctor and the Operations Manager. If the treating doctor, or Centre Leader/Practice Manager cannot perform the duties related to a particular adverse event, they will escalate their concerns to the General Manager who will arrange support and/or alternative arrangements.

The Quality Manager of the practice is responsible to follow up with evaluation surveys of the patient, their support person(s) and staff where a formal open disclosure meeting has taken place.

5. Procedure

Genesiscare Australia follows the eight guiding principles of Open Disclosure as set out in the Open Disclosure Framework 2013.

When an adverse event has occurred, the response will depend on the individual circumstances, the level of harm and the patient and support person(s) wishes.

GenesisCare acknowledges that when an adverse event has occurred, we have an obligation to undertake the following:

- acknowledge and explain to the patient that something has gone wrong
- offer an apology or expression of regret with sincerity and empathy
- provide a factual explanation of what happened
- discuss the potential consequences of the adverse event
- provide the patient, and support person(s), with the opportunity to relate their experience and participate in a dialogue
- use the learnings from the adverse event in a quality improvement activity to reduce the risk of recurrence
- share with the patient the steps that are, or will be, taken to prevent a recurrence of the adverse event

5.1. General indications of level of response

Open disclosure may be of a higher-level response or lower-level response depending on the severity of the adverse event, and the wishes of the patient and their support person(s).

General indications – lower-level response

1. No permanent injury – minor harm or injury
2. No increased level of care required
3. No or minor psychological or emotional distress
4. No Harm or near miss incident with ongoing patient risk

For examples related to GenesisCare services please see Appendix 8.1.
Please note: A lower-level response will be escalated to a higher-level response if the patient and /or support person(s) are not satisfied with the initial response.

Near Miss incidents do not (generally) require open disclosure - but open disclosure may be considered appropriate, depending on whether there is ongoing risk to the patient or others.

General indications – higher-level response

1. Death or major permanent loss of function
2. Permanent or considerable lessening of body/function
3. Significant escalation of care/change in clinical management
4. Major psychological or emotional distress
5. At the request of the patient
6. Sentinel event incident

For examples related to GenesisCare services, see Appendix 8.1.

5.2. The Open Disclosure Process

(see also flow charts in Appendix 8.2)

1. Incident detection or recognition

The open disclosure process commences with the recognition that a patient has suffered unintended harm during their care and/or treatment at GenesisCare. This could be via an incident, complaint or audit. Reporting of incidents must occur as per the Incident, Near Miss and Sentinel Event Management Policy.

2. Initial response

As soon as an adverse event causing harm is identified, the priority is prompt and appropriate clinical care and prevention of further harm.

3. Determine level of response

The level of harm sustained by the patient will determine the level of response. The staff or team who identify the adverse event should undertake a quick assessment of the level of severity/harm and the appropriate steps, the treating doctor and Centre Leader/Practice Manager will be informed immediately. The Quality Manager will be informed within 24 hours and can provide guidance in the open disclosure process.

4. Management of the Open Disclosure Process

The open disclosure discussion with the patient and/or support person(s) should:

- be led by the treating doctor (see Appendix B for documentation requirements)
    - In the rare circumstance that it is inappropriate for the Doctor to lead, the General Manager will decide who is the appropriate person to lead.
- occur as soon as possible following recognition of the harm.
- be face to face if possible
- be conducted in a quiet, private area to maintain confidentiality.

The open disclosure conversation will include the following:

- an introduction of the people attending
- an apology/expression of regret
- an explanation of what happened, as well as the anticipated impact upon the patient
- an opportunity for the patient to relate their experience
- time to listen to the patient's and/or their family or support person's understanding of what happened and address any questions or concerns they have
- an explanation of how and when they will be provided with further information if required
- Identification of additional support and referrals if required.
- Information about how GenesisCare will improve to prevent a recurrence of the adverse event.

a) Lower-Level Response

For lower-level response, a meeting between the treating doctor and the patient and support person(s) may be all that is required. Alternatively, the Centre Leader/Practice Manager and/or clinical team members may also participate if deemed appropriate. Documentation of the meeting and the outcome must be recorded in the patient's medical record. The Open Disclosure Meeting Planner and Record may not be required. It is preferred that the treating doctor has been trained in open disclosure.

