OPEN DISCLOSURE POLICY

***Policy Statement*:**

The organisation is committed to cultivating a culture where residents, families, staff, and other stakeholders feel safe, supported, and encouraged to raise concerns. We actively promote open communication that is transparent, timely, consultative, and responsive.

When incidents occur, we are committed to accepting responsibility, providing clear and accurate information, and offering a genuine apology or expression of regret. Our approach to open disclosure ensures communication is delivered respectfully, in a culturally safe and inclusive manner, so that residents and their supporters feel heard, valued, and involved in decision-making about their care.

We encourage and expect all stakeholders to report incidents without fear of blame or retribution, focusing on a culture of learning, staff development, and continuous improvement. This approach strengthens trust, promotes accountability, and drives ongoing enhancement of the safety and quality of care we provide.

The organisation delivers Open Disclosure in accordance with the Aged Care Act 2024 (Cth), the Strengthened Aged Care Quality Standards (2025), and the Serious Incident Response Scheme (Rules 2024), ensuring communication is culturally safe, trauma-informed, and accessible to all residents and their supporters.

1 Open Disclosure

Open Disclosure gives practical effect to the Statement of Rights (Aged Care Act 2024), including the rights to open communication, to be heard, to make complaints without reprisal, and to receive information in an accessible way.

Open Disclosure refers to the open, honest, and timely communication between aged care providers, residents, their supporters and staff when something goes wrong with the care or services provided.

Open Disclosure involves:

- Acknowledging the incident, particularly if it caused harm or had the potential to cause harm
- Explaining clearly and respectfully what occurred.
- Apologising or expressing regret where appropriate.
- Describing the actions being taken to address the issue and prevent recurrence.
- Engaging the resident and/or their family in discussions about resolution and future care planning.
- Ensuring all communication is culturally safe, inclusive, and delivered in a way the resident can understand (e.g., using plain language, interpreters, or translated materials if required).

The purpose of Open Disclosure is to:

- Promote transparency and trust between residents, families, and providers.
- Support resident dignity, rights, and cultural needs under the Aged Care Act and Statement of Rights.
- Foster a learning culture that uses incidents to improve the quality and safety of care.

Open Disclosure is not a legal process and does not mean the provider is admitting fault or liability. Its purpose is to promote honest communication, not to assign blame. In Australia, laws exist to protect statements of apology or regret made during Open Disclosure from being used against a provider in certain legal or disciplinary proceedings.

This ensures that those involved can speak openly and respectfully without fear that their words will automatically be taken as an admission of fault. Open Disclosure occurs alongside, and does not replace, mandatory notifications such as the Serious Incident Response Scheme (SIRS) where applicable.

2 IDENTIFYING WHEN CARE OR SERVICES GO WRONG

Recognising when something has gone wrong is the first step in ensuring the safety, wellbeing, and rights of residents. The organisation is committed to identifying issues promptly through multiple sources of information and feedback. This proactive approach ensures that risks are addressed early, residents are supported, and opportunities for learning and improvement are acted upon. The following outlines the key ways the organisation may become aware that care or services have not met expected standards.

Feedback and incident information will be communicated and recorded in a manner the person can understand, using interpreters, translated materials, or communication aids where required.

Feedback

- Comments, concerns, or suggestions shared verbally, in writing, or via surveys.
- Feedback during meetings, care conferences, or daily interactions.

Complaints

- Internal complaints raised by residents, their supporters, staff, or visitors.
- External complaints referred from the Aged Care Quality and Safety Commission, advocacy services, or other agencies.

Incident Reporting

- Staff reporting incidents, near misses, or hazards through the organisation's incident management system.
- Clinical incidents such as falls, medication errors, pressure injuries, or unexpected health events.

Staff Observations

- Frontline staff noticing changes in a resident's wellbeing, environment, or care outcomes.
- Escalation of concerns by care workers, nurses, or allied health professionals.

Audits and Monitoring

- Results of internal audits, accreditation assessments, and quality reviews.
- Data from key risk indicators such as infection rates, medication errors, and use of restrictive practices.

Resident Outcomes and Clinical Indicators

- Monitoring of clinical outcomes (e.g., unplanned weight loss, falls, hospital transfers).
- Tracking trends in health and safety incidents.

External Feedback

- Coroner's findings, hospital discharge summaries, or GP reports (provided as an example not an exhaustive list).
- Advice and or findings from regulators, peak bodies, or professional associations.

