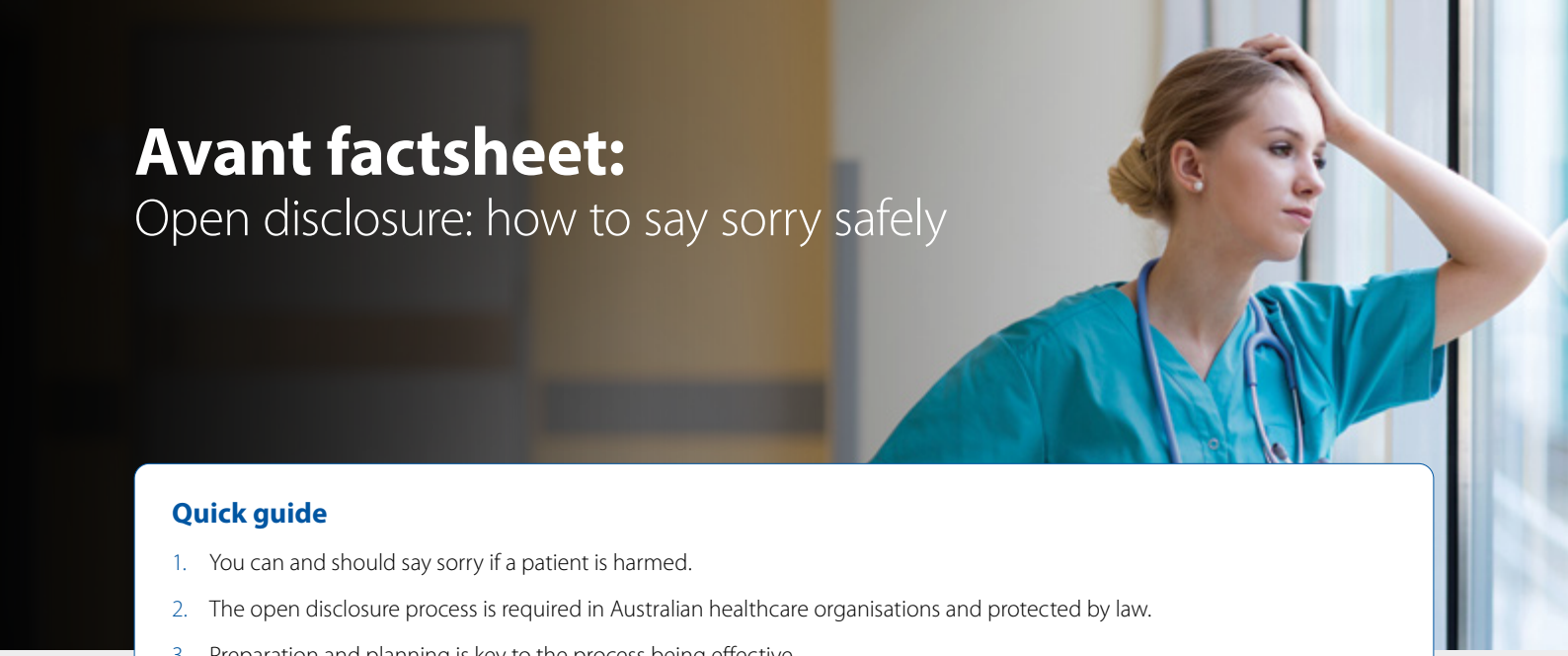
Avant factsheet:
Open disclosure: how to say sorry safely



Quick guide

1. You can and should say sorry if a patient is harmed.
2. The open disclosure process is required in Australian healthcare organisations and protected by law.
3. Preparation and planning is key to the process being effective.

What is open disclosure?

Recognising and responding to adverse events is an important aspect of delivering healthcare.

In Australia, a national open disclosure framework has been developed for communicating with patients who have experienced harm during healthcare, and their families and other supporters. It may also be appropriate to follow an open disclosure process for a near miss event.

Why provide open disclosure?

The most common reason patients and families give for complaining after an incident is to better understand what occurred. They may also need to understand the likely consequences for them, and what ongoing support they may need.

Patients are often comforted if they know that the clinical team has learned from the incident and processes have been changed to reduce the chance of the same thing happening to others in the future.

Health service organisations accredited to the National Safety and Quality Health Service Standards (including public and private hospitals, day surgery units and dental clinics) must implement open disclosure in accordance with the Australian Open Disclosure Framework. These organisations will have their own open disclosure policies and procedures, and if you practise in one of these contexts you may be required by the organisation to participate in open disclosure activity. You should ensure you are familiar with and follow your organisation's policies and procedures on open disclosure.

