NATIONAL
OPEN DISCLOSURE
PROGRAMME

National Open Disclosure Programme

Annual Report 2022

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar

National Quality and Patient Safety Direct

NATIONAL
OPEN DISCLOSURE
PROGRAMME

CONTENTS

Section	Title	Page
1	Mission, Vision and Values of the National Open Disclosure Office	3
2	Key Developments in Open Disclosure during 2022	4
3	Governance of the National Open Disclosure Programme	6
4	Update on the National Open Disclosure Training and Education Programme 2021.	10
5	Performance Measurement	24
6	Open Disclosure Legislation	31
7	National Open Disclosure Policy Framework	33
8	National Open Disclosure Themed Week	35
9	Open Disclosure “Share the Learning”.	41
10	Partnering with Patients and Service Users	50
11	Stakeholder Involvement	54
12	Supporting staff in the implementation of the HSE Open Disclosure Policy and following patient safety incidents.	58
13	Appendix A: Copy of Letter from National Director of HR 07/07/2022 re Open Disclosure mandatory training requirements	61

Section 1: Mission, Vision and Values of the National Open Disclosure Office and Programme

Figure 1: Mission, Vision and Values of the National Open Disclosure Office and Programme

Section 2: Summary of the Key Developments in the HSE Open Disclosure Programme during 2022

The following is a summary of the key developments in the HSE National Open Disclosure Programme during 2022.

	Summary Development Update	Further information
2.1: Performance Measurement of the HSE Open Disclosure Programme for assurance purposes:	The establishment of 5 work streams to measure compliance with the HSE Open Disclosure Policy through the implementation of the recommendations of the Open Disclosure Performance Measurement Committee in 2021.	See section 5
2.2: National Open Disclosure Training and Education Programme:	The continued roll out, monitoring and evaluation of all elements of the National Open Disclosure training and education programme.	See Section 4
2.3: Resource development:	Resources developed to support the implementation of the HSE Open Disclosure policy, to support patients, their families and staff involved in patient safety incidents and to support staff and patients when they are engaging in the open disclosure process.	See Section 4
2.4: Legislation:	Continued work on the implementation of current legislation (Part 4 of the Civil Liability Amendment Act 2017 and Accompanying Regulations 2018) and in preparation for the pending Patient Safety (Notifiable Patient Safety Incidents) Bill 2019.	See section 6
2.5: Revision of the HSE Open Disclosure Policy:	Following the 2021 consultation process the HSE Open Disclosure Policy was revised. The publication of this policy is currently on hold as it will need further alignment with the National Open Disclosure Policy Framework and Patient Safety Bill when finalised and published.	See section 3
2.6: Open Disclosure Themed Week:	The National Open Disclosure office and local leads facilitated an open disclosure themed week to promote and raise awareness of the importance of open disclosure to patients and their families and to patient safety and quality improvement generally.	See section 8
2.7: Publications:	The National Open Disclosure Office published the 2021 annual report, quarterly newsletters, the 2021 national training report, a patient safety supplement, and information articles in HSE Health Matters and WIN magazine.	Annual reports and newsletters are published on the HSE website and available here.

Development	Summary Update	Further information
2.8: Governance	Work continued in strengthening the governance framework for the National Open Disclosure Programme.	See section 3
2.9: Support for Patients/Service Users	The update of the "Information for the public" page on the Open Disclosure section of the HSE website. The development of a resource listing some of the support services and resources available for patients, service users and their relevant persons following an incident. The continual promotion of support for patients, service users and their relevant persons in all training programmes and events.	See sections 4 and 10
2.10: Support for Staff	The facilitation of two webinars focused on staff support. The continual promotion of staff support in all training programmes and events. The development of a resource listing some of the support services, training programmes and resources available for staff. The promotion of the "ASSIST ME" staff support guidance document and poster.	See sections 4 and 12

Section 3: Governance of the National Open Disclosure Programme

HSE Patient Safety Strategy 2019-2024 Commitment 6: Leadership and Governance to Improve Patient Safety:

"We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance".

3.1: Development and implementation of the HSE Open Disclosure Policy

The HSE Open Disclosure Policy was first written in 2013. It had a significant revision in 2019. It was again revised in 2022.

The revision of the HSE Open Disclosure Policy was completed in Quarter 1 of 2022, following extensive national consultation. A decision was made by the National Open Disclosure Steering Committee on 25th May, 2022 that the launch of the policy needs to be considered in light of the pending Patient Safety Bill and National Open Disclosure Policy Framework and that it was important to work closely with the Department of Health to ensure a coordinated approach. It was agreed that the launch of the policy should be in line with the timeframe of the publication of the framework and enactment of the legislation and on that basis the launch of the policy was paused.

The implementation of the HSE Open Disclosure Policy is critical in relation to the delivery of safe, quality services to patients and service users. The primary responsibility and accountability for the effective management of patient safety incidents, including the open disclosure process, remains at organisational level where the patient safety incident occurs. Effective governance arrangements are required to support timely and effective open disclosure. Central to this is an explicit management commitment to safety that promotes a culture of openness, trust and learning between persons who may be affected by patient safety incidents and those delivering and managing the services within which the patient safety incident occurs.

Governance arrangements must support:

(i) the implementation of the open disclosure policy to ensure the effective management of open disclosure following all patient safety incidents,

(ii) the monitoring and reporting of policy compliance and performance,

(iii) the identification and prompt management of underperformance,

(iv) the development and implementation of improvement plans to address underperformance and

(v) the escalation of underperformance, as necessary.

To underpin the effectiveness of these arrangements, explicit management commitment to the development of capacity and capability and the consistent use of NIMS for the management of data and information relating to open disclosure is required.

This annual report outlines some of the essential elements relevant to the implementation of the policy such as governance, training, etc.

3.2: Accountability arrangements:

Clarity in relation to the roles and responsibilities of staff at all organisational levels is a fundamental governance requirement for effective incident management. Open Disclosure is an integral component of the incident management process. It is the role and responsibility of the Senior Accountable Officer (SAO) to have overall accountability within their area of responsibility for the management of incidents which includes compliance with the HSE Open Disclosure Policy. This includes ensuring that the management arrangements and the roles of all staff in relation to open disclosure are clearly defined.

3.2.1: The HSE Performance and Accountability Framework 2020 sets out the accountability structure for the HSE and clarifies the named individuals who have delegated responsibility and accountability for all aspects of service delivery across the four domains of the National Scorecard i.e. access to and integration of services, the quality and safety of those services, achieving this within specific financial, governance and compliance requirements and by effectively harnessing the efforts of our workforce. For the purpose of the HSE's Delegation and Performance and Accountability Frameworks, Hospital Group CEOs, CHO Chief Officers, Director of NAS, the Head of PCRS and Heads of other national services are considered the accountable officers for their areas of responsibility. They are therefore fully responsible and accountable for the services they lead and deliver. Accountable officers are required to have formal performance management arrangements in place with the individual services they are responsible for, to ensure delivery against performance expectations and targets.

3.2.2: The HSE National Service plan for 2022 included the following actions relating to Open Disclosure.

"Priority Areas for Action 2022

Design and deliver programmatic interventions to improve compliance with incident management policies and standards, including open disclosure.

Monitor the health and social care requirements for the pending introduction of legislation on Pre-Action Protocols and Patient Safety Bill and facilitate the introduction of the necessary systems and resources to support the legislation

Development of Regional Health Areas

The objectives of regionalisation are aligned with the overall aims and objectives of Sláintecare. These centre around the principles of integration of care: equity of access, improving patient outcomes and experiences, as well as transparency and accountability".

3.2.3: The National Open Disclosure Steering Committee which is chaired by the National Clinical Director for Quality and Patient Safety, Dr Orla Healy, oversees the progress of the Open Disclosure programme of work. In fulfilling this role, the National Open Disclosure Steering Committee advance, champion, support and provide strategic advice on the on-going implementation of the National Open Disclosure Programme and policy.

3.2.4: The National Quality and Patient Safety Directorate (NQPSD) works in partnership with HSE operations, patient representatives and other internal and external partners to improve patient safety and the quality of care by:

- building quality and patient safety capacity and capability in practice
- using data to inform improvements
- developing and monitoring the incident management framework and open disclosure policy and guidance
- providing a platform for sharing and learning; reducing common causes of harm and enabling safe systems of care and sustainable improvements.

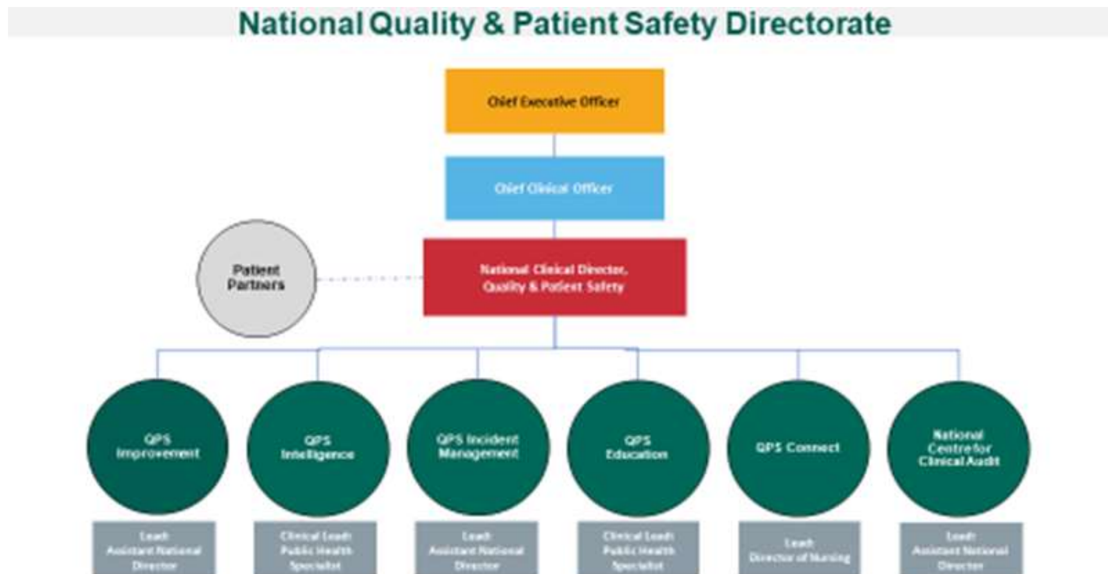


Figure 2: NQPSD Organogram. Open Disclosure sits within the QPS Incident Management function.

3.2.5: The Quality and Patient Safety Incident Management Team

The Quality and Patient Safety Incident Management team is part of the NQPSD within the office of the Chief Clinical Officer. It brings together three key teams and functions critical to incident management, namely the National Open Disclosure office and team, the Incident Management team and the HSE National Incident Management System team. The national Open Disclosure policy and programme is co-ordinated via the National Open Disclosure office and reflects the strategic and policy direction established by the HSE leadership team and is consistent with the policies and strategy of the HSE and Department of Health.

The National Open Disclosure Office provides strategic guidance and support on the implementation of:

(i) The HSE Open Disclosure Policy;
(ii) Part 4 of the Civil Liability (Amendment) Act 2017;
(iii) The Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018;
(iv) The provisions relating to mandatory open disclosure within the forthcoming Patient Safety Bill';
(v) The recommendations pertaining to Open Disclosure in the Report by Dr Gabriel Scally into matters arising in CervicalCheck 2018;
(vi) The National Open Disclosure Training Programme;
(vii) The National Open Disclosure Performance Measurement and Quality Assurance programme.

The work of the office feeds into and is key to the operational plan for Incident management in the National Quality and Patient Safety Directorate. The team apply a collaborative approach across the three functions and

wider Directorate. These plans further align with the strategic objectives of the office of the Chief Clinical Officer and the HSE National Service Plan for 2022.

Expansion of the National Open Disclosure Office

Vacancies were recruited into. Submission was made for additional posts in the 2022 estimates process to support the preparation for and implementation of the pending Patient Safety Bill, the pending revised Part 4 of the Civil Liability Amendment Act 2017, the implementation of the pending National Open Disclosure Policy Framework and the pending revised HSE National Open Disclosure policy. This was unsuccessful.

3.2.6: Open Disclosure Leads: The number of appointed and trained clinical and managerial open disclosure champions

There are Open Disclosure leads in all hospital groups, community healthcare organisations, screening service, National Ambulance Service and in many of the Section 38 and 39 voluntary agencies – details for leads across services is available here. The role of the Lead is to manage, support and oversee the implementation of the HSE Open Disclosure Policy, programme (including the national training programme) and legislation across all services/departments in their service area and to provide reports to the Local Accountable Officer in relation to the same. The leads work closely with the staff in the National Open Disclosure Office. The National Open Disclosure Office supports the leads in their work and keep the leads up to date with programme developments through the facilitation of quarterly update meetings, quarterly newsletters and quarterly training reports.

3.2.7: Changes to CARP statement

The CARP statement which is completed annually by all management staff at grade VIII and above was revised as follows for 2022 in relation to Open Disclosure:

"*I have completed the mandatory Open Disclosure Training and ensure that open disclosure is included in the procedures for managing incidents in my area of responsibility".*

Section 4: Update on the National Open Disclosure Training and Education Programme 2022

HSE Patient Safety Strategy 2019-2024 Commitment 2: Empowering and Engaging Staff to Improve Patient Safety

"We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety".

4.1: Development and implementation of open disclosure training for all clinical and non-clinical staff including agency staff.

Open disclosure training is mandatory for all staff working in HSE and in HSE funded services since January 2019 as per the instruction of the Director General of the HSE in August 2018. A letter was issued from the National Director of HR in July 2022 setting out the mandatory training requirements, how to access training and accountability arrangements in relation to the same. (**See Appendix A**). It is the responsibility of each service manager to ensure that staff are trained in open disclosure as relevant to their role and to maintain local training records to provide assurance that the service is meeting mandatory training requirements.

