

OPEN DISCLOSURE	Document Number: Gov_Pol_006
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1. Purpose

Perth Day Hospital is committed to upholding the principles of **Open Disclosure** in alignment with the **National Safety and Quality Health Service (NSQHS) Standards, Standard 1**, and the **Australian Open Disclosure Framework**. Open disclosure ensures transparency, respect, and trust in the patient-healthcare provider relationship following an adverse event or clinical incident.

2. Policy Statement

The Hospital's management and executive team support an open, honest, and empathetic approach to communicating with patients, their families, and carers when things do not go as expected in the delivery of care. The open disclosure process will be implemented consistently to:

- Communicate effectively and respectfully after an incident.
- Acknowledge harm or potential harm.
- Provide timely information about what occurred.
- Explain steps taken to prevent recurrence.
- Support continuous quality improvement and risk mitigation.

3. Procedure

3.1 Initiating Open Disclosure

- Open disclosure will commence as soon as practicable after the identification of a clinical incident or adverse event.
- It includes an **expression of regret** or apology, delivered in a compassionate and timely manner.

3.2 Information Sharing

- Patients and their support persons must be kept informed throughout the investigation process.
- Feedback must include findings, contributing factors, and any changes implemented to improve patient safety.

3.3 Responsibility for Disclosure

- The **treating medical officer** holds the primary responsibility for communicating with the patient or their representative.
- A **nominated hospital representative** (Medical Director, CEO or Director of Nursing) must be present.
- If the treating doctor is unavailable, a trained hospital representative will lead the process.
- It is the duty of the **CEO** to ensure appropriately trained staff are available to conduct the disclosure.
- **No other staff member** is authorised to discuss the incident without approval.
- If a treating doctor refuses to participate in the disclosure, the matter will be escalated to the **Chair of the Medical Advisory Committee (MAC)** and **Medical Director** to enforce compliance before patient discharge.

4. Principles of Open Disclosure

Perth Day Hospital applies the following principles from the Australian Open Disclosure Framework:

1. **Open and Timely Communication**
Patients and families will be informed honestly and promptly.
2. **Acknowledgment of the Incident**
Immediate recognition that an event occurred, and that an investigation will follow.
3. **Expression of Regret or Apology**
Sincere regret will be expressed without speculation, admission of legal liability, or assigning blame.
4. **Meeting the Needs of Patients and Families**
Ensuring emotional and informational support is provided.
5. **Supporting Staff**
Staff involved will be supported through the process with access to training and debriefing.
6. **Systems Improvement and Clinical Risk Management**
Learnings from events will inform risk mitigation strategies and quality improvements.
7. **Governance and Accountability**
Strong oversight and structured processes will guide the management of incidents.
8. **Confidentiality**
Information will be shared with consent and in accordance with legal requirements and privacy obligations.

5. Events Requiring Open Disclosure

The following incidents require formal open disclosure:

- **Sentinel Events** (e.g. wrong site surgery, retained instruments)

- **Critical or Clinical Incidents**
- **Adverse Events or Unexpected Outcomes**
- **Patient Transfer to Higher-Level Facility**
- **Falls Resulting in Injury or Fracture**

6. Other Events That May Require Open Disclosure

Open disclosure may also be considered for:

- Development of a **pressure injury**
- **Falls** causing significant skin injury
- **Healthcare-associated infections**
- **Medication errors** or incorrect treatment
- **Omissions in care**

7. Documentation

All stages of the open disclosure process must be **documented** in the patient's **medical record**, including:

- Date and time of the disclosure discussion
- Attendees
- Summary of conversation
- Any follow-up actions

8. Reporting and Monitoring

Open disclosure incidents will be monitored and reported annually to:

- **Hospital Management and Quality Committee (HMQ)**
- **Medical Advisory Committee (MAC)**
- **Executive Meetings**

Reporting will include:

- Total number of open disclosure events
- Number of completed open disclosure processes
- Source or trigger for each process, including:
 - Patient complaints
 - Clinical incidents
 - Case note reviews
 - Staff or visitor observations
 - Direct patient or carer requests

9. References

- **Australian Commission on Safety and Quality in Health Care.** *National Safety and Quality Health Service Standards*, 2nd ed. Sydney: ACSQHC; 2021.
- **Australian Open Disclosure Framework.** ACSQHC.

7. References

- Australian Commission on Safety and Quality in Health Care. *Australian Charter of Healthcare Rights* (2020).
<https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights>
- WA Department of Health. *Western Australian Strategic Plan for Safety and Quality in Health Care 2013–2017: Placing Patients First*. Perth: Quality Improvement and Change Management Unit, 2014.
<https://ww2.health.wa.gov.au>