Australian Government
Aged Care Quality and Safety Commission

Engage
Empower
Safeguard

Open disclosure
Framework and guidance

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Contents

Introduction

More than 1.3 million people receive aged care services in Australia. This includes residential care, home care and flexible care services. The community expects high quality aged care and services, with a focus on the consumer's experience and quality of life.

To deliver person centred-care service, providers need to listen to consumers to understand what is important to them. They can then base the planning, delivery and evaluation of care and services on an ongoing partnership with the consumer and those they choose to be involved.

Communication is central to this partnership. Providing timely information in a form and language that is understood helps consumers to exercise control, make informed choices and get the most out of their care and services. Honest, informed conversation with a consumer when something goes wrong that may have harmed or had the potential to harm the consumer is no different.

What is open disclosure?

Open disclosure is the open discussion that an aged care provider has with consumers when something goes wrong that has harmed or had the potential to cause harm to a consumer.

Open disclosure refers to the practice of communicating with a consumer when things go wrong, addressing any immediate needs or concerns and providing support, apologising and explaining the steps the provider has taken to prevent it happening again. Open disclosure may also involve the consumer's family, carers, and other support people and representatives when a consumer would like them to be involved.

Honest and timely disclosure to consumers is not only ethically, morally and professionally expected but also the first stage in promoting and fostering an environment and culture that, through honest discussion, encourages learning needed to improve care and services. As such, it underpins the organisational culture and behaviours needed for continuous learning and service improvement in partnership with consumers. Through improved transparency it enhances public trust in aged care services. [1, 2, 3, 4, 5, 6]

Open disclosure is not about a legal process or providers admitting fault. An apology to consumers is not considered to be an admission of fault or liability and is not considered in determining fault or liability. All Australian jurisdictions have enacted laws that are designed to protect statements of apology or regret made after 'incidents' from subsequent use in certain legal settings. [7] Further guidance on the legal aspects of apologising should be sought from relevant state and territory authorities.

The purpose of this document

The purpose of this document is firstly to provide a framework for continuous improvement of communication with consumers when things go wrong. Secondly, it aims to provide practical guidance to providers to support implementation of open disclosure practices.

This document is in two parts:

- **Part A** describes when open disclosure should be used, principles, elements and case studies of open disclosure, organisational enablers to promote open disclosure and the requirements of the Aged Care Quality Standards; and
- **Part B** provides practical guidance and tools to support providers to use open disclosure.

This guidance is not prescriptive in defining how providers should implement open disclosure in policies and procedures. Variation in policies and practice is to be expected and encouraged to facilitate adaption to local context and circumstances.

1 Lamb, R. "Open disclosure: the only approach to medical error." (2004): 3-5.

2 Iedema, Rick, et al. "Patients' and family members' experiences of open disclosure following adverse events." International Journal for Quality in Health Care 20.6 (2008): 421-432.

3 Manser, Tanja, and Sven Staender. "Aftermath of an adverse event: supporting health care professionals to meet patient expectations through open disclosure." Acta Anaesthesiologica Scandinavica 49.6 (2005): 728-734.

4 Iedema, Rick, et al. "The National Open Disclosure Pilot: evaluation of a policy implementation initiative." Medical Journal of Australia 188.7 (2008): 397-400.

5 Studdert, David M., Donella Piper, and Rick Iedema. "Legal aspects of open disclosure II: attitudes of health professionals—findings from a national survey." Medical Journal of Australia 193.6 (2010): 351-355.

6 Wagner, Laura M., et al. "Nurses' perceptions of error reporting and disclosure in nursing homes." Journal of nursing care quality 27.1 (2012): 63-69.

7 *Civil Law (Wrongs) Act 2002* in Australian Capital Territory; *Civil Liability Act 2002* in New South Wales; *Personal Injuries (Liabilities and Damages) Act 2003* in Northern Territory; *Civil Liability Act 2003* in Queensland; *Civil Liability Act 1936* in South Australia; *Civil Liability Act 2002* in Tasmania; *Wrongs Act 1958* in Victoria; *Civil Liability Act 2002* in Western Australia.

Open Disclosure and the Aged Care Quality Standards

Open disclosure is a requirement under the Aged Care Quality Standards.

There are two specific references to open disclosure in the Standards.
Standard 6: Feedback and Complaints, requires providers to use an open disclosure process when things go wrong.
Standard 8: Organisational governance, where clinical care is provided, organisations are required to have a Clinical Governance Framework which includes open disclosure.

More generally, a number of the Standards are applicable when considering the value of open disclosure. For example, open disclosure is relevant to the requirement that providers treat consumers with dignity and respect (under Standard 1), to undertake ongoing assessment and planning for care and services in partnership with the consumer (under Standard 2), and to effectively manage high-impact or high-prevalence risks associated with the care of each consumer (under Standard 3).

The Aged Care Quality and Safety Commission assesses service provider performance against requirements of the Quality Standards, including those related to open disclosure.

In doing so, it will seek to understand how providers have applied open disclosure in their service and how they have taken account of best practice guidance and implemented approaches relevant to the services they deliver. (Further information about this is outlined in Part A).

The Commission will consider evidence of open disclosure as a positive sign that the organisation has effective systems to identify and monitor risk and adverse events. It will also be seen that the organisation seeks to learn from such events to improve the quality of care and services for consumers.

Evidence of open disclosure also signals to the Commission the level of the provider's partnership and engagement with consumers to ensure their safety, health and wellbeing is at the centre of planning, delivering and evaluating their care.

