Open Disclosure	P_STD1_026
Policy Level	Service Stream
Application	UnitingCare Health
Contact Officer	Group General Manager Clinical Governance

1 Policy Intent

1.1 This policy describes the acceptable process for Open Disclosure in UnitingCare Hospitals which is consistent with the *Australian Open Disclosure Framework (the Framework)*.[1]

> **Open disclosure** is open discussion with a patient about an incident(s) that resulted in harm to them while they were receiving health care. Open disclosure involves several elements including 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 to prevent it happening again. Open disclosure is an exchange of information that may take place over several meetings.

2 Purpose

2.1 To provide UCH employees and accredited health practitioners with an ethical framework for the disclosure of an incident or adverse event, in keeping with the principles outlined in the Framework.[2]

2.2 This policy fulfils the requirements of the National Safety and Quality Health Service (NSQHS) *Standard 1: Governance for Safety and Quality in Health Service Organisations*. This Standard (Action 1.11) requires health service organisations to implement an open disclosure program consistent with the Australian Open Disclosure Framework, as well as monitoring their program to improve the effectiveness of their process.[3]

2.3 The principles in this policy and processes identified within, apply to all UCH hospitals employees and accredited health practitioners.

3 Principles[4]

3.1 **Open and timely communication** Patients, families and carers should be provided with information regarding what happened in an open, timely and honest manner. The process may be fluid and involves ongoing communication.

[1] Australian Open Disclosure Framework: Better communication, a better way to care. Australian Commission for Safety and Quality in Health Care 2013
[2] Ibid
[3] Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Sydney: ACSQHC. 2017
[4] Australian Open Disclosure Framework: Supporting materials and resources. Open disclosure principles, element and process ACSQHC 2013.

3.2 **Acknowledgement** All adverse events should be communicated to the patient, carers and or family as soon as is practical. The service should acknowledge the adverse event and initiate open disclosure

3.3 **Apology or expression of regret** As soon as possible after the event, there should be an apology or expression of regret made for any harm that has resulted from an adverse event. This should include the words 'I (or we) am/are sorry', but not contain speculation, blame statements or admit liability.

3.4 Supporting, and meeting the needs and expectations of patients, their family and carers the patient, their family and careers can expect:

3.4.1 to be fully informed of the facts surrounding the event including consequences

3.4.2 treated with respect, empathy and consideration and

3.4.3 supported in a manner appropriate to their needs.

3.5 Supporting, and meeting the needs and expectations and expectations of those providing care Hospitals should ensure an environment in which all staff are:

3.5.1 supported through the open disclosure process

3.5.2 encouraged and enables to recognise and report adverse events appropriately

3.5.3 prepared by education and training to participate in and support the open disclosure process.

3.6 **Integrated clinical risk management and systems improvement** Review and investigation of adverse events and outcomes are conducted through processes focussed on the management of clinical risk and quality improvement. Findings should focus on ensuring continuous improvement and the maintenance of effective systems.

3.7 **Good governance** Open disclosure requires good governance frameworks together with clinical risk management and quality improvement processes. These systems support robust investigation and analysis of events with a view to preventing their recurrence. Good governance involves a system of accountability throughout the organisation including staff, executive and the Board to ensure that appropriate changes are made and their effectiveness is reviewed. Good governance should include internal performance monitoring and reporting .

3.8 **Confidentiality** Policies and procedures should be developed by health service organisations with full consideration for patient and clinician privacy and confidentiality, in compliance with relevant law (including Commonwealth, state and territory privacy and health records legislation).

4 Policy statements

4.1 UCH recognises the importance of the process of open disclosure as a component of an integrated clinical governance and risk management system

4.2 UCH is committed to open and transparent communication with patients and their family or carers

4.3 Comprehensive or full open disclosure must only be undertaken by a UCH employee who has undertaken full open disclosure training and is authorised by the hospital executive to undertake comprehensive or full open disclosure.

4.4 Open disclosure does not imply that an individual or service has blameworthy facts to disclose or is liable in regards to an unexpected outcome to the episode of care.

4.5 The level of response required through the open disclosure process will be proportionate to the patient outcome as the result of the identified event. **(Refer to appendix 1: reportable events; appendix 2: events and potential responses to situations and incidents; appendix 3: criteria for determining response level).**

5 Open disclosure process

5.1 Open disclosure is to include

5.1.1 Timely, open and honest communication with the patient, family/carer or nominated person providing factual information about what happened and discussing the actual or potential consequences of the adverse event or near miss.

5.1.2 Give an apology or expression of regret and explain the steps being taken to manage the adverse event as well as the prevention of future occurrences.

