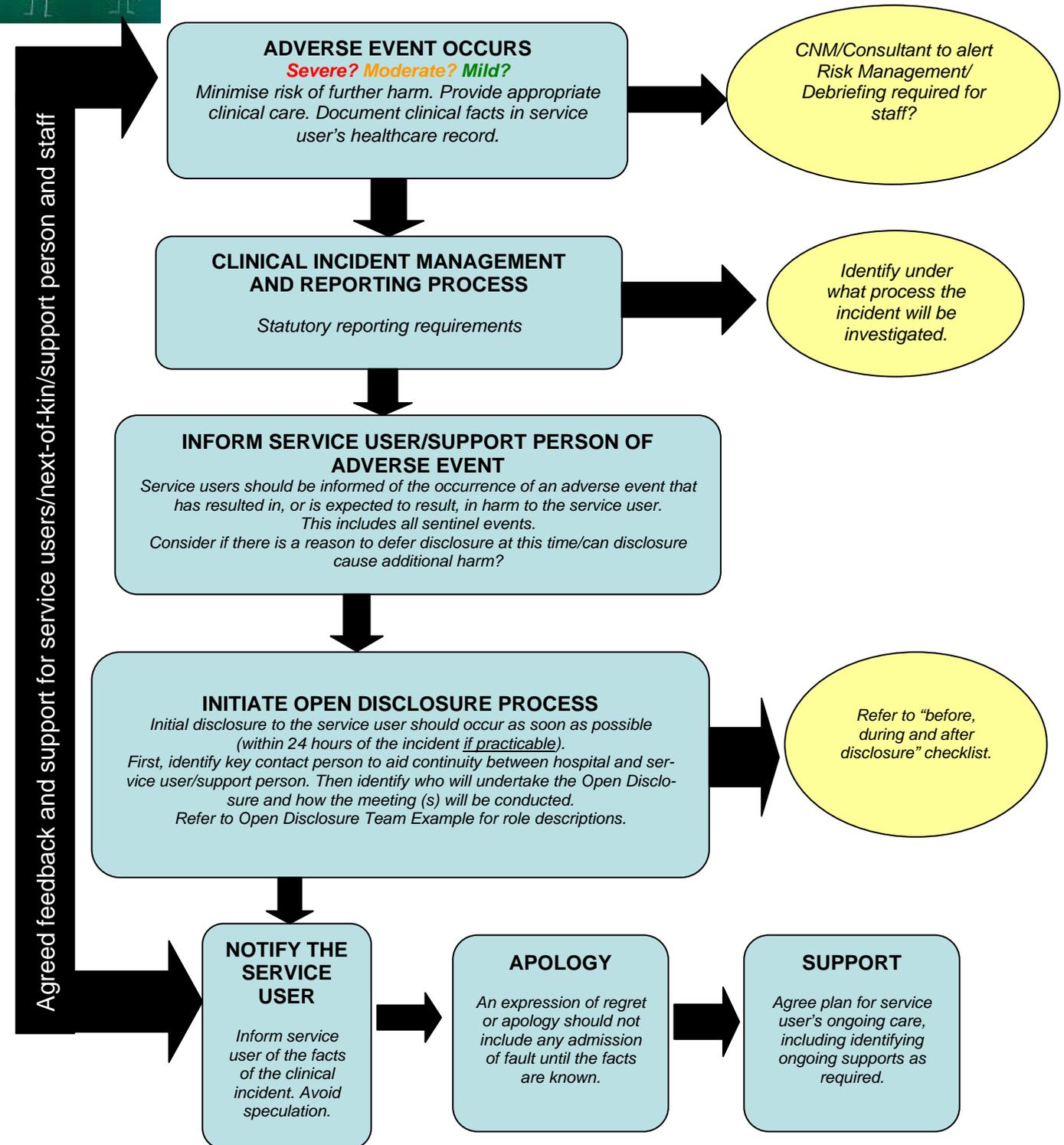




The Open Disclosure Pathway Algorithm

(Adopted from the Australian Open Disclosure Standard, 2008, p.4)



*Near Miss Event - Assessed on a case by case basis depending on the potential impact it could have had on the service user (s) if it had materialised and considering the potential risk of harm in the future. // * CNM- Clinical Nurse Manager

(Adopted from the Australian Open Disclosure Standard, 2008, p. 4)

Communicating with Service Users and their Families following Adverse Events in Healthcare

It is the policy of the HSE that incidents are identified, managed, *disclosed* and reported and that learning is derived from them. Research has demonstrated that if we ignore or avoid communicating with service users when things go wrong they are more likely to pursue other routes such as the complaints process or the legislative route to get answers to their questions. *Open disclosure* is a requirement of the National Standards for Safer Better Healthcare 2012.



What is Open Disclosure ?

Open Disclosure is defined by the Australian Commission on Safety and Quality in Health Care as “an open, consistent approach to communicating with service users when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the service user informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event.”

What are the benefits of Open Disclosure?

| Benefits for Service Users | Benefits for Staff |
|---|---|
| Open disclosure may assist in providing closure for the service user. | Encourages a culture of honesty and openness. |
| It can assist the healing partnership between the service user and the healthcare provider. | Helps to foster an environment where staff are more willing to learn from adverse outcomes. |
| It will help to rebuild trust and confidence that is vital for the service user/healthcare partnership. | Enhances the professional relationship between health and social care services management staff and clinicians. |
| It encourages a culture of honesty and openness. | Enhances how professionals communicate with each other with regard to clinical outcomes. |
| It can lead to enhanced relations with service users and healthcare providers. | Leads to better relations with service users and service user. |
| | Leads to improved staff recovery and closure. |



The 10 Principles which underpin the Open Disclosure Process:

Acknowledgement - to the service user that an adverse event has occurred.

Truthfulness, timeliness and clarity of communication:- factual information provided to the service user ideally within 24-48hours of the adverse event being known.

Apology/ expression of regret:- for the service user’s experience and their condition and for any errors which have been established during the review/investigation process.

Recognising the expectations of service users: The service user may reasonably expect to be fully informed of the facts and consequences in relation to the adverse event and to be treated with empathy and respect.

Staff Support: - providing support to staff involved in the adverse event – the second victims of an adverse event.

Risk management and systems improvement: - to ensure that learning from adverse events occurs and that actions are taken to try to prevent a recurrence of the event.

Multidisciplinary responsibility: - open disclosure involves multidisciplinary accountability and response.

Clinical governance:- the open disclosure process is one of the key elements of the HSE clinical governance system.

Confidentiality: ensuring that all health and social care policies and procedures in relation to privacy and confidentiality for service users and staff should be consulted with and adhered to.

Continuity of care: Steps need to be taken to reassure the service user in relation to the management of their immediate care needs and to also reassure them that their care will not be compromised going forward.