b) Higher level responses

For Higher level responses, a planning meeting with the clinical care team is beneficial. The planning meeting will be coordinated by the Centre Leader/Practice Manager and should occur within 48 hours of recognition of the adverse event. The planning meeting should:

- confirm the identity of the person to lead the open disclosure, if not the treating doctor
- confirm the identity of the open disclosure coordinator
- ensure all necessary facts relating to the incident are established
- identify and arrange immediate support needs for staff as required
- determine the need for an interpreter
- using the Open Disclosure Meeting Planner and Record plan the details of the meeting, including the timing, location and attendees for the initial open disclosure meeting with the patient and their support person(s).

5. Holding the higher-level open disclosure meeting

- the meeting will occur as planned and documented in the Open Disclosure Meeting Planner and Record.
- the treating doctor will lead the discussion
- the coordinator will document the meeting
- agreement will be reached on the outcome of the meeting and any further actions, or meetings will be documented in the Open Disclosure Meeting Planner and Record.

6. Providing follow-up

It is the responsibility of the open disclosure coordinator to:

- provide a contact name and number to the person and/or support person(s)
- convene further meetings with the patient and/or support person(s) as required

For higher level responses, follow up with the patient and their support person(s) is critical. Please note for lower-level responses follow up may not be required.

7. Documenting the open disclosure process

The treating doctor will make a record directly into the patient notes regarding the open disclosure.

For higher level responses, the open disclosure coordinator is responsible for documenting a record of the discussion using the Open Disclosure Meeting Planner and Record (Appendix 8.3) to the patient's EMR labelled Open disclosure.

The formal document of the meeting should include:

- the time, place, date of the disclosure discussion and the name and relationships of those present
- the plan of providing further information to the patient and/or support person
- offers of support and response received
- summary of the discussion
- plans for
    - follow up meeting
    - Any further action agreed
- copies of letters sent to the patient, their family or support person or GP as per patient wishes.

8. Completing the open disclosure process

a) lower-level responses, it is likely that the open disclosure process will be completed after the initial discussion, if all parties concur. If parties do not concur, ongoing communication should occur and/or the response be escalated to a response for a higher-level response.

b) For higher level responses, open disclosure is a process, not a single discussion. As such, follow up with the patient and/or support person(s) is important. The process is concluded when the open disclosure team, patient and/or support person(s) reach a shared agreement. In general, feedback to the patient will depend on the patient's preference and occur following completion of the in depth or root cause analysis investigation.

Once open disclosure has been completed:

- Documentation should be complete in the patient's record and in the incident management system
- A staff debrief meeting should be held.

Evaluation /feedback survey (Appendix 8.4)

- An evaluation survey is to be offered to patient, their support team and staff members who participated in the open disclosure for higher level responses. An evaluation may not be appropriate in lower-level cases where the treating doctor met with the patient, and support persons, without a team present, however if a team approach is used, the survey may be utilised to assess the process. The evaluation survey will be managed by the Quality Manager, and Associated Documents list.

Staff Support and Resources

All staff members will be supported throughout the process of open disclosure. Staff members are encouraged to raise any concerns they have with their supervisor and to access support through the Employee Assistance Program or mental health first aiders as needed. Staff members have the right to choose not to be involved in the open disclosure, either because they have not had sufficient training or for another reason.

A number of resources are available to staff to assist with the open disclosure process – see Section 7 References.

Language or Cultural Diversity Considerations:

Where someone has difficulty communicating in English or at the patient's request, a professional interpreter should be used in the open disclosure processes outlined above. An interpreter from the same cultural background may also be able to advise on other issues (e.g., whether the gender of the health care professional who makes the disclosure is an issue that needs to be considered).

Expenses associated with managing and treating the adverse event

At the discretion of the General Manager, consideration will be given to the handling of patient expenses associated with managing and treating the adverse event, such as additional care and transport, and/or Ex Gratia payment or waiving of fees.

