Fronditha care

Open Disclosure Campaign

WEEK 6

LEARN FROM THE EXPERIENCES AND MAKE IMPROVEMENTS

The final topic in our 6-week Open Disclosure Awareness campaign draws our attention to **Element 5 – Learn from the experiences and make improvements**.

This highlights how Open Disclosure can be used in a positive way to engage with consumers, improve service delivery and enhance safe and quality care outcomes.

Open Disclosure is an opportunity to strengthen our relationships and build trust with consumers and stakeholders, learn from these experiences and implement strategies to minimise the risk of a recurrence.

Stakeholders are empowered to actively participate in improving service provision by providing feedback about what we can do better and offering suggestions on how we might achieve this.

It is also crucial to 'check in' with the consumer to ensure that the improvements that have been implemented are having the desired outcomes.

Overall, "Practising open disclosure will foster a culture of learning, quality and safety".

What we do at Fronditha Care:

- We are keen to learn from experiences and see Open Disclosure as an opportunity
- We actively look for things we can improve
- We respond when things are identified
- We look to our consumers and staff to share their ideas about how we can do better
- We have a robust and documented continuous improvement process
- We go back and check that what we have implemented is working
- We are committed to providing safe and quality care

WEEK 6

LEARN FROM THE EXPERIENCES AND MAKE IMPROVEMENTS

Continuing from last week's case scenarios, below you will find how to apply Element 5 of Open Disclosure – Learn from the experiences and make improvements.

1 A personal support worker fails to attend a consumer's home for meal preparation

Following the home visit the Care Advisor remained in contact with Eva and Chloe to monitor how services were going in the home and the levels of satisfaction of the consumer and representative.

The Care Advisor with the Services and Administration Team also tracked the number of 'missed services' where it was identified that no staff member was available to replace the absent staff member's lunch time service.

This had occurred once in the last 3 months and staff were able to follow the Care Plan and engage with the consumer's informal supports to ensure they could attend on that occasion.

The Care Advisor then followed up with Eva and Chloe to evaluate if the arrangements/contingency plans they had agreed on, were having the desired outcome. Both Eva and Chloe provided positive feedback about the ongoing transparent communication, service coordination, planning and care outcomes.

They spoke favourably about feeling part of the process and helping to find solutions that directly improved their care experiences.

This was again evaluated as part of the 6 monthly and 12 monthly care plan reviews at which time the improvements were embedded into practice and it was agreed by all that the matter could now be closed.

2 The case of personal belongings disposed of in the rubbish bin

The Manager arranged a follow up meeting with Mr.G and staff to provide each and everyone the opportunity to be involved in finding the best solution to improve the specific process .

As a result of the lessons learned, the continuous improvement process indicated that, quality activities needed to be initiated to include a full review of the discharge process ;review of the schedule for ordering of the specific Tote bags; and review of the content of the training schedule to include specifics relating to the discharge process .

The audit schedule was also updated to include ongoing monitoring of the process.

The Manager has also initiated immediate tool box sessions to ensure that all staff have understanding of the organization's discharge and bereavement process . A staff in-service program was held and communication to relevant workforce about changes and improvements was provided.

The Manager has also briefed the organizations governing body of the outcome of the Open disclosure process applied in this matter and the steps taken to improve the quality and safety management systems of the organization.

Mr.G expressed satisfaction with the steps taken by the organization to make sure that the same thing does not happen again. He was also thankful for all the support provided to him during this difficult time.

** All names and scenarios are fictional. Any resemblance to real persons or cases is purely coincidental.*

For the full case scenario visit:
https://frondithacare.org.au/open-disclosure-awareness/