All staff must complete Open Disclosure e-learning Module 1 "Communicating Effectively through Open Disclosure" which is available on HSeLanD.

Staff who may be involved in formal open disclosure meetings e.g. senior managers, senior nursing, midwifery and health and social care professionals, medical staff, QPS staff and staff fulfilling the role of the Designated Person must **also** complete: E-learning Module 2 "Open Disclosure: Applying Principles to Practice" and Module 3 Face to Face Skills Workshop (3 hours) on the management of the open disclosure process. These staff must be identified locally and provided with access to this training.

A submission was made for the inclusion of mandatory training requirements for Open Disclosure to be included in the SLAs for agency staff including medical staff, nurses and midwives, social care workers, health and social care professionals and health care assistants.

Further work is planned and communication commenced in relation to the inclusion of mandatory training requirements for Open Disclosure in the SLAs for funded services

4.2: How to access Open Disclosure Training programmes

- Module 1: Communicating Effectively through Open Disclosure available on HSeLanD – login here
- Module 2: Open Disclosure: Applying Principles to Practice available on HSeLanD – login here
- Face to Face Training can be accessed by contacting the Open Disclosure Lead for their service area available here.

4.3: Continuing Professional Development(CPD) and Continuing Educations Units(CEUs):

All of the above Open Disclosure training programmes attract CPD/CEUs as follows:

- Module 1: 2 External CPD points (RCPI) and 2 CEUs (NMBI)
- Module 2: 3 External CPD points (RCPI) and 3 CEUs (NMBI)

- Face to Face Skills Training: 3 External CPD points (RCPI) and 3 CEUs (NMBI)

4.4: Overview of the National Open Disclosure Training and Education Programme:

The National Open Disclosure Training and Education Programme continued throughout 2022. The pandemic and associated Covid-19 Government restrictions continued to impact on the delivery of face to face training with the majority of training being accessed virtually.

During 2022 delivery of the National Open Disclosure Training and Education Programme included the following components:

- The uptake of Module 1 of the Open Disclosure on-line training and education programme on HSeLanD – *"Communicating Effectively through Open Disclosure*". There were **62,650** completions of this module during 2022.
- The uptake of Module 2 of the on-line training and education programme on HSeLanD: "Open Disclosure: Applying Principles to Practice". There were **14,732** completions of this module during 2022.
- The roll out of the National Train the Trainer programme for the revised, accredited 3 hour face to face skills workshop.
- The roll out of the revised 3 hour face to face skills workshop across services with the majority of face to face training happening in Quarter 3 and Quarter 4 due to Covid-19 restrictions. **702** staff attended the face to face workshop.
- The maintenance of national training databases and provision of quarterly training reports.
- The provision of updates on a quarterly basis to open disclosure area and site leads.
- The continued evaluation of all training programmes.
- The continuation of the Open Disclosure webinar series.
- Continued work to improve the access to and uptake of Open Disclosure training by medical staff.
- The development of further open disclosure training and education resources.
- The facilitation of presentations/workshops at various events including training days, conferences, post graduate programmes etc.
- An abstract and poster presentation at the National Patient Safety Conference on the pilot of the development of the revised face to face workshop

4.5: 2022 Full Training Report

A detailed training report for 2022 which includes a breakdown of the uptake of training per programme and per service area is available here .

4.6: Training Target

The National Open Disclosure Training Programme currently aims to achieve an annual 30% staff uptake of Module 1 of the online training programme with an aim to reach 90% over a 3 year period. This is based on the requirement to complete mandatory training every 3 years. Work Stream 4 of the Open Disclosure Performance Measurement programme has been tasked with the development of an indicator to accurately capture the percentage of relevant staff who are up to date with their Open Disclosure training within the past 3 years and so this indicator may change going forward.

4.7: Data Limitations

There are currently a number of limitations which impact on the provision of accurate national training data as outlined in the table below:

No	Limitation	Current actions to address limitation
1	Constantly moving HSE headcount data.	Quarterly headcount data reports are obtained from HSE Strategic Workforce Planning and Intelligence, National HR Directorate to inform training reports.
2	Smartsurvey (National training database for recording face to face Open Disclosure training) data is dependent on upload of face to face training data by trainers.	Constant reminders are sent out to trainers regarding the need to upload training data. Trainers are contacted to upload training 2 weeks prior to training reports being commenced.
3	HSeLanD e-learning stats are dependent on staff members identifying themselves as working in the correct service area / organisations / grade category on their HSeLanD profile and to update this when they move/get promoted/ etc.	HSeLanD users are reminded regularly through a range of means to ensure their registration details are current. HSeLanD is working with services in relation to new user authentication software tools.
4	The training data provided includes everyone who completed any form of open disclosure training in the three years (36 months) prior to the report. This includes staff that have left the HSE (retired/resigned from the HSE) or moved post within the HSE over that period.	Training data provided is based on most up to date HSE staff numbers obtained quarterly from HSE Strategic Workforce Planning and Intelligence.
5	As there are two training programmes available on HSeLanD, staff may have (i)Completed each module more than once (ii)Completed more than 1 training programme, and therefore may be counted more than once.	Both modules on HSeLanD are counted separately. In December 2022 training for Open Disclosure office staff was commenced by Aurion on how to remove duplicates from data for each module and how to identify users who have completed both modules.
6	There could be triple counting when HSeLanD data is added to face to face training data.	This relates to staff who may have competed one or both online modules and the face to face training programme. A process does not exist to identify staff who have completed all three modules. This information will be held by local management teams who have the ultimate responsibility to ensure that staff have completed the appropriate level of training.

No	Limitation	Current actions to address limitation
7	Staff may have several accounts on HSeLanD using different email addresses.	A project is underway within HSeLanD to identify any duplications. There is an action to follow up with identified accounts to amalgamate training records into single user account.
8	It was identified in Quarter 4 of 2022 that HSeLanD data includes users outside HSE and HSE funded services e.g. private hospitals, private nursing homes, TUSLA, Volunteers, students.	Training was commenced for the National Office staff in December 2022 on how to exclude users outside HSE and HSE funded services and how to report on HSE, Section 38 and Section 39 organisations separately.
9	Not all HSeLanD service lists are accurate e.g. Data on training completions by UHL staff can be found in two locations on HSeLanD.	Both locations checked and counted to inform reports. This has been notified to HSeLanD.
11	Downloading reports can be slow if longer period requested	Reports requested for shorter period or additional time allowed for longer reports.

However, even though there are limitations to the data, the total numbers affected are relatively low (i.e. not many staff perform the same e-learning multiple times, it is primarily HSE staff who use the system, etc.)

It is a fantastic platform and similar training access is not available in other jurisdictions at national level. It highlights the importance of maintaining good local training records however. The total number of staff accessing the training is substantial as outlined below.

4.8: The number of trained clinical and non-clinical staff 2020- 2022:

There was a significant increase in the uptake of open disclosure training programmes during 2022 with a total of **78,084** completions of open disclosure training programmes throughout the year. This indicates an encouraging 103% increase on the previous year.

Year	Number of completions of Open Disclosure Training Programmes
2020	39,314
2021	38,376
2022	78,084
Total 2020-2022	**128,624**

Table 1: Number of completions of Open Disclosure Training Programmes 2020-2022 (these figures includes both e-learning module and face to face training)

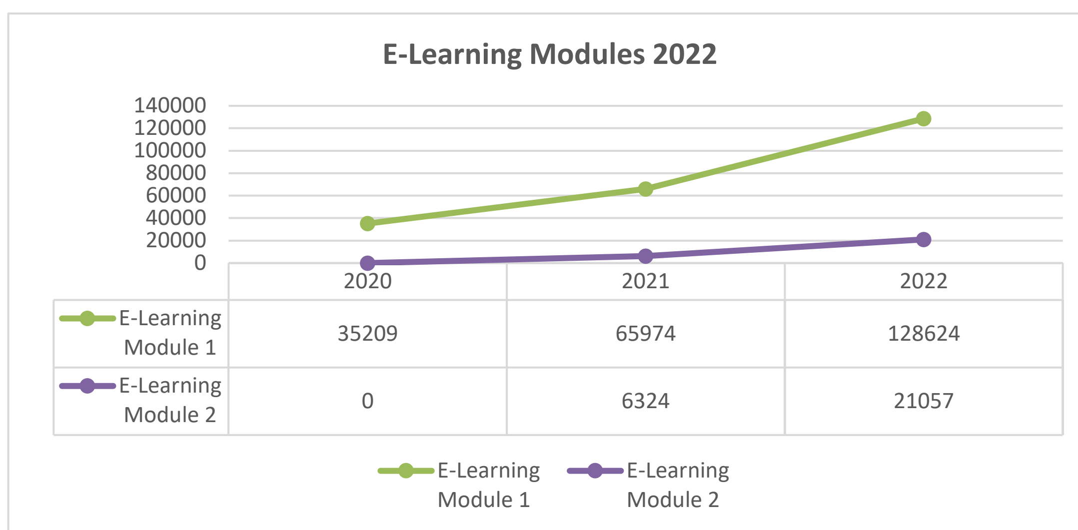


Table 2: Number of completions of E-learning Modules registered on HSeLanD during 2020-2022

Feedback received on Module 1 and Module 2 during 2022

Module 1

Question	Total No. of Responses	% Agreed / Strongly Agreed	Average Response*
The e-learning content met my expectations.	42682	86%	4.4
The programme was relatable and applicable to my role	41914	82%	4.3
As this was an online programme, I was able to access and complete it at my own pace and in my own time.	41946	89%	4.5
I preferred completing the programme online rather than in a classroom setting.	41838	80%	4.3
The content of the programme was clear and easy to understand.	41681	89%	4.5
The programme contains an appropriate mix of text, images, and interactive elements.	41574	88%	4.5
Having completed this eLearning programme, I am more knowledgeable about the topics covered.	41481	90%	4.5
I have learned practical skills that I will apply in my area of work.	41388	85%	4.4
I was able to achieve the learning outcomes as stated in the programme.	41298	88%	4.5
I would recommend this programme to others.	41256	87%	4.5

**** Note where: 4 = Agreed and 5 = Strongly Agreed***

Module 1 Sample Feedback Comments:

- I wouldn't change anything, I found it very helpful and feel I'd be supported in all aspects of my job.
- This program was excellent and had nothing to change. It would be more appreciated if you can add more practical sections.

- It was detailed and covered the relevant aspects of the policy and sketched scenarios that I have actually encountered and felt at sea and alone about.
- I found the subject/content to be very practical and useful advice on next steps for making open disclosure applicable to settings outside of hospitals.
- I thought it was great especially the story from the paediatric nurses experience - very insightful.
- I thought the course was very good. I liked the stories and more could be included for learning. Stories involving a more serious case e.g. someone dying, would be useful.
- The programme was well planned and informative. Besides further in-person training, this format meets the needs of those who are required to take it.

Module 2

Question	Total No. of Responses	% Agreed / Strongly Agreed	Average Response*
The e-learning content met my expectations.	13714	85%	4.4
The programme was relatable and applicable to my role	13579	82%	4.3
As this was an online programme, I was able to access and complete it at my own pace and in my own time.	13543	87%	4.5
I preferred completing the programme online rather than in a classroom setting.	13512	80%	4.3
The content of the programme was clear and easy to understand.	13477	87%	4.5
The programme contains an appropriate mix of text, images, and interactive elements.	13447	87%	4.4
Having completed this eLearning programme, I am more knowledgeable about the topics covered.	13441	88%	4.4
I have learned practical skills that I will apply in my area of work.	13399	84%	4.3
I was able to achieve the learning outcomes as stated in the programme.	13373	87%	4.4
I would recommend this programme to others.	13329	85%	4.4

**** Note where: 4 = Agreed and 5 = Strongly Agreed***

Module 2 Sample Feedback Comments:

- I wouldn't change anything in terms of the programme itself. It was very informative. It would be good to add the role of admin staff to this situation as this would not apply to my job.
- I found the course very informative. I honestly do not feel that anything needs to be changed. If I was being hyper critical possibility of more practical videos of principle working on a ground level.
- I feel that perhaps the reflective part could also be incorporated into the module rather than externally. The module video scenarios were excellent.
- I thought the course was very informative. I am a visual learner and found the video links with actors and the bright colours used throughout the presentation very helpful and engaging.
- I thought the video example of the formal meeting was excellent. I would love to have seen an example from a mental health setting played out that wasn't in relation to a medical procedure.
- I wouldn't change anything. I enjoyed updating my knowledge and developing my skills as it benefits me and those in my care.

Table 3 : Number of staff who attended face to face skills workshop during 2020-2022

Feedback on revised Face to Face Workshop during 2022

All Open Disclosure workshops are evaluated using a standardised evaluation tool. Analysis of a random sample (44) of workshop evaluations from across three different sites identified the following:

Will this training change or influence your practice:

Yes – 97.7% (43)

No – 2.3% (1)

Were the stated objectives met?

Yes – 100% (44)

What is your overall assessment of the training?

Very Satisfied – 68.2% (30)

Satisfied – 29.5% (13)

Partially Satisfied – 2.3% (1)

How will this training change or influence your practice?

- Timely Information
- Support Staff and Patient
- Multidisciplinary Approach
- Documentation
- Ensure any minor / no harm incidents are documented
- Now aware of Assist and Assist Me structures to facilitate conversations
- Honesty at all times with patients and their families
- Supporting colleagues and knowledge of EAP
- Share the learning
- Importance of preparation
- De-briefing
- Acknowledgement of the patients story
- Use more non-verbal language
- Be more careful using language of blame
- Continuity of care
- Accountability

Learning Points from the training:

- Encourage more staff to get educated
- How to handle particular situations
- Assist Approach
- Staff Support
- Start open disclosure asap
- Good communication skill are essential
- Organisation and Family Meeting procedure
- Awareness of website supports
- Awareness of impact of Patient Safety Bill
- Importance of genuine apology with no ‘buts’
- Naming Emotions

4.9: The continued roll out of the accredited National Open Disclosure Train the Trainer programme to support the delivery of the revised Open Disclosure 3 hour face-to-face skills workshop.

