



THE **HADER** CLINIC
Corporate Policy

Open Disclosure Policy

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1 Policy Statement

In accordance with Regulation 62 of the Health Services (Health Service Establishments) Regulations 2024, this facility has adopted the following Open Disclosure Policy to ensure the quality and safety of health services provided to our clients.

This policy is:

- Documented in writing; and
- Published on our website for public access.

The policy includes clear processes for open discussion between our facility, the client, and the client's family and carers following any adverse event that results in harm to the client.

The proprietor and management are responsible for ensuring full implementation of this policy across the organisation.

2 Policy Rationale

To ensure transparent, timely, and compassionate communication with individuals (clients/patients), their families, and carers in the event of incidents or adverse events within our facility.

3 Policy Scope

Applies to all staff, contractors, and volunteers delivering clinical or support services.

4 Roles and Responsibilities

4.1 Clinical Board of Governance

- Ensure that The Hader Clinic provides safe, high-quality, and transparent clinical care, and that open disclosure is conducted in a way that meets legislative, ethical, and regulatory standards.
- Regularly review reports on adverse events and the number, type, and outcomes of open disclosure episodes.
- Monitor compliance with open disclosure procedures, timelines, and documentation standards.
- Ensure systems are in place for trend analysis, tracking of serious adverse events, and learning from clinical incidents.
- Promote an organisational culture that supports open communication, learning, and psychological safety for both patients and staff.
- Ensure that staff are supported when participating in open disclosure – and that the process is never punitive but constructive.
- Hold senior clinical and managerial leaders accountable for:
 - Proper implementation of open disclosure
 - Timely escalation of significant incidents
 - Transparent communication with patients and carers
- Oversee the organisation's compliance with external reporting obligations, including notifiable incidents and SAPSE events (Serious Adverse Patient Safety Events).
- Participate in or oversee post-incident reviews, root cause analyses, or morbidity and mortality reviews when major harm has occurred.
- Ensure that recommendations arising from open disclosure investigations are implemented, monitored, and evaluated for effectiveness.

4.2 Medical Advisory Committee (MAC)

- Ensure that medical practitioners comply with open disclosure requirements and clinical incident reporting obligations.
- Provide oversight of incidents involving medical staff or serious clinical risks.
- Review significant clinical incidents and advise on whether a formal open disclosure process is required.
- Escalate to external bodies or support statutory reporting if applicable (e.g. Duty of Candour, AHPRA, Coroner).
- Appoint or support the appointment of the most appropriate senior clinician to lead the open disclosure process (e.g., treating doctor, medical director).
- Ensure that medical staff involved in the incident are supported and participate in good faith.
- Endorse changes to clinical policies and procedures based on findings from open disclosure and investigation processes.
- Monitor practitioner performance related to adverse events and provide recommendations where practitioner conduct or competence is in question.

4.3 Medical Practitioners

- Participate in the open disclosure conversation when the adverse event involves their care or area of practice.
- Provide clear, factual explanations to the client and their family or carers.
- Offer an expression of regret or apology as per the open disclosure framework, using appropriate language without assigning blame or speculating.
- Ensure that accurate, objective notes are entered into the patient record regarding the adverse event and disclosure discussion.
- Participate in root cause analysis or incident reviews, if required.
- Contribute to learning and improvement strategies.
- Report adverse events in line with facility policies.
- Support a culture of safety and transparency within the clinical team.

4.4 Director of Nursing (DON)

- Ensure the open disclosure policy is implemented and followed
- Oversee the identification, assessment, and escalation of adverse events.
- Ensure timely and appropriate clinical care is provided post-incident.
- Participate in or appoint a clinical lead for open disclosure meetings
- Ensure clinical documentation reflects accurate and complete open disclosure records.
- Support communication with clients, families, and carers
- Review trends in adverse events and ensure learnings from incidents are acted upon in practice improvements and protocols.

4.5 Quality and Safety Manager

- Comply with mandatory reporting requirements for SAPSE and SDC.
- At quarterly intervals report compliance with SAPSE and SDC via the Health Collect portal.
- Review trends in adverse events and ensure learnings from incidents are acted upon in practice improvements and protocols.
- Ensure the open disclosure policy is up to date and complies with all legislative and regulatory requirements.
 - Integrate open disclosure into clinical risk management, incident reporting, and accreditation processes.
- Work with the clinical team to assess incidents and determine the appropriate level of open disclosure (e.g., informal vs formal).
 - Support classification of incidents (e.g., SAC rating or SAPSE trigger).
- Coordinate staff education and training on open disclosure and Duty of Candour.
 - Ensure all relevant staff are trained in communication, documentation, and trauma-informed approaches.
- Monitor compliance, evaluate open disclosure processes, and report performance to the Clinical Governance Committee.
 - Use findings from open disclosure events to inform quality improvement initiatives.

