

Open disclosure

Open Disclosure Framework

Information for aged care providers

Version 1.0 | November 2026

Australian Government
Aged Care Quality and Safety Commission

Choice
Dignity
Respect

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Aged Care Quality and Safety Commission's Journey,
an artwork by Chern'ee Sutton, a proud Kalkadoon woman

Acknowledgement of Country

In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

Foreword

Aged care in Australia should be safe, respectful and centred on the needs, preferences and rights of older people. This includes supporting older people to make informed choices, participate in decisions about their care and maintain control over matters that affect their lives. When something goes wrong, however, older people are not always included in conversations about what happened, why it occurred or what actions will be taken in response. This can affect older people's trust and confidence in the care they receive.

We know that when concerns, incidents or complaints are not acknowledged and addressed openly, relationships can be damaged. Older people, their families and supporters may feel unheard, uncertain or disconnected from the people responsible for their care. By contrast, open and honest communication can strengthen trust, support resolution and promote better outcomes for the older person involved. This is why open disclosure is so important.

Open disclosure is about engaging openly, honestly and respectfully with older people, their families and supporters when concerns arise, including incidents, near misses, complaints, feedback and issues identified through governance, risk management, quality improvement processes. When practised well, open disclosure helps older people feel heard and safe. It reinforces their right to be active participants in decisions about their care and provides an opportunity to restore confidence when expectations have not been met.

Open disclosure creates meaningful conversations between providers, aged care workers and older people about:

- what happened and why
- the impact on the older person
- the actions being taken to address the issue and reduce the likelihood of it happening again.

This approach supports the delivery of rights-based care and reflects the principles of the Statement of Rights under the *Aged Care Act 2024* (the Aged Care Act).



Under the Aged Care Act, older people have a right to:

- open communication and support from providers when issues arise in relation to their care
- receive information about their services in a way they can understand
- express their views, and have those views listened and responded to
- access records and information relating to their rights and aged care services.

Conversations following an incident or complaint can be challenging, particularly when trust has been affected. Nonetheless, they are essential. Open disclosure provides an opportunity to demonstrate accountability, foster understanding and rebuild trust. More importantly, it upholds the rights of the older person.

Australia has been a leader in open disclosure in both health care and aged care settings. The Commission has long recognised the importance of open disclosure as a means of responding to complaints, incidents and concerns in a way that is transparent, respectful and focused on learning and improvement. As part of this approach, we have encouraged providers to communicate openly, offer a sincere apology, take responsibility and commit to meaningful improvements.

It has now been 7 years since the publication of the first Aged Care Open Disclosure Framework (framework). The framework has been updated to reflect the considerable progress made across the sector and reinforces the important role open disclosure plays in delivering safe, high-quality and person-centred aged care.

As the Aged Care Complaints Commissioner, I am committed to supporting a culture of openness, accountability and continuous improvement across the aged care sector. By embedding open disclosure practices when concerns arise, we can better uphold the rights of older people and protect their safety, health, wellbeing and quality of life at all stages of their aged care journey.



Treasure Jennings
Aged Care Complaints Commissioner



Overview

Open disclosure is the open, honest and empathic (understanding with compassion) conversation that a registered aged care provider has with an older person when something goes wrong with their care and services.

This conversation may also include the person's supporters (family, friends, kin, carers, representatives, registered supporters and substitute decision-makers) where appropriate. Registered aged care providers need to practise open disclosure when an incident, possible incident, complaint or feedback happens.

Open disclosure upholds the rights of the older person. It places them at the centre of the decision-making process and gives them control of what happens to them.

Open disclosure starts a conversation between a registered provider, aged care worker, and older person. It helps them to speak openly about:

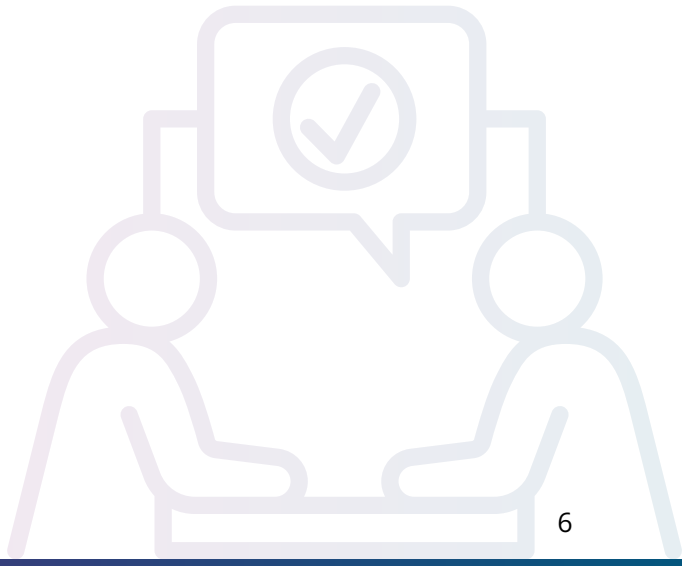
- what happened and why
- how the incident affected the older person
- what the provider will do to resolve (fix) it and stop it happening again, in line with the older person's needs and preferences.

Older people have the right to receive quality and safe care that works for them.

When care does not go to plan, providers are responsible for making sure they tell the older person and involving them in decisions on how to fix the issue. They also need to make sure that the older person feels confident that providers will fix the issue in a way that meets their needs and preferences as much as possible.

Purpose of the framework

This Open Disclosure Framework (framework) sets out the Aged Care Quality and Safety Commission's (Commission's) expectations of how open disclosure needs to be practised (used) to ensure open communication when things go wrong. It replaces the 2019 framework and guidance.



Scope and application

This framework supports providers in all registration categories to meet their open disclosure responsibilities under the:

- *Aged Care Act 2024* (Aged Care Act)
- Aged Care Rules 2025 (Aged Care Rules)

Registered aged care providers (providers) receive Australian Government funding to provide care to older people. Providers are responsible for making sure their services meet the open disclosure requirements.

Healthcare professionals might have other open disclosure requirements under federal, state or territory legislation, or as part of their professional responsibilities. This framework does not replace those requirements.



Practising open disclosure

Open disclosure upholds older people's rights by asking them what they want to happen to put things right when things go wrong. It supports providers and workers to understand the issue from the older person's point of view and find a solution that meets their needs and preferences as much as possible.

It can be unsettling for older people when something goes wrong with their care. Fixing the issue is often not enough to restore trust and confidence. Open disclosure empowers the older person to make decisions about their care. This can help them feel more satisfied and strengthen their relationship with the provider.

Communicating in an open, honest, and empathic way can help ease feelings of anger, grief and helplessness. It can reassure the older person that their provider understands what went wrong and will take action to resolve the issues and stop them happening again. Having the opportunity to talk about how they were affected, ask questions, and give their opinion can make the older person feel heard, understood and cared for.

Open disclosure is also good for workers and providers. It can help relieve feelings of guilt or shame by giving them the chance to show care, compassion and regret for what went wrong and how it affected the older person. Honest and timely disclosure helps to create an environment of openness, continuous learning and better care outcomes.

