

# Open Disclosure

## A Brief Guide for Health and Social Care Staff

Communicating with service users and their families following adverse events in healthcare



Feidhmeannacht na Seirbhíse Sláinte  
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Tús Áite do  
Shábháilteacht **1** Othar  
Patient Safety **1** First

Gníomhaireacht Éileamh an Stáit  
State Claims Agency

## 1. Introduction

The Health Service Executive (HSE) is dedicated and committed to providing safe and high quality health care to service users. However, as professionals working in health and social care services we are not infallible. Our desired outcome for service users and their families is not always the final outcome. There are many variables in our work and sometimes, despite our best plans and efforts, things can go wrong. In some instances our actions may have impacted on the end result but not always. 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. The merits of open disclosure are endorsed by health service providers, indemnifying and professional bodies in the Republic of Ireland and throughout the world and the benefits are significant for all those who provide and use our services.

## 2. 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 patients when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event.”

Open disclosure is sometimes referred to as Open Communication.

## 3. What are the Principles which underpin the Open Disclosure Process ?

There are ten principles designed to assist healthcare organisations to create and embed a culture of open disclosure. These have been adopted from the UK National Service user Safety Agency.<sup>1</sup> The disclosure process should encompass these principles.

1. **Acknowledgement:** Health and social care services should acknowledge to the service user that an adverse event has occurred and initiate the open disclosure process, in line with national policy.
2. **Truthfulness, timeliness and clarity of communication:** The service user should be provided with information in a timely manner - focusing on the factual information available at the time. Ideally the open disclosure process should commence within 48 hours of the event occurring

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<sup>1</sup> National Service user Safety Agency, National Reporting and Learning Service: saying sorry when things go wrong Being Open-communicating service user safety incidents with service users, their families and carers. 2009, p.14.

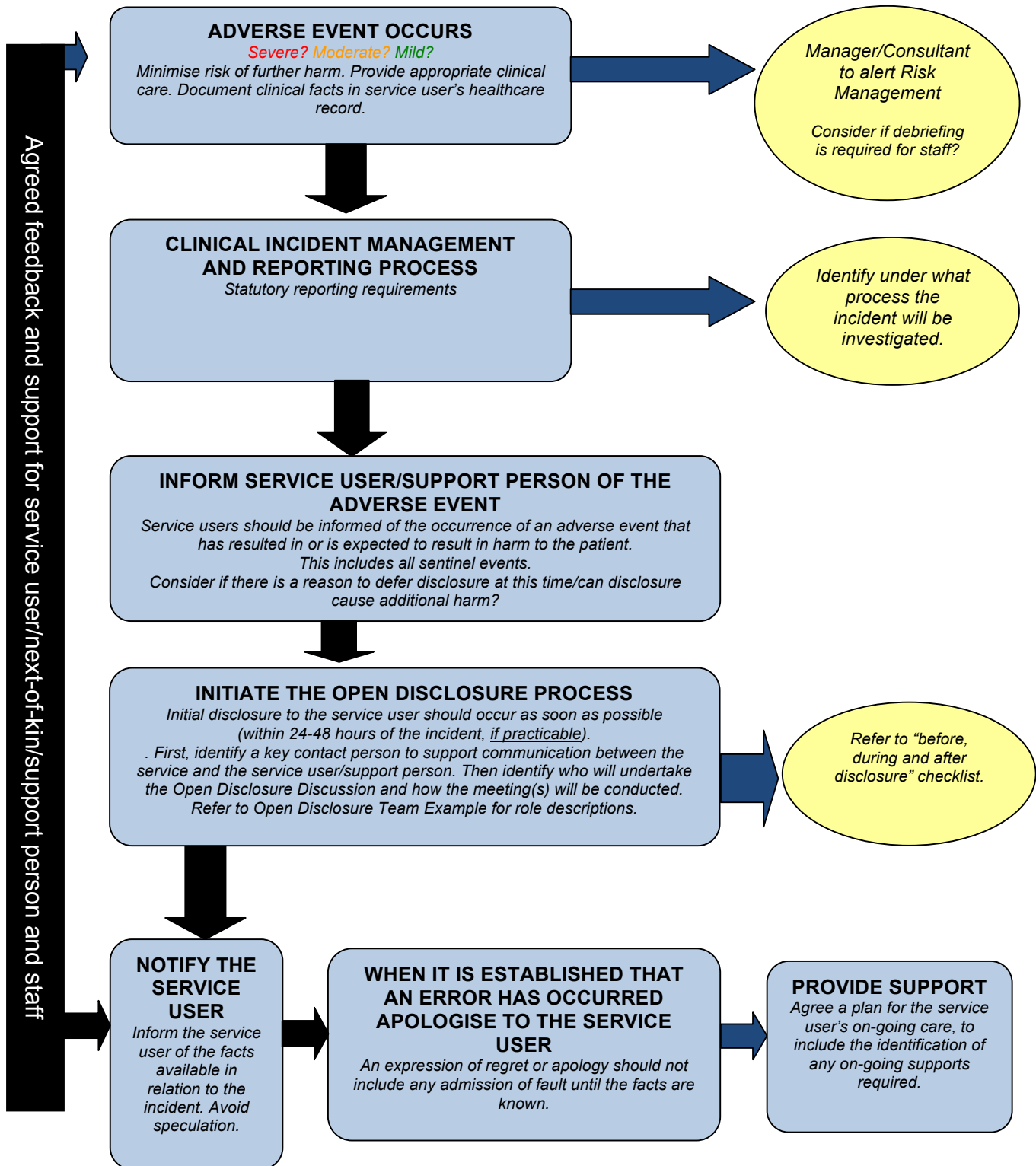
or the event becoming known and as soon as the service user is physically and emotionally available to receive the information.

