Open Disclosure Protocol

Protocol:

Open disclosure is an open discussion with a patient and / or carer about an incident that resulted in harm to that patient while they were receiving care. The elements of open disclosure are:

- an apology or expression of regret including using the word “sorry” for what has occurred and for the patient’s experience
- a factual explanation of what happened, as well as the actual and potential consequences
- an opportunity for the patient to relate their experience
- and an explanation of the steps being taken to manage the event and prevent recurrence.

Epworth HealthCare is guided by the Australian Open Disclosure Framework (the Framework) to ensure staff and clinicians practising at Epworth complete open disclosure with their patients and / or support person(s) when a patient has suffered unintended harm (either physical, social and/or psychological).

Responsibilities:

All clinical staff are responsible to recognise that a patient has suffered unintended harm during their care and / or treatment at Epworth.

The following staff are required to complete open disclosure training.

- Director Medical Services (DMS)
- Director Clinical Services (DCS)
- Associate Directors Clinical Services
- Hospital Coordinators
- Quality Coordinators
- Clinical Managers

Staff are able to access the training through the eLearning portal.

Open Disclosure process

1. Incident detection or recognition that a patient has suffered unintended harm during their care and / or treatment at Epworth

The open disclosure process commences with the recognition that a patient has suffered unintended harm during their care and/or treatment at Epworth.

An adverse event might be identified:

- by a staff member at the time of the incident
- by a staff member when an unexpected outcome is discovered
- by a patient or carer who expresses concern or dissatisfaction with the patient’s health care, either at the time of the incident or retrospectively
- through incident detection systems, such as RiskMan reporting or clinical audit
- through patient feedback mechanisms

Reporting and escalation of incidents should occur as per the Incident Management Protocol.

2. Initial response

As soon as an adverse event causing harm is identified, the first priority is prompt and appropriate clinical care and prevention of further harm (please refer to Incident Management Protocol).

Adverse events occurring elsewhere

If an adverse event has been identified that occurred in another organisation, the staff member who first identifies the possibility of an earlier adverse event should notify the site Quality Coordinator. The site Quality Coordinator will establish whether the:

- adverse event has already been recognised
- process of open disclosure has commenced elsewhere.

If the open disclosure process has not already commenced, Epworth will initiate the open disclosure process in consultation with the organisation in which the adverse event occurred.

3. Determine level of response

The level of harm sustained by the patient will determine the level of response.

i. Response for ISR 3 and 4 rated incidents
- A Response for ISR 3 and 4 rated incidents should be used for incidents that do not result in a permanent injury or significant increase in care requirements.
- Concerns raised by a patient or their family or support person that can be resolved by the treating unit.

ii. Response for ISR 1 and 2 rated incidents
- A Response for ISR 1 and 2 rated incidents will be initiated for incidents that have resulted in death or major permanent loss of function such as
    - permanent lessening of body function or
    - a need for surgical intervention, transfer for higher level care or major change in clinical management and
    - a serious and complex complaint or concerns an issue with broader implications for the group.

Please note, the response should be escalated from a response for ISR 3 or 4 rated incidents to a response for ISR 1 and 2 rated incidents if any of the criteria below are met:

- ISR rating is changed from 3 or 4 to 1 or 2,
- The patient and / or family are not satisfied with the initial response.

4. Management of the Open Disclosure Process

Unless there is a specific indication or the patient requests it, the open disclosure process, incident investigation and implementation of changes will occur at the Division level, with participation of those directly involved in the event.

The open disclosure discussion with the patient and / or support person(s) should:

- occur as soon as possible following recognition of the harm. Please refer to Timing of Disclosure section below for further information
- be face to face
- be conducted in a quiet, private area to maintain confidentiality
- provide information regarding the expected process (refer Appendices – Adverse events and Open disclosure, Patient, family/carer brochure)

The open disclosure conversation will include the following:

- an introduction of the people attending
- an apology / expression of regret
- an explanation of what happened, as well as the anticipated impact upon the patient
- an opportunity for the patient to relate their experience
- time to listen to the patient's and/or their family or support person's understanding of what happened and address any questions or concerns they have
- an explanation of how and when they will be provided with further information if required, including written
- Identification of additional support and referrals if required.

