**DOCUMENTATION TEMPLATE**

**Formal Open Disclosure Meeting**

*This is a confidential document which may be used to formally record the open disclosure meeting and if used must be kept in the open disclosure / incident management file*

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient’s full name**  |  | **Patient Identification Number (if applicable)** |  |
| **Date of birth** |  | **Venue for Meeting** |  |
| **Date of Meeting** |  | **Time of Meeting** |  |
| **Type of Meeting*****Face to Face / Telephone / Other*** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date incident occurred** |  | **Date incident became known to the service** |  |
| **How incident became known** |  | **Date of initial discussion with the patient/relevant person** |  |

**Meeting Attended By:**

|  |  |
| --- | --- |
| **Staff** | **Lead Discloser (Name and Role): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Other staff attending (Name and Role)****1.****2.****3** |
| **Patient/Relevant person** | **Patient attended Yes / No (please circle as appropriate)****Details of persons attending with or on behalf of the patient (state names and relationship to patient).****1.****2.****3** |

**Information provided at the Open Disclosure Meeting**

|  |  |
| --- | --- |
| **Information Provided** | **Details**  |
| * Description of the incident:
 |  |
| * Physical and psychological consequences of the incident for the patient: (known or potential)
 |  |
| * Treatment and care plan for the patient in relation to any consequences of the incident:
 |  |
| * Actions taken or planned by the health services provider to address the incident: (include procedures or processes to be implemented)
 |  |
| * Apology/expression of regret provided:
 | **Yes / No**  |
| * Details of the apology/expression of regret made by the health services provider:
 |  |
| * Patient story – the patient/relevant person’s perception of the incident and how it has impacted them:
 |  |
| * Questions asked and responses provided:
 |  |

**Information provided at the Open Disclosure Meeting**

|  |  |
| --- | --- |
| **Health service contact person** (Designated contact person assigned as point of contact for patient and support persons) | **Name:** **Position:****Contact Telephone No:** **Email address:**  |
| Actions agreed and next steps: |  |
| Plans for follow-up: |  |
| Details of supports offered and agreed: |  |
| Date of next meeting (if applicable): |  |

**Further comments/patient feedback:**

**Signature of Principal Healthcare Practitioner:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print name:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_