An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

National Open Disclosure Programme

Annual Report 2023

About National Quality and Patient Safety Directorate

The National Quality and Patient Safety Directorate (NQPSD) was established in mid-2021 as a result of the HSE Central Reform Review. The NQPSD is part of the HSE Office of the Chief Clinical Officer, and is led by Dr Orla Healy, National Clinical Director, Quality and Patient Safety.

Purpose

Our vision for patient safety is that all patients using health and social care services will consistently receive the safest care possible by:

- Building quality and patient safety capacity and capability in practice
- Using data to inform improvements
- Developing and monitoring the incident management framework and Open Disclosure policy and guidance
- Providing a platform for sharing and learning; reducing common causes of harm and enabling safe systems of care and sustainable improvements.

Teams

In line with the "Patient Safety Strategy 2019-2024", the NQPSD delivers on its purpose through the following teams:

- **Office of the National Clinical Director:** Working in partnership with HSE operations, patient partners and other internal and external partners to improve patient safety and the quality of care.
- **QPS Improvement:** Using of improvement methodologies to address common causes of harm.
- **QPS Intelligence:** Using data to inform improvements in quality and patient safety.
- **QPS Incident Management:** Working with people to identify, understand and share safety learning, advocate for Open Disclosure and develop the national incident management system in the HSE.
- **QPS Education:** Enabling QPS capacity and capability in practice.
- **QPS Connect:** Communicating, sharing learning, making connections.
- **National Centre for Clinical Audit:** Supporting Clinical Audit service providers locally and nationally.

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Section 1: Mission, Vision and Values of the National Open Disclosure Office and Programme

Figure 1: Mission, Vision and Values of the National Open Disclosure Office and Programme

1.1: Maintaining the Ethos of Open Disclosure during 2023

The HSE Open Disclosure policy and programme applies to patient safety incidents and reflects the importance of the rights of patients to be fully informed about their healthcare as and when they so wish and to be informed about patient safety incidents that occur during that care process in a timely manner, however and whenever they may arise.

The ethos of this policy is to ensure that the rights of all patients and staff involved in and/or affected by patient safety incidents are fully respected and supported, that they are communicated with in an open, honest, timely and compassionate manner and that they are treated with dignity and respect.

Open disclosure is a core professional requirement which is anchored in professional ethics. Communicating effectively with persons affected in a compassionate, empathic and thoughtful manner, especially when providing information about a patient safety incident, is a crucial part of the therapeutic relationship and if done well can mitigate anxiety and enhance trust in the staff, the organisation and the health and social care system.

Training and education programmes on open disclosure are clear in their message that, first and foremost, organisations and staff must engage in timely, empathic and meaningful open disclosure because:

(i) it is the right thing to do;

(ii) patients have a right and reasonably expect to be fully informed about incidents that occur during the delivery of health and social care to them;

(iii) it is what we would expect for ourselves or a loved one;

> *"The golden rule in medicine means treating patients and families the way we would want to be treated or would want our loved ones to be treated in similar circumstances. The Golden Rule is based on the idea of reciprocity and being able to see ourselves in others. If I were that patient, how would I want to be treated? What if this was my spouse, my child, my parent or sibling, how would I want them to be treated?*
>
> *In most instances adherence to The Golden Rule leads to health care decisions and clinical attitudes that are compassionate and embrace the essence of person-centered care"* (Chochinov 2022)

(iv) it is important that we learn from the past experiences of patients and families who did not experience open disclosure or who experienced open disclosure that was managed poorly and the second harm or compounded harm experienced as a result.

There is a strong focus in training and education programmes on the communication skills required to manage open disclosure effectively and opportunities are provided for staff to practice these skills.

Open disclosure resources for staff and organisations support a standardised approach to the management of the open disclosure process, the support of all those impacted by patient safety incidents and good documentation practices.

The messaging during **Open Disclosure Themed Week 2nd to 8th October 2023** focused on the WHO World Patient Safety Day theme of *"Engaging patients for patient safety – Elevating the Voice of Patients"* with message boards, training events and social media posts demonstrating that open disclosure is "*the right thing to do".*

Section 2: Summary of the Key Developments in the HSE Open Disclosure Programme during 2023

The following is a summary of the key developments in the HSE National Open Disclosure Programme during 2023. Further and more detailed information on all of these developments will be provided throughout the report as indicated in the table below.

Development	Summary Update	Further information
2.1: Roll out and further development of the National Open Disclosure Training Programme	The roll out of the National Open Disclosure Training Programme continued and was developed further throughout 2023. The training target of 30% uptake of E-Learning Module 1:" Communicating effectively through Open Disclosure" was exceeded for the year (a 38% compliance rate was recorded for 2023 for this module across HSE service and Section 38 agencies). There was a **39%** increase in the uptake of all open disclosure training during 2023 (this includes both E-Learning modules and face to face training) with a **188%** increase in the uptake of face to face skills training. Work was commenced on the following: • the development of a training programme on the role of the Designated Person; • the collection of open disclosure training data from the Forum of Postgraduate Training Bodies and the National Doctors Training Programme; • the inclusion of a 2 hour open disclosure workshop as part of the medical training programme at UCD for fourth and fifth year medical students and in their 4th year and 5th year examinations; • the NQPSD Upskilling Project.	See Section 4
2.2: Continuation of the Open Disclosure Programme Webinar Series.	The National Open Disclosure Office facilitated 8 webinars in 2023 on a number of open disclosure and incident management related topics. **4263** collective attendances were recorded for these webinars from across HSE and HSE funded services, patient representative groups, patient advocacy groups and a	See Section 4

Development	Summary Update	Further information
	number of external agencies including State Claims Agency, Department of Health and Royal Colleges.	
2.3: The enactment of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.	The Patient Safety (Notifiable Incidents and Open Disclosure) Act was signed into law by President Michal D Higgins on 2nd May, 2023. The provisions of this legislation include the revision of Part 4 of the Civil Liability Amendment Act 2017 to align it with the Patient Safety Act 2023. The date for commencement of the Act has not yet been confirmed by the Department of Health. The HSE has commenced the preparatory work for the implementation of this legislation across HSE and HSE funded health and social care services.	See Section 6
2.4: The publication and launch of the National Open Disclosure Framework by the Department of Health (DoH).	The National Open Disclosure Framework was finalised during 2023 and launched by the National Patient Safety Office in the DoH on 19th October at the NPSO Patient Safety Conference.	See Section 7
2.5: Continued work on the development of a Performance Measurement Programme for open disclosure.	Significant work was undertaken by the 4 work streams established to develop a performance measurement programme for open disclosure including work on the development of the following: • key performance indicators for the Patient Safety Act 2023, • audit and assurance tools, • a tool/mechanism to measure patient experience of open disclosure and • training data sets to demonstrate compliance with mandatory training requirements.	See section 5
2.6: Open Disclosure Themed Week across HSE and HSE funded health and social care services.	The National Open Disclosure Office, in collaboration with area and site Open Disclosure Leads, Open Disclosure Trainers and Service Managers across HSE and HSE funded services, facilitated an open disclosure themed week from 2nd to 8th October, 2023 to promote and raise awareness of the importance of open disclosure to patients and their families and to promote patient safety and quality improvement generally. The theme for the week was aligned to the WHO theme for	See Section 8

Development	Summary Update	Further information
	World Patient Safety Day "**Engaging patients for patient safety – Elevating the Voice of Patients".**	
2.7: Consultation with services on the management of open disclosure in complex situations.	The staff in the National Open Disclosure Office continued to provide consultation for services on the management of open disclosure in complex situations – this included on-site visits, virtual meetings, telephone and email support.	See Section 11
2.8: Revision of the HSE Open Disclosure Policy	Following the 2021 consultation process the HSE Open Disclosure Policy was revised. A decision was made by the National Open Disclosure Steering Committee to put the publication of the policy on hold as it required further alignment with the National Open Disclosure Framework published in October 2023 and the Patient Safety Act 2023. Work is underway to make the necessary revisions on the policy.	See Section 3
2.9 Publications:	The National Open Disclosure Office published a number of documents throughout 2023 including the 2022 annual report and executive summary report, quarterly newsletters, the 2022 National Open Disclosure Training Report and quarterly training reports. In addition articles were submitted to HSE Health Matters, the NQPSD Quality and Safety Matters Newsletters, the Irish Hospital Consultants Association Annual Report and the Irish Institute of Radiography and Radiation Therapy Radaiocht newsletter.	See Section 12 Annual reports and newsletters are published on the HSE website and are available here.
2.10: Continued work, collaboration and partnership with internal and external Stakeholders	The programme of work on open disclosure involved continuous engagement with a number of internal and external stakeholders throughout the year.	See Sections 10 and 11

NATIONAL OPEN DISCLOSURE PROGRAMME 2023

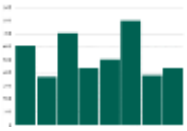
✓ **38%** annual compliance
E-Learning Module 1 for HSE and HSE Funded Services (Sec 38's only)
(Target 30% annually / 90% over 3 years)

Developing the **Role of the Designated Person** through training, webinars, sharing the learning

Training uptake by Medical and Dental Staff increased by 39% in 2023

↑39%

8 WEBINARS attracting 4,263 ATTENDANCES



Publication and launch of the **National Open Disclosure Framework** by the DOH on 19th October 2023

188% increase in uptake of Face to Face Skills Workshop, facilitated by Open Disclosure Trainers across services

OPEN DISCLOSURE THEMED WEEK
02–08 October

Elevating the Voice of Patients

STAKEHOLDER ENGAGEMENT

- Continued work, collaboration and partnership with internal and external Stakeholders, including **Patient Representatives** and **Advocacy Groups**
- Consultation with services on the management of open disclosure in complex situations.

Ongoing promotion and awareness of the importance of Staff Support following patient safety incidents

PERFORMANCE MEASUREMENT

Continued work on the development of a Performance Measurement programme for Open disclosure.

LEGISLATION

- ✓ The enactment of the **Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023** on 2nd May
- ✓ HSE Preparatory Work on the Act, including the establishment of the PSA Implementation Working Group and relevant work streams.

Section 3: Governance of the National Open Disclosure Programme

HSE Patient Safety Strategy 2019-2024 Commitment 6: Leadership and Governance to Improve Patient Safety:
"We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance".

3.1: Clinical and Corporate Governance

In order to support the development and implementation of an open disclosure framework for health and social care services in Ireland, the Independent Patient Safety Council (IPSC) developed robust recommendations and comprehensive principles to underpin this work with the aim of improving the health and social care culture where open disclosure is integral to everyday practice. Open disclosure Principle 6 in the National Open Disclosure Framework 2023 relates to the requirement for services to have clinical and corporate governance structures in place.

Principle 6: Clinical and Corporate Governance for Open Disclosure

- Providers must have governance frameworks with appropriate accountability structures in place which ensure that open disclosure occurs and is integrated with other clinical and corporate governance processes including clinical incident reporting and management procedures, systems analysis reviews, complaints management, and privacy and confidentiality procedures. The governance framework for open disclosure encompasses provider's policies, clinical governance frameworks, corporate governance frameworks, monitoring, regulation, and legislation.

Table 1: National Open Disclosure Framework; Open Disclosure Principle 6

3.2: The DoH National Open Disclosure Framework October 2023

The National Open Disclosure Framework was launched on 19th October, 2023, at the National Patient Safety Office (NPSO) conference. This is an initiative of the Department of Health (DoH) which aims to promote a clear and consistent approach by health and social care service providers, and other organisations where appropriate, to open communication with patients/service users and any relevant support person following a patient safety incident or an adverse event.

The Framework is designed to provide overarching principles and a national, consistent approach to open disclosure in health and social care in Ireland. It is designed to be used in the development, or upgrading, of an organisation's internal policies, processes, and practices regarding patient safety incidents and adverse events, and to facilitate open communication.