3 ELEMENTS OF OPEN DISCLOSURE

Flexibility of Approach: These elements are not intended to occur in a strict order, and not all elements will be necessary in every situation. The process may be adapted to suit the local context, the resident's preferences, cultural considerations, and the specific circumstances of the event.

Acknowledgement of the Incident

- Recognising and reporting that an adverse event, near miss, or harm has occurred.
- Acknowledgement should be timely and genuine.

Truthful, Clear Communication

- Providing a clear, factual explanation of what happened, in a respectful and compassionate manner.
- Using plain language and, where required, interpreters, cultural brokers, or translated materials to ensure understanding.

Apology or Expression of Regret

- Offering a sincere apology or statement of regret.
- Ensure the apology is genuine, culturally appropriate and consistent with applicable 'apology protection' laws, noting that a statement of apology or regret is not, by itself, an admission of liability.

Supporting the Resident and Family

- Providing emotional support and reassurance.
- Offering access to advocacy, counselling, or cultural/spiritual supports where appropriate.

Explanation of Next Steps

- Outlining what actions will be taken to investigate the event and prevent recurrence.
- Involving the resident and/or their supporter in discussions and decisions about ongoing care and resolution.
- Residents are supported to make decisions about their participation in Open Disclosure in line with supported-decision-making principles and the Statement of Rights.

Ongoing Communication

- Keeping the resident and family informed throughout the process.
- Sharing investigation outcomes and quality improvement actions taken.

Documentation and System Learning

- Recording the open disclosure discussion and agreed actions.
- Using the incident as an opportunity for organisational learning and quality improvement.

4 IMPLEMENTATION OF ELEMENTS

The organisation and its workforce are committed to implementing the elements of Open Disclosure in a way that is person-centred, culturally safe, trauma-informed, and communicated in clear, accessible language so that residents, their families, and supporters including those with cognitive, sensory or language barriers can fully understand and actively participate in the process.

When an incident or complaint occurs, the organisation will take timely, person-centred action to protect the safety and wellbeing of everyone involved. Acknowledgements will be given as soon as possible and in a private, safe environment that respects dignity.

Addressing Immediate Needs and Providing Support
The organisation will:

- Act promptly to stabilise the situation, remove or mitigate immediate risks, and prevent further harm.
- Ensure actions are culturally safe, trauma-informed, and respectful of the resident's preferences, dignity, and choices.
- Provide emotional and practical support, which may include:
    - Identifying and addressing any additional clinical care needs or health risks.
    - Facilitating access to advocates, interpreters, translators, communication aids, and hearing support services.
    - Supporting access to external complaints resolution bodies or aged care advocacy services.
    - Offering psychological first aid, medical support, and debriefing to staff affected by the incident.
- Engage with the resident (and supporters, where appropriate) to ask how they wish to be involved in the Open Disclosure process, including who should be present and their preferred communication method.
- Communicate clearly, sensitively, and in a way the resident can understand about what has happened and what immediate steps are being taken.
- Document all actions taken to ensure accountability, transparency, and to support follow-up care planning.
- Maintain the privacy and confidentiality of residents, supporters, and staff in accordance with Privacy Act 1988 and the organisation Privacy and Confidentiality Policy.
- Make required notifications under SIRS and other regulators (where applicable) in parallel with Open Disclosure and record the reference numbers within the incident record.

Acknowledging and Apologising
The organisation will:

- Promptly acknowledge the resident's concern or incident as soon as it becomes known.
- Provide a genuine, person-centred apology or expression of regret that is culturally safe, trauma-informed, and respectful.
- Ensure the apology focuses on the impact of the event on the resident, not just the facts.
- Communicate in a way the resident (and their supporters, where appropriate) can understand.
- Document the acknowledgement and apology in accordance with organisational requirements.

Finding Out and Explaining What Happened
The organisation is committed to investigating concerns and incidents with openness, respect, and fairness. This process will be culturally safe, trauma-informed, person-centred, and carried out in a way that the resident (and supporters, where appropriate) can understand.

The organisation will:

- Conduct a timely and thorough investigation to establish what occurred, involving residents, staff, families, and relevant stakeholders as appropriate.
- Communicate findings clearly and respectfully, explaining in plain language:
  - What happened.
  - Why it happened, where this can be determined.
  - What actions are being taken to prevent a recurrence and improve care.
- Provide the resident with an opportunity to:
  - Share their story and how the event affected them.
  - Ask questions and receive clear, honest answers.
  - Express their preferences for how they wish to be kept updated.
- Offer follow-up meetings and ongoing emotional, clinical, or advocacy support as needed.
- Document the process comprehensively, in line with organisational policies, clinical governance requirements, and legislative obligations. Offer the resident (supporter) a written summary of the discussion and agreed actions, in plain language and, where needed, translated or Easy Read formats.
- Use the information gathered to inform continuous improvement activities, reducing the likelihood of similar incidents in the future.

