Patient Safety Together:
learning, sharing and improving

PATIENT SAFETY SUPPLEMENT

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Open Disclosure conversations with vulnerable persons

This Patient Safety Supplement focuses and shares learning on open disclosure conversations following a patient safety incident involving a vulnerable person.

The purpose of this Patient Safety Supplement is to demonstrate that a person who is vulnerable, for whatever reason, is entitled to open disclosure on an equal basis with others. Learning can be shared with colleagues and other services to promote the rights and safety of the person involved.

Ann's Story

Ann is an 18-year old person who has an autism spectrum disorder and complex communication needs and attends a day service with four other people. Ann was pushed by another service user and fell which resulted in a cut to her leg and elbow.

After ensuring that Ann's injuries had been attended to the Clinical Nurse Manager (CNM) set up an open disclosure meeting with Ann and her support worker, who she has a good relationship with. The CNM acknowledged Ann's fall to her, said sorry that it happened and for the obvious upset that it had caused.

The open disclosure meeting took place in an environment where Ann felt most relaxed. A total communication approach was used to optimise Ann's understanding of what was being said in the meeting. The team refreshed their Lámh sign language, including the word for "sorry" and used pictures to guide Ann through the meeting. The team also used an easy read agenda to help with the meeting. The team encouraged Ann and her support worker to bring an item of comfort for Ann. It was also pre-arranged that Ann would do something after the meeting that she really liked and in this case Ann went to the park with her support worker. This ensured that Ann had a clear indication that the meeting was finished. With Ann's consent her father was also informed about what happened and an apology was provided to him.

Following on from the incident and open disclosure meeting a review of the service was completed and a safeguarding investigation was completed.

Expert Comment and Recommendations

Open Disclosure must occur following all patient safety incidents, in particular when there was harm, in compliance with the HSE Open Disclosure Policy (2019). As outlined in Ann's story, staff must work on the presumption that every adult has the capacity to make decisions about their care. ***A person whose decision-making capacity is in question is entitled to open disclosure on an equal basis with others and should be provided with all the necessary supports to facilitate their involvement in the process.*** Open disclosure to the relevant person must be undertaken with the consent of the person involved.

Ms. Angela Tysall

National Lead for Open Disclosure

NATIONAL OPEN DISCLOSURE PROGRAMME

A rights based, supportive approach to open disclosure is required ensuring that those involved are involved in the process from the outset and that the focus is on;

- the specific circumstances relating to the patient safety incident
- the person involved
- the specific needs of that person

The support of an independent advocate must also be considered and facilitated as appropriate.

Documentation of Open Disclosure

Details of the open disclosure discussion held, including an account of the apology provided, must be recorded in the healthcare record. A record of the formal open disclosure meeting must also be provided to the person and / or their relevant person, as appropriate. If the conversation is not documented, then there is no evidence that it has taken place.

The open disclosure fields on the National Incident Management System (NIMS) must also be completed as part of the incident record. The required recording of open disclosure conversations on NIMS continues to improve since the launch of the updated HSE Open Disclosure Policy in 2019.

The National Advocacy Service

The National Advocacy Service (NAS) provides an independent, confidential and free issue based advocacy service that puts the person at the center and adheres to the highest professional standards. NAS recognises that people have a right to be told when something goes wrong with their care or treatment in line with the National HSE Open Disclosure Policy (2019). NAS has a particular remit to work with people with disabilities who are in vulnerable situations, such as people who are isolated from their community of choice or mainstream society, may communicate differently and who have limited formal or natural supports.

For further information on the supports available from NAS please see their website https://advocacy.ie/ , email info@advocacy.ie or Tel 0818 07 3000.

Patient Safety Strategies and Resources supporting Open Disclosure

- HSE Patient Safety Strategy (2019-2024) available here
- HSE Open Disclosure Policy (2019) available here
- St Michael's House Easy Read Open Disclosure Policy available here
- HSE Incident Management Framework (2020) available here
- Open Disclosure National Training Programme -—link to access training here
- HSE Staff Support Programme and link to webpage here
- Assisted Decision Making (Capacity) Act (2015) information available here
- National Advocacy Services—information available here

Future Focus

- The Patient Safety (Notifiable Patient Safety Incidents) Bill 2019 will provide legislative provisions for mandatory open disclosure within the HSE and its funded services. The enactment of this Bill is expected in 2023.
- The National Open Disclosure Policy Framework, which is expected to be published in 2023, will inform the direction of national policy on open disclosure across all public and private health and social care services.

Developed by

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