An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phriomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

Open Disclosure

Sharing the Learning – Documenting Open Disclosure

Documenting Open Disclosure: Webinar Objectives

The objectives of todays webinar are as follows:

- To update attendees on HSE Open Disclosure policy requirements for documenting open disclosure
- To provide guidance on the tools available to support good documentation
- To provide examples of Open Disclosure documentation using case scenarios
- To provide an update on pending changes to documenting Open Disclosure on NIMS

Open Disclosure – Definition – HSE Policy

Open disclosure is defined as an open, consistent, compassionate and timely approach to communicating with patients and, where appropriate, their relevant person following patient safety incidents. It includes expressing regret for what has happened, keeping the patient informed and providing reassurance in relation to on-going care and treatment, learning and the steps being taken by the health services provider to try to prevent a recurrence of the incident. (HSE 2019)

Open disclosure is a discussion and an exchange of information that may take place in one conversation or over one or more meetings.

Open Disclosure Meeting – Meaning under legislation

"Open disclosure is where a health services provider discloses, at an open disclosure meeting, to

- a patient that a patient safety incident has occurred in the course of the provision of a health service to him or her
- a relevant person that a patient safety incident has occurred in the course of the provision of a health service to the patient concerned, or
- a patient and a relevant person that a patient safety incident has occurred in the course of the provision of a health service to the patient.

Civil Liability Amendment Act 2017 and PSB 2019

Patient Safety Incident – Meaning under legislation

"An incident which occurs during the course of the provision of a health service" which:

(a)has caused an unintended or unanticipated injury, or harm, to the patient

(b) did not result in actual injury or harm to the patient but was one which the health services provider has reasonable grounds to believe placed the patient at risk of unintended or unanticipated injury or harm or

(c) unanticipated or unintended injury or harm to the patient was prevented, either by "timely intervention or by chance", but the incident was one which the health services provider has reasonable grounds for believing could have resulted in injury or harm, if not prevented.

Therefore includes : harm events, no harm events and near miss events.

Civil Liability Amendment Act 2017 and PSB 2019

Learning from Legal aspects of Documentation Webinar 15th April, 2023

Why keep good documentation?

- On-going patient care & quality
- Clinical audit
- Trust
- Defence of litigation – records should form a reliable evidential base

"Every practitioner must be taken as knowing that records may later be used in court proceedings or other investigations or inquiries and hence their importance is self-evident."

(McManus v. Medical Council [2012] IEHC 350 Kearns P at p30)

Purpose of good documentation

- Record of treatment of Patient
- Informs of the 'standards of care' at time of care in relation to diagnosis and treatment of patient
- May be evidence of practice in existence at the time – which may be informative in relation to whether a practice was or was not practiced as stated.

Good Record Keeping: the Basics

Legible	Omit irrelevant patient/colleague remarks
Time and date entered	Keep records factual
Signature and name	Record consent clearly
Omit abbreviations	Document seminal events in detail

HSE OPEN DISCLOSURE POLICY REQUIREMENTS

Documentation of open disclosure:

Key points: Maintaining documentation

- Keep the patient record up to date in relation to open disclosure discussions
- Maintain a record of the open disclosure process – initial discussion, follow up meetings, clarification requests, additional information meetings
- Keep on record all documents relating to the open disclosure process in the Open Disclosure/Incident Management file e.g minutes of meetings, letters to the patent/service user/relevant person
- Provide the patient/relevant person with relevant documentation throughout the process
- Record Open Disclosure on NIMS
- Maintain documentation requirements when managing Open Disclosure under the provisions of the current Part 4 of the Civil Liability Amendment Act and Patient Safety Bill when commenced.

HSE OPEN DISCLOSURE POLICY REQUIREMENTS

Documentation of open disclosure:

<u>Low Level Open Disclosure Meeting:</u> The patient safety incident and details of clinical care will be recorded in the patient's healthcare record.