5.1.3 refer appendix 4: key components of open disclosure discussions

5.2 The patient may nominate a person (nominated person) to act and or receive information on their behalf.

5.3 Any information given to a nominated person must be appropriate to the circumstances and give consideration to the patient's wishes, confidentiality and privacy requirements and UCH policy

5.4 Where it is not possible for the patient to nominate a person to enter into communication of their behalf due to their clinical circumstance (eg.change in competency, an emergency) clinicians and administrators should use their discretion in relation to any person accompanying the patient (and who don't have a pre-existing legal relationship with the patient) with respect to disclosure of information.

5.5 Where open disclosure is deferred due to the patient's clinical condition or request, by either the patient or their carer, then such circumstances and the rationale for deferring needs to be clearly documented in the patient record.

5.6 Any access to the information contained within the patient's health record must by undertaken in accordance with the Privacy Act 1988 (C'wealth), relevant UCH policy and local hospital procedure. Such release of information must only be undertaken following consultation with UCQ legal counsel and Uniting Church Insurance Claims Manager.

5.7 In the event that intentionally unsafe acts or suspected criminal behaviour is identified during the open disclosure process then such events must be

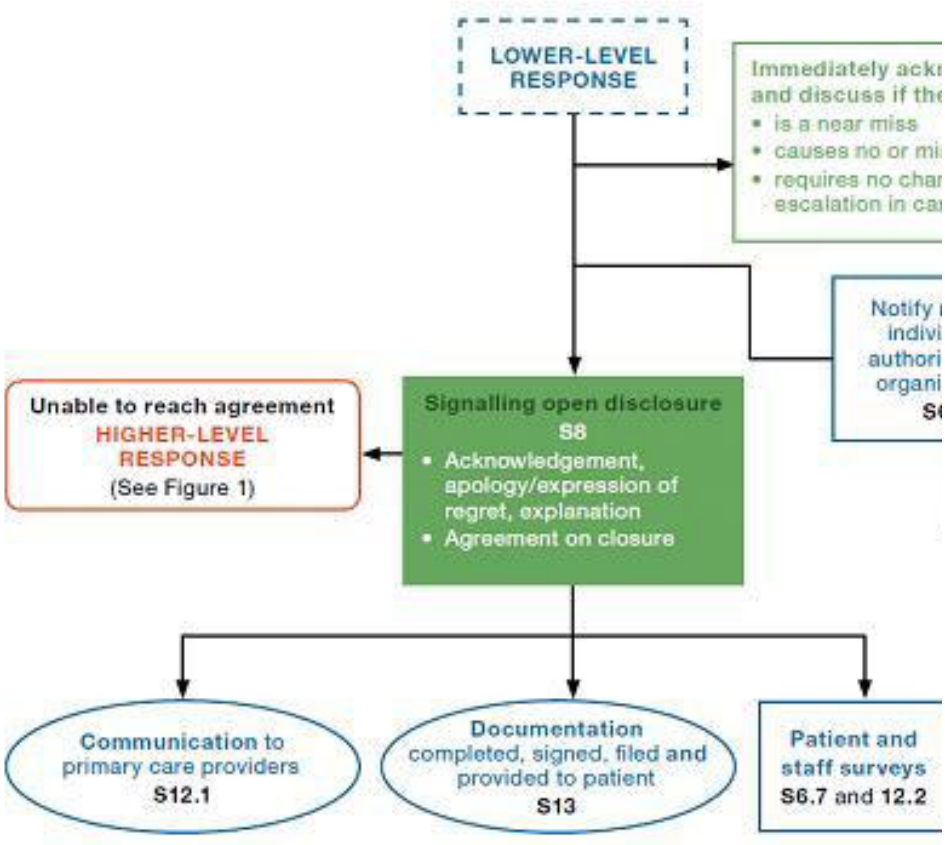
5.7.1 Immediately escalated to the hospital General Manager and the UCH General Manager Clinical Governance Hospitals, who will inform the UCH Group Executive.

5.7.2 Reporting of such events by the clinician is mandatory under the Health Practitioner Regulation Nation Law Act (Qld) 2009 and is to be undertaken by the hospital in accordance with the requirements set out in the *Guidelines for Mandatory Notification* of the relevant practitioner group.

