# Whiddon Open Disclosure Policy and Principles for RAC and CC

Whiddon

# **Document Control**

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# **Open Disclosure**

#### Introduction

Whiddon acknowledges that from time to time, despite our best efforts, events or errors may occur either directly or indirectly with one of our aged care consumers, that results in feelings being hurt, or worse, there has been an adverse outcome. Should any such incident, error or event occur, we appreciate and understand that it could be confusing and even traumatising.

We believe under such circumstances, the resident or client and their family deserve "open disclosure", that is an explanation of what went wrong, why it went wrong and how it went wrong, a heartfelt apology and an expression of regret from an appropriate staff member of Whiddon, and demonstrated action from Whiddon to given them comfort, that it will not happen again or likely not happen again.

At Whiddon we believe open disclosure between Whiddon ,residents and clients is important. Whiddon will apply a process that is open, honest, empathic, timely and most importantly that personal discussions occur between residents, clients and their support person(s).

We feel it necessary to involve team members following an incident relating to a resident or client in our care, where the outcome to that individual has been adverse to them in one or more ways. Whiddon encourages team members to take responsibility if they have caused harm or upset to a client or resident.

This policy is designed to assist the reader to understand the importance Whiddon places on open disclosure and accordingly how we expect and require team members to apply it when interacting with our residents and clients. It forms the underpinning scaffold of our care and service delivery, it supports the MyLife model of care, The Whiddon Way our workplace and workforce culture, and will be generally be upheld at all times, subject to unique circumstances.

Open disclosure is not about a legal process or Whiddon admitting fault. An apology to consumers is not considered to be an admission of fault or liability and is not considered in determining fault or liability. All Australian jurisdictions have enacted laws that are designed to protect statements of apology or regret made after 'incidents' from subsequent use in certain legal settings

#### **Purpose**

The purpose of this document is firstly to provide a framework for continuous improvement of communication with residents or clients when things go wrong. Secondly, it aims to provide practical guidance to Whiddon team members to support the implementation of open disclosure practices.

# Application of Policy

This policy applies to all Whiddon team members, management, directors, employees, contractors, volunteers and Whiddon residents, clients and their advocates. Where appropriate, this policy may be enforced via management interventions, education, training and other measures.

#### Open Disclosure and the Single Quality Framework Aged Care Quality Standards

Open disclosure is a requirement under the Aged Care Quality Standards. There are two specific references to open disclosure in the Standards. Standard 6: Feedback and Complaints, requires providers to use an open disclosure process when things go wrong. Standard 8: Organisational governance, where clinical care is provided, organisations are required to have a Clinical Governance Framework which includes open disclosure. More generally, a number of the Standards are applicable when considering the value of open disclosure. For example, open disclosure is relevant to the requirement that providers treat consumers with dignity and respect (under Standard 1), to undertake ongoing assessment and planning for care and services in partnership with the consumer

(under Standard 2), and to effectively manage high-impact or high-prevalence risks associated with the care of each consumer (under Standard 3).

The Aged Care Quality and Safety Commission (the Commission) assesses service provider performance against requirements of the Quality Standards, including those related to open disclosure. In doing so, it will seek to understand how providers have applied open disclosure in their service and how they have taken account of best practice guidance and implemented approaches relevant to the services they deliver.

The Commission will consider evidence of open disclosure as a positive sign that the organisation has effective systems to identify and monitor risk and adverse events. It will also be seen that the organisation seeks to learn from such events to improve the quality of care and services for consumers. Evidence of open disclosure also signals to the Commission the level of the provider's partnership and engagement with consumers to ensure their safety, health and wellbeing is at the centre of planning, delivering and evaluating their care.

#### Definition

Open disclosure is the open discussion that an aged care provider (Whiddon) has with residents or clients (Consumers/Care recipients) or their representatives when something goes wrong that has harmed or had the potential to cause harm to the person.

Open disclosure refers to the practice of communicating with a consumer when things go wrong, addressing any immediate needs or concerns and providing support, apologising and explaining the steps that the Whiddon team has taken to prevent it happening again.

Open disclosure may also involve the resident or client family, carers, and other support people and representatives when a resident or client would like them to be involved. Honest and timely disclosure is not only ethically, morally and professionally expected but also the first stage in promoting and fostering an environment and culture that, through honest discussion, encourages learning needed to improve care and services.