The HSE National Open Disclosure Training programme is continually adapted to reflect the changing needs of services and in response to developments in Open Disclosure nationally including changes to policy and legislation and feedback provided via training programme evaluations.

4.9.1: Background

The revised 3 hours face to face skills based training programme was developed in 2021 with staff from Sligo University Hospital and CHO1 to provide natural follow on training and to complement the on-line modules. This programme provides an opportunity for staff to practice the key skills required to effectively manage an open disclosure meeting to get the best outcome for the patient/ relevant person and staff involved. The workshop includes:

- an overview of the Open Disclosure Programme;
- information and discussion on the Open Disclosure process;
- updates on all current and pending legislation pertaining to Open Disclosure;
- case scenarios specific to the group attending training and related role play activities;
- the management of communication challenges;
- the management of complexities that may arise during the Open Disclosure process;
- guidance on the documentation of Open Disclosure discussions;
- discussion and group work on how to support patients, their relevant persons and staff during the process and
- the provision of a number of resources to support staff when preparing for and engaging in Open Disclosure discussions with patients and their families including resources to support all those affected by patient safety incidents.

Trainees are provided with a number of resources to support the delivery of training including a training manual which provides guidance on the management of all of the workshop components.

4.9.2: Attendance at the Train the Trainer Programme

The Open Disclosure Train the Trainer Programme is delivered in 2 parts as follows:
Part 1: 3 hour Virtual training programme delivered via Microsoft teams
Part 2: 1 full day face to face workshop.

The National Open Disclosure team work with the Open Disclosure leads across all service areas in the identification of staff to be trained as trainers and staff nomination forms are submitted by these leads to the National Open Disclosure Office. Work is prioritised in areas who are most in need of trainers. The nomination of staff involves a commitment by local management to

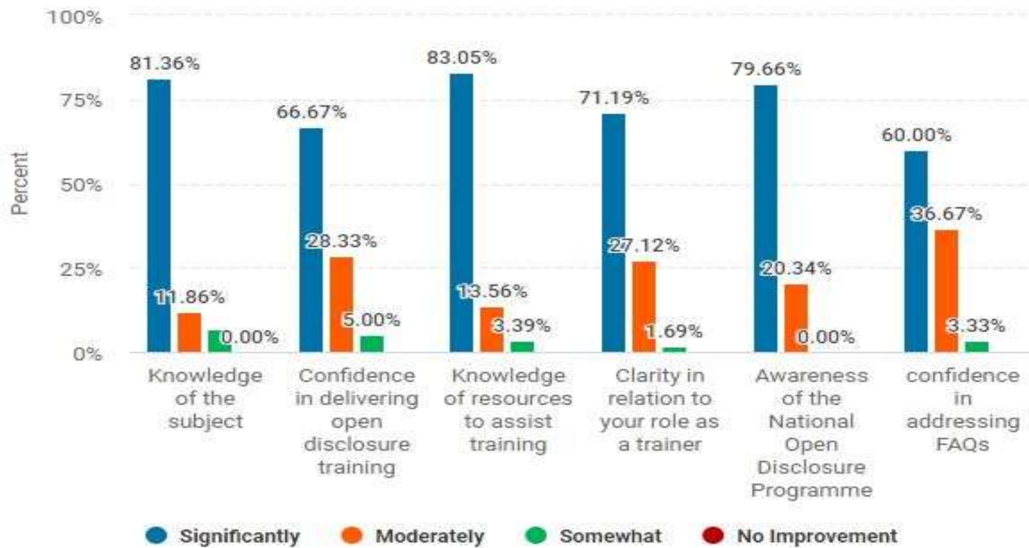
(i) release the staff member to attend the open disclosure train the trainer programme,
(ii) support the staff member in the delivery of open disclosure training within the service area and
(iii) release the staff member to complete a minimum of four half days per year of training to maintain their competency as an open disclosure trainer.

During 2022 a total of 89 staff completed the 1.5 day train the trainer programme. A further 43 staff completed Part 1 of the programme and 3 staff completed Part 2. These staff will complete their training in 2023. Attendees included (i) staff who were already trained as Open Disclosure trainers for the previous face to face programme and who were re-training on how to deliver the revised workshop and (ii) new trainers.

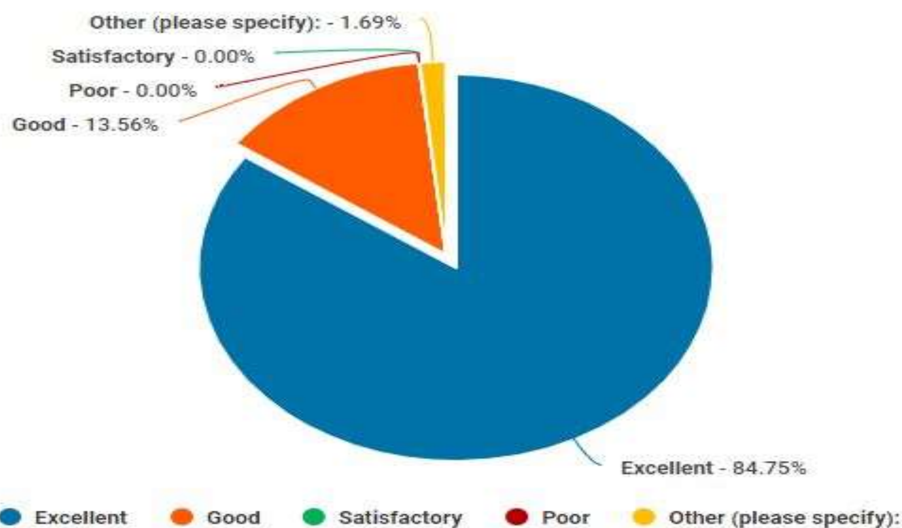
4.9.3: Evaluation of the National Open Disclosure Train the Trainer programme

All train the trainer programmes are evaluated using a standardised evaluation tool and the results are analysed using Smartsurvey. The following is a summary of the evaluation of the National Train the Trainer Programme by course participants in 2022.

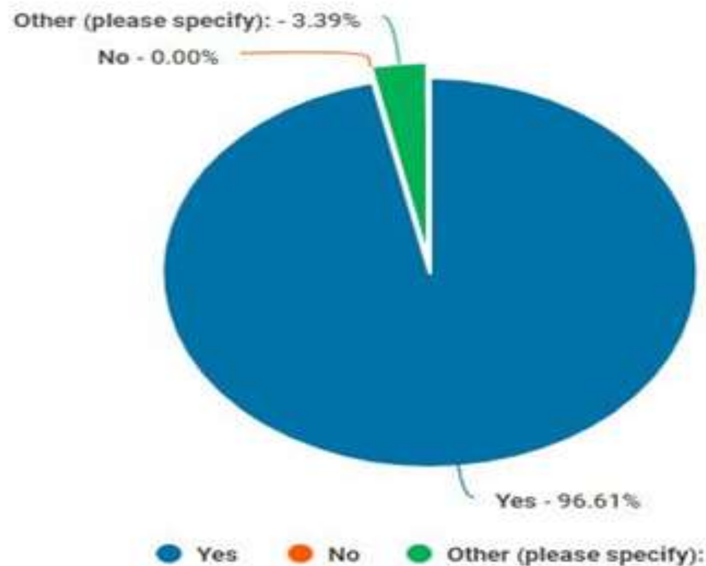
In relation to your specific training needs, to what degree did the programme improve your:



How would you rate the content of the Train the Trainer programme?



Were the stated objectives of the training programme met?



What participants said they liked about this training programme

- Relaxed environment. Felt very comfortable to share own knowledge and to ask questions/get clarity;
- Educators incredibly knowledgeable and keen to share their expertise;
- The role play and interactive work
- Clear objectives. All questions and queries addressed. Staff approachable and knowledgeable;
- Interaction between the course participants and trainers was excellent;
- Each participant had the opportunity to deliver a designated part of the programme, very helpful;
- Practical hands-on approach. TTT trainees we were nicely facilitated to take on trainer role.

What participants said they would recommend to improve this programme

- Would have liked to attend the workshop first before doing this course;
- More time;
- Ensure virtual three hour training is completed prior to face to face training component;
- I wouldn't change anything , I was very happy with this training programme

4.10: Uptake of training by Medical Staff:

4.10.1: Ongoing work with and involvement of medical staff in the promotion of Open Disclosure and mandatory training requirements

Work continued during 2022 to improve the uptake of open disclosure training by medical staff as follows:

- Involvement of medical staff in the development and testing of the revised face to face skills programme – developing a workshop that would meet the specific needs of medical staff and delivered in a manner which would meet their preferred learning style;
- Medical representation on the National Open Disclosure Steering Committee;

- Invitation to and attendance of medical staff at Open Disclosure webinars;
- Inclusion of medical staff in the Open Disclosure train the trainer programme;
- Open Disclosure Clinical Lead role developed in Sligo University Hospital; plans to try to roll this out across all hospital sites with clinical leads in community settings also;
- Specialty specific case scenarios are used in training that medical staff can relate to;
- Using a directorate approach to training and encouragement of clinician presence and leadership in training programmes;
- Representation by two senior consultants (Professor Brian Kinirons, Personal Professor in Anaesthesia, National University of Ireland, Galway, Medical Director, National Doctors Training and Professor Martin Mc Cormack, Chief Executive Officer, College of Anaesthesiologists of Ireland, Secretary Forum of Postgraduate Medical Training Bodies) on the Open Disclosure Performance Measurement work stream 4 which is tasked with the development of an Open Disclosure training indicator;
- Representation from the Medical Council (Jantze Cotter, Director Professional Competence, Research, Ethics & Facilities) on the Open Disclosure Performance Measurement work stream 4 which is tasked with the development of an Open Disclosure training indicator;
- Record of NCHD uptake of training on the Doctors Integrated Management E-portal (DIME)/National Employment Record (NER) by the NDTP (see 4.11.3 below for further details on pilot work with 2 hospital groups to address the number of NCHDs who have not uploaded evidence of attendance at Open Disclosure training to the DIME system);
- Inclusion of Open Disclosure training as mandatory since July 2021 for interns via the NCHD hub on HSeLanD - through the Intern Network Executive;
- Inclusion of Open Disclosure in the Medical Council Safe Start Programme for new registrants;
- Submission to the annual report of the IHCA in August 2022;
- Continuing engagement with the undergraduate programmes;
- Promotion of the on-line modules at all events;
- Ensuring that training bodies are aware of the online modules and resources available to support staff when they are preparing for and engaging in an open disclosure meeting;
- The promotion of the Open Disclosure Quick Reference Guide and Toolkit;
- Ensuring that all Open Disclosure training programmes are CPD accredited;
- Masterclass with clinical directors arranged for March 2023.

4.10.2: Uptake of training by Medical Staff in 2022

In 2022 there was **5149** completions of Open Disclosure training programmes by doctors (Consultants / NCHDs).

Open Disclosure Training Completions Consultants 2022

Face to Face Open Disclosure Training	**114**
E-learning Module 1	**589**
E-learning Module 2	**161**

Total training completions recorded for Consultants in 2022 is **864**

Open Disclosure Training Completions NCHDs 2022

Face to Face Open Disclosure Training	**178**
E-learning Module 1	**2832**
E-learning Module 2	**1275**

Total training completions recorded for NCHDs in 2022 is **4285**

Open Disclosure Training Completions by Medical Staff 2020-2022

Year	Medical staff headcount	Uptake of training
2020	11,762	2284
2021	12,113	2435
2022	12,697	5149 (5383 when including dental)

4.10.3: Pilot project with Saolta Hospital Group and University Hospital Group Limerick to address the data provided on the number of NCHDs who have not uploaded evidence of attendance at Open Disclosure training to the DIME/NER system.

The Doctors Integrated Management E-portal (DIME) is a quadripartite system which encompasses National Doctors Training & Planning (NDTP), the Irish Medical Council, the Postgraduate Medical Training Bodies and Clinical Sites. The DIME system continues to be upgraded and developed on an on-going basis and currently consists of eight separate modules including the NCHD Post Matching Module, National Employment Record (NER) Module, Consultant Post Matching Module, Occupational Health Module, Consultant Applications Portal (CAP) Module, Training Supports Scheme Module, Clinical Course & Exam Refund Scheme Module and E-Portfolio Module.

National Employment Record (NER) Module: In October 2015, the NER module was rolled out nationally. This enhanced existing DIME functionality by incorporating an efficient management system of pre-employment screening documentation that NCHDs must provide prior to commencing a new post. The NER Module reduces the burden of paperwork on NCHDs by providing a central location for this documentation to be stored and accessed by their employers. Training certificates can also be uploaded via the NER app which is now available.

Work was commenced in December 2022 with the Open Disclosure Leads in Saolta Hospital Group and UHLG to address the number of NCHDs who have not uploaded evidence of attendance at Open Disclosure training to the DIME/NER system. Reports were provided by the NDTP to the National Open Disclosure Office providing data per hospital site outlining the number of submitted Open Disclosure training certs by NCHDs, the number of certs verified by Medical Manpower departments, the number of certs missing and the number of certs nearing expiry. The NDTP has circulated a communication to all NCHDs on the DIME system to remind them of mandatory training requirements relating to Open Disclosure and to upload their training certs to the NER system. The Open Disclosure Hospital Group Leads are working locally with individual hospital sites and leads and contacting NCHDs at local level also. The involvement of Medical Manpower departments, clinical directors, NDTP leads and NCHD leads in this piece of work also has been recommended by the National Open Disclosure Office.