(also refer appendix 5 in relation to the use of the below flowcharts)

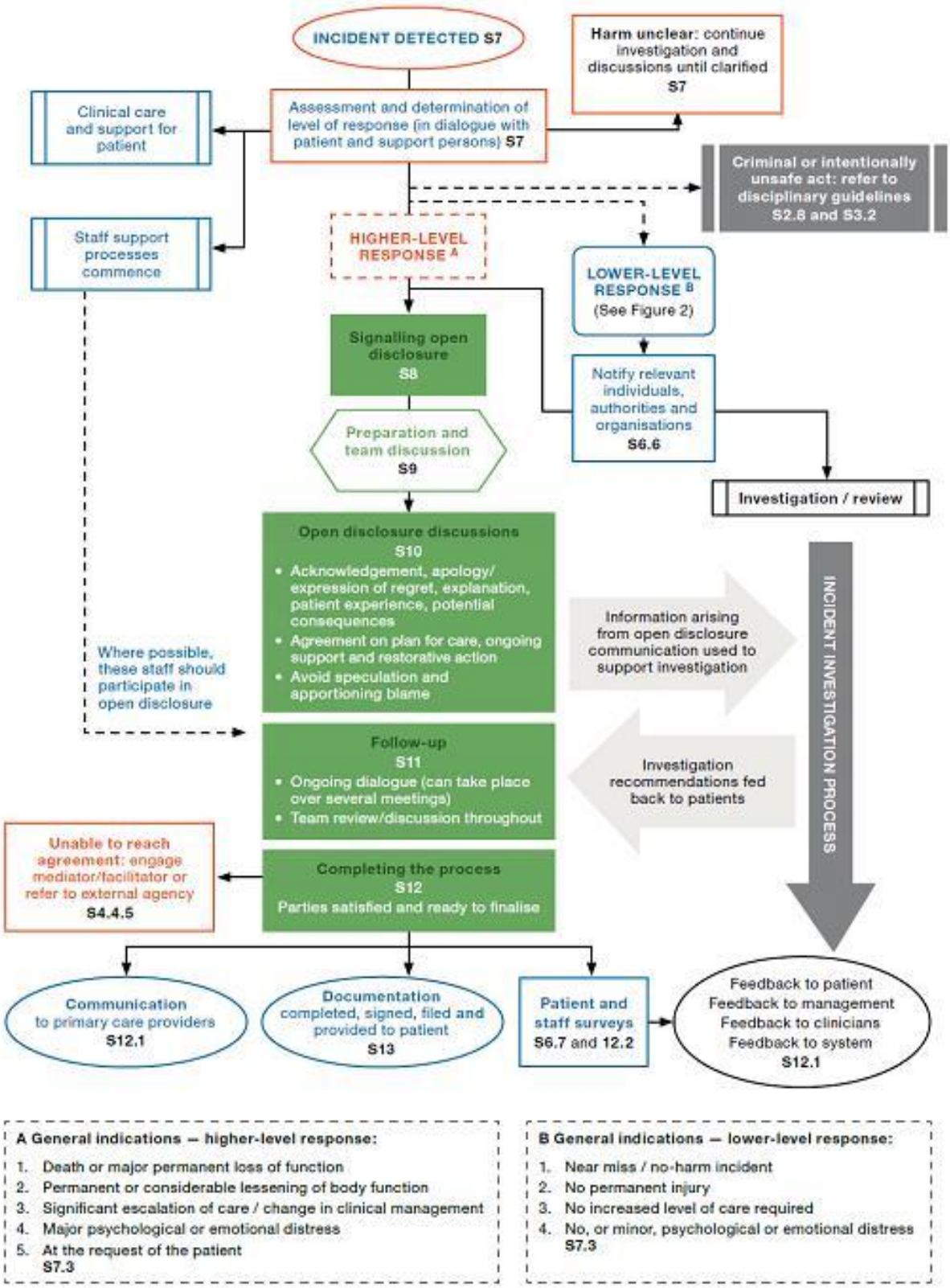
S = section in the Open Disclosure Framework

5.8 **Low level response framework flowchart**



5.9 **High level response framework flowchart**

S = section in the Open Disclosure Framework



6 Responsibilities and Requirements

6.1 **Requirements**

6.1.1 Hospitals must have a process for informing patients, their family/carer about the open disclosure process, verbally and in writing. The communication is to be in a language or communication style that they understand as part of the admission process.

6.1.2 Hospitals must have a system for recognising, reporting and escalating incidents causing harm, adverse events /outcomes and near misses to enable appropriate and timely open disclosure to be undertaken. (**Refer to flow charts (section 5) and appendix 5: process summary of open disclosure).**

6.1.3 UCH is required to develop and implement a system that enables adverse events and adverse outcomes to be thoroughly investigated.

6.1.4 UCH must incorporate the findings of reviews and or investigations into quality activities directed to change and improve systems of care.