3. Apology/ expression of regret: An apology/expression of regret, regarding the condition of the service user and for what has happened as a result of an adverse event, is important and should be forthcoming. When it is clear, following a review of the adverse event, that the healthcare provider is responsible for the harm to the service user (e.g. wrong site surgery) it is imperative that there is an acknowledgment of responsibility and an apology provided as soon as possible.
4. 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.
5. 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/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.
6. 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.
7. Multidisciplinary responsibility: Open disclosure involves multidisciplinary accountability and response. Clinical, senior professional and managerial staff should be identified to lead in and support the process.
8. Clinical governance: The open disclosure process is one of the key elements of the HSE clinical governance system. Health and social care services are required to have appropriate accountability structures in place which ensure that open disclosure occurs and that it is 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.

9. Confidentiality: The information collated following an adverse event is often of a sensitive nature and therefore service user confidentiality is paramount. Service user information is generally held under legal and ethical obligations of 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.
  
10. 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. Transfer of care to another facility may be requested by the service user and should be facilitated when it is possible to do so. A member of staff should be identified who will act as a contact person for the service user to keep them informed of the situation and to maintain open channels of communication between the service user and the health and social care service.

#### 4. The Open Disclosure Process:



## 5: Examples of Words/Language which can be used during the initial discussion with the Service User

These are examples of phrases that may assist in the disclosure process. Using the MPS A.S.S.I.S.T model of communication we have developed sample phrases to assist you in each part of the open disclosure discussion.

Stage of Process	Sample Phrases
Acknowledgement	<p>“We are here to discuss the harm that you have experienced/the complications with your surgery/treatment”</p> <p>“I realise that this has caused you great pain/distress/anxiety/worry”</p> <p>“I can only imagine how upset you must be”</p> <p>“ I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you”</p> <p>“I understand that you are angry/disappointed about what has happened”</p> <p>“I think I would feel the same way too”</p>
Sorry	<p>“ I am so sorry this has happened to you”</p> <p>“ I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation”</p> <p>“ I truly regret that you have suffered xxx which is a recognised complication associated with the x procedure/treatment”. “I am so sorry about the anxiety this has caused you”</p> <p>“ A review of your case has indicated that an error occurred – we are truly sorry about this”</p>
Story	<p><b><u>Their Story</u></b></p> <p>“Tell me about your understanding of your condition”</p> <p>“Can you tell me what has been happening to you”</p> <p>“What is your understanding of what has been happening to you”</p> <p><b><u>Your understanding of their Story: (Summarising)</u></b></p> <p>“I understand from what you said that” xxx “and you are very upset and angry about this”</p> <p><b>Is this correct?(i.e. summarise their story and acknowledge any emotions/concerns demonstrated.</b></p> <p>“Am I right in saying that you .....</p>