4.10.4: Work with the Forum of Post Graduate Training Bodies:

The National Open Disclosure Office continually engages with the training schools and bodies in the roll out of the HSE Policy and national training programme. It was also a recommendation of the National Open Disclosure Steering Committee that training data on the uptake of Open Disclosure training should include training data from the post graduate training bodies. This is now being addressed via the Open Disclosure Performance Measurement work stream for training. Work has commenced with the training bodies on the identification of a list of courses which include Open Disclosure in the curriculum. Training bodies have been asked for their co-operation in the provision of training data and that the Open Disclosure online module be included in medical staff induction and pre-induction programmes. It is also planned to call out Open Disclosure in the "Memorandum of Agreement" with Training Bodies on training site accreditation (timeline July 2023).

4.11: Webinars

The National Open Disclosure Office facilitated 7 webinars during 2022. The purpose of these webinars is to (i) maintain communication with Open Disclosure leads, trainers and staff working across all of our health and social care services, external agencies and patient representative / patient advocacy groups, (ii) keep the importance of Open Disclosure on the agenda across all services and (iii) to provide continual support to staff across the system in the implementation of the HSE Open Disclosure policy.

Webinar topics are identified thorough the webinar evaluation process in an effort to provide information on topics which are of interest and of benefit to our audience. Each webinar was CPD accredited by RCPI (2 external CPD points) and NMBI (1.5 CEUs). Numerous stakeholders were involved in the delivery of the webinar programme. The total attendance across 2022 webinars = **2,396**. Details of webinars delivered by the programme include:

Webinar Title	Date	Total Attendees
The Role of Advocacy Services in Supporting Open Disclosure	9th February 2022	317
Preparing for Important Conversations (NHCP)	9th March 2022	354
Open Disclosure: the State Claims Agency's Perspective	13th April 2022	391
Overview of GDPR	18th May 2022	331
Open Disclosure: Supporting Staff following Patient Safety Incidents	21st September 2022	352
Open Disclosure: The Role of Managers in Supporting Staff following Patient Safety Incidents	12th October 2022	323
Open Disclosure: Approaches to Implementation	9th November 2022	328

4.11.1: Evaluation of the Webinar Programme: Attendees at all webinars were invited to complete a short survey immediately after each webinar. Averages were calculated across all evaluations. Of the webinar feedback received (762 responses in total):

% of Respondents who Agreed or Strongly Agreed that:	Average % based on completed evaluations
The content of the webinar was relevant to them	**95%**
The webinar has helped them to develop their knowledge and understanding of the subject area	**96%**
The subject area was presented effectively	**94%**
The pace of the webinar was satisfactory	**91.5%**
Plan to apply what they learned from the webinar in their work	**94.5%**

- 95.7% of respondents stated that the webinar met or exceeded their expectations
- All respondents were invited to leave additional feedback / comments. Examples of some comments include:

"The support of the OD team is excellent both in arranging and managing the webinars. Thank you."

"Excellent and engaging - thank you! I also appreciated that it was online, as it allows me to attend and then get back to work for the day"

"The webinars arranged by the OD office are excellent learning tools for expanding knowledge base that can be applied to help our patients on their journeys through the healthcare system. Well done all."

"I think this was a very good piece of work and it hopefully was recorded and can be edited and circulated to all Line Managers, so that we can let all staff watch the webinar and take what they need from it."

Webinars provide easily accessible support tools for the vast number of staff in the HSE, section 38 and 39 organizations - please keep presenting!

4.12: Development of Training and Education Resources during 2022

The following resources were developed by the National Open Disclosure team during 2022:

Review and update of the Open Disclosure website

Revised and updated dedicated public webpage

List of support services and resources for patients and service users following an incident

List of support services and resources for staff following an incident

The following resources were updated during 2022:

Sample Flyer Open Disclosure Workshop (CPD Accredited) March 2022

Open disclosure briefing presentation (March 2022)

Open disclosure Face to Face Skills Workshop (March 2022)

Participant Pack for Workshop (March 2022)

Sample Attendance Sheet Face to Face Skills Workshop (August 2022)

Section 5: Performance Measurement

HSE Patient Safety Strategy 2019-2024 Commitment 5: Using Information to Improve Patient Safety

"*We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety.*"

5.1: Background:

Open Disclosure is a requirement set by the HSE when a patient safety incident occurs, especially where a patient or service user was harmed. Being open and transparent is a professional, ethical and policy requirement. The soon to be enacted Patient Safety Bill will also legislate for a statutory requirement of Open Disclosure in a number of defined notifiable incidents.

The draft National Open Disclosure Policy Framework developed by the Department of Health in 2022 set out specific reporting requirements by health care providers including the HSE. Consultation on the draft document was completed in September 2022 and the final document is due to be published in early 2023. Some of the requirements from the draft document are as follows:

- *Monitoring involves activities such as reporting, recording, measurement of open disclosure in practice, training, education, and policy implementation. Evaluation involves the collection and analysis of open disclosure data to inform future policy. The effective monitoring and evaluation of open disclosure in policy and practice will demonstrate how health and social care organisations comply with the principles set out in this Framework and how they are contributing to its implementation.*

- *Health and social care organisations should develop open disclosure key performance indicators, evaluate open disclosure performance, and integrate outcomes into quality improvement, clinical governance, and performance monitoring.*

- *The health and social care service providers' annual report will include information regarding:*
    - *Development and implementation of open disclosure policy.*
    - *Development and implementation of open disclosure training for all clinical and non-clinical staff including agency staff.*
    - *Evidence of the availability of support structure for all staff clinical and non-clinical including agency staff.*
    - *The number of trained clinical and non-clinical staff including agency staff.*
    - *The number of appointed and trained clinical and managerial open disclosure champions.*
    - *The number of open disclosure events initiated and closed.*

- *Health and social care service providers must also comply with the requirements for mandatory open disclosure as set out in the Patient Safety (Notifiable Patients Safety Incidents) Bill 2019 (once enacted).*

In advance of these national developments, the HSE National Open Disclosure Steering Committee, defined the performance and compliance measures it sought to develop to provide assurance to persons affected, the public, the staff/local service/organisation and the HSE that Open Disclosure requirements are being met consistently and where there are gaps that support is being provided to achieve this.

5.2: HSE National Service Plan 2022

Open disclosure was included in the HSE National Service Plan (2022) as follows:

> ***"Priority Areas for Action 2022***
>
> *Design and deliver programmatic interventions to improve compliance with incident management policies and standards, including open disclosure*
>
> *Monitor the health and social care requirements for the pending introduction of legislation on Pre-Action Protocols and Patient Safety Bill and facilitate the introduction of the necessary systems and resources to support the legislation*
>
> ***Development of Regional Health Areas***
>
> *The objectives of regionalisation are aligned with the overall aims and objectives of Sláintecare. These centre around the principles of integration of care: equity of access, improving patient outcomes and experiences, as well as transparency and accountability".*

5.3: Recommendations submitted by the Open Disclosure Performance Measurement Committee and accepted by the National Open Disclosure Steering Committee in 2021:

(A) The development of a KPI for Open Disclosure for the HSE Service Plan.

Develop an initial KPI in relation to measuring the performance of services in regard to compliance with the provisions for mandatory open disclosure in the pending Patient Safety Bill (PSB) in alignment with the open disclosure process as outlined in the legislation. A significant amount of defining, measuring, validating and testing of any metric (including data collection and dissemination) related to the Patient Safety Bill will be required to include a 'Key Performance Indicator' into the National Service Plan. A Working Group should be established to complete this work with representation from, inter alia, NIMS, Screening Services, Community Services, Acute Services, National Quality & Patient Safety and the Integrated Information Services. NIMS will be adapted in terms of functionality to allow for data capture. The remit of assurance will be wider than this however in terms data validation, escalation etc. and the working group will seek to develop this.

(B) The development and implementation of the Open Disclosure Policy Compliance. To develop a robust assurance framework on the implementation of the Open Disclosure Policy (2019) and subsequent Patient Safety Bill to support the service delivery system. This includes the review of guidance of the National Standards for Safer, Better Healthcare (3.5 Open Disclosure); the development of an Open Disclosure Policy audit tool, and modification to the Incident Management Framework audit tool.

(C) Measurement of patient experience in relation to open disclosure.
Development of a Patient Experience Survey or other assessment tool to measure patient's/relevant persons' experience following the open disclosure process to be designed and implemented. A work stream with patient representatives, QPS staff and others will be set-up to support this important and sensitive piece of work. Additionally, an invitation to quote has been submitted to support this work stream.

(D) Uptake of Open Disclosure Training:
Develop an indicator to accurately capture the percentage of relevant staff who are up to date with their Open Disclosure training within the past 3 years. In lieu of accurate data, the National Open Disclosure Office to continue to provide quarterly and annual activity reports on the uptake of open disclosure training per service area including e-learning modules, face to face training programmes and other virtual training programmes to

demonstrate compliance with 3 yearly mandatory training requirements. A Working Group should be established to complete this work with representation from, inter alia, NIMS, Screening Services, Community Services, Acute Services, National Quality & Patient Safety, Office of Midwifery and Nurses Services Directorate (OMNSD), National Doctor and Training Programme (NDTP) Health and Social Care Professionals (HSCP) and HR.

(E) On-going Project Group

This work needs to continue as a project with the specific aforementioned work-streams reporting into the project group. Terms of Reference to be developed collaboratively with the, what will now be disbanded, Open Disclosure Performance Measurement Sub-Committee and submitted to the Steering Group as final steps for that group.

5.4: Update on the progress made during 2022 on the implementation of the recommendations of the Performance Measurement Committee.

Recommendation	Update on Progress made during 2022
(A)The development of a KPI for Open Disclosure for the HSE Service Plan.	The work steam has been launched with membership secured and terms of reference for this work stream have been developed and agreed by the group. The work of this group during 2022 includes the following: (a)A mapping exercise of the reporting, notification, documentation and process requirements in the Patient Safety Bill has been undertaken to assist with the identification of the required data entry fields. There are many requirements within the Bill and key measurement requirements will include evidence that an open disclosure discussion has occurred, that a written record of the discussion has been provided to the patient/relevant person within 5 days of the meeting and that any review of the patient safety incident has been shared with the patient and/or their relevant person, as appropriate. (b)Work has commenced on the identification of data fields for the entry screen and the review screen to collect the required information and to make improvements to the system outside of the KPI measurement. (c)A mapping exercise has been undertaken of incident categories/types currently reported on NIMS and how they align to the notifiable incidents listed in the PSB. (d)Further clarity/explanation has been requested from the DOH in relation to some of the Notifiable Incidents listed within the Bill. (e)A patient representative has been sought for the group to ensure patient/service user views are represented. **Note:** The Department of Health have also convened a working group with representatives from the HSE, State Claims Agency, Mental Health Commission and HIQA to discuss the management of the notification of patient safety incidents as per the provisions of the Bill.

Recommendation	Update on Progress made during 2022
(B) The development and implementation of the Open Disclosure Policy Compliance	The work stream has been launched with membership secured and terms of reference for this work stream have been developed and agreed by the group. The work of this group during 2022 includes the following: (a) Work has been undertaken on the review of the current Incident management Framework (IMF) self-assessment audit tool to ensure that the audit tool includes assessment of compliance with both the IMF and the HSE Open Disclosure Policy. A guideline has been developed to accompany the tool. (b)The use of the current QA&I Tool for the National Standards for Safer Better Healthcare 2012 and specifically for standard 3.5 which relates to Open Disclosure has been explored. (c)An organisation self-assessment implementation checklist tool has been developed to support the implementation of the HSE Open Disclosure Policy at local level. This checklist includes a Quality Improvement Plan, a section on annual reporting requirements and guidance on how to use the tool. These tools will be further tested and feedback used to inform further changes during 2023.
(C) Measurement of patient experience in relation to open disclosure.	The work stream has been launched with membership secured and terms of reference for this work stream have been developed and agreed by the Group. The work of this group during 2022 includes the following: (a)Funding was secured for the research and development of the patient experience tool. (b)Following an invitation to quote UCD have been successful in their bid and will be conducting the research and development of this tool in collaboration with Work Stream 3. (c)UCD are now at the ethics approval (d)The HSE contract has been drawn up and signed by all parties.
(D) Uptake of Open Disclosure Training:	The work steam has been launched with membership secured and terms of reference for this work stream have been developed and agreed by the group. The work of this group during 2022 includes the following: (a)An exploration of the current training data provided in the annual and quarterly training reports. (b)An overview of the current data limitations and work commenced with HSeLanD and Aurion in relation to managing the data limitations identified. (c)A programme of work with the National Doctors Training Programme (NDTP)in relation to improving the uptake of open disclosure training by NCHDs. NDTP data extracted from

	the Doctors Integrated Management E-System on the uptake of training by NCHD's has led to the commencement of a pilot piece of work in x 2 hospital groups to look at ways to improve uptake of training. (d) Work with the Forum of Postgraduate Training bodies in relation to providing data on the uptake of open disclosure training provide by the colleges, to explore the inclusion of open disclosure training in medical staff induction and pre-induction programmes and to call out Open Disclosure in the "Memorandum of agreement" with Training Bodies re agreement on training site accreditation (timeline July 2023). (e)Setting up a work group with other HSE mandatory training leads to explore a consistent approach to the provision of mandatory training data.
Recommendation	**Update on Progress made during 2022**
(E) On-going Project Oversight Group	The work stream has been launched with membership secured. The work of this group during 2022 includes the following: (a)The development of the terms of reference for the full performance measurement programme i.e. all 5 work streams (b) The establishment of the 4 work streams above. (c) Maintaining oversight of the work of the groups including identification of risks and challenges. Oversight of the work streams is included in weekly huddles of the National Open Disclosure Office attended by the AND for Incident Management. (d)Providing updates on the work of the groups to the National Open Disclosure Steering Committee.

5.4: Risks Identified in relation to the implementation of the Recommendations of the Performance Measurement Committee.