As such, it underpins Whiddon's My Life Care Model and the Whiddon Way (our culture and behaviours) needed for continuous learning and service improvement in partnership with residents and clients. Through improved transparency it enhances public trust in aged care services.

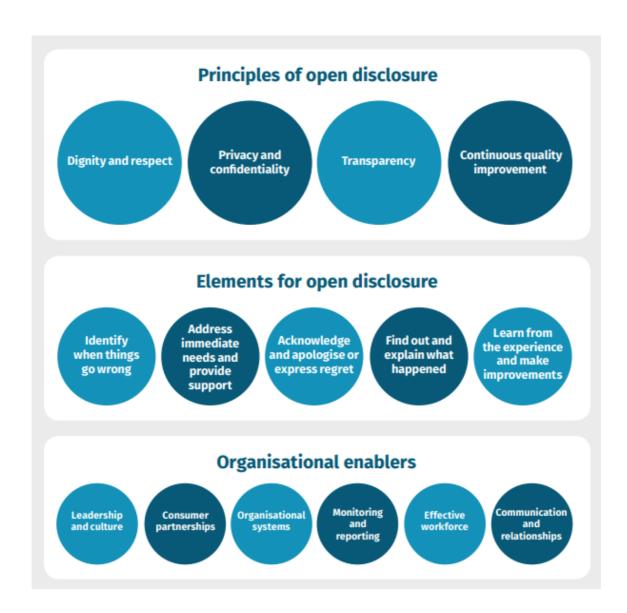
# **Policy**

Whiddon team members will ensure that open disclosure principles, processes and intent are applied and maintained to promote respectful, compassionate ,timely and open communication between residents, clients or their representative when things go wrong.

#### Open Disclosure Framework and Principles

As per the Commission's open disclosure framework and guidance document the principles to implementing open disclosure principles aligns with Whiddon's 'My Life care model', where we acknowledge the importance of understanding an individual, respecting and acting upon choices, maintaining a person's dignity and developing meaningful relationships.

The principles of open disclosure require an organisation to establish a culture that is open, transparent, leadership driven and resident and client centric. To this end Whiddon has established relationship based care where all team members are supported and encouraged to develop meaningful and purposeful relationships with residents and clients.



## When Should Open Disclosure be Applied?

Whiddon teammembers should apply open disclosure when something has gobe wring that has caused harm or had the potential to cuse harm to a resident or client. Harm may be physical, psychological or social resulting in loss of quality of life, impairment, suffering, injury, disability or death.

A Whiddon team member may identify something has gone wrong through several channels: At the point of care delivery for residents or clients where team members have identified that something has gone wrong with the delivery of care and services; At the level of managing risks systematically in residential and community care, monitoring care outcomes by senior managers such as incident reporting and management, quality reviews and monitoring quality indicators; Through established complaints feedback mechanisms and engagement with families and resident or resident and client advocates; Through self-assessment and continuous improvement processes;

# Below are some examples where open disclosure can be applied.

A provider fails to prevent or control the spread of an infection	A provider incorrectly administers medication to a consumer	A consumer slips and falls while getting out of bed	A staff member does not adequately manage personal hygiene of a consumer when providing personal care at home
A staff member uses abusive language towards a consumer	A provider fails to meet the nutritional needs of a consumer	A staff member poorly manages a consumer's incontinence	A staff member fails to visit a consumer's home to provide personal care
A provider uses physical restraints without the consent of a consumer or their support person / representative	A support person / representative complains that the provider is failing to accommodate a consumer's auditory impairments	A provider fails to recognise and respond to a consumer who is suffering from delirium, cognitive and related functional decline and deterioration	A consumer experiences pressure injury as a result of being left in their bed for too long
A provider fails to provide adequate end-of-life care	When a provider receives an external report that makes findings of substandard care or risk to safety, health and wellbeing of consumer(s).	A consumer verbally abuses another consumer	A provider fails to provide meals that meet the cultural preferences of a consumer

# Principles of Open Disclosure

There are 4 key values/principles of Open disclosure, which are linked to the Charte of Aged Care Rights, which articulate consumer rights and what consumers on expect in aged care service.



# **Dignity and Respect**

Open Disclosure is underpinned by recognising each resident and client's right to be treated with dignity and respect. This is essential to each person's sense of self and supports quality of life. It means communicating respectfully and recognising and respecting a resident or client individuality in all aspects of care and services.

