Department of Health
POLICY

Tasmanian Government

Open Disclosure

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Custodian and Review Responsibility:	Clinical Governance, Clinical Quality, Regulation and Accreditation
Contact:	Professor Dinesh Arya Deputy Secretary CQRA, Chief Medical Officer
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Routine Disclosure:	Yes

Purpose

- The purpose of the *Open Disclosure Policy* (the Policy) is to outline the core principles required to achieve open and honest communication between patients, clients, residents (*herein called the 'patient'*), children and young people, carers, families and/or a substitute decision maker (*herein called support person*) and healthcare providers following unexpected healthcare outcomes, harm and/or safeguarding concerns.
- This policy is to be read in conjunction with the Australian Open Disclosure Framework[1], the Department of Health (DoH) Child Safety and Wellbeing Framework[2] and the DoH Statewide Complaints Management Framework[3] and the DoH Policy on Safety Event Management.

Mandatory Requirements

- The DoH is committed to delivering high quality and efficient healthcare services for the Tasmanian community. Open disclosure is the patient, child or young person's right, is anchored in professional ethics, is a core health service provider obligation, and is part of the care continuum.[4,5]
- Open disclosure is to occur whenever a patient, child or young person has been harmed whilst receiving healthcare. Formal open disclosure processes must be undertaken for all serious safety events or complaints with the addition of serious psychological harm events and safeguarding concerns.[6]
- Any patient, child or young person harmed while receiving care or services is to receive an open and honest explanation of what happened, why it happened, what actions have and will be taken as a result, and the patient, child or young person, carer, families and support person(s) must be afforded an opportunity to relate their experience.[7,8]
- Open disclosure processes are to be consistent with the Australian Open Disclosure Framework[9,10] and must impart trauma-informed care through awareness of how harm impacts on the lives and mental health support needs of patients, children and young people, their carer, family, support person(s), and healthcare providers.[11]
- Open disclosure is to occur as soon as practicable and is to be documented in relevant corporate records and in the Safety Reporting and Learning System (SRLS).
- This is a DoH wide Policy and must not be re-interpreted so that subordinate policies exist.
- **Failure to comply with this policy**, without providing a good reason for doing so, may lead to disciplinary action.

[1] Australian Commission on Quality and Safety in Health Care 2013. Australian Open Disclosure Framework: Better communication, a better way to care. ACSQHC: Sydney.
[2] Department of Health 2022. Child Safety and Wellbeing DoH Wide – Framework [Online]. [Accessed 9 April 2024].
[3] Department of Health 2023. Statewide Complaints Management Framework – DoH Wide Framework [Online]. [Accessed 9 April 2024].
[4] Department of Health South Australia 2020. Open Disclosure Policy [Online]. [Accessed 16 April 2024].
[5] Medical Board: Ahpra 2020. Good medical practice: a code of conduct for doctors in Australia [Online]. [Accessed 16 April 2024].
[6] Australian Commission on Safety and Quality in Health Care 2020. Review: Implementation of the Australia Open Disclosure Framework: Final consultation report [Online]. [Accessed 9 April 2024].
[7] Department of Health 2023. Patient Incident Management and Open Disclosure Policy Directive [Online]. [Accessed 15 April 2024].
[8] Aged Care Quality Commission. Aged Care Open Disclosure Framework and Guidance [Online]. [Accessed 14 April 2024].
[9] Australian Commission on Quality and Safety in Health Care 2013. Australian Open Disclosure Framework: Better communication, a better way to care. ACSQHC: Sydney.
[10] Australian Commission on Safety and Quality in Health Care 2021. National Safety and Quality Health Service Standards: Action 1.12 [Online]. [Accessed 17 April 2024].
[11] Centre for Health Care Strategies 2024. Trauma Informed Care Resource Centre [Online]. [Accessed 12 April 2024].