4.6 All staff

- Report adverse events immediately.
- Provide immediate clinical support to the patient post-incident.
- Support the open disclosure process if involved, or refer to senior staff.

5 Definitions

- 5.1 Adverse Event: Any incident resulting in harm, including near-misses.
- 5.2 Open Disclosure: Voluntary, compassionate communication for all harm events, guided by the Australian Framework.
- 5.3 Serious Adverse Patient Safety Event (SAPSE): Likely to result in serious harm or death—triggers Statutory Duty of Candour.
- 5.4 Statutory Duty of Candour (SDC): Legal obligation for SAPSEs, requiring apology, facts, response, and prevention plans within legislated timelines

6 Policy

6.1 Health Services (Health Service Establishments) Regulations 2024 (Victoria) Regulation 62

1. For the purpose of ensuring the quality and safety of health services provided at a health service establishment, the proprietor of a health service establishment must prepare an open disclosure policy in accordance with this regulation.
2. The open disclosure policy must be—
 - (a) documented in writing; and
 - (b) published on the health service establishment's website.
3. The open disclosure policy must include processes by which open discussion between the health service establishment and a patient and the patient's family and carers are to occur following any adverse event that results in harm to the patient.
4. The proprietor of a health service establishment must ensure that the open disclosure policy is implemented.

6.2 Categorisation of Events

The incident response will be determined by the effect, severity or consequence of the incident.

Lower-level responses : No lasting harm—manage via standard open disclosure.

Higher-level response: SAPSE: Serious harm—initiate SDC protocols.

6.2.1 Lower-level response

- Near misses and no-harm incidents
- No permanent injury
- No increased level of care (e.g. transfer to intensive care unit) required
- No, or minor, psychological or emotional distress

6.2.2 Higher-level response

- 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)
- Major psychological or emotional distress
- At the request of the patient

7 Principles of Open Disclosure

Based on the Australian framework and NSQHS requirements

7.1 Open and timely communication

- When something goes wrong, clients and their families or carers should be informed clearly, honestly, and as soon as possible.
- Open disclosure is an ongoing process where new information is shared as it becomes available.

7.2 Acknowledgement

- Any adverse event must be acknowledged quickly and respectfully.
- The Hader Clinic will let clients and families know that something has occurred and begin the open disclosure process without delay.

7.3 Apology or expression of regret

- Clients and families should receive a genuine apology or expression of regret as soon as possible after harm occurs.
- This should include clear words such as “I am sorry” or “We are sorry,” without placing blame, speculating, or making legal admissions.

7.4 Supporting, and meeting the needs and expectations of clients

Clients and their support networks have the right to:

- Be fully informed about what happened and the impacts
- Be treated with empathy, dignity, and respect
- Receive appropriate emotional, psychological, or practical support throughout the process

7.5 Supporting, and meeting the needs and expectations of those providing health care

The Hader Clinic will foster a culture where staff:

- Feel safe and are encouraged to report adverse events
- Are properly trained to take part in open disclosure
- Are supported throughout the process, both emotionally and professionally

7.6 Integrated clinical risk management and systems improvement

- All adverse events will be reviewed thoroughly, focusing on identifying risks and improving systems.
- Information gathered during open disclosure should feed into broader quality and safety initiatives to reduce future harm.

7.7 Good governance

- Strong governance structures are essential to ensure open disclosure is done well.
- Executives must support accountability, learning, and improvement by overseeing investigations and making sure changes are implemented and monitored.

7.8 Confidentiality

- Open disclosure must respect the privacy of clients and staff.
- Policies must align with privacy and health records laws, while still supporting honest and open communication.

8 Open Disclosure Procedure

Maintain clear, compassionate, and accurate verbal and written communication throughout the process

8.1 When to initiate Open Disclosure

- If a client experiences any adverse event that results in harm, an open disclosure process must begin.
- This includes clinical errors, medication issues, withdrawal complications, injury, psychological harm, or system failures.

