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VEI Open Disclosure Policy

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Contents

1 Purpose

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. This policy guides the organisation in the use of the open disclosure system.

2 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.

3 Policy Statement

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.

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. An 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 (e.g., 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 Procedure

Vision Eye Institute requires that the circumstances of any adverse event involving a patient as a result of a mistake or error is fully and frankly disclosed to the patient and/or their carer. Below are the principles of open disclosure followed at VEI, as described in the Australian Open Disclosure Framework and adapted to the small practice context.

5.1 Analysis of the Event

A patient safety incident is any unplanned or unintended event or circumstance which could have resulted or did result in harm to a patient. This includes harm from an outcome of an illness or its treatment that did not meet the patient's or the clinician's expectation for improvement or cure.

Patient safety incidents may be classified as follows:

A harmful incident:

A patient safety incident that resulted in harm to a patient, including harm resulting when a patient did not receive his/her planned or expected treatment. The term 'harmful incident' covers what used to be known as an 'adverse event' and/or a 'sentinel event.'

A no harm incident:

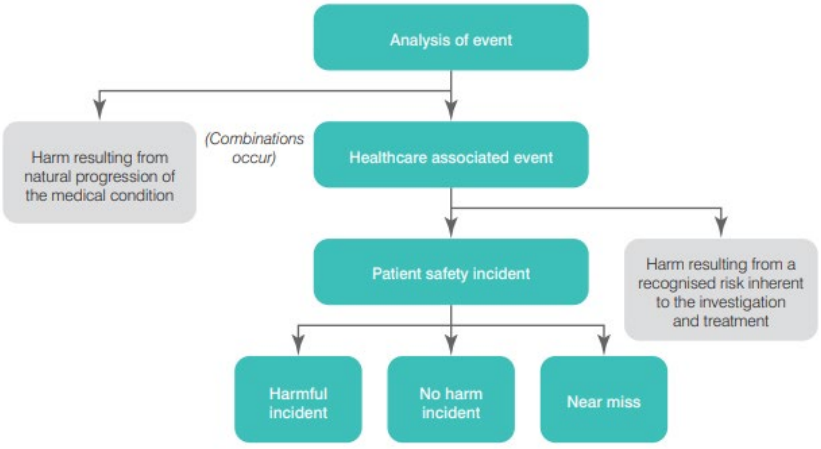
A patient safety incident occurs but does not result in patient harm – for example a blood transfusion being given to the wrong patient, but the patient was unharmed because the blood was compatible.

A near miss:

A patient safety incident that did not cause harm but had the potential to do so – for example a unit of blood being connected to the wrong patient's intravenous line, but the error was detected before the transfusion started.

An incident may have been caused:

- because something has gone wrong during the patient's episode of care – an event has occurred that was unplanned or unintended
- because the outcome of the patient's illness or its treatment did not meet the patient's or his/her doctor's expectation for improvement or cure – for example a patient develops brain metastases from underlying lung cancer
- from a recognised risk inherent to an investigation or treatment – for example a patient's bowel is perforated during a routine colonoscopy
- because the patient did not receive his/her planned or expected treatment – for example he/she did not receive his/her medications as ordered



5.2 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.

5.3 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.

5.4 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.

5.5 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 they are fully informed and in agreement with any proposed ongoing care

5.6 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.

5.7 Integrated clinical risk management and systems improvement

VEI has processes in place 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 shall be incorporated into these processes.

5.8 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 (via Invision) as well as reading this policy and associated documents.

5.9 Confidentiality

VEI Open Disclosure Policy ensures patient and clinician privacy and confidentiality is maintained in accordance 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

For information pertaining to the Victorian Statutory Duty of Candour, please refer to *3.1.8 Serious Adverse Event Review policy.*

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 (i.e., age, culturally and linguistically diversity, mental state), and should include:

- The patient/carer being told the name and role of everyone attending the meeting, with this information provided in writing;
- A sincere and unprompted apology including the words “I am sorry”;
- A factual explanation of events, including known facts and consequences, is given and does not speculate, attribute blame, criticise individuals or imply legal liability;
- 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; 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;
- 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);
- If further meetings are required an open disclosure plan is agreed upon, recorded and signed;
- Offer practical and emotional support to the patient/carer (as appropriate);

- Ensure all staff involved in the open disclosure event receive the support and guidance they require; 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 *3.1.12 VEI Incident Management 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 Responsibilities

7.1 Compliance, monitoring, and review

The NDON in conjunction with the ELT and site managers, is responsible for ensuring that this policy:

- aligns with relevant legislation, government policy and/or VEI requirements/strategies/values
- is implemented and monitored (i.e. the policy and procedure is followed, reflects the changing policy environment, and emerging issues are identified), and
- is reviewed to evaluate its continuing effectiveness (e.g. achieving its purpose, remains relevant/current).

7.2 Reporting

No additional reporting is required.