It means providing timely information in a form and language that is understood to help resident and client to exercise control, make informed choices, and get the most from their care and services. When something goes wrong that may have harmed or had the potential to harm the resident or client, they need to know this, understand how it affects them, and have a say in addressing the issue such as making changes to their care. Particular attention should be given to how best to communicate with residents or clients with diverse backgrounds when something has gone wrong with their care or services. This should be done in a way that is culturally safe and builds their trust and confidence that the service will work with them to address the area of actual or potential harm and focus on improving outcomes for them.

# **Privacy and Confidentiality**

Privacy must be maintained consistent with privacy law and the resident or client preferences. A discussion with the resident and client and /or their representative can determine what information they are comfortable to have shared – and with whom. This should be done before any personal information is shared about something that has gone wrong. It is important to clarify the extent of information that can be shared with others at the service. If the resident or client does not wish to be identified and does not grant permission to share specific details, Whiddon team members must determine how and what information can be communicated without breaching the resident and client privacy and confidentiality

## Transparency

Residents and clients need three key pieces of information communicated to them when harm or potential harm – a 'near miss – has occurred as a result of their care and services. First, they need to know what happened and understand what immediate action has been taken to address the harm to themselves, second, they need to know what changes will be made to decrease the likelihood that such an event will happen again; and third, they need an apology. Whiddon promotes that all service managers/ community coordinators identify who is affected by actual or potential harm, be honest, open and transparent about what happened, and be prepared to communicate proactively at a level appropriate to the severity of the impact. This may mean communicating more broadly than just to the affected resident or client, for example, when there has been an instance of food poisoning. Resident and client trust and confidence in the service is eroded if a service is slow to respond or perceived to be attempting to cover up circumstances of actual or potential harm. This reduces the likelihood of early resolution with the consumer and problem solving in partnership to address the risk of recurrence. It increases the likelihood of escalating complaints and external criticism of the service.

## Continuous Quality Improvement

Open disclosure is an important part of quality improvement. Whiddon has a culture of learning, applying continuous improvement and places a high value on monitoring, analysing and reporting information about the quality and safety of care and services. This means information gained through practising open disclosure is seen as an opportunity to identify where things have gone wrong, to understand why – through active inquiry – to understand any systemic causes, and to take positive steps to prevent such an event from happening again.

## **Elements of Open Disclosure**

There are five key elements of open disclosure

These elements are not intended to occur in a particular order; nor will all be used in all circumstances. Variation in how open disclosure is used is to be expected and encouraged. This is to facilitate adaption to local context and circumstances surrounding what happened.



#### Identifying When Things go Wrong

Practising open disclosure begins with identifying when something has gone wrong that has harmed or had the potential to cause harm to a resident or client.

We may identify something has gobe wrong through a range of channels:

- ✓ By a consumer, client their family, carers, other support people and representatives
- ✓ By a team member
- ✓ Through an internal complaints process
- ✓ Through an internal quality review
- ✓ Through an incident management system
- ✓ By the ACQSC as part of a complaint or quality assessment process.

Whiddon encourages and promotes a culture where people feel supported and are encouraged to raise concerns when something has gone wrong. It is demonstrated by how the Whiddon service is managed, how staff feel comfortable to speak up when something has gone wrong, and know what to do, how management responds to these situations, and weather people at the service see action taken as a result. The service culture is very influential and will be evident to resident or cliebts and their family, careres, other support people and their representatives, as well as team members.

# Address Immediate Needs and Provide Support

Following identification that something has gone wrong take immediate action to address any actual or potential harm. This should include ensuring that adverse effects arising from what went wrong are ameliorated and future potential harm is prevented. Practical and emotional support should then be provided and based on the needs and preferences of the individuals involved. Practical and emotional support may include:

- Identifying additional clinical care needs required of the resident or client
- Identifying additional emotional care needs required of the resident or client
- Facilitating access to an advocate, translation services or other communication and hearing support services
- Appropriately involving family, carers, other support people and representatives who have been appointed to act or make decisions on a resident or clients behalf in the process
- supporting access to alternative, external complaints handling options
- Offering and, when required, providing support to and management of team members involved.

Whiddon team members must provide residents or clients with privacy and confidentiality. This includes asking residents or clients whether they would like a family member or other nominated support person to be involved in the process. If the residents or client wishes to involve others, they can be involved from the outset to give appropriate support to the residents or clients and to help with understanding how the matter has affected or may have affected the resident or client.