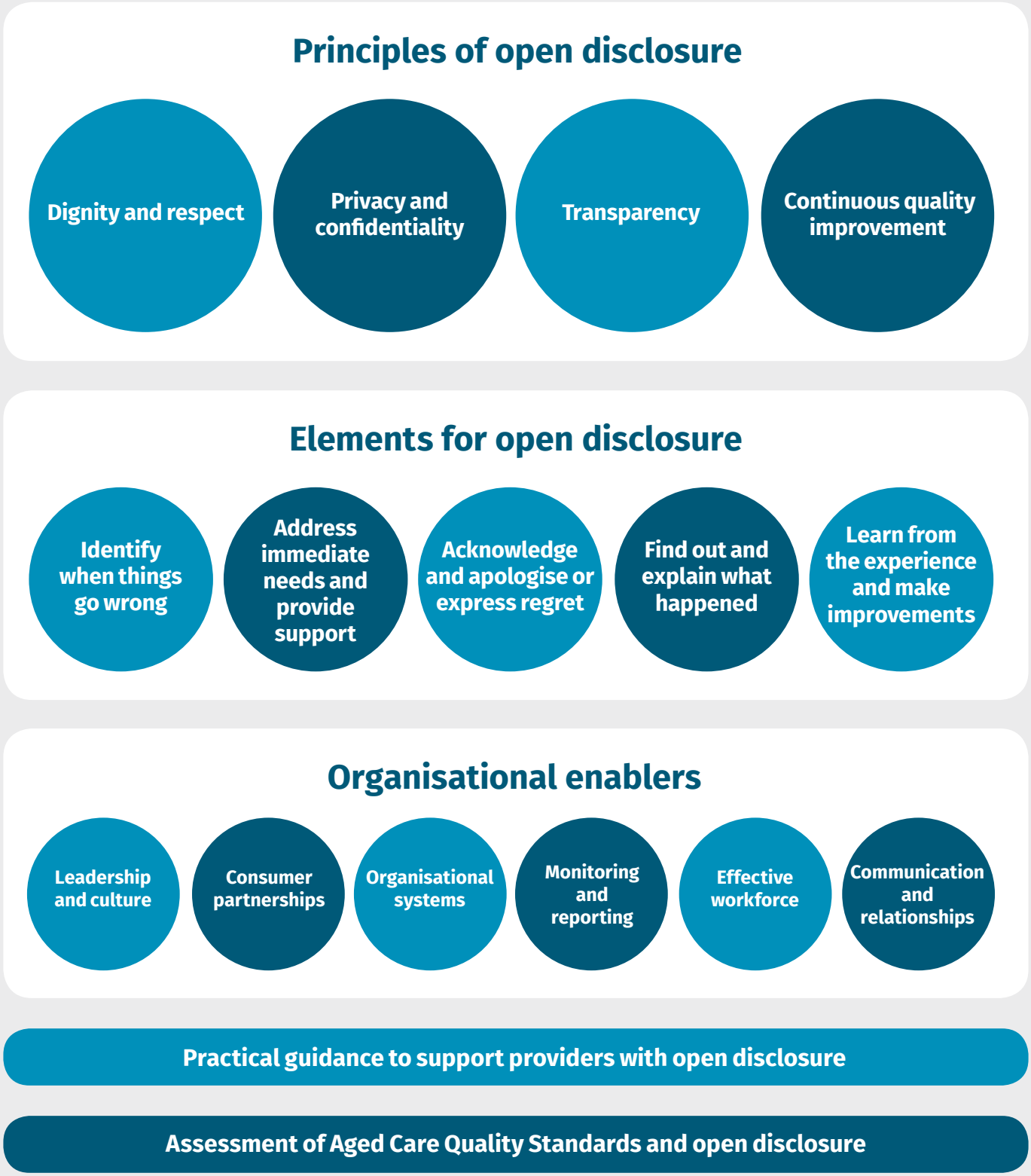
Part A: Open disclosure framework

This section describes when open disclosure should be used, the principles and elements of open disclosure, organisational enablers to promote open disclosure and the requirements under the Aged Care Quality Standards.

Figure 1 below illustrates the framework for open disclosure. It includes:

- Principles of open disclosure;
- Elements and case studies of open disclosure;
- Organisational enablers;
- Practical resources that will support providers to use open disclosure; and
- The Aged Care Quality Standards and open disclosure.

Figure 1: Framework for open disclosure



When should open disclosure be used

Providers should practise open disclosure when something has gone wrong that has caused harm or had the potential to cause harm to a consumer. Harm may be physical, psychological or social resulting in loss of quality of life, impairment, suffering, injury, disability or death. This is the definition of harm used in this guidance.

A provider may identify something has gone wrong through several channels:

- At the point of care delivery for individual consumers where service staff have identified that something has gone wrong with the delivery of care and services;
- At the level of managing risks systematically in the organisation, monitoring care outcomes by senior managers such as incident reporting and management, quality reviews and monitoring quality indicators;
- Through established consumer feedback mechanisms and engagement with families and consumer advocates;
- Through self-assessment and continuous improvement processes; or
- Through external reviews of systems and processes for quality and safety (for example findings of the Aged Care Quality and Safety Commission performance assessment against Quality Standards).

This guidance has been developed to support providers to practise open disclosure when something has gone wrong. The principles of open disclosure described in this document are also relevant for providers when responding to complaints relating as to a consumer's experience of the care and services they receive. The Commission has published a Better Practice Guide to Complaints Handling[8] to support aged care providers in handling complaints. The Best Practice Guide to Complaints Handling complements this guidance.

Some examples of the breadth of circumstances in which open disclosure could be used are in Figure 2.

8 Aged Care Quality and Safety Commission. Better Practice Guide to Complaint Handling in Aged Care Services, 2019

Figure 2: Examples of circumstances in which open disclosure could be used

Principles

Four principles underpin open disclosure in aged care. They are linked to the Charter of Aged Care Rights, which articulate consumer rights and what consumers can expect from an aged care service.

Figure 3: Principles of open disclosure

Dignity and respect

Open disclosure is underpinned by recognising each consumer's right to be treated with dignity and respect. This is essential to each person's sense of self and supports quality of life.

It means communicating respectfully and recognising and respecting a consumer's individuality in all aspects of care and services. It means providing timely information in a form and language that is understood to help consumers to exercise control, make informed choices, and get the most from their care and services.

When something goes wrong that may have harmed or had the potential to harm the consumer, they need to know this, understand how it affects them, and have a say in addressing the issue (such as making changes to their care).

Particular attention should be given to how best to communicate with consumers with diverse backgrounds when something has gone wrong with their care or services. This should be done in a way that is culturally safe and builds their trust and confidence that the service will work with them to address the area of actual or potential harm and focus on improving outcomes for them.

Privacy and confidentiality

The consumer's privacy must be maintained consistent with privacy law and the consumer's wishes. A discussion with the consumer and /or their representative can determine what information they are comfortable to have shared – and with whom. This should be done before any personal information is shared about something that has gone wrong.

It is important to clarify the extent of information that can be shared with others at the service. If the consumer does not wish to be identified and does not grant permission to share specific details, providers must determine how and what information can be communicated without breaching the consumer's privacy and confidentiality.

This statement is an example of transparency, while protecting consumer privacy:

"The service is investigating an unexpected equipment failure during a routine manual handling procedure that resulted in harm to a consumer. While our focus is caring for the consumer and protecting their privacy, we are also working diligently to determine if other equipment may be affected and implement measures to prevent its reoccurrence."

Transparency

Consumers need three key pieces of information communicated to them when harm or potential harm – a 'near miss – has occurred as a result of their care and services. First, they need to know what happened and understand what immediate action has been taken to address the harm to themselves, second, they need to know what changes will be made to decrease the likelihood that such an event will happen again; and third, they need an apology.

It is important that providers identify who is affected by actual or potential harm, be honest, open and transparent about what happened, and be prepared to communicate proactively at a level appropriate to the severity of the impact. This may mean communicating more broadly to consumers of a service, for example, when there has been an instance of food poisoning.

Consumer trust and confidence in the service is eroded if a provider is slow to respond or perceived to be attempting to cover up circumstances of actual or potential harm. This reduces the likelihood of early resolution with the consumer and problem solving in partnership to address the risk of recurrence. It increases the likelihood of escalating complaints and external criticism of the service.

Continuous quality improvement

Open disclosure is an important part of quality improvement. An organisation with a culture of learning and continuous improvement will place a high value on monitoring, analysing and reporting information about the quality and safety of care and services. This means information gained through practising open disclosure is seen as an opportunity to identify where things have gone wrong, to understand why – through active inquiry – to understand any systemic causes, and to take positive steps to prevent such an event from happening again.