6. Evaluation

- Key metrics reported to Safety and Quality committee
  - Number of higher-level open disclosure events/number of sentinel events or incidents with major harm
  - Number of open disclosure surveys completed/number of open disclosure events
- Satisfaction rating on open disclosure surveys where a team meeting took place.
- By exception complaints regarding open disclosure, serious adverse events to GenesisCare or external body

7. References

1. Open Disclosure Standard: A National Standard for Open Disclosure in Public and Private Hospitals, following an adverse event in Health Care, Australian Council for Safety and Quality in Health Care, Canberra: Commonwealth of Australia, 2003

2. NSQHS National Safety and Quality Health Service Standards – Second edition
   Standard 1: Clinical Governance
   Standard 2: Partnering with Consumers

3. Australian Open Disclosure Framework, Better communication a better way to care, Australian Commission on Safety and Quality in Health Care, Canberra: Commonwealth of Australia, 2014

4. Australian Commission on Safety and Quality in Health Care (2013) Open disclosure meeting planning and preparation template ACSQHC, Sydney.

5. Australian Sentinel Event List (version 2) Specifications: Australian Commission on Safety and Quality in Health Care, 2020.

Associated Documents

Incident, Near Miss and Sentinel Event Management Policy GQY-POL-005
Feedback, Complaints and Notifications Management Policy GQY-POL-019

Resources

Australian Open Disclosure Framework, resources for clinicians and health care providers found at https://www.safetyandquality.gov.au/our-work/open-disclosure resources

8. Appendix

8.1. Examples of lower and higher-level response and near miss incidents
8.2. Open Disclosure Flow Charts
8.3. Open Disclosure Meeting Planner and Record
8.4. Patient and Staff Evaluation Surveys

Appendix 8.1: Examples of lower and higher-level response and near miss incidents

Examples of low-level response

Examples only, appropriate response to be determined in discussion with treating doctor, Centre Leader and Quality Manager.

- **delay in treatment** due to a GenesisCare process error that is not expected to a have a clinical impact on disease progression outcome but has caused distress to the patient.

Examples of higher-level response

Examples only, appropriate response to be determined in discussion with treating doctor.

- Radiation dose treatment error.
- Wrong procedure or site with significant harm or risk of future harm to the patient.
- variation from prescribed cytotoxic regime with clinical impact
- Medication error
- Harm from equipment failure or collision resulting in major physical harm to the patient or major change in clinical management, e.g. admission to hospital, surgical intervention or transfer to intensive care unit.
- Delay in treatment due to a GenesisCare process error that has resulted in significant advancement of disease process.
- Delay in treatment due to a GenesisCare process error that has not resulted in a clinical impact but has caused severe psychological distress to the patient. The patient is offered open disclosure and accepts, seeking a higher-level response. an incorrect cardiac diagnostic test is performed, no adverse effect but correct test must now be undertaken
- Patient suffered a cardiac arrest after administration of an incorrect medication.
- patient privacy complaint e.g. lack of respect for their privacy - patient would like to express their concern and ensure that other patients do not experience similar treatment.
- transmission based precautions not implemented or a breach occurs in cleaning of reusable medical device that poses a risk of infection to the patient on whom the equipment was used

