STANDARD OPERATIONAL POLICY AND PROCEDURES

TOPIC	Open Disclosure – SOPP 74.02		
RESPONSIBILITY	All Areas		
AUTHORISATION	Chief Executive		
SIGNED		**DATE**	17/05/2022
VERSION	1.7	**LAST REVIEWED**	February 2022
EFFECTIVE	December 2008	**NEXT REVIEW**	February 2025

1. PURPOSE

To ensure that EGHS provides safe high quality health care and experiences to our consumers by actively following the Victorian Clinical Governance Framework and through its Community Participation Framework to actively engage and partner with consumers.

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

2. OUTCOME

To identify and appropriately manage consumers 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.

To ensure all staff are responsible and accountable for safe and high quality care, EGHS continuous improvement will be informed by regular monitoring and evaluation of performance.

3. ROLES AND RESPONSIBILITIES

All staff are responsible and accountable to know, understand and support each other to meet the requirements of the Victorian Clinical Governance Framework. All staff will be aware of the Community Participation Framework and actively engage and partner with consumers, demonstrate ownership and accountability of quality and safe care, and participate in regular evaluation and monitoring of performance to inform improvement.

4. 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: A family member, friend or partner of those who care for a consumer. They are a nominated person who can provide appropriate support and care to the consumer.

5. PROTOCOL

After an incident has been identified:

- Address the immediate clinical management issues.
- Identify support for staff/consumers.
- Record incident on the Victorian Health Incident Management System (VHIMS).
- Determine level of response according to incident severity.
- Commence documenting:
  - Low level: In progress notes of the medical record
  - High level: Complete Open Disclosure Checklist and Plan for High Level Response - 74.02.03 and Open Disclosure Summary - GR146.

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 VHIMS severity rating scale. These are incidents that have no permanent injury or no increased level of care.
2. High Level incidents are rated at 1 or 2 on the VHIMS 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.

Consumers engaging with EGHS have access to written information on open disclosure. For example, the Australian Commission on Safety and Quality in Health Care (ACSQHC)'s Fact Sheet- Open Disclosure - What to Expect if you Experience Harm During Health Care?

5.1. Low Level Response

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

- Health professional(s) initiate a discussion with the consumer and/or their carer as soon as possible after discussion with Manager.
- Interpreter arranged as necessary.
- Discussion with consumer 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 consumer
  - advising on when and how they will be provided with further information
  - listening to the consumer's concerns and responding to questions
- Documentation of what was discussed, who was involved and the outcome of the discussion is recorded in the progress notes of 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).
- Consumer and/or their carer is provided with the name of someone to contact should they have further questions.
- Consumer is provided with the 'adverse event brochure' (this should supplement, not substitute information given to the consumer).

5.2. High Level Response

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

- Health professional(s) involved in the consumer's prior and ongoing care meet to plan the open disclosure process and dialogue with the Director of Clinical Services and/or Director of Medical Services and/or Chief Executive Officer, then discuss with the consumer and/or carer.
- Open Disclosure Checklist and Plan for High Level Response - 74.02.03 completed and information agreed.
- Meeting date and location arranged.
- Interpreter arranged as necessary.
- Discussion with consumer 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 consumer
  - advising the consumer when and how they will be provided with any further information
  - listening to consumer concerns and responding to questions
  - additional support or referrals identified
- Information provided to consumer and meeting outcomes documented Open Disclosure Summary - GR146.
- 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).
- Consumer is provided with the name of someone to contact should they have further questions.
- Consumer is provided with the 'adverse event brochure' (this should supplement, not substitute information given to the consumer).
- Process evaluated and improvements identified, communication to relevant committees as necessary.

5.3. 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 consumer's 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 consumer will be kept informed of the progress of the investigation and how they will be informed
- Provide ongoing support
- Provide information on how to escalate their concerns further if needed.
- Provide details of a key contact

5.4. What Not to Discuss

Those involved in the open disclosure should not:

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

6. OPEN DISCLOSURE AND THE LAW

6.1 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 verbally 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.

6.2. 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."

6.3 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."

7. 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 and Plan for High Level Response - 74.02.03 once completed is to be attached to the incident report on VHIMS.

8. REFERENCES

Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed- version 2. Sydney: ACSQHC; 2021

Delivering high-quality healthcare, Victorian clinical governance framework. Melbourne: SCV; 2017.

Australian Government Aged Care Quality and Safety Commission. Aged Care Quality Standards. July 2018.

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

9. RELATED DOCUMENTS

Incident Reporting, Investigation and Management - SOPP 15.01

Open Disclosure Checklist and Plan for High Level Response - 74.02.03

Open Disclosure Summary - GR146

ASQHC - Open Disclosure - What to Expect if you Experience Harm During Health Care?

Community Participation Framework