CURA DAY HOSPITALS GROUP (CURA)
OPEN DISCLOSURE POLICY

1. Intent

Cura Day Hospitals Group (**Cura**), its hospitals, Governing Body, Staff and Visiting Medical Practitioners engage in the practice and principles of Open Disclosure and this Policy provides direction to Cura Personnel and VMOs to practice open disclosure in a manner which is consistent with the Australian Commission on Safety and Quality in Health Care - Australian Open Disclosure Framework.

2. Scope and Target Audience

All employees and visiting medical practitioners (VMOs)

3. Purpose

3.1 Every day across Australia, many thousands of healthcare interventions occur. These interventions are often complex, delivered in high-pressure environments using highly advanced equipment, and involve multiple healthcare providers working together in teams and across organisations. Such interventions usually result in excellent clinical outcomes but can also carry significant risks. Sometimes incidents occur, and some result in harm.

3.2 Harm can be defined as an impairment of structure or function of the body and/or any deleterious effect arising from an incident, including disease, injury, suffering, disability, and death. Harm can be physical, social, or psychological.

3.3 Open disclosure is the open discussion of adverse events that result in harm to a patient while receiving health care with the patient, their family, and carers. The elements of open disclosure are:

(a) an apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry'
(b) a factual explanation of what happened
(c) an opportunity for the patient, their family, and carers to relate their experience
(d) a discussion of the potential consequences of the adverse event
(e) an explanation of the steps being taken to manage the adverse event and prevent recurrence.

3.4 Open disclosure is NOT a one-way provision of information, rather it is a discussion between two parties and an exchange of information that can take place in several meetings over a period of time. Open disclosure can be conducted through multiple modes, including face-to-face meetings, via tele/videoconference, by phone or via email. It is the responsibility of each health service to work with the person and/or their support people to determine the best form of communication, and how the open disclosure process will occur.

3.5 Open disclosure is a fundamental patient right and in 2013, the Australian Commission

on Quality and Safety in Health Care developed the Open Disclosure Framework in 2013 which is the nationally consistent basis for open disclosure in Australian health care. The Australian Open Disclosure Framework has been formally endorsed by Australian Health Ministers and has been officially endorsed by the following professional organisations:

(a) Australian College of Nursing
(b) Australian and New Zealand College of Anesthetists
(c) Royal Australian and New Zealand Colleges of Obstetricians and Gynecologists
(d) Royal Australasian College of Physicians
(e) Royal Australasian College of Surgeons
(f) Society of Hospital Pharmacists of Australia

3.6 Open disclosure mandatory for all health care organisations and the professionals who work within them. It is anchored in professional ethics and professional Codes of Conduct and is an essential component of good clinical practice, effective clinical communication, and the care continuum.

3.7 Open disclosure can have a direct benefit for the individuals involved, as well as system-wide benefits.

3.7.1 For people where a harm has occurred and/or their support people

(a) Gaining an understanding of what happened and why, including an opportunity to ask questions and have concerns addressed
(b) Restoring trust in health care
(c) Ameliorating feelings of anger, guilt, grief, or helplessness
(d) Encouraging the person and/or their support people to participate in health care quality improvement processes.

3.7.2 For healthcare providers

(a) Enabling the mitigation of ongoing consequences of harmful incidents
(b) Enabling healthcare providers to manage the stress and affective consequences of a harmful incident or complaint
(c) Ameliorating feelings of guilt and shame
(d) Facilitating full and frank incident investigations that can be used to improve the safety and quality
(e) Fulfilling professional, ethical, and moral obligations to truthfully disclose information about harmful incidents.

3.7.3 At the system-wide level

(a) Facilitating a safer health system
(b) Improving system responsiveness to the person's and community's needs
(c) Strengthening public trust in healthcare institutions, including relationships between the healthcare provider and the person receiving health care
(d) Increasing and improving notification, reporting and investigation of incidents, resulting in more targeted quality improvement activity
(e) Improving workforce morale and retention
(f) Embedding transparency and openness into healthcare services.

4. Open Disclosure Principles

There are eight (8) guiding principles for open disclosure:

	Principle	Details
1	Open and timely communication	When things go wrong, patients, families and carers should be provided with information about what happened in a timely, open, and honest manner. Information provision will be ongoing as further investigation occurs.
2	Acknowledgement	All adverse events should be acknowledged to patients, families and carers as soon as is practicable.
3	Apology or expression of regret	As early as is possible, patients, families and carers should receive an apology or expression of regret for any harm that has resulted from an adverse event. This can include psychological harm. 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.
4	Supporting, and meeting the needs and expectations of patients, their families, and carers	The patient, their family and carers can expect to be: • Fully informed of the facts surrounding the adverse event and its consequences • Treated with empathy, respect, and consideration • Supported in a manner appropriate to their needs.
5	Supporting, and meeting the needs and expectations of those providing care	Health service organisations should create an environment in which all staff are • 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.
6	Clinical risk management and systems improvement	Thorough clinical review and investigation of adverse events and adverse outcomes should be conducted through processes that focus on the management of clinical risk and quality improvement. Findings of these reviews should focus on improving systems of care and be reviewed for their effectiveness. The information obtained about incidents from the

		open disclosure process should be incorporated into quality improvement activity.
7	Good governance	Open disclosure requires good governance frameworks, and clinical risk and quality improvement processes. Through these systems, adverse events should be investigated and analysed to prevent them from recurring. 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.
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). However, this principle needs to be considered in the context of Principle 1.

5. The Policy

5.1 Each Cura Facility CEO/Director of Nursing (DoN):

(a) will be responsible for ensuring that Open Disclosure is provided when required and that the Open Disclosure process is consistent with the Commission's Framework.

(b) will be responsible for ensuring that the clinical workforce including staff and visiting medical practitioners are trained in Open Disclosure processes.

(c) will report all Open Disclosure activities to the Operations Manager as per the procedure.

5.2 The Facility Patient Pre-Admission Information Booklets must have an explanation of the Open Disclosure process.

5.3 The Open Disclosure process will be explained to patients/carers/family at Admission and this activity will be initialed as completed on the relevant Care Pathway.

5.4 All VMOs credentialed at each Facility will receive a copy of this policy and any amended policies when occurs.

5.5 All Cura employed clinical staff will be required and are accountable for their completion of the Cura Learning System Open Disclosure On-Line learning when they first commence at Cura and annually thereafter.

5.6 All incidents requiring a higher-level response will be recorded and reported at Staff, Leadership, Medical and Consumer Advisory or Quality Committees where consumers are active members.

6. Open Disclosure Process

6.1 As soon as possible following Cura staff becoming aware that a patient incident has occurred, irrespective of any harm being caused, Open Disclosure will occur. An offer to meet in person with the patient, their family or carer will occur for any incident. Such an offer may be declined by the patient or family and the details of the offer will be documented both in the patient's progress notes and the Riskman incident report.

6.2 Open disclosure will include:

(a) an Expression of Regret. (Refer to Principle 3);

(b) a factual explanation of what happened;

(c) the potential consequences; and

(d) the steps being taken to manage the event and prevention of recurrence.

6.3 There are two response levels, which will be determined in consultation with the patient, their family/ carers. (Also refer to the Appendix 2 which is the Flow Charts for each response level.)

(a) **Lower-level response:** Incidents resulting in no permanent injury, not requiring an increased level of care (e.g., transfer to operating theatre or intensive care unit), and resulting in no, or minor, psychological, or emotional distress (e.g., near misses and no-harm incidents) will require a lower-level response. Lower-level responses will be managed internally and notation of what was said and by whom to whom will be documented in the patient's progress notes and in the Riskman incident report.