Open disclosure is not the same as incident management, complaints and feedback management, or other processes for identifying, assessing and resolving underlying issues. It works alongside and supports these processes by making sure the older person is meaningfully involved in the whole process as an active and respected partner.

For more information on how open disclosure works alongside incident management and complaints and feedback management, see Better practice guide to complaints handling in aged care services and Effective incident management systems: Best practice guidance.

To improve readability, this framework uses 'you' when referring to providers.



Provider responsibilities

Providers need to practise open disclosure when something has gone wrong with an older person's care and services. This includes incidents, possible incidents, complaints, feedback and other issues. You can detect issues in many ways, including through:

- comments from an older person (and their supporters)
- comments from a worker
- your incident management system
- your feedback and complaints management system
- internal quality reviews
- your governance, risk management and quality improvement systems
- the Commission, as part of an incident, complaint, or registration audit process.

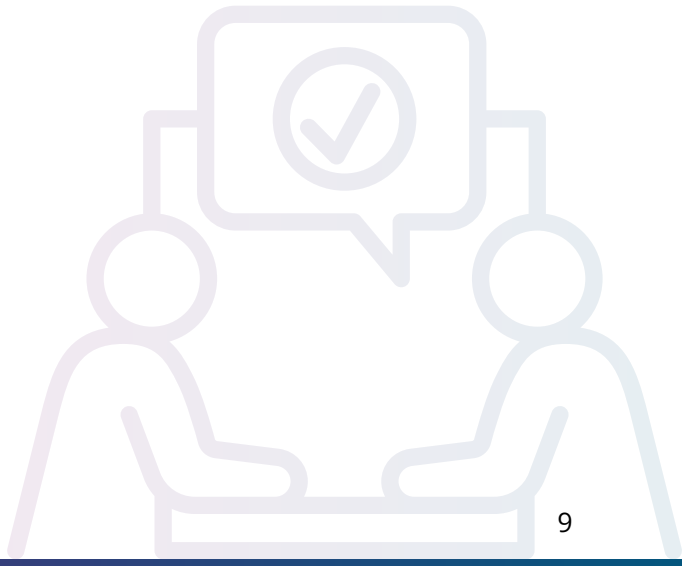
You need to also practise open disclosure to resolve a complaint that an older person (or their supporter) has made to the Commission.

You need to practise open disclosure even when the incident, possible incident, complaint or feedback has not caused physical, psychological, emotional, social or financial harm to the older person. Be aware you may not always agree with the older person on whether something has gone wrong or the effect it has had.

Requirements in the Aged Care Act, Aged Care Rules and Quality Standards

Open disclosure is a provider responsibility. You are required by law to practise it.

This section lists the provisions in the Aged Care Act, Aged Care Rules and Aged Care Quality Standards (Quality Standards) that focus on open disclosure. While this section covers the most relevant provisions, it does not include every provision that may be relevant to open disclosure.

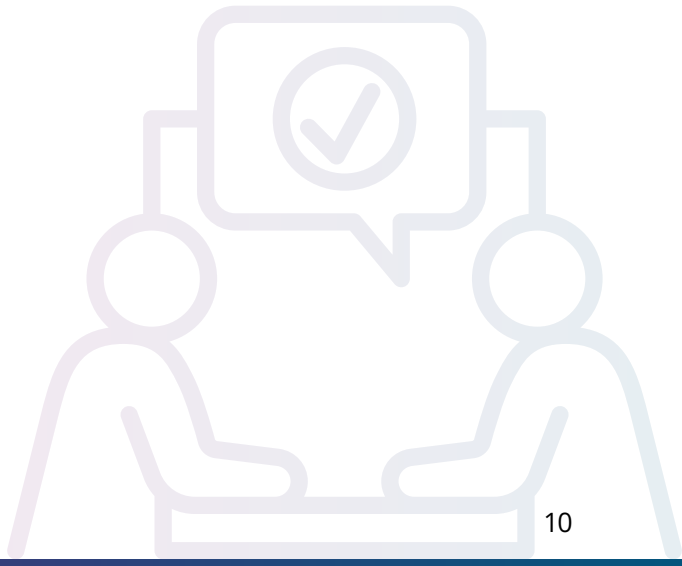


Aged Care Act

The Aged Care Act includes the Statement of Rights. As a condition of your registration, you need to understand these rights and have systems to make sure you act in line with them. Practising open disclosure is a way for you to show that you are upholding older people's rights.

Table 1. A summary of the most relevant rights related to open disclosure in the Aged Care Act

Rights	Section
Right to exercise choice, be supported to make decisions, and take personal risks.	s 23(1)
Right to seek, and be provided with, records and information about their rights and their aged care services.	s 23(6)
Right to be informed in a way the individual understands about their aged care services and express opinions and be heard.	s 23(7)
Right to communication in the individual's preferred language or method of communication, with access to interpreters and communication aids as required.	s 23(8)
Right to open communication and support from providers when issues arise, to make complaints without fear of reprisal, and have the complaints dealt with fairly and promptly.	s 23(9)
Right to be supported by an advocate or other person of the individual's choice.	s 23(10)
Right to access a person designated by the individual, or a person designated by an appropriate authority.	s 23(13)



Aged Care Rules

The Aged Care Rules set out the requirements for providers to practise open disclosure to resolve incidents, possible incidents, complaints and feedback. This includes:

- policies and procedures that describe worker and responsible person responsibilities to practise open disclosure built into your incident management system and complaints and feedback system
- training for workers on how to practise open disclosure (see Division 1 and Division 2 of Part 10 of Chapter 4 of the Aged Care Rules).

Table 2. A summary of the provisions that directly name open disclosure in the Aged Care Rules

Provisions	Section
To promote the safety, health, wellbeing and quality of life of the people they provide care for, providers' incident management systems need to support open disclosure and resolve incidents between individuals and the provider.	s 164–15(a)(iii)
Providers need to manage incidents in accordance with their incident management systems and use an open disclosure process.	s 164–40 (1)(b)(v)
Providers' complaints and feedback management systems need to support open disclosure and resolve complaints between individuals and the provider	s 165–10(a)
Providers' complaints and feedback management systems require them to practise open disclosure and prioritise restorative practices.	s 165–15(1)(n)
Providers need to use an open disclosure process for matters raised through complaints or feedback, and if things go wrong in managing complaints or feedback or resolving issues raised in complaints or feedback.	s 165–35(2)



Quality Standards

Standard 2: The Organisation sets out the outcomes that a provider's governing body are required to meet. It describes the quality systems and supervision you need to have to make sure you deliver care and services safely. It includes the actions you can take to meet your responsibilities, including using open disclosure.

Table 3. A summary of the outcomes and actions related to open disclosure in the Quality Standards

Outcomes	Actions
2.3 Accountability, quality system and policies and procedures	The provider has systems, policies and procedures that: • enable them to continuously improve • support them to use open disclosure to communicate with older people, their supporters and aged care workers when things go wrong (action 2.3.6).
2.6a Complaints and feedback management for aged care workers	The provider takes timely action to resolve complaints and uses an open disclosure process when things go wrong (action 2.6.3).
2.6b Complaints and feedback management for individuals	The provider takes timely action to resolve complaints and uses an open disclosure process when things go wrong (action 2.6.4).