3.3: The HSE National Open Disclosure Policy

The HSE Open Disclosure Policy was first written in 2013. It had a significant revision in 2019 and was again revised in 2022 following extensive national consultation. A decision was made by the National Open Disclosure Steering Committee on 25th May, 2022 that the launch of the policy would be put on hold in light of the pending Patient Safety Bill and National Open Disclosure Framework. It was agreed that it was important to work closely with the Department of Health to ensure a coordinated approach and that the launch of the policy should be in line with the timeframe of the publication of the framework and enactment of the legislation. Work commenced in October, 2023 on the review of this policy following the publication of the National Open Disclosure Framework on 19th October, 2023.

The implementation of the HSE Open Disclosure Policy is critical in relation to the delivery of safe, quality services to patients and service users.

Governance arrangements must support:

(i) the implementation of the open disclosure policy to ensure the effective management of open disclosure following all patient safety incidents,
(ii) the monitoring and reporting of policy compliance and performance,
(iii) the identification and prompt management of underperformance,
(iv) the development and implementation of improvement plans to address underperformance and
(v) the escalation of underperformance, as necessary.

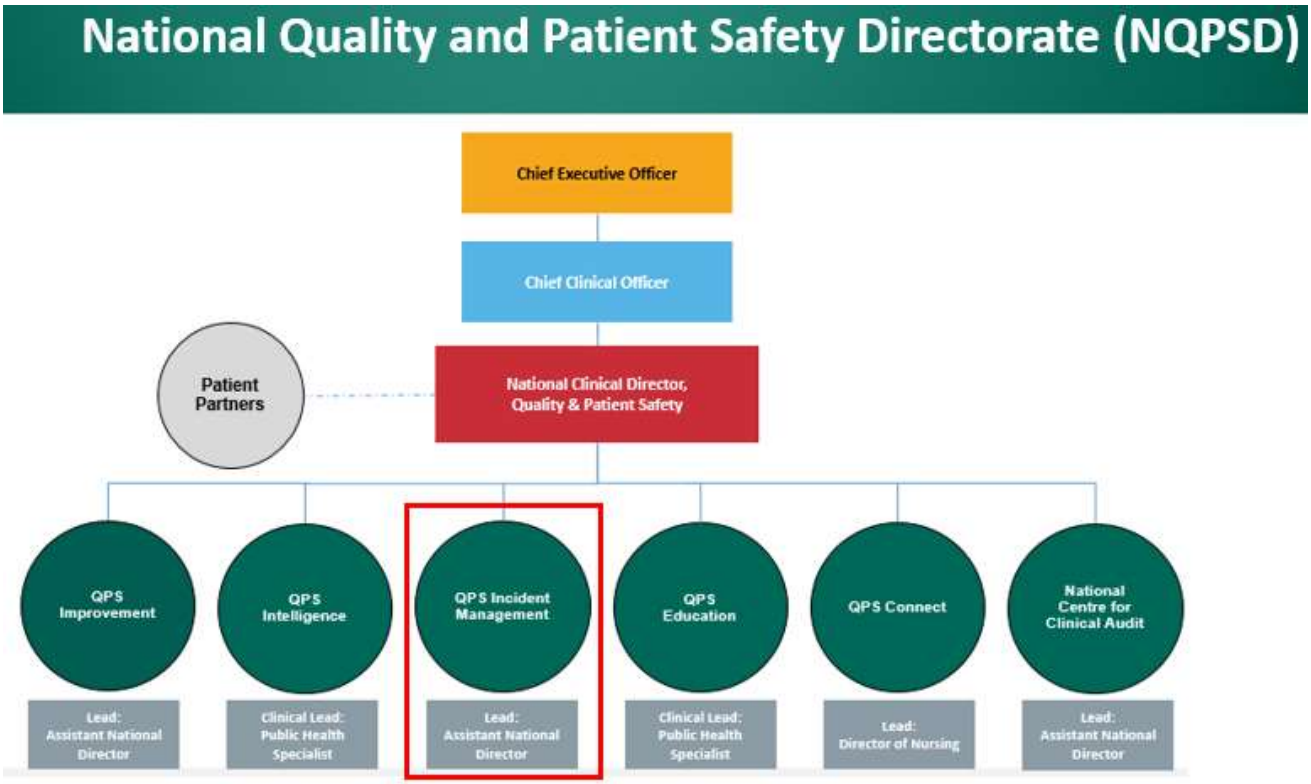
To underpin the effectiveness of these arrangements, explicit management commitment to the development of capacity and capability and the consistent use of NIMS for the management of data and information relating to open disclosure is required.

This annual report outlines some of the essential elements relevant to the implementation of the policy such as governance, training, performance measurement and stakeholder engagement, etc.

3.4: Governance arrangements for Open Disclosure in the HSE:

3.4.1: Organogram:

The National Open Disclosure Office and Programme sits within the Quality and Patient Safety Incident Management function of the National Quality and Patient Safety Directorate under the direction of the National Clinical Director for Quality and Patient Safety, Dr Orla Healy.



The Quality and Patient Safety Incident Management (QPSIM) team brings together three key teams and functions critical to incident management, namely the National Open Disclosure Office and team, the Incident Management team and the HSE National Incident Management System team. The National Open Disclosure Policy and Programme is co-ordinated via QPSIM and the National Open Disclosure Office and reflects the strategic and policy direction established by the HSE leadership team and is consistent with the policies and strategy of the HSE and Department of Health.

The National Open Disclosure Office provides strategic guidance and support on the implementation of:

(i) The HSE Open Disclosure Policy;

(ii) Part 4 of the Civil Liability (Amendment) Act 2017;

(iii) The Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018;

(iv) The provisions relating to mandatory open disclosure within the Patient Safety (Open Disclosure and Notifiable Incidents) Act 2023;

(v) The recommendations related to open disclosure in the Report by Dr Gabriel Scally into matters arising in CervicalCheck 2018;

(vi) The National Open Disclosure Training Programme;

(vii) The National Open Disclosure Performance Measurement and Quality Assurance programme.

The work of the National Open Disclosure Office feeds into and is key to the operational plan for QPS Incident Management in the National Quality and Patient Safety Directorate. The team apply a collaborative approach across the three functions and wider Directorate. These plans further align with the strategic objectives of the office of the Chief Clinical Officer and the HSE National Service Plan for 2023.

3.4.2: Accountability arrangements:

The HSE Performance and Accountability Framework 2020 sets out the accountability structure for the HSE and clarifies the named individuals who have delegated responsibility and accountability for all aspects of service delivery across the four domains of the National Scorecard i.e. access to and integration of services, the quality and safety of those services, achieving this within specific financial, governance and compliance requirements and by effectively harnessing the efforts of our workforce. For the purpose of the HSE's Delegation and Performance and Accountability Frameworks, Hospital Group CEOs, CHO Chief Officers, Director of NAS, the Head of PCRS and Heads of other national services are considered the accountable officers for their areas of responsibility. They are therefore fully responsible and accountable for the services they lead and deliver. Accountable officers are required to have formal performance management arrangements in place with the individual services they are responsible for, to ensure delivery against performance expectations and targets.

The primary responsibility and accountability for the effective management of patient safety incidents, including the open disclosure process, remains at organisational level where the patient safety incident occurs. Effective governance arrangements are required to support timely and effective open disclosure. Central to this is an explicit management commitment to safety that promotes a culture of openness, trust and learning between persons who may be affected by patient safety incidents and those delivering and managing the services within which the patient safety incident occurs.

Clarity in relation to the roles and responsibilities of staff at all organisational levels is a fundamental governance requirement for effective incident management. Open disclosure is an integral component of the incident management process. It is the role and responsibility of the Senior Accountable Officer (SAO) to have overall accountability within their area of responsibility for the management of incidents which includes compliance with the HSE Open Disclosure Policy. This includes ensuring that the management arrangements and the roles of all staff in relation to open disclosure are clearly defined.

3.4.3: The National Open Disclosure Steering Committee (NODSC)

The National Open Disclosure Steering Committee is chaired by the National Clinical Director for Quality and Patient Safety, Dr Orla Healy. This committee, which has representation from across HSE services, the State Claims Agency, patient representatives and the RCSI oversees the progress of the open disclosure programme of work. In fulfilling this

role, the National Open Disclosure Steering Committee advance, champion, support and provide strategic advice on the on-going implementation of the National Open Disclosure Programme and Policy.

The committee met on a quarterly basis throughout 2023. Further information on the committee, terms of reference and the minutes of committee meetings held throughout the year are available here.

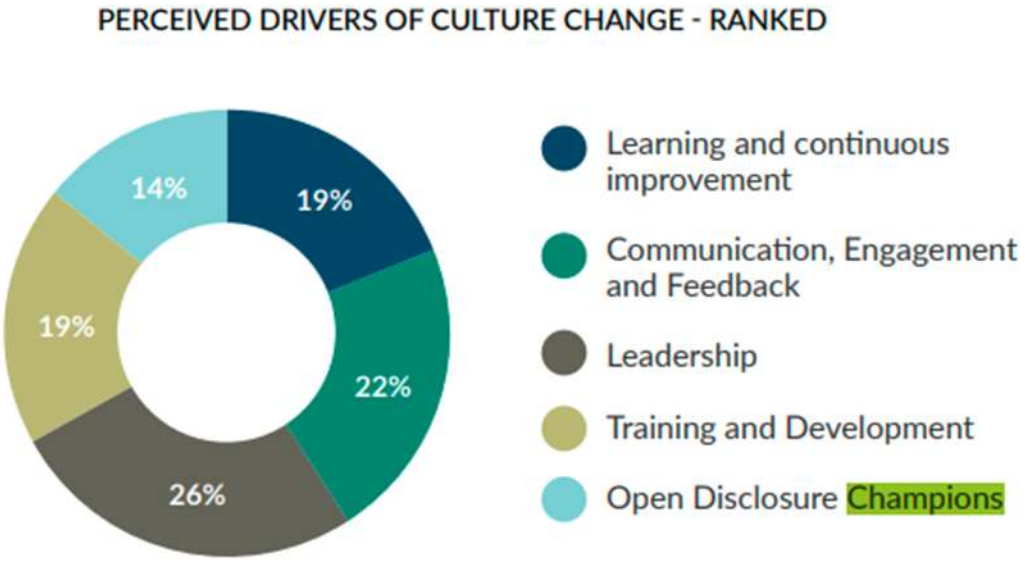
3.4.4: Open Disclosure Leads: The number of appointed and trained clinical and managerial Open Disclosure Champions

There are Open Disclosure Leads in all hospital groups, acute hospital sites, community healthcare organisations, screening services, National Ambulance Service and in many of the Section 38 and 39 voluntary agencies – details for leads across services is available here.

The role of the Lead is to manage, support and oversee the implementation of the HSE Open Disclosure Policy, programme (including the national training programme) and legislation across all services/departments in their service area and to provide reports to the Local Accountable Officer in relation to the same. The Leads work closely with the staff in the National Open Disclosure Office. The National Open Disclosure Office supports the leads in their work and keep the leads up to date with programme developments through the facilitation of quarterly update meetings, quarterly newsletters and quarterly training reports.

The National Open Disclosure Framework makes provisions going forward for service providers to identify clinical and managerial champions to lead and promote open disclosure in policy, education, and practice. The framework indicates that:

"strong clinical leadership is necessary to build a just culture of Open Disclosure and reporting within health and social care organisations. Health and Social Care providers should appoint clinical leaders tasked with ensuring Open Disclosure practice is embedded across the organisation. Clinical leaders should have protected time outside of their clinical duties to undertake this work. Championing of Open Disclosure is equally important in non-clinical settings and champions must be identified and appointed to lead and promote Open Disclosure policy. The importance of such champions was highlighted both in the report by the IPSC on underpinning principles and by a number of stakeholders in the focused engagement process around this work".



