

# Statewide Implementation of Open Disclosure: Because it's the right thing to do

In collaboration with the Clinical Excellence Commission, the NSW Department of Health implemented Open Disclosure in the NSW public health system under a comprehensive communication, education and sustainability framework to ensure that the right environment, support, resources and culture were in place to ensure patients and their families or carers are fully informed following an incident.



From 1 July 2007 to 31 December 2007 there were:

- 1,348,265 operations performed
- 969,887 emergency department attendances
- 10,662,490 interactions with patients who were not admitted (out-patient and other services).
- 753,938 admissions to hospitals and other health facilities

During this time, 57,808 incidents were reported, of which 294 were classified as serious patient incidents.\*



## What is Open Disclosure?

Open Disclosure is the process that occurs when healthcare professionals respond to or inform a patient and their support person(s) of an incident that has resulted in harm or injury to the patient.

The principles are:

- Openness and timeliness of communication
- Acknowledgement of the incident
- Expression of regret/apology
- Recognition of the reasonable expectations of patients and their support person(s)
- Support for staff to enable effective open disclosure
- Confidentiality

*NSW Health is to be commended for its commitment to this project and the College will encourage its members to support its application.*

The Royal Australian and New Zealand College of Ophthalmologists

*Open Disclosure is a lonely thing, you feel like you are on your own when you are going through it so it makes me feel supported knowing that both the Area and NSW Health support it.*

Open Disclosure Workshop participant

## OPEN DISCLOSURE: SETTING THE SCENE

- 2003** - National Standard on Open Disclosure developed by the Australian Commission for Safety and Quality in Health Care and endorsed by the Australian Health Ministers Conference.
- 2004** - Statewide NSW Patient Safety and Clinical Quality Program launched, where a guiding principle was openness about failures; and development of a culture in which errors are reported to prevent the same mistakes happening again.
- 2005** - Clinical Governance Units established to guide implementation of patient quality and safety initiatives, including Open Disclosure.
- 2006** - National Steering Committee established to evaluate Open Disclosure at nominated pilot sites across Australia. From December 2006 to December 2007 Open Disclosure was implemented in New South Wales.
- 2008** - Open Disclosure spread and sustainability strategies under development for New South Wales.
- 2009** - Further revision undertaken in response to report from NSW Ombudsman.

## CRITICAL SUCCESS FACTORS

- A legal framework providing statutory protection for apologies
- Consultation with legal advisors, insurers and clinicians prior to implementation
- Support and advocacy by senior health professionals
- A statewide education strategy customised to the individual Area Health Services
- Improved utilisation of an incident information management system
- Practical support through experiential skills training

## COMMUNICATION & EDUCATION

Health service executives are responsible for establishing and maintaining Open Disclosure in all hospitals. The implementation involved:

- A communication strategy with key messages customised to key stakeholders
- An education strategy that included role-play workshops to teach senior clinicians and managers how to undertake disclosures associated with serious clinical incidents
- Online staff training modules for the Open Disclosure principles and requirements to patients involved in less serious incidents.

## ENGAGING STAFF

Engaging staff has built confidence, skill and capacity to confidently instigate Open Disclosure following a serious incident.

770 senior clinicians and managers in NSW participated in the workshops. The role plays generated experiential evidence-based solutions to real-life Open Disclosure challenges in dealing with patients, families and staff. The training also established a mentor-cohort to provide advice and support other health professionals.

Online training modules will assist 80,000 NSW health staff to handle disclosures for less serious incidents.

## Explain Apologise Reassure

Explain the facts and acknowledge the incident  
Apologise according to Open Disclosure guidelines  
Reassure the patient that the incident will be addressed

## NEXT STEPS

- Incorporate Open Disclosure into training, education and orientation programs in health services
- develop communities of practice and mentor networks and conduct workshops to ensure new staff are confident in the communication skills necessary for Open Disclosure.
- make available Open Disclosure e-resources developed by local health services on the Open Disclosure website
- work with professional Colleges to ensure members are familiar with the Open Disclosure process

*“I was impressed that the workshop stressed that Open Disclosure is not an individual responsibility and there is a need for culture change.”*

*“I was given direction on how to conduct Open Disclosure and how to phrase an apology - something that has always worried me.”*

Open Disclosure Workshop participants