Record the salient points discussed with the patient and/or their relevant person during the open disclosure meeting, including the details of:

(i) who was present at the open disclosure meeting;
(ii) the information provided; what happened, when, how and why it happened – facts available – responses to questions/clarifications arising;
(iii) the impact of the patient safety incident on the patient, if any;
(iv) the details of the apology provided and
(v) agreed care/treatment plan and actions (to manage incident and to prevent recurrence)

Documenting a low level event – Medication Error

Incident: Mary was administered an additional x 2 Paracetamol tablets in error within a 3 hour period as her Paracetamol was prescribed "Prn" and also regularly every 6 hours on her prescription chart.

31/03/2023 at 14.25; Open Disclosure discussion with Mary: Attended by: M. Santos(CNM1) and J. Gallagher(S/N)

Acknowledge	I informed Mary that a medication error had occurred and explained that this happened due to the way her Paracetamol was prescribed on her medication chart.
Sorry	I apologised to Mary for the error that occurred and for the anxiety she experienced as a result.
Story	Mary said that she was feeling ok.
Inquire	She asked if this could happen again.
Solutions	I reassured Mary that her Prescription chart had been amended immediately to ensure that this will not happen again. All staff will be informed of the incident. Incident reported on NIMS.
Travel	Continue to monitor B/P and pulse today. MS to check in with Mary later and speak to Marys daughter, Jenny, at Mary's request. Mary encouraged to ask to speak to MS or nurse in charge should any further questions/concerns arise.

Signed:

Documenting Open Disclosure on NIMS – developing NIMS data fields

NIMS: The details of the incident and open disclosure of the incident to the patient/relevant person must also be recorded on the **National Incident Management System (NIMS) .**

SECTION L: TO BE COMPLETED BY LINE/DEPARTMENT MANAGER (For entry on Incident Review screen on NIMS)

Has open disclosure happened? (tick one only ✓) ☐ **Yes** ☐ **No**

If No, please specify: _____

Work is in progress to develop the Open Disclosure data fields on NIMS further to meet the data requirements for the pending Patient Safety Bill. This will include Open Disclosure data fields on the entry screen.

Documenting Open Disclosure(OD) on NIMS – pending developments

- NIMS will be the data system to collect data on compliance with mandatory open disclosure provisions in the pending Patient Safety Bill.
- There will be OD data fields on NIMS Entry Screen and Review Screen.
- OD Data entered on Entry Screen will automatically populate in Review Screen.
- Data fields will be elaborated to capture
    - Is the incident a Notifiable Incident(NI)? (Patient Safety Bill)
    - Date the service became aware of the incident:
    - That there was an Open Disclosure Meeting:
    - The Date the Open Disclosure Meeting took place:
    - That one of the two exemptions does not apply:
    - That a statement in writing was sent to the patient/relevant person:
    - Date the statement in writing was sent:

High level event – Category 1/Category 2 incident

High Level Open Disclosure: The patient safety incident and details of clinical care will be recorded in the patient's healthcare record.

The Initial Discussion: The salient points discussed with patients and/or their relevant person during the initial discussion, including the details of

(i) who was present
(ii) the information provided,
(iii) the known/likely impact of the patient safety incident on the patient
(iv) the apology provided and
(v) agreed care/treatment plan, actions and next steps, (to manage incident and to prevent recurrence)

must be documented in the patient's healthcare record.

The patient/relevant person will be provided with the name and telephone number of a **contact person(designated person)** should further questions arise. The name of the **designated person** will also be recorded in the Incident Management/Open Disclosure file.

The details of the incident and open disclosure of the incident to the patient/relevant person will also be reported/documented on the **National Incident Management System (NIMS).**

High level Open Disclosure Meeting

This meeting will be minuted and the verified notes of the meeting will be sent to the patient/relevant person.

The notes of the meeting will be provided in a timely manner and may be provided to the patient/relevant person in the form of minutes/documentation template or a letter detailing the minutes of the meeting. (**Note for pending PSB: this statement must be provided within 5 days of the meeting).**

When the minutes of the meeting are provided or a documentation template is used these should be accompanied by a supportive covering letter re-iterating any apology provided.

Document in the clinical/care record that an open disclosure meeting was held as follows:
Example: Date: xx/xx/xx Time: xx.xx Open Disclosure meeting with ……(enter patient's name) and ……. (enter name of relevant person/support person(s))
See notes of meeting which are available in the ……(Incident management File or Open Disclosure File)
Signed: ……(Principle Healthcare Practitioner).

