POLICY	OPEN DISCLOSURE	
THE BAYS	**Category:**	Organisational
	Person responsible:	Director of Clinical Services
	Approved by:	Clinical Practice & Medical Advisory Committees
	Scope:	Acute

1. PURPOSE

The purpose of this policy is to provide a clear, consistent, and patient-centred approach to open disclosure following clinical incidents that result in, or have the potential to result in, patient harm. This policy ensures compliance with the Victorian Statutory Duty of Candour by supporting open, honest, and timely communication with patients, families, and carers.

2. SCOPE

This policy applies to all employees, contractors, and credentialed clinicians of The Bays Healthcare Group who are involved in, or become aware of, a clinical incident, particularly those resulting in actual or potential patient harm

This policy applies to:

- SAC1 and SAC2 clinical incidents (Sentinel and Serious events), which require a formal high level open disclosure response
- Less severe adverse events (SAC3 or SAC4)**,** where a low level open disclosure response is considered appropriate
- All patients, families, and carers affected by such incidents

3. DEFINITIONS

Open disclosure - An open discussion with a patient and/or their support person about an incident that resulted in harm during healthcare delivery.

Adverse event - An incident in which harm resulted to a person receiving health care.

Patient Safety Incident: An event or circumstance that could have or did lead to unintended or unnecessary harm to a patient.

Serious Harm: Harm that is more than negligible, including permanent harm, increased length of stay, or significant escalation of care.

Statutory Duty of Candour -A legal obligation requiring health services to disclose certain patient safety incidents that result in serious harm or death.

4. POLICY

The Bays Healthcare Group is committed to open disclosure following any incident that results in harm, or has the potential to result in harm, to a patient. Open disclosure will be conducted in a respectful, compassionate, and patient-centred manner, consistent with the principles of the Victorian Open Disclosure Framework.

5. LEVELS OF OPEN DISCLOSURE

Open disclosure at The Bays is delivered through a two level response, depending on the severity and the impact of the incident:

Low level open disclosure response - A briefer open disclosure process, usually in response to incidents resulting in no permanent injury, requiring no increased level of care (e.g. transfer to operating theatre or high dependency unit), and resulting in no, or minor, psychological or emotional distress (e.g. near misses and no-harm incidents).

High level open disclosure response - A comprehensive open disclosure process usually in response to an incident resulting in death or major permanent loss of function, permanent or considerable lessening of body function, significant escalation of care or major change in clinical management.

A higher-level response may also be instigated at the request of the patient even if the outcome of the adverse event is not as severe.

6. EXECUTIVE NOTIFICATION AND INVOLVEMENT

The Director of Clinical Services (DCS) and/or Chief Executive Officer (CEO) must be notified of all clinical incidents and will participate in all high-level open disclosure discussions, in collaboration with Visiting Medical Officers (VMOs), and with the patient and/or their family or carers.

7. PRINCIPLES OF COMMUNICATION

Open disclosure is guided by the following principles:

- **Open and honest communication -** Transparency with patients when an adverse event occurs. This includes explaining what happened in a clear, timely, and truthful way.
- **Acknowledgement and apology** - Patients should receive a genuine acknowledgement of the incident, including an apology where appropriate. This is about empathy—not admitting legal liability.
- **Patient-centred approach -** Communication should focus on the needs of the patient, their family, and carers. They should be treated with respect, compassion, and involved in discussions.
- **Timeliness -** Disclosure should happen as soon as reasonably possible after the incident, not delayed unnecessarily.
- **Support for patients, families, and staff -** Both those affected by the incident and the healthcare staff involved should be offered appropriate support (emotional, psychological, practical).
- **Learning and improvement -** Health services should use incidents as opportunities to learn, improve systems, and reduce the risk of similar events happening again.
- **Documentation and governance -**The disclosure process should be properly documented and aligned with organisational policies, ensuring accountability and consistency.

8. REFERENCES

NSQHS National Safety and Quality Health Service Standards – Second edition

Standard 1: Clinical Governance
Standard 2: Partnering with Consumers

Australian Open Disclosure Framework, Better communication a better way to care, Australian Commission on Safety and Quality in Health Care, Canberra: Commonwealth of Australia, 2014

Key differences and changes between the OD Framework and OD standard, Australian Commission on Safety and Quality in Health Care, Canberra: Commonwealth of Australia, 2013

Hospitals, following an adverse event in Health Care, Australian Council for Safety and Quality in Health Care, Canberra: Commonwealth of Australia, 2003

Open Disclosure for Victorian health services: a guide book, DHS, Melbourne, Victoria, 2008

Open Disclosure Flow Chart for Healthcare Consumers, Australian Commission on Safety and Quality in Health Care website http://www.safetyandquality.gov.au/wp-content/uploads/2013/05/A3-Open-Disclosure-Flow-Chart-Consumers-May-2013.pdf