VEI Open Disclosure Policy

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1. Background

Vision Eye Institute is committed to the provision of safe and quality healthcare to the patients it serves. Despite our best efforts, there are occasions when individuals are adversely affected by the healthcare they receive. While such events are sometimes unavoidable, there are occasions when it results from preventable mistakes or errors in the provision of care.

2. Philosophy

Vision Eye Institute is committed to implementing and practicing open disclosure in accordance with the *Australian Open Disclosure Framework.* It encourages a just, open and supportive culture where individual accountability and integrity is preserved and supported with mediation by a thoughtful and supportive response to errors. This includes establishing processes and resources to support and facilitate staff to engage in open discussion with the patient, and their family and carer(s) about adverse events that result in harm to the patient while receiving care.

3. Scope

Open Disclosure applies to all VEI staff involved in patient care, and communication with patients and/or their carers should reflect the fact that care is provided by a wide and comprehensive team. VEI staff are all provided training in open disclosure. Clear guidelines are provided to ensure staff are aware of their respective roles and responsibilities in the open disclosure process promoting a commitment to ensure that the right people give the right information at the right time.

The treating doctor should be consulted for guidance prior to the commencement of any open disclosure and only the lead person should engage in discussions with the patient to ensure accurate and consistent information is relayed. Doctors should consult their indemnity insurers for guidance when commencing an open disclosure process.

The elements of open disclosure include:

- an apology or expression of regret, which should include the words ‘I am sorry’ or ‘we are sorry’
- a factual explanation of what happened
- an opportunity for the patient to relate their experience
- a discussion of the potential consequences of the adverse event
- an explanation of the steps being taken to manage the adverse event and prevent recurrence.

4. Definitions

Terms	Definition (as defined by ACQSHC 2013)
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 or damage caused to by another.
Adverse event	An incident in which harm resulted to a person receiving health care.
Apology	An expression of sorrow, sympathy and (where applicable) remorse by an individual, group or institution for a harm or grievance. It should include the words ‘I am sorry’ or ‘we are sorry’. Apology may also include an acknowledgment of responsibility, which is not an admission of liability.
Carer:	A person who provides unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal

	illness or general frailty. Carers include parents and guardians caring for children. A person is not a carer if he or she provides this support and assistance under a contract of service or a contract for the provision of services; or in the course of doing voluntary work for a charitable, welfare or community organisation; or as part of the requirements of a course of education or training.
Clinician	A healthcare provider who is trained as a health professional. Clinicians include registered and non-registered practitioners, or a team of health professionals who spend the majority of their time providing direct clinical care.
Ex gratia	'Out of good will', usually referring to financial reimbursement or recovery payments. By definition, ex gratia payments are not an admission of liability.
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 (eg when the adverse event is deemed unpreventable).
Lead Person	The doctor or staff member responsible for open disclosure discussion with the patient and/or carer.
Open Disclosure	An open discussion with a patient about a clinical incident that adversely affected the patient while they were receiving health care. 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. Open disclosure is a discussion and an exchange of information that may take place over several meetings.
Patient	A person receiving or registered to receive medical treatment at Vision Eye Institute.

5. Policy Statements

Vision Eye Institute requires that any adverse event involving a patient as a result of a mistake or error is to have the circumstances associated with the event fully and frankly disclosed to the patient and/or their carer.

Following are the principles of open disclosure to be followed as described in the *Australian Open Disclosure Framework* and adapted to the small practice context.

5.1. Open and timely communication

If care doesn't go to plan, the patient should be provided with information about what happened in a timely, open and honest manner. The open disclosure process is fluid and will often involve the provision of ongoing information.

5.2. Acknowledgement

All adverse events should be acknowledged to the patient as soon as practicable, and open disclosure initiated. Indemnity insurers should be notified as appropriate.

5.3. Apology or expression of regret

As early as possible, the patient should receive an apology or expression of regret for any harm that resulted from an adverse event. An apology or expression of regret should include the words 'I am sorry' or 'we are sorry', but must not contain speculative statements, admission of liability or apportioning of blame.

5.4. Supporting, and meeting the needs and expectations of patients

The patient can expect to be:

- fully informed of the facts surrounding an adverse event and its consequences
- treated with empathy, respect and consideration
- supported in a manner appropriate to their needs

This may include possible further management or rehabilitation, which is planned in discussion with the patient and/or carer, to ensure that they are fully informed and in agreement with any proposed ongoing care.

5.5. Supporting, and meeting the needs and expectations of those providing health care

Clinicians and other practitioners should be:

- encouraged and able to recognise and report adverse events
- prepared through training and education to participate in open disclosure
- supported through the open disclosure process.

5.6. Integrated clinical risk management and systems improvement

Small healthcare practices should have a process enabling the review of adverse events to prevent recurrence, enable lessons to be learnt and the quality of care to be improved. The information attained about incidents from open disclosure should be incorporated into these processes.