High level open disclosure meeting

The information provided in the minutes/letter will include the date and time of the meeting, the names and roles of those present and salient points discussed at the meeting including:

- the date and description of the patient safety incident;
- when and how the incident became known to the health and social care service provider;
- key information provided in relation to the patient safety incident;
- how the incident has /is likely to impact the patient;
- the apology provided;
- agreed actions, care/treatment plan;
- agreed next steps and
- the name and contact details for the designated person.

Any matters relating to clinical care/treatment will be documented in the healthcare record and a note entered to indicate that an open disclosure meeting was held.

Best Practice for Documenting a high level open disclosure meeting

- Consider documentation requirements as per the HSE Open Disclosure Policy.

- Use standardised documentation template to guide discussion and ensure that all of the components of the Open Disclosure process have been addressed and documented during the course of the meeting.

Resources available:

- Sample Open Disclosure documentation template available here
- Open Disclosure Quick Reference Guide and Toolkit available here

Documentation templates provided can be adapted for local use.

Best Practice for Documenting a High level open disclosure meeting

When sending out the minutes of a meeting or a standardised documentation template always include an accompanying letter to personalise the records for the patient/service user/relevant person involved. The letter should include the following:

- Thank the patient/service user/relevant person for attending the meeting,
- Re-iterate the purpose of the meeting,
- Inform them that the main points discussed in the meeting and actions agreed are attached in the meeting record.
- Offer them an opportunity to review the meeting record and to contact the designated person if they require any matters to be clarified or amended or if any further questions/concerns arise.
- Include name and contact details for the designated person.
- Re-iterate the apology provided at the meeting.

Options for Documenting a high level open disclosure meeting

1. Minutes of the meeting + supportive covering letter

2. Completed documentation template + supportive covering letter

3. Letter containing the salient points of the meeting as outlined above.

Ensure that letter/documentation is supportive and personalised to the person(s) involved and given situation.

Example of a supportive covering letter.

Dear…… ***(Remember that all documentation should be personalised to the individual and given situation)***

Thank you for attending the Open Disclosure meeting on ….(insert date) at…(insert time). The purpose of this meeting was to discuss the medication error that occurred on…..(insert date) when you were administered an additional dose of your blood pressure medication.

Please see the attached document which provides the details of the main points discussed at this meeting and actions arising as a result. We have commenced work on the actions agreed and will keep you up to date on developments through Ms Angela Tysall who has been appointed as your contact person for the service. Angela's contact details are as follows: Email: xxxxxxxxxxx ; Telephone: xxxxxxxx. Should you have any questions or require clarification on any matter discussed at this meeting or arising after this meeting please do not hesitate to contact Angela who is available Monday to Friday from 0900-5pm.

I would like to take this opportunity to re-iterate my sincere apologies to you for the error that occurred, for the symptoms you experienced as a result and for the upset and worry that this has caused for you as you described during our meeting. The service is implementing the actions agreed to try to ensure that this does not happen again.

Yours sincerely,
Insert signature
(Insert name and role of Principal Healthcare Practitioner)

Enc: State name of document attached e.g.Minutes of Open Disclosure Meeting (Date) or Completed Open Disclosure Documentation template(Date)

Things to Avoid in Documentation

- Medical jargon
- Defensive language
- Legal terminology – words such as liable, negligent
- Speculation/blame
- Non personalised standard communications
- Standard apologies – an apology must be personal to the individual/relevant person affected, to the given situation and to the impact experienced.
- An apology that isn't an apology e.g. *"I am sorry that you feel that way"*
- Abbreviations
- "However" and "But"

Resoures available to support good documentation

- Pre, during and post Open Disclosure checklists available here
- Open Disclosure Documentation Template available here
- Open Disclosure Quick Reference Guide and Toolkit available here
  Contains pre, during and post OD checklist, documentation template, sample language document which includes language to avoid
- ASSIST Model of Communication – follow ASSIST Model to guide documentation available here
- Management of Apology in Open Disclosure – available here

All of the above documents are available on the Open Disclosure website https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/resources-for-staff-and-organisations.html

Patient Safety Culture
&
Documenting Open Disclosure

Mary O' Dwyer

HSE MID WEST
COMMUNITY HEALTHCARE
Mental Health | Older Persons | Disabilities
Primary Care | Health & Wellbeing

Safety Culture

Culture

- Organisational Culture is made up of shared values, beliefs and assumptions about how people should behave and interact. It defines **how decisions are made** and **how work is done**. Culture shapes peoples' behaviour and values at work.