You can find more information about the Quality Standards and how to meet your responsibilities in the Strengthened Aged Care Quality Standards guidance.



The principles of open disclosure

The Commission expects open disclosure in aged care to be guided by the principles of being person-centred, restorative, responsive, transparent and focused on continuous improvement.

Person-centred

Open disclosure is person-centred. This means it is respectful and responsive to the needs, preferences and values of the older person.

In practice, this means:

- recognising the unique identity, culture, ability, beliefs and life experiences of the older person
- communicating in a way that is clear, appropriate and accessible to support meaningful discussion and decision-making.

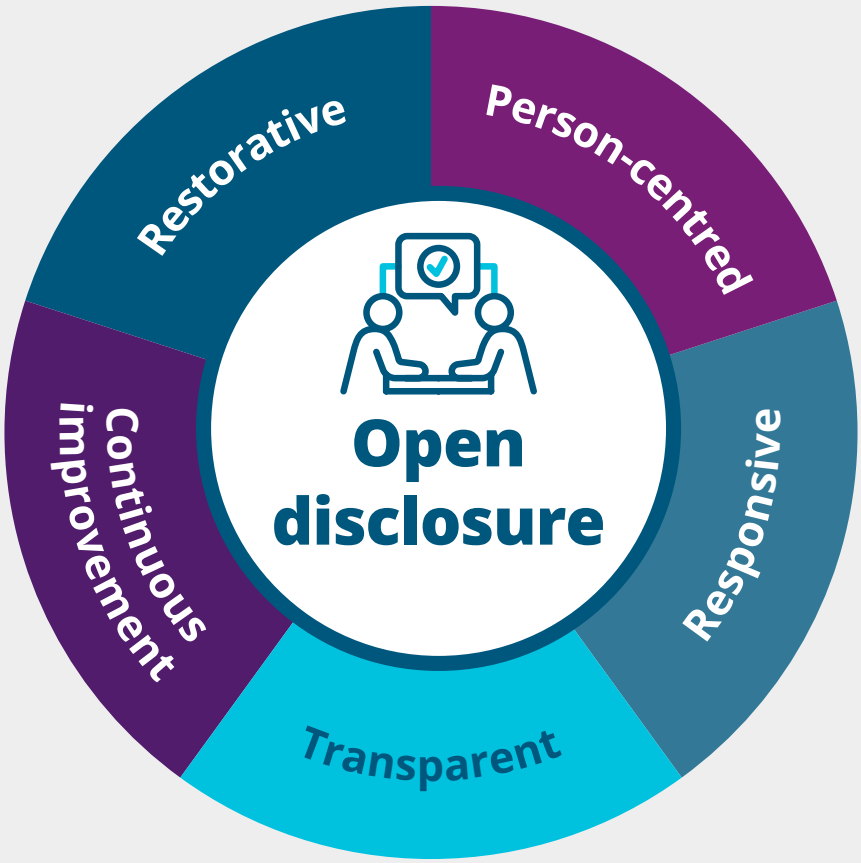


Figure 1. Principles of open disclosure

To practise open disclosure in a person-centred way, you should think about:

Personhood

Respect the value, dignity and identity of the older person, no matter what their cognitive, physical or psychological abilities are. Avoid making assumptions about the person's needs, preferences and ability to make decisions, including assumptions based on their age, health, cultural background and communication style.

Supported decision-making

Support the older person to take part in open disclosure conversations and make decisions about their own care as much as possible. The older person's ability to make decisions should not stop you involving them in open disclosure conversations. If you are concerned about the older person's ability to understand, respond to, or take part in the conversation, ask them what support they need, and give them that support.

If a situation needs a decision and you are concerned about the older person's ability to make that decision, even after you have provided support, involve the person's substitute decision-maker (a person who is legally allowed to make health, medical, residential and other personal decisions for an older person who can no longer make decisions themself).

You should still include the older person in the conversation, communicate with them and act in line with their needs and preferences as much as possible. If the older person does not have a substitute decision-maker, you should follow the requirements that apply in your state or territory.

Always assume the older person can make a decision, even when they have appointed a substitute decision-maker. A person's decision-making capacity can change depending on the decision they need to make.

Communication needs and preferences

Understand and respond to the communication needs and preferences of the older person, including their preferred:

- form of communication – for example, verbal, written or visual
- method of communication – for example, in-person meeting, video call, phone, or email
- communication aids – for example, communication boards, picture cards, or hearing aids.

You might need to have some conversations at specific times of the day or at a particular location, so the person feels safe and comfortable.

The person leading the conversation should think about if they need to adjust their speaking pace, tone and/or volume.



Cultural safety and language

Respect the cultural identities and language preferences of the older person. Make sure the conversation is culturally safe, culturally appropriate, trauma-aware and healing-informed. When talking to older people who identify as Aboriginal or Torres Strait Islander people or are from culturally and linguistically diverse backgrounds, follow cultural protocols (customs) appropriately (correctly). For example, do they have cultural preferences about seating arrangements, physical space, or using or not using eye contact?

Be aware of how a person's culture, values and attitudes could affect how they understand and interact with others. Consider engaging a cultural support person to make sure the process is inclusive, respectful, and culturally safe.

Only the older person can say if the process is culturally safe or not.

Make sure the older person can access any language services they need.

Gender identity and sexual orientation

Use the older person's correct name and pronouns. Make sure you use language that is inclusive, safe and respectful. Avoid making assumptions about a person's gender identity or sexual orientation or disclosing that information to third parties without their consent (agreement). This can cause psychological and physical harm and reduce trust.

Need for support persons or an independent advocate

Check with the person if they would like to involve their supporter or substitute decision-maker, or work with an independent aged care advocate (advocate) to help them take part in open disclosure.

Opportunities for discussions, questions, and decisions

Provide time and space for the person to:

- process and understand the information you give them
- share their experiences and views
- ask questions
- make decisions without being rushed.



Restorative

Open disclosure is restorative. This means it aims to restore the older person's trust and confidence and repair the relationship between the older person (and their supporters) and the provider or worker involved.

In practice, this means you should:

- communicate with care and compassion
- acknowledge the person's views, feelings, and experiences without judgement
- listen to understand, and ask questions if you need to
- offer a sincere and unprompted apology for what happened
- work with the person to discuss, agree on, and follow through with a solution
- do what you say you will do.

These actions create an environment where the person feels safe to speak openly and honestly without fear of reprisal (negative consequences).

Responsive

Open disclosure is responsive. This means it is timely, in proportional to the risk to the older person, and responds to the older person's needs.

In practice, being responsive means responding to the issues as soon as possible in line with the older person's needs and preferences to safeguard their rights, safety, health, wellbeing and quality of life. You should:

- have an initial (first) conversation with the older person as soon as possible
- provide regular updates to the older person (and their supporters)
- share new information and tell them what actions you have taken when you can.



Transparent

Open disclosure is transparent (open and honest).

In practice, this means you should tell the older person openly and honestly:

- what happened
- why it happened
- what you have done or plan to do to fix the issue.

Do not hide any details or make guesses. Share information openly and honestly and be clear about what you know, what you do not know, and what you are still finding out.

Older people (and their supporters) can quickly lose trust and confidence if it looks like you are trying to cover up what happened.