Elements of open disclosure

There are five main elements of open disclosure. They are illustrated in Figure 4 and detailed further below.

These elements are not intended to occur in a particular order; nor will all be used in all circumstances. Variation in how open disclosure is used is to be expected and encouraged. This is to facilitate adaption to local context and circumstances surrounding what happened.

Case studies are also included in this document as examples of some circumstances in which open disclosure has been used.

Figure 4: Five elements for open disclosure

Identify when things go wrong

Practising open disclosure begins with identifying when something has gone wrong that has harmed or had the potential to cause harm to a consumer.

A provider could identify something has gone wrong through a range of channels:

- By a consumer, their family, carers, other support people and representatives;
- By a staff member;
- Through an internal complaints process;
- Through an internal quality review;
- Through an incident management system; or
- By the Commission as part of a complaint or a quality assessment process.

A culture where people feel supported and are encouraged to raise concerns when something has gone wrong will support open disclosure. It is demonstrated by how the service is conducted, how staff feel comfortable to speak up when something has gone wrong, and know what to do, how management responds to these situations, and whether people at the service see action taken as a result. The service culture is very influential and will be evident to consumers and their family, carers, other support people and representatives, as well as staff members.

Case study 1

Mr Lee made a complaint to the service manager of his residential aged care home after being left in his wheelchair. Sitting for extended periods in the wheelchair causes Mr Lee painful muscle cramps and lower back pain. It was the second time it had happened that week. Mr Lee had requested assistance to be transferred out of his wheelchair when returning to his room from lunch, but his care worker was busy assisting someone else and didn't assist him.

How open disclosure was used

Ms Dawson, the service manager, met with Mr Lee and talked through what had happened. Mr Lee explained what happened and Ms Dawson apologised for his experience. She said she would investigate the situation further and would update him when more information was available. Ms Dawson asked Mr Lee whether he would like his son to be contacted and to be made aware of what had happened or would like any further support. Mr Lee said he would like his son to be involved.

Ms Dawson scheduled a meeting with all care staff to discuss what had happened and identify what changes could be made to rostering and procedures to prevent the situation from happening again.

A follow up meeting was organised with Mr Lee and his son after Ms Dawson had gathered further information. She explained the rostering problems that had led to staff not being available to assist Mr Lee. He and his son were given information about the changes that had been made to the rosters to prevent the situation from happening again. They told Ms Dawson that they were happy with the explanation provided and Ms Dawson advised that she would follow up with them in a month to ensure there were no further concerns.

Address immediate needs and provide support

Following identification that something has gone wrong take immediate action to address any actual or potential harm. This should include ensuring that adverse effects arising from what went wrong are ameliorated and future potential harm is prevented.

Practical and emotional support should then be provided and based on the needs and preferences of the individuals involved.

Practical and emotional support may include:

- Identifying additional clinical care needs required of the consumer;
- Facilitating access to an advocate, translation services or other communication and hearing support services;
- Appropriately involving family, carers, other support people and representatives who have been appointed to act or make decisions on a consumer's behalf in the process;
- Supporting access to alternative, external complaints handling options; or
- Offering and, when required, providing support to and management of staff members involved.

Providers must protect a consumer's privacy and confidentiality. This includes asking consumers whether they would like a family member or other nominated support person to be involved in the process. If the consumer wishes to involve others, they can be involved from the outset to give appropriate support to the consumer and to help with understanding how the matter has affected or may have affected the consumer.

Case study 2

Mrs Brown fell out of a sling while being hoisted into her bed. Her fall was broken by a care worker. She sustained an injury to her right foot with immediate pain and inability to bear weight. A staff member involved notified the registered nurse on duty and later lodged an incident report.

How open disclosure was used

The nurse on duty asked Mrs Brown and the staff members involved whether they were okay and conducted a clinical assessment of Mrs Brown. One of the care workers was referred for medical assessment. A GP was contacted and attended Mrs Brown after bruising was found on her right foot. Mrs Brown's sister, her next of kin, was also notified of the incident, in line with the wishes expressed by Mrs Brown.

The nurse on duty met with staff members to offer support and care, understand what had happened and assess what could be learnt from the situation. A teleconference was organised with Mrs Brown, her sister and the staff members involved that afternoon. The nurse in charge apologised for what had happened and offered Mrs Brown the opportunity to describe what had happened and how it had affected her.

A subsequent meeting was organised with Mrs Brown and her sister following the completion of an internal investigation of the incident. Information was provided about why the fall had occurred. The nurse in charge explained that as follow-up actions, the hoist was inspected, and staff had received additional training on using the hoist for transfers. Mrs Brown and her sister were happy with the service's response.

Acknowledge and apologise or express regret

Acknowledging and apologising or expressing regret when things go wrong is part of open disclosure. It is not about saying someone is at fault. Open disclosure may occur over the course of several discussions.

As early as possible, providers should:

- Acknowledge the concerns of a consumer;
- Provide a sincere and unprompted apology or expression of regret for harm or grievance caused. An apology or expression of regret should include the words 'I am sorry' or 'we are sorry'; and
- Follow up with the consumer to ensure they understand the acknowledgement or expression of regret.

Providing information about what has happened and communicating with consumers in a way that they are able to understand may include:

- involving family members proposed by the consumer;
- facilitating access to a consumer advocate;
- involving a cultural or community group to which the consumer belongs;
- using appropriate translation services; or
- using other assistance services where communication or hearing support is needed.

Communication works best when roles and responsibilities for communicating with consumers as part of this process are clearly defined within the organisation. The individual leading the communication would usually be the most senior staff member involved in the care of the consumer.

Case study 3

Ms Osorio receives assistance with cleaning her apartment from a local provider. However, the employee who cleans her apartment often ignores her cleaning requests, what areas she needs cleaned and how she would prefer the cleaning to be done. On one occasion she was told, "to shut up and stop being picky". Ms Osorio often feels humiliated and hurt by the way in which the employee speaks to her. Ms Osorio did not want to make a fuss and instead asked for a different staff member to provide her cleaning services. When the new employee started, he spoke with Ms Osorio who shared the details of what had happened. Ms Osorio gave permission for her concerns about the individual employee to be passed on to the supervisor so that they knew the reasoning behind Ms Osorio's request.

How open disclosure was used

The service manager called Ms Osorio to apologise and asked what had happened. Ms Osorio explained her concerns, including that she felt humiliated by the way the employee spoke to her.

The service manager undertook to talk to the employee about her concerns and to get back to Ms Osorio within a week. She also facilitated access to a consumer advocate from Ms Osorio's cultural community who visited Ms Osorio and discussed the incident. The service manager contacted Ms Osorio to let her know she had investigated her concerns and while (for privacy reasons) she couldn't provide information on specific actions taken with the employee, assured Ms Osorio that her concerns had been actioned. The service manager explained that all employees had undertaken training on how to respond to concerns. Ms Osorio was happy with the steps the service manager had taken and said she felt more comfortable in raising concerns in the future. The service manager then followed up with Ms Osorio a month later to seek feedback on the service.

