Every patient has the right to be treated with care, consideration and dignity.

At this health service we respect this right, and we’re committed to improving the safety and quality of the care we deliver. That’s why we have a policy of open disclosure for when things don’t go as planned with the care we provide. Open disclosure assists patients when they are unintentionally harmed during health care.

This leaflet aims to inform you, the patient, your family and carers about the open disclosure process.

For more information

**Patient Liaison Officer**
The Alfred and Sandringham Hospitals

55 Commercial Road Melbourne
Victoria 3004 Australia
Telephone 03 9076 8001
Facsimile 03 9076 3714
Pager 03 9076 2000 ask for 4722
Email feedback@alfred.org.au

Patient Liaison Officer
Caulfield Hospital
Telephone 03 9076 6127

Open disclosure
of things that don’t go to plan

A guide for patients
More than 200,000 people are treated in Australian hospitals each day. Occasionally something doesn’t go to plan and a patient can be harmed unintentionally.

Australian health service organisations are working to improve the way they handle things that don’t go to plan.

Part of improving the way they manage these situations is by being open with you about what happened.

The process of communicating with you when things haven’t gone as expected is called open disclosure.

What is open disclosure?
Open disclosure is open discussion about incidents that caused harm to a patient.

If you have been harmed during your treatment, your doctor, nurse or other healthcare worker should talk with you about it.

Health services encourage their staff, as well as patients and their family or carers, to identify and report when things go wrong or when patients are harmed so that care can be improved.

What is the benefit of open disclosure?
Open disclosure is designed for when things don’t go to plan in health care. It will:

1. Inform you and help you to understand what went wrong with your care
2. Let you know what is being done to investigate what went wrong
3. Explain the consequences of the incident for you and your care
4. Assist you with any support you might need
5. Let you know the steps the health service organisation will be taking to make care safer in the future.

When would open disclosure occur?
Most things that don’t go to plan in health care are minor or are found before they affect you.

For things which don’t result in harm, your doctor or nurse will talk with you about what went wrong in the same way they talk with you about other aspects of your treatment. They should talk with you as soon as they are aware of the incident.

If you are seriously harmed, you will be informed as soon as possible and an open disclosure meeting will be held.

If you think a serious incident has occurred which has not been acknowledged, tell your doctor, nurse or other health service staff.

Is there any other information available?
There is a booklet for patients beginning an open disclosure process called Open disclosure of things that don’t go to plan in health care.

You can get copies of it from the health service or from the Australian Commission on Safety and Quality in Health Care’s web site www.safetyandquality.gov.au