6.1.5 Hospitals must establish a set of relevant open disclosure measures so as to facilitate quality improvement outcomes, monitoring and reporting to management. **(Refer to appendix 6 for suggested measures)**

6.2 **Responsibilities**

6.2.1 **UCH Group Executive** is responsible for

6.2.1.1 ensuring UCH have appropriate procedures, processes and practices in place to support open disclosure

6.2.1.2 ensuring those with operational responsibility have the means to implement this policy.

6.2.2 **Hospital General Manager** is responsible for

6.2.2.1 supporting open disclosure as a patient right and an organisational requirement.

6.2.2.2 Are responsible for open disclosure practice and implementation.

6.2.2.3 Designating key staff to participate in and undertaking open disclosure.

6.2.2.4 Ensuring appropriate training is provided to appropriate roles within the hospital to facilitate the process of open disclosure

6.2.2.5 Providing resources to support open disclosure practices in accordance with the Australian Open Disclosure Framework.

6.2.2.6 Actively promoting and disseminating information about open disclosure policy and process to all UCH staff and accredited health professionals.

6.2.2.7 Ensure that patients are informed about their rights, complaint and open disclosure processes.

6.2.3 **Director of Medical Services is responsible for**

6.2.3.1 Actively promoting and disseminating information about open disclosure policy and process to all UCH staff and accredited health professionals.

6.2.3.2 Ensure that patients are informed about their rights, complaint and open disclosure processes.

6.2.4 **Director of Clinical Services** is responsible for

6.2.4.1 Actively promoting and disseminating information about open disclosure policy and process to all UCH staff and accredited health professionals.

6.2.4.2 Ensure that patients are informed about their rights, complaint and open disclosure processes.

6.2.4.3 Designating key staff to participate in, and have responsibility for open disclosure practice and implementation.

6.2.5 **Clinical Manager** is responsible for

6.2.5.1 Monitoring incident and adverse outcomes of care for patients in their area of responsibility.

6.2.5.2 Facilitating timely open disclosure by escalating instances of harm to the hospital executive and General Manager.

6.2.5.3 Note: escalation reporting includes informing the hospital executive of identified complications of treatment / care provided by practitioners. This may be discussed with the individual practitioner prior to escalation to afford the opportunity to personally inform the hospital executive.

6.2.6 **Accredited Health Practitioner** is responsible for

6.2.6.1 Acknowledging their role in events and conveying an apology or expression of regret.

6.2.6.2 Participating in open disclosure training and education as required.

6.2.6.3 Participating in the open disclosure process as required.

6.2.6.4 Supporting their colleagues following an adverse event

6.2.6.5 Refraining from blaming and potentially defamatory actions.

6.2.6.6 Supporting a balanced approach in the open disclosure process with through ethical behaviour and utilising the principles of transparency and openness.

6.2.7 **UCH Employee** is responsible for

6.2.7.1 Acknowledging their role in an adverse event and conveying an apology or expression of regret

6.2.7.2 Participating in open disclosure training and education as required

6.2.7.3 Participating in the open disclosure process as required

6.2.7.4 Supporting their colleagues following an adverse event

6.2.7.5 Refraining from blaming and potentially defamatory actions.

7 Definitions

7.1 **Accreditation** means a status that is conferred on a health service organisation or individual when they are assessed as having met particular standards relating to quality of care and patient safety.

7.2 **Admission of liability** means a statement of a person that admits, or tends to admit a person's or organisation's liability in negligence or harm or damage caused by another.

7.3 **Adverse event** means an incident in which harm resulted to a person receiving health care. Note: term is interchangeable with "harmful incident". See *harm*

7.4 **Adverse outcome** means an outcome of an illness or its treatment that has not met the clinician's or the patient's expectation for improvement of care.

7.5 **Apology** means an expression of sorrow, sympathy and (where applicable) remorse by an individual, group or institution for a harm or grievance. An apology should include the words "I am sorry" or "we are sorry". An apology may also include an acknowledgement of responsibility which is not an admission of liability. See also A*dmission of liability*, *Expression of regret.*

7.6 **Carer** means 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 they provide this support and assistance under a contract of service or a contract or 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.

7.7 **Clinician** means 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.

7.8 **Clinical risk management** means the clinical, administrative and manufacturing activities that organisations undertake to identify, evaluate and reduce the risk of injury to patients and visitors, and the risk of loss to the organisation itself.

7.9 **Clinical workforce** means the nursing, medical and allied health professionals who provide patient care as well as patient care assistants, technicians and students who provide care under supervision.

7.10 **Commission** means Australian Commission on Safety and Quality in Health Care.

7.11 **Complication** means a detrimental patient condition that arises during the process of providing health care.

