FACTSHEET

MEDISEC

We look after you

Open Disclosure

The law concerning Open Disclosure is currently governed by the Civil Liability (Amendment) Act 2017. The Act provides the legal framework to support voluntary open disclosure; it applies to all patient safety incidents including near misses and no-harm events. It provides for an open and consistent approach to communicating with patients and their families, allowing an apology, as appropriate, when things go wrong in healthcare. The approach is intended to create a positive voluntary climate for open disclosure.

This factsheet is intended to guide you through the statutory process in detail, but at the outset, the principles of Open Disclosure can be usefully summarised as:

- a timely acknowledgement to the patient about what happened and what impact it had on the patient, physically, emotionally and socially.
- an apology or expression of regret, which includes the phrase 'I am sorry' or 'we are sorry'.
- a factual explanation of what happened – without speculation or conjecture.
- providing an opportunity for the patient and their support persons to relate their experience/story.
- a discussion of the potential consequences of the adverse event.
- an explanation of the steps being taken to manage the adverse event and to minimise the likelihood of a recurrence of such an event.
- keeping the patient and their nominated support person(s) informed and involved in the review, learning and quality improvement process.
- providing ongoing practical support for patients to manage the effects of harm and agreeing on matters regarding their ongoing care and treatment.

What are patient safety incidents?

The Act defines a patient safety incident as one of the following:

- an incident that resulted in an unintended or unanticipated injury, or harm, to a patient during the course of provision of a health service
- an incident that has not resulted in actual injury or harm but where a clinician has reasonable grounds to believe a patient was placed at risk of unintended injury or harm
- the prevention, by timely intervention or chance, of an unanticipated injury or harm which the clinician has reasonable grounds to believe that, in the absence of the prevention, could have resulted in injury or harm to a patient.

What legal protection is offered?

When done correctly, the Act and Regulations state that your disclosure and apology made during an open disclosure meeting shall not:

- constitute or be used as evidence of an admission of fault or liability;
- invalidate any insurance or indemnity;
- constitute an express or implied admission of professional misconduct, poor professional performance or unfitness to practise in any regulatory Fitness to Practise proceedings; or
- be admissible as evidence of professional misconduct, poor professional performance or unfitness to practise.

Where possible, it is advisable to contact Medisec in advance of open disclosure so we can advise you how best to proceed.

To whom should patient safety incidents be disclosed?

You may disclose to:

(a) The patient concerned

(b) A relevant person where:

- Having regard to the patient's age, capacity or health status, it is appropriate, in your opinion, to disclose the patient safety incident to a relevant person
- The patient has died; or
- The patient has requested that disclosure be made to the relevant person and not the patient.

or

(c) Both the patient and a relevant person where:

- Having regard to the patient's age, capacity or health status, it is appropriate, in your opinion, to disclose the patient safety incident to both the patient and a relevant person; or
- The patient has requested that disclosure is also made to the relevant person.

You may, for example, form the opinion that it is appropriate to disclose the patient safety incident to a relevant person if the patient has cognitive impairment.

Who may disclose the information?

The patient's principal healthcare practitioner shall make the disclosure, unless:

- the principal healthcare practitioner is not available or not otherwise in a position to make the disclosure; or
- having regard to the circumstances of the patient safety incident, the principal healthcare practitioner is satisfied that Open Disclosure should be made by another health practitioner.

Please do not hesitate to contact Medisec if you have any queries regarding the above.

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