Open Disclosure Policy

1 SUMMARY

All Doctors on Riccarton staff should openly and honestly discuss adverse health events, as soon as possible after an event is identified, including events that may cause harm to patients or may affect or have affected their care but did not cause harm.

All instances of harm resulting from receiving health care must be acknowledged to the patient and/or whanau as soon as possible after the event is identified.

2 POLICY STATEMENT

Right 6 of the Code of Health and Disability Services Consumers' Rights gives all consumers the right to be fully informed i.e. to receive the information that a reasonable consumer in his or her situation would expect to receive.

Open disclosure standards are included in the Health and Disability Services Standard NZS 8134:2021 which came into effect in February, 2022,

Disclosure should include acknowledgement of the incident, an explanation of what happened, how it happened, why it happened and, where appropriate, what actions have been taken to prevent it happening again. It should also include a sincere apology.

3 PURPOSE

To provide a clear and consistent approach to open disclosure by healthcare providers and offer a work environment that supports and enables staff to recognise and report adverse events and support them through the process.

4 SCOPE

This policy applies to all staff working at Doctors on Riccarton.

5 POLICY DETAIL AND PROCEDURES

- Once an event that has caused harm, may cause harm or may affect future care has been identified it, the Complaints Officer must be notified.
- The event should be disclosed to the patient within **24 hours** and acknowledged in writing within 5 working days in a frank and honest way disclosing all the circumstances with consideration given to cultural and language needs.
- An error that affected the consumer's care but does not appear to have caused harm may also need to be disclosed to the consumer. Notification of an error may be relevant to future care decisions, for example whether or not to go ahead with the same procedure on another occasion. The effects of an error may not be immediately apparent.
- The severity of an adverse event is to be determined using the Severity Assessment Code (SAC) Appendix 1
- All SAC level 1 and 2 rated adverse events, plus events from the Always Report and Review list are to be reported to the Health Quality & Safety Commission within **15 working days** from the date the event is reported

- Support should be offered to patient and/or whanau, delivered with empathy and appropriate to the patient and/or whanau's needs.
- A full account of the outcome of any investigation undertaken and any changes implemented must be fully disclosed to the patient and/or whanau.
- Patient, whanau and staff privacy are to be maintained.
- Staff must be provided with a work environment that supports and enables them to recognise and report adverse events.
- Staff involved in an adverse event must be supported through the open disclosure process.

6 PROCESS

- The Complaints Officer shall determine when/where/how the disclosure should take place, who should make the disclosure, and is to be kept informed of the disclosure outcomes, and guide the process.
- Disclosure to the patient and/or whanau should ideally be made by the health professional with the overall responsibility for the patient.
- If the health professional with overall responsibility for the patient was not involved in the event, they should ideally accompany the health professional responsible.
- If the event was perpetrated in a team environment the following should occur
  - Discussion about what happened
  - Discussion on how it happened
  - Consequences to the patient – at the time or possible future implications
  - How to avoid in the future
  - How the patient and/or whanau will be approached and supported
  - A debrief after the patient and/or whanau have been advised and/or supported should occur
- Disclosure is ongoing not a single conversation
- The consumer must be given contact details and information about the local health and disability consumer advocate as well as options for making a complaint.
- The event, harm sustained, possible future implications, the disclosure process and subsequent action must be documented in the patients' health record
- A sincere apology is the opportunity to say, 'We are sorry this happened to you', can provide comfort to the patient and assist with healing and resolution. The apology will ideally be delivered face to face with the patient by the health professional with overall responsibility for the patient