7.12 **Consumer** means a patient and potential patient, carers and organisation representing consumer interests.

7.13 **Corporate risk** means the potential liabilities, exposures and dangers faced by an organisation or corporation. These can be financial or reputational.

7.14 **Corporate risk management** means activities of an organisation or corporation to identify and reduce potential financial or reputational liabilities, exposure and dangers.

7.15 **Disability** means any type of impairment of body structure or function, activity limitation or restriction of participation in society.

7.16 **Error** means a failure to carry out a planned action as intended or application of an incorrect plan through either doing the wrong thing (commission) or falling to do the right thing (omission) at either the planning or the execution phase of health care intervention.

7.17 **Ex gratia** means "out of good will", usually referring to financial reimbursement or recovery payments. By definition, ex gratia payments are not an admission of liability.

7.18 **Expression of regret** means 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 circumstance for example when harm is deemed unpreventable.

7.19 Good governance involves a system of accountability through a health service organisation’s senior management, executive or governing body to ensure that appropriate changes are implemented and their effectiveness is reviewed. Good governance should include internal performance monitoring and reporting.

7.20 **Harm** means the impairment of structure or function of the body and / or any deleterious effect arising therefrom, including disease, injury, suffering, disability and death. Harm maybe physical, psychological or social.

7.21 **Harmful incident** means an incident that led to patient harm. Such incidents can either be part of the healthcare process, or occur in the healthcare setting (ie. While the patient is admitted to, or in the care, of a health service organisation. Note: this term is interchangeable with “adverse event”

7.22 **Health care** means the prevention, treatment and management of illness and the preservation of mental and physical wellbeing through the services offered by the medical and allied health professionals.

7.23 **Health care record** see *patient record*

7.24 **Health service contact** means a nominated employee of the health service organisation who acts as an ongoing point of contact and provides information and support to the patient throughout the open disclosure process.

7.25 **Health Service Organisation (HSO)** means a separately constituted health service that is responsible for the clinical governance, administration and financial management of a service unit providing health care. A service unit involves a group of clinicians and others working a systematic way to deliver health care to patients. This can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patient’s homes, community settings, practices and clinicians’’ rooms. Unless specified the term, *health service organisation* includes all of these and other settings in which health care is provided.

7.26 **Higher level response** means a comprehensive / full open disclosure process usually in response to an incident resulting in a death or major permanent loss of function, permanent or considerable lessening of body function, significant escalation of care or major change in clinical management (eg. Admission to hospital surgical intervention, a higher level of care or transfer to an intensive care unit) or major psychological or emotional distress. These criteria should be determined in consultation with patients, their family and carers. A higher level response maybe instigated at the request of the patient even if the outcome of the adverse event is not as severe. See also *lower level response*

7.27 **Incident** see *adverse event*

7.28 **Liability** means the legal responsibility for an action.

7.29 **Lower level response** means a briefer open disclosure process usually in response to incidents resulting in no permanent injury, requiring no increased level of care (eg. Transfer to the operating theatre or intensive care unit), and resulting in no, or minor psychological or emotional distress (eg. Near misses and no-harm incidents). These criteria should be determined in consultation with patients, their family and carers. See *higher level response*

7.30 **Medical record** see *patient record*

7.31 **Multidisciplinary team** means a healthcare team comprising individuals from various professions (nursing, medical, allied health, administrative, management) and disciplines within these professions.

7.32 **National Safety and Quality Health Service (NSQHS) Standards** means a set of 8 standards which provide a clear statement about the level of care consumers can expect from health service organisations They also play an essential part in accreditation arrangement which commenced in January 2013. See accreditation.

7.33 **Near miss** means an incident that did not cause harm but had the potential to do so.

7.34 **Next of kin** is synonymous with family member and may include spouse or domestic partner, son or daughter who has attained the age of 18, parent, brother or sister who has attained the age of 18

7.35 **No harm incident** means an error or system failure that reaches the patient but does not result in patient harm

7.36 **Nominated contact person** means any individual who is formally identified by the patient as a nominated recipient of information regarding their care in accordance with local processes and legal requirements.

7.37 **Non-clinical workforce** means the workforce in a health service organisation who do not provide direct clinical care but support the business of health service delivery through administration, corporate record management, management support or volunteering.

7.38 **Open disclosure** means an open discussion with a patient about an incident(s) that resulted in harm to the patient while receiving health care. The elements of open disclosure are an apology or expression of regret (including the work “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.

7.39 **Outcome** means the status of an individual, a group of people or a population that is wholly or partially attributable to an action, agent (ie. One who/which acts to produce a change) or circumstance (ie. All factors connected with influencing an event, agent or person).