#### Acknowledge and Apologise or Express Regret

Acknowledging and apologising or expressing regret when things go wrong is part of open disclosure. It is not about saying someone is at fault. Open disclosure may occur over the course of several discussions. As early as possible, Whiddon managers:

- Acknowledge the concerns of a resident or client
- Provide a sincere and unprompted apology or expression of regret for harm or grievance caused. An apology or expression of regret should include the words 'I am sorry' or 'we are sorry'; and
- Follow up with the resident or client to ensure they understand the acknowledgement or expression of regret. Providing information about what has happened and communicating with resident or client in a way that they are able to understand may include: involving family members proposed by the consumer;
- Facilitating access to a resident or client advocate
- Involving a cultural or community group to which the resident or client belongs
- Using appropriate translation services

Using other assistance services where communication or hearing support is needed. Communication works best when roles and responsibilities for communicating with resident or client as part of this process are clearly defined within the organisation. At Whiddon the individual leading the communication would usually be the most senior staff member involved in the care of the resident or client.

#### Find Out and Explain What Happened

It is important for an appropriately skilled team member, to gather all necessary information to find out and understand what has happened if something has gone wrong. This requirement is part of the Whiddon investigation process which is entered into eQstats

The required inquiry and analysis can be done in different ways, depending on the nature and scale of the harm. It will involve information being sought from residents or clients and/or families and staff affected by the incident to help inform these questions:

- What happened?
- Why did it happen?
- When did it happen?
- Who was involved?
- What was the outcome?
- How can it be prevented from occurring again?

This is not a process to apportion blame; it is designed for learning and understanding how to improve outcomes for resident or clients.

Key steps to communicate with the resident or clients include:

- A factual explanation of what happened is provided in a way that ensures the resident or clients understands the information
- A resident or clients is offered an opportunity to tell their story, explain how this has affected them, provide their views and ask questions. It is important these views and concerns are listened to, understood and considered
- A resident or clients is offered follow-up meetings and meaningful support. They are assured they will be given any further information gathered or findings and recommendations made as part of evaluating what happened; and
- All discussions and meeting minutes are to be documented in the resident or clients progress notes and copies as required uploaded into eQstats as a record of consultation and discussion having occurred.

#### Learn from the Experience and Make Improvements

Open disclosure gives Whiddon team members the opportunity to learn, to find and act on things they could improve about their current systems, practice or culture. Practising open disclosure will foster a culture of learning and quality and safety. In some cases, despite best efforts, things go wrong for the resident or clients. Open disclosure can be used in a positive way to engage with resident or clients.

Whiddon promotes a culture of continuous improvement, to this end unfortunate incidents can be an opportunity that identifies ways in which we can improve outcomes for residents or clients. Through open disclosure, team members and residents or clients can be actively involved in the continuous improvement of practice and be given the opportunity to provide feedback to inform continuous improvement of the service. At Whiddon we have a risk management system that allows incidents to be captured, analysed and linked to continuous improvement registers

# **Organisational Enablers**

Open disclosure is an integral part of Whiddon's Governance.

Whiddon has a robust Clinical Governance framework that is an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, and planning, monitoring and improvement mechanisms. They are implemented to support good clinical care and clinical outcomes for each resident and client.

Systematic action is needed across six areas to establish effective clinical governance; action in these areas also enables Whiddon to implement open disclosure and contributes to better outcomes for residents, clients and Whiddon as an organisation

The six enablers are:

- 1. Leadership and culture
- 2. Consumer partnerships
- 3. Organisational systems
- 4. Monitoring and reporting
- 5. Effective workforce
- 6. Communication and relationships

#### Leadership and Culture

Strong leadership is critical for effective use of open disclosure. Leaders are responsible for promoting a culture of safe, inclusive and quality care and services that is embedded in all aspects of Whiddon life and owned by everyone. Whiddon encourages its leaders to model and promote openness when things go wrong so that people feel supported and are encouraged to identify and raise issues and concerns. Whiddon leaders must demonstrate their commitment to learning from the experience and making improvements.

Whiddon strives to develop and implement appropriate policies, procedures and practices which are centred on involving residents or clients directly or indirectly.

Whiddon leaders understand the legal aspects of open disclosure, including that an apology or expression of regret does not admit fault or imply blame.

## Resident and Client Partnerships

Partnerships with resident and clients are the foundation of effective open disclosure. Whiddon introduced and continues to promote Relationship Based Care where mutual trust and respect is paramount in developing a culture that supports open communication and learning.

