Complies with NSQHS- Standard 1.7, 1.10, 1.11, 1.12, 6.9, 2

OPEN DISCLOSURE

Purpose: To ensure effective and consistent communication is provided following an adverse event i.e. an incident in which unintended harm has resulted to a person receiving health care. If this happens you can expect to have an open discussion with your healthcare provider your family or carer about what happened, what is being done about it and what we are doing to prevent this from happening again. Management at the centre adopts the principles and processes outlined in the Australian Open Disclosure Framework, 2013.

As soon as an adverse event causing harm is identified, the first priority is prompt and appropriate clinical care and prevention of further harm.

All adverse events at EDPC will generate an issues and incident report and proceed to the Open Disclosure Process as outlined ACSQHC "Open disclosure principles, elements and process".

All staff and VMO's are familiarised with the process on induction and from time to time during the course of their employment or association with the facility.

The Open Disclosure Framework along with the Victorian Clinical Governance Policy Framework aims to ensure that patients are central to quality and safety issues and improvement initiatives. The "Framework", resource tools and guidelines is available at public/quality management/open disclosure.

In accordance with the Victorian Charter of Human Rights and Responsibilities Act 2005, public entities including health services have a legal obligation to discuss adverse events with the effected patient and or family or carer.

Management recognises that it is essential to support staff and visiting medical officers so that they respond effectively and learn from adverse events, to subsequently improve patient safety.
In the event of a sentinel event as listed at Public/qms/sentinel events, the Secretary (Department Head) of the DHHS is promptly notified.

The EDPC Open Disclosure Process includes

1. Complete Checklist
2. Read Saying Sorry- A guide to apologising and expressing regret during open disclosure
3. Open disclosure meeting planning and preparation
4. Complete IIR
5. Report to department of health, TGA, sentinel events portal, MAC

Unless there is a specific indication or the patient requests it, the Open Disclosure process, incident investigation and implementation of changes will occur with participation of those directly involved in the event. The Open Disclosure discussion with the patient and / or carer should occur as soon as possible following the recognition of the harm. The discussion should be face to face and conducted in a quiet, private area to maintain confidentiality. The attendees are provided information regarding the expected process. Refer to – Adverse events and Open disclosure, Patient, family/carer brochure referenced below.

Open Disclosure is much more than apologising or expressing regret. It's overall success can often depend on how the apology or expression of regret is delivered.

In this regard, the three key points for those engaging in Open Disclosure are:

- **Do not fear saying sorry.** Providing you don't engage in unwarranted speculation about the incident or apportion blame to other individuals, entities or institutions, there are no medico-legal grounds for avoiding the word 'sorry'.

  Similarly, there is no reason to fear it from an interpersonal point of view. Remember that apology is a natural human response after an unexpected event. Patients who have been harmed, their families, carers and other persons affected by the incident, will appreciate and benefit from a sincere apology.

  Equally, you and your colleagues can also benefit from this interaction. The conversation can be difficult but, according to the available evidence, may lead to a better outcome.

- **Consider your delivery.** Think about your phrasing and non-verbal aspects of your delivery. It is important to remember that what you say is not always what is heard, and that this can be influenced by non-verbal cues such as maintaining eye contact. Other aspects of delivery such as body language, positioning and potential distractions can undermine the conversation.

- **Listen.** Apologising and expressing regret is also about listening and giving the patient an opportunity to tell how they feel, and how the incident has affected them. Practise, and engage in, active listening and always give the patient the opportunity to respond.

The open disclosure conversation will include an introduction of the people attending, an apology and 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 or support person's understanding of what happened and address any questions or concerns they have. The clinician will provide an explanation of how and when they will be provided with further information if required, including written additional support and referrals if required.
It is the clinician's responsibility to document the discussion in the notes.
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 the external complaints processes available to them.
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. Cultural background and gender of clinician or interpreter should be considered when planning the process.

Reference:

Victorian Government Department of Health and Human Services. (2008), Open disclosure for Victorian health services: A guidebook.
https://www.vgls.vic.gov.au/client/en_AU/search/asset/1300552/0

Victorian Government Department of Health & Human Services. (2013). Adverse events and Open disclosure – Patient, family/carer brochure
https://www2.health.vic.gov.au/Api/downloadmedia/%7B2A02284E-0C92-42FB-AEAF-C188A5E856EC%7D

Australian Commission on Quality and Safety in Healthcare Flow chart outlining the key steps of open disclosure

https://www.safetyandquality.gov.au/our-work/clinical-governance/open-disclosure

Complies with NSQHS- Standard 1.7, 1.10, 1.11, 1.12, 6.9, 2

https://www.safetyandquality.gov.au/sites/default/files/migrated/Australian-Open-Disclosure-Framework-Feb-2014.pdf

EDPC Open Disclosure ppt

http://www.health.vic.gov.au/clinrisk/opendisc.htm

Victorian Charter of Human Rights and Responsibilities Act 2006. https://www.humanrights.vic.gov.au/legal-and-policy/victorias-human-rights-laws/the-charter/#:~:text=The%20Charter%20of%20Human%20Rights%20and%20Responsibilities%20(the%20Charter)%20is,and%20the%20people%20it%20serves.

https://www2.health.vic.gov.au Sentinel Events