(b) **Higher-level response:** Where an incident results in death or major permanent loss of function, permanent or considerable lessening of body function, 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), or major psychological or emotional distress a higher-level response will be required. Such incidents will be reported immediately to the Operations Manager and Legal Counsel. The Operations Manager/Legal Counsel/Cura CEO will provide further instruction of how the higher-level response will be initiated and followed through including notification of Sentinel Events and Root Cause Analysis. Higher-level responses can also be instigated at the request of the patient even if the outcome of the adverse event is not as severe.

6.4 Lessons learned will be communicated to the Patient/family/carer/facility staff and VMOs.

6.5 The Open Disclosure process and meetings will be documented and kept securely.

7. Open Disclosure Considerations

7.1 The Patient may bring whomever they wish to the open disclosure meeting. All persons receiving open disclosure are entitled to bring a support person. Examples of a support person include, but are not limited to, partners, guardians, social workers, and trained patient advocates.

7.2 A power of attorney, legal guardian, spouse, next of kin should be included in all discussions and open disclosure meeting.

8. Culturally and Linguistically Diverse (CALD) Patients

Wherever practical, Cura should take steps to meet the Patients treatment, access, language, and communication needs.

9. References

- Australian Commission on Safety and Quality in Health Care (ACSQHC) (2013), *Australian Open Disclosure Framework,* ACSQHC, Sydney.
- Australian Commission on Safety and Quality in Health Care (ACSQHC) (2020), *Australian Charter of Healthcare Rights 2nd Edition*
- Australian Commission on Safety and Quality in Health Care (September 2011), *National Safety and Quality Health Service Standards,* ACSQHC, Sydney.
- Australian Commission on Safety and Quality in Health Care (February 2020) , *Review: Implementation of the Australian Open Disclosure Framework ,* ACSQHC, Sydney.
- National Safety and Quality Standards (2021) Standard 1 Clinical Governance. ACSQHC, Sydney
- National Safety and Quality Standards (2021) Standard 2 Participating with Consumers. ACSQHC, Sydney

Appendix 1 – Definition of Terms

Term	Definition
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 another.
Adverse event/Adverse Incident	The Australian Open Disclosure Framework defines an 'adverse event' as an incident in which a person receiving health care was harmed. Note: This term is used interchangeably with 'harmful incident'. See Harm
Adverse outcome	An outcome of an illness or its treatment that has not met the clinician's or the patient's expectation for improvement or cure.
Apology	An expression of sorrow, sympathy and (where applicable) remorse by an individual, group or institution for a harm or grievance. It should include the words 'I am sorry' or 'we are sorry'. Apology may also include an acknowledgment of responsibility, which is not an admission of liability. See also Admission of liability, Expression of regret
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 while doing voluntary work for a charitable, welfare or community organisation, or as part of the requirements of a course of education or training.
Clinical disclosure	The informal process where the treating clinician informs the patient /family/carer of the occurrence of an adverse event and an apology for the occurrence of the event. It is generally used for less serious events.
Clinical Incident	Clinical incident Unplanned / unintended event or circumstance which could have or did result in harm to the patient due to / or because of healthcare.
Clinical risk	The combination of the probability of occurrence of harm and the severity of that harm.
Clinical risk management	See Risk management
Clinical workforce	The nursing, medical and allied health professionals who provide patient care, and students who provide patient care under supervision. This may also include laboratory scientists.