Learning and Continuous Improvement

The organisation recognises that every incident, complaint, and piece of feedback provides an opportunity to improve the quality and safety of care. A focus on learning, rather than blame, helps create a just and learning culture where staff feel supported to report issues and residents feel confident that their voices lead to change.

The organisation will:

- Take timely and effective action to address identified opportunities for improvement and prevent recurrence.
- Review, maintain, and update the Continuous Improvement Plan to reflect learnings from incidents, near misses, complaints, and resident feedback (where appropriate)
- Involve residents, families, and staff in improvement activities, encouraging co-design of solutions where appropriate.
- Engage with residents and supporters to learn from their lived experience, share outcomes of improvement initiatives, and build transparency and trust.
- Report learnings to governance bodies to ensure oversight, accountability, and system-wide improvement.
- Embed improvements into policies, procedures, staff training, and daily practice, ensuring sustained change.

5 ORGANISATIONAL ENABLERS

To ensure Open Disclosure is meaningful, timely, culturally safe, trauma-informed, person-centred, and effective, the organisation will provide the following enablers:

Leadership Commitment

- Senior leaders and the governing body actively promote a culture of openness, learning, and psychological safety that respects diversity and individual rights.

- Open Disclosure is regularly reviewed through governance processes, risk management systems, and quality improvement reporting to ensure accountability and transparency.

Policies and Procedures

- A clear and up-to-date Open Disclosure Policy is maintained and regularly reviewed to reflect best practice, cultural safety, trauma-informed care, and the rights of residents.
- Procedures clearly define roles, responsibilities, escalation pathways, and how to communicate with residents (and their supporters) in a way they can understand.

Workforce Training and Support

- All staff receive education on Open Disclosure, person-centred communication, cultural safety, and trauma-informed care.
- Managers and clinicians are supported and trained to have sensitive conversations with empathy, respect, and clarity.
- Support systems (e.g., debriefing, Employee Assistance Program) are available for all staff involved in incidents, promoting psychological safety and wellbeing.

Resident Engagement

- Residents and supporters are informed about their rights, including the right to be involved when something goes wrong.
- Information is provided in accessible, culturally appropriate formats that take into account language, health literacy, and emotional needs.
- Residents (their supporters) are partners in decisions about their care and in improvement processes.
- Open Disclosure information and resources are available in plain-language and translated formats to support understanding, equity, and culturally safe access.

Systems for Reporting and Feedback

- Accessible incident reporting and complaints systems are in place and easy for staff, residents, and supporters to use.
- Incident records, Open Disclosure notes and outcomes are captured in the Incident Management System and linked to the Continuous Improvement Plan.
- Data is analysed for trends, and findings are communicated transparently to staff, residents, and supporters to support shared learning.

Resources and Time Allocation

- Managers and staff are given adequate time and resources to conduct Open Disclosure conversations properly, respectfully, and without rushing the process.
- Access to interpreters, advocates, Aboriginal and Torres Strait Islander liaison officers, and culturally appropriate support services is provided where needed.

Continuous Improvement

- Lessons learned from incidents are captured, analysed, and embedded into the Continuous Improvement Plan and risk management systems.
- Improvement outcomes and successes are shared with residents, supporters, and staff to build trust, demonstrate accountability, and reinforce a culture of safety.
- Enablers are monitored and reviewed regularly to ensure they remain effective and responsive to the needs of residents and staff.

6 EDUCATION

The organisation is committed to fostering a culture of safety, transparency, and learning by equipping all staff with the knowledge and skills required to participate in Open Disclosure.

Training is delivered to ensure a consistent, informed, and role-appropriate approach, enabling staff to respond effectively, respectfully, and in a manner that is person-centred, culturally safe, and trauma-informed.

