Cáilíocht Náisiúnta agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Chliniciúil
National Quality and Patient Safety
Office of the Chief Clinical Officer

NATIONAL OPEN DISCLOSURE OFFICE
PROGRAMME NEWSLETTER

Issue 18 | April 2025

Dear Colleagues and Friends,

We are delighted to provide you with some high-level updates in relation to open disclosure. There has been significant momentum already this year. Services and staff are working hard towards the implementation of national developments such as the Patient Safety Act 2023 and the Department of Health National Open Disclosure Framework 2023.

We continue to amass learning from notifiable incidents reported by HSE and HSE-funded services, which we share with Open Disclosure Leads, services, and capture in this newsletter. Please be aware that the incidents are quite serious, and the shared learning on the last page of this newsletter refers to incidents where service users sadly died.

In Quarter 1 we also worked with services on the first Open Disclosure Annual Report submitted to the Minister/Department of Health outlining the progress HSE and HSE-funded services are making towards implementing the requirements of the National Open Disclosure Framework. We were thrilled to incorporate the many examples of exemplar work underway in the Regions and National Services to help embed open disclosure. Our HSE Senior Leadership Team have sought assurance in relation to compliance with the Patient Safety Act 2023. Next year's annual report will include overall compliance information with open disclosure and we will need to ensure all section 38 organisations are included in the regional feedback collated, as stipulated by the Department of Health.

Much focus this year will continue to be on supporting services. In particular, we will be working with maternity services and the National Women's and Infant Health Programme on supporting staff and our service users in this area of work.We are pleased to learn that open disclosure questions will be included in future patient experience surveys developed by HIQA, starting with the National Mental Health Experience Survey Questionnaire.

For now we would like to thank you for your unwavering support, leadership and engagement in driving a culture of openness and transparency.

With Best wishes,

Lorraine, Róisín, Ellie, Kelly, Mary and Killian

NATIONAL
OPEN DISCLOSURE
PROGRAMME

News from across QPS Incident Management

DID YOU KNOW the QPS Incident Management Team's "Patient Safety Together" programme shares up-to-date patient safety information with everyone - staff, patients, and the public - to help improve health and social care services.

Outputs are freely available on an open-access online platform. There are a wealth of resources including National Patient Safety Alerts, Patient safety Supplements, Patient Safety Stories, and much more!

SCAN ME

Scan the QR code to visit the Patient Safety Together website at https://www2.healthservice.hse.ie/organisation/nqpsd/pst/

Patient Safety Together: learning, sharing and improving

Open Disclosure Training & Education 2025

We continuously review and plan our training schedule for the year. This includes the Train the Trainer Programmes, Skills Workshops, virtual briefings, webinars and other educational activities. We also provide coaching clinics and education resources to services.

If you require support with planning or delivering open disclosure training for your service, we are happy to help! Please email us at: OpenDisclosure.Office@hse.ie

This newsletter is an interactive PDF. When you click on a hyperlink, it will bring you to the website or other resource mentioned. To access, just hover and click on the text. This is the symbol you will see beside a hyperlink:

Training and Education

updates on our National Open Disclosure Office Training and Education

In February, we delivered a workshop to support people who are currently, or may in the future be, assigned the role of the Designated Person in open disclosure and incident management.

The role of the Designated Person is essential to support patients, service users and families who have suffered harm, ensuring that they do not feel isolated and that their support and communication needs are met. The importance of this role is highlighted in the HSE Open Disclosure Policy and is a legal requirement of the Patient Safety Act 2023.

Many of these individuals may be new to the area of quality, patient safety and incident management. As such, our goal on the day was to ensure that everyone was provided with a good understanding and background to the role.

As outlined in the Patient Safety Act 2023, a 'Designated Person' is someone who has been assigned to act as a liaison between the health or social care service provider and the patient or relevant person (or both of them) in relation to the open disclosure of a notifiable incident.

The day featured guest speakers, group work, reflection, and opportunities for networking. It was attended by over 120 people from across local, regional and national services.

The post-event evaluation demonstrated it was very welcome and well received. Feedback included "well organised", "very informative", "loved the discussions, networking opportunities, the presenters".

The National Open Disclosure Office will be planning future events and coaching / support for designated persons in the year ahead.

Resources to support the designated person include:

- **The role of the designated person (PDF)**
- **Designated person checklist (Word)**
- **E-learning programme on the role of the designated person on HSeLanD**

Upcoming training, events, and networking opportunities

Train-the-Trainer Part A: Virtual Programme (online)

- 13 May 10am - 1pm

Open Disclosure Webinar (online)

- 14 May 12pm - 1.30pm

Open Disclosure Leads Meeting (online)

- 5 June 2pm - 3pm

Contact us for information on CPD (RCPI) and CEU (NMBI) for our training and events.

Open Disclosure Webinars

We facilitate regular webinars on open disclosure related topics with a variety of guest presenters. We welcome all staff to attend these webinars. Each webinar is CPD accredited by RCPI and NMBI for those who attend the live event. Recordings are available if you wish to listen back or for those of you who cannot attend on the day.