Find out and explain what happened

It is important for a provider to gather all necessary information to find out and understand what has happened if something has gone wrong. The required inquiry and analysis can be done in different ways, depending on the nature and scale of the harm.

It will involve information being sought from consumers and/or families and staff affected by the incident to help inform these questions:

- What happened?
- Why did it happen? and
- How can it be prevented from occurring again?

This is not a process to apportion blame; it is designed for learning and understanding how to improve outcomes for consumers.

Key steps to communicate with the consumer include:

- A factual explanation of what happened is provided in a way that ensures the consumer understands the information;
- A consumer is offered an opportunity to tell their story, explain how this has affected them, provide their views and ask questions. It is important these views and concerns are listened to, understood and considered;
- A consumer is offered follow-up meetings and support. They are assured they will be given any further information gathered or findings and recommendations made as part of evaluating what happened; and
- In line with existing requirements related to record keeping, the provider documents the process and keeps a record of conversations and outcomes, as appropriate.

Case study 4

Ms Goodwill has advanced dementia that has impacted on her ability to communicate; her family is only able to visit once a month as they live interstate, so they are not always able to raise concerns on her behalf.

How open disclosure was used

The service through its auditing process identified that Ms Goodwill had lost three kilos over the month and no action had been taken as would have been expected by the service's policies and procedures. While it was quickly identified by the service there was no immediate impact to Ms Goodwill's health and wellbeing, it was treated as a 'near miss'.

The service notified Ms Goodwill's family, apologised and a commitment made to investigate and provide transparent and timely feedback on how the incident occurred. Ms Goodwill's sister advised the service that when she visited, she noticed her sister didn't like the food and sometimes she needed help to eat and it was not provided. The open disclosure to the family assisted the provider's investigation and resulted in Ms Goodwill's family being involved in menu selection, the requirement for meals not eaten to be recorded and analysed once a week by the management team.

Learn from the experience and make improvements

Open disclosure gives providers the opportunity to learn, to find and act on things they could improve about their current systems, practice or culture. Practising open disclosure will foster a culture of learning and quality and safety.

In some cases, despite best efforts, things go wrong for the consumer. Open disclosure can be used in a positive way to engage with consumers. Providers can learn from these experiences and identify ways in which they can improve outcomes for consumers. Through open disclosure, staff members and consumers can be actively involved in the continuous improvement of practice and be given the opportunity to provide feedback to inform continuous improvement of the service.

When a provider identifies that something has gone wrong, they should also monitor, analyse and use information gathered during open disclosure to try to prevent what has happened from occurring again and to improve the quality of care and services.

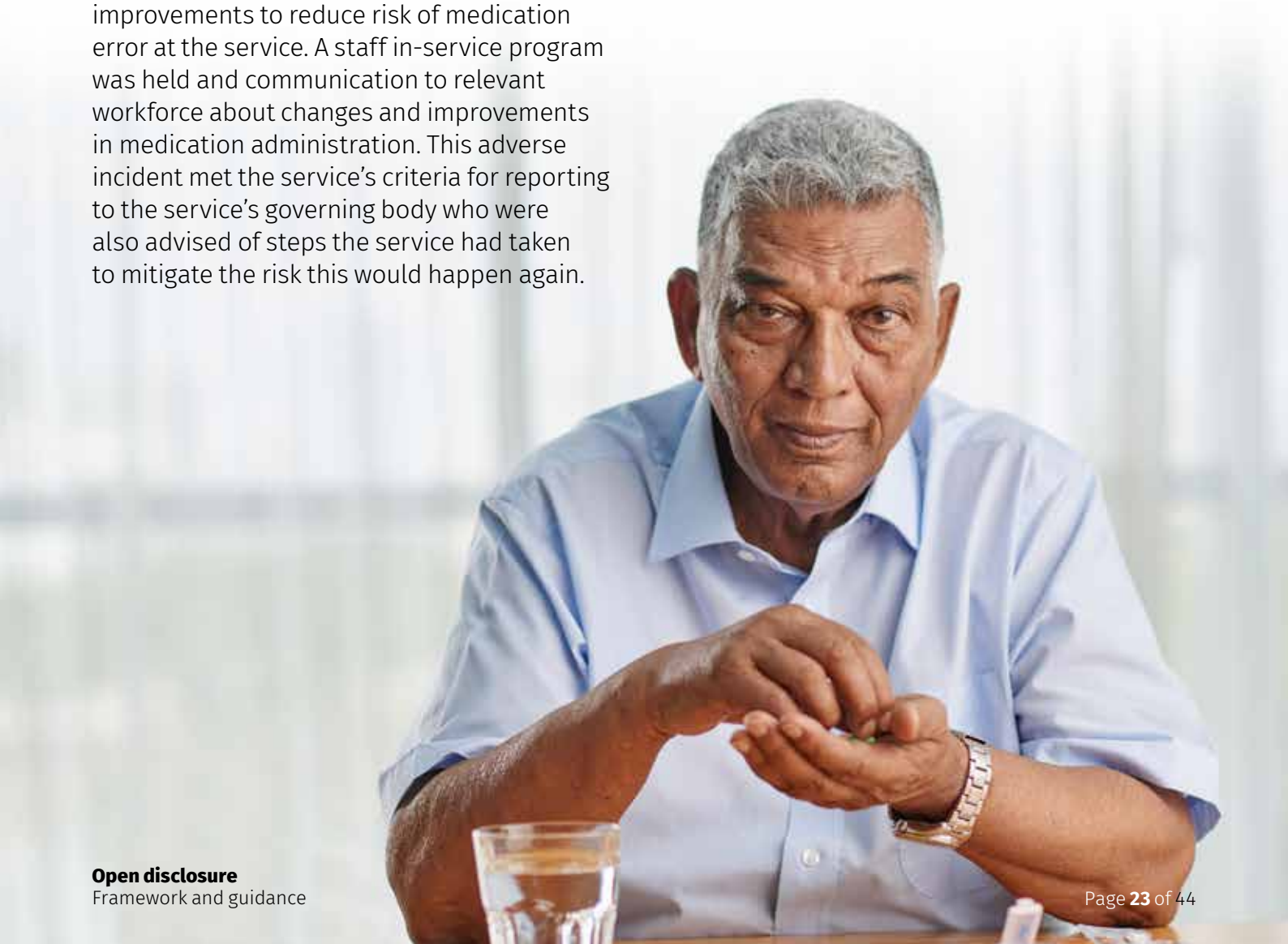
Case study 5

Mr Gupta was a new resident at the residential aged care home. On his second day there, the nurse who makes the medication rounds administered medications not intended for him. One of the incorrect medications had a serious adverse effect on his blood pressure and Mr Gupta was hospitalised for treatment. The service responded to this incident in line with incident management requirements and created a record of the incident detailing the event and service response.

How open disclosure was used

A professional review of medication management was done, with the medication competencies for staff checked to ensure their skills assessments were up to date. This resulted in some systematic improvements to reduce risk of medication error at the service. A staff in-service program was held and communication to relevant workforce about changes and improvements in medication administration. This adverse incident met the service's criteria for reporting to the service's governing body who were also advised of steps the service had taken to mitigate the risk this would happen again.