7.40 **Patient** means a person receiving health care. Synonyms for patient include “consumer” and “client”.

7.41 **Patient harm** see *harm*

7.42 **Patient record** consists of, but is not limited to, a record of the patient’s medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medications charts for an episode of care.

7.43 **Patient safety** means the reduction of risk of unnecessary harm associated with health care to an acceptable minimum. An acceptable minimum refers to the collective notions of current knowledge, resources available and the context in which care was delivered, weighed against the risk of non-treatment or other treatment.

7.44 **Qualified privilege legislation** varies between jurisdictions but generally protects the confidentiality of individually identified information that became known solely as a result of a declared safety and quality activity. Certain conditions apply to the dissemination of information under qualified privilege.

7.45 **Quality (health care)** means the degree to which health services increase the likelihood of desired outcomes and are consistent with current professional knowledge.

7.46 **Quality improvement** means the continuous study and adaptation of a healthcare organisation's functions and processes to increase the probability of achieving desired outcomes and better meet the needs of patients and other users of services.

7.47 **Reimbursement** means the act of paying for somebody's expenses without an admission of liability.

7.48 **Risk** means the chance of something happening that will have a negative effect. It is measure by consequences and likelihood.

7.49 **Risk management** means the design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the institution.

7.50 **Service recovery** means the process used to "recover" dissatisfied individuals or patients by identifying and fixing the problem, or making amends for the failure in customer or clinical services.

7.51 **Staff** means anyone working within a health service organisation, including self employed professionals such as visiting medical officers.

7.52 **Statute** means a written law passed by a legislature at the state or federal level.

7.53 **Support** person means an individual who has a relationship with the patient. References to "support person" can include family members / next of kin; carers; friends, a partner or other person who cares for the patient; guardians or substitute decision makers; social workers or religious representatives; where available, trained patient advocates.

7.54 **System failure** means a fault, breakdown or dysfunction within operational methods, processes or infrastructure.

7.55 **Systems improvement** means the changes made to dysfunctional operational methods, processes and infrastructure to ensure improved quality and safety.

7.56 **Treatment** means the way an illness or disability is managed by drugs, surgery, physiotherapy or other interventions to affect an improvement in, or cure of, the patient's condition.

8 Context and References

8.1 Australian Open Disclosure Framework: Better communication, a better way to care (2013), Australian Commission for Safety and Quality in Health Care.

8.2 Open disclosure principles, elements and process. Australian Open Disclosure Framework: supporting materials and resources (2013) Australian Commission for Safety and Quality in Health Care.

8.3 Implementing and practising open disclosure: Guide for health service managers. Australian Open Disclosure Framework: supporting materials and resources (2013) Australian Commission for Safety and Quality in Health Care.

8.4 Coroner's Act 2003 (Qld)

8.5 Privacy Act 1988 (C'Wealth)

8.6 Civil Liability Act 2003 (Qld)

8.7 Health Practitioner Regulation National Law Act Qld 2009 (the National Law)

8.8 Health and Hospital Boards Act 2011 (Qld)

9 Related Documents

9.1 UCQ Risk Management Framework

9.2 UCQ Risk Management Policy

9.3 UCQ Client Incident Management Framework

9.4 UCQ Privacy Policy

9.5 UCH Incident Management Procedure

9.6 UCH Complaint Policy

9.7 UCH Incident Investigation Policy

9.8 UCH By Laws for Accredited Health Practitioners

10 Review and Version Control

Version	Authorising	Approval	Effective	Change History	Review

	Position	Date	Date		Date
V1.0	UCH CEO	07/2004	07/2004	New policy	07/2008
V2.0	UCH CEO	05/2005	05/2005		05/2009
V3.0	UCH CEO	07/2009	07/2009	No change	07/2013
V4.0	Executive Director UCH	02/2014	02/2014	Full review. Transfer to new format	02/2017
V5.0		03/2018	03/2018	Review. Update roles, responsibilities and related documents. No change to content	03/2021
V6.0	GE Hospitals	06/2021	06/2021	Full content review with changes. Transfer to new template. Updated numbering convention	06/2024

Appendix 1: Reportable events

Reportable events pursuant to the Health and Hospital Boards Act 2011 (Qld)

(a) maternal death or serious maternal morbidity associated with labour or delivery;

(b) the death of a person associated with the incorrect management of the person's medication;

(c) the death of a person, or neurological damage suffered by a person, caused by an intravascular gas embolism;

(d) the wrong procedure being performed on a person, or a procedure being performed on the wrong part of a person's body, resulting in the death of the person or an injury being suffered by the person;