- **Patients experience culture in the decisions** that are made and **behaviours that they see, hear and feel.**

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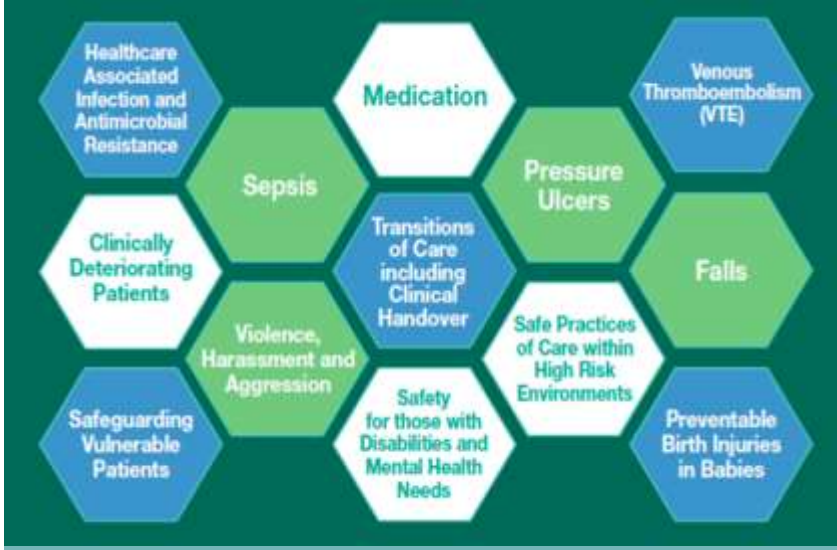
Adverse Events & Incidents

Adverse Event: An incident which results in harm, which may or may not be the result of an error.

Incident: An event or circumstance which could have, or did lead to unintended and/or unnecessary harm.

Incidents include:

- adverse events which result in harm;
- near misses which could have resulted in harm, but did not cause harm, either by chance or timely intervention;
- staff or service user complaints which are associated with harm.



1 in 7

An adverse event occurred in approximately 1 in 7 acute hospital admissions in Ireland
Irish National Adverse Event Study (2015)

Open disclosure is habit

.Disclosing to the patient:

- This might already be a risk identified in their care plan.
- What happened?
- The now and the next
- What did we learn?

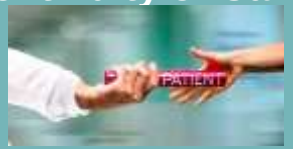
Documenting the disclosure is part of the normal process of care delivery as a record of the information provided, plans agreed and to ensure continuity of care.

Shared documentation of Open Disclosure supports:

✓ Transparency and shared understanding

✓ Informed consent and decision- making

Continuity of Care



Step 1:
Document initial disclosure on detection of Stage II pressure ulcer

01/05/2023	Open Disclosure on detection of Stage II pressure ulcer	
11.30	I advised Tom that while observing his skin today @ 09.10, a Stage II pressure ulcer was detected on his right heel - a red area, approx. 2cm x 2cm. I apologised that this had happened. Tom said that he had noticed a tenderness on his heel.	
	Changes to Tom's care plan to treat the pressure ulcer discussed with Tom- need to re- position regularly to prevent pressure ulcers, keep pressure off that spot as much as possible to help it heal. Pressure ulcer information leaflet given to Tom and questions answered. Photo of pressure ulcer taken with Tom's consent.	
	Advised Tom that this will be reported as an incident today to J. Doe CNM. I explained that J Doe will be meeting with Tom to talk about this incident.	
	I ask Tom if he wanted me to talk about the pressure ulcer with his contact person- Tom wants his daughter, Ann, to be told what happened.	Mary Murphy PIN 33347

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Step 2:

Document phonecall to person by the patient

01/05/2023	Phone to nominated person	
15.30	I explained to Ann O' Brien that Tom asked me to ring her to advise her about the pressure ulcer that developed on his right heel since he was admitted to our ward on 28/04/2023. Ann told me that she knew what a pressure ulcer was and wanted to know how did this happen? Was he ok? I told her that Tom said his heel was tender this morning. I apologised for this happening to Tom.	
	I told Ann that when I was checking Tom's skin today @ 09.10, I noticed a Stage II pressure ulcer on his right heel - a red area, approx. 2cm x 2cm. We have started a treatment plan to heal the pressure ulcer and prevent other pressure ulcers developing- need to re- position regularly, keep pressure off that spot as much as possible. We will be checking Tom's skin now twice a day. I explained that since Tom was admitted a special mattress was on his bed to help prevent pressure ulcers.	
	I explained that pressure sores are always reported in the HSE as an incident and the CNM II, J Doe, will be reviewing Tom's care. In line with the HSE policy of Open Disclosure, J Doe will talk to Tom about this incident. If Tom wishes, Ann can be there with him for that meeting. Ann said that she would talk to Tom about this when she comes in to see him tomorrow.	Mary Murphy PIN 33347

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Step 3:

Document disclosure of outcome of incident review

03/05/2023 14.00	Open Disclosure meeting re: Stage II Pressure Ulcer reported on 01/05/2023.	
	Present: Tom and Ann O' Brien (attended at Tom's request), Mary Murphy, Staff Nurse and Jane Doe, CNM II. See notes of meeting which are available in the Incident Management File	Jane Doe, CNM II. PIN 44466

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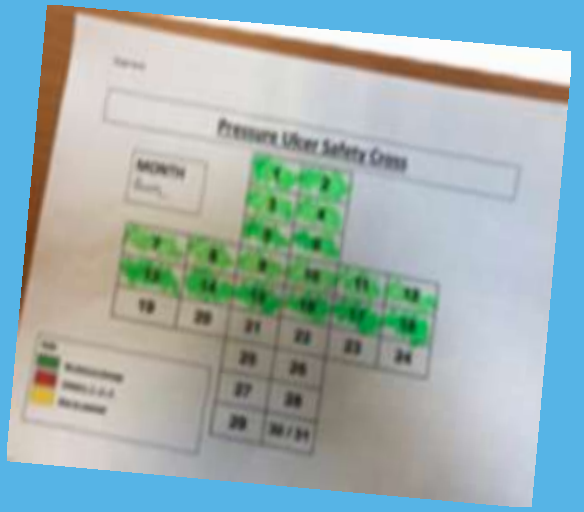
Patient Safety Culture
&
Documenting Open Disclosure

- ✓ Make incident data visible on Safety Boards.
- ✓ Tools such as the Safety Cross or Safety Stick are easy way to display incident data in real-time about common causes of harm such as falls or pressure ulcers.
- ✓ Foundation stones for Patient Safety and Learning



Sharing incident data on the Ward Safety Boards

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Safety Culture
&
Documenting Open Disclosure

- Open Disclosure is a habit, part of our normal process when an incident occurs.
- A routine of Open Disclosure is an integral part of a Patient's experience of a safety culture that is just, where reports of incidents are used to generate new learning, making the system safer for Patients.

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Open Disclosure Documentation QIP

Beaumont Hospital

May 2023

Documentation Audits - Methodology

- Cases discussed at Serious Incident Review Team
- Healthcare record audit
  - First meeting
  - Meeting following review
  - Subsequent meetings (as applicable)
- Bespoke quick snap education

Open Disclosure – Audit Performa

Open Disclosure – Documentation Audit

MRN	Date of Incident	Incident Theme

Was incident noted in medical notes? Y / N

Was incident noted in Nursing Notes? Y / N / NA

Documentation of Open Disclosure Meeting	
Is there evidence of;	*Y / N / NA*
Date and time	
Who was present in room/phone/ bedside	
What information was provided to patient	
Details of the apology	
Apology offered by whom	
Agreed actions	
If follow up meeting was required	
Entry signed, name printed, MCN/NMBI	
Date and time of follow-up	
Who was present in room/phone/ bedside	
Brief outline of incident / reason second meeting	
Details of the apology	
Apology offered by whom	
Key discussion points	
Outcome of investigation / review	
Additional questions / answers	
Other	
Entry signed, name printed, MCN/NMBI	