Following his transfer back to the residential aged care home, the service manager discussed the incident with Mr Gupta who asked that his son be involved and that a translator be used for the discussion. The service manager arranged a meeting, explained what had happened and apologised for the incident. She explained the steps the service had taken to ensure medication administration was being completed appropriately and assured Mr Gupta and his son about the steps taken to prevent the incident from happening again. Mr Gupta and his son were happy with the explanation provided and agreed that the steps taken would help reduce the risk of the incident being repeated.



Organisational enablers

Open disclosure is an integral part of organisational governance. To enable effective open disclosure including clinical governance, an organisation needs to have strong clinical governance arrangements in place.

Clinical governance is an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms. They are implemented to support good clinical care and clinical outcomes for each aged care consumer.

Systematic action is needed across six areas to establish effective clinical governance; action in these areas also enables organisations to implement open disclosure and contributes to better outcomes for consumers and providers.

The six enablers are:

- Leadership and culture;
- Consumer partnerships;
- Organisational systems;
- Monitoring and reporting;
- Effective workforce; and
- Communication and relationships.

Leadership and culture

Strong leadership is critical for effective use of open disclosure. Leaders are responsible for promoting a culture of safe, inclusive and quality care and services that is embedded in all aspects of organisational life and owned by everyone.

Leaders need to model and promote openness when things go wrong so that people feel supported and are encouraged to identify and raise issues and concerns.

Leaders demonstrate the provider's commitment to learning from the experience and making improvements. This includes ensuring appropriate policies, procedures and practices are in place, are working as intended, and are centred on involving consumers in deciding how care and services are provided.

Leaders need to understand the legal aspects of open disclosure, including that an apology or expression of regret does not admit fault or imply blame.

Consumer partnerships

Partnerships with consumers are the foundation of effective open disclosure. Partnerships are based on mutual trust and respect within a culture that supports open communication and learning.

Consumers need to be supported and encouraged to raise concerns when something has gone wrong. Their needs and preferences should guide any support that is provided as part of the open disclosure process, including the involvement of family, carers and other support people and representatives. Open and respectful communication helps to build partnerships and is part of effective open disclosure.

Consumers can also be actively involved in the improvements that can occur after something has gone wrong. Open disclosure processes with individual consumers can identify areas for quality improvement, and a partnership approach can be taken as these improvements are implemented.

Organisational systems

A systematic approach is needed to ensure instances of harm or potential harm to consumers are consistently identified, and that open disclosure is practised appropriately. Providers need to ensure that policies, processes and procedures that support effective open disclosure are built into the way an organisation operates, particularly its governance, risk management and improvement systems.

Providers need to have systems and processes that support reporting of incidents, review of complaints and feedback, and enable suitable responses to be actioned and documented. Systems and processes also need to ensure that communication occurs effectively, and consumers receive the support and information they need.

These systems help to ensure that consumers and their families, carers, other support people and representatives and staff members can engage with open disclosure effectively and for providers to respond appropriately and continuously improve.

Monitoring and reporting

Ongoing monitoring and review processes are important to understand the effectiveness of open disclosure, outcomes for consumers, and to identify any areas for improvement. Open disclosure is part of the organisation's broader focus on clinical quality and safety performance that needs to be monitored and reported regularly to the provider's governing body.

Consumers, family, carers and other support people and representatives can be given the opportunity to provide feedback on the open disclosure process. Based on the circumstances of the open disclosure process, sensitivity around how this is conducted would be required.

Any changes implemented following open disclosure should be monitored for their effectiveness. Information about the outcomes of quality improvements can be given to the consumer, their family and carers.

Effective workforce

Effective open disclosure relies on the provider's workforce, and, where relevant, visiting practitioners.

Clear roles and responsibilities need to be described for a provider's governing body, executive, the workforce, consumers and their family, carers, other support people and representatives about open disclosure.

Learning and development for all staff enables providers to apply a consistent and informed approach to open disclosure. Providers need to ensure staff are equipped with the training and resources required to use open disclosure successfully according to their role.

This may include education on how to communicate confidently with consumers and their representatives, and how to tailor communication to the consumer's needs and preferences.

Training staff in effectively communicating with consumers will ensure consumers are engaged throughout the open disclosure process and feel supported to talk about their experience. Providers need to ensure that staff know how to identify and raise concerns when something goes wrong, and to provide support to a consumer during open disclosure conversations.

Communication and relationships

Communication underpins effective open disclosure. It is also linked to each of the other enablers. Good communication processes are needed to establish the culture of openness, partnership and learning that supports open disclosure. Organisational processes and staff training are needed to ensure consistently good communication. Good record keeping systems are needed to ensure that information about open disclosure is recorded.

In addition to communication processes within an organisation, external communication and relationships are also important for open disclosure. Aged care services are part of a broader network of aged care and health organisations from which consumers may receive care and services. Visiting practitioners may need to be involved in open disclosure processes if they have provided care to consumers where there has been harm or the potential for harm. In accordance with the wishes of the consumer, it may also be appropriate to communicate with external providers about what has occurred.