7.3 Records management

Staff must maintain all records relevant to administering this policy and procedure in a recognised VEI recordkeeping system

8 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	Australian Commission on Quality and Safety in Health Care VEI
Incident Management 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
Statutory Duty of Candour	VIC Government
CEC Open Disclosure Handbook	NSW Clinical Excellence Commission

9 Grievance Resolution

Any employee grievance arising from the implementation of this policy may follow the usual resolution process outlined in the Employee Grievance Policy.

10 Policy Amendment

The organisation reserves the right to amend any policy and/or procedure without notice.

Requests for changes or improvements to this policy/procedure shall be forwarded to the Document Owner identified on the front cover of this document.

Changes to this procedure must be approved by the position/committee with approval authority as identified on the front cover of this document.

11 Risk Rating

Extreme	Reviewed bi-annually
High	Reviewed annually
Medium	Reviewed every two years
Low	Reviewed every three years

12 Consequence of Breaching this Policy

Non-compliance with any component of this policy will be treated seriously and, depending on the circumstances, performance management processes may be implemented.

13 Appendix

Appendix 1: Open Disclosure Checklist

14 Revision History

Version	Date Approved	Approved by	Amendment
3	March 2023	CCC	Scheduled review – new template. Addition of revised checklist as Appendix.
4	March 2024	CCC	Scheduled review – addition of VIC legislation, and a new section of analysis of the event – to build context as to why open disclosure is required.
5	March 2025	CCC	Scheduled review – change to review period from 1 to 2 years. Change of role title from NQRM to NDON.

Appendix One – Open Disclosure Checklist

Patient Name: _____ Date of Birth: _____ Date of Incident that initiated the open disclosure process:- _____ Brief Outline of Incident: _____ _____ _____	
Please notify the Executive Leadership Team when planning a formal open disclosure discussion	
❑	Consider legal and insurance issues for the organisation and the clinicians – notify the relevant people
❑	Document in the patient's health record that clinician disclosure has occurred, including • a confirmation that an apology was provided • a brief outline of the information provided to the patient and/or their support person • future steps to be taken (if required)
❑	Provide the patient and/or their support person with the relevant person's name and contact details should they have any concerns or questions
❑	**Establish a formal open disclosure team** -multidisciplinary: senior clinicians and executive, open disclosure advisor. Determine who will lead the discussion with the patient and/or support person
❑	Liaise with patient and/or their support person to arrange: • the date, time, and location for discussion • who they would like to be present
❑	Hold the team discussion - anticipate the patient's and/or their support person's concerns and questions about the formal open disclosure discussion, and prepare appropriate responses
❑	Use language and terminology that is appropriate for the patient – avoid jargon. If using this checklist during the discussion, explain the reason to the patient/support person
❑	Assess the need for, and as required, arrange support for the patient and/or their support person e.g., social worker, patient safety representative, health care interpreter
❑	If possible, establish the patient's and/or support person's **understanding of the incident** before the formal open disclosure discussion
❑	Check if the patient (if able) has consented/agreed to sharing information with their support person(s), family members, others
❑	Locate a quiet, private area to hold the discussion, free from interruptions
❑	Prepare any information for the patient and/or their support person in an appropriate format

❑	**Acknowledge and apologise**: • Acknowledge what happened – known facts • Apologise for the patient safety incident "I am/we are sorry that this has happened" • Acknowledge the consequences for the patient and/or their support person
❑	**Explain** the formal open disclosure process, including: • The process for investigating the incident and timelines • The patient and/or support person will be able to contribute to the investigation • How the patient and/or support person will be kept informed • What the formal open disclosure process does not include • Any restrictions on information that is able to be provided and the reasons
❑	**Describe the facts** of the patient safety incident and any outcomes known at the time
❑	Provide **the findings of any review** or investigation that are able to be shared
❑	**Discuss and agree** on a plan for care for the patient and/or his/her support person: • Ongoing care and support (if required) addressing short- and long-term consequences • Names and contact details for people/services who will be providing care • Information on the patient's right to continue his/her care elsewhere if preferred • Information on how to take the matter further, including legal processes available to him/her • Offers of practical and emotional support as needed • An offer to reimburse out of pocket expenses
❑	Review with the patient and/or support person(s) and health care staff present what was discussed and any decisions made
❑	Offer to arrange **follow up** discussions as required
❑	Prepare a **summary** of the formal open disclosure discussion
❑	**Document** formal open disclosure actions including the date of the meeting in the patient's health record and the incident management system - RiskMan
❑	Offer clinicians and others involved in the incident and/or the formal open disclosure discussion the opportunity to debrief with the open disclosure advisor or other support services
❑	Offer patients, support people and clinicians/managers involved in open disclosure the opportunity to evaluate their experience of the process
❑	Monitor and record the implementation of any changes recommended as a result of the review of the patient safety incident, and the effectiveness of those measures
❑	Share any lessons learned from investigation of the patient safety incident at appropriate forums

Comments:_____

_____

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_____

Name of person completing the form:
Site:
Designation:
Date: