Quality & Safety

A column by Maureen Flynn

NATIONAL OPEN DISCLOSURE POLICY

'OPEN disclosure' (OD) or 'open communication' is an open, consistent approach to communicating with patients when things go wrong in healthcare. It includes expressing regret for what has happened, keeping the patient informed, providing feedback both on investigations and the steps taken to prevent a recurrence of the adverse event.

On November 12, 2013, Health Minister Dr James Reilly launched a national policy and guidelines on OD with three supporting documents, including a staff support booklet, patient information leaflet and staff briefing guide.

Principles of OD

OD is not about blame, but about integrity and professionalism. There are 10 guiding principles involved:

- *Acknowledgement:* Acknowledging to the service user that an adverse event has occurred.
- *Truthfulness, timeliness and clarity of communication:* Providing the service user with the facts about what has happened as soon as possible after the adverse event happens or becomes known, and ensuring they have a clear understanding of what they are being told.
- *Apology, if appropriate:* If it is clear, following a review of the adverse event, that the healthcare provider is responsible for the harm to the service user (eg. wrong site surgery) it is imperative that there is an acknowledgment of responsibility and an apology provided as soon as possible.
- *Recognising patient and carer expectations:* The service user may reasonably expect to be fully informed of the facts and consequences relating to the adverse event and to be treated with empathy and respect.
- *Professional support:* Health and social care services should promote the development of a 'just culture' as staff will then feel more encouraged and willing to report incidents, adverse events and near-miss events. Staff can also expect to be supported by the service following an adverse event and throughout the open disclosure and incident review process.

- *Risk management and systems improvement:* The investigation of adverse events should be undertaken in line with the HSE incident management policy and be inclusive of the review of recommendations to ensure that any recommendations/actions taken are effective and that they will reduce the likelihood of a recurrence of the event.
- *Multidisciplinary responsibility:* OD involves multidisciplinary accountability and response. Clinical, senior professional and managerial staff should be identified to lead in and support the process.
- *Clinical governance:* Health and social care services are required to have appropriate accountability structures in place to ensure that OD occurs. OD should be integrated with other clinical governance systems and processes, including clinical incident reporting and management procedures, systems analysis reviews, complaints management and privacy and confidentiality procedures.
- *Confidentiality:* All health and social care policies, procedures, and guidelines in relation to privacy and confidentiality for service users and staff should be consulted with and adhered to.
- *Continuity of care:* Providing the necessary clinical care, reassurance and support in the future.

Why is open disclosure important?

The window of opportunity for OD is often missed due to defensiveness, damage limitation efforts and fear of damage to reputation at an individual and corporate level. OD is an: ethical response to the service user/family. It helps service users and staff to cope with an adverse event and to get closure on it. OD leads to improved relationships between service users and care services and increases public confidence in our services. It also improves patient safety and can reduce litigation.

OD is now national policy and a requirement in meeting: the National Standards for Safer Better Healthcare (2012) which state that 'service providers fully and openly inform and support service users as soon as possible after an adverse event affecting them has occurred, or becomes known and continue to provide information and support as needed'; the National Healthcare Charter, 'You and Your Health Service'; and the HSE incident management policy.

Supporting open disclosure

The OD resources (see **www.hse.ie/opendisclosure**) can be used by multidisciplinary teams to: support disclosure communication; respond to patients' perceptions and experience of adverse events; offer an apology; support patients and staff in the long- and short-term; and use patients' insights to improve health services.

Feedback on the resources is welcomed.

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For more information, visit: www.hse.ie/opendisclosure or email: angela.tysall@hse.ie or aduffy@ntma.ie