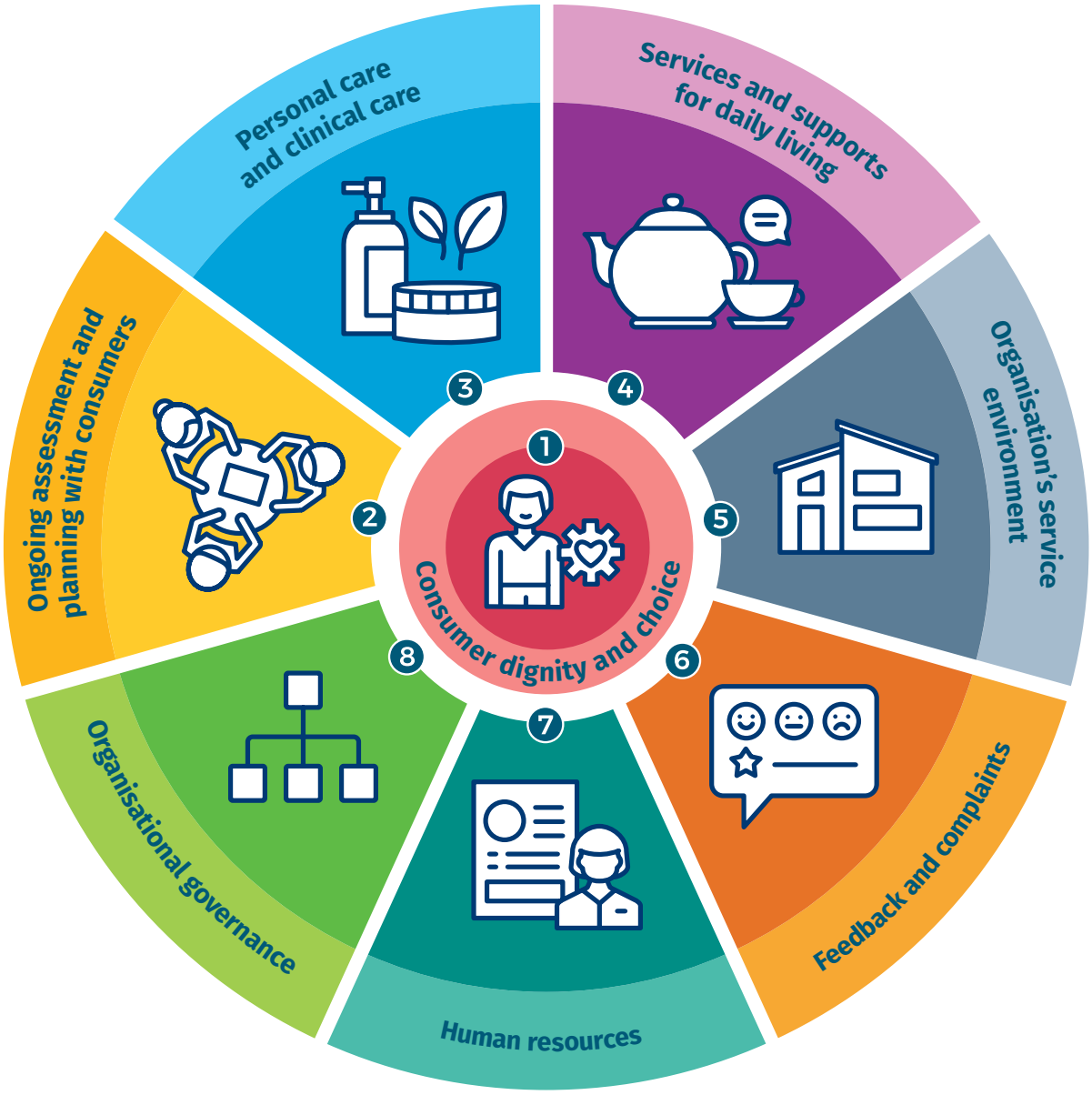
Aged Care Standards and open disclosure

The Aged Care Quality Standards focus on outcomes for consumers. They reflect the level of care and services the community can expect from providers of Australian Government-subsidised aged care services.

The Standards include requirements for providers in relation to open disclosure. These requirements are primarily contained in four of the Standards, outlined in Table 1.

Table 1: A service can demonstrate its approach to open disclosure under the following requirements of the Aged Care Quality Standards.

Aged Care Quality Standard	Open disclosure requirement
Standard 1 Consumer dignity and choice, requirements: 1 (3) (a), (b), (c), (d), (e) and (f)	Providers are required to demonstrate each consumer is treated with dignity, with their identity, culture and diversity valued.
Standard 3 Personal and clinical care, requirement: 3 (3) (b)	Providers are required to demonstrate effective management of high-impact or high-prevalence risks associated with care of each consumer.
Standard 6 Feedback and complaints, requirement: 6 (3) (c)	Organisations are required to demonstrate they use an open disclosure process when things go wrong.
Standard 8 Organisational governance, requirement: 8 (3) (e)	Where clinical care is provided, organisations are required to demonstrate they have a clinical governance framework that includes open disclosure.



Under the Standards, providers are required to treat consumers with dignity and respect in all aspects of care and services, including when something goes wrong. They are required to demonstrate how they have used an open disclosure process in response to matters requiring an acknowledgement and apology when a mistake has been made.

Providers should have systems in place to support open disclosure, including systems for communicating with consumers when harm has been caused or where there is the potential for harm – 'a near miss'. Providers should have systems to listen to consumers and families, understand their experience of what happened, and be able to explain the steps the provider has taken to prevent it happening again.

The Commission's approach to open disclosure during performance assessment

During an assessment of a provider's performance against the Standards, the Commission will seek to understand how the provider has applied open disclosure in their service and how they have taken account of best practice guidance and implemented approaches relevant to the services they deliver.

During an assessment of a provider's performance against the Standards, the Commission will seek to understand how the provider has applied open disclosure in their service and how they have taken account of best practice guidance and implemented approaches relevant to the services they deliver.

Assessment of open disclosure under the Standards will be primarily derived from evidence collected from observations, interviews and documentation reviewed during the site visit. It will also draw upon information from sources such as the provider's self-assessment, consumers, complaints received and information from the Department of Health.

During an assessment, evidence will be sought of how providers are embedding and supporting a culture of learning from mistakes into their service delivery. They will assess how the service demonstrates that it:

- Understands the requirements of open disclosure;
- Applies this, and it is evident in the way that care is provided to consumers;
- Monitors how the requirements are being applied and the outcomes achieved for consumers; and
- Reviews outcomes and adjusts practice based on review (continuous improvement).

For example, quality assessors may ask for:

- Consumer feedback on open disclosure;
- Examples of matters where an open disclosure process was followed;
- Information about the circumstances of the matter to understand what happened;
- What the consumer and their representatives sought by way of apology or rectification;
- Information on how the service communicated with the consumer and their representatives;
- What changes or strategies have been implemented and the outcomes for consumers;
- Feedback from the consumer and representative, if applicable, on the implemented changes or strategies;
- The lessons learned and how these feed into the plan for continuous improvement; or
- The types of complaints and agreed improvements when working with the Commission to resolve complaints.

For example, when consumers make a complaint, some will approach the Commission because they have unresolved concerns or complaints about the service or the provider. Complaints officers may consider the performance of a provider in relation to open disclosure, where relevant, when helping resolve a complaint. This will be an input into the assessment and monitoring functions.

The regulatory approach of the Commission recognises that in any organisation, care and services may sometimes go wrong. In instances where potential or actual harm occurs to a consumer, the Commission will expect to see how open disclosure has been applied. Organisations that appear to be slow in responding to consumers when something has gone wrong that could have resulted in harm or are perceived to be attempting to cover up such circumstances, and those that cannot demonstrate how they have learned from such events, will be subject to greater oversight from the regulator.

For further information on how providers are assessed against the Aged Care Quality Standards visit the Commission's website at **agedcarequality.gov.au/providers/assessment-processes**

Part B: Practical guidance for providers

Practising open disclosure is communicating with a consumer when things go wrong.

It is listening to their experience of what has happened, apologising and explaining any immediate actions the provider has taken in relation to the consumer's experience, as well as the steps the provider has taken to prevent it happening again. This may also involve the consumer's family, carers, other support people and representatives when a consumer would like them to be involved.

This is the second part of guidance developed for providers of aged care services.

- **Part A** describes when open disclosure should be used, principles, elements and case studies of open disclosure, organisational enablers to promote open disclosure and the requirements of the Aged Care Quality Standards.
- **Part B** provides practical guidance to support providers to use open disclosure.

This includes:

- An open disclosure planning tool to help providers measure their performance against open disclosure elements and requirements under the Aged Care Quality Standards;
- Guidance on how to say sorry and communicate with consumers; and
- Guidance on communicating with family members.

Open disclosure planning tool

This tool is intended to help providers to measure their performance against the open disclosure elements and requirements under the Aged Care Quality Standards.