Continuous improvement

Open disclosure focuses on continuous improvement.

Reflect on (think about) the information you collect through the open disclosure process and use it to identify ways that you can improve the safety and quality of your care and services. Make these changes.

Investigating what has gone wrong and why helps you to find out what happened and take steps to stop similar problems from happening again. This includes making changes to your systems and processes if they are not working well. Open disclosure is an important part of how your organisation can learn, improve and uphold older people's rights day to day.

You should not use open disclosure to blame anyone.



The 5 elements of open disclosure

The elements are 5 things we expect providers to do to practise open disclosure while resolving incidents, possible incidents, complaints and feedback.

By taking these steps, you can make sure the older person, and their supporters where appropriate, are meaningfully involved in the whole process. The 5 elements are in line with the incident management and complaints management system requirements in the Aged Care Rules.

You may need to have more than one conversation to address all relevant areas.

You can apply the 5 elements in different ways and in different orders to suit the circumstances and the preferences of the older person. If you miss one or more elements in the open disclosure process (for example, you do not share the outcome of the investigation), you should document in the appropriate systems:

- the reason you missed the element/s
- alternative/s you offered
- your plans to apply the element/s later, if relevant.

Keep a clear record of all the open disclosure conversations you have with the older person. Follow the record keeping requirements that apply. Include:

- decisions made with the older person
- actions you have taken or will take to fix the problem, including any changes to your systems, policies, and procedures
- outcomes achieved.

If the older person is not satisfied with the open disclosure process, help them to make a complaint, speak to an advocate, or raise their concern with the Commission.

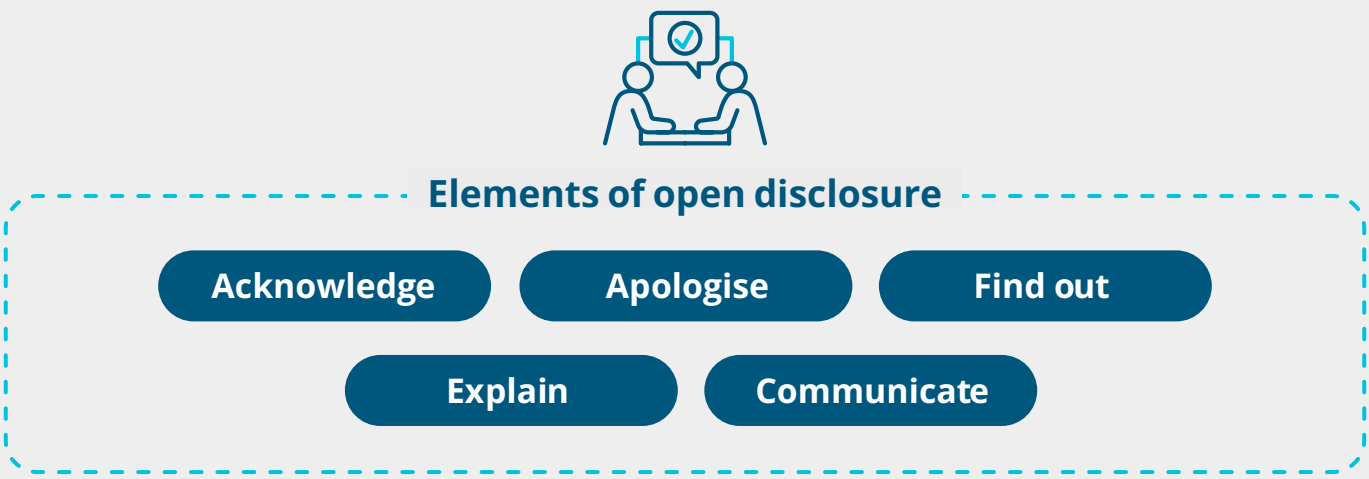


Figure 2. Elements of open disclosure

Before you start

Before you start the open disclosure conversation, check if the older person is ready to talk about the issue. You might need to reschedule or postpone the conversation if they need more time to feel safe, well and ready to communicate with you. If so, you should take a trauma-aware approach to safeguard the person's safety and wellbeing. This should be your priority. For example, you could use psychological first aid.

Provide any practical and emotional support the person needs. When they are ready, have the conversation as soon as you reasonably can. Do not delay it.

To make sure the open disclosure process is safe and independent (free from inappropriate influence, pressure or conflict of interest), the person who leads it should not be named in the incident, possible incident, complaint or feedback.

If the older person wants to involve their supporters, an advocate, or language services, ask the older person to confirm what information they are comfortable sharing, and with whom. You can find information about the different types of registered supporters and their information and privacy requirements in the Registration policy.

You need to protect the older person's privacy in line with your privacy responsibilities.

Acknowledge

Acknowledge what went wrong and the effect it had on the older person by talking with and listening to them. Explain what you know about what happened. Describe actions you have taken and that you plan to take. Invite the older person to share their experience and tell you their concerns. Ask them what outcome they want.

Acknowledging an issue early shows that you care about the older person and empathise with them. For the older person, this makes them feel heard and validates their feelings, thoughts and reactions to what happened. It reassures them that their provider knows and understands what went wrong and will take actions to fix it.



Apologise

Apologise for what went wrong and how it affected the older person.

Apologising is central to open disclosure. It shows that:

- you are sorry about what went wrong
- you acknowledge how it affected the older person
- you are committed to improving the care and services your organisation provides.

Apologising helps to rebuild trust and makes older people (and their supporters) feel seen, respected and valued.

Be sincere

Your apology should be sincere and include the words 'I am sorry' or 'We are sorry'. It should also be unprompted. This means you should do it without having to be asked.

Be specific about what you are apologising for, and what you are doing (or plan to do) to fix the issue. You should not speculate (guess) about what happened or place blame on the worker or provider. Make sure your body language, facial expression, and eye contact match the apology.

Think about timing

The timing of your apology matters. If you apologise too late in the process it can seem performative or insincere (like you are doing it for show or to look good, and you do not really mean it).

Apologise early to acknowledge something has gone wrong – even if you do not know all the facts. Once the person has told you how the issue has affected them, apologise to acknowledge how they feel and any distress they have experienced. You should not put off saying you are sorry because you do not have all the information.

Think about local laws

All Australian states and territories have laws about making apologies in a civil liability context (laws that explain what an apology or expression of regret is, and whether it can be used as evidence of fault or legal liability in a civil case).

You need to consider the laws in your state or territory and get independent legal advice when creating open disclosure policies and procedures.



Find out

Find out what happened, why it happened, and how to resolve it and stop it happening again.