Education provided encompasses but is not limited to:

- **Open Disclosure Principles and Process**
  - What Open Disclosure is, why it is important, and how it aligns with the Aged Care Act 2024, the Strengthened Aged Care Quality Standards, and the Statement of Rights.
  - Understanding that Open Disclosure is not a legal admission of fault but a process for respectful communication, transparency, and continuous improvement.
  - Role clarity (who leads the conversation), documentation standards, offering advocates/interpreters, and how to provide written summaries.
- **Resident Rights and Responsibilities**
  - Understanding and applying the Statement of Rights, including dignity, choice, privacy, and involvement in care decisions.
  - Empowering residents and their supporters to participate meaningfully in Open Disclosure conversations.
- **Code of Conduct for Aged Care Workers**
  - Applying the Code's requirements for respectful communication, cultural safety, privacy, and acting with integrity when things go wrong.
  - Maintaining professional boundaries and accountability in Open Disclosure conversations.
- **Incident Reporting and Escalation**
  - Recognising and reporting incidents, near misses, hazards, and complaints promptly.
  - Using organisational systems for documentation and escalation, including timeframes.
- **Serious Incident Response Scheme (SIRS)**
  - Mandatory reporting requirements, categories of reportable incidents, and organisational responsibilities.
  - Timeframes and decision support; interaction between SIRS, Open Disclosure and police/other authorities.
- **Feedback and Complaints Handling**
  - Encouraging and responding to resident and supporter feedback.
  - Linking feedback to improvement actions and communicating outcomes transparently.
- **Continuous Improvement**
  - Capturing lessons from incidents and embedding them into the Continuous Improvement Plan.
  - Sharing outcomes and improvements with staff and residents to build trust.
- **Privacy, Dignity, and Confidentiality**
  - Protecting resident and staff information during investigations, documentation, and discussions.
  - Legislative requirements under the Privacy Act and organisational confidentiality policies.

- **Cultural Safety and Diversity**
  - Respecting cultural identity, values, beliefs, and decision-making practices.
  - Engaging interpreters, cultural liaison officers, and tailoring communication to residents' needs.
- **LGBTIQ+ Awareness and Inclusion**
  - Understanding and respecting diverse sexual orientations, gender identities, and relationships.
  - Inclusive language and affirming care practices.
- **Trauma Awareness**
  - Recognising the impact of past trauma and adopting approaches that minimise distress and avoid retraumatisation.
  - Supporting psychological safety for both residents and staff.

Training is delivered through orientation programs, annual refresher sessions, scenario-based learning, and targeted training for leaders and clinicians responsible for leading Open Disclosure conversations. Participation and competency are monitored to ensure workforce capability and compliance with organisational, legislative, and regulatory requirements.

7 ORGANISATION RESPONSIBILITIES OUTLINE

This policy provides key information relating to Open Disclosure. The organisation Governance and Risk Management Policy, Incident Management Systems Policy and Feedback Policy provide further information in relation to escalation, roles and responsibilities, actions and timeframes for the management of incidents and feedback.

The table below contains information specific to Open Disclosure and is intended as an outline of responsibilities only.

Role/Position	Responsibilities
Governing Body / Board	• ensure the organisation has an effective Open Disclosure Policy and Procedure • promote a positive safety and learning culture. • maintain oversight incidents, complaints, feedback, risk analysis, and quality indicator data • monitor organisational performance including how well open disclosure processes are working, how incidents are handled, and improvements are implemented • receive de-identified incident, complaint and feedback reports that inherently include Open Disclosure outcomes through the organisation's existing Incident Management System and Continuous Improvement reporting processes
Chief Executive Officer / Senior Management	• oversee organisational compliance with the Aged Care Act 2024 and Aged Care Quality Standards • ensure adequate resources (staff, training, communication supports) are available to implement Open Disclosure.
Senior Management / Clinical Governance	• review significant incidents and ensure systemic improvements are actioned (where identified) • review and monitor implementation and review data from incidents, complaints, and improvement

	• review audit information in regard to compliance with organisational processes
Facility Manager	• coordinate investigations, documentation, and continuous improvement activities • monitor trends in incidents and complaints and report findings to Clinical Governance • maintain the Continuous Improvement Plan and ensure learnings are implemented reporting to Clinical Governance • audit open disclosure processes and report to Clinical Governance
Facility Manager / Clinical Care Manager	• initiate the Open Disclosure process following an incident or complaint (if required) • ensure residents (supporters) are promptly informed and supported • facilitate access to advocacy, translation, or cultural liaison services (if required) • oversee documentation of Open Disclosure activities • ensure Open Disclosure is completed and documented for all applicable incidents within the Incident Management System
Registered Nurse / Clinical Lead	• assess and address immediate clinical needs to ensure resident safety • participate in investigations and provide clinical input • support residents (supporters) and staff throughout the process • acknowledge and provide apology if reporting incident to resident (supporter) • complete organisation reporting tools, documenting care and support provided and or initiated
All Staff	• report incidents, near misses, or concerns promptly • assist residents (supporters) to provide feedback • support residents (supporters) by communicating observations to the EN/RN in charge (or other senior person CN/CCM/FM) as soon as practical • participate in follow-up actions and continuous improvements where relevant
Residents / Supporters / Stakeholders	• share feedback, concerns, or complaints with the organisation, its workforce • work in partnership, participating in discussions about what happened, its impact, and preferred solutions • contribute to continuous improvement activities if appropriate

8 DEFINITIONS

CEO – Chief Executive Officer; the most senior leader reporting to the Governing Body, responsible for operational, financial, and clinical governance oversight of the organisation.