It does not replace a provider's Continuous Improvement Plan. It is one of many tools and guidance that a provider should use to identify opportunities for improvement. It includes reflective questions and examples of actions and evidence from the guidance material on the Aged Care Quality Standards[9] that providers can use to demonstrate they have met the elements of open disclosure.

Identify when things go wrong

Reflective questions for providers to consider:

- Do consumers and their family, carers, other support people and representatives feel encouraged and supported to raise concerns when something has gone wrong?
- Do consumers and their family, carers, other support people and representatives understand the multiple ways they can raise concerns when something has gone wrong? Do these options meet the needs and preferences of consumers?
- Do staff members understand how to raise concerns when something goes wrong, and feel comfortable and safe in doing so?
- What systems, policies and procedures are in place to identify when things go wrong?

Examples of actions and evidence

- Resources and/or information materials have been developed for consumers and their family, carers, other support people and representatives and staff members that outline how to raise concerns when something has gone wrong.
- Staff members, consumers and their family, carers, other support people and representatives say they know how to raise concerns when something has gone wrong, feel comfortable and safe and are encouraged to do so.
- The provider has systems, policies and procedures in place to identify when things go wrong and detail how to respond to quality concerns or complaints, including those identified by the Commission or other external parties.

9 Aged Care Quality and Safety Commission (2019), 'Guidance and Resources for Providers to support the Aged Care Quality Standards', available at < https://www.agedcarequality.gov.au/sites/default/files/media/Aged%20Care%20Quality%20Standards%201-8%20Guidance%20and%20Resources.pdf>.

Address immediate needs and provide support to the consumer and staff members

Reflective questions for providers to consider:

- Is prompt action always taken to address the immediate needs of the consumer or staff member adversely impacted by something going wrong?
- Do consumers and staff members feel supported when things go wrong?
- What strategies and communication aids are used to adapt communication to meet the diverse needs of consumers?
- Have you involved a consumer's family member or other nominated support person in the process when the consumer wanted them to be involved?
- Do staff members know how to access advocacy services, translation services and other communication and hearing support services for consumers? and
- Are staff members clear on their roles and responsibilities in relation to providing emotional and practical support?

Examples of actions and evidence

- Records show consumers and staff members have received prompt and appropriate clinical care and support that meets their needs and preferences when required.
- Consumers say their family, carers, other support people and representatives are recognised and involved when they want them to be, and say they are provided with access to advocacy, translation services and communication tools when required.
- All staff members are trained in and know how to access support for a consumer and to adapt their communication to meet the diverse needs of consumers.
- The provider has clear assessment processes in place that identify the support that consumers need when something goes wrong.
- The provider has policies and procedures in place that describe how a provider protects the privacy and confidentiality of consumers and staff members.
- The provider has systems, policies and procedures in place that provide guidance to staff members on how to respond when things go wrong and describe what supports a consumer may require and how to access them.

Acknowledge and apologise or express regret

Reflective questions for providers to consider:

- Are your staff members clear on their roles, responsibilities and timeframes when communicating with consumers? and
- Have you acknowledged what happened and provided an apology or expression of regret in a timely manner?

Examples of actions and evidence

- Consumers say they always receive an apology or expression of regret when things go wrong, and they are treated with dignity and respect throughout the process.
- Staff members responsible for communicating to consumers during open disclosure are trained in doing so.
- The provider has policies and procedures in place that describe the roles and responsibilities of staff members involved in open disclosure. They include timeframes for communicating with a consumer. Additionally, the most senior staff member involved in a person's care is designated as responsible for communicating with a consumer, where possible.

Find out and explain what happened

Reflective questions for providers to consider:

- Do you seek to understand what has happened? Are there sources of expertise available when necessary to investigate and analyse when something has gone wrong?
- Does the consumer understand what happened?
- Was an explanation provided as early as possible?
- Have staff members offered the consumer an opportunity to tell their story, to explain how this has affected them, to provide their views and to ask questions?
- Has the consumer been offered follow-up meetings or support? and
- Has the consumer been offered advice on how to raise further issues?

Examples of actions and evidence

- Consumers say they were provided an explanation of what happened and offered the opportunity to tell their story, explain how this has affected them and to provide their views and to ask questions.
- Staff members understand and are trained in how to effectively engage and communicate with all consumers to ensure their experience and views are documented.
- The provider has policies and procedures in place that describe how to investigate and analyse when something has gone wrong and how to provide that information to consumers as part of open disclosure.

Learn from the experience and make improvements

Reflective questions for providers to consider:

- Are consumers and their family, carers, other support people and representatives (based on the wishes of the consumer) and your staff members involved in reviewing information and finding solutions to improve care and services?
- Are staff members and consumers involved in finding solutions and providing input into continuous improvement processes?
- What have you done to promote and support a culture of learning? What have you done to implement and sustain the changes needed in care and services from lessons learned?
- How do you monitor, analyse and use information gathered when something has gone wrong to improve the quality of care and services? and
- How is the governing body made aware of outcomes and learnings from open disclosure?

Examples of actions and evidence

- When things go wrong, consumers and staff members say they were provided with any findings, can describe what has been done to respond and say the provider has taken steps to make sure the same thing does not happen again.
- The provider's continuous improvement plan describes an approach to learning from open disclosure.
- Outcomes from open disclosure are reported to the provider's governing body as part of a provider's strategic plan.
- The provider's policies and procedures show how the provider asks for feedback from and engages directly with consumers and their family, carers, other support people and representatives (based on the wishes of the consumer) and staff members about how satisfied they were with open disclosure.

Communicating with consumers

How do I word an apology or express regret?

The exact wording and phrasing of an apology or expression of regret will vary in each circumstance. The following points should be considered:

- The words 'I am sorry' or 'we are sorry' should be included;
- The individual leading the discussion on behalf of the provider should, where possible, be the most senior staff member involved in the care of the consumer;
- Sincerity is the key element. The effectiveness of an apology or expression of regret depends on the way it is delivered, including the tone of voice, as well as non-verbal communication;
- The apology or expression of regret should make clear what is regretted or being apologised for, and what is being done to address the situation; and
- An apology or expression of regret is essential in helping a consumer and staff members involved in their recovery.

What else will help me to engage with the consumer?

A consumer should be offered an opportunity to tell their story, explain how this has affected them and provide their views and ask questions of you. You can demonstrate that you have actively listened to what they are telling you by saying back to the consumer, in your own words, what they have told you. The staff member delivering the apology and expression of regret, and others present, should be aware of non-verbal gestures or prompts they are providing, for example, body language.

Apply individual strategies and communication aids to adapt your communication to meet the specific needs of consumers. Consider what other support can be offered. These could include access advocacy services, translation services and other communication and hearing support services.

What should I be careful not to do?

Apologies that are vague, passive or conditional are not going to be satisfactory to the consumer and won't provide an assurance that the service is genuine in its efforts to understand and address the matter. For example," We're sorry ...but the mistake certainly didn't change the outcome..."