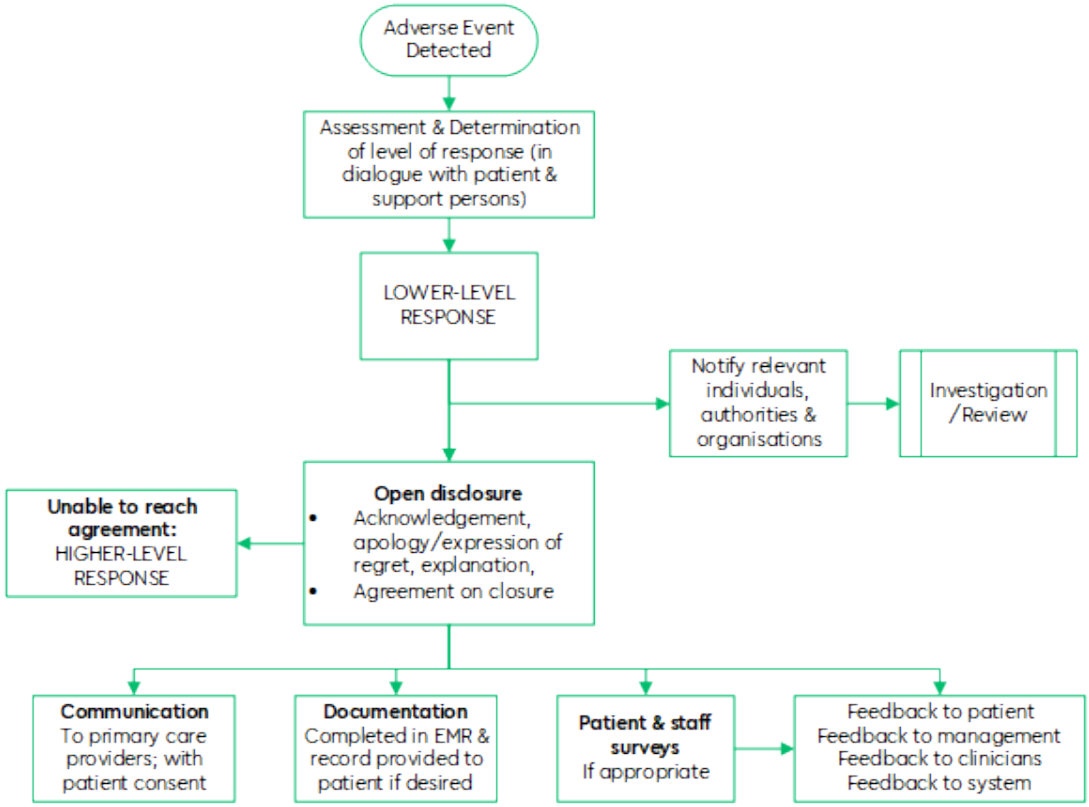
Near Miss Incident examples that would NOT require open disclosure

Examples only, if in doubt discuss with Centre leader/Practice Manager and /or treating doctor

- Planning error that is identified and amended prior to treatment
- Medication error that is identified and corrected prior to administration
- Radiation dose variation is so minor as to have zero clinical significance
- Patient complains about not finding a car park