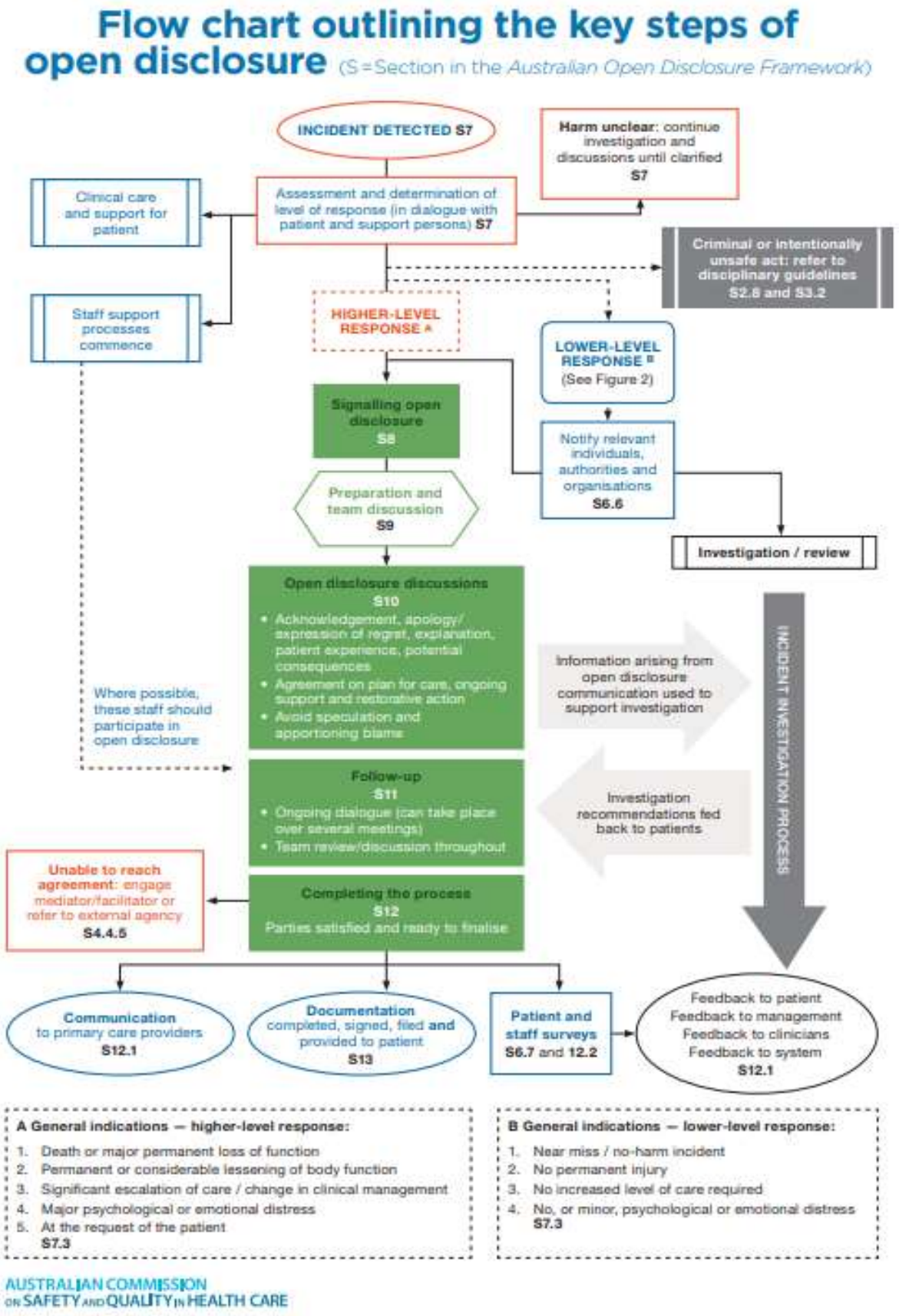
Clinician	A healthcare provider who is trained as a health professional. Clinicians include registered and non-registered practitioners, or a team of health professionals who spend most of their time providing direct clinical care.
Commission	Australian Commission on Safety and Quality in Health Care
Complication	A detrimental patient condition that arises during the process of providing health care.
Consumer	Patients and potential patients, carers and organisations representing consumers' interests.
Corporate risk	Potential liabilities, exposures and dangers faced by an organisation or corporation. These can be financial or reputational.
Corporate risk management	See Risk management
Disability	Any type of impairment of body structure or function, activity limitation or restriction of participation in society.
Error	Failure to carry out a planned action as intended or application of an incorrect plan through either doing the wrong thing (commission) or failing to do the right thing (omission) at either the planning or execution phase of healthcare intervention.
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 harm is deemed unpreventable). See also Apology
Harm	Impairment of structure or function of the body and/or any deleterious effect arising therefrom, including disease, injury, suffering, disability, and death. Harm may be physical, social, or psychological.
Harmful incident	An incident that led to patient harm. Such incidents can either be part of the healthcare process, or occur in the healthcare setting (i.e., while the patient is admitted to, or in the care of, a health service organisation). Note: This term is used interchangeably with 'adverse event'.
Health care	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 professions
Health service organisation	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

