The Art of Vein Care

Open Disclosure Policy

V1.0

OPEN DISCLOSURE POLICY

1. OVERVIEW

1.1 Introduction

The Art of Vein Care (AVC) has an ethical obligation to disclose honestly and openly adverse or sentinel events with consumers, including patients and their carers and other relevant internal or external stakeholders.

Please refer also to Incident Management Policy and Incidents Reportable to NSW Health Private Health Care Branch Policy, for further guidance.

1.2 Purpose

This policy is intended to offer guidance regarding the open disclosure of adverse events, and to describe the procedures for such disclosure.

1.3 Governance

Responsibility for the implementation of this policy rests with the following:

- AVC Managing Director (MD)
- AVC Clinical Workforce

Open disclosure will be undertaken by the Managers and Doctors.

2. WHAT IS OPEN DISCLOSURE?

2.1 Definitions

Open disclosure is defined in the Australian Open Disclosure Framework as:

"an open discussion with a patient (and/or their support person(s)) about a patient safety incident which could have resulted, or did result in harm to that patient while they were receiving health care.

Essential elements of open disclosure are:

- *an apology*
- *a factual explanation of what happened.*

- *an opportunity for the patient to relate their experience*
- *a discussion of the potential consequences*
- *an explanation of the steps being taken to manage the event and prevent recurrence.*

The open disclosure process is a discussion between two parties and may include a series of discussions and exchanges of information that take place over several meetings."

2.2 Principles of Open Disclosure

The Art of Vein Care is committed to providing a supportive environment where patient incidents are identified and reported without affixing blame.

AVC key priorities for open disclosure are as follows:

- the minimisation or redress (where possible) of patient harm;
- ethical, forthright, and empathetic communication with consumers (patients, their families and/or carers);
- maintaining at all times the inherent dignity of AVC consumers and treating patients, their families, and/or carers with respect and compassion;
- effective and timely support of AVC clinical workforce members involved in adverse events; and
- the prevention of future adverse events or the recurrent of prior adverse events through appropriate risk identification, analysis, and management.

AVC recognises that providing its clinical workforce with the security of a no blame environment encourages openness of reporting, which is in turn a crucial component of appropriate risk identification.

Open disclosure must comply with legal and ethical requirements for privacy and confidentiality for the patient and/or their support person, and health care staff.

Open disclosure must be managed to completion irrespective of other circumstances occurring at the same time for example commencement of HCCC, coronial or legal proceedings.

3. PROCEDURE FOR OPEN DISCLOSURE

3.1 What Adverse Events Require Disclosure?

Patients and/or their representatives must be informed of the probable or actual occurrence of any adverse event that has resulted in, or is expected to result in, harm to the patient, including the following:

- Adverse events that have had or are expected to have a clinical effect on the patient that is perceptible to either the patient or the health care team;
- Adverse events that necessitate a change in the patient's care;
- Adverse events with a known risk of future health consequences, even if the likelihood of that risk is extremely small;

- Adverse events that require treatments or procedures without the patient's consent – patients have a right to be informed about what is done to them and why;
- Adverse events which require reporting to state health authorities.

Such an occurrence can include events such as:

- Medication error
- An unexpected death
- Unplanned admission to a Hospital
- Unexpected return to operating theatre
- Retained item after surgery
- Incorrect procedure or treatment
- A fall resulting in a fracture

Disclosure of near misses is at the discretion of the providers involved, but is advisable when, for example, a patient or family member becomes aware that a near miss has occurred and open disclosure can assist in alleviating anxiety or distress.

Advice may need to be sought when open disclosure involves:

- death of a patient because of a patient safety incident, a known error or suspected suicide
- a breakdown in the relationship between the patient and AVC
- issues of clinician accountability or suspected intentional unsafe acts or suspected criminal behaviour.

3.2 When Should Disclosure of an Adverse Event Occur?

An adverse event should be disclosed as soon as practicable. If a patient requires urgent treatment to minimise harm from an adverse event, disclosure should occur immediately.

All patient safety incidents should be investigated to understand the contributing factors involved in the incident. Being transparent about what happened, as well as how and why it happened, is very important for the understanding of patients and/or their support person.

If urgent treatment is not required, disclosure may be delayed but only for as long as necessary for members of the clinical workforce to collect relevant information and determine how to proceed with open disclosure. Disclosure should occur within 24 hours of the discovery of an adverse event.

3.3 How Should Adverse Events Be Communicated?

Communication after an adverse event must be open, honest and timely.

The clinical representative will have discussions with the Patient involved and their support person as well as separate discussions with colleagues and any other relevant non-clinical stakeholder as required.

Disclosure of adverse events needs to occur in an appropriate setting and be done face to face. The location needs to be a quiet private place and adequate time needs to be set aside with no interruptions. The Patient should be given the opportunity to invite a support person to attend the discussion.

Assess whether there are any cultural considerations or special circumstances, which may impact on the open disclosure discussion and which require additional preparation, arrange interpreter services if required. Prepare information for the patient and/or their support person in an appropriate format.