Key definitions

- **Apology** – means an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter, which does not contain an admission of fault in connection with the matter.[12]
- **Open Disclosure** – is an open discussion with a patient, children and young person, carer, and support person(s), regarding an adverse event that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences, and the steps taken to manage the event and prevent recurrence.[13]
- **Clinician Disclosure**[14] – is the initial, informal process that is required, optimally within 24 hours, whenever a patient, child or young person has been harmed as a result of receiving healthcare treatment or care. The discussion can occur at the point-of-care between the clinician and the patient, child or young person, carer, family and/or support person with consideration given to confidentiality.
- **Formal Open Disclosure** – is a structured process that follows on from the clinician disclosure, to ensure effective communications between the patient and/or their family, carer or support person, the senior clinician and the health service occur in a timely manner. The formal process might involve a number of meetings.[4]
- **Restorative Just Culture** – is an approach with the aim to repair damaged relationships following a harm event by building trust and confidence in a restorative manner. It recognises the needs of the workforce, patients, children, young people, carers, families and support person(s), in a holistic view, with shared decision-making, and develops a culture of respect.[15]
- **Serious Safety Events** – are defined under the DoH Policy on Safety Event Management and include Severity Assessment Code (SAC) 1, SAC 2, the Australian Sentinel Events List[16], and other reportable events under legislation, national agreements, including those reportable to the Chief Psychiatrist.
- **Trauma-Informed Care (TIC)** – refers to a range of interventions that acknowledge the need for health care practitioners to consider trauma in a patient, child or young person's healthcare presentation. TIC aims to recognise how trauma impacts on their lives and their mental health support needs. TIC also prioritises the wellbeing and health of the workforce by acknowledging and supporting staff experiencing secondary trauma in the workplace.[17]

Policy Principles

This policy is based on the following eight principles of the *Australian Open Disclosure Framework*[18]:

1 **Open and timely communication**: The patient, child or young person, carer and support person(s) must be provided with information about what happened following unexpected healthcare outcomes, harm and/or safeguarding concerns as soon as practicable, using an honest, factual explanation of what occurred in a language that is understood. Open disclosure can take place over one or more discussions.

[12] *Civil Liability Act 2002 (7(3))*
[13] Australian Commission on Quality and Safety in Health Care 2013. Australian Open Disclosure Framework: Better communication, a better way to care. ACSQHC: Sydney.
[14] NSW Health. Clinician Disclosure [Online]. [Accessed 17 May 2024].
[15] Clinical Excellence Commission 2023. Co-developing a restorative just and learning culture [Online]. [Accessed 14 April 2024].
[16] Australian Commission on Safety and Quality in Health Care 2020. Australian Sentinel Events List (version 2) [Online]. [Accessed 15 April 2024].
[17] NSW Health 2022. What is trauma-informed care? [Online]. [Accessed 12 April 2024].
[18] Australian Commission on Quality and Safety in Health Care 2013. Australian Open Disclosure Framework: Better communication, a better way to care. ACSQHC: Sydney.

2 **Acknowledgement**: Health service areas are to acknowledge all unexpected healthcare outcomes, harm and/or safeguarding concerns to the patient, child or young person, carers, their family and/or substitute decision maker as soon as practicable and initiate open disclosure.

3 **Apology[19] or expression of regret**: As early as practicable, the patient, child or young person, carer, and support person(s) are to receive an expression of regret for any harm that resulted from an unexpected event. An expression of regret should include the words "I am sorry" or "we are sorry that this has happened". An expression of regret is not to contain speculative statements, admission of liability or apportioning of blame.[20]

4 **Supporting, and meeting the needs and expectations of patients, children and young people, carers, family, and support person(s)**: Health service areas are to fully inform the patient, child or and young person, carers, families and/or a substitute decision maker of the facts surrounding an unexpected event and its consequences. Empathy and respect are to be demonstrated, as well as ensuring there are support mechanisms[21] in place appropriate to their needs.

5 **Supporting, and meeting the needs and expectations of those providing health care**: Health service areas are to create a restorative, just and learning culture[22] in which the workforce, and those that receive care, are encouraged to be able to recognise and report unexpected healthcare outcomes, harm and/or safeguarding concerns.

Health service areas are also to put resources in place to support trauma informed care and avoid systems and processes that may lead to re-traumatisation. The workforce must be prepared for clinician disclosure and participation in formal open disclosure through training and education.

6 **Integrated clinical risk management and systems improvement**: A structured system-based method or approach is to be used to investigate unexpected healthcare outcomes, harm and/or safeguarding concerns that focuses on risk management and informs quality improvement.[23] Findings and their associated recommendations, must be designed to improve systems of care and be reviewed for their effectiveness.

7 **Good governance**: Open disclosure requires 'good' governance frameworks, and effective clinical risk management and quality improvement processes. Through these systems, unexpected healthcare outcomes, harm and/or safeguarding concerns are to be investigated and analysed to prevent them recurring. Good governance involves a system of accountability through a health service areas senior management, executive and governing body who are to ensure internal performance monitoring and reporting includes the evaluation of implemented quality improvements.

8 **Confidentiality**: Health service areas are to develop and monitor open disclosure guidance that is co-produced with patients, children and young people, carer, family, support person(s) and the workforce, which incorporates legislated privacy and confidentiality requirements, regulations, and includes reference to applicable Departmental policy directives including health records management.