8.2 Detecting and Assessing Incidents

- Identify adverse events using all available reporting systems or clinical observations
- Provide immediate care to the client to minimise further harm
- Evaluate the incident to determine the severity of harm and the appropriate level of response
- Offer immediate support to involved staff
- Initiate the appropriate response — from a basic to a formal level, depending on the event
- Notify relevant internal personnel and external authorities, as required
- Ensure strict confidentiality for both clients and staff involved

8.3 Signalling the Need for Open Disclosure

Acknowledge the adverse event to the client, their family or carers. include an apology or expression of regret

- In lower-level incidents, open disclosure may conclude at this stage
- If appropriate, escalate to a formal open disclosure process
- Collaborate with the client and their family or nominated contact to determine:
 - The level of formality for disclosure
 - The preferred time and location for the conversation
 - Who should attend the discussion
- Confirm these details in writing
- Provide a clear point of contact within the service for ongoing communication
- Avoid any speculation, assumptions, or assigning of blame

8.4 Preparing for open disclosure

- Organise a multidisciplinary meeting to plan the open disclosure conversation
- Identify appropriate team members who will be involved in the disclosure
- Nominate a lead clinician or facilitator, considering prior discussions with the patient or family
- Gather all relevant clinical and investigative information
- Ensure the client, family or carers have a dedicated contact person within The Hader Clinic

8.5 Engaging in open disclosure discussions

- Introduce everyone attending the meeting and explain their roles
- Offer a genuine and unprompted apology or expression of regret, using clear words such as “I am sorry” or “We are sorry”
- Provide a clear explanation of what is known about the incident
- Encourage the client and family to share their perspective, ask questions, and discuss how the event has impacted them
- Collaboratively develop and sign an open disclosure plan
- Assure the client and family they will be informed of the outcomes of any reviews or investigations, including any actions taken to improve care
- Offer appropriate emotional and practical support to both client and staff
- Where the event involved another service, include relevant staff from that service when possible
- Conduct additional meetings if needed to support communication and understanding

8.6 Providing Follow-up

- Ensure a senior clinician or manager follows up with the client and family, where appropriate
- Confirm and plan for the client's ongoing care
- Share findings from investigations and communicate what has been done to prevent future occurrences
- Offer the opportunity for the client or family to speak with another clinician about the incident and its handling

8.7 Completing the Process

- Finalise the open disclosure process by either reaching agreement on the outcome or offering an alternative approach
- Provide a closing communication, both verbally and in writing, including the results of any investigations
- Communicate the outcome of the disclosure and any relevant clinical details to other treating clinicians involved in the patient's care
- Ensure evaluation surveys or feedback forms are completed to review and improve the process

9 Documentation

- Keep the client's clinical record updated with all relevant clinical and disclosure information
- Record all stages of the open disclosure process in a consistent and timely manner
- Store any related documents in the client's clinical record, ensuring accessibility and confidentiality
- Provide copies of key documents to the client or their representative throughout the process, where appropriate

Record:

- The incident and harm assessment
- Who was involved in the disclosure
- What was said, when, and to whom
- Client/carer questions or concerns
- Store documentation securely in the client record and incident reporting system.

10 Statutory Duty of Candour

If an incident meets the threshold of a Serious Adverse Patient Safety Event (SAPSE) follow the Duty of Candour procedures as per Safer Care Victoria.

10.1 This includes:

- Formal apology
- Written explanation
- Review and outcome
- Offer of participation in the review
- Provision of findings

11 Education and training

- Staff are trained in open disclosure, communication, and just-culture principles
- Director of Nursing and Quality and Safety Manager will be trained in the Statutory Duty of Candour procedures.

12 [Legislation and Framework](#)

Health Services (Health Service Establishments) Regulations 2024 (Vic)
Health Legislation Amendment (Quality and Safety) Act 2022 (Vic)

Charter of Human Rights and Responsibilities Act 2006 (Vic)
Australian Open Disclosure Framework (National Safety and Quality Health Service [NSQHS] Standards)

13 [References](#)

14 [Australian Open Disclosure Framework](#)

15 [Victorian Duty of Candour Guidelines \(Safer Care Victoria\)](#)

16 [Related Policies and Procedures](#)

PL21121 Incident Reporting and Management Policy and Procedure (DRAFT)
PL18169 Clinical Governance Framework

[2. Additional Documents](#)

Victorian Duty of Candour Guidelines 2022.pdf

Adverse Patient Safety Events.pdf

Australian-Open-Disclosure-Framework-Feb-2014.pdf