Appendix 8.2: Open Disclosure Flow Charts

Flow Chart A: Lower Level Response



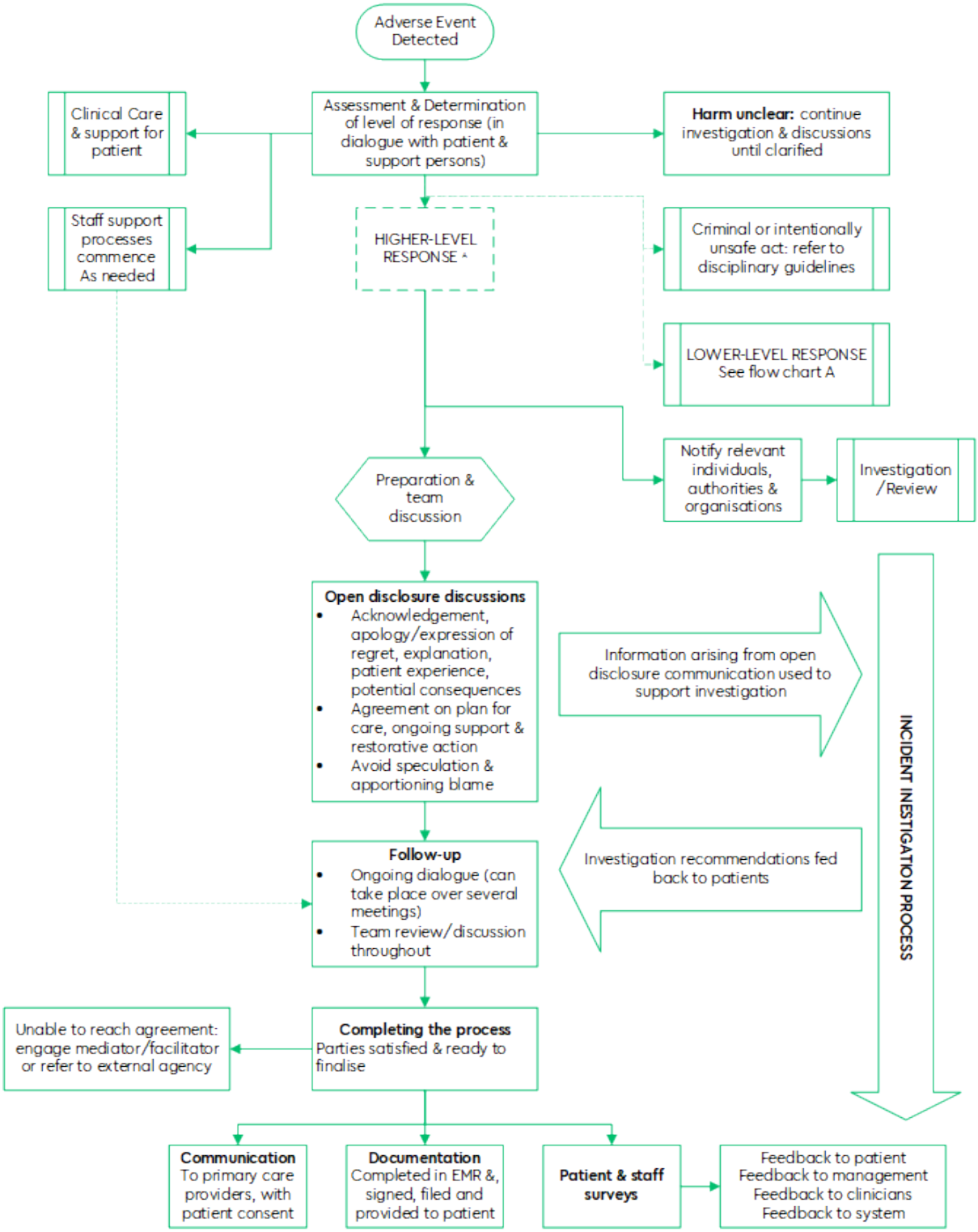
A General indications – lower-level response:

1. No-harm incident/Minor harm incident
2. No permanent injury
3. No increased level of care required
4. No or minor, psychological or emotional distress

B General indications – higher-level response:

1. Death or major permanent loss of function
2. Permanent or considerable lessening of body function
3. Significant escalation or care/change in clinical management
4. Major psychological or emotional distress
5. At the request of the patient

Flow Chart B: Higher Level Response



Appendix 8.3: Open Disclosure Meeting Planner and Record

The *Open disclosure meeting planning and preparation record* is designed to assist staff planning and preparing for open disclosure meetings. (may not be required in lower level cases where an individual meeting with the treating doctor is sufficient) It is also intended to facilitate communication and information sharing among the healthcare team and other relevant personnel throughout the subsequent open disclosure process.

All relevant information should be entered in the template and placed in the patient Medical record as a scanned document with the title Open Disclosure Meeting Record.

When the first meeting has been completed this template should be scanned into the patient medical record with the title Open Disclosure Record.

If subsequent meetings are held, these would also be recorded on this form and scanned in with the same title at the later date.

Genesiscare Open Disclosure Meeting Planner and Record.

1. Data & information

Patient's full name (including title)	
URN	
Date of birth	
Admission diagnosis and comments about management as relevant.	
Patient treatment date	
Names and relationships of relevant support persons invited by the patient	
Date of incident triggering the open disclosure process	
Incident number	
Incident description *Known facts only*	
Incident outcome *Known facts only, avoid cause and effect statements*	
Plan for further incident management and investigation *(such as RCA, report to department, Coroner)*	
Healthcare providers/clinicians involved in patient care *Include consultants, and others as appropriate*	

2. First meeting

Interpreter required for patient? *If so, provide details of language and arrangements that have been or to be made*	Yes / No
Has the patient (if able) consented to sharing information with family members/support persons? *Give details*	
Have insurers been notified? (both GenesisCare and medical practitioner) *Include date of notification*	
Date of first meeting	
Location of first meeting *Other details such as room booking, arrangements to ensure confidentiality if shared ward etc.*	
Patient/support person(s) understanding of the incident prior to the first meeting	
Person to be responsible for note taking	
Who will be the health service contact for the patient and support person(s)	