The framework also makes provisions for an annual report on open disclosure to be submitted by health and social care service providers to the Minister/Department of Health as from April 2025 to demonstrate how they are meeting the requirements of the Framework. This annual report will include information regarding the number of appointed and trained clinical and managerial open disclosure champions.

3.5: The HSE National Service Plan 2023

The HSE National Service plan for 2023 included the following actions relating to open disclosure.

Cross-Service Domains

A. Clinical, Quality and Patient Safety: Key Objectives

Key Objective 3: Drive quality and safety improvement through implementation of the HSE Patient Safety Strategy 2019-2024

a) Deliver on the key commitments of the Patient Safety Strategy 2019-2024 with all services and stakeholders through programmes to address the common causes of harm and develop a patient safety surveillance system and a quality and patient safety competency framework while advancing open disclosure and incident management

b) Progress work towards the implementation of the Patient Safety Bill and revised open disclosure policy (pending enactment of the Bill and implementation of the National Framework for Open Disclosure) that will build on greater accountability in health and social care.

Key Objective 7: Work with CHOs and Hospital Groups to drive implementation of the Patient Safety Strategy 2019-2024 thereby reducing common causes of harm

c) Improve compliance with incident management policies and standards, including open disclosure and support the proactive identification of patient safety risks

3.6: Controls Assurance Processes in the National Open Disclosure Office

The National Open Disclosure Office undertook a significant piece of work during 2023 to ensure that internal systems and processes in the office are in compliance with the Controls Assurance Review Process.

This included updating the original CARP plan outlining the requirements of each section of the CARP statement and how the office is demonstrating compliance. The work also involved the development of further data tools, processes, information for staff on regulations, how to access relevant policies, procedures, protocols and guidelines and ensuring all staff are compliant with mandatory training requirements (currently 100% compliance).

Section 4: Update on the National Open Disclosure Training and Education Programme 2023

HSE Patient Safety Strategy 2019-2024 Commitment 2: Empowering and Engaging Staff to Improve Patient Safety
"We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety".

4.1: Development and implementation of open disclosure training for all clinical and non-clinical staff including agency staff.

Open disclosure training is mandatory for all staff working in HSE and in HSE-funded services since January 2019 as per the instruction of the Director General of the HSE in August 2018. A letter was issued from the National Director of HR in July 2022 setting out the mandatory training requirements, how to access training and accountability arrangements in relation to the same. It is the responsibility of each service manager to ensure that staff are trained in open disclosure as relevant to their role and to maintain local training records to provide assurance that the service is meeting mandatory training requirements.

The HSE National Open Disclosure Training programme is continually adapted to reflect the changing needs of services and in response to developments in open disclosure nationally including changes to policy, legislation, the publication of the National Open Disclosure Framework and in response to feedback provided via training programme evaluations and from Open Disclosure Leads and Trainers.

4.1.1: Mandatory training requirements: All staff must complete open disclosure E-learning Module 1 "Communicating Effectively through Open Disclosure" which is available on HSeLanD.

Staff who may be involved in formal open disclosure meetings e.g. senior managers, senior nursing, midwifery and health and social care professionals, medical staff, QPS staff and staff fulfilling the role of the Designated Person must **also** complete: E-learning Module 2 "Open Disclosure: Applying Principles to Practice" and Module 3 Face to Face Skills Workshop (3 hours) on the management of the open disclosure process. These staff must be identified locally and provided with access to this training.

Open disclosure is included in mandatory training requirements in the Service Level Agreements for agency staff including medical staff, nurses and midwives, social care workers, health and social care professionals and health care assistants. This is in line with the requirements of the National Open Disclosure Framework 2023 as follows:

*"Health and social care service providers must ensure that all clinical and non-clinical staff, existing and new entrants, and **agency staff**, participate in induction, initial, and refresher training that prepares them to effectively participate in Open Disclosure as part of their role"*

4.2: How to access Open Disclosure Training programmes

- Module 1: Communicating Effectively through Open Disclosure is available on HSeLanD – login here
- Module 2: Open Disclosure: Applying Principles to Practice is available on HSeLanD – login here
- Face to Face Training can be accessed by contacting the Open Disclosure Lead for the service area – list and contact details for leads is available here.

4.3: Continuing Professional Development (CPD) and Continuing Educations Units (CEUs):

All of the above open disclosure training programmes attract CPD/CEUs as follows:

- Module 1: 2 External CPD points (RCPI) and 2 CEUs (NMBI)
- Module 2: 3 External CPD points (RCPI) and 3 CEUs (NMBI)
- Face to Face Skills Training: 3 External CPD points (RCPI) and 3 CEUs (NMBI)
- Train the Trainer Programme (1.5 days): 9 External CPD points (RCPI) and 11 CEUs (NMBI)

4.4: Overview of the National Open Disclosure Training and Education Programme 2023:

The roll out of the National Open Disclosure Training and Education Programme continued throughout 2023 and involved a number of significant new developments throughout the year. The programme included the following components:

- E-Learning Module 1: *"Communicating Effectively through Open Disclosure"* on HSeLanD. There were **88,342** completions of this module during 2023 (all HSeLanD users).
- E-Learning Module 2: *"Open Disclosure: Applying Principles to Practice"* on HSeLanD. There were **17,955** completions of this module during 2023 (all HSeLanD users).
- National Train the Trainer Programme: **95** staff from across HSE and HSE funded services completed the full 1.5 days train the trainer programme in 2023. This programme trains staff in the delivery of the 3 hour face to face skills workshop.
- 3 hour Face to face Skills Workshop: Training data for 2023 demonstrates a significant increase (188%) in the roll out and uptake of the 3 hour face to face skills workshop with **2024** completions of the workshop across services. Face to face training had been suspended during the Coronavirus pandemic and it is encouraging to see the return of this important programme. This training supports staff in the management of open disclosure discussions with patients and their families, provides a structure for the management of these meetings and facilitates opportunities to practice open disclosure and to identify, discuss and practice the key communication skills required.

- Working with the NQPS Education Team on (i) the pilot of the delivery of a combined NQPS training programme in Saolta and CHO1 and (ii) contribution to the NQPSD Training and Education prospectus.

- Maintenance of National Training Databases: All face to face training is recorded on a national training database and the National Open Disclosure Office also holds a database of Open Disclosure Trainers across HSE and HSE funded services. In addition data is extracted from HSeLanD on a quarterly basis on the uptake of both e-learning modules.

- The provision of an annual training report and quarterly training reports to all services and to Open Disclosure Leads and Trainers.

- The ongoing evaluation of all training programmes.

- The continuation of the open disclosure webinar series – 8 webinars were facilitated by the National Open Disclosure Office during 2023.

- Continued work to improve the access to and uptake of open disclosure training by medical staff.

- The updating of existing resources and development of further open disclosure resources to assist staff and services in the implementation of the HSE Open Disclosure policy and in the management of open disclosure meetings.

- The facilitation of presentations/workshops at various events including training days, webinars, conferences, undergraduate and post graduate training and education programmes etc.

- Commencement of a pilot programme with UCD on the introduction of a 2 hour open disclosure education programme to 4th and 5th year medical students and including open disclosure in end of 4th year MCQ exams and end of 5th year OSCEs.

- Working with the RCSI in the facilitation of their Mastering Adverse Events full day simulation training for NCHDs across a variety of surgical specialties. Managing the open disclosure process and engaging in open disclosure meetings is a key component of this programme.

- Working with the Forum of Postgraduate Training Bodies on the provision of training data on all modules that include open disclosure and the inclusion of open disclosure training requirements in the draft Memorandum of Agreement between the Postgraduate Training Bodies and HSE and in site accreditation standards.

- Working with the National Doctors Training Programme (NDTP) on the provision of quarterly reports on open disclosure training data from the Doctors Integrated Management E-portal (DIME) and National Employment Record (NER).

4.5: 2023 Full Training Report

A detailed training report for 2023 which includes a breakdown of the uptake of training per programme and per service area is available here.

4.6: Training Targets

The National Open Disclosure Training Programme currently aims to achieve an annual 30% staff uptake of Module 1 of the online training programme with an aim to reach 90% over a 3 year period. This is based on the requirement to complete mandatory training every 3 years and Module 1 being the module which is required to be completed by all grades of staff. This target was exceeded in 2023 with a **38%** annual compliance rate for HSE and HSE funded services (this includes Section 38's only).

Work Stream 4 of the Open Disclosure Performance Measurement programme was tasked with the development of an indicator to accurately capture the percentage of relevant staff who are up to date with their open disclosure training within the past 3 years. The work of this group led to the development of x 2 draft training indicators as follows:

- % of NCHDs registered on the Doctors Integrated Management E-system (DIME) National Employment Record (NER) who have uploaded evidence of completion of open disclosure training to DIME/NER system within the past 3 years.
- Number of consultant doctors who have completed face to face training.

See Section 5 of this report for further details on the work undertaken on the development of a performance measurement process for the National Open Disclosure Training Programme.

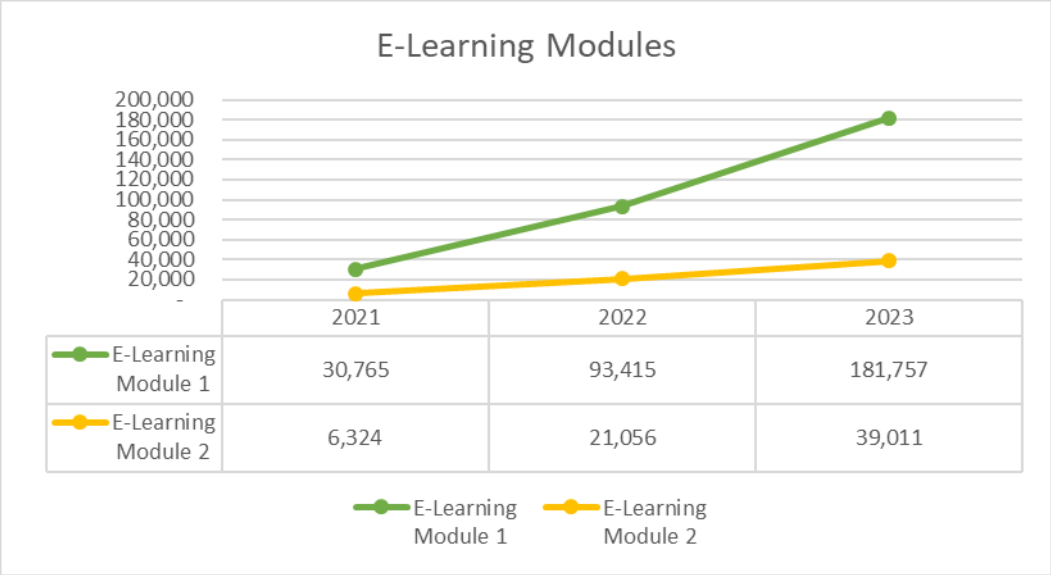
4.7: The number of trained clinical and non-clinical staff 2021- 2023:

There was a significant increase in the uptake of open disclosure training programmes during 2023 with a total of **108,321** completions of open disclosure training programmes throughout the year (this includes the total number of completions of E-Learning modules 1 and 2 by all HSeLanD users and face to face workshops – some of these may include staff who completed 1 or 2 or all 3). This indicates an encouraging 39% increase in total numbers on the previous year.

Year	Number of completions of Open Disclosure Training Programmes
2021	38,376
2022	78,084
2023	108,321
Total 2021-2023	**224,781**

Number of completions of Open Disclosure Training Programmes 2021-2023
(these figures includes both e-learning modules and face to face training)

The following table displays the number of completions of the Open Disclosure E-Learning Modules during 2021-2023.



Total completions for E-Learning Module 1

2021-2023 = **181,757**

This is a rolling cumulative total.