Certain phrases should be avoided during an apology or expression of regret. This is to ensure that there is no direct or implied blame of other staff members or the provider. For example, "'It's all my/our/his/her fault...' or 'I am liable', or 'I was/we were negligent...'

Avoid speculative statements. If all the facts are not yet known it is better to provide information about the process and what you are doing to understand what went wrong. The conversation can include assurance about when you can return with further information. Perhaps there are specific questions the consumer would like answered that you can include in your inquiry about what went wrong.

Communicating with family members

Who should I involve in open disclosure?

Consumers have a right to control what personal information is recorded and with whom it is subsequently shared. To ensure there is not a breach of privacy or confidentiality, seek consent from a consumer if you are disclosing information to a family member or carer. Where a consumer is capable of making decisions, only the consumer can consent to information being disclosed to a support person. The process should enable a person who requires decision-making support to make, and/or communicate, decisions about their care and who is involved.[10]

What if the consumer does not have capacity to make decisions?

If a consumer does not have capacity, an 'authorised representative' has the authority to nominate who receives information and should be involved in the open disclosure process. The authorised representative may be a legal guardian, or an attorney appointed under an enduring power of attorney. It cannot be assumed that the person named in an order or power of attorney has the legal right to act in all circumstances on behalf of the consumer. The authorised representative may also be a support person nominated by the consumer, prior to their loss of capacity, to receive information.

When considering the capacity of a consumer to make decisions, providers should always respect and consider the needs and preferences of the consumer, and consider shared decision making. This involves integrating the consumer's values, goals and concerns with best available evidence about the risks and benefits of their care.[11]

10 Supported Decision Making in Aged Care. A Policy Development Guideline for Aged Care Providers in Australia https://cdpc.sydney.edu.au/wp-content/uploads/2019/06/SDM-Policy-Guidelines.pdf

11 Australian Commission on Safety and Quality in Health Care, 'Shared Decision Making', https://www.safetyandquality.gov.au/our-work/shared-decision-making/.

At what stage should I involve an identified representative?

When it has been identified that a consumer would like their family, carers, other support people and representatives involved in open disclosure, they should be involved from the outset so they can give appropriate support to the consumer.

What if there is conflict between a consumer and their family during open disclosure?

In cases of a conflict, such as between family and partners or friends about who should receive information, the consumer's wishes take precedence. Providers need to comply with relevant law and policy frameworks that safeguard persons who may require decision-making support, including preventing abuse and undue influence.

When a representative is appointed to make decisions for a person who requires decision-making support, the representative should be directed by the will, preferences and rights of the person. That is, they should do whatever they can to support the person to make their own decision, or if this is not possible, use a 'substituted judgement' approach (motivated) by 'what the person would have wanted' had they been able to make the decision themselves).[12]

12 Supported Decision Making in Aged Care. A Policy Development Guideline for Aged Care Providers in Australia https://cdpc.sydney.edu.au/wp-content/uploads/2019/06/SDM-Policy-Guidelines.pdf

Case study 6

Mr Matthews was a resident at ABC nursing home for several years. He was transferred to hospital one night due to a sudden deterioration in his health. The service attempted to contact his next of kin and discovered that they did not have accurate information. So, the family first learned of his hospitalisation from the hospital was the following morning. His family was distressed. They complained to the manager of the service that had been provided this information that they had not been informed about his deterioration in health or his transfer to hospital.

How open disclosure was used

The service manager met with Mr Matthews' children to discuss the issue and their concerns. She apologised to the family and acknowledged that the family finding out about Mr Matthews' admission to hospital from the hospital should not have happened. She acknowledged the service needed to maintain accurate records to be able to contact family in a timely way. She undertook to find out what had happened and to report back to the family.

After speaking with her staff, the service manager held a follow up meeting with Mr Matthews' children. She again apologised for the lack of information provided to the family at a difficult time. She explained the service had reviewed all residents' records and its clerical processes to ensure records were accurate and up to date on next-of-kin information so that this would not occur again. The staff involved asked the service manager to pass on their apologies to Mr Matthews' children.

Mr Matthews' children were happy with the information provided by the service manager and thanked her and her staff for the prompt response to their concerns. The children were happy with the steps taken by the service manager to ensure this behaviour was not repeated for other families.

Appendix A: Key terms

Clinical Governance

Clinical governance is an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms that are implemented to support good clinical care and good outcomes for each aged care consumer.

Consumer

Consumer means a person to whom an organisation provides or is to provide care through an aged care service.

Continuous improvement

Continuous improvement is a systematic, ongoing effort to raise an organisation's performance in achieving outcomes for consumers under the Aged Care Quality Standards. Continuous improvement:

- Responds to the needs and feedback of consumers;
- Supports the workforce to improve and innovate in providing safe and quality care and services; and
- Can address practices, process or outputs to achieve a desired outcome.

Commission

Aged Care Quality and Safety Commission.

Harm

Harm may be physical, psychological or social resulting in loss of quality of life, impairment, suffering, injury, disability or death.

Open disclosure

Open disclosure is the open discussion that a provider of care or services has with consumers when things go wrong that have harmed or had the potential to cause harm to a consumer. This may also involve the consumer's family, carers and other support people, when a consumer would like them to be involved. It involves an expression of regret by the provider and a factual explanation of what happened, the actual and potential consequences and what steps are being taken to manage this and prevent it happening again.

Organisation, provider or service provider

This guidance material applies to organisations (or service providers) providing:

- Residential care;
- Home care;
- Flexible care, including innovative care services, Multi-Purpose Services (in line with the spirit and, intent of the Standards), National Aboriginal and Torres Strait Islander Flexible Aged Care Program and Short Term Restorative Care and Transition Care; and
- Commonwealth Home Support Program.

Representative

A consumer representative includes:

- A person appointed under relevant legislation to act or make decisions on behalf of a consumer; or
- A person the consumer nominates to be told about matters affecting the consumer.

Supported decision-making

The process of enabling a person who requires decision-making support to make, and/or communicate, decisions about their own life. The decision-making is supported, but the decision is theirs.

Workforce

A member of the workforce is anyone the organisation employs, hires, retains or contracts (directly or through an employment or recruitment agency) to provide care and services, maintenance or administration, under the control of the organisation. It also includes volunteers who provide care and services for the organisation.

Appendix B: Resources and references

The following resources and references may assist providers with open disclosure:

- NSW Health Open Disclosure Policy, NSW Health
- Open disclosure framework, Department of Health and Human Services (Vic)
- Australian Open Disclosure Framework, Australian Commission on Safety and Quality in Health Care
- Australian Open Disclosure Framework resources for clinicians and health care providers, Australian Commission on Safety and Quality in Health Care
- Patient incident management and open disclosure Policy Directive, SA Health
- Open Disclosure Handbook, Clinical Excellence Commission
- Better Practice Guide to Complaints Handling in Aged Care Services, Aged Care Quality and Safety Commission
- Supported Decision Making in Aged Care. A Policy Development Guideline for Aged Care Providers in Australia https://cdpc.sydney.edu.au/wp-content/uploads/2019/06/SDM-Policy-Guidelines.pdf

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