As communication with the patient may be before the full investigation has been completed, it is important that the communicator prepares for the discussion. This reduces the risk of making inaccurate or speculative statements. The following should be considered when communication with the patient:

- What are the known facts about what has happened and how it happened?
- What do we know about the possible effects on patient health?
- What do we know about the causation issues? Explore whether causation is multi-factorial?
- Harm should be acknowledged, and an apology or expression of regret provided as appropriate, including using the words "I am sorry" or "we are sorry". NB: an apology made by or on behalf of a person in connections with any matter alleged to have been caused by the person does not constitute an express or implied admission of fault or liability.
- Blame must not be apportioned to any group, individual or institution.
- Explaining the open disclosure process: When are we likely to know more? What/how are we going to investigate. The result of investigation should not be pre-empted.

Do not communicate subjective views as to who is to blame or what caused the incident. Do not include hearsay (what someone else has said) gossip or speculation.

All communications are to be professional, circumspect, and sensitive.

Provide opportunities for the patient and their support person to relate to their experiences, concerns, and feelings and to ask questions. Listen and respond appropriately.

A written account of the open disclosure meeting will be documented in the patient record and a copy provided to the patient; their support person/carer as required.

3.4 Low Level Response vs. High Level Response to an adverse incident

If the harm is minor, such as incidents that do not increase the level of care required for the patient and where no, or minor, psychological or emotional distress occurs, the open disclosure process will usually be completed following the initial discussion. This is considered a low-level response.

Should the harm result in permanent loss or lessening of function, significant escalation of care, major psychological or emotional distress or death a high-level response is required. A high-level response may also be instigated at the request of the patient.

In a high-level response, a more formal process including investigation and formal meetings may be required. It is important to maintain good communication and documentation throughout the process. See flow charts outlining a low level and high-level response below.

3.5 Follow Up after Open Disclosure

Following the initial discussion should there be need for a more extensive investigation into the adverse incident. Ensure that the patient is aware of the next steps in the process, assuring them that any further findings will be communicated to them at the end of the investigation.

Provide them with contact details for AVC to answer any questions the patient may have.

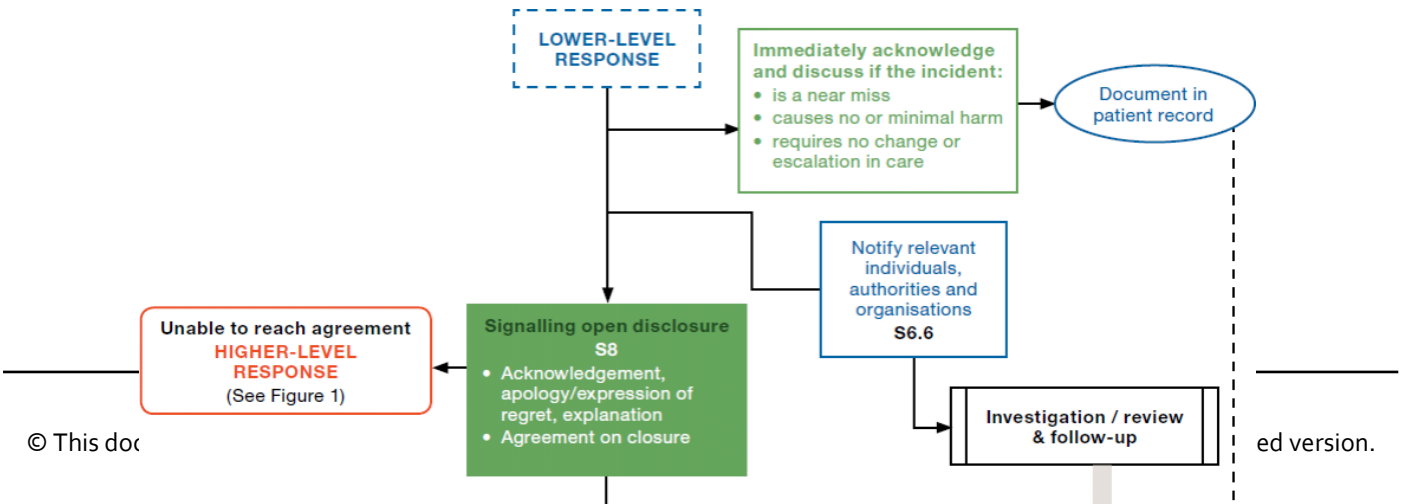
Encourage them to communicate with the Doctor if there are any further effects relevant to the incident.

Where possible, patients should be given the opportunity to provide feedback on the open disclosure process.