Recommendation	Risk Identified	Action
(A)The development of a KPI for Open Disclosure for the HSE Service Plan.	Not all notifiable incidents as outlined in the Patient Safety Bill are currently captured on NIMS – it is likely that a drop-down list will be required.	Mapping of notifiable incidents list in Patient Safety Bill and adaptation of NIMS. Review of SRE List planned in 2023. Clarity sought from DOH on some of the notifiable incidents.
(D) Uptake of Open Disclosure Training	The provision of an accurate indicator for the uptake of open disclosure training is dependent on all of the data limitations being addressed.	Ongoing work with Aurion, HSeLanD and HSE national training programme leads.

5.5: Current Open Disclosure Performance Measures

5.5.1: Performance of the National Open Disclosure Office and Programme:

The work of the National Open Disclosure office is part of the operational plan of the Quality and Patient Safety Incident Management Team. This operational plan is aligned with the annual operational plan for the National Quality and Patient Safety Directorate and the Office of the Chief Clinical Officer. Updates on the work of the office are provided to the National Open Disclosure Steering Committee who provide advice and guidance on the work of the office. An annual report is produced and provided to the Safety and Quality Committee of the Board of the HSE.

5.5.2: Performance of the National Open Disclosure Training Programme:

On a quarterly basis, the National Open Disclosure Office provides a breakdown of training statistics for the programme. This report is issued to Chief Officers of the Community Healthcare Organisations; Hospital Groups Chief Executive Officers; NAS; National Screening Services; Open Disclosure Leads; Open Disclosure Trainers and the National Open Disclosure Steering Committee.

An end of year training report looks at all open disclosure training statistics for 2022 and also provides statistics for the last 3 year period. The data for these statistics is generated through the National Open Disclosure Training Database, HSeLanD and HSE Strategic Workforce Planning & Intelligence. Data in relation to staff that have completed face to face training is logged onto the National Open Disclosure Training Database by the open disclosure trainer. Data in relation to staff that have completed online training is generated through a report run on HSeLanD. Percentage of training uptake is then established by comparing these figures with staff headcount data from the Employment Data Report provided by HSE Strategic Workforce Planning and Intelligence, National HR Directorate.

The National Open Disclosure Office strongly urges services to nominate a HSeLanD Data Manager who can apply to have access to a detailed report (including individual staff details) of all HSeLanD learning within their organisation. This data can be cross-checked with local HR files to identify staff that that have not yet completed the training module.

See **Section 4** of this report for further information on training and training data.

5.5.3: Performance of the National Open Disclosure Steering Committee (NODSC)

The performance of the NODSC is measured in line with the Terms of Reference of the committee.
Note: The performance measures included in the Terms of Reference for the NODSC are as follows:

- Percentage of attendance at meetings by members.
- Completion of follow up actions.
- An annual evaluation of committee objectives.

The terms of reference for the committee were reviewed and updated in March 2022.

Percentage of attendance at meetings during 2022	65%
Completion of follow up actions	There were 22 follow up actions by the committee in 2022 Actions completed = 18 Actions that remain open = 3 Actions that are ongoing = 1

Section 6: Open Disclosure Legislation

The HSE Patient Safety Strategy 219-2024 Commitment 6: Leadership and Governance to improve Patient Safety

"*We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance*"

6.1: The Patient Safety (Notifiable Patient Safety Incidents) Bill 2019.

The Patient Safety Bill introduces a new requirement for mandatory open disclosure of specific patient safety incidents, (referred to as notifiable patient safety incidents). This mandatory open disclosure and external notification of notifiable incidents will equally apply to the public and private health services.

The Bill includes a schedule containing a list of serious, primarily death related incidents, that will be subject to mandatory open disclosure and notification, e.g. patient death following wrong site surgery, patient death associated with a medication error. The Bill also provides the Minister for Health with the power to make regulations setting out additional incidents that will be subject to mandatory notification. It provides for notification of incidents to HIQA, the Chief Inspector of Social Services, the Mental Health Commission and the State Claims Agency. It also provides for the extension of HIQA's remit to the private hospital sector and contains provisions supporting the conduct of clinical audit in the health service. The Bill provides for offences for failure to comply with the requirements of this legislation: However, these apply to the health services provider and not individual practitioners.

The Bill has passed Committee Stage on 10th March, 2022 and there are two further amendments to the Bill proposed at the next stage i.e. Report stage – one amendment pertaining to providing HIQA's Chief Inspector of Social Services with a discretionary power to carry out or commission a review of certain significant patient safety incidents which have occurred during the provision of clinical care to residents of nursing homes and the second amendment pertaining to an additional notifiable patient safety incident in relation to cancer screening services.

The Bill is currently before Dail Eireann, Fourth Stage (also known as Report Stage) where the Bill and amendments that arose at Committee stage are being considered.

Schedule 2 of the Bill contains a number of amendments to Part 4 of the Civil Liability (Amendment) Act 2017 to align the open disclosure procedural requirements set out in the Civil Liability (Amendment) Act 2017 with the provisions of this Bill.

The HSE are preparing for the implementation of the legislation. It is likely however that a corporate risk around the implementation of the legislation will be submitted to the Safety and Quality Committee to help mitigate against any challenges in relation to resources and the data capture for the purpose of compliance measurement.

6.2: Information and Training on Open Disclosure Legislation: (i) Part 4 of the Civil Liability Amendment (CLA) Act 2017 (ii) The Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018 (iii) The General Scheme of the Patient Safety Bill July 2018 and revised Bill December 2019.

There is regular engagement with the National Patient Safety Office (NPSO) in the Department of Health in relation to the progress of the Patient Safety Bill and review of Part 4 of the Civil Liability Amendment Act.

Work continued throughout 2022 on the implementation of Part 4 of the CLA Act 2017 and the accompanying regulations and on preparation for the pending Patient Safety Bill. Information on the legislation is included in all face-to-face training programmes, including the train the trainer programme. Information on the legislation is included in the revised open disclosure skills workshop established in 2021. Staff are prompted to consider the provisions of the CLA Act 2017 and directed to further information on the legislation in Module 1 and Module 2 of the E-learning programme.

Open Disclosure leads and staff from across all service areas were updated on the legislation via meetings and the office quarterly newsletters. The HSE Open Disclosure website has pages dedicated to the legislation and containing links to (i) the legislation, (ii) HSE guidelines on managing the open disclosure process in line with the provisions of Part 4 of the CLA, (iii) the CLA forms and (iv) a FAQ document on the CLA Act and associated regulations. The HSE policy also provides information for staff on the protective provisions of the CLA Act 2017 and directs staff to these resources.

6.3 Review of the Implementation of Recommendations of the Scoping Inquiry into the CervicalCheck Screening Programme

Dr Gabriel Scally led out on a final review and report on the progress in implementing the recommendations put forward by the Scoping Inquiry into CervicalCheck available here. Whilst generally positive, the report did make a number of comments in relation to Open Disclosure, in particular in relation to the delay of the enactment of legislation to implement a 'Duty of Candour'.

Section 7: The National Policy Framework for Open Disclosure in Healthcare in Ireland.

HSE Patient Safety Strategy 2019-2024 Commitment 4 Reducing Common Causes of Harm

"We will undertake to reduce patient harm, with particular focus on the most common causes of harm".

7.1: Background

In 2020, the Independent Patient Safety Council was asked to present the Minister with recommendations on a National Policy Framework for Open Disclosure in Healthcare in Ireland, to assist organisations and clinicians to apply the principles of open disclosure to communicate with patients when healthcare does not go to plan.

In January 2021, the Council provided the Minister for Health with its recommendations on a National Policy Framework for Open Disclosure in Healthcare in Ireland. Minister for Health Stephen Donnelly welcomed the recommendations as a significant step forward in developing, fostering and embedding a culture of open, honest and transparent communication across the health sector, in particular for patients, service users and their families when something goes wrong that has harmed or had the potential to cause harm to a patient or service user. On foot of these recommendations and high-level implementation approaches, the Department of Health are developing a National Policy Framework for Open Disclosure in Healthcare in Ireland.

7.2: Update on the development of the National Open Disclosure Policy Framework

The framework is informed by the HSE Open Disclosure Policy and will apply to the wider health sector. It includes sections on evidence of learning from Open Disclosure and informing policy change, monitoring and reporting at organisational level, independent support services for patients, implementation and annual reporting by healthcare providers and other bodies to the DoH. There is a focus on identifying good practice and supporting ongoing culture change. The development of the framework has involved working closely with the HSE and other stakeholders.

The Draft Policy Framework for Open Disclosure in the Irish Health and Social Care Sector was published on 29th August, 2022. The Minister for Health Stephen Donnelly launched a public consultation on this draft national policy framework in the Irish health sector on the same day. Submissions closed on 30th September 2022. The consultation consisted of an online survey which sought the views and opinions of health and social care professionals, organisations and interested members of the public, on the some of the key elements of the draft framework. The views and opinions collected will be considered and will be used to inform the final draft of the framework prior to publication.

It is anticipated that the framework will be published in quarter 1 of 2023.

The National Open Disclosure Team and National Open Disclosure Steering Committee submitted significant combined feedback on the framework. This annual report has been written with consideration of the reporting requirements of the Framework that the DoH will be seeking. All requirements are referenced within this annual report. The performance work streams will seek to address outstanding gaps which primarily relate to the measurement of:

- Training development and reporting figures in particular in relation to agency staff
- The number of open disclosure events initiated and closed

7.3: Related reading:

Independent Patient Safety Council Recommendations Framework Open Disclosure with Crowe Report

Explanatory leaflet on report findings and the Independent Patient Safety Council Recommendations

Section 8: The National Open Disclosure Themed Week

The HSE National Open Disclosure Office planned, supported and facilitated its first themed week across all health and social care services during the week 7th to 13th November, 2022. This work was undertaken working in collaboration with Open Disclosure service area and site leads across all service areas.

The purpose of this week was to promote and raise awareness of the importance of open disclosure to patients and their families and to patient safety and quality improvement generally. This week provided an opportunity for services also to ensure that staff are aware of their obligations in relation to Open Disclosure and are compliant with mandatory training requirements. The week provided an opportunity to increase staff and public awareness of the resources available to them to support them in the implementation of the HSE Open Disclosure Policy and in planning for and engaging in open disclosure conversations.

8.1: Engagement with the Open Disclosure Themed week.

- Communications preparation via the NQPSD Connect team and HSE National Communications Team included the development of Open Disclosure logos for the week, a planned HSE all staff update, planned social media promotion (Twitter and LinkedIn), a promotional power point slide used in advance of the week to promote the week and the advertisement of mandatory open disclosure training on the HSE events and training opportunities webpage and all staff email.
- Novelty items and resource packs were designed, developed and distributed to services engaging in the themed week.
- The week was advertised in the Open Disclosure Quarter 2 Newsletter and the Open Disclosure Quarter 3 newsletter was circulated on 4th November in advance of the week. This newsletter contained a one page information sheet to be used at staff handovers to provide staff with an overview of open disclosure and their responsibilities in relation to the same.
- A news item was developed for and published by HSeLanD and open disclosure training was promoted before and during the themed week on the carousel on HSeLanD.
- A letter was sent from Dr Orla Healy to external agencies promoting the week and seeking engagement in the themed week.
- Patient advocacy and patient representative groups were contacted and advised of the planned week and their input sought to ensure that the patient voice was represented and visible throughout the week.
- A webinar on approaches to implementation of the HSE Open Disclosure policy was held.
- 2 new resources were developed for launch during the themed week and the public page of the website was updated and prepared for launch also during the week.

8.2: Outline of the Week:

Day	Theme	Activities
Monday 7th Nov, 2022	The Patients Perspective	Messaging on social media on the importance and benefits of open disclosure for patients, service users and their families. Patient representative groups, independent patient representatives and advocacy services were actively involved in messaging and promotions on the day and throughout the week. Launch of the updated public page on the HSE Open Disclosure website. Launch of Resource: "***List of Support Services and Resources for Patients and Service Users following an Incident"*** Various promotional and training events across HSE and HSE funded services – see section 8.3 below for examples of some of the events happening across services.
Tuesday 8th November, 2022	Documentation	Messaging on social media on the importance of documenting open disclosure in the patient record and providing a written record of formal meetings to patients /service users/their relevant persons. Links were provided to various resources to support good documentation. Various promotional and training events across HSE and HSE funded services – see section 8.3 below for examples of some of the events happening across services.
Wednesday 9th November, 2022	Implementation	Open Disclosure Webinar on "Approaches to Implementation". This included information on general implementation principles and presentations from staff across acute and community services on the various implementation approaches. The webinar included a presentation from Ms Bernie O'Reilly, Patient Advocate, who brought the patient story and perspective (328 attendees). Messaging on social media regarding implementation and providing links to various resources and tools to support implementation. Various promotional and training events across HSE and HSE funded services – see section 8.3 below for examples of some of the events happening across services.

Day	Theme	Activities
Thursday 10th November 2022	Training	Messaging on social media to promote training and reminding staff of mandatory training requirements. Staff from the National Open Disclosure Office were out and about in services engaging in promotional activities including training. The advertisement of mandatory open disclosure training on the HSE events and training opportunities webpage and all staff email. Various promotional and training events across HSE and HSE funded services – see section 8.3 below for examples of some of the events happening across services.
Friday 11th November 2022	Staff Support	Messaging on social media promoting the support of all staff involved in/affected by patient safety incidents and providing links to support services and resources available. Launch of new staff resource: ***"List of Support Services and Resources for Staff following an Incident"*** Staff from the National Open Disclosure Office were out and about in services engaging in promotional activities including training. Various promotional and training events across HSE and HSE funded services – see section 8.3 below for examples of some of the events happening across services.