[19] *Civil Liability Act 2002 (Tas)*
[20] Australian Commission on Safety and Quality in Health Care 2013. Saying sorry: A guide to apologising and expressing regret during open disclosure [Online]. [Accessed 14 April 2024].
[21] Department of Health 2023. Statewide Complaints Management Framework – DoH Wide Framework [Online]. [Accessed 9 April 2024].
[22] Clinical Excellence Commission 2023. Guide to Co-developing a Restorative Just and Learning Culture [Online]. [Accessed 14 April 2024].
[23] Department of Health 2023. Policy on Safety Event Management [Online]. [Accessed 13 April 2024].

Training

- Health service areas must ensure open disclosure education and training programs address the skills and knowledge required to prepare health practitioners and equip them to participate confidently in clinician disclosure, and for senior clinicians and other key personnel, formal open disclosure.
- The DoH will work in conjunction with health service areas to provide the resources to support open disclosure practice in accordance with the *Australian Open Disclosure Framework*[24], and actively promote the dissemination of information about open disclosure to all staff.

Measures

- Aligned to the Quality Governance Framework for Tasmania's Publicly Funded Health Services[25], health service areas must monitor the effectiveness of open disclosure processes and practices through the following core measures:

  1 100% of senior health practitioners who are required to lead formal open disclosure discussions have undertaken open disclosure skills-based training for professional development.

  2 100% of SAC 1 and SAC 2 patient, child and young person safety events, serious complaints[26], Sentinel Events[27], and other reportable events under legislation, national agreements, including those reportable to the Chief Psychiatrist have evidence of formal open disclosure within relevant corporate records and in the Safety Reporting and Learning System (SRLS).

  3 By June 30 2025 an annual open disclosure evaluation survey[28,29] is undertaken by health service areas on the open disclosure process in practice and tabled at the peak clinical governance/morbidity and mortality committee (*however named*) for monitoring of corrective or preventative action(s), and the evaluation of implemented quality improvements.

Audit

- This policy forms an internal control for the purposes of mitigating harm, loss or damage from breaches and failures of management systems across the DoH. To monitor the effectiveness of the policy requirements, an audit in accordance with the policy review timeframes will be undertaken and will involve the systematic collection of information across health service areas. The overall focus of this audit will be one of continuous improvement to Department activities.

[24] Australian Commission on Quality and Safety in Health Care 2013. Australian Open Disclosure Framework: Better communication, a better way to care. ACSQHC: Sydney.
[25] Department of Health 2023. Quality Governance Framework for Tasmania's Publicly Funded Health Services [Online]. [Accessed 12 April 2024].
[26] DoH Statewide Complaints Management Framework
[27] Australian Commission on Safety and Quality in Health Care 2020. Australian Sentinel Events List (version 2) [Online]. [Accessed 15 April 2024].
[28] Australian Commission on Safety and Quality in Health Care 2020. Patient, family, carer and support person evaluation survey template [Online]. [Accessed 14 April 2024].
[29] Australian Commission on Quality and Safety in Health Care 2013. Staff evaluation survey template [Online]. [Accessed 17 May 2024].

Roles and Responsibilities

- **All staff** within the DoH must be aware of and comply with the DoH Policy on Open Disclosure and foster an environment that facilitates open and effective communication, using trauma-informed language, showing compassion, empathy and validating and normalising the experiences of patients, children and young people, carer(s), families and support person(s).

  Health practitioners are to complete introductory eLearning open disclosure training specified by the health service area at the time of orientation.

- The **Secretary,** DoH is responsible to the Minister(s) of the day for the management of DoH risk, including integrated clinical risk management and systems improvement. The Secretary is ultimately accountable for the implementation of a governance framework to support performance monitoring and management across a number of components including achievement of strategic priorities and initiatives, quality and safety performance, achievement of accreditation and key performance indicators.[30]

  The **Health Executive (HE)** is responsible for ensuring that integrated risk management and systems improvement is managed effectively and is aligned with DoH strategic priorities, business objectives, legislative and regulatory requirements. The HE is to promote open disclosure as a core health service provider obligation through open disclosure performance measurement, evaluation and transparent reporting on shared learnings for quality improvement.

- The **Chief Medical Officer and Chief Psychiatrist (CMO and CP)** has responsibility for statewide clinical governance systems including facilitating a coordinated approach to patient safety and quality improvement. The CMO and CP (or delegate) will provide advice on clinical risk exposure related to relevant regulatory, legislative and statutory obligations.