Clinical Governance – An integrated system of leadership, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms that support safe, high-quality clinical care and positive outcomes for each resident.

Clinical Indicators – Quantitative measures used to monitor and evaluate the quality and safety of clinical care. Indicators identify risks, track performance, and inform continuous improvement.

Continuous Improvement – A systematic, organisation-wide approach to identifying, implementing, and evaluating opportunities for improvement in care and services. It includes learning from feedback, incidents, audits and outcomes to maintain safe, respectful, and high-quality care.

Governing Body – The group of persons (e.g., Board of Directors or Committee of Management) with ultimate responsibility for the governance of the aged-care organisation. The Governing Body includes people with the collective skills, experience and knowledge to safely oversee clinical care, risk, and business operations.

Harm – Any physical, psychological, emotional, social, cultural or financial injury, damage, or negative impact experienced by a resident as a result of an incident, omission, or system failure, including harm arising from re-traumatisation or culturally unsafe practice.

Open Disclosure – The open, honest, consistent and timely communication that occurs when something goes wrong with a resident's care or services. It includes acknowledging the incident, providing information, offering an apology or expression of regret, and explaining actions taken to prevent recurrence. It is conducted in a way that is culturally safe, inclusive and respectful of each person's identity, beliefs, and communication needs.

Organisation – The approved provider of aged-care services, including its Governing Body, executives, managers and workforce.

Resident – A person who lives in an aged-care home and receives care and services from the organisation.

Resident's Supporter – (Previously referred to as representative) Includes registered supporters, substitute decision-makers, or others lawfully authorised to act on the resident's behalf in accordance with supported-decision-making principles.

Serious Incident Response Scheme (SIRS) – The national framework requiring approved providers to manage, record and notify certain incidents involving residents to the Aged Care Quality and Safety Commission within prescribed timeframes.

Stakeholders – Individuals, groups or organisations that have an interest in, or are affected by, the care and services provided by the organisation. This includes residents, supporters, staff, volunteers, contractors, allied-health providers and regulators.

Statement of Rights – The set of legislated rights under section 23 of the Aged Care Act 2024 that outline what every person receiving aged care in Australia can expect from their provider. These rights must be upheld by all aged-care organisations and their workforce.

Supported Decision-Making – A rights-based approach that enables a person who requires decision-making support to make and/or communicate decisions about their own life. Support is provided to help the person understand, consider and communicate their choices, using their preferred language, communication method, or aids where required; however, the decision remains theirs.

Supporter – A person chosen, registered or legally appointed to support a resident to make decisions, receive information or communicate with the provider. Also referred to as a "resident's supporter".

Workforce – Anyone employed, hired, retained or contracted by the organisation (directly or through an agency) to provide care, services, maintenance or administration under the organisation's control. It also includes students and volunteers who deliver care or services on behalf of the organisation.

9 REFERENCES AND RELATED POLICIES

Aged Care Quality and Safety Commission (2022) Open Disclosure Framework. Canberra: ACQSC. https://www.agedcarequality.gov.au/resources/open-disclosure-framework
Aged Care Quality and Safety Commission (2024) Code of Conduct for Aged Care. Canberra: ACQSC. https://www.agedcarequality.gov.au/for-providers/code-conduct
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Government of South Australia (1984) Equal Opportunity Act 1984 (SA). Adelaide: Government of South Australia. https://www.legislation.sa.gov.au/lz?path=/c/a/equal%20opportunity%20act%201984
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Government of South Australia (2012) Work Health and Safety Act 2012 (SA). Adelaide: Government of South Australia. https://www.legislation.sa.gov.au/lz?path=/c/a/work%20health%20and%20safety%20act%202012

Related Organisation Policies

- Governance and Risk Management Policy
- Incident Management Systems Policy
- Privacy and Confidentiality Policy
- Learning and Development Policy
- Cultural Diversity and Inclusion Policy
- Philosophy of Care Policy
- Choice and Decision-Making Policy
- High-Risk and High-Prevalence Policy
- Code of Conduct