8.3: Examples of Open Disclosure training and promotional events across services

There was a great response from across the healthcare system with many promotional events facilitated across different service areas. Promotional activities included:

- promotional stands;
- training events;
- promotion of training;
- designated open disclosure training suites set up to facilitate on-site training;
- open disclosure competitions with prizes(e.g. quizzes, word searches);
- the development of novelty items such as cupcakes, stickers, t-shirts, bookmarks, pens, posters, cups;
- circulation of open disclosure newsletters;
- provision of updates to staff at handover and
- the development of dedicated Open Disclosure resource packs.

Twitter was very active with promotional activities. See below examples of some of the promotional initiatives and resources across acute and community services.

Beaumont Hospital Promotional stand and designated training suite

Dalkey Nursing unit

CHO 2 Training event

DNCC Training and promotional events

Coolock Health Centre

Dublin Midland Hospital Group

Letterkenny University Hospital

Mater University Hospital

Nenagh Hospital

Roselawn Health Centre

St Colmcilles Hospital

St Lukes Hospital, Kilkenny

National Open Disclosure Office Promotional logos

University Hospital Limerick

Sligo University Hospital

Tallaght University Hospital

Tullamore Acute and Community

St Josephs Mental Health ID Service

Wexford University Hospital

Naas Hospital

8.4: Feedback received from Open Disclosure Leads received following the Open Disclosure Themed Week

"Raised awareness, got people talking about it.

Will assist us in progressing the face-to-face training".

"The immediate benefit was creating discourse around open disclosure.

At the pop up stands we were able to answer simple queries that people had.

Promoting the mandatory training side of Open Disclosure".

"Re- created interest. Collective approach involved all staff -very positive keeps Open Disclosure on the radar".

"Enhanced the importance of Open Disclosure, raised staff awareness and an incentive to complete Modules 1&2 on HselanD".

"Raised awareness of Open Disclosure organisation wide".

"Promotion of Open Disclosure and the importance of same

Awareness Webinar also facilitated with this

Presence of staff from national office was great"

"A week was too long and it clashed with other national days. It might be best to have 1 day next year".

"I would suggest that it needs to become an annual event. I would ask if the various approaches could be shared out from the sites so we can learn from each other. We hope to do a patient's story on this. Pick a strong colour associated with open disclosure so the at we can light up the buildings as well"

"Some hospitals were too late in receiving promotional material"

Supplies for people doing awareness events need to be increased. One small box for an entire CHO doesn't work".

Section 9: Open Disclosure “Share the Learning”.

HSE Patient Safety Strategy 2019-2024 Commitment 5: Using Information to Improve Patient Safety

“We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety.”

The focus of the “share the learning” section of this year’s annual report is on the management of multiple disclosures i.e. when a patient safety incident involves more than one patient /service user.

9.1: General considerations when managing Open Disclosure following patient safety incidents which affect multiple patients/service users

There may be times when a single event will require notification to a large number of people or when multi-incident events occur. The incident(s) will be managed as per the provisions of the HSE Incident Management Framework (IMF) (2020) and other relevant HSE policies/guidelines e.g. Guideline for the Implementation of a Look-back Review Process in the HSE (2015).

Large scale disclosures need to be well thought out with some degree of rationale as to who needs to be engaged with. Considered and effective management of such events is essential as, if not effectively managed, can lead to significant issues of public confidence which can have long term effects for patients, service users, their relevant person(s) and staff. The Senior Accountable Officer (SAO) and Serious Incident Management Team (SIMT) have an important role in ensuring that there is effective oversight and coordination of such events including the management of the open disclosure process for all those affected.

<u>9.1.1: Risk assessment</u>

A risk assessment will assist in identifying which patients have potentially been exposed to a patient safety incident and who are therefore at risk and require disclosure. Where the likelihood of exposure/harm is high, the need to contact all affected patients is straightforward. When the likelihood of harm decreases, the probability of harm in conjunction with weighing up ethical obligations is required. It is vital that this decision is made with the necessary input from all relevant parties and with consideration from a number of perspectives e.g. medical, ethical, epidemiological, regulatory, administrative, legal, risk management, open disclosure and communications aspects. It is also vital that there is input from patient representatives/patient advocacy in relation to the approach to and management of the open disclosure process. This will assist in determining a structured, informed, targeted and patient centred approach.

<u>9.1.2: Locating patients</u>

Locating patients can present a challenge especially if the patient safety incident is in the distant past. The health and social care service provider must be able to demonstrate all of the reasonable measures taken to try to locate patients identified to be at risk and this must be documented in the open disclosure/incident management file. This is particularly important if they cannot be contacted.

9.1.3: Managing the open disclosure process

Once an incident has been identified, communication with the patient/their relevant person(s) must happen as soon as possible. A communication plan must be developed which will include a standardised approach to:

(i) the establishment of the open disclosure team(s);

(ii)ensuring that the team members are fully informed in relation to the incident and are able to address potential questions arising – consider the development of a FAQ document;

(iii) the provision of training for the team members to ensure that open disclosure is managed in a consistent, informed, standardised way which complies with HSE policy, is fair and just to all those involved in or affected by the incident and which ensures that open disclosure is managed with empathy and compassion;

(iv) contacting those affected and managing the initial communication - best practice suggests that communication is undertaken concurrently and that the initial disclosure should ideally be undertaken in person especially when the likelihood of harm is high. Where the likelihood of harm/risk to the patient is low or where a face to face meeting is not feasible for whatever reason, written/telephone communication may be considered;

(v) ensuring that the individual communication and support needs of every patient and /or their relevant person(s) are being met, as far as is reasonably practicable;

(vi) undertaking the open disclosure meetings and ensuring that each meeting is focused on the patient involved including their individual story, how they have been impacted, their individual needs, the apology required and agreed plan of care/treatment;

(vii) managing the follow-up of open disclosure meetings;

(viii) providing information e.g. dedicated phone lines/ website/information materials/FAQs;

(ix) maintaining communication and the assignment of a designated person/key contact person to facilitate timely responses- more than one designated person may be required if there are a large number of patients involved - a case load may be assigned;

(x) the documentation of open disclosure meetings and follow up written communication to the patient/relevant person;

(xi) the management of the media - in circumstances where the event is in the public domain the primary duty of care of the service must remain with those affected by the patient safety incident and all information must be managed sensitively and with respect to the patient's rights to privacy and confidentiality. All requests from the media should be directed to the relevant HSE Communications Department or, in the case of HSE funded services, to the relevant Hospital Group or Agency.

In situations where an index case leads to a look back review, open disclosure to the index case and others as and when they are identified must be undertaken as soon as possible and must not be delayed.

9.2: Support structure for all staff clinical and non-clinical including agency staff during incidents of multiple disclosures

The National Open Disclosure Team provide ongoing support, guidance and training for staff who are involved in the management of multiple disclosures. Due to matters relating to GDPR and confidentiality and the sensitivity attached to multiple disclosure situations our approach to share the learning for this report has been via the circulation of a questionnaire which was sent to a number of staff who have been involved in the management of multiple disclosures. The questionnaire involved 12 questions and was divided into 4 sections as follows:

- Preparation and planning
- Managing Open Disclosure Meetings
- Supports and Resources
- Comments and recommendations

The following is a high level summary of the feedback received and the National Open Disclosure Office plans to write up the full and more detailed response and make it available for staff.

9.2.1: Feedback from staff on Preparation and Planning for Multiple Disclosure Meetings

What worked well in relation to planning and coordinating the multiple disclosure response?

"The appointment of a designated person(s) at an early stage to maintain contact with and to support the patient, service user/relevant person involved"

- Being prepared and taking time in the preparation and planning stage;
- Team: Good MDT approach with a delegation of duties and daily meetings; Identifying open disclosure team and roles for the meeting, the same team being involved throughout;
- Providing pre meeting training and coaching for team; agreeing facts and apology to be provided;
- Support from local lead and national team;
- An Open Disclosure pack was prepared for each team which included the Open Disclosure briefing notes, checklist, template for documenting the minutes of the meetings, information leaflet on support services or counselling services for individuals and family members involved, FAQ document prepared re potential questions regarding the on-going investigation, blank FOI request form in the event that an individual requested a copy of their records;
- Questions or issues that the patient/service user/family members had were established in advance of the meeting which reduced the number of "don't knows" or "we'll have to go away and find out" responses during the meetings;
- Dedicating specific time, resources and admin support;

What were the challenges and how were these managed?

> ***"Understanding the emotions in the room from guilt through to anger, feelings of betrayal. These were managed by demonstrating understanding, recognising the emotions in what somebody is saying and affirming it is alright to express those emotions. This creates a safe space to express real feelings"***

- Large number of service users involved; Not possible to have face to face meetings, hence delays in getting communications out to all;
- Process was slow: The process was slow as we relied on external bodies to give information from their analysis and have it cross checked and validated with the clinical team. There was a need to know where each service user—was in the system, hence the various cohorts and the bespoke communications;
- Communication: A dedicated communications team was established to maintain communication with relevant stakeholders – this team were under the direction of SIMT and Chair. Managing the media and political system cannot be disregarded. This takes time and must be managed professionally;
- Senior clinicians and managers were very anxious about meeting patients/service users and family members to communicate an error in which they were not personally involved. Reluctance of clinicians to embrace the process. Fear, comprehension of their role in Open Disclosure, correct approach and how to speak about another clinicians work/practice whilst complying with the principles of Open Disclosure;
- The presence of a solicitor at many meetings requirement management i.e. some team members declined to do the Open Disclosure meeting if a solicitor was present and this meant that an alternative senior clinician/senior manager had to step in for these meetings;
- The administrative work of co-ordinating multiple meetings, teams and meeting venues and documentation for each meeting cannot be underestimated;
- It was impossible to identify 1 designated support team so alternative options had to be put in place. This included an information helpline and a clinical support team;
- Meeting and managing the expectations of all the service user/families involved;
- Understanding the emotions in the room from guilt through to anger, feelings of betrayal. These were managed by demonstrating understanding, recognising the emotions in what somebody is saying and affirming it is alright to express those emotions. This creates a safe space to express real feelings;
- Difficulty in establishing correct contact details for relevant persons.
- Managing a situation when the relevant person does not answer/respond to messages left after the initial Open Disclosure conversation. When is the time to stop and step away versus the challenge to communicate and follow the policy?
- Arranging the Open Disclosure meetings to suit the patient/service user/relevant person's needs, especially those travelling distances rather than suiting HSE staff.

What learning would you like to share with others from your experience of preparing for multiple disclosure meetings?

> ***"Don't be a corporate machine in denial for fear of recrimination. Be human in your approach and dynamic in your empathy, Be honest to the nth degree – think of what you have to lose compared to the trust you gain"***

- A significant number of service users had no issue regards treatment as they were on the appropriate pathway, however writing to them with that detail provided assurance and when the media told the story, the service was confident in stating that all service users had been contacted. This assured the public;
- Recognising that Open disclosure is not just a once off event and a number of meetings and communications may be required.
- The importance of:
  (i) MDT engagement and support,
  (ii) the role of the designated person.
  (iii) support and guidance from SIMT team,
  (iv)access to subject matter experts and subject matter experts at OD meetings,
  (v) training and coaching for OD team,
  (vi) standardised approach to OD meetings and preparation of resource packs,
  (vii) dedicated resources and admin support,
  (viii) Good communications strategy/plan;
- Travel the road with the service user/relevant person no matter how long the journey is – follow up on actions agreed.

9.2.2: Managing the Open Disclosure Meetings

What worked well in the management of the open disclosure meetings?

> ***"Team members had completed the Open Disclosure Training and availed of the Open Disclosure briefings provided to all teams in advance of undertaking the meetings"***

- Team met 30 minutes before to familiarize themselves with specifics of case, review clinical case summary, NIRF and any concerns/questions voiced on initial call.
- Allocating sufficient time for each meeting to ensure that the service user/relevant person had ample time to discuss their concerns and to consider the information being provided to them;
- Use of Open Disclosure Quick Reference Guide and Toolkit;
- Debrief opportunity provided to team members after the Open Disclosure meetings particularly for those who undertook multiple over several days;
- Ensuing that all minutes of meetings and any supporting documentation was provided to the participants in a timely manner;
- Being in a position to offer independent counselling services to the persons affected by the incident;

What learning would you like to share with others from your experience?

"Sometimes listening is more important than speaking.....giving the patient/service user time to speak and be heard was very important;
Constant checking by the facilitator as to the completion of questions using phrases such as "has that clarified that question for you?" and "Are there other issues we need to try to resolve today"?

- Ensure control is maintained in the processes as external challenges can influence decision making (i.e. media pressures, requests from external stakeholders, public representatives etc;
- Maintain focus on the task in question, to communicate accurately and efficiently to those impacted (Patients, service users, relevant persons and staff);
- The process was not only about open disclosure but also about ensuring that treatment pathways were put in place, as required; Open Disclosure starts with the very first contact and should not be replaced by a process purely to meet legal requirements,
- Recognition of the huge impact on staff as some resigned, moved or required staff support;
- Prepare well for meetings;
- Specific contact details for one designated person, Same team involved in all meetings;
- The Travel in the ASSIST model, so important. Go the extra (mile) when families bring additional concerns;
- Disclosures occurring over a long time frame bring a risk of media publications before the process of disclosure has commenced/finished – important to start the process as early as possible;
- The first Principal of Open Disclosure is honesty, to the service, the service user, carer and self. If something is open, then it has no hidden part;
- So important for all those involved to know why they are undertaking OD. .. it is the right thing to do. If everyone keeps that central to the tasks and communications required, then it becomes easier to engage.

Feedback received from patients/service users/relevant persons

Many families and service users thanked the Open Disclosure team for being honest and for apologising for what had happened.