- The **DoH Legal Unit (LU)** provides advice on legal and insurance obligations to the workforce[31], and will advise on large-scale open disclosure eg where multiple people are affected by the same harm event.

- **Executive Director of Clinical Governance (EDCG)** (however named) is responsible for promoting continuous quality improvement for the systems and processes required for effective implementation of the Policy on Open Disclosure.

  Local Management (LM) have an oversight and monitoring role regarding the implementation of the Policy on Open Disclosure. LM are to have integrated clinical governance, risk management, safety event/incident notification, and investigation systems and processes implemented, required by applicable regulatory requirements eg the Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards[32], Aged Care Quality Standards[33], and National Disability Insurance Scheme Practice Standards[34].

  LM are to maintain a restorative, just and learning culture[35] in which the workforce, and those that receive care, are encouraged to be able to recognise and report unexpected healthcare outcomes, harm and/or safeguarding concerns and have the capability to support trauma informed care and avoid systems and processes that may lead to re-traumatisation.

- The **Internal Audit (IA)** branch advises the **Audit and Risk Committee (ARC)** on the effectiveness of the Department's risk management controls. The DoH Policy on Open Disclosure

[30] Tasmanian Health Service Act 2018. Ministerial Charter [Online]. [Accessed 14 April 2024].
[31] *State Service Act 2000 (Tas)*
[32] Australian Commission on Safety and Quality in Health Care 2021. National Safety and Quality Health Service Standards [Online]. [Accessed 14 April 2024].
[33] Aged Care Commission. Aged Care Quality Standards [Online]. [Accessed 12 April 2024].
[34] National Disability Insurance Scheme. Practice Standards [Online]. [Accessed 17 April 2024].
[35] Clinical Excellence Commission 2023. Guide to Co-developing a Restorative Just and Learning Culture [Online]. [Accessed 14 April 2024].

forms a key preventative control subordinate to the DoH Quality Governance Framework for Tasmania's Publicly Funded Health Services.[36]

- **Group/Service/Professional Leads (G/S/P Leads)** are responsible for appointing clinical and/or non-clinical open disclosure leaders/advisors who can educate, advocate, mentor, build relationships and navigate between professions, units/departments and/or levels across health service areas and the Department, on open disclosure issues and practices.[37]

  G/S/P Leads are to monitor participation in skills-based open disclosure education and training as part of professional development programs.

  G/S/P Leads may be required to provide advice for specific circumstances including children and young people; patients with mental health conditions; patients with cognitive impairment; inter-facility transfers whereby the event had occurred elsewhere; and a protracted delay in identification of the event.

  Business Unit Managers are responsible for ensuring the workforce are prepared for clinician disclosure and participation in formal open disclosure and ensuring that when it is not possible for the most senior clinician responsible for the care of the patient, child or young person to be present, an appropriate senior clinical person who is trained in open disclosure processes is to lead the disclosure.

  Managers are to provide staff involved in the open disclosure process with access to assistance and support and with the information they need to fulfil the role required of them.

- **Statewide Complaints Oversight Management Unit (SCOMU)** are to provide reports on the effectiveness, appropriateness and patient centeredness (acceptability) of open disclosure practices for serious complaints to the peak governing body.

Related Documents/Legislation

- Australian Open Disclosure Framework 2013
- Australian Charter of Healthcare Rights 2020
- DoH Quality Governance Framework for Tasmania's Publicly Funded Health Services 2023
- DoH Policy on Safety Event Management P19/000032
- DoH Child Safety and Wellbeing Framework
- DoH Statewide Complaints Management Framework
- *Aged Care Act 1997*
- *Ambulance Service Act 1982*
- *Ambulance Service Amendment Act 2013*
- *Children, Young Persons and Their Families Act 1997*
- Charter of Aged Care Rights
- *Child and Youth Safe Organisations Act 2023*
- *Carers Recognition Act 2023*
- *Civil Liability Act 2002*

[36] Department of Health 2023. Quality Governance Framework for Tasmania's Publicly Funded Health Services [Online]. [Accessed 14 April 2024].
[37] Australian Commission on Safety and Quality in Health Care 2020. Review: Implementation of the Australian Open Disclosure Framework [Online]. [Accessed 14 April 2024].

- *Guardianship and Administration Act 1995*
- DoH Risk Management Framework 2022
- *Public Health Act 1997*
- *Health Act 1997*
- *Health Service Establishments Act 2006*
- *Health Service Establishments Regulations 2011*
- *National Disability Insurance Scheme Act 2013*
- *State Service Act 2000*
- *Tasmanian Health Service Act 2018*
- *Tasmanian Health Service Regulations 2018*