Staff should not speculate, attribute blame, criticise individuals or admit liability. All known facts relevant to the incident can be made available to the patient and their family or support person, subject to internal verification and legal advice given in the case.

a) Response for ISR 3 and 4 rated incidents

For ISR 3 and 4 rated incidents, the treating clinician is responsible for discussing the incident with the patient and their family or support person if required. If the treating clinician has not been trained in open disclosure, assistance will be provided by the clinical manager of the area, Director of Clinical Services or Director of Medical Services.

b) Response for ISR 1 and 2 rated incidents

For ISR 1 and 2 rated incidents, a planning meeting with the clinical care team may be beneficial. This meeting should occur within 48 hours of recognition of the adverse event and will:

- identify the clinician to lead the discussion. The lead clinician should be the most senior clinician who is responsible for the care of the patient and trained in open disclosure,
- ensure all necessary facts relating to the incident are established,
- identify and arrange immediate support needs for staff as required,
- determine the need for an interpreter
- determine the timing, location and attendees for the initial meeting. Please refer to Timing of Disclosure section below for further information

An "Open disclosure checklist and plan for Response for ISR 1 and 2 rated incidents" is available to support staff through this process (refer to Appendices).

5. Providing follow-up

It is the responsibility of the open disclosure team to:

- provide a contact name and number to the person and / or support person(s)
- convene further meetings with the patient and / or support person(s) as required.

For ISR 1 and 2 rated incidents, follow up with the patient, their family and carers is critical. Please note, for ISR 3 and 4 rated incidents, follow up may not be required.

6. Documenting the Open Disclosure process

The lead clinician is responsible for documenting a record of the discussion in the patient's medical record. Organisational notification of the completion of open disclosure is via the incident management system (RiskMan) through the investigation field.

For ISR 1 and 2 rated incidents, the open disclosure of an adverse event and the facts relevant to it must be recorded and forwarded to the divisional Director Clinical Services when completed.

This record should document:

- the time, place, date of the disclosure discussion and the name and relationships of those present
- the plan of providing further information to the patient and their family or support person
- offers of support and response received
- questions asked by the patient or their family or support person and the answers given; plans for follow up as discussed with the patient's progress notes relating to the clinical situation and accurate summary of all points explained to the patient and their family or support person
- copies of letters sent to the patient, their family or support person or GP (if any)

7. Completing the Open Disclosure Process

a) For ISR 3 and 4 rated incidents, it is likely that the open disclosure process will be completed after the initial discussion, if all parties concur. If parties do not concur, ongoing communication should occur and / or the response be escalated to a response for an ISR 1 or 2 incident.

b) For ISR 1 and 2 rated incidents, open disclosure is a process, not a single discussion. As such, follow up with the patient and / or support person(s) is important. The process is concluded when the clinical care team, patient and / or support person(s) reach a shared agreement.

In general, feedback to the patient will depend on the patient's preference and occur following completion of the in depth or root cause analysis investigation. This may take the form of a face–to–face meeting, telephone call or letter.

The meeting, discussion or letter may include for example:

- reference to the clinical or other relevant facts
- reference to details of the concerns or issues raised by the patient and support person
- an expression of regret for the harm suffered e.g. "I am sorry" or "we are sorry"
- a summary of the factors contributing to the adverse events
- Information on what has been and will be done to avoid a repetition of the adverse event, and how these improvements will be monitored.

If the patient or their family or support person is not satisfied with the outcome of the disclosure discussion information on how to take the matter further, including internal and external complaints processes available to them should be given.

Once open disclosure has been completed,

- Documentation should occur in the in-depth review (IDCR) / Root cause analysis paperwork
- the divisional DMS and DCS should be notified, if not involved in the open disclosure process
- A staff debrief meeting should be held.

Timing of disclosure meeting

The initial disclosure discussion with the patient and their family or support person should occur as soon as possible after recognition of the adverse event. Factors to consider when considering timing of the disclosure discussion will include:

- clinical condition of the patient
- availability of key staff
- availability of the patient's family or support person
- availability of support staff
- patient preference
- emotional and psychological state of the patient
- directives from the State Coroner in the event of a reportable death requiring investigation.

Timing of the meeting should not be limited by availability of the open disclosure team.

Choosing the individual to make the disclosure

The lead clinician should be the most appropriate and senior clinician who is responsible for the care of the patient and trained in open disclosure. This clinician may be the nurse in charge or medical practitioner depending on the adverse event.

This clinician should

- be known to the patient, and / or support person(s)
- be familiar with the incident whereby the patient sustained unintended harm
- be able to provide reassurance and feedback to the patient and / or support person(s)
- have received open disclosure training
- have good interpersonal and communication skills

For ISR 1 and 2 rated incidents, the clinician will be supported by the divisional DMS.