(e) the retention of an instrument, or other material, in a person's body during surgery that requires further surgery to remedy the retention;

(f) the death of a person, or an injury suffered by a person, caused by a haemolytic blood transfusion reaction resulting from the wrong blood type being used for the person during a blood transfusion;

(g) the suspected suicide of a person receiving inpatient health care;

(h) the suspected suicide of a person with a mental illness who is under the care of a provider of mental health services while residing in the community; and

*(i) any other death of a person, or an injury** suffered by a person, that was not reasonably expected to be an outcome of the health service provided to the person.*

** 'Injury' is taken to mean an injury that is likely to be permanent.

Appendix 2: Potential response to situations and incidents

Incident type	Response
1. Harm from natural progression of condition or disease process *e.g. a treatment for cancer was unsuccessful*	**Discuss and explain** ***(lower-level)***
2. Complication or natural disease progression a. Anticipated by patient/family via education and consent process b. Not anticipated by patient/family via education and consent process (**go to 3**) *e.g. patient not adequately informed of the possibility of respiratory complications of general anaesthesia and feels that this would have altered their decision to proceed with treatment*	**a. Discuss and explain** ***(lower-level)*** **b. Open disclosure** ***(higher or lower- level depending on severity)***
3. Patient harm/adverse event *e.g. Adverse drug event (wrong dose medication)*	**Open disclosure** ***(higher or lower-level depending on severity and impact on patient)***
4. Clinical ('no harm') incident: reaches patient but no harm *e.g. Medication error (no/minimal effect on patient)*	**Generally disclose** ***(lower-level)***
5. Clinical ('near miss') incident: does not reach patient *e.g. an intercepted wrong-patient biopsy*	**Team decision based on:** • context • circumstances • potential ramifications ***(lower-level)***
6. Patient perception or report of harm *e.g. patient perception of delay in diagnosis resulting in poor patient outcome*	**Discuss and agree on appropriate form of disclosure** ***(higher or lower- level)***

Appendix 3: Criteria for determining response level for open disclosure

	Criteria
Lower-level response	1. Near misses and no-harm incidents 2. No permanent injury 3. No increased level of care (e.g. transfer to operating theatre or intensive care unit) required 4. No, or minor, psychological or emotional distress
Higher-level	1. Death or major permanent loss of function 2. Permanent or considerable lessening of body function

response	3. Significant escalation of care or major change in clinical management (e.g. admission to hospital, surgical intervention, a higher level of care, or transfer to intensive care unit) 4. Major psychological or emotional distress 5. At the request of the patient

Appendix 4: Key components of open disclosure discussions

1. Detecting and assessing incidents	• Detect adverse event through a variety of mechanisms • Provide prompt clinical care to the patient to prevent further harm • Assess the incident for severity of harm and level of response • Provide support for staff • Initiate a response, ranging from lower to higher levels • Notify relevant personnel and authorities • Ensure privacy and confidentiality of patients and clinicians are observed

2. Signalling the need for open disclosure	• Acknowledge the adverse event to the patient, their family and carers including an apology or expression of regret.
	• **A lower level response can conclude at this stage.**
	• Signal the need for open disclosure
	• Negotiate with the patient, their family and carers or nominated contact person
	  ○ the formality of open disclosure required
	  ○ the time and place for open disclosure
	  ○ who should be there during open disclosure
	• Provide written confirmation
	• Provide a health service contact for the patient, their family and carers
	• Avoid speculation and blame
	• Maintain good verbal and written communication throughout the open disclosure process

3. Preparing for open disclosure	• Hold a multidisciplinary team discussion to prepare for open disclosure • Consider who will participate in open disclosure • Appoint an individual to lead the open disclosure based on previous discussion with the patient, their family and carers • Gather all the necessary information • Identify the health service contact for the patient, their family and carers (if this is not done already)
4. Engaging in open disclosure	• Provide the patient, their family and carers with the names and roles of all attendees • Provide a sincere and unprompted apology or expression of regret including the words *I am* or *we are sorry* • Clearly explain the incident • Give the patient, their family and carers the opportunity to tell their story, exchange views and observations about the incident and ask questions • Encourage the patient, their family and carers to describe the