In 2023 **88,342** completions of E-Learning Module 1 were registered on HSeLanD

In 2023 **17,955** completions of E-Learning Module 2 were registered on HSeLanD.

- This chart displays a rolling cumulative total of open disclosure training completions registered on HSeLanD 2021-2023
- The HSE cyber-attack contributed to the reduction in uptake of training in 2021.
- Open Disclosure E-Learning Module 2 'Open Disclosure: Applying Principles to Practice' was launched on HSeLanD on 30th April 202

The following table displays the number of completions of the open Disclosure face to face skills workshop during 2021-2023.

Total completions for the face-to-face skills workshops 2021-2023 = **2,727**

This is a rolling cumulative total.

In 2023 **2,024** completions of face-to-face skills training.

Note: This figure does not include Open Disclosure Train the Trainer workshops.

- This chart displays a rolling cumulative total of Open Disclosure training completions registered on the National Open Disclosure Database.
- Open Disclosure face to face training was significantly impacted by Covid-19 and associated restrictions in 2021 and Q1 and Q2 of 2022.

4.8: The continued roll out of the accredited National Open Disclosure Train the Trainer programme to support the delivery of the open disclosure 3 hour face-to-face skills workshop.

The National Open Disclosure trainers continued to facilitate the 1.5 day Train the Trainer (TTT) programme throughout 2023. This programme enables staff to deliver the 3 hour skills workshop in their service areas.

The aim of the programme is to ensure that staff working in all service areas including Hospital Groups, Community Healthcare Organisations, National Ambulance Service, Screening Services and voluntary agencies can access open disclosure skills training locally, the training being provided by staff who have completed the full National TTT Programme and delivering the standardised training programme developed by the National Open Disclosure Team. This ensures a consistent approach to the training across all service areas.

The trainers are provided with on-line access to up to date training materials, resources and evaluation tools and are kept updated on new developments via quarterly newsletters and communications from the National Open Disclosure Office. Trainees are provided with a training manual which provides guidance on the management of all of the workshop components. The National Open Disclosure Training Team also provide on-site support to new trainers as required.

4.8.1: Attendance at the Train the Trainer Programme

The Open Disclosure Train the Trainer Programme is delivered in 2 parts as follows:

Part 1: Virtual training programme delivered via Microsoft teams (3 hours)

Part 2: Face to face workshop (full day)

The National Open Disclosure Team work with the Open Disclosure Leads across all service areas in the identification of staff to be trained as trainers and staff nomination forms are submitted by these leads to the National Open Disclosure Office. Work is prioritised in areas who are most in need of trainers. The nomination of staff involves a commitment by local management to:

(i) release the staff member to attend the open disclosure train the trainer programme,

(ii) support the staff member in the delivery of open disclosure training within the service area and

(iii) release the staff member to complete a minimum of four half days per year of training to maintain their competency as an Open Disclosure Trainer.

In 2023, the National Open Disclosure trainers delivered 9 virtual TTT programmes. A total of **113** participants attended this virtual training in 2023.

The National Open Disclosure trainers hosted 10 full day workshops in 2023. A total of **101** attendees attended the TTT workshops in 2023.

95 staff completed the full 1.5 day Train the Trainer programme.

There are currently 474 Open Disclosure Trainers on the trainer's database, representing a range of services including HSE and HSE-funded services and patient representatives.

4.9: Evaluation of Open Disclosure Training Programmes during 2023

All open disclosure training programmes are evaluated using standardised evaluation tools. E-Learning modules have a post completion evaluation and 3 months post completion practice evaluation survey which explores the application of learning to practice.

All face to face programmes are evaluated using a standardised evaluation tool which is available in hard copy or which can be completed on-line using a Smart Survey questionnaire.

4.10: Improving the uptake of Open Disclosure Training by Medical Staff:

Dubhfeasa Slattery: Open Disclosure—doctors need ongoing training and peer support - BMJ 2019 – full article here

Extracts:
"If we want Open Disclosure to work, we need to properly train doctors in responding to adverse events"

*"If we want Open Disclosure to always happen, then we need to train doctors and other healthcare professionals in how to do it across the continuum of their education and CPD. Proficiency in Open Disclosure should be identified as a key, core competency and—similar to clinical examination skills—it should be specifically taught and assessed at undergraduate and postgraduate level. Ideally, this training would be delivered by healthcare professionals who have experience of implementing Open Disclosure in their frontline clinical work***.**

"*Open Disclosure is a difficult thing to do at a time of extreme vulnerability for the patient and the doctor, but by recognising this and putting measures in place, we can make this easier for all involved".*

(by Dr Dubhfeasa Slattery, Professor and chair of medical professionalism at the Royal College of Surgeons in Ireland and the Bon Secours Health System and a Consultant Respiratory Paediatrician at Children's Health Ireland, Temple St. Dublin).

As highlighted in previous annual reports for the National Open Disclosure Programme, considerable work has been undertaken over the last number of years to improve the uptake of open disclosure training by medical staff and to extend this training into the undergraduate and post graduate training programmes for doctors, nurses, midwives and health and social care professionals.

The National Open Disclosure Framework 2023 states that:

"Health and social care service providers must ensure that all clinical and non-clinical staff, existing and new entrants, and agency staff, participate in induction, initial, and refresher training that prepares them to effectively participate in Open Disclosure as part of their role. Induction, initial, and refresher training should deliver the knowledge, skills, and competency needed by all clinical and non-clinical staff including agency staff to effectively participate in Open Disclosure and comply with any relevant organisational policies and procedures".

The Framework makes provisions for health and social care service providers to identify and appoint clinical and managerial champions "*to lead and promote Open Disclosure policy, education, and training, and monitor practice*".

The Framework requires that "*Education bodies involved in the delivery of undergraduate and postgraduate academic programmes with clinical/practical components to the health and social care professions must include communication skills with a specific focus on Open Disclosure in their programmes and ensure that the programmes adequately prepare graduates to understand and participate in Open Disclosure as part of their professional practice*".

4.10.1: Work undertaken during 2023 to improve the uptake of Open Disclosure Training by Medical Staff:

The HSE continued to work collaboratively during 2023 with various stakeholders to enhance this work. This has involved collaboration with the undergraduate and post graduate training bodies, professional regulatory bodies, National Doctors Training Programme and Clinical Directors. Medical input to the programme during 2023 included the following:

- Continued medical representation on the National Open Disclosure Steering Committee;
- Work with the Forum of Postgraduate Training Bodies on (i) the identification of training programmes that include open disclosure and the provision of data to the HSE on the number of completions of these programmes and (ii) the inclusion of open disclosure training requirements in the Memorandum of Agreement between the Postgraduate Training Bodies and HSE and in site accreditation standards.
- The commencement of a pilot programme with UCD involving the introduction of a 2 hour open disclosure workshop to 4th year and 5th year medical students, the inclusion of open disclosure in the end of 4th year MCQ examinations and going forward the inclusion of open disclosure in the end of 5th year Objective Structured Clinical Examinations (OSCEs). **296** fourth year medical students attended the first workshop in December 2023 – this included in-person and virtual attendees.
- Input was provided to the Medical Council on the section relating to open disclosure in the **9th revision of the Guide to Professional Conduct & Ethics for Registered Medical Practitioners** which was published in October 2023 and which came into effect on 01/01/2024. Ms. Lorraine Schwanberg (Assistant National Director for Incident Management and Open Disclosure) spoke to the importance of open disclosure at the launch of the guide. The guidance in relation to open disclosure has been strengthened significantly in this edition as follows:

2.2 Where an unintended and unanticipated outcome occurs, you must:
• Make sure that the effect on the patient is minimised as far as possible and that they receive further appropriate care as necessary.
• Facilitate timely and compassionate Open Disclosure and support the patient through this process.
• Report the incident, learn from it and take part in any review of the incident.

***4.1** When a patient safety incident occurs, the response from health service providers, including doctors, must be professional, and empathetic.*
***4.2** You must practice, promote and support a culture of Open Disclosure.*
***4.3** You must comply with any applicable legislation and any national policies regarding Open Disclosure.*

- Facilitation of 1.5 hours Open Disclosure Masterclass to Clinical Directors as part of their masterclass series in March 2023;
- Work with the National Doctors Training programme on the provision of data on the number of NCHDs who have uploaded evidence of completion of open disclosure training to the DIME system – the NDTP provide quarterly reports to the National Open Disclosure Office on the number of NCHDs who have uploaded evidence of attendance at open disclosure training to the DIME/NER;
- Facilitation of an open disclosure workshop for 37 General Practitioner Tutors (GPs) in January 2023;
- Facilitation of open disclosure presentation at a National NCHD study Day in June 2023;
- Facilitation of presentation on open disclosure legislation at two Grand Rounds sessions in Sligo University Hospital (14th September, 2023) and St Luke's Hospital, Kilkenny (17th November, 2023);
- Facilitation of presentation on open disclosure at the Irish Orthopaedic Anaesthetists' Association Conference on 01 December, 2023;
- Invitation to and attendance of medical staff at open disclosure webinars;
- Inclusion of medical staff in the Open Disclosure Train the Trainer(TTT) Programme – 4 medical staff completed the TTT programme and 4 further medical staff have completed part of the programme and are scheduled to complete the programme in 2024;
- Specialty specific case scenarios are used in training that medical staff can relate to;
- Using a directorate approach to training and encouragement of clinician presence and leadership in training programmes;
- Representation by two senior consultants on the Open Disclosure Performance Measurement Work Stream 4 which is tasked with the development of an open disclosure training indicator;
- Representation from the Medical Council on the Open Disclosure Performance Measurement Work Stream 4 which is tasked with the development of an open disclosure training indicator;
- Submission to the annual report of the Irish Hospital Consultants Association (IHCA) in August 2023;

- Ensuring that all open disclosure training programmes and webinars are CPD accredited in an effort to encourage attendance by medical staff.

4.10.2: Data on the uptake of training by Medical Staff during 2023

In 2023 there was **7477** completions of open disclosure training programmes by doctors (Consultants / NCHDs – includes medical dental grades). This demonstrates an encouraging **39%** increase on the previous year. The mandatory training requirement for staff who, as part of their role, may have to engage in formal open disclosure meetings is to complete modules 1 and 2 and Face to Face training initially. Completion of Module 2 or face to face training will then meet three yearly refresher requirements for this staff group.

