Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Open Disclosure Policy

Communicating with Patients Following Patient Safety Incidents

Reference Number NATOD-POL-001

Policy Summary
12 June 2019

Note: Please note that this is a summary document and that staff are obliged to read the full policy document and to manage open disclosure as per the full policy document

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt
National Quality Improvement Team

It is the policy of the HSE that we

1. communicate with our patients in an open, honest, transparent and empathic manner following patient safety incidents,
2. provide our patients with a sincere and meaningful apology when they are harmed as a result of a patient safety incident, and
3. begin the communication process within 24 – 48 hours of the incident occurring or becoming known to the health services provider or as soon as possible after the incident happens.

This policy replaces the HSE Open Disclosure Policy 2013.

The revised policy is aligned with the provisions of

- Part 4 of the Civil Liability Amendment Act, 2017,
- the Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018,
- the Assisted Decision Making Act 2015, and
- the HSE Incident Management Framework 2018.

Summary of Policy Requirements:

No.	Policy Section	Summary
1	**Open Communication**	Patients have the right to full knowledge about their healthcare and to be informed when things go wrong during their health care journey.
2	**Presumption of Capacity**	A person whose decision-making capacity is in question is entitled to open disclosure on an equal basis with others and to be supported through that process.
3	**Provision of appropriate medical care and treatment**	Treat patients with compassion and empathy. Our focus must first be on the physical needs of the patient. Provide appropriate medical treatment or other care to manage any harm that has occurred, to relieve suffering and minimise the potential for further harm to occur.
4	**Events that trigger Open Disclosure**	There are three types of patient safety incidents, these are: • harm or suspected harm • no harm • near miss We must disclose all *harm* and *suspected harm* incidents. We must generally disclose *no harm* incidents. Assess *near miss* incidents on a case by case basis. We must inform patients of a *near miss* or *no harm* event if there is potential for it to become a *harm* event in the future.
5	**Timing of open disclosure**	We must start the open disclosure process within 24 to 48 hours or as soon as is practical after an incident occurs or becomes known to us.
6	**Assessing the Level of response required to Patient Safety Incident**	Our response can vary from low level to high level. The level chosen will depend on the harm which has occurred and the expectations of the patient. The member of staff who discovers the incident will assess it, consult with the principal healthcare practitioner or manager, as appropriate, and determine the level of response required.

No.	Policy Section	Summary
7	**Preparation for an Open Disclosure meeting**	You must prepare for an open disclosure meeting by giving due consideration to: • what has happened and how or why it happened • the facts available, • the key stakeholders involved, • the membership of the open disclosure team, • who the disclosure will be made to • any additional supports this person(s) will require, • when and where the open disclosure will be made • the apology to be provided and • the preparation of any necessary paperwork. Consider whether the protections of Part 4 of the Civil Liability Amendment Act 2017 are being sought. Manage open disclosure as per the procedure set out in the Act and regulations.
8	**Information to be provided at an Open Disclosure meeting**	We must inform the patient of all the facts available to us at the time of the open disclosure meeting about the patient safety incident. (See Table 2 in policy for full details of the information to be provided)
9	**The Apology**	When we identify a failure or error in the delivery of care/treatment we must provide the patient with a sincere and meaningful apology in a timely manner which is personal to the patient and to the given situation.
10	**Providing additional information**	We must provide any extra relevant information obtained after the first open disclosure discussion to the patient in a timely and supportive manner.
11	**The assignment of a designated person**	To maintain personal contact between the patient and ourselves we must give the patient the name and contact details of a designated staff member as a point of contact for them as soon as possible. This will help ensure the patient feels supported, listened to and included in the open disclosure process.
12	**Clarification of Information provided**	We must quickly respond in a factual manner to all questions and requests received by the designated staff member from the patient or relevant person after an open disclosure meeting.
13	**Providing a safe, supportive environment for staff**	The HSE will provide a safe, supportive and caring environment for staff involved in or affected by patient safety incidents. We will ensure that staff have access to relevant training on the open disclosure policy.
14	**Deferral of Open Disclosure**	Open disclosure of a patient safety incident must only be deferred in rare or exceptional cases. Staff members must always base the decision to defer on the safety and well-being of the patient. Section 3.15 of the policy sets out detailed requirements about deferring open disclosure and the escalation processes required. All staff members must adhere to these requirements.
15	**Open Disclosure to the patient's relevant person**	Disclosing information to an adult patient's relevant person must only be undertaken with the consent of the patient, where possible. Section 3.16 of the policy gives details on managing open disclosure to the patient's relevant person in all circumstances, including when a patient dies.

No.	Policy Section	Summary
16	**Record keeping**	We must document the most important points of the open disclosure meeting, including details of any apology, in the patient's clinical/care record. Store other documentation, for example: prescribed statements, checklists, minutes of meetings, in a separate file to the health care record, for example an incident management file or an open disclosure file.
17	**Follow up care**	Send the patient the minutes of the formal open disclosure meeting after it has happened. The designated staff member must contact the patient on an agreed date and time.to talk to them about their experience of the open disclosure process.
18	**Governance**	Open disclosure is an integral component of the incident management process. Primary responsibility and accountability for the effective management of patient safety incidents, including the open disclosure process, is at the organisational level where the patient safety incident occurs. We must ensure that the correct governance structures are in place, at service level, to support timely and effective open disclosure.
19	**Implementation**	HSE services will develop an implementation plan to support the roll out of the open disclosure policy – see section 12.0 of the policy
20	**Evaluation and Audit**	The Senior Accountable Officer is responsible for the monitoring of performance in relation to open disclosure and verification of compliance with this policy.