	<p><b><u>Your Story</u></b></p> <p>“Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned?”</p> <p>“Do you mind if I tell you what we have been able to establish at this stage?”</p> <p>“We have been able/unable to determine at this stage that .....”</p> <p>“We are not sure at this stage about exactly what happened but we have established that ..... We will remain in contact with you as information unfolds”</p> <p>“You may at a later stage experience xx if this happens you should .....”</p>
Inquire	<p>“Do you have any questions about what we just discussed?”</p> <p>“How do you feel about this?”</p> <p>“Is there anything we talked about that is not clear to you?”</p>
Solutions	<p>“What do you think should happen now?”</p> <p>“Do you mind if I tell you what I think we should do “</p> <p>“I have reviewed your case and this is what I think we need to do next”</p> <p>what do you think about that?</p> <p>“These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?”</p> <p>“I have discussed your condition with my colleague Dr x we both think that you would benefit from xx. What do you think about that?”</p>
Travel	<p>“Our service takes this very seriously and we have already started an investigation into the incident to see if we can find out what caused it to happen”</p> <p>“We will be taking steps to learn from this event so that we can try to prevent it happening again in the future”</p> <p>“I will be with you every step of the way as we get through this and this is what I think we need to do now”</p> <p>“We will keep you up to date in relation to our progress with the investigation and you will receive a report in relation to the findings and recommendations of the investigation team”.</p> <p>“Would you like us to contact you to set up another meeting to discuss our progress with the investigation?”</p> <p>“I will be seeing you regularly and will see you next in ..... days/weeks.</p> <p>“You will see me at each appointment”</p> <p>“Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by .....”</p> <p>“If you think of any questions write them down and bring them with you to your next appointment”.</p> <p>“Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services”</p>

## 6. Why is Open Disclosure Important?

- ❖ The principles of Open Disclosure form the basis of an ethical response by the organisation to the service user/family in relation to the adverse event.
- ❖ In the immediate aftermath of an event, the window of opportunity which Dr Albert Wu calls the 'Golden Moment' is often lost because of defensiveness, efforts at damage limitation and fear of reputational damage both at individual and corporate level.
- ❖ Open disclosure benefits service users and staff in relation to coping with an adverse event and in reaching a stage of closure following their experience of the event.
- ❖ Research has demonstrated that 98% of service users expect to be told if they have been involved in an adverse event.
- ❖ For service users the open disclosure process (a) can assist the healing partnership between the service user and the healthcare provider, (b) will help to rebuild the trust and confidence that is vital for the service user in relation to the service they are attending (c) can reassure the service user in relation to their ongoing care and their ability to continue an effective relationship with the health care provider (d) encourages a culture of honesty and openness and (e) can lead to enhanced relations with service users and healthcare providers.
- ❖ For healthcare staff the open disclosure process (a) encourages a culture of honesty and openness, (b) helps to foster an environment where staff are more willing to learn from adverse events, (c) enhances management and clinician relationships, (d) leads to better relations with service users and their families and (e) assists staff recovery from the event.
- ❖ Research has demonstrated that very often service users pursue legal action or the complaints process because of a failure of the health/social care service to (a) communicate with them effectively following the adverse event, (b) acknowledge that something happened (c) provide an apology where an apology is due and (d) demonstrate the steps being taken to prevent a recurrence of the event.
- ❖ Research has demonstrated that an effective open disclosure process can lead to a reduction in the ratio of litigated cases.

## 7: Is open disclosure a mandatory requirement?

(a) Open Disclosure is now a requirement as per standard 3.5 of the National Standards for Safer Better Healthcare 2012 which states 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.”*

(b) The HSE National Healthcare Charter 2012 states that *“Service users can expect open and appropriate communication throughout their care, especially when plans change or if something goes wrong.”*



(c) Open Disclosure is now national policy and is also a requirement as per the provisions of the HSE Incident Management Policy.

(d) The Medical Council of Ireland in their "Guide to Professional Conduct and Ethics for Registered General Practitioners" state that:

*"Service users and their families are entitled to honest, open and prompt communication with them about adverse events that may have caused them harm."*

### **7. What resources are available to health and social care organisations to support the successful implementation of the open disclosure process?**

Open disclosure requires a cultural shift and can only be successfully implemented using a change management approach and with significant leadership by senior management staff, including senior clinicians, within the organisation.

The HSE and State Claims Agency have developed a National Guideline document "Communicating with Service Users and their Families following Adverse Events in Healthcare August 2013" to inform and support health and social care services in relation to the effective implementation of an open disclosure policy. This document provides detailed information and guidance in relation to preparing your organisation for open disclosure, supporting service users and staff, managing the process including sample language to be used and managing specific circumstances e.g. open disclosure and service users with mental health problems/disabilities. The document also contains a section on frequently asked questions and provides sample checklists e.g. Organisational Readiness Checklist and Pre, During and Post Disclosure checklist.

The National Leads in Open Disclosure have developed a proposal document for health and social care services to support the successful implementation of Open Disclosure using a change management approach.

There is also a service user information leaflet available.

For further information on Open Disclosure please contact:

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Information is also available on the HSE website as follows:

[www.hse.ie](http://www.hse.ie)