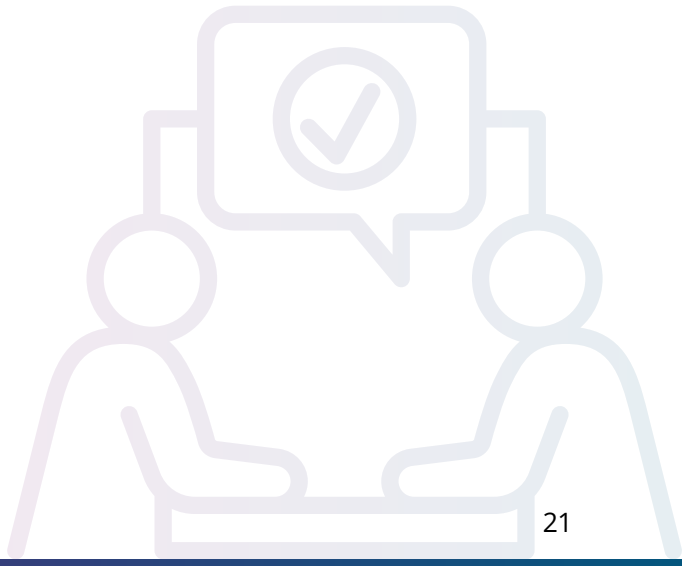
When you investigate what happened as part of your incident management or complaint and feedback management process, you need to involve the older person (and their supporters) to understand their experience and point of view.

You should find out what could have caused the issue (there could be more than one factor) and what you can and should do to fix it and stop it happening again. The scope and method of your investigation (what you investigate and how you do it) should be in proportion to the nature, severity and scale of the issue.

Not every incident, possible incident, complaint or feedback needs a formal investigation. For guidance on when a formal investigation is needed, see the Better practice guide to complaints handling in aged care services or the Effective incident management systems: Best practice guidance.

Involving the older person can help you to:

- get a better understanding of what happened by hearing directly from the older person. They might be able to tell you something that is not already in your clinical records or workers' accounts
- restore the older person's trust and confidence by showing them that their experience and point of view matters and that you are listening
- find a solution that fixes the issue
- find ways to improve the safety and quality of your care. For example, they might be able to help you understand:
  - if the same or a similar issue has happened before
  - factors that might have caused it, that you missed in the past
- find out if you need to tell other people or organisations to stop the issue happening again
- assess how effectively you managed and resolved the issue.



Explain

Explain what happened and why in a way that the older person understands. Answer their questions.

This includes:

- providing factual (true) information – tell them what you know, what you do not know, and what you are still finding out. Explain what you will do to find out more. Avoid speculating (making guesses) or blaming anyone
- giving the older person the opportunity to give their views and ask questions
- explaining what you are doing, or will do, to fix the issue. Include changes that you are going to make to improve your systems, processes and practices.

Communicate

Communicate respectfully and proactively (without the older person or their supporters needing to ask) through the whole process and after you have resolved the issues.

You should communicate with the older person even if other processes (such as police, coronial, professional or regulatory inquiries) are happening.

Communicating should include:

- providing regular updates on new information and findings through the whole incident management process or complaints and feedback management process
- following up after you have taken actions you agreed to take, to discuss whether the actions are effective and achieving the outcomes they wanted.



Embedding open disclosure

Clinical governance is the set of organisational systems that enable (help) providers to deliver safe and quality care for older people. Strong clinical governance is key to effective and consistent open disclosure practice.

Leadership and organisational support

Strong leadership is critical to embedding effective open disclosure practice. Leaders are workers with management and leadership responsibilities.

Leaders can help their workers to practise open disclosure by:

- offering training and resources to help them understand when and how to practise open disclosure in the process
- providing enough time to prepare for and have meaningful open disclosure conversations by changing rosters or adjusting workload as needed
- making sure they have policies, procedures and systems that support consistent open disclosure practice.

Open disclosure can be challenging and emotionally demanding for workers. Leaders can safeguard (protect) workers' emotional wellbeing by providing organisational support. For example, by having debriefings after open disclosure conversations, having a peer support network, and offering psychological support, such as through an employee assistance program.

Leaders also have an important role in creating psychological safety and a just culture, where workers feel safe and encouraged to speak up when things go wrong.



Psychological safety

Psychological safety is the shared belief that workers can speak up when they have concerns and admit mistakes without fear of negative consequences, such as being shamed or punished.

Leaders can foster (create) psychological safety through everyday actions such as:

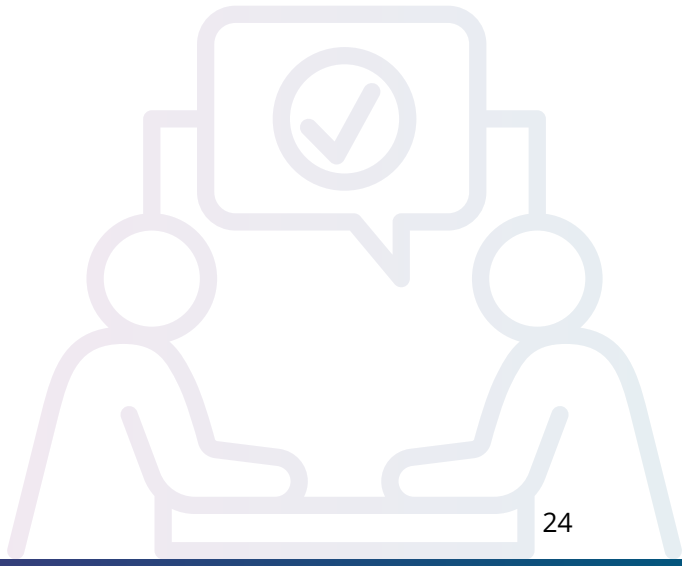
- through active listening
- encouraging workers to speak up (including confidentially or anonymously)
- responding to differing views respectfully
- being compassionate and inclusive
- admitting their own mistakes
- partnering with older people and workers to improve care.

Creating a just culture

A just culture is a culture where workers feel safe to speak up and are confident they will be treated fairly when something goes wrong.

Psychological safety, combined with a systems thinking approach (looking at the whole system and how all the parts work together and affect each other) to understand why something has gone wrong, helps leaders create just cultures where the focus is on learning and improvement, rather than finding someone to blame.

A just culture encourages organisational learning while taking professional and organisational responsibility for things that go wrong. For every incident, possible incident, complaint or feedback, you should think about the people and system factors that may have contributed to it, such as staffing, skill mix, workload and work environment.



Systems

Providers should build open disclosure into their everyday operations. This means embedding open disclosure into the governance, risk management, and quality improvement systems, policies, and processes that your workers use. This supports workers to quickly recognise and document when something has gone wrong, or could have gone wrong, and practise open disclosure consistently. It also helps to normalise practising open disclosure.

Organisational systems, policies and procedures

Incident management and complaints and feedback management systems, policies and procedures need to support open disclosure processes. It is important that workers understand when and how they should practise open disclosure, and how they should document it at every stage of the process. You can find specific system requirements in the Aged Care Rules.

Workforce capability

Effective open disclosure relies on the capability (skills) of your workforce. This includes volunteers, relief workers (who fill in when you need extra support) and visiting health practitioners. You should be confident that your workers know how to:

- identify and raise concerns when something goes wrong
- provide support to an older person during an open disclosure conversation.

You should clearly define and communicate the open disclosure roles and responsibilities of your workers and responsible persons across all levels of your organisation, from frontline workers to senior leaders. You also need to make sure that your responsible persons and workers have the training and resources they need to practise open disclosure in their roles.

You can support your workers to practise open disclosure better by also providing training and education in:

- effective governance
- managing incidents
- managing complaints
- trauma-aware care
- communication and active listening.