2023 Open Disclosure Training - Consultants

E-Learning Module 1	942 completions
E-Learning Module 2	179 completions
Face to Face Open Disclosure Skills Workshop	178 completions
Other Face to Face Training*	142 completions

*Other face-to-face training included: Briefings and Train The Trainer completions

Total training completions recorded for Consultants in 2023: **1,441**

2023 Open Disclosure Training - NCHDs

E-Learning Module 1	3,965 completions
E-Learning Module 2	1,489 completions
Face to Face Open Disclosure Skills Workshop	287 completions
Other Face to Face Training	26 completions

*Other face-to-face training included: Briefings and Train The Trainer completions

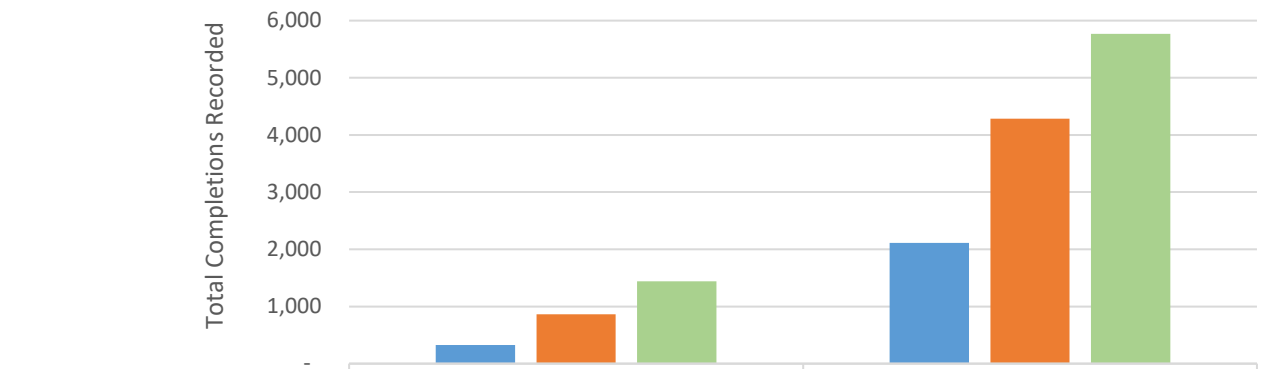
Total training completions recorded for NCHD's in 2023: **5,767.**

2023 Open Disclosure Training - Other Medical Dental Grades

E-Learning Module 1	235 completions
E-Learning Module 2	34 completions

Total training completions recorded for Other Medical Dental Grades in 2023: **269.**

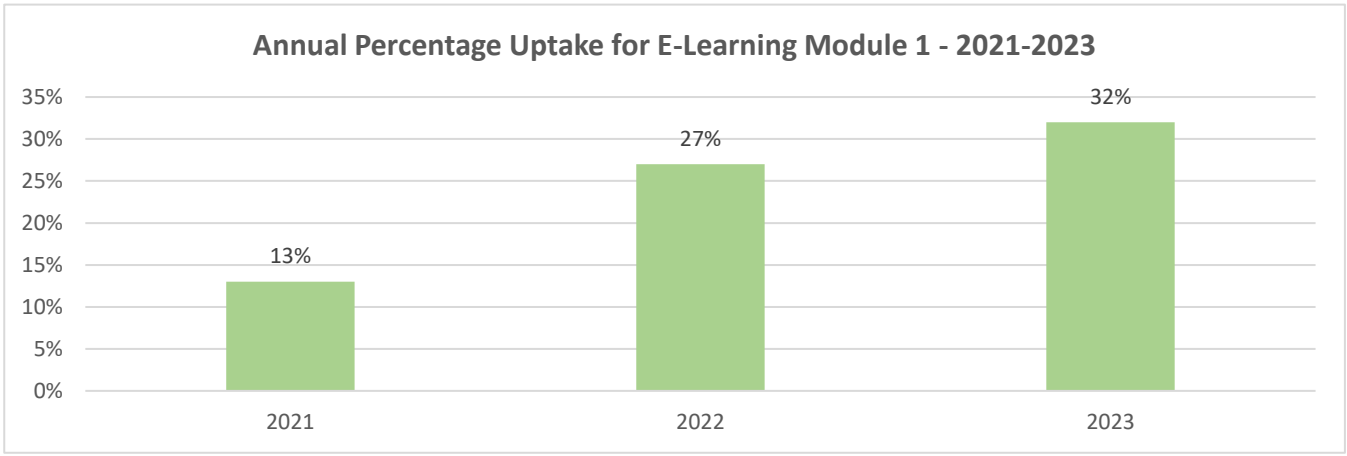
4.10.3: Completions of Open Disclosure Training by Medical Staff 2021-2023



	Consultants	NCHD's
2021 - All Training Completions	323	2,112
2022 - All Training Completions	864	4,285
2023 - All Training Completions	1,441	5,767

- This chart displays total completions of open disclosure training by Consultants and NCHD's in 2021, 2022 and 2023
- This includes all open disclosure training (both e-learning modules, face to face skills workshop and other face to face training).
- The majority of training for all Consultants and NCHD's was through completions of the e-learning modules.
- Open disclosure face to face training was significantly impacted by Covid-19 and associated restrictions in 2021 and Q1 and Q2 of 2022.
- The uptake of online open disclosure training for Q2 and Q3 2021 was significantly impacted by the cyber-attack.
- Over the three-year period, a total of **2,628** completions of open disclosure training were registered for Consultants.
- Over the three-year period, a total of **12,164** completions of open disclosure training were registered for NCHD's.

This chart displays the annual percentage compliance rate for E-Learning Module 1 for 2021, 2022 and 2023



- This chart displays training completions of E-Learning Module 1 for the Medical Dental grade group as a percentage, based on the headcount as of December Health Personnel Census Report 2021, 2022, 2023 respectively.
- The uptake of online open disclosure training for Q2 and Q3 2021 was significantly impacted by the cyber-attack
- For 2023 data – data has been refined and only includes Medical Dental staff registered on HSeLanD as HSE and Section 38 staff for a more accurate percentage based on headcount.

4.10.4: National Doctor's Training and Planning (NDTP) Data

In collaboration with the National Doctor's Training and Planning (NDTP) data from the Doctors Integrated Management E-system (DIME) has been made available to the National Open Disclosure Office to monitor open disclosure training compliance. This is part of the actions/recommendation arising from Open Disclosure Performance Measurement Work Stream 4. In June 2023 a memo was issued to all NCHD's via the DIME system to upload evidence of open disclosure training.

DIME Data

Date of Data extract	Number of Verified and Submitted Open Disclosure Documents	Number of Open Disclosure Documents that are Rejected, Missing or Expired or Nearing Expiry	Total Number of Open Disclosure Documents
Dec 2023	**4,097**	**4,691**	**8,788**

This data reflects the number of NCHDs who have uploaded evidence of completion of any training in open disclosure and is not representative of % compliance in open disclosure training by NCHDs as reflected in 4.10.3 above. This data includes NCHD's in HSE and HSE Funded services, but also NCHD's working in private Hospitals and/or Section 39's.

4.10.5: Uptake of Open Disclosure Training in the Forum of Postgraduate Training Bodies

The following data was provided by the Forum on the number of completions of courses during 2023 that include training on open disclosure in their course content. The content of the training is not validated by the HSE but the organisation welcomes that this important topic is becoming more embedded in under and post-graduate training.

Name of Training Body	Course Details	Number of completions
RCSI	Human Factors Patient Safety programme for trainees across Emergency Medicine and Surgery. Managing Adverse Events full day training programme.	100
RCSI	Human factors in patient safety – first year trainees	120
RCSI	Human Factors in patient Safety – second year trainees	120
RCPI	Gateway to Communication programme	215
Royal College of Anaesthetists	Open disclosure was covered in all mandatory training & simulation courses in 2023 and on the SAT & CPSP/SMSB Induction programmes. Trainee Mandatory Courses – 4 courses run once a year Trainee Simulation Courses – 10 individual courses run x 4 times per year SAT induction / CPSP and SMSB Induction – 2 individual courses run once a year	307 anaesthesiologists

4.11: National Screening Service: CervicalCheck: Training workshops on the Management and Communication of Personal Cervical Screening Reviews (PCSRs):

The National Open Disclosure Office, in collaboration with members of the CervicalCheck Interval Cancer Audit Implementation Group, developed and facilitated 5 workshops for various members of the teams involved in the management and communication of Personal Cervical Screening Reviews. These workshops included the following:

(a) 2 Workshops for Call Centre Staff

Event	Venue	Date	Time	Number of attendees
X 2 Open Disclosure Workshops for Call Centre Staff, Cork	Cork	Monday, 20th March 2023	9.30am - 12.30pm and 2pm -5pm	20

The aim of these workshops was to build the capacity of attendees to respond to patient calls as part of the CervicalCheck Call Answering Team. The objective of these workshops was to:

- increase staff awareness on the background to Personal Cervical Screening Reviews, the PCSR process and potential outcomes;
- discuss the types of calls to expect, how to respond to the calls and how to escalate matters when required;
- ensure staff recognised the impact of communication and the importance of being empathic, person centred and of being more aware of their own communication style;
- provide an opportunity to practice the key skills required to effectively manage calls to get the best outcome for the patient/ relevant person and staff involved;
- increase staff confidence in managing situations that arise and any challenges that arise as part of a team;
- raise awareness of the patient perspective, the support needed and how staff may guide patients/their relevant person to the best support available for them and
- recognise the importance of team dynamics, support for each other and their own support needs throughout the process.

(b) 3 Workshops to support the Cervical Check Clinical Teams involved in meeting with patients/ relevant persons following requests for Personal Cervical Screening Reviews.

Event	Title	Date	Time	Location	Number of attendees
Skills Workshop	Personal Cervical Screening Review training **Initial Meeting**	Friday, 19th May 2023	10am to 1pm	Face to Face (NSS)	13
Skills workshop	Personal Cervical Screening Reviews **Results meeting** training	Friday, 16th June 2023	10am to 1pm	Face to Face (NSS)	10
Skills workshop	Personal Cervical Screening Reviews **Results meeting** training	Friday, 15th December 2023	10am to 12MD	Virtual via MS Teams	5

The aim and objective of these workshops was to

(i) build the capacity of attendees to prepare for and manage the **introductory meeting** with patients/relevant persons who have requested a Personal Cervical Screening Review in the HSE National Screening Service,

(ii) to build the capacity of attendees to prepare for and manage the **results meeting** with patients/relevant persons who have requested a Personal Cervical Screening Review in the HSE CervicalCheck Service and

(iii) to support the attendees by **reflecting on learning** to date and preparing for further meetings using a consistent and standardised approach.

Feedback on the workshops:

- The group discussions around managing specific outcomes was really helpful particularly to hear the perspectives of different experts including clinicians, Point of Contact person, and patient reactions.
- The round table discussion that took place, rather than a classroom environment, was very helpful as all present at the training were totally committed to the process.
- The role plays were particularly valuable and challenging - more practice definitely needed.
- The content was PCSR specific.
- Excellent preparation.
- It was a really helpful session that brought to light specific challenges through discussions with the team following the scenario role play.

4.12: National Open Disclosure Office Webinar Series

The National Open Disclosure Office facilitated 8 webinars during 2023. The purpose of these webinars is to (i) maintain communication with Open Disclosure Leads, Trainers and staff working across all of our health and social care services, external agencies and patient representative / patient advocacy groups, (ii) keep the importance of open disclosure on the agenda across all services and (iii) to provide continual support to staff across the system in the implementation of the HSE Open Disclosure Policy and Programme.

Webinar topics are identified through the webinar evaluation process in an effort to provide information on topics which are of interest and of benefit to our audience. Each webinar was CPD accredited by RCPI (2 external CPD points) and NMBI (1.5 CEUs). Numerous stakeholders were involved in the delivery of the webinar programme. The total attendance across 2023 webinars = **4263** (an increase of 78% on attendance during the previous year). Details of webinars delivered by the programme include:

Webinar Title	Date	No. of Attendees	Facilitator(s)
Managing Difficult Conversations: Getting it Right when Things go Wrong (Part 3)	15 February 2023	608	Professor Eva Doherty (RCSI)
Positive Health and Wellbeing: What does the science tell us?	15 March 2023	369	Professor Ciaran O'Boyle (RCSI)
Medico-legal aspects of record-keeping and documentation	12 April 2023	711	Asim A Sheikh (Barrister at Law)
Sharing the Learning - Documenting Open Disclosure	17 May 2023	439	Angela Tysall, National OD Office Linda McEvoy, Beaumont Hospital Mary O'Dwyer, HSE Midwest Noreen Kennedy, St Johns Hospital, Limerick Cathy Sexton, Cavan Monaghan Hospitals
"Update on (i) The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (ii) The National Open Disclosure Policy Framework "	14 June 2023	507	**DOH – National Patient Safety Office** Maurice O'Donnell – Principal Officer Susan Reilly- Assistant Principal Officer Liam McCormack- Assistant Principal Officer Arnel Kidpalos- Assistant Principal Officer Stephen Dredge – Administrative Officer
Managing Conflict - Tips and Tools for Resolving Conflict with Colleagues	12 September 2023	804	Professor Eva Doherty (RCSI)
Learn Together: Patient Involvement in the Incident Management Process	11 October 2023	384	Jane O'Hara, Professor of Healthcare Quality and Safety Learn Together UK
The Role of the Designated Person in Incident Management and Open Disclosure	15 November 2023	441	Catherine Hand, National OD Office Brenda Ryan, Screening Service, Liz Barry, PALS Manager UHL, Gary Watkins , St John of Gods, Georgina Cruise, National Patient Advocacy Service (Panel)
	TOTAL	**4263**	

4.12.1: Webinar evaluation:

The following table represents feedback averaged over the 8 webinars facilitated by the National Open Disclosure Office during 2023.

