**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*

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| --- | --- | --- | --- |
| **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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_