These skills can help to strengthen a culture of openness, partnership and learning.



Monitoring and reporting

You should monitor (check) how well you are using open disclosure at your organisation and use what you find to improve the safety and quality of care, governance, and performance monitoring. You should report your findings to your governing body.

This could involve regularly reviewing progress notes, meeting records, and reports in your incident management system, complaints and feedback management system, and other supporting systems to see how well open disclosure has been practised.

You should give older people (and their supporters) the opportunity to give feedback on your open disclosure process. This can give you useful information about the older person's experience, which can help you to identify how you can improve.

You should also give workers who have practised open disclosure the opportunity to provide feedback. Be sensitive about how you ask for feedback, especially if the issue was distressing. Consider how feedback can be collected using existing feedback processes to make it easier.

If you make changes to your processes and systems using learnings from open disclosure processes, you should check how effective these changes are at resolving the issues and improving safety and quality outcomes. Share the outcomes of these improvements with older people (and their supporters) when possible.

Working with other organisations

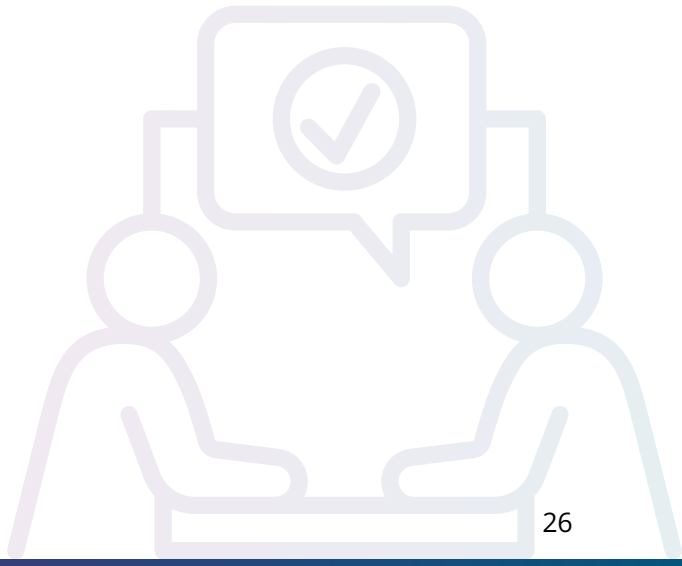
Having strong partnerships with other providers and organisations can help you to practise open disclosure when an incident, possible incident, complaint or feedback involves external providers, health organisations and visiting health practitioners.

Involving external providers and practitioners in the open disclosure process helps you to:

- get a clearer understanding of what happened
- identify the contributing factors
- find the most appropriate way to resolve the issue.

Before you share information with different people, consult with the older person, where possible. Find out what information they are comfortable sharing and with whom. Only share information you need to share to fix the issue.

You should only disclose personal information without consent when it is appropriate and authorised (permitted) by law.



Commission role

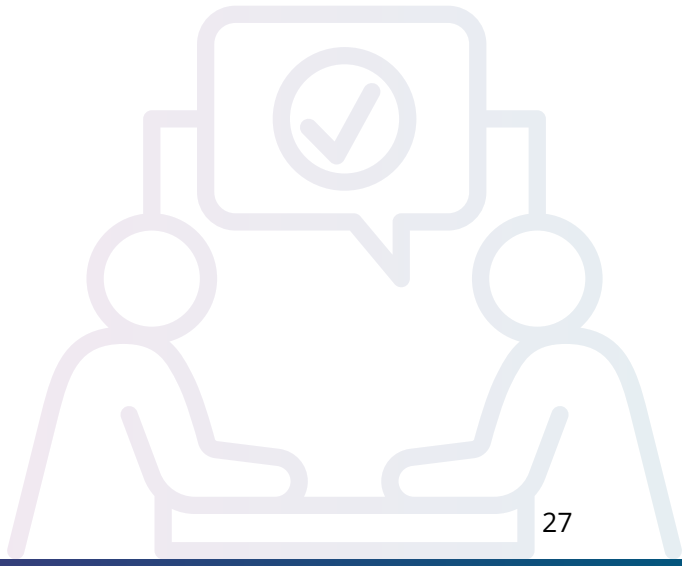
How we assess compliance

We use information we collect from regulatory and monitoring activities to assess if you are complying with your open disclosure responsibilities.

We look for:

- system-level controls that support workers to practise open disclosure, including a governance structure and organisational systems that support workers to practise open disclosure to manage and resolve incidents, possible incidents, complaints and feedback
- policies and processes that describe how to manage incidents, possible incidents, complaints and feedback at your organisation. These documents should describe how to practise open disclosure alongside those processes, and the roles and responsibilities of workers and responsible persons
- practices to make sure older people (and their supporters) and workers understand how to report concerns, provide feedback and raise complaints
- providing workers with training and education on open disclosure
- evidence that you are monitoring and reviewing your open disclosure processes to understand their effectiveness and identify any areas for improvement. For example, reviewing cases in the complaints and feedback management system to identify opportunities to make system-level improvements
- evidence that you are practising open disclosure as you resolve incidents, possible incidents, complaints and feedback in line with your policies and procedures. For example, we may ask for records in your incident management systems to see how you are practising open disclosure evidence that older people (and their supporters) and workers understand how to raise concerns when something goes wrong, and feel supported and safe to do so.

When someone reports an incident or possible incident to us, or we receive a complaint or feedback, our staff will assess it and decide if you have practised open disclosure in line with your legal responsibilities.



How we respond to non-compliance

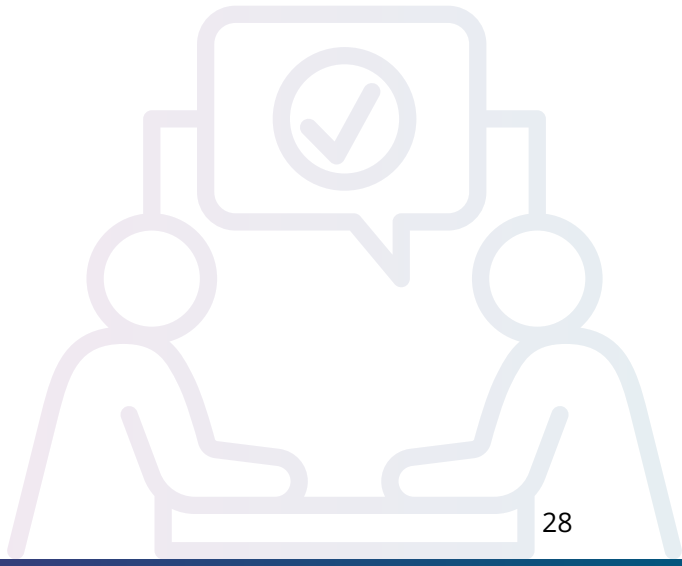
When you are not complying with your responsibilities, we will work with you to find out:

- the nature of the non-compliance
- the risk of harm to older people when the provider is not managing the risk
- if you are willing and able to manage the risk and fix the non-compliance in a reasonable time.

We will take regulatory actions that are in proportion to the level of risk to older people, in line with our Compliance and Enforcement Policy.