5.7. Good governance

VEI practices have appropriate governance and accountability which includes internal performance monitoring and feedback. Additionally all staff are required to complete the online Open Disclosure training module **(**Department of Health Open Disclosure**)** as well as reading this policy and associated documents.

5.8. Confidentiality

VEI Open Disclosure Policy ensures patient and clinician privacy and confidentiality is conducted in compliance with VEI's Privacy Policy and relevant law (including federal, state and territory privacy and health records legislation), and is considered in the context of Principle 1: Open and timely communication.

6. Conducting Open Disclosure:

6.1 Team Discussion

Where appropriate, the treating doctor and all staff involved in the adverse event are to communicate as soon as possible after the event to achieve the following (ACSQHC, 2013):

- gather all necessary information, including establish the basic facts;
- Ensure the patient record is up to date;
- Assess the event to determine the appropriate response and identify who will take responsibility (lead person) for discussion with the patient/carer;

- Consider the appropriateness of engaging patient support at this early stage, including the use of a facilitator or patient advocate;
- Identify immediate support needs for everyone involved;
- Ensure that all team members maintain a consistent approach in any discussions with the patient, their family and carers;
- Consider legal and insurance issues, both for the organisation and the doctor(s) and where appropriate notify, and consult with, professional indemnity insurer;
- Consider how to address issues regarding ongoing care such as billing and other costs, which should be addressed at the earliest opportunity; and
- Arrange the first meeting in consultation with the patient.

6.2 Key Components of Open Disclosure Discussions with Patient/Carer:

The needs of the patients should be considered when planning communication of Open Disclosure (ie: age, culturally and linguistically diversity, mental state), and should include:

6.2.1. The patient/carer being told the name and role of everyone attending the meeting, with this information provided in writing;

6.2.2. A sincere and unprompted apology including the words “I am sorry”;

6.2.3. A factual explanation of events, including known facts and consequences, is given and does not speculate, attribute blame, criticise individuals or imply legal liability;

6.2.4. The patient/carer is provided with the opportunity to explain their views on what happened and encourage the patient, their family and carers to describe the personal effects of the adverse event;

6.2.5. Developing and agreeing on an open disclosure plan with the patient/carer including an outline of what the patient/carer hopes to achieve from the process and any questions they would like to have answered;

6.2.6. The patient/carer is to be assured that they will be kept informed of any further reviews and findings relating to how/why the adverse event occurred. Inform them of how, when and by whom they will receive feedback (If necessary several meetings may be held);

6.2.7. If further meetings are required an open disclosure plan is agreed upon, recorded and signed;

6.2.8. Offer practical and emotional support to the patient/carer (as appropriate);

6.2.9. Ensure all staff involved in the open disclosure event receive the support and guidance they require;

6.2.10. In cases where the adverse event spans more than one location or service, ensure that all relevant individuals are involved in the open disclosure process.

6.3 Documentation:

It is important that the VEI patient record is kept up to date with all details and verified facts. The incident should be reported in Riskman as soon as practicable and in accordance with 1.1.8 VEI Accident, Incident Reporting and Investigation Policy.

Documentation (both in the patient record and the incident report) should not: attribute blame to any personnel or organisation; contain defamatory statements or record opinions regarding any staff, patient or others (unless they are expert opinions with supporting evidence).

Documentation should contain:

- clear details of all factual information related to the adverse event;

- details of all communications, meetings and correspondence related to the open disclosure process including date, time, duration and location;
- details of any questions posed by the patient/carer;
- progress notes on the clinical care of the patient;
- details of offers of support, assistance or ex gratia;
- follow up plans.

Following conclusion of the open disclosure process surveys should be offered to patients and staff to seek feedback on how they found the process.

7. Further Information

Further information and guidance on open disclosure can be found at Open Disclosure resources for clinicians and health care providers

8. Risk Rating

Extreme	Audited 3 monthly
High	Audited 6 monthly
Medium	Audited annually
Low	Audited biennially

9. References

Name/Link	Source
Open disclosure principles, elements and process	Australian Commission on Quality and Safety in Health Care
Australian Open Disclosure Framework Supporting materials and resources Implementing the Australian Open Disclosure Framework in small practices	Australian Commission on Quality and Safety in Health Care
VEI Accident Incident Reporting and Investigation Policy	VEI Internal
VEI Privacy Policy	VEI Internal
Privacy Act 1988 (Commonwealth)	Commonwealth Government
Privacy and Personal Information Protection Act 1998 (PPIP Act)	NSW Government
Right to Information Act 2009	QLD Government
Information Privacy Principles (IPPS) Instruction	SA Government
The Health Records Act 2001 (Vic)	VIC Government
Online learning tool: Open Disclosure Training	Victorian Government Health Information