What is the process?

An open disclosure discussion may take place in one conversation or over one or more meetings. It involves:

- acknowledging that an adverse event has occurred
- apologising or expressing regret for what has occurred (including the words "I am/we are sorry")
- outlining what facts are known about what has happened
- discussing the potential consequences for the patient (including possible side effects, increased hospital stay and expected cost) and how you plan to manage these
- actively listening to the patient's experience of the event, or the experience of those close to the patient
- providing information on what further steps are planned to determine what went wrong and how similar events may be prevented in the future.

How can I prepare?

Training and support

Responding appropriately can be difficult in the aftermath of an adverse event. It can be even harder if you feel unprepared for such a discussion. You should seek support from colleagues if you do not feel confident with your abilities at the time open disclosure is needed. Consider the training available to you such as courses through your healthcare organisation or Avant, which can help you to develop expertise in case you ever need it.

Communication during the treating relationship

The strength of the relationship and rapport you have with the patient before any incident will also contribute to a successful open disclosure process. Taking the time to communicate with patients and supporters, having sound consent discussions, conveying the risks that are significant to patients, and actively listening to concerns will place you in a strong position to deal with adverse events if they arise.

Planning the discussion

Preparation before the formal meeting is important to ensure an open disclosure discussion goes as well as possible. This includes establishing the facts of what happened and ensuring you have a good understanding of the issues that led to the adverse event.

Reviewing medical records

The medical records need to be current. Depending on the circumstances, it may be appropriate to make an addendum in the clinical records, ensuring any additional entry has the date and time the information was added, making it clear it is not a contemporaneous entry. It may otherwise be appropriate to include other information in an incident report or other relevant document. You should not alter the medical record.

Preparing the team

Plan where the discussion will take place and who will be present from the clinical team. It is important to have an extra support person in the room to provide backup and to document the discussion. Identify one person to take the lead in the discussion. Ensure the team are all aware of the facts.

Forewarning the patient

If it takes some time to arrange an open disclosure meeting, it may be unreasonable to ask the patient to wait for information until the formal discussion. It may be appropriate to give the patient some information and let them know you would like to discuss this further at a meeting. This also allows them to prepare and arrange to have supporters attend the meeting if they wish.

During the discussion

Begin the discussion by introducing everyone in the room. Don't assume the patient or their supporters will know everyone.

Outline the facts of the incident. This may need to be in small pieces giving the patient time to absorb the information and ask questions. Listening to the patient and their supporters is key.

Should I apologise?

An apology is an essential part of the process. This is the case irrespective of whether the incident was preventable, a known possibility, or completely unexpected. The apology is not about blame or liability but rather about expressing empathy with the patient for the events that occurred. You are apologising for what happened, not for any personal error or failing.

The apology should use the words "I am sorry...". A phrase such as "I am sorry xxx happened to you, it is not the outcome we wanted" is often appropriate.

You should provide the apology sincerely and be clear what you are apologising for. Be careful not to speculate or apportion blame to yourself or others in the clinical team.

For more guidance on apologising after an adverse event please see Avant's video: Open disclosure how to say sorry

Does apologising mean I can be sued?

All jurisdictions in Australia have 'apology' laws, which protect statements of apology or regret made after healthcare incidents from being used later in court. One aim of this legislation is to encourage doctors to feel able to express regret to patients.

After the discussion

Document the discussion

Make clear notes of the discussion.

Follow up with the patient

A patient's decision to take legal action or complain may result from them feeling abandoned after an adverse event, or feeling that communication with them has been poor, insensitive, or delayed. Often, the focus of patient's hurt, and anger is not the injury itself, but the failure of a health professional to 'do the right thing' in the aftermath of the event.

It is important to stay in touch. Give the patient details of someone they can contact if they have any further questions. Check in with them at regular intervals, as clinically appropriate, especially if they have a prolonged recovery.

Also consider limiting any out of pocket expenses the patient may incur. In particular ensure that demands are not sent for outstanding fees.

Notify your insurer

If you are involved in an adverse event, you will need to notify your insurance company in accordance with their incident notification requirements.

Where can I get more support?

Being involved in an adverse event or near miss can be a stressful experience, even more so if you are involved in the open disclosure process and apologising to the patient.

Seeking support from your colleagues and your family is important. You can also contact Avant to discuss what confidential options you have for ongoing support, call **1800 128 268**.

Additional resources

For detailed guidance on the open disclosure process, see The Australian Commission on Safety and Quality in Healthcare – Open disclosure resources for clinicians and healthcare providers

Avant factsheet: Managing an adverse event

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