We will look for opportunities to provide education and support you to make improvements, where possible, and when it is appropriate. Depending on the specific circumstance, we may put conditions on registration, suspend or revoke (cancel) registration, or seek a civil penalty (ask a court to order them to pay a fine).

If an older person or their supporters think that you are not meeting their open disclosure responsibilities, they can speak with an advocate or make a complaint to the Commission.



Case studies

These case studies show examples of how you can practise open disclosure alongside incident management and complaints and feedback management to resolve incidents, possible incidents, complaints and feedback. They are a guide only. They are not meant to stop you using other ways to address issues that could be as effective, or more effective, in a specific situation.

Case study 1 – Angela

Angela is an aged care home resident living with dementia. A worker noticed that Angela seemed to be having difficulties eating, drinking and swallowing. They also noticed that she was pushing away food she used to eat.

The worker told the registered nurse about their concerns, including the foods Angela was having difficulty eating. The nurse referred Angela to a speech pathologist, who could assess Angela in one week.

The provider was worried about Angela's risk of choking while waiting for the appointment. They changed Angela's diet from regular foods (IDDSI Level 7) to soft and bite-sized foods (IDDSI Level 6) without discussing it with her.

In the next few days, other workers noticed Angela becoming upset at mealtimes, and sometimes refusing to eat some or all of her meals. During a barbecue lunch, the clinical care coordinator, Mai, saw Angela becoming distressed when she was served her food.

Angela looked at the meals being served to other residents and her own plate. She took a few bites before pushing the plate away and saying, 'I'm not hungry'.



Response

Mai sat with Angela to understand what was preventing her from eating. Angela explained that she did not like that her food looked different to other people's (cut up into smaller pieces), and that her choices were limited and not enjoyable.

Mai realised that Angela did not know why they had changed her diet. She apologised and explained what had happened. She told Angela that the nurse had referred her to the speech pathologist to assess her eating, drinking and swallowing. In this conversation, Angela consented (agreed) to go to the appointment. She also agreed to keep eating soft and bite-sized foods while waiting for the appointment.

Mai asked Angela if she needed support to feel safe and comfortable when meeting with the speech pathologist. Angela expressed a clear preference to have the assessment in the morning. She asked for her partner, Jordan, who also lived at the service, to be with her.

Mai documented their conversation and the next steps they had agreed in Angela's progress notes and in the complaints and feedback management system.

The next week the speech pathologist, Steve, thoroughly assessed Angela's eating, drinking and swallowing. After the assessment, Steve recommended management strategies that included Angela's preferences. She wanted to find safe swallowing strategies that worked for her, and that included texture-modified foods.

Steve also gave Angela and the provider information about suitable foods for theme days that supported her clinical needs and her food and social preferences. The provider documented the strategies they had agreed in Angela's care plan. Angela and Jordan agreed to attend a follow-up meeting in one month to review her food intake and dining experiences.

At the follow-up meeting, Angela said she was happy with how things were going and that some of the texture-modified meals were better than she had expected. With Angela's consent, Mai documented the outcome and closed the case in the complaint and feedback management system.

Mai looked through the system to find similar cases. She planned to speak to the service director about the success of her conversation with Angela and ways they could use this approach in the future. This would include educating workers on the importance of:

- discussing options with the older person before making changes to their food or fluids
- not making decisions without talking to the person first.

Case study 2 – Graham

Graham has been living in a residential aged care home for more than 3 years. After having a stroke 5 months ago, Graham needs assistance with transfers, including getting in and out of bed using a hoist and sling.

After one transfer, Graham told a worker that he felt lower than usual in the sling during the transfer, and it did not feel secure. He asked them to check the sling before the next transfer. The worker could not see any damage to the sling and told Graham they would let the supervisor know.

The next morning, when 2 workers were transferring Graham from his wheelchair to his bed, Graham began to slide forward in the sling. The worker facing him noticed he was slipping and moved quickly to support him. They stopped Graham from falling, but he twisted his left ankle and the worker injured their shoulder. Another worker witnessed the incident. They immediately reported it to the care manager and lodged an incident report.



Response

The care manager, Voula, immediately checked in with Graham and the workers to see if they were okay and to do a clinical assessment. Graham said he felt okay but unsettled. He asked for pain relief medication for the pain in his ankle.

Voula acknowledged and apologised for Graham's discomfort. She reassured him that she would find out why the incident happened. She also explained that a GP would come to check on the bruising and swelling of his ankle.

During the conversation, Voula asked Graham if she could contact his son (Graham's registered supporter) and invite him to the open disclosure meeting. She also asked if he would like to speak to an advocate. Graham said he would prefer to have the conversation by himself. He said that his son supported him to make decisions about his care and felt there was no need to worry him about it.

Voula promptly documented the conversation with Graham and their agreed next steps in the incident management system and care documentation system. She also referred the worker with the shoulder injury for a medical assessment.

Voula spoke to other workers on the same shift to:

- understand what happened
- identify immediate risks
- decide what to do next.

Graham's worker explained that Graham had given them feedback about the sling, but they did not have a chance to lodge Graham's concern before the incident happened. Voula thanked the worker for their honesty. She reinforced how important it is to document feedback in the appropriate systems in a timely way, so they can quickly escalate and respond to issues.

Voula asked for the sling to be removed immediately so workers would not use it again. She reported the incident to the Commission as a priority 1 reportable incident because it:

- could be neglect
- had caused an ankle injury that needed medical attention.

Voula met with Graham after she had completed her internal investigation. She told Graham why the incident happened. Voula apologised for what had happened and for not acting on his concern when he first raised it. She explained that, as follow-up actions, a physiotherapist would visit him to do a transfer assessment, and they would get a new sling.

Voula also explained that to stop similar incidents from happening again, she would assess staffing levels and rostering to make sure workers have enough time to document issues in the right systems.

She would also make sure the provider delivered training to workers on:

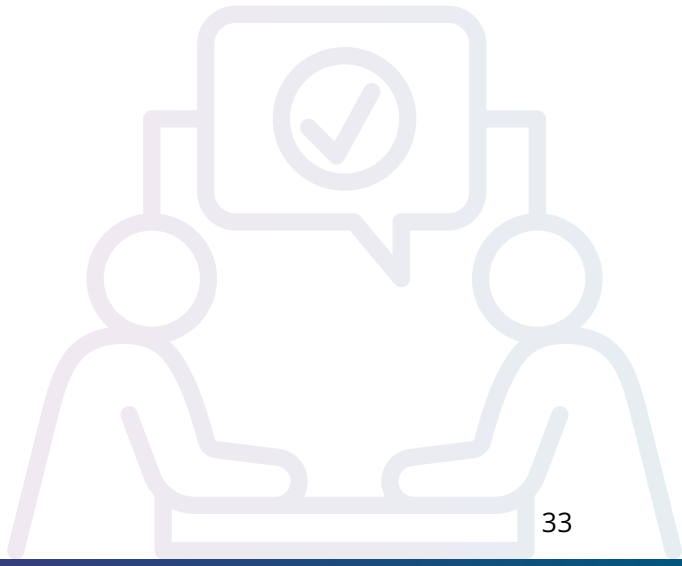
- the importance of documenting and escalating issues and risks in a timely way
- getting a physiotherapist or an occupational therapist to do a transfer assessment for each older person, when needed
- using the right sling for transfers.