3. Planning the disclosure dialogue

Nominated individual to lead the discussion	
Expected patient concerns	
Apology or expression of regret *Avoid speculation and apportioning of blame*	
Description of what happened *Known facts only, avoid blaming individuals and self*	
Listening to patient and support person(s) concerns (ensure they feel listened to)	
Discussion of what will happen next *(such as further treatment, investigation into the incident)*	
Information to be provided about short/long-term effects	
Information on out-of-pocket expenses and costs of ongoing care prepared with relevant parties	
Assurance for patient and support person(s) that they will be informed when further information comes to hand	
Information about further support available to the patient and support person(s)	
Information provided in relation on how to take the matter further at any time *(such as internal and external complaint process. Avoid discussion about compensation without insurer consent, do not give legal advice but suggest patient seeks legal advice if information about compensation sought.)*	
Next meeting date and location If agreed or NA if no further meeting planned.	

4. First meeting outcomes

Actual date and location of meeting	
Names of all present at first meeting *Include titles/position/relationship to patient etc.*	
Concerns expressed by patient and support person(s) including requests for further information to be supplied	
Further support personnel identified *(such as pastoral worker or social worker)*	
Name(s) of personnel given to patient and support person(s) if they have further questions prior to subsequent meetings	

5. Details and outcomes of subsequent meetings (if required)

Date and location of meeting(s)	
Names of all present *Include titles/position/relationship to patient etc.*	
Concerns expressed by patient and support person(s)	
Further support personnel identified	
Responsibility for providing documentation to the patient and support person(s)	
Name(s) of personnel given to patient and support person(s) if they have further questions prior to subsequent meetings	
Further action planned	

6. Evaluation

Open disclosure survey forms provided to clinical staff, Offered to patient (and support persons if desired by patient)	
Open disclosure process evaluated	

Appendix 8.4 Patient and Staff Evaluation Surveys

Quality Manager to contact Quality Systems Manager for access to surveys on Survey Monkey

Open Disclosure: Patients, families, carers and support persons evaluation survey

What is the survey about?

This survey has been developed to enable feedback from patients, families their carers about the open disclosure process. The aim of this survey is to improve the open disclosure experience for people involved in an incident that resulted in harm to a patient while receiving health care – this includes patients, their family and carers as well as health service staff.

This survey is about your experience with **open disclosure**. When completing the survey, please reflect on your experience either as a patient or as a family member, friend or carer.

All responses will remain confidential.

You can request that this survey be conducted as a face-to-face interview.

Terms used in the survey: To help you complete the survey, the following terms are used:

Harmful incident	An incident that led to patient harm. Such incidents can either be part of the healthcare process, or occur in the healthcare setting (i.e. while the patient is admitted to, or in the care of, a health service organisation). Note: This term is used interchangeably with 'adverse event'.
Staff	Anyone working within a health service organisation, including self-employed professionals such as visiting medical officers.
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. 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 patient 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.
Support person	An individual who has a relationship with the patient. References to 'support person' in this document can include: • family members / next of kin • carers • friends, a partner or other person who cares for the patient • guardians or substitute decision makers • social workers or religious representatives • where available, trained patient advocates. References to support person should be read with the words, 'where appropriate'.

Survey Questions

1. I am a (please tick **all** relevant answers)
   - ❑ Patient
   - ❑ Relative of the patient
   - ❑ Friend of the patient
   - ❑ Carer of the patient
   - ❑ Support person
   - ❑ Other

2. Date of the **incident** that resulted in harm _____

3. On a scale from 1-10 (**1** being **least serious** and **10** the **most serious**) how serious were the effects of the harmful incident?