In exceptional circumstances, where it is not possible for the clinician responsible for the clinical care of the patient to be present, the divisional DMS will be responsible for the open disclosure discussion.

If the treating clinician has not been trained in open disclosure, assistance will be provided by the clinical manager of the area, Director Clinical Services or Director Medical Services.

If further assistance is required, the Executive Director Clinical Services / Chief Nursing Officer and the Executive Director Academic & Medical / Chief Medical Officer are available to assist clinicians with the disclosure process if required.

Notification requirements

All notifications occur as per the Incident Management Protocol and Reportable Deaths Protocol.

Language or Cultural Diversity Considerations:

Where someone has difficulty communicating in English or at the patient's request, a professional interpreter should be used in the open disclosure processes outlined above.

An interpreter from the same cultural background may also be able to advise on other issues (e.g. whether the gender of the health care professional who makes the disclosure is an issue that needs to be considered).

Expenses associated with managing and treating the adverse event

It is at the discretion of the Executive Director to consider the handling of patient expenses associated with managing and treating the adverse event.

Definitions:

- **Admission of liability:** A statement by a person that admits, or tends to admit a person's or organisation's liability in negligence for harm caused or damage caused by another.
- **Adverse Event:** An incident in which harm resulted to a person receiving health care
- **Adverse Outcome:** An outcome of an illness or its treatment that has not met the clinician's or the patient's expectations for improvement or cure.
- **Carer(s):** a person who provides unpaid care and support to the patient who has a disability mental illness chronic condition terminal illness or general frailty (includes parents and guardians of children).
- **Clinician:** a health care provider who is a trained healthcare professional. Includes registered and non- registered practitioners or a team of health professionals who spend the majority of their time providing direct clinical care.
- **Expression of Regret:** An expression of sorrow for a harm or grievance. It should include the words 'I am sorry' or 'we are sorry'. An expression of regret may be preferred over an apology in special circumstances (e.g. when harm is deemed unpreventable).
- **Harm:** Impairment of structure or function of the body and/or any deleterious effect arising therefrom, including disease, injury, suffering, disability and death. Harm may be physical, social or psychological.
- **Incident**: An event or circumstances, which could have, or did lead, to unintended and/or unnecessary harm to persons, complaint, loss or damage.
- **Liability:** Responsibility for an action in a legal sense.
- **Open Disclosure:** an open discussion with a patient about an incident that resulted in harm to that patient while they were receiving healthcare. The elements of open disclosure are an apology or expression of regret (including the word "sorry") a factual explanation of what happened an opportunity for the patient to relate their experience and an explanation of the steps being taken to manage the event and prevent recurrence.
- **Staff:** Anyone working within Epworth, including clinicians.
- **Support Person:** An individual who has a relationship with the patient. References to 'support person' in this document can include:
    - family members / next of kin
    - carers
    - friends,
    - a partner or other person who cares for the patient
    - guardians or substitute decision-makers
    - social workers or religious representatives
    - where available, trained patient advocates.

- **Treatment: The way an illness or disability is managed by drugs, surgery, physiotherapy or** other intervention to affect improvement in or cure of the patient's condition.

Standard:

- Australian Commission on Safety and Quality in Health Care (2013), Australian Open Disclosure Framework. ACSQHC, Sydney. Retrieved from https://www.safetyandquality.gov.au/wp-content/uploads/2013/03/Australian-Open-Disclosure-Framework-Feb-2014.pdf
- Australian Commission on Safety and Quality in Health Care (ACSQHC) (September 2011), National Safety and Quality Health Service Standards, ACSQHC, Sydney. Standard 1, Criterion 1.16

Focus Area(s):

- Standard 1: Governance for Safety and Quality in Health Service Organisations

References

- Victorian Government Department of Health and Human Services. (2011), *Victorian health incident management policy guide*. Retrieved from https://www2.health.vic.gov.au/Api/downloadmedia/%7BAA47AEBB-0004-41D6-BC17-9FD6C8DF38E8%7D
- Victorian Government Department of Health and Human Services. (2008), Open disclosure for Victorian health services: A guidebook. Retrieved from https://www2.health.vic.gov.au/about/publications/researchandreports/Open-disclosure-for-Victorian-health-services---A-guidebook
- Victorian Government Department of Health & Human Services. (2013). *Adverse events and Open disclosure – Patient, family/carer brochure.* Retrieved from https://www2.health.vic.gov.au/Api/downloadmedia/%7B2A02284E-0C92-42FB-AEAF-C188A5E856EC%7D

Departments:

- Allied Health Services, Academic and Medical Services, Nursing & Midwifery

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