Evaluation	% of Respondents who agreed or strongly agreed
The content of the webinar was relevant for me.	95%
The webinar has helped me to develop my knowledge and understanding of the subject area.	96%
The subject area was presented effectively.	97%
The pace of the webinar was satisfactory.	97%
I plan to apply what I learned from the webinar in my work.	94%

In addition an average of 98% of attendees over the 8 webinars indicated that the webinars exceeded or met their expectations.

All respondents were invited to leave additional feedback / comments. Examples of some comments include:

"Best presentation in ages".

"The content was so fascinating and also practical, it could be put in use straight away. The presentation style was captivating, down to earth, easy to follow".

"90 minutes v well spent"

"I thought it was excellent and very well delivered. It was probably the most informative talk I have heard in a while".

"Excellent view of the key issues"

"Excellent webinar - loved the case histories to share the learning"

"Great Webinar - lifted my day"

"I look forward to applying what I learned to practice".

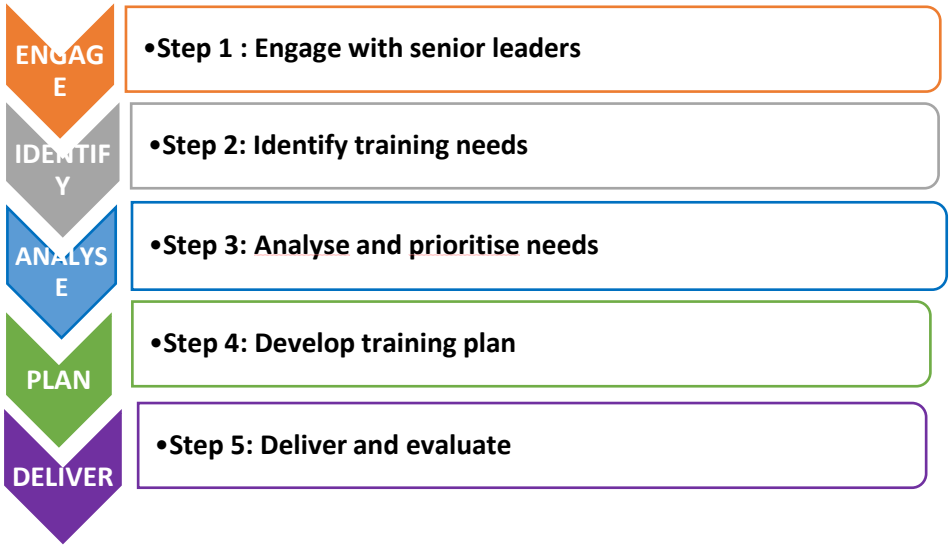
"Thank you for organising. I always find it hard to make the time to attend a webinar in full, but mid-way through yesterday's presentation, I closed the office door and prioritised that time to listen (with attention)…."

"Excellent presentations that enriched our knowledge and guided us for safer practice"

"I am very new to my role but I found it excellent and very informative. I have a much better understanding of OD now".

4.13: Contribution to the NQPSD Pilot "Skilling up for QPS" Training Programme in CHO1 and Saolta Hospital Group:

The 'Skilling up for QPS' project proposed to move to a more integrated delivery of QPS programmes focusing on one health region at a time. This proposed integrated approach involved engaging with senior leaders to build local ownership, identifying and prioritising QPS learning needs and delivering training to staff from both acute and community settings together during a concentrated period. Sustaining and spreading QPS training required the identification of local QPS trainers was supported though facilitator/train-the-trainer programmes as well as the establishment of local communities of practice. There are 5 steps involved in this process as follows:



After a joint discussion with both CHO 1 and Letterkenny University Hospital, it was decided to prioritise the following programmes which would be delivered face to face in Donegal.

- SIMT
- System Analysis Review
- Open Disclosure Skills Training
- After Action Review
- Coaching for Improvement
- Foundation in Human Factors

Many of the programmes identified in the needs analysis are available on HSeLanD as e-learning modules that can be taken at any time. In particular, the open disclosure mandatory training was identified and it was highlighted that we needed to consider how best we could facilitate staff to be able to complete this mandatory module.

Training suites were set up to facilitate access to online Open Disclosure mandatory training programmes on HSeLanD and x 3 skills workshops were facilitated – x 2 in Donegal and x 1 in Sligo.

This programme is currently being evaluated.

4.14: Development of Training, Education and Support Resources during 2023

The following training, education and support resources were developed during 2023:

(a)Electronic Communications toolkit for the Open Disclosure Themed Week containing many resources to be used locally, for example open disclosure call to action flyer, 1-page newsletter, loop presentation etc.

(b) 8 Promotional videos for Open Disclosure Themed week – 6 involving patient representatives, 1 involving the CCO and 1 involving the CEO.

(c) Open Disclosure Resource Packs – provided to services for Open Disclosure Themed Week.

(d) Open Disclosure Pop Up Stand.

(e) Open Disclosure Message Boards based on Twitter cards.

(f) The Open Disclosure Implementation Toolkit – a toolkit for services to use to self-assess in relation to their progress on implementation of the HSE Open Disclosure Policy.

The following resources were revised and updated during 2023:

- Open disclosure virtual half day Train the Trainer Programme.
- Open disclosure full day Face to Face Train the Trainer Programme.
- Open disclosure virtual training manual.
- Open Disclosure Face to Face Skills Workshop.
- The IMF self-assessment audit tool (in progress).

4.15: Disclaimer: Data Improvement and Data Limitations

4.14.1: Data Improvement: The National Open Disclosure Team, in collaboration with the team in HSeLanD, continue to improve the training data provided to services. During 2023 improvements to data provided included the removal of duplicates on the system, separate reporting on training completed by staff working in HSE services, HSE funded services and other services, breakdown on uptake of training by staff in each service area in the Community Healthcare Organisations (primary care, mental health, intellectual disability and older persons services) and data on year to date % compliance with completion of Module 1 of the Open Disclosure E-Learning programme per hospital group and CHO area (this is the module that is common to all staff groups).

4.14.2: Data Limitations: A number of limitations remain which impact on the provision of accurate national training data. The data for these statistics is generated through the National Open Disclosure Training Database, HSeLanD and HSE Strategic Workforce Planning & Intelligence. Data in relation to staff that have completed face to face training is logged on the National Open Disclosure Training Database by the Open Disclosure Trainer. Data in relation to staff that have completed online training is generated through a report run on HSeLanD. Percentage of training uptake is then established by comparing these figures with staff headcount data from the Employment Data Report provided by HSE Strategic Workforce Planning and Intelligence, National HR Directorate.

The reports published by the National Open Disclosure Office should be used as a guide only to inform services of training data available to the national office. The accuracy of the statistics run for different organisations is dependent on the correct data being entered on the system. A reminder is sent to all Open Disclosure Trainers to upload their training in advance of the publication of the training report. The e-learning statistics are dependent on staff members identifying themselves as working in the correct services / organisations/roles on HSeLanD. It is therefore important for staff to update their work location and role on HSeLanD.

Further limitations identified in relation to data presented in training reports include the following:

- The data includes everyone who completed any form of open disclosure training and includes staff that have retired, resigned from the HSE or moved post within the HSE over that period.

- As there are various training programmes available, staff may have attended more than 1 training session, and therefore may be counted more than once in some of the training data. It is therefore essential, for assurance purposes and to identify gaps in training that individual services/organisations can ensure that their staff are compliant in meeting mandatory open disclosure training requirements by accurately maintaining training records at a local level.
- Data on HSeLanD includes HSeLanD users who work outside of HSE and HSE funded services. The National Open Disclosure Office strongly urges services to nominate a HSeLanD Data Manager who can apply to have access to a detailed report (including individual staff details) of all HSeLanD learning within their organisation. This data can be cross-checked with local HR files to identify staff that that have not yet completed the training module.

Section 5: Performance Measurement

HSE Patient Safety Strategy 2019-2024 Commitment 5: Using Information to Improve Patient Safety
"We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety."

5.1: Background:

Open Disclosure is **HSE Policy** since November 2013.

The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 was enacted on 3rd May 2023 and contains provisions for mandatory Open Disclosure in a number of defined notifiable incidents.

The National Open Disclosure Framework published by the Department of Health in October 2023 sets out the requirements for the monitoring and evaluation of Open Disclosure as follows:

- *"Ongoing monitoring and evaluation of Open Disclosure is essential for the successful implementation of the Framework and to embed a culture of Open Disclosure across the Irish health and social care sector. Monitoring involves activities such as reporting, recording, measurement of Open Disclosure in practice, training, education, and policy implementation. Evaluation involves the collection and analysis of Open Disclosure data to inform future policy. The effective monitoring and evaluation of Open Disclosure in policy and practice will demonstrate how health and social care organisations comply with the principles set out in this Framework and how they are contributing to its implementation".*
- *"Health and social care organisations should develop Open Disclosure key performance indicators, evaluate Open Disclosure performance, and integrate outcomes into quality improvement, clinical governance, and performance monitoring. The mechanisms and indicators for monitoring and evaluation of Open Disclosure will depend on the type of organisation and its functions. Health and social care service providers, health and social care service regulators, professional regulators, and education bodies all have a role to play by collecting and analysing data on Open Disclosure, patient safety incidents and adverse events and establishing any associated learning to improve quality and safety in health and social care services in Ireland".*
- *"The continuous monitoring and evaluation of Open Disclosure, patient safety incidents and adverse events in practice will reduce risk, inform future policy, and ensure the shift from a 'blame' culture to a 'just culture' where open communication is valued and accepted as the norm. Health and social care service providers need to ensure appropriate direction and internal control through a system of clinical and corporate governance. By continuously monitoring performance and evaluating healthcare systems and processes for learning and improvement, health and social care service providers can ensure good governance, risk management, and quality improvement. Monitoring and evaluation of data on patient safety incidents, adverse events and Open Disclosure is a vital part of this process".*

- *An annual report on Open Disclosure must be submitted by health and social care service providers to the Minister/Department of Health to demonstrate how they are meeting the requirements of the Framework. The health and social care service providers' annual report will include information regarding:*
    - *Development and implementation of Open Disclosure policy.*
    - *Development and implementation of Open Disclosure training for all clinical and non-clinical staff including agency staff.*
    - *Evidence of the availability of support structure for all staff clinical and non-clinical including agency staff.*
    - *The number of trained clinical and non-clinical staff including agency staff.*
    - *The number of appointed and trained clinical and managerial Open Disclosure champions.*
    - *The number of Open Disclosure events initiated and closed".*

- *"Health and social care service providers must also comply with the requirements for mandatory Open Disclosure as set out in the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023".*

The HSE National Service Plan 2023 includes the following:

Key Objective 3: Drive quality and safety improvement through implementation of the HSE Patient Safety Strategy 2019-2024

a) Deliver on the key commitments of the Patient Safety Strategy 2019-2024 with all services and stakeholders through programmes to address the common causes of harm and develop a patient safety surveillance system and a quality and patient safety competency framework while advancing Open Disclosure and incident management

b) Progress work towards the implementation of the Patient Safety Bill and revised Open Disclosure policy (pending enactment of the Bill and implementation of the National Policy Framework for Open Disclosure) that will build on greater accountability in health and social care.