	personal effects of the adverse event • Agree on, record and sign an open disclosure plan • Assure the patient, their family and carers that they will be informed of further investigation findings and recommendations for system improvement • Offer practical and emotional support to the patient, their family and carers • Support staff members throughout the process • If the adverse event took place in another health service organisation, include relevant staff if possible. • If necessary, hold several meetings or discussions to achieve these aims
5. Providing follow-up	• Ensure follow-up by senior clinicians or management, where appropriate • Agree on future care • Share the findings of investigations and the resulting practice changes • Offer the patient, their family and carers the opportunity to discuss the process with another clinician (e.g. a general practitioner)
6. Completing the process	• Reach an agreement between the patient, their family and carers and the clinician, or provide an alternative course of action • Provide the patient, their family and carers with final written and verbal communication, including investigation findings • Communicate the details of the adverse event, and outcomes of the open disclosure process, to other relevant clinicians • Complete the evaluation surveys
7. Maintaining documentation	• Keep the patient record up to date • Maintain a record of the open disclosure process • File documents relating to the open disclosure process in the patient record • Provide the patient with documentation throughout the process

Appendix 5: Summary of the open disclosure process to be used in conjunction with the flow charts.

Stages of Open Disclosure Process	***Required Actions***
1. ***Detecting and assessing incidents***	▪ Detect adverse events through a variety of mechanisms. ▪ Provide prompt clinical care to the patient to prevent further harm. ▪ Assess the incident for severity of harm and level of response ▪ Provide support for staff. ▪ Initiate a response ranging from lower to higher levels ▪ Notify relevant personnel and authorities. ▪ Ensure privacy and confidentiality of patients and clinicians are observed.
2. ***Signaling the need for open disclosure***	▪ Acknowledge the adverse event to the patient, their family (carers) including an apology or expression of regret. ▪ **A lower level response can conclude at this stage**. ▪ Signal the need for open disclosure. ▪ Negotiate with the patient, their family (carer) or nominated contact person: ▪ The formality of open disclosure ▪ The time and place for open disclosure ▪ Who should be there during open disclosure ▪ Provide written confirmation. ▪ Provide a hospital contact for the patient, their family (carers). ▪ Avoid speculation and blame. ▪ Maintain good verbal and written communication throughout the open disclosure process.
3. ***Preparing for open disclosure***.	▪ Hold a multidisciplinary team discussion to prepare for open disclosure. ▪ Consider who will participate in the open disclosure. ▪ Appoint an individual to lead the open disclosure based on previous discussions with the patient, their family (carer) if not done already.
4. ***Engaging in open disclosure***.	▪ Provide the patient, their family (carer) with the names and roles of all attendees. ▪ Provide a sincere and unprompted apology or expression of regret including the words “I am sorry” or “We are sorry”. ▪ Give the patient, their family (carer) the opportunity to tell their story, exchange views and observations about the incident and ask questions. ▪ Encourage the patient, their family (carer) to describe the personal effects of the adverse event ▪ Agree on, record and sign an open disclosure plan. ▪ Assure the patient, their family (carer) that they will be informed of further investigation findings and recommendations for system improvement. ▪ Offer practical and emotional support throughout the process. ▪ If the adverse event, took place in another health service organisation, include relevant staff if possible. ▪ If necessary, hold several meetings or discussions to achieve this aim.

Stages of Open Disclosure Process	*Required Actions*
5. Providing follow up	▪ Ensure follow-up by senior clinicians or management, where appropriate. ▪ Agree on future care. ▪ Share the findings of investigations and the resulting practice changes. ▪ Offer the patient, their family (carer) the opportunity to discuss the process with another clinician (e.g. a GP).
6. Completing the process.	▪ Reach an agreement between the patient, their family (carer) and the clinician, or provide an alternative course of action. ▪ Provide the patient, their family (carer) with a final written and verbal communication, including investigation findings. ▪ Communicate the details of the adverse event, and outcomes of the open disclosure process, to other relevant clinicians. ▪ Complete evaluation surveys.
7. Maintaining documentation	▪ Keep the patient record up to date. ▪ Maintain a record of the open disclosure process. ▪ File documents relating to the open disclosure process in the patient record. ▪ Provide the patient with documentation throughout the process.

(Australian Commission on Safety & Quality in Health Care – Australian Open Disclosure Framework)

Appendix 6: Suggested measures for internal quality improvement of open disclosure

Number of open disclosure processes commenced in the reporting period. Number of open disclosure processes concluded in the reporting period. Number and percentage of open disclosure processes referred to mediation.
Number and percentage of open disclosure triggered by: ▪ Complaints ▪ Clinical incident notification ▪ Case note review ▪ General observation ▪ Patient request
Percentage of sentinel events formally disclosed.
Percentage of open disclosure vs. open disclosure requests through: ▪ Patient initiations ▪ Complaints
Results of patient surveys. Results of staff surveys.
Percentage of clinicians trained in open disclosure.
Results of feedback to training. Results of feedback to open disclosure.