An Roinn Sláinte
Department of Health

Development of an Open Disclosure Policy Framework for Healthcare in Ireland

12 May 2021
HSE Webinar, Legislation and Open Disclosure Policy Framework

Independent Patient Safety Council

- The Independent Patient Safety Council consists of multi stakeholders and was set up to provide advice and guidance to the Minister for Health on patient safety policy matters as agreed in a work programme with the Minister.

- Established in late 2019, its first priority was to produce recommendations for the development of a national policy framework for open disclosure in healthcare in Ireland.

- The Council presented its recommendations to the Minister in January 2021.

What is an open disclosure policy framework?

- The framework aims to provide unity and consistency of approaches to open disclosure across public and private health service providers, service and health professional regulators, healthcare educators and other relevant bodies and organisations.

- The framework will provide an overarching approach and can be drawn from to suit the needs of the various organisations.

- It will address issues such as high-level principles, common approaches to support and harness positive open disclosure cultures and behaviours.

- It will identify mechanisms and initiatives that support the consistent, coherent and sustainable implementation of open disclosure.

What is the scope of the framework?

- The framework will sit at a level above that of the HSE policy and at a high level to allow for adoption and alignment of approaches across healthcare providers, regulators, educational bodies and other relevant bodies.

- It will aim for a principles and policy direction approach more so than policy application and practice.

Scope of the framework, continued

- Good work and ongoing progress has been made by HSE's open disclosure policy. The framework has the potential to continue the positive progress of what is already being done and to bring about further improvements.

- Aims to make open disclosure the norm, not merely the focus of mandatory disclosures

  - *Keeping the focus on the concepts of humanity and empathy*

  - *Recognising the importance the timeliness of the first and early communications, in reducing any further possible harm or trauma*

Findings of the Independent Patient Safety Council

- Independent research and national stakeholder and public consultation by Crowe Consultants was commissioned in 2020 on behalf of the Independent Patient Safety Council.

- Findings of the research and consultation

  - *Open disclosure practice in health and social care in Ireland has been getting better in the past few years but there are still times when patients/service users and families do not get all of the right information*

  - *When something doesn't go the way it was supposed to in health and social care, most patients/service users and families want:*

    - to get the right information at the right time, so that they can clearly understand what happened;
    - someone to say sorry about what happened in a sincere way;
    - to know what has been done; and
    - To know that the services have taken action to make sure that the chances of it happening again are reduced.

Findings of the Independent Patient Safety Council, contd.

- *Patients/service users and their families can find it difficult to get the right information or to understand what happened and they need help and support to do this.*
- *Staff also need support*
- *Health and social care workers fear the consequences of being open, e.g., potential for litigation, loss of reputation*
- *Existence of blame culture*
- *There should be consequences when open disclosure does not happen*

Recommendations of the Independent Patient Safety Council

- **Open, Honest, Compassionate, and Timely Communication**
  - *This means that patients/service users and families must be told all the right information at the right time when something has gone wrong in relation to their care, that nothing should be held back, and that they should be treated with respect and compassion by the health and social care staff and organisations involved.*

- **Patient/Service User and Support Persons' Entitlements in Open Disclosure**
  - *This principle says that patients/service users and families are entitled to be told something has happened, have it explained clearly, receive an apology, and be told what has been done to try to put it right. They should be able to get help to understand what happened and to deal with the open disclosure process.*

Recommendations of the Independent Patient Safety Council, contd.

- **Supporting Health and Social Care Staff**
  - *This says that as well as supporting the patient/service user and their family when something has gone wrong in their care, the staff members involved should be helped and given support to deal with what has happened in the best way – for the patient/service user and family and for themselves. Staff should have the information they need so that they know how to discuss what happened with patients/service users and families in the best way.*

- **Promoting a Culture of Open Disclosure**
  - *This principle says that the health and social care system needs to work on the problems that make it difficult for health and social care staff to provide the right information at the right time to patients/service users and their families. It means that organisations providing health and social care must encourage their staff to do this the right way and not make them fearful of what might happen if they tell someone that something has gone wrong.*

Recommendations of the Independent Patient Safety Council, contd.

- **Open Disclosure for Improving Health and Social Care Policy and Practice**
  - *When things go wrong in patient/service user care, there is an opportunity for the way things are done to be improved, so that this problem does not happen again or as often in future. Organisations who provide health and social care must have systems in place to learn from when things go wrong, and encourage staff to be open about mistakes or problems so that things can be improved.*

- **Clinical and Corporate Governance for Open Disclosure**
  - *This principle sets out what should be done to make sure that open disclosure is happening in the right way and what should happen if it is not. Organisations who provide health and social care must have systems in place to be able to track what is happening with open disclosure and to report on this regularly. It must be clear to all staff what should happen with open disclosure and what the consequences for not giving the right information to patients/service users and families will be. Organisations where this is not happening may have penalties.*

Development of Framework

- **Informed by HSE OD Policy**
- application to wider health sector
- evidence of learning from OD & informing policy change
- system of monitoring/reporting at organisational level
- Independent support services for patients

- **Implementation**
- annual reporting: comply/explain
- focus on identifying good practice & supporting ongoing culture change

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Continue to work closely with HSE and other stakeholders

Develop draft framework (September 2021)

Public Consultation (October/November 2021)

Finalise framework (Feb/March 2022)