General Comments:-

Key Findings

- Initial meeting / open disclosure noted in healthcare records
- Specific details pertaining apology poorly documented
- Poor documentation on follow-up meetings / discussion on review outcomes

Quality Improvement Work

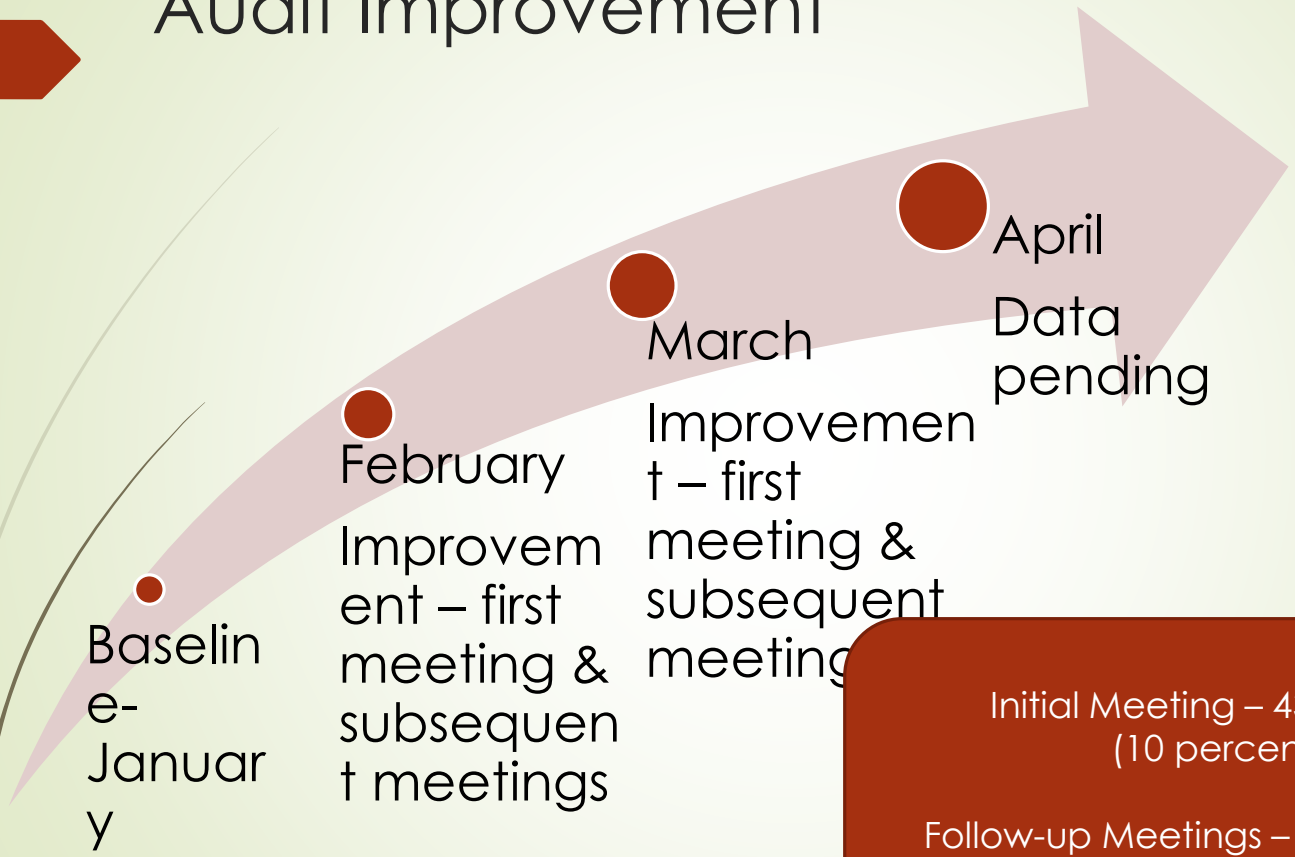
Open Disclosure Documentation Packs

Open Disclosure Documentation Packs

Open Disclosure Meeting

Date		Time
Meeting Type (please tick)	Initial Meeting	Follow-up meeting
Person(s) present		
Incident / Reason for Meeting		
Review Findings / Plan		
Apology / Expression of Regret		
Other Relevant Information (continue in HCR if needed)		
Signature		
Printed Name		
IMC / NMBI / CORU		