	in a systematic way to deliver health care to patients. This can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' 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.
Health service contact	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.
Higher-level response	A comprehensive open disclosure process usually in response to an incident resulting in death or major permanent loss of function, permanent or considerable lessening of body function, 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), or major psychological or emotional distress. These criteria should be determined in consultation with patients, their family, and carers. A higher-level response may also be instigated at the request of the patient even if the outcome of the adverse event is not as severe. See also Lower-level response Incident & See Adverse event.
Liability	The legal responsibility for an action.
Lower-level response	A briefer open disclosure process usually in response to incidents resulting in no permanent injury, requiring no increased level of care (e.g., transfer to operating theatre or intensive care unit), and resulting in no, or minor, psychological, or emotional distress (e.g., near misses and no-harm incidents). These criteria should be determined in consultation with patients, their family, and carers. See also Higher-level response
Near miss	An incident that did not cause harm but had the potential to do so.
Next of kin	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
No-harm incident	An error or system failure that reaches the patient but does not result in patient harm. Nominated contact person 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
Non-clinical	The workforce in a health service organisation

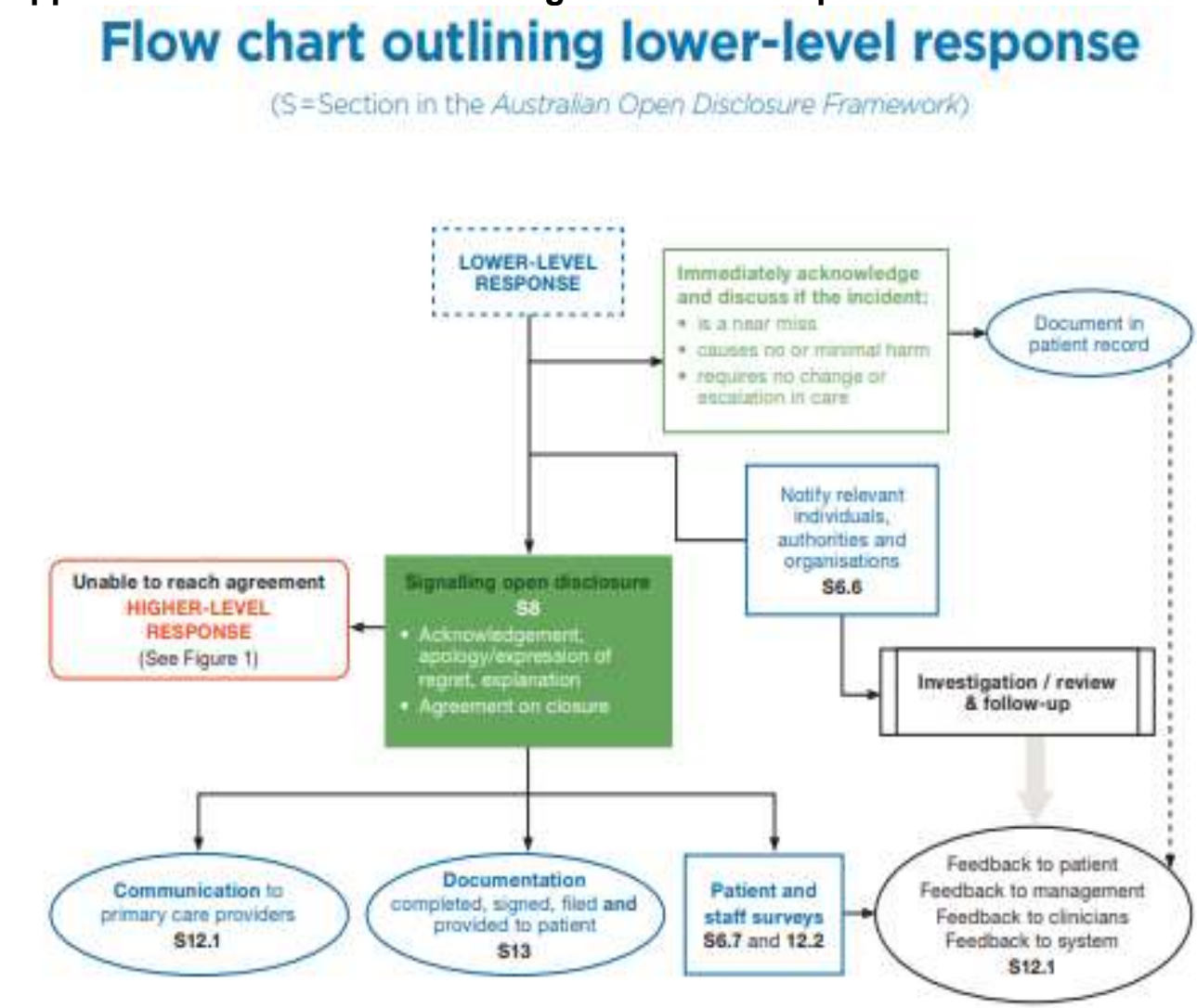
workforce	who do not provide direct clinical care but support the business of health service delivery through administration, corporate record management, management support or volunteering.
Open disclosure	An open discussion with a patient about an incident(s) that resulted in harm to that patient while 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.
Outcome	The status of an individual, a group of people or a population that is wholly or partially attributable to an action, agent (i.e., one who/which acts to produce a change) or circumstance (i.e., all factors connected with influencing an event, agent, or person).