"This was the first time in 5 yrs I have felt listened to"

- Family members/service users acknowledged the offer of independent counselling;
- Many families and service users thanked the Open Disclosure team for being honest and for apologising for what had happened;
- "This was the first time in 5 yrs I have felt listened to";
- "If you apologise again I'm going to complain - everyone from the helpline onwards apologised; Mistakes happen. We hope you learned from it";
- "My mum could not get anyone to listen to her. So thank you for apologising to both of us. I don't want it to happen to anyone else"
- All very happy with the new service they were in receipt of;

- One family advised of administration issues re booking of appointments in new service and was able to feed that back to the service;
- Thankful for the honesty and the willingness of the HSE to inform them of the incident.

9.2.3: Supports and Resources to assist the management of Multiple Disclosures

What resources/supports did you access to support you in managing the multiple disclosures?

"Open Disclosure website resources i.e. handouts, checklists, Quick Reference Guide and Toolkit"

"Open Disclosure area lead available to support Open Disclosure teams and participate in complex meetings"

- Staff: Communications lead and support team, open disclosure area lead, senior management and administrative support, clinicians from the services involved, clinical experts, patient services Lead, administration support, SIMT, National Open Disclosure team;
- Guidance slides developed by Open Disclosure Lead;
- Rooms/facilities and the time of the service user;
- FOI access request forms;
- Specific excel sheet for those requiring Open Disclosure;
- Local Standard Operating procedure, FAQ, telephone script documents developed. SIMT approval on documents and approach;
- Dedicated business manager and QPS lead who engaged in all steps of process and attended SIMT meetings, providing updates to various requests, locally and nationally.

What supports were offered to patients/service users/families?

"Ongoing travel with the service user on their healthcare journey"

"Access to Open Disclosure designated person for any concerns after engaging in process"

- Clinical support through GPs and consultants;
- Helpline with clinical expertise;
- Letters issued to each service user, Information leaflet, FAQ document;
- Independent counselling;
- Support to arrange follow up appointments;
- Support to access records under FOI as appropriate;
- Compensation scheme under agreement with State Claims Agency /Department of Health;
- Clinical interventions;
- Review of additional family members where concerns arose;
- Obtaining their feedback to help improve the service;

What supports were offered to staff ?

> ***"National OD Lead offered support to staff by taking phone calls, attending in person meeting with those preparing for the OD meetings and ongoing follow up support for any queries and debriefing of the QPS lead".***

- Line management and peer support;
- Repositioning of roles as requested from staff;
- Regular communications and updates;
- HR expanded resource by WTE x3 including staff psychology expert x 1 ;
- Regular visits and updates provided by senior staff;
- Employee Assistance Programme: Staff debrief and support sessions (1:1 and group sessions with EAP appointed facilitator);
- Staff liaison person identified for each discipline;
- Open Disclosure Training;
- Availability of Open Disclosure Leads and input from these leads to SIMT prior to and during investigations;
- Administration staff for larger reviews;
- Debriefing after each meeting taken place by OD team, loosely based on the After Action Review questions as led by the QPS lead;
- National OD Lead offered support to staff by taking phone calls, attending in person meeting with those preparing for the OD meetings and ongoing follow up support for any queries and debriefing of the QPS lead.

9.3: Learning from the Open Disclosure Recommendations in the report "Consultation with 221+ Members Research Report February 2022".

The following recommendation were made in relation to Open Disclosure and Post-Disclosure in the report "Consultation with 221+ Members Research Report February 2022".

Open Disclosure

Recommendation	Rationale
• An appropriate healthcare professional should prepare the patient, in empathetic language, about what will happen at the disclosure. This can be done through a phone call or a letter. • The patient should be encouraged to bring a support person to the meeting The patient should be given choices on where to receive the review results; o There should be an option to choose a nominated clinic/hospital o HSE/NSS to find a way to involve the GP for example by making it possible for the patient to schedule the disclosure meeting in the GP clinic	Research participants were clear that it is important that the patient is as well prepared as possible to reduce the risk of traumatisation that the majority of participants describe being subjected to.

At the meeting professionals need to use simple language, show empathy and understanding, be calm and give plenty of time for the patient to ask questions. The attending professionals should provide a detailed transcript of meeting and send this to patient afterwards if requested while also giving the patient the option to receive the transcript later.	When the disclosure gives the impression of a mechanic procedure it neglects the patients' needs and wellbeing while it also damages the trust and perception of CervicalCheck. If patients feel rushed, they are not encouraged or do not feel confident to ask questions
The attending professionals should prepare the patient for the post-disclosure process: • Explaining what common emotional reactions people can have • Presenting the patient with the opportunity to have a call organised from a support worker to offer psychological support and answer any questions • Providing the patient with contact details for a support person in case she needs urgent support.	In order to show holistic care for the patient, it is necessary that that the system cares for the patient after disclosure as this is reported as being when issues arise and is therefore a time when women need help and support.

Post-Disclosure

Recommendation	Rationale
HSE/NSS to strengthen support services offered to patients. This includes: • Arranging calls from a relevant professional who can answer questions and can provide psychological support to deal with emotional aftermath of audit and disclosure processes • Providing the patient with an opportunity for counselling • Providing opportunities for additional meetings with relevant medical professionals as required	It is necessary for the system to acknowledge that the patient journey is prolonged by the disclosure of results; a lot of especially mental support is needed in this phase. Taking responsibility for this support will help establish HSE/NSS as caring and responsive of women's needs

Section 10: Partnering with Patients and Service Users

HSE Patient Safety Strategy 2019-2024 Commitment 1: Empowering and Engaging Patients to Improve Patient Safety

"*We will foster a culture of partnership to maximise positive patient experiences and outcomes and minimise the risk of error and harm. This will include working with and learning from patients to design, deliver, evaluate and improve care".*

10.1: Background:

"*Partnering with patients and the public is to share decision making power and ensure they can influence decisions on the design, delivery and evaluation of services. Partnering with patients is central to delivering person-centred care; which refers to "services that are respectful and responsive to individual's needs and values and partners in designing and delivering that care". (*Health Service Executive (HSE) Framework for Improving Quality in our Health Service 2018).

*"Engaging and involving patients in the design, planning and delivery of all care demonstrates a commitment to person centred care. It ensures that care is appropriate to patients' needs and is respectful of their preferences. Engagement builds a culture of listening to and learning from the care experiences of patients and their families. Focusing and delivering on the outcomes that matter to patients can only be achieved through meaningful engagement and partnership with patients, carers and their families" (*The Health Foundation. Person-centred care made simple: what everyone should know about person centred care. London: The Health Foundation; 2014*").*

10.2: The National Open Disclosure Programme approach to Partnering with Patients and Service Users.

The mission of the National Open Disclosure Programme is to promote and support a culture of honesty and transparency through compassionate and empathic communication with our patients, service users, their families and staff. Central to achieving our mission is our engagement and partnership with patients, service users, patient representative and patient advocacy groups. The overall philosophy and approach of the programme is based on the patient voice and patient rights, needs, expectations and preferences.

10.3: Examples of the involvement of Patients, Patient Representatives and Patient Advocacy services in the National Open Disclosure Programme during 2022

10.3.1: National Open Disclosure Steering Committee:

There are two patient representative members on the National Open Disclosure Committee, one representative from Patients for Patient Safety Ireland and one representative from the CervicalCheck 221+ Patient Support Group. They are very active members on the committee and have input into the actions and decisions made by the committee.

10.3.2: Webinars:

Invitations are sent to members of Patients for Patient Safety Ireland, the National Patient Forum, staff from the Patient Advocacy Service, National Advocacy Service, SAGE and other advocacy services to attend all webinars

facilitated by the National Open Disclosure Office. These webinars are regularly attended by representatives from all of these groups who engage proactively in the chat and question and answer sections of the webinars.

Webinars facilitated by the National Open Disclosure Office included the following:

- The Role of Advocacy Services in Supporting Open Disclosure on 9th February, 2022 with 317 attendees
- Open Disclosure: Approaches to Implementation on 9th November, 2022 (328 attendees). Ms Bernie O'Reilly, patient representative and member of Patients for Patient Safety Ireland presented her story and the importance of open disclosure for patients and their families.

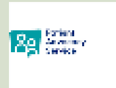
10.3.3: Patient Advocacy:

The National Open Disclosure team continued to work very closely with and maintain very positive working relationships with patient advocacy services throughout 2022.

Patient Advocacy Service (PAS): Two monthly meetings were held with senior staff in PAS, the Assistant National Director(AND) for Incident Management and the General Manager of the Open Disclosure Office. The purpose of these meetings is to (i) provide updates on the work of the Incident Management and Open Disclosure team and PAS, (ii) discuss trends or concerns arising in the complaints and incident management process and (iii)work together in an effort to address any issues arising.

PAS staff facilitated a webinar on the role of PAS in open disclosure and further training has been offered for PAS staff on open disclosure – this was deferred to 2023. PAS provided input to the development of the resource "List of Support Services and Resources for Patients and Service Users following an Incident" available here.
There is PAS representation on the Open Disclosure Performance Measurement Work Stream 3 which has been tasked with the development of an Open Disclosure service user experience tool.

PAS were actively involved in promoting Open Disclosure during the Open Disclosure themed week.



"On Day 1 of @HSELive #OpenDisclosure week, we support the call for a culture of #patientsafety, care, compassion and openness across Ireland's health service – supporting #patients and their families to have a say in there are". (Patient Advocacy Service)

National Advocacy Service (NAS): Representatives from NAS are invited to and attend the Open Disclosure webinar series. A Patient Safety Supplement was developed with NAS on the management of open disclosure to vulnerable persons.

10.3.4: Patients for Patient Safety Ireland: This group has representation on the National Open Disclosure Steering Committee. The AND for Incident Management and General Manager of the National Open Disclosure Office met with and provided an update to the group on the work of the office and incident management team in September 2022 on World Patient Safety Day. This group continually engage in and promote Open Disclosure activities and events and were very visible and active during the Open Disclosure themed week. The group also provided input to the development of the resource "List of Support Services and Resources for Patients and Service Users following an Incident"

NATIONAL OPEN DISCLOSURE PROGRAMME

Quotes from PFPSI during Open Disclosure Themed Week

" Focus on Open Disclosure this week.

We all expect honesty

Lots done, lots more to do"

"Welcoming #opendisclosure week. Thank you @angelatysall and @NationalQPS.

There is an urgent need to support healthcare professionals – through staff support liaison – to embrace #opendisclosure.

And more support for patients through PALS"

"Support honesty,

Commend it,

Deliver it"

10.3.5: Development of the resource "List of Support Services and Resources for Patients and Service Users following an Incident"

This resource for patients and service users provides information on advocacy services, patient representative groups, bereavement support services, national organisations and charities, HSE documents and patient information leaflets. It was developed by the National Open Disclosure team with input from patient representatives and patient advocacy services. The document was launched during the Open Disclosure Themed Week.

10.3.6: Update and launch of the Open Disclosure Public webpage

Significant work was undertaken in updating and improving the public page on the Open Disclosure website here. The webpage provides information on Open Disclosure and the rights of patients, links to advocacy services, the patient information leaflet, patient support services resource document and links to the HSE Feedback policy.

10.3.7: Open Disclosure Performance Measurement Work Streams

There is patient and patient advocacy representation on Work Stream 3 of the Performance Measurement programme of work including Patient Advocacy Service, PALS representative from University Hospital Limerick and the chairperson of the patient forums at Sligo University Hospital and University Hospital Limerick.

A patient representative has been sought also for Work Stream 1 of the Performance Measurement programme.

10.3.8: Cervical Check: Training programme for the communication of Personal Care Reviews:

The Open Disclosure team are supporting CervicalCheck in the development and roll out of a standardised training programme in relation to managing the communication of personal care reviews. Work has commenced with plans for roll out in 2023.

10.39: Patient and Staff Stories

The Open Disclosure team have contributed significantly to the development of the Patient and Staff Stories Toolkit for developing stories. This toolkit was developed by Work Stream 3 established by the Patient Safety Learning , Sharing and Improving Together team. The purpose of this Toolkit is to support patient safety learning which is aligned to the commitments made by the HSE Patient Safety Strategy 2019-2024. Patient and Staff Stories are designed to give a voice to patients/ service users and staff based on their experience and to provide an opportunity to others to understand the importance of patient safety from the perspective of those that access services or work within them. Each story represents the personal experience of the person and the Toolkit aims to facilitate and support the person in articulating their experience in the form of a story.

It is intended that this Toolkit will be available for education and training purposed in HSE and HSE funded services, available on our website and this will become a regular and accepted method to gather service user and staff experiences in order to improve services and outcomes. This Toolkit provides a step by step guide on the development of patient and staff stories including: Identifying stories for inclusion, facilitating participation, stages of story collection, video stories, governance checklist, consent process, active listening guide, confidentiality, data protection guidance and action planner/ tracker.

Two members of National Open Disclosure team were involved in this work stream and supported the process of identification and inclusion of two patient partner representative who participated on this committee.

Section 11: Stakeholder Involvement

HSE Patient Safety Strategy 2019-2024 Commitment 2: Empowering and Engaging Staff to Improve Patient Safety

"*We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety".*

11.1: Background:

Section 2 of the HSE Change Guide "People needs defining change" sets out the importance of early and sustained engagement with stakeholders from the outset of any project or change initiative. The strands of the engagement process set out in this guide include the following:

- Identify and map people connections
- Understand key stakeholders
- Tailor engagement to key groups
- Plan and engage with a purpose and
- Develop and sustain communication and engagement

Ensuring that all the right stakeholders have been included and timely and informed communications with these stakeholders has been an integral part in the implementation of the HSE Open Disclosure policy to date. From the outset the National Open Disclosure programme staff have engaged with a number of stakeholder and have steadily extended the collaboration with various stakeholders as the project has progressed. These stakeholders include HSE services, HSE funded services, professional and regulatory bodies, indemnifying bodies, trade unions, patient representative and patient advocacy groups, royal colleges, training bodies, the Department of Health and other government agencies. All of these agencies support us in driving the importance of open disclosure, improving the uptake of open disclosure training and the implementation of the HSE Open Disclosure policy.