Key Objective 7: Work with CHOs and Hospital Groups to drive implementation of the Patient Safety Strategy 2019-2024 thereby reducing common causes of harm

c) Improve compliance with incident management policies and standards, including Open Disclosure and support the proactive identification of patient safety risks.

In advance of these national developments, the **HSE National Open Disclosure Steering Committee,** defined the performance and compliance measures (set out in **5.2** below) it sought to develop to provide assurance to persons affected, the public, the staff/local service/organisation and the HSE that Open Disclosure requirements are being met consistently and where there are gaps that support is being provided to achieve this.

5.2: Recommendations submitted by the Open Disclosure Performance Measurement Committee and accepted by the National Open Disclosure Steering Committee in 2021:

(A) The development of a KPI for open disclosure for the HSE Service Plan.

Develop an initial KPI in relation to measuring the performance of services in regard to compliance with the provisions for mandatory open disclosure in the pending Patient Safety Bill (PSB) in alignment with the open disclosure process as outlined in the legislation. A significant amount of defining, measuring, validating and testing of any metric (including data collection and dissemination) related to the Patient Safety Bill will be required to include a 'Key Performance Indicator' into the National Service Plan. A Working Group should be established to complete this work with representation from, inter alia, NIMS, Screening Services, Community Services, Acute Services, National Quality & Patient Safety and the Integrated Information Services. NIMS will be adapted in terms of functionality to allow for data capture. The remit of assurance will be wider than this however in terms data validation, escalation etc. and the working group will seek to develop this.

(B) The development and implementation of the Open Disclosure Policy Compliance.

To develop a robust assurance framework on the implementation of the Open Disclosure Policy (2019) and subsequent Patient Safety Bill (now Act) to support the service delivery system. This includes the review of guidance of the National Standards for Safer, Better Healthcare (3.5 Open Disclosure); the development of an Open Disclosure Policy audit tool, and modification to the Incident Management Framework audit tool.

(C) Measurement of patient experience in relation to Open Disclosure.

Development of a Patient Experience Survey or other assessment tool to measure patient's/relevant persons' experience following the open disclosure process to be designed and implemented. A work stream with patient representatives, QPS staff and others will be set-up to support this important and sensitive piece of work. Additionally, an invitation to quote has been submitted to support this work stream.

(D) Uptake of Open Disclosure Training:

Develop an indicator to accurately capture the percentage of relevant staff who are up to date with their open disclosure training within the past 3 years. In lieu of accurate data, the National Open Disclosure Office to continue to provide quarterly and annual activity reports on the uptake of open disclosure training per service area including e-learning modules, face to face training programmes and other virtual training programmes to demonstrate compliance with 3 yearly mandatory training requirements. A Working Group should be established to complete this work with representation from, inter alia, NIMS, Screening Services, Community Services, Acute Services, National Quality & Patient Safety, Office of Midwifery and Nurses Services Directorate (OMNSD), National Doctor and Training Programme (NDTP) Health and Social Care Professionals (HSCP) and HR.

E) On-going Project Group

This work needs to continue as a project with the specific aforementioned work-streams reporting into the project group. Terms of Reference to be developed collaboratively with the, what will now be disbanded, Open Disclosure Performance Measurement Sub-Committee and submitted to the Steering Group as final steps for that group.

5.3: Update on the progress made during 2023 on the implementation of the recommendations of the Performance Measurement Committee.

(A) The development of a KPI for Open Disclosure for the HSE Service Plan.

Performance Measurement Work Stream 1 continued work on the development of a KPI for the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023, the identification of data required and the adaptation of NIMS to provide this data. The following two key performance indicators (KPIs) were proposed by the work stream members and agreed by the National Open Disclosure Steering Committee:

Proposed KPI's

1. An open disclosure meeting has taken place for a NI within 20 working days of the service becoming aware of the incident (target 95%) – this will be incremental initially.

2. A written record (statement in writing) of the open disclosure meeting is shared with the patient or relevant person within 5 days of the date the meeting took place (target 95%) - this will be set lower and increase incrementally initially.

Work has involved mapping the Notifiable Incidents as set out in the Patient Safety Act with the current Serious Reportable Events list on NIMS and will involve a specific dropdown box on NIMS for notifiable incidents. Work has commenced with the State Claims Agency in relation to developing and prioritising the technical changes required.

(B) The development and implementation of Open Disclosure Policy Compliance.

Performance Measurement Work stream 2 continued to focus on the development of audit and assurance mechanisms to demonstrate compliance with the implementation of the HSE Open Disclosure Policy.

The work of this group has involved the review and further development of the IMF self-assessment audit tool and the development of an Open Disclosure Implementation Toolkit.

The IMF Self-Assessment Audit Tool: The IMF Self-Assessment Audit Tool was previously developed by the HSE Quality Assurance and Verification Division. The tool has been reviewed and developed further to include additional open disclosure and other data fields and a guidance document to support the use of the tool. The tool was tested by members of the Work Stream Group who found it to be fit for purpose for self-assessment on the management of Category 1 and Category 2 incidents. A demonstration of the Audit Tool was provided to the National Open Disclosure Steering Committee in August 2023 and feedback from the committee has informed

further improvements. Further work is now planned on the tool to offer services an opportunity to self-assess against the principles of the IMF.

The Open Disclosure Implementation Toolkit: The Open Disclosure Implementation Toolkit has been developed to assist organisations in self-assessment in relation to the implementation of open disclosure policy and legislation. This tool incorporates user guidance, a QI plan and guidance on annual reporting requirements as set out in the National Open Disclosure Framework. The tool focuses on a change management approach to the implementation of the policy including assessment on leadership, policy, legislation, incident management, record keeping, support for patients/service users, support for staff, training, visibility and performance measurement. It has been tested in some services and evaluated positively. The tool was signed off by the National Open Disclosure Steering Committee in May 2023 and is now available on the HSE Open Disclosure Website here.

(C) Measurement of patient experience in relation to Open Disclosure.

Performance Measurement Work Stream 3 continued their work in collaboration with researchers from UCD on the development of a tool or mechanism to measure patient experience of the open disclosure process. This work was funded by NQPSD.

The focus of the work of this group included the following:

(i) A Literature Review was undertaken, which was consistent with evidence-based practice, to source all relevant studies regarding the design, content and approach in eliciting experiences of the open disclosure process. This will provide an evidence summary/policy brief to inform the co-design process.

(ii) The second phase of this project involved the recruitment and interview of healthcare staff and patients/ service users who have experience of open disclosure (WP2). The aim is to gather a range of perspectives and experiences to explore the most appropriate means of seeking feedback, understand what worked well or did not work so well, and elicit views on the most meaningful types of feedback to collect to ensure on-going improvements of the process. This information will also inform the co-design workshop.

(iii) Ethics approval was granted by HSE and UCD ethics committees to ensure participants were protected. This ethics approval was required to cover work planned in interviews and in the co-design workshop.

(iv) To ensure compliance with GDPR legislation for research concerning health related data (special protections), the following was completed :

- creation of data sharing agreement between UCD and RCSI in a joint approach to collection and analysis of data – approved by UCD and RCSI and
- approval of a Data Protection Impact Assessment by UCD and HSE ethics to demonstrate consideration of sensitive issues, potential risks and steps to mitigate these.

(v) The recruitment phase of this project has now been completed with 10 Advocates/ Healthcare Staff and 6 Patient / Service Users recruited. Initial contact was made via email and phone through Committee members, National Open Disclosure Leads and patient partners and then proceeded by participants themselves contacting the UCD research team directly. A poster was developed to support recruitment of patient/ service users. This was approved by HSE and UCD Ethics committees. The interviews of all participants are currently being completed.

(vi) A co-design workshop with stakeholders is planned for March 2024. This will involve key stakeholders including patient advocates, QPS leads, senior managers in quality, safety and risk, researchers, and experts by experience (PPI representatives) who will be invited to participate in a half-day workshop. A participant information document and consent form is prepared for this workshop. This workshop will focus on (i) the most appropriate means of reaching out to gather experiences of the open disclosure process, and (ii) the most appropriate and meaningful approach to capturing feedback and assessment of the process to ensure potential for continuous improvement. Following this a peer review publication will be prepared with recommendations from the co-design team on the most appropriate approach to collecting patient experience of the open disclosure process.

(D) Uptake of Open Disclosure Training:

Performance Measurement Work Stream 4 focused on the development of an indicator to accurately capture the percentage of staff who are up to date with their open disclosure training within the past 3 years. This work involved:

(i) an examination of the current data provided in quarterly and annual open disclosure training reports and the associated data limitations;

(ii) working with staff in HSeLanD on managing some of the identified limitations and improving the quality of data provided to services to include the removal of duplicates on the system, separate reporting on training completed by staff working in HSE services, HSE funded services and other services, breakdown on uptake of training by staff in each service area in the Community Healthcare Organisations (primary care, mental health, intellectual disability and older persons services) and data on year to date % compliance with completion of Module 1 of the Open Disclosure E-Learning programme per Hospital Group and CHO area.

(iii) Work with the Forum of Postgraduate Training bodies in relation to:

- providing data on the uptake of open disclosure training provided by the colleges,
- establishing a list of courses in each training body that include open disclosure,
- exploring the inclusion of open disclosure training in medical staff induction and pre-induction programmes and
- calling out open disclosure in the draft "Memorandum of Agreement" with Training Bodies and in site accreditation standards.

(iv) A programme of work with the National Doctors Training Programme in relation to:

- Extracting data from the Doctors Integrated Management E-System on the uptake of training by NCHD's,
- Analysing this data per service area,
- Discussing an approach to managing the failure of NCHDs to upload evidence of attendance at training on DIME;
- Communication to all NCHDs x 2 to remind them of mandatory open disclosure training requirements;
- Meeting with Medical manpower leads to update them on mandatory open disclosure training requirements and the requirement for NCHDs to upload evidence of training to DIME.

(v) The development of x 2 Draft training indicators as follows:

1. % of NCHDs registered on the Doctors Integrated Management E-system(DIME) who have uploaded evidence of completion of open disclosure training to DIME/NER system within past 3 years;
2. Number of consultant doctors who have completed face to face training*.
   *It was agreed that uptake would be monitored initially during 2023 and 2024 before setting a training target.

5.4: Open Disclosure NIMS Data 2023

A key reporting requirement to the DoH under the National Open Disclosure Framework 2023 is the reporting of the number of open disclosure events by the health care provider. Currently an accurate data set to report on this does not exist. The National Incident Management System (NIMS) currently provides inadequate insight. Whilst incidents are reported here the questions and data re open disclosure is inadequate for reporting purposes. It is critical for the HSE to make improvements in this area to be able to report on this effectively in the future.

Completion of the data is lacking and engagement with the 'review screen' section of the system is limited for a number of different reasons. Whilst this is improving through the work of the roll-out of ePOE, the actual incident management system and engagement with it needs to improve further. Making the technical changes to NIMS is a priority for the HSE in 2024 to ensure it can meet its reporting requirements under the Patient Safety Act and National Open Disclosure Framework. These technical changes are being spear-headed by the State Claims Agency in conjunction with the HSE. These changes will allow staff to more accurately capture key steps of the open disclosure process. They will be able to track if there was an open disclosure meeting, if this was followed up in writing and that the review report was shared.

Alongside the improvements to the NIMS, there will be educational programmes on the data entry and reporting requirements and the development or report templates for health regions to help with their assurance and oversight roles.

5.5: Performance of the National Open Disclosure Training Programme:

The National Open Disclosure Office produced open disclosure training reports on a quarterly basis throughout 2023. These reports were issued to Chief Officers of the Community Healthcare Organisations; Hospital Groups Chief Executive Officers; NAS; National Screening Services; Open Disclosure Leads; Open Disclosure Trainers and the National Open Disclosure Steering Committee. An end of year training report for 2023 was also developed, circulated and published on the open disclosure website.