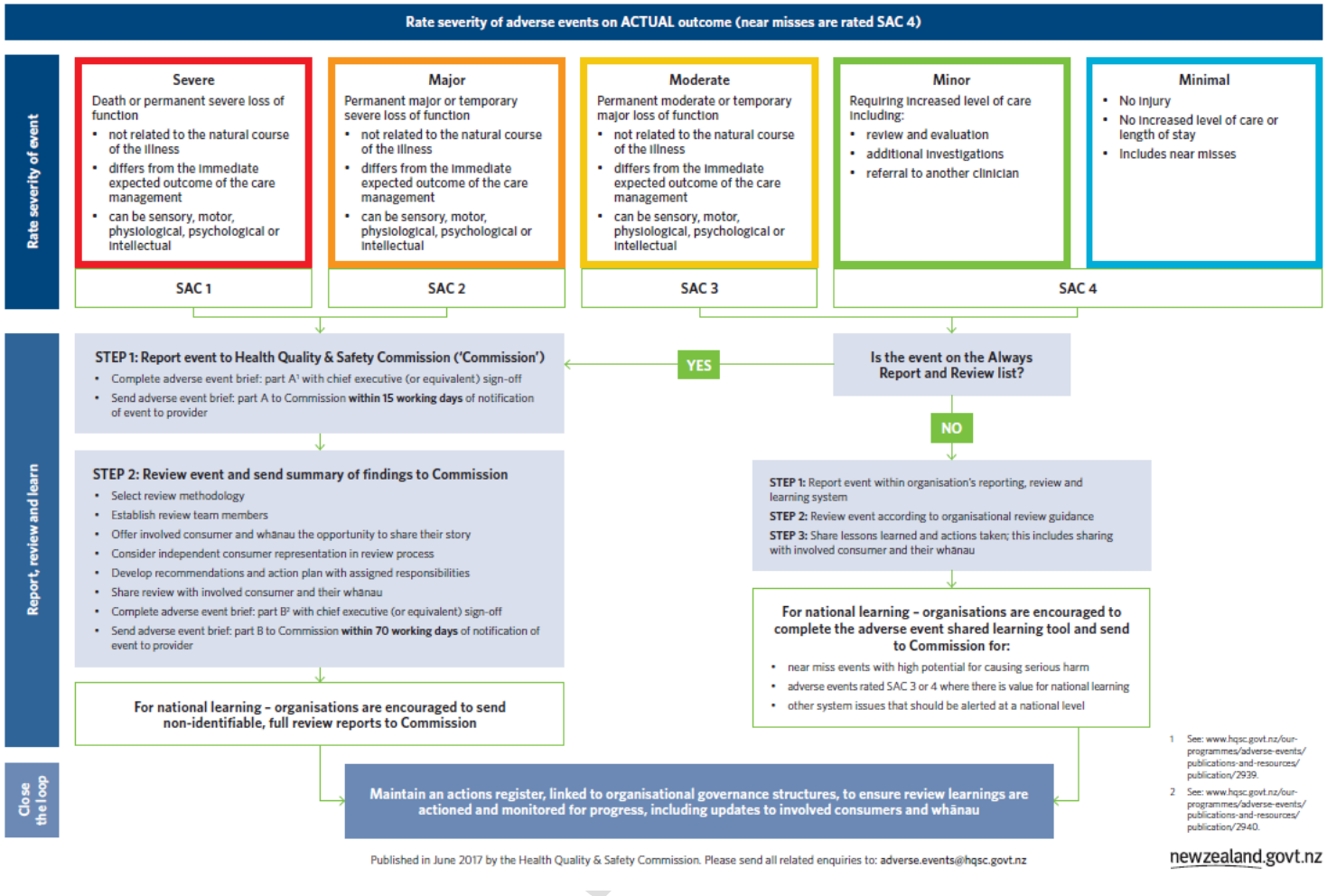
7 RELATED POLICIES & INFORMATION PATHWAYS

- DOR Incident Management policy
- DOR Health and Safety policy
- Ministry of Health
- HealthPathways
- Medical Council of New Zealand

8 REFERENCES

- HDC Guidance on Open Disclosure Policies November 2019 https://www.hdc.org.nz/making-a-complaint/complaint-process/guidance-on-open-disclosure-policies/
- NZ Health and Disability Services Standard -8134.2021.pdf
- National Adverse Events Reporting Policy 2023 – Te Tāhū Hauora Health Quality & Safety Commission https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/national-adverse-events-reporting-policy/

Severity Assessment Code (SAC) rating and triage tool for adverse event reporting



APPENDIX 1

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