No effects			Mild effects		Moderate effects			Severe effects	
1	2	3	4	5	6	7	8	9	10

4. When were you **first** told about the harmful incident? (Please tick **one**)
   - ❑ Within 48 hours
   - ❑ 1-2 weeks
   - ❑ Within 1 month
   - ❑ More than 1 month
   - ❑ I was not told about the unexpected event

5. Was this timeframe acceptable for **initial** contact? (Please tick **one**)
   - ❑ Yes
   - ❑ No – it was too early
   - ❑ No – it was too late
   - ❑ Unsure

6. How long after the harmful incident did the first **planned** open disclosure meeting occur? (Please tick **one**)
   - ❑ Within 48 hours
   - ❑ 1-2 weeks
   - ❑ Within 1 month
   - ❑ More than 1 month
   - ❑ More than 6 months

7. Was there **anyone** you would have liked to attend the open disclosure meeting/s who was not included? (Please tick **one**)
   - ❑ No
   - ❑ Yes (please specify)_____

Please indicate your **level of agreement** by circling the relevant answer:

		Strongly DISAGREE	Slightly DISAGREE	Neutral	Slightly AGREE	Strongly AGREE	NA or unknown
	Open Disclosure Process						
8.	I was given the name of a health service staff member who would act as an ongoing **point of contact** throughout the open disclosure process	1	2	3	4	5	NA
9.	I was given the opportunity to have a support person(s) present who was **not** a health service organisation staff member	1	2	3	4	5	NA
10.	I was given an **apology or expression of regret** including the words ***I am/we are sorry***	1	2	3	4	5	NA
11.	I was given an **explanation** about the harmful incident	1	2	3	4	5	NA
12.	This explanation was **clear**	1	2	3	4	5	NA
13.	I was given **adequate time** to talk about my experience of the harmful incident	1	2	3	4	5	NA
14.	I had opportunity to **ask questions** about the harmful incident	1	2	3	4	5	NA
15.	Clear information was given about the **consequences** of the harmful incident	1	2	3	4	5	NA
16.	I was give information about how the hospital will **prevent** similar harmful incidents in the future	1	2	3	4	5	NA
17.	Health service organisation staff also gave **written** information about what we discussed in the open disclosure meeting(s)	1	2	3	4	5	NA
18.	Health service organisation staff did **not** try to avoid the open disclosure	1	2	3	4	5	NA

	Outcomes						
19.	Health service organisation staff treated me with **respect**	1	2	3	4	5	NA
20.	Health service organisation staff were good at **listening** to me	1	2	3	4	5	NA
21.	I was offered appropriate support to deal with the harmful incident on an **ongoing basis**	1	2	3	4	5	NA
22.	I was given the option of arranging **additional meetings** if I have further questions in the future	1	2	3	4	5	NA
23.	I found open disclosure **helpful**	1	2	3	4	5	NA
24.	I would be willing to return to this health service for **future care**	1	2	3	4	5	NA
25.	I am **satisfied** with the open disclosure process	1	2	3	4	5	NA

26. Please tell us how could the open disclosure process could be improved for patients/support persons?

_____

_____

_____

_____

Thank you for completing this survey.

Open Disclosure: staff survey

What is the survey about?
This survey has been developed to enable feedback from staff about the open disclosure process. The aim of this survey is to improve the open disclosure experience for people involved in an incident that resulted in harm to a patient while receiving health care – this includes patients, their family and carers, as well as staff.

This survey is about your experience with **open disclosure**. When completing the survey please reflect on your experience of a specific open disclosure case you participated in. **All responses will remain confidential.**

Terms used in the survey:

Harmful incident	An incident that led to patient harm. Such incidents can either be part of the healthcare process, or occur in the healthcare setting (i.e. while the patient is admitted to, or in the care of, a health service organisation). Note: This term is used interchangeably with 'adverse event'.
Staff	Anyone working within a health service organisation, including self-employed professionals such as visiting medical officers.
Initial discussion	Informal, unscheduled, bedside discussion about the incident between clinician(s) and patient and/or their support person.
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. 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 patient 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.
Support person	An individual who has a relationship with the patient. References to 'support person' in this document can include: • family members / next of kin • carers • friends, a partner or other person who cares for the patient • guardians or substitute decision makers • social workers or religious representatives • where available, trained patient advocates. References to support person should be read with the words, 'where appropriate'.

Survey Questions

1. I have participated in the following forms of open disclosure training (please tick **all** relevant answers)
   - ❑ Seminars or presentations on open disclosure
   - ❑ Interactive workshops on open disclosure
   - ❑ I have used online and/or audiovisual resources for open disclosure training
   - ❑ I have read independently about open disclosure
   - ❑ No training

2. What was your professional relationship with the patient at the time of the harmful incident and/or open disclosure? (Please tick **one**)

Doctor	❑	Speciality:
Centre leader		
Radiation therapist	❑	
Nurse	❑	
Allied health professional	❑	Speciality:
Other (please specify)	❑	
Not applicable	❑	

3. After the harmful incident, I participated in: (please tick **all** relevant answers)
   - ❑ Initial discussion with the patient and/or their family and carer(s))'Signalling open disclosure)
   - ❑ Pre-meeting discussions
   - ❑ Open disclosure discussion
   - ❑ I did not participate in patient meetings

4. On a scale from 1-10 (**1** being **least serious** and **10** the **most serious**) how serious were the effects of the harmful incident on the patient?

No effects			Mild effects		Moderate effects			Severe effects	
1	2	3	4	5	6	7	8	9	10

5. Was the patient/support person informed about the plan to commence open disclosure? (Please tick **one**)
   - ❑ Yes
   - ❑ No
   - ❑ Unsure

Please answer the following questions about **your experiences** of a specific open disclosure case:

		Strongly DISAGREE	Slightly DISAGREE	Neutral	Slightly AGREE	Strongly AGREE	NA or unknown
	Preparation for Open Disclosure						
6.	I had received adequate **training** in open disclosure	1	2	3	4	5	NA
7.	My **colleagues** were supportive	1	2	3	4	5	NA
8.	My **manager(s)** were supportive	1	2	3	4	5	NA
9.	I was **confident** about participating in open disclosure	1	2	3	4	5	NA
10.	The open disclosure discussion was **stressful**	1	2	3	4	5	NA
11.	The hospital **encouraged** open disclosure	1	2	3	4	5	NA
	Open Disclosure Procedure						
12.	The patient/support person were given a health service **point of contact** throughout the open disclosure process	1	2	3	4	5	NA
13.	The patient/support person were given an **accurate explanation** about the harmful incident	1	2	3	4	5	NA
14.	Accurate information was given about **consequences** associated with the harmful incident	1	2	3	4	5	NA
15.	Information about the **timeframe** and **actions planned** to prevent similar future harmful incidents was **clear**	1	2	3	4	5	NA
16.	The patient/support person were given the opportunity to **ask questions**	1	2	3	4	5	NA
17.	I believe the patient/support person **understood** the information provided **during** open disclosure	1	2	3	4	5	NA
18.	The patient/support person received clear, **written** information about what was discussed	1	2	3	4	5	NA
	Outcomes						
19.	An **apology** including the words 'I'm sorry' was offered during open disclosure	1	2	3	4	5	NA
20.	Appropriate **ongoing support** was offered to the patient/support person	1	2	3	4	5	NA
21.	The conclusion of the open disclosure process was **mutually agreed** between the patient/support person and the health service organisation staff	1	2	3	4	5	NA
22.	I am satisfied with the **results** of the open disclosure	1	2	3	4	5	NA
23.	The health service organisation met **its responsibility** to the patient/support person	1	2	3	4	5	NA
24.	My **professional reputation** was enhanced by open disclosure discussion(s)	1	2	3	4	5	NA
25.	The health service organisation met its responsibility **to staff** involved	1	2	3	4	5	NA

How could this organisation improve the way harmful incidents are discussed during Open Disclosure?

26. For **staff**?

27. For **patients/support persons**?

28. For the **organisation**?

Thank you for completing this survey

Please return the completed survey to National Quality Manager via email

Revision History

Version	Revision Date	Revised By (Position Title)	Description of change
2.0	December 2021	CMO Quality team working group	Updated to a procedure. Previous document number GQY-POL-008. Addition of surveys in appendix.
1.0	September 2013	CMO NQM	Creation of document