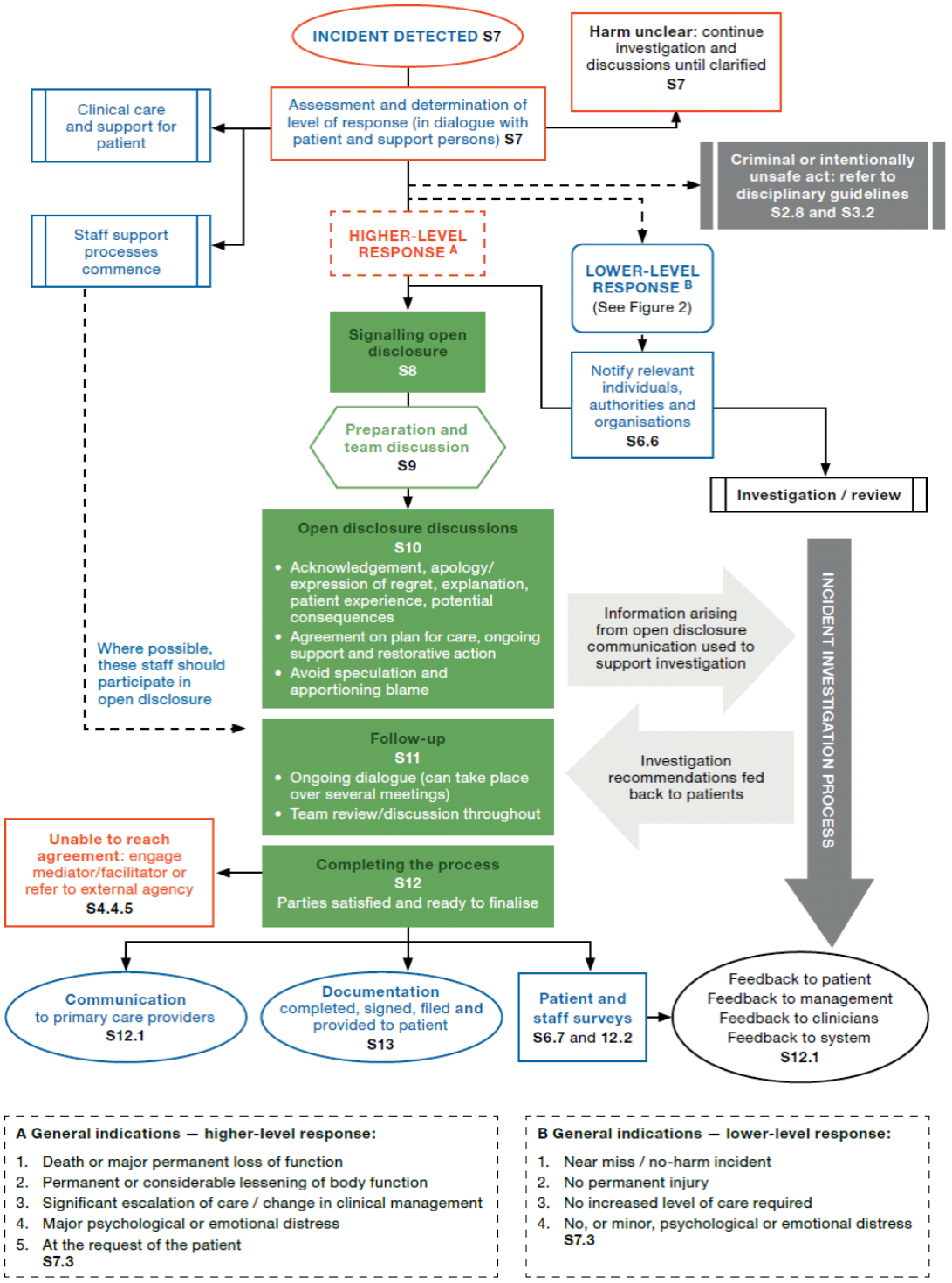
Provide feedback to relevant staff on the outcome of the open disclosure meeting, including any system improvements agreed with the patient and/or their support person.

Provide support and opportunities for formal and informal debriefing for the staff involved in the patient adverse event.

Lower-level response (S = Section of Australian Open Disclosure Framework)



Higher-level response (S = Section of Australian Open Disclosure Framework)



4. COMPLIANCE CRITERIA

- Staff satisfaction with involvement in policy development and implementation process
- Staff have read and understand this policy
- Framework meets NSQHS Standards for Small Hospital Services

5. POLICY REVIEW

Every 3 years or before in the case of changes to legislation and/or an updated policy directive by NSW Health.

6. QUALITY IMPROVEMENT ACTIVITIES TO ENSURE EFFECTIVENESS OF SYSTEM

1. Audits - Patient Feedback on Open Disclosure Process
2. Minutes of meetings
3. Incident reports
4. Training of relevant personnel in open disclosure process

7. REFERENCES

NSW Health, PD2014_028 – Open Disclosure Policy

Australian Commission on Safety and Quality in Healthcare - Implementing the Australian Open Disclosure Framework in small practices, 2013

Australian Commission on Safety and Quality in Healthcare, 2013 – Australian Open Disclosure Framework

Australian Commission on Safety and Quality in Healthcare - Implementing and practising open disclosure: Guide for health service managers, 2013

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