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 medication charts for an episode of care.
Patient safety	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.
Qualified privilege legislation	Qualified privilege legislation varies between jurisdictions but generally protects the confidentiality of individually identified information that became known solely because of a declared safety and quality activity. Certain conditions apply to the dissemination of information under qualified privilege.
Quality (health care)	The degree to which health services increase the likelihood of desired outcomes and are consistent with current professional knowledge.
Quality improvement	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.
Reimbursement	The act of paying for somebody's expenses without an admission of liability
Risk	The chance of something happening that will have a negative effect. It is measured by consequences and likelihood.

Risk management	The design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors, and the institution.
Clinical risk management	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.
Corporate risk management	Activities of an organisation or corporation to identify and reduce potential financial or reputational liabilities, exposures, and dangers.
Service recovery	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.
Staff	Anyone working within a health service organisation, including self-employed professionals such as visiting medical officers.
Statute	A written law passed by a legislature at the state or federal level.
Support person	An individual who has a relationship with the patient. References to 'support person' in this policy 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. References to support person should be read with the words, 'where appropriate'.
System failure	A fault, breakdown or dysfunction within operational methods, processes, or infrastructure.
Systems improvement	The changes made to dysfunctional operational methods, processes, and infrastructure to ensure improved quality and safety.
Treatment	The way an illness or disability is managed by drugs, surgery, physiotherapy, or other intervention to affect an improvement in, or cure of, the patient's condition.

Appendix 2 – Flow chart outlining the key steps of Open Disclosure



Appendix 3 – Flow Chart outlining lower-level response



AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE