“The key to looking after persons affected when things go wrong is maintaining trust through good communication.”

Maintaining Trust

The establishment of trust begins at the first contact with the service user and continues throughout their care. Trust greatly enhances the ability of all involved to manage the consequences of an incident. The consequences of an incident are two-fold, firstly the primary harm caused by the incident e.g. an injury followed by any secondary harm caused to the service user by things such as poor communication, a lack of empathy or a failure to supply the necessary supports (physical and psychosocial).

The Relationship between Honesty and Litigation

Some health and social care professionals may fear that complete honesty after an incident will increase the chances of litigation or complaint. Evidence, however, demonstrates that adequate, timely and factual disclosure to the service user can make all the difference in relation to them coming to terms with the consequences of an incident. The desire for information and frustration through not receiving it, are commonly cited as reasons for litigation.

So what do Service Users want?

1. To know that all the required actions have been taken to address any harm that might have occurred to them.
2. To have the incident acknowledged to them.
3. To know and understand what has happened to them.
4. To be offered a sincere apology/expression of regret.
5. To have their questions answered honestly and factually.
6. To have their story heard and staff to listen and understand things from their perspective.
7. To be involved in decisions about their care and be aware of the options available to them.
8. To be provided with factual information which they can understand in relation to:
   - the event
   - actions taken by the organisation following the event
   - actions planned to try to prevent a recurrence of the event
   - reviews which are happening in relation to the event and the outcome of same
   - steps taken in relation to any recommendations made by the review team
   - what supports are available to them, if required, and how to access these support services.
8. To have ongoing communication with the healthcare team.
9. To be provided with an agreed plan and reassurance in relation to their ongoing care and follow up.
Initial Disclosure Discussion

- Acknowledge (with empathy) what has happened
- Apologise/express regret
- Provide factual explanation
- Provide reassurance regarding ongoing care plan
- Address any queries
- Offer practical and emotional support
- Agree next steps

Documentation

- Maintain and provide written records of all discussions
- Record salient points of open disclosure meeting in healthcare record

Supporting Service Users - Overview

Incident detection or recognition
- Detection and notification through appropriate systems
- Prompt and appropriate clinical care to prevent further harm

Preliminary team discussion
- Initial assessment
- Establish timeline
- Choose who will lead communication

Initial Disclosure discussion
- Verbal and written apology
- Provide known facts to date
- Offer practical and emotional support
- Identify next steps for keeping informed

Follow – up discussions
- Provide update on known facts at regular intervals
- Respond to queries
- Discuss findings of review and analysis
- Inform on continuity of care
- Share summary with relevant people
- Monitor action plan
- Communicate learning with staff

Process completion
- Record review and analysis relating to incident
- Provide written records of all discussions
- Communicate learning with staff

Adapted from Being open process National Patient Safety Agency (UK)

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