Our residents, clients and team members need to be supported and encouraged to raise concerns when something has gone wrong. Their needs and preferences should guide any support that is provided as part of the open disclosure process, including the involvement of family, carers and other support people and representatives. Open and respectful communication helps to build partnerships and is part of effective open disclosure. Residents and clients can also be actively involved in the improvements that can occur after something has gone wrong.

Open disclosure processes with individual residents and clients can identify areas for quality improvement, and a partnership approach can be taken as these improvements are implemented. It is important to celebrate these partnerships and achievements.

# **Organisational Systems**

Whiddon has a systematic approach to ensure instances of harm or potential harm to residents and clients are consistently being identified, and that open disclosure is practised appropriately.

Whiddon has policies, processes and procedures that support effective open disclosure via its clinical governance framework, Whiddon Enterprise Risk Framework, and continuous improvement systems. At Whiddon we have systems and processes that support reporting of incidents via eQstats, review of complaints and feedback via our 'Have Your Say' complaints resolution process.

#### Monitoring and Reporting

Ongoing monitoring and review processes are important to understand the effectiveness of open disclosure, outcomes for residents and clients and to identify any areas for improvement. Open disclosure is part of Whiddon's broader focus on clinical quality and safety performance that needs to be monitored and reported regularly to the executive and board.

Residents, family, carers and other support people and representatives can be given the opportunity to provide feedback on the open disclosure process.

Based on the circumstances of the open disclosure process, sensitivity around how this is conducted would be required. Any changes implemented following open disclosure should be monitored for their effectiveness. Information about the outcomes of quality improvements can be given to the resident, client, their family and carers.

#### **Effective Workforce**

Effective open disclosure relies on Whiddon's team members, and, where relevant, visiting practitioners. Whiddon has clear roles and responsibilities and where relevant open disclosure expectations are articulated.

At Whiddon we have partnered with an external learning and development consortium and via this partnership our team members can access an education resource on open disclosure. All team members are able to apply a consistent and informed approach to open disclosure. Education resources will be reviewed and updated periodically.

# Communication and Relationships

Communication underpins effective open disclosure. It is also linked to each of the other enablers. Good communication processes are needed to establish the culture of openness, partnership and learning that supports open disclosure. Whiddon processes and staff training support and ensure consistently good communication.

Documentation of all communications is essential, it is record of the discussions, agreements and progress undertaken as part of the open disclosure process. The communication processes within Whiddon, external communication and relationships are also important for open disclosure. Whiddon services are part of a broader network of aged care and health organisations from which residents and clients may receive care and services. Visiting practitioners may need to be involved in open disclosure processes if they have provided care to residents and clients where there has been harm or the potential for harm. In accordance with the wishes of the residents and clients, it may also be appropriate to communicate with external providers about what has occurred.

#### How will you demonstrate that you have applied open disclosure in your service?

✓ You will investigate all serious and or adverse events. This will be conducted as part of Whiddon's risk management process and the learnings will be applied to improving the delivery of care and services via the continuous improvement process in a timely manner

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- ✓ All involved parties (team members, residents or clients, their representatives ) will be informed about what happened in an open and honest manner at all times. They will be supported with compassion, respect and in a manner appropriate to meeting their emotional needs and choices.
- ✓ Whiddon team members will issue an expression of genuine regret for any harm or distress that may have resulted from the incident. This will be offered by an appropriately skilled person.

- ✓ All communication, consultations, discussions, investigation reports, agreements, apologies will be documented and stored in Step7 of the eQstats incident reporting.
- ✓ Residents or clients and or their representatives will acknowledge that the process has met their needs or addressed their issues, this will be captured as part of the consultation process.
- ✓ You will review and monitor and provide ongoing consultation with the resident or client or their representatives as negotiated.
- ✓ Whiddon team members are to monitor the resident or client as identified and agreed, or as assessed according to their physical and mental status, to ensure no ongoing negative sideeffects have been sustained.
- ✓ As per Whiddon practice all critical incidents, complaints, near misses must be reported. immediately to the Regional Manager/Operations Manager who will escalate the matter to the Executive General Manager Care Services and the General Manager Clinical Governance. Incidents or events reportable to external bodies (e.g. police, coroner) must be reported to the Executive General Manager Care Services who will escalate to the CEO and or Board and other relevant stakeholders as soon as is practicable and within 24 hours.