Audit Improvement



Initial Meeting – 43% Improvement
(10 percentile point)

Follow-up Meetings – 4200% Improvement
(43% percentile point)

01 797 7354 /01 809 2077

lindamcevoy@beaumont.ie

THANK YOU

Guidance on: Documentation of the Salient Points of Open Disclosure in the Clinical File following a Patient Safety Incident

Noreen Kennedy Quality & Patient Safety Manager
St Johns Hospital
Update May 2023

Why

IMF Audit

compliance

NIKI forms

inconsistency

Reviews/Pas

salient points undocumented

Meetings with families

-OD often had

Discussions with members of the MDT

-salient points undocumented

How:

- Spoke to staff
- Used national guidance
- Looked at what existed
- Reviewed training
- Reviewed induction overview
- Took guidance from what staff wanted

Guidance on Documenting the Salient Points of Open Disclosure in a Clinical File following a Patient Safety Incident

TO BE USED FOR:	
1.	Low Level Open Disclosure meeting where a no harm or minimal harm incident has occurred (i.e. Category 3 Incident low level Open Disclosure)
2.	Category 1 & 2 Incidents for documentation of the initial meeting. The QRPS department must be contacted in advance to assist with process.

The documentation of the Open Disclosure discussion will be done by the person leading the open disclosure.

Stick the **Open Disclosure Sticker** on the page where you document your discussion.

As a guide please record details under the following headings:

- Date and time of the incident
- Date and time of Open disclosure meeting
- To whom was the disclosure made to – (Consider if open disclosure is not being made to the patient that consent been obtained to disclose to the relevant person)
- Who was present at the open disclosure meeting
- The salient points discussed with the patient and/or their relevant person during the open disclosure meeting
  1. Details of the patient safety incident
  2. The impact of the patient safety incident on the patient, if any
  3. The apology provided
  4. Name of staff member to contact should further questions arise
  5. The agreed care/treatment plan and actions in relation to the patient safety incident
- Sign and Date:

It is best practice for the staff present at the meeting to ensure that an accurate record is maintained in the clinical file. Nursing staff present may also record in their nursing notes that the meeting has taken place and it important this information is provided at Nursing Handover including actions taken/ agreed.

The details of the incident and open disclosure of the incident to the patient/relevant person must be documented on a **National Incident Report Form (NIRF 01 Person)** by a member of staff who was either involved in the incident or a member of the treating medical team.

Contact QRPS Department on 110/247 if you have any queries

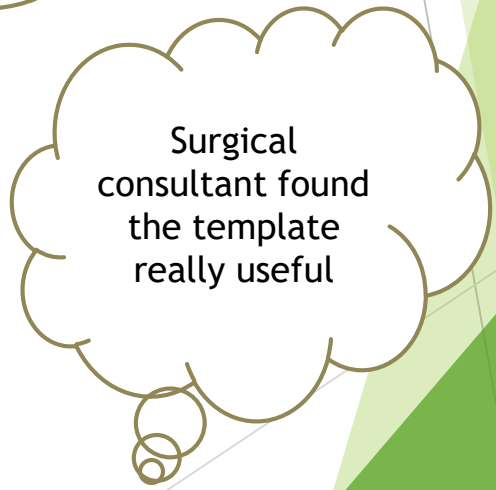
Sticker to alert that Open Disclosure has taken place.

Open Disclosure

Feedback

- Something simple
- Easy to use
- Clear

- Feedback for draft template was very positive
- Implementation



IMF Audit Tool			
Category 1	2021	2022	2023
Open Disclosure carried out in line with HSE Policy	100%	100%	100%
Salient Points of Open Disclosure were recorded in Healthcare Record	60%	100%	100%
Category 2	2021	2022	2023
Open Disclosure carried out in line with HSE Policy	100%	78%	100%
Salient Points of Open Disclosure were recorded in Healthcare Record	40%	60%	67%

