

1. Open Disclosure Policy

Background

The Canterbury DHB is committed to the provision of safe quality health care to the patients/consumers and communities it serves. Despite best efforts, there are occasions when individuals are harmed by the health care they receive. While such harm is sometimes unavoidable, there are occasions when it results from preventable mistakes or errors in the provision of that care.

Philosophy

Canterbury DHB is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process. This is emphasised in the Culture of Patient Safety Policy and the No Blame Incident/Accident Reporting Policy sponsored and developed by the Quality & Patient Safety Council.

Scope

Open disclosure applies to all staff involved in patient/consumer care and communication with patients/consumers and/or support person should reflect the fact that care is provided by multi-disciplinary teams.

Policy Statements

The Canterbury District Health Board requires that any patient/consumer harmed as a result of a mistake or an error is to have the circumstances associated with the event fully and frankly disclosed to them and/or their support person.

Acknowledgment

All events where a patient/consumer is harmed as a result of a mistake or error must be acknowledged to the patient/consumer and their support person as soon as possible after the event is identified.

Openness, timeliness and clarity of communication

Information about an event that causes harm must be given to the patient/consumer and/or support person in a timely, open and honest manner.

Apology

The patient/consumer and/or support person must receive an honest and genuine apology for any harm that has resulted from a mistake or error as soon as possible after the event.

Recognition of the reasonable expectations of patients/consumers and their support person

The patient and/or support person may reasonably expect to be:

- i) fully informed of the facts surrounding an event where harm has occurred and the consequences of that harm;
- ii) treated with empathy, respect and consideration and to be provided with such support as is necessary in a manner appropriate to their needs;
- iii) fully informed as to the outcome of any investigation undertaken together with any changes instituted as a result of that investigation.

Confidentiality

Open disclosure processes must be confidential and ensure that patient/consumer, support person and staff privacy is maintained in a manner consistent with relevant legislation.

Ongoing Care

When a patient/consumer has been harmed in the course of receiving health care any required further management or rehabilitation must be planned in discussion with the patient/consumer and/or support person in order to ensure that they are fully informed of and in agreement with any proposed ongoing care.

Associated Documents

- CDHB Volume 2 – Legal and Quality
- Culture of Patient Safety Policy
- No Blame Incident/Accident Reporting Policy
- Incident Management Policy
- Overall Management of Sentinel Events Policy
- Protected Quality Assurance Activity Policy

Legal Privilege

Quality Assurance Activity Protection under the Health Practitioners Competency Assurance Act for “Adverse Outcome Audit Activity”, does not affect open disclosure processes. However, any information or documentation arising as part of the quality assurance investigation may not be disclosed under the open disclosure process.

References

Open Disclosure Standard: A National Standard for Open Communication in Public and Private Hospitals, following an Adverse Event in Healthcare, July 2003.

Being Open: Communicating Patient Safety Incidents with Patients and their Carers: NHS National Patient Safety Agency 2005

Policy Owner	Quality and Patient Safety Council
Policy Authoriser	Clinical Board
Date of Authorisation	27 March 2007