11.2: Stakeholder Engagement during 2022

The HSE National Open Disclosure Team continued to work proactively with many internal and external stakeholders, on an on-going basis throughout 2022 as part of the implementation strategy for the National Open Disclosure Policy and programme. The type of collaboration varied from provision of training, attending meetings, engaging in and supporting various work streams, presentations at study day/conferences, providing and receiving data, embedding open disclosure in policies, curriculums, systems and programmes, responding to queries, providing support and guidance, supporting local policy development and sharing learning.

The following is a list of *some* of the engagements in 2022 with various internal and external stakeholders:

Organisation	Summary of engagement
HSE Services	• Training programme supported across all HSE and HSE funded services. • Quarterly update meetings with Open Disclosure leads across all service areas. • Quarterly newsletters circulated to all service areas. • Quarterly and annual training reports circulated to all service areas. • The National Open Disclosure Programme annual report for 2021 was published on the Open Disclosure section of the HSE website and provides an update of the work of the office. • Open Disclosure webinar series – there are currently approximately 3650 staff on the invitation list to the webinar series from across all HSE, HSE funded services and external agencies. These staff circulate the invitation further to members of their teams. 7 webinars were facilitated during 2022 with two of these focusing on staff support; • There is representation from HSE services on the National Open Disclosure Steering Committee (NODSC) and the Performance Measurement works streams. • There are Open Disclosure leads in all service areas and site leads in acute hospitals. • There are Open Disclosure trainers in all service areas. • There is a designated Open Disclosure office email address from which the office staff respond to queries, invitations, feedback, requests for advice, requests for training and requests for resources for all HSE and HSE funded services. • The pilot of the revised face to face training programme with Sligo University Hospital and CHO1 continued dung Quarter 1 of 2022. • Onsite coaching was provide by the National Open Disclosure lead for staff in 2 service areas to support them in preparing for and managing complex open disclosure meetings. • Staff from the Open Disclosure team are involved in supporting 3 national workgroups. • The Open Disclosure themed week was organised and facilitated to support and deliver key messaging in relation to Open Disclosure across all service areas.
Department of Health	• There is ongoing communication between the National Patient Safety Office (NPSO) and the Incident Management/Open Disclosure Team. • There is representation from the NPSO on Work stream 1 of the Open Disclosure Performance Measurement Programme.
Federation of Voluntary Bodies (FedVol)	• The Federation of Voluntary Bodies are included in all general communications from the National Open Disclosure Office and are invited to all training /information events. • The National Open Disclosure website contains contact details for the Open Disclosure Leads identified across the various voluntary agencies.

	• Training programme supported and train the trainer provided across HSE funded services.
Organisation	**Summary of engagement**
State Claims Agency(SCA)	• There is representation from the SCA on the NODSC and work stream 1 of the Open Disclosure Performance Measurement programme; • Management and senior staff from the SCA facilitated a webinar on the SCA Perspective of Open Disclosure on 13th April, 2022.
Royal College of Physicians Ireland (RCPI)	• The National Open Disclosure Team promote the RCPI "Gateway to Communication" programme at all training and education events and via email/newsletter. • The RCPI award CPD for the Open Disclosure E-learning programmes, face to face skills training, webinars and train the trainer programme.
Royal College of Surgeons Ireland(RCSI)	• The National Open Disclosure Steering Committee includes representation from the RCSI. • "*Making Difficult Conversations Easier*" webinar was delivered by Professor Eva Doherty, RCSI as part of Open Disclosure webinar programme.
General Practice	• Open Disclosure included in training programme for GP trainees and GP Principals. • Request made by GP Tutors groups for Open Disclosure presentation at their masterclass in January 2023 and preparatory work commenced on resources and training materials for this event.
University College Dublin (UCD)	• Open disclosure workshop and assessments of candidates on the Graduate Diploma in Quality and Risk Management.
National University of Ireland, Galway (NUIG)	• Open disclosure overview and update facilitated by OD team on NUIG Advanced Nurse Practice and Medicinal Prescribing and Clinical Governance Courses.
The National Doctors Training Programme (NDTP)	• The National Open Disclosure Steering Committee includes representation from the NDTP. • The NDTP continues to support the National Open Disclosure Team in promoting mandatory open disclosure training arrangements for NCHD's through the Doctors Integrated Management System / National Employment Record (DIME / NER). • The NDTP provide reports to the National Open Disclosure Office on the uptake of open Disclosure training certs to DIME/NER. • There is representation form the NDTP on Work Stream 4 of the Open Disclosure Performance Measurement programme.
Irish Hospital Consultants Association (IHCA)	• Open Disclosure update requested from IHCA for inclusion in their 2022 Annual Report.
HIQA	• There is representation from HIQA on one of the Ope Disclosure Performance Measurement Work Streams
Medical Council	• Open Disclosure Lead attended Medical Council workshop on the review of the Guide to Professional Conduct and Ethics for Registered Medical Practitioners .

	• Submission made to the Medical Council for the Open Disclosure section of the Guide. • There is Medical Council representation on Work Stream 4 of the Open Disclosure Performance Measurement programme.
Organisation	**Summary of engagement**
Nursing and Midwifery Planning and Development Unit (NMPDU) **Centre of Nursing and Midwifery Education (CMME)**	• The National Open Disclosure Steering Committee includes representation from the NMPDU. • Open Disclosure training is delivered in various CNME's across the country. • There is representation from the CNME on Work Stream 4 of the Open Disclosure Performance Measurement Programme.
Patient representatives and patient advocacy groups	• See Section 10 for details
National Screening Services (NSS)	• There is representation from NSS on the National Open Disclosure Steering Committee and Work Stream 1 of the Open Disclosure Performance Measurement programme. • Open Disclosure team is represented on the CervicalCheck implementation group. • There is an Open Disclosure lead for screening services. • The National Open Disclosure team are supporting the development of a training programme for the communication of personal care reviews.

Section 12: Supporting staff in the implementation of the HSE Open Disclosure Policy and following patient safety incidents.

HSE Patient Safety Strategy 2019-2024 Commitment 2: Empowering and Engaging Staff to Improve Patient Safety

"*We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety".*

12.1: Background:

"*A harmful incident presents a crisis not only for the patient's health, but also for their relationship with their clinicians. An adverse event threatens the patient–doctor relationship, damaging the trust the patient has placed in their providers.Similar to trauma, for which R Adams Cowley described a "Golden Hour" to deliver lifesaving care, there is an analogous window of opportunity for patient safety incidents.*[1] *In this "Golden Moment" that follows a patient adverse event, the clinicians involved must take action before patient trust erodes, and judgments harden. This is the moment to communicate openly with the patient and family. It is also the time to support involved healthcare staff, and to draw lessons from the incident. But again, all too often, that moment is lost. The Golden Moment can be lost due to the prevailing culture—which inspires a fear of punishment or litigation—and by lack of awareness, as well as by inadequate training. After acting to mitigate medical harm, clinicians, uncertain what to do, may hesitate and delay. Incidents are not discussed with patients and families. At the same time, clinicians do not receive timely support. The silence and inaction adds insult to injury for patients, and clinicians also suffer unnecessarily. The system fails to learn and future patients are harmed.There are a multitude of reasons why clinicians are reluctant to discuss errors with patients. These include fear of eliciting a negative response, as well as pride and fear of litigation. An additional barrier is inadequate training—clinician may not know what to say, or may doubt that a discussion with the patient will be successful*" (Wu 2019, Journal of Patient Safety and Risk ManagementVolume 24, Issue 5).

The identification and support of all staff involved in and/or affected by patient safety incidents is one of the principles in the management of patient safety incidents and the Open Disclosure process. As part of the Quality and Patient Safety Incident Management team, the National Open Diclosure programme works with the wider team to raise awareness of, promote and support the provision of timely and ongoing support for staff involved in/affected by patient safety incidents. The team focuses on the provision of training, support and resoures for organisations and staff to assist them in preparing for and engaging in effective open disclosure discussion with patients, service users and their relevant persons.

12.2: Examples of how the National Open Disclosure Programme supported staff throughout 2022

The following are examples of the support provided to staff and organisations during 2022 in relation to the implementation of the HSE Incident Management Framework and Open Disclosure programme, in preparing for and managing open disclosure meetings and promoting the support of staff involved in/affected by patient safety incidents.

12.2.1: Training:

- The inclusion of the importance of staff support in all training programmes and provision of information on the resources available;
- The development and delivery of training programmes for all staff to increase their confidence and to provide a structured approach to engaging in open discloure meetings;
- Providing support to local trainers;
- Developing and providing access to a wide range of training resources;
- Obtaining feedback from staff on the taining provided and adapting the programmes as required;
- Ensuring that all training programmes are CPD/CEU accredited;

A full range of training resources is avilable here

12.2.2: Resources:

- Developing and providing access to a number of resources to suport staff and organisations in preparing for and managing open disclosure meetings;
- Developing resources identified by staff that would assist them in the implementation of the policy;
- Maintaining an archive of these resources and updating them regularly;
- Raising awareness of the resources available via regular communications to staff across all services;
- The development of a guidance document during 2022 on the resources availabe to support staff following incidents "List of Support Services and Resources for Staff following an Incident" available here;
- The Open Disclosure programme developed its own "ASSIST ME" staff support booklet which is available on the website and which is provided during open disclosure training. The programme has also developed a summary"ASSIST ME" poster which is also available on the website. These re promoted via communication and on social media.
- There is an organisation checklist to support implementation and work commened during 2022 on the development of an implementation self-assessment tool.
- There is a page dedicated to sraff support on the website an dnking to al of the suport services and resources available – view webpage here.

Full range of staff support resources is available here

12.2.3: Webinars

- Facilitating webinars on Open Disclosure related topics and the recording and publication of these webinars on the Open Disclosure section of the HSE NQPSD website so that they may be accessed at a later date. Webinar powerpoInt presentations and recordings are available here;
- Two webinars were facilitated during 2022 in collaboration with the HSE Employee Assistance programme, Occupational Health, Health and Wellbeing and the HSE Health and Safety Function on the topic of supporting managers and staff following patient safety incidents;
- All webinars are CPD/CEU accredited.

12.2.4: Communications and publications

The National Open DIsclosure Office provide regular updates to staff working across all health and social care services via:

- The development, cirulation and publication of quarterly programme newsletters avalable here;
- The publication of the programme annual report available here;
- The development and cirulation of quarterly training reports and publication of an annual training report available here;
- Quarterly meetings and updates provided to Open Disclosure leads;
- Abstract and poster display at the Patient Safety Conferrence;
- The publication of an Open Disclosure information article in "Health Matters" available here;
- The publication of an Open Disclosure information article in WIN magazine;
- The development and publication of a Patient Safety Supplement on how to manage open disclosure to vulnerable persons;
- Responding to all email queries and requests via individual email addresses and the dedicated Open Disclosure office email address opendisclosure.office@hse.ie;
- Providing on-site coaching/training, telephone and written advice relating to all open disclosure topics and particulary in supporting staff in preparing for and engaging in complex open disclosure meetings.

12.2.5: Events

- The first Open Disclosure themed week was hosted in 2022 to raise awareness of the importance of open disclosure, training requirements and resources available. See section 8 of this report for more details;
- The Open Disclosure team took part in an incident management workshop which was delivered at the National Patient Safety Conference. The team also contributed to an Open Disclosure/Incident Management resource stand and display on the day.

Appendix A: Copy of Letter from National Director of HR 07/07/2022 re Open Disclosure mandatory training requirements

The following memo outlining mandatory open disclosure training requirements was issued by the National Director of HR on 07 July 2022 to all HSE and HSE funded services.

Memo

To: **Chief Executive Officer**
Each National Director
Each Assistant National Director HR
Each Assistant Chief Finance Officer
Each Hospital Group CEO
Each Hospital Group Director of HR
Each Chief Officer CHO
Each Head of HR CHO
Head of HR, PCRS
Each CEO Section 38 Agencies
Each HR Manager Section 38 Agencies
Each Employee Relations Manager
Each Group Director of Nursing & Midwifery
Each Group Director of Midwifery
Each Clinical Director
Director National Ambulance Service

From: **Anne Marie Hoey, National Director Human Resources**

Date: **7th July 2022**

Subject: **HE Memo - Open Disclosure Training: Mandatory for all Staff**

Dear Colleagues,

Open disclosure training is mandatory for all staff working in HSE and in HSE funded services with refresher training required every three years.

All staff must complete Open Disclosure e-learning **Module 1 "Communicating Effectively through Open Disclosure"** which is available on HSeLanD.

Staff who may be involved in formal open disclosure meetings e.g. senior managers, senior nursing, midwifery and health and social care professionals, medical staff, QPS staff and staff fulfilling the role of the Designated Person must also complete:

- E-learning Module 2 "Open Disclosure: Applying Principles to Practice" and
- Module 3 Face to Face Skills Workshop (3 hours) on the management of the open disclosure process.

Refresher training must be undertaken by all staff every 3 years.

Accountability

It is the responsibility of each service manager to ensure that staff are trained in open disclosure and to maintain local training records to provide assurance that the service is meeting mandatory training requirements.

Access to Training

Module 1: Communicating Effectively through Open Disclosure available on HSeLanD – login here

Module 2: Open Disclosure: Applying Principles to Practice available on HSeLanD – login here

Face to Face Training can be accessed by contacting the Open Disclosure Lead for your area available here.

Continuing Professional Development (CPD)

All of the above Open Disclosure training programmes attract CPD/Continuing Education Units as follows:

Module 1: 2 External CPD points (RCPI) and 2 CEUs (NMBI)

Module 2: 3 External CPD points (RCPI) and 3 CEUs (NMBI)

Face to Face Skills Training: 3 External CPD points (RCPI) and 3 CEUs (NMBI)

For further information and queries contact the National Open Disclosure Office on opendisclosure.office@hse.ie

Yours Sincerely

Anne Marie Hoey
National Director, Human Resources