Feb 2025 | **After Actions Review (AAR) - a concise review tool following incidents**

Our February webinar focused on the benefits of After Action Review (AAR), a structured review process which seeks to rapidly identify and reinvest learning for safety improvement. AAR was introduced in the HSE in 2018 as part of the Incident Management Framework as a concise review tool following patient safety incidents.

WATCH NOW

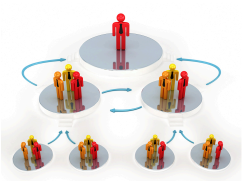
505 Attendees

99% of survey participants felt the webinar met or exceeded their expectations

Featuring:

- Prof Dara Byrne, National Clinical Lead For Simulation, HSE National Simulation Office
- Dr Siobhan McCarthy, Lecturer/Programme Director, Graduate School Of Healthcare Management, RCSI
- Una Healy, Safety & Risk Lead Manager, Quality & Safety Improvement Directorate, St James's Hospital
- Lorraine Schwanberg, Assistant National Director, Incident Management, NIMS and Open Disclosure

May 2025 | **Communication & care: How does culture shape quality in health and social care?**



Our May webinar will focus on the forthcoming HSE Culture Framework: "Enabling Framework for Organisational Culture". Developed through considerable co-creation and consultation, the forthcoming culture framework represents a significant moment in HSE's culture journey. Our webinar will look at:

- What has been learnt from the engagement with teams, patients, the public and academia about culture in the HSE, as part of the development of the Culture Framework.
- How the Culture Framework will enhance working environments to support openness and transparency with patients.
- How open disclosure fits into the framework, and its ambition to measure the improvement in culture.

Wed 14 May
12 - 1.30pm

Featuring:

- Joe Ryan, National Director, HSE Public Involvement, Culture and Risk Management

Sharing The Learning

We are often requested by health and social care services to provide coaching and support on the open disclosure process in relation to incidents, particularly notifiable incidents. We work with the services to unpack nuances of the Patient Safety Act and how to manage incidents and open disclosure. At a recent Open Disclosure Leads meeting, we committed to seek new ways to share our learning across services, including through this newsletter.

The following "Lessons Learned" stem from real-world examples of how notifiable incidents have been managed by services. They offer relatable issues that services may learn from in the context of improving quality and patient care.

NOTFIABLE INCIDENT 1.12

1.12 (Death where the cause is believed to be suicide)

Sadly, there have been incidents reported whereby service users left or absconded healthcare premises, and subsequently are believed to have died by suicide. Whilst such incidents would need to be reviewed as category 1 incidents under the Incident Management Framework, they are not NIs under the Patient Safety Act 2023 as the incidents did not occur at healthcare premises. They should not be reported as NIs, but other regulatory reporting will still be required, for example to the Mental Health Commission using the Comprehensive Information System (CIS) if it involved an approved centre.

Separately, where a service user is transferred between sites, for example from a mental health service to an acute service, and an incident then occurs of suspected suicide onsite in the acute service, then the acute service must notify HIQA of NI 1.12 through NIMS and lead out on open disclosure. Again, the mental health service will still need to complete other regulatory reporting requirements, such as the reporting to the MHC using CIS if it is an approved centre.

The only NIs that are notifiable to the MHC are those that occur in an approved centre. All notifiable incidents taking place in community mental health services should be reported to HIQA via NIMS, and not to the MHC.

For further guidance on NIs from the MHC, see: https://www.mhcirl.ie/what-we-do/regulation/notifiable-incidents-patient-safety-act

NOTFIABLE INCIDENTS 2.1 AND 1.11

2.1 (Referral for therapeutic hypothermia)

1.11 (Perinatal death)

It is important that services engage and liaise to support open disclosure in these sometimes complex scenarios, where clinical care is a priority. That is, between clinical teams - be that obstetrics, neonatology and in some areas paediatrics - as well as across different organisations where a number of services had input in a particular pathway of care.

Where an infant is transferred from a regional hospital to a tertiary hospital for therapeutic hypothermia, it is the responsibility of the regional hospital to notify HIQA of the NI through NIMS, and follow-up on the open disclosure process.

Where the baby sadly dies following transfer for therapeutic hypothermia, then the regional hospital reports NI 2.1 for the therapeutic hyperthermia and the tertiary hospital reports NI 1.11 (if the definition applies) to HIQA using NIMS. In this instance, the regional and tertiary hospitals should work together to meet the needs of the family. This can mean that one open disclosure meeting and one designated person will suffice and offer a better experience for the family in such difficult circumstances. This has been agreed with the Department of Health. Services are advised to keep both NIMS entries updated with all relevant information and dates. Importantly, there should be good communication across the clinical teams and services.

Connect with Us!

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QPS Incident Management Team

Incident Management | National Open Disclosure Programme | Patient Safety Together: learning, sharing and improving | NIMS

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