STANDARD OPERATIONAL POLICY AND PROCEDURES

TOPIC	Open Disclosure – SOPP 74.02		
RESPONSIBILITY	All Areas		
AUTHORISATION	Chief Executive		
SIGNED	Andrew Freeman.	**DATE**	24/01/2019
VERSION	1.5	**LAST REVIEWED**	January 2019
EFFECTIVE	December 2008	**NEXT REVIEW**	January 2022

1. PURPOSE

East Grampians Health Service (EGHS) is committed to openly disclosing to patients and their families adverse events that have occurred while receiving health care.

2. OUTCOME

To identify and appropriately manage patients who have experienced an adverse or unexpected outcome while receiving health care at EGHS. This policy should be read and enacted in conjunction with the Australian Open Disclosure Framework.

3. DEFINITIONS

Adverse Event: An incident in which harm resulted to a person receiving health care.

Adverse Outcome: An outcome of an illness or its treatment has not met the expectations for improvement or cure.

Expression of regret: An expression of sorrow for the harm or grievance.

Support person: This may include a family member, friend, partner of those who care for the patient. They are a nominated person who can provide appropriate support and care to the patient.

4. PROTOCOL

After an incident has been identified:

- Address the immediate clinical management issues.
- Identify support for staff/patients.
- Record incident on Victorian Health Incident Management System (VHIMS).
- Determine level of response according to incident severity.
- Commence documenting the open disclosure checklist.

There are two levels of incident severity in the open disclosure protocol.

1. Low Level incidents which are rated at 3 or 4 on the EGHS severity rating scale. These are incidents that have no permanent injury or increased level of care.

2. High Level incidents are rated at 1 or 2 on the EGHS incident severity rating scale. These are incidents that have serious impact or consequence for example death, permanent loss of function, need for surgery or ICU or major changes in clinical management.

4.1 Low Level Response

See flow chart low level response *(Page 17. Australian Open Disclosure Framework)*

- Health professional(s) initiate a discussion with the patient and/or their carer as soon as possible after discussion with Manager.
- Interpreter arranged as necessary.
- Discussion with patient and/or carer includes:
  - an apology or expression of regret
  - an explanation about what happened (facts as known at the time)
  - a discussion about what will happen next and the anticipated impact upon the patient
  - advising on when and how they will be provided with further information.
  - health professionals listen to patient's concerns and respond to questions
- Information provided to patient and/or carer and meeting outcomes documented in the medical record.
- Notify relevant individuals, authorities and organisations.
- The fact that open disclosure occurred is recorded in the health service's incident recording system/database (VHIMS).
- Patient and/or their carer is provided with the name of someone to contact should they have further questions.
- Patient is provided with the 'adverse event brochure' (this should supplement, not substitute information given to the patient).

4.2 High Level Response

See flow chart high level response *(Page 16. Australian Open Disclosure Framework)*

- Health professional(s) involved in the patient's prior and ongoing care meet to plan the open disclosure process and dialogue with the Director of Clinical Services and/or Chief Executive Officer, then discuss with the patient and/or carer.
- Checklist completed and information agreed.
- Meeting date and location arranged.
- Interpreter arranged as necessary.
- Discussion with patient includes:
  - an apology or expression of regret
  - an explanation about what happened (facts as known at the time)
  - a discussion about what will happen next and the anticipated impact upon the patient
  - advising the patient when and how they will be provided with any further information
  - health professionals listening to patient concerns and responding to questions

- additional support or referrals identified.

- Information provided to patient and meeting outcomes documented in the medical record.
- Notify relevant individuals, authorities and organisations.
- Additional supports or referrals identified in the meeting are arranged.
- The fact that open disclosure occurred is recorded in the health service's incident recording system/database (VHIMS).
- Patient is provided with the name of someone to contact should they have further questions.
- Patient is provided with the 'adverse event brochure' (this should supplement, not substitute information given to the patient).
- Process evaluated and improvements identified, communication to relevant committees as necessary.

4.3 What to Discuss

Those involved in the open disclosure discussion should:

- Express empathy and regret for the harm that has been suffered
- Outline the facts as known
- Listen to the patients understanding of the events
- Address queries and concerns
- Provide information of next steps
- Provide information on likely short and long term effects (if known)
- Provide assurances that the patient will be kept informed of the progress of the investigation and how they will be informed
- Provide ongoing support
- Provide information on how to take things further if needed.
- Provide details of a key contact

4.4 What Not to Discuss

Those involved in the open disclosure should not:

- Speculate
- Attribute blame
- Criticise individuals
- Admit liability
- Argue

5. OPEN DISCLOSURE AND THE LAW

5.1 The *Wrongs Act 1958*

Section 14J provides that:

"In a civil proceeding where the death or injury of a person is an issue or is relevant to an issue of fact or law, an apology does not constitute –

a) an admission of liability for the death or injury; or

b) an admission of unprofessional conduct, carelessness, incompetence or unsatisfactory professional performance, however expressed, for the purposes of any act regulating the practice or conduct of a professional occupation."

This applies whether or not the apology is made orally or in writing or before or after the proceedings were commenced.

However, a statement will still be admissible with respect to a fact in issue or tending to establish a fact in issue.

5.2 The Open Disclosure Standard

Specifically acknowledges that an organisation's open disclosure policy needs to pay due regard with relevant legal obligations, including insurance issues and responsibilities of various groups of healthcare professionals.

The Standard states:

"That healthcare professionals should take care not to:

(i) state or agree that they are liable for the harm caused to the patient;

(ii) state or agree that another healthcare professional is liable for the harm caused to the patient; or

(iii) state or agree that the healthcare organisation is liable for the harm caused to the patient."

5.3 The *Freedom of Information Act*

This applies to documents concerning a patient in a public hospital in Victoria.

The Open Disclosure Standard states that:

"Documents should restrict themselves to clinical facts which have been verified, as far as is possible, as accurate and should not:

(a) Attribute blame to any healthcare professional or to the organisation.

(b) Record opinions about staff, patients, support persons or others, unless those are expert opinions with supporting evidence with the opinion recorded.

(c) Contain statements about another person which are, or are likely to be, defamatory."

6. DOCUMENTATION

- Correspondence placed in clinical file and relevant information to be attached in VHIMS.
- Write in clinical notes all relevant clinical and non-clinical information regarding Open Disclosure.
- Open disclosure checklist once completed is to be attached to the incident report on VHIMS.

7. REFERENCES

National Safety and Quality Health Service Standards – Standard One

Aged Care Quality Standard – Standard 6

Australian Open Disclosure Framework – Better Communication, a better way to care – Australian Commission on Safety and Quality in Health Care 2013

8. RELATED DOCUMENTS

Policies:

INCIDENT REPORTING, INVESTIGATION AND MANAGEMENT - SOPP 15.01

Other relevant documents:

Open Disclosure Checklist and Plan for High Level Response - 74.02.03