She would also arrange for physiotherapists and occupational therapists to do a full onsite review of the slings at the service.

Graham was satisfied with these responses.

Voula told Graham she would check in with him again to see how he was recovering and if these actions were effective.

At their follow-up conversation, Graham said he felt more secure and comfortable in the new sling. With Graham's consent, Voula documented the outcome and closed the case in the incident management system.



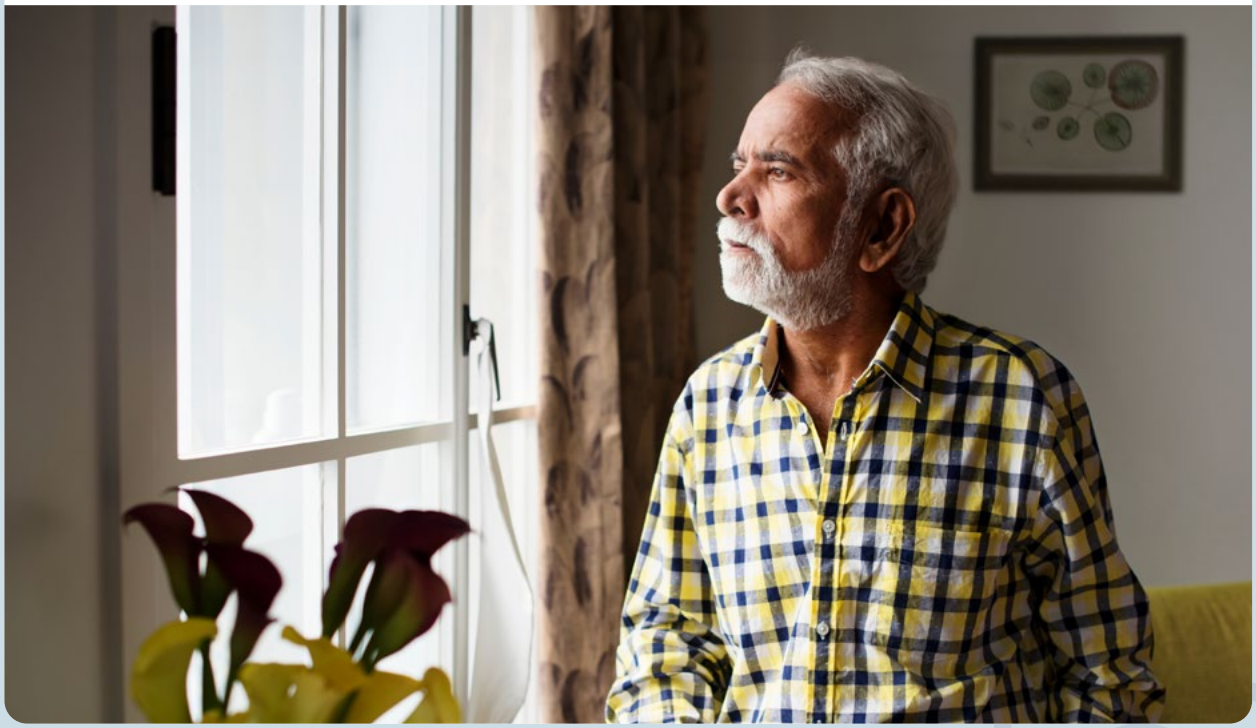
Case study 3 – Prakash

Prakash has been receiving Support at Home services for 12 months. He needs help with showering and preparing meals because his arthritis has worsened. He relies on the provider for his meals and personal care.

One morning, Prakash's support worker did not arrive for their scheduled visit. After waiting for 2 hours, he contacted the service coordinator, Emily, to check if the worker was still coming.

Emily reviewed the roster and found that they had scheduled the visit on the wrong date, by accident, when they had recently updated their system. They had not scheduled for a worker to visit Prakash that morning.

Prakash told Emily that he felt frustrated because his neighbours were visiting him that evening. He had planned to shower and prepare a meal before they arrived and was relying on the scheduled visit for assistance.



Response

Emily acknowledged Prakash's frustration and the inconvenience he was experiencing, and apologised for it. She explained what had happened and offered to find out if another support worker would be available to attend later that afternoon to assist with showering and preparing a meal before his neighbours arrived. Prakash agreed and said he would prefer to have a male support worker.

A male support worker arrived at Prakash's home 2 hours later. While Prakash was disappointed that his usual support worker could not make it, he was pleased that he could have his shower and prepare dinner in time for his neighbours' visit.

Emily documented the missed visit and the replacement visit offered in the complaints and feedback management system and the incident management system. The missed visit may have put Prakash at risk of harm if he had tried to shower and prepare meals without assistance.

As part of her review of the issue, Emily confirmed that the visit had been scheduled for the wrong date because of the system update. She reviewed records in the system and confirmed that Prakash was the only person who had a missed visit.

In line with Prakash's preference, she contacted him by phone to explain the findings. She apologised again and gave him an opportunity to ask questions and raise further concerns. Emily also confirmed that they would not charge him extra for the replacement visit.

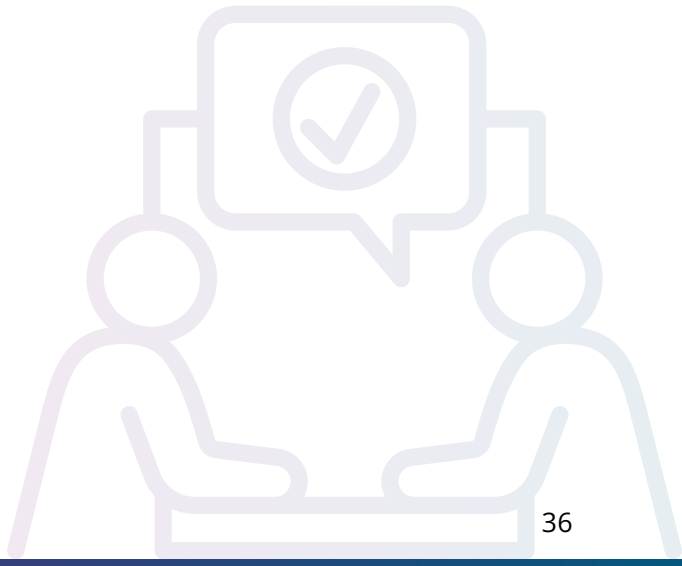
Prakash thanked Emily for her quick response and said he hoped a similar incident would not happen again. Emily said she would work with the rostering team to introduce an extra check of roster changes to reduce the risk of a similar error happening in the future.

Emily checked the rostering and scheduling system over the following weeks. She did not detect any more missed visits. She called Prakash to let him know the incident had not happened again to close the loop. Prakash was happy with the outcome. She recorded the outcome of the review in the complaints and feedback management system, updated the incident record and closed the case.



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  - Open Disclosure Policy – Tasmania
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  - Open Disclosure Policy – Western Australia
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Aged Care Quality and Safety Commission
GPO Box 9819, in your capital city

Find this resource online

agedcarequality.gov.au/resource-library/open-disclosure-framework

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