Current Practice

- Documentation of Open Disclosure has improved
- Open Disclosure documentation is incorporated into face to face Open Disclosure Training & induction
- Ask staff to document retrospectively if nothing documented in the clinical file
- Re-audit
- Aiming for for 100% compliance

Open Disclosure

Audit & Policy Compliance checklist

Cathy Sexton

Quality & Patient Safety Department

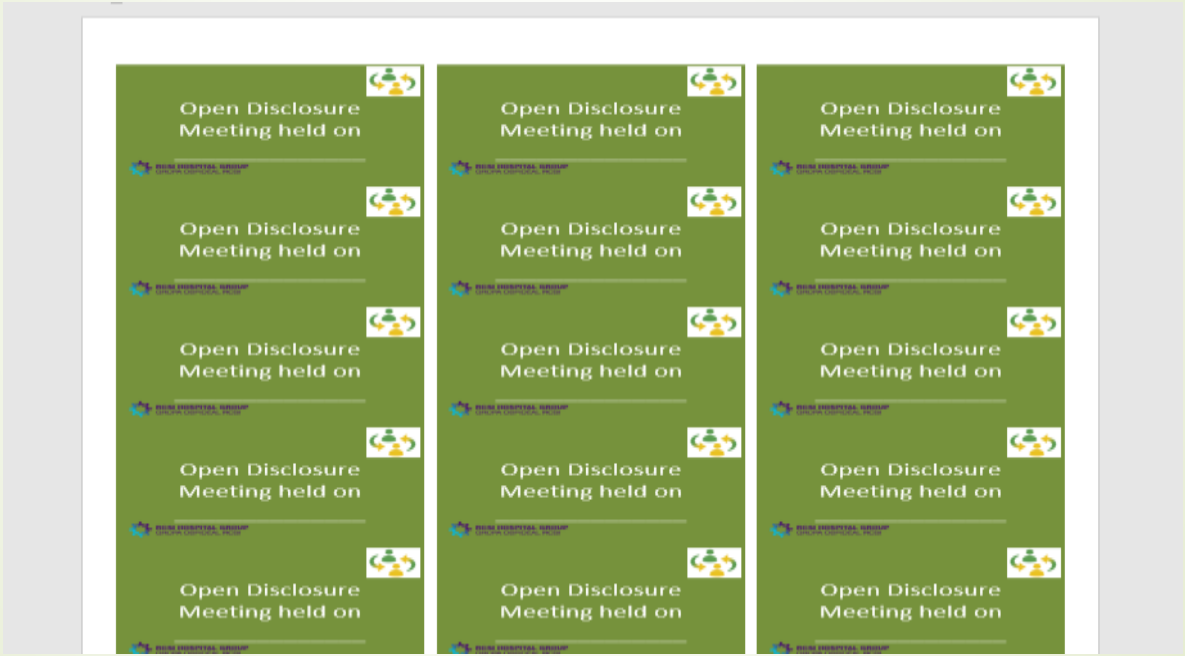
Cavan Monaghan Hospital

Sharing the learning from the Audit on OD

- CMHSIMF –Commissioned OD audit
- Audit was registered and process agreed as follows:

1. Review the no of SRE'S/SI reported in 2022 (12 SRE's &11 SI) using the OD Policy as the standard for the audit
2. Randomly selected 10 HCR+incident reports from this sample
3. Used the open disclosure Policy Compliance checklist to check where we are at present.
4. Audit results

Open Disclosure stickers for HCR




Thank
you

Documenting Open Disclosure –Summary Points

- Document all Open Disclosure discussions well.
- All documentation should be personalised to the individual(s) involved and given situation.
- Utilise the resources available to support good documentation

- **Low level Open Disclosure:**
  - Document salient points in clinical/care record and
  - Complete OD data fields on NIMS/NIRF

- **High Level Open Disclosure:**
  - Document salient points of initial discussion in clinical/care record
  - Document on NIMS
  - Record minutes of formal open disclosure meeting – use documentation template
  - Insert brief entry n clinical care record to indicate that a meeting has taken place and refer to where the notes of the meeting are held
  - Provide minutes/completed documentation template to the patient/relevant person in a timely manner with a supportive covering letter or a letter which contains all of the salient points of the meeting and apology provided.
  - Update OD data fields on NIMS as required.

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