The end of year training report provides training statistics for 2023 and also statistics for the last 3 year period. The data for these statistics is generated through the National Open Disclosure Training Database, HSeLanD and HSE Strategic Workforce Planning & Intelligence. Data in relation to staff that have completed face to face training is logged onto the National Open Disclosure Training Database by Open Disclosure Trainers. Data in relation to staff that have completed online training is generated through a report run on HSeLanD. Percentage of training uptake is then established by comparing these figures with staff headcount data from the Employment Data Report provided by HSE Strategic Workforce Planning and Intelligence, National HR Directorate.

The National Open Disclosure Office strongly urges services to nominate a HSeLanD Data Manager who can apply to have access to a detailed report (including individual staff details) of all HSeLanD learning within their organisation. This data can be cross-checked with local HR files to identify staff that that have not yet completed the training module.

All open disclosure training programmes and webinars are evaluated using standardised evaluation tools. See the annual training and education report for further information on training data and evaluation of training.

5.5: Performance of the National Open Disclosure Steering Committee (NODSC)

The performance of the NODSC is measured in line with the Terms of Reference of the committee.

Note: The performance measures included in the Terms of Reference for the NODSC are as follows:

- Percentage of attendance at meetings by members.
- Completion of follow up actions.
- An annual evaluation of committee objectives.

Percentage of attendance at meetings during 2023	56%

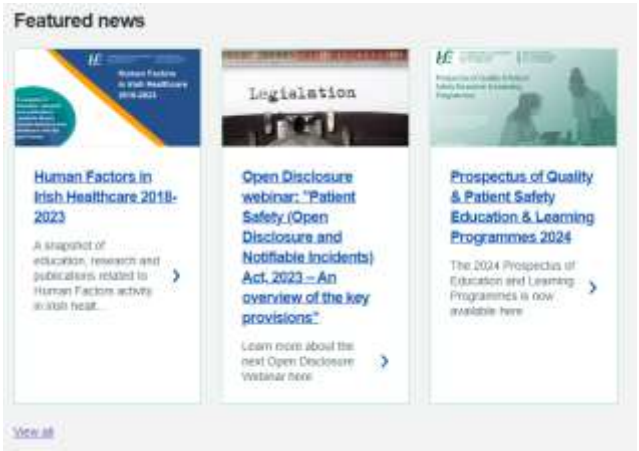
Completion of follow up actions 2023	There were 15 follow up actions by the committee in 2023 Actions completed = 13 Actions that remain open = 2

5.6: Open Disclosure Website Activity January to December 2023

The open disclosure website saw a significant update and transformation in 2023, as part of the wider NQPSD website project in collaboration with the HSE Digital Team. The objective of this digital initiative is to build trust, understanding, engagement and support for the health service, taking all end-user groups into consideration including service users, healthcare staff, deciders, media and members of the public.

A full review of all open disclosure webpages, uploaded documents and resources was undertaken before the migration of the open disclosure website to the new content management system and the new layout and design. To further improve search functionality and accessibility to the open disclosure website and available open disclosure resources to all users, a list of keywords and descriptors for all uploaded open disclosure documents was developed. The project will continue in 2024. .

The National Open Disclosure Programme is integrated into the new National Quality and Patient Safety Directorate (NQPSD) website and contributes regularly to the content of the NQPSD Featured News section, which was launched in March 2023.



The open disclosure website is used as a central repository for hosting open disclosure information and resources. There are pages dedicated to hosting (i) resources which provide easily accessible information to assist staff and services when preparing for and managing an open disclosure meeting (ii) resources to support Open Disclosure Trainers in the preparation and running of the skills workshop, to provide practical tools to support training sessions, (iii) information and resources to support the public in understanding open disclosure. Analytic reports for the year, presented below, show strong user engagement on these pages.

In general, 2023 showed a steady flow of traffic to the open disclosure website. As part of the work on performance measurement the “Open Disclosure Implementation Toolkit” was launched in September 2023 and is part of the top three documents users have downloaded from the site in 2023. The statistics and graphs below outline the annual number of sessions and users, most viewed pages and most downloaded documents. (Please note: This data represents users who have accepted analytics cookies).

Summary of page usage:

Most Viewed Pages

Order	Overview of page	No. of Views
1	Open Disclosure Home Page	17820
2	Open Disclosure Leads	12059
3	Civil Liability Amendment Act	8309
4	Information and Resources for Staff Support	3890
5	Mandatory Training Requirements	3586
6	Webinars	3468
7	Open Disclosure Policy and Guidelines	2175
8	Information and Resources for Staff & Organisations	1616
9	Information and Resources for Open Disclosure Trainers	1094
10	Patient Safety (Notifiable Patient Safety Incidents) Bill 2019	794
11	Open Disclosure Themed Week Webpage	471
12	Information and Resources for Public	442
13	Open Disclosure Publications	300
14	Open Disclosure Team Contact Details (page no longer in use)	297
15	Open Disclosure Steering Committee	170
16	Useful Links	62

Most Downloaded Documents

Order	Document	No. of Downloads
1	HSE Open Disclosure Policy	1811
2	Themed Week Communications Toolkit	294
3	Open Disclosure Implementation Toolkit	151
4	Open Disclosure Workshop Presentation (July 2023)	134
5	Open Disclosure Quick Reference Guide	122
6	Assist Model Poster	90
7	E-Learning Poster	75
8	Open Disclosure Meeting Checklist	73
9	Assist Me Model Booklet	68
10	Summary Guide to the Patient Safety (Notifiable Patient Safety Incidents) Bill 2019	60
11	Documentation Template	59
12	Patient and Family Leaflet	58
13	Workshop Participant Pack	46
14	Webinar Presentation Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023	39
15	Sample Language to assist Open Disclosure conversations	38
16	Sample Flyer Open Disclosure Workshop	34
17	Preparation for training checklist	30
18	Share the Learning Template	30
19	Covid 19 Guidelines	28
20	Open Disclosure Skills Workshop Sample Lesson Plan	27

Section 6: Legislation

The HSE Patient Safety Strategy 219-2024 Commitment 6: Leadership and Governance to improve Patient Safety

"We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance"

6.1: The Legislatory Basis for Open Disclosure

6.2: The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023

The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 was signed into law by President Michael D Higgins on 3rd May 2023. The Act introduces a new requirement for mandatory open disclosure and external notification of specific notifiable incidents. This mandatory open disclosure and external notification of notifiable incidents will equally apply to public and private health services.

The date for commencement of the Act is not known but it is anticipated that it may commence in May/June of 2024.

The 2023 Act makes provisions for:

- mandatory open disclosure of notifiable incidents (See Appendix B for list of Notifiable Incidents as per Schedule 1, Part 1 and Part 2 of the Act) ;
- certain restrictions (i.e. protective provisions) on the use of the information and any apology provided in such disclosures;
- mandatory open disclosure of patient requested reviews (referred to as Part 5 Reviews);
- procedures in respect of clinical audit, and the data obtained in clinical audits;

- notification of notifiable incidents to certain agencies i.e. HIQA, Mental Health Commission and the Chief Inspector of Social Services;
- the amendment the Health Act 2007 to provide for the application of standards set by the Health Information and Quality Authority to private hospitals;
- the amendment the Health Act 2007 to provide for the review by the Chief Inspector of Social Services of certain incidents occurring in the course of the provision of a health service to a person by certain entities (i.e. nursing homes);
- the amendment of the National Treasury Management Agency (Amendment) Act 2000 and Part 4 of the Civil Liability (Amendment) Act 2017.

6.2.1: In the context of Open Disclosure of Notifiable Incidents the following provisions apply:

- Obligation to make an open disclosure of notifiable incidents (NIs);
- Obligation to inform the health services provider that a notifiable incident has occurred;
- Obligation on health services provider to notify HIQA, the Chief Inspector of Social Services and/or the Mental Health Commission within seven days of a notifiable incident happening or becoming known;
- The open disclosure of a notifiable incident is made to the patient, their relevant person or the patient and their relevant person;
- The information and apology provided during the open disclosure will not invalidate insurance; constitute admission of liability or fault, or be admissible in proceedings;
- The health services provider publishes a statement on its procedure for making an open disclosure of a notifiable incident;
- A designated person is appointed to support the patient and/or their relevant person;
- A written statement will be provided to the patient, relevant person or patient and relevant person within five days of holding the notifiable incident open disclosure meeting;
- The management of refusal, by the patient and/or relevant person, to participate in open disclosure of notifiable incident is in line with the provisions of the Act;
- The management of an additional information meeting is in line with the provisions of the Act;
- The management of clarification requests and responses is in line with the provisions of the Act;
- The management of the situation when the health services provider is unable to contact a patient or relevant person to make an open disclosure is in line with the provisions of the Act.

6.2.2: In the context of Patient Requested Reviews (Part 5 reviews) the Act makes the following provisions:

- Part 5 reviews apply in bowel, breast and cervical screening services;
- A health services provider shall inform the patient in writing, either before or at the time that it carries out the cancer screening on that patient and after a screening has been undertaken, of his or her right to make a request under section 35 for a Part 5 review;

- A patient may request a review of the results of a screening which has been carried out by a cancer screening service in relation to the patient (relates to patients who develop an interval cancer);
- The health services provider which received the request shall carry out the review;
- Where a Part 5 review has been carried out the health services provider must hold a Part 5 review disclosure meeting in order to make the open disclosure of the review to the patient or relevant person (or both of them).

6.2.3: Offences

The Act makes provisions that

- A person who fails to comply without a reasonable excuse shall be guilty of an offence and shall be liable on summary conviction to a Class A fine (the fine may vary up to €5000).
- The above relates to failure to hold an open disclosure meeting and/or to report the patient safety incident to the relevant authority e.g. HIQA, Chief Inspector of Social Services, the Mental Health Commission.

Failure to comply relates to
(1) Failure to notify the relevant authority (regulatory body) **(Sections 27, 28 and 29)**
(2) Failure to hold an open disclosure meeting which includes as follows

Non-compliance to hold a NI OD Meeting **Section 5(1)**	Non-compliance to hold requested NI OD meeting following an initial refusal by patient/relevant person **Section 19(9)**	Non-compliance to hold a NI OD meeting when there was an initial challenge to contact the patient/relevant person and where contact is later established. **Section 20(5)**	Non-compliance to hold a Part 5 Review Meeting **Section 37(1)**	Non-compliance to hold requested Part 5 review meeting following an initial refusal by patient/relevant person **Section 50(9)**	Non-compliance to hold a Part 5 review meeting when there was an initial challenge to contact patient/relevant person and where contact is later established **Section 51(5)**

6.3: Part 4 of the Civil Liability Amendment Act, 2017 and The Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018

Part 4 of the Civil Liability Amendment (CLA) Act 2017 and The Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018 were commenced in September 2018. Part 4 of the CLA Act contains protective legislative provisions in relation to the information and any apology provided in an open disclosure meeting as follows:

The information provided and an apology given at an open disclosure meeting:

- shall not constitute an express or implied admission of fault or liability in relation to the incident or any clinical negligence action arising from the incident;
- will not be admissible as evidence of fault or liability in Court in relation to the incident or clinical negligence action arising from the incident;
- will not invalidate the indemnity or insurance cover of the health service provider;

- shall not constitute an express or implied admission of fault, professional misconduct, poor professional performance or unfitness to practice or other failure or omission in relation to any complaint made by the patient to a regulatory body subsequently;
- shall not be admissible as evidence of fault, professional misconduct, poor professional performance, unfitness to practise a health service, or other failure or omission, in proceedings to determine a complaint, application or allegation.

This legislation relates to voluntary open disclosure (i.e. health services providers can choose to seek the protections of the Act or not.) Protections apply only when open disclosure is managed in accordance with the provisions of the legislation and completion of documentation as set out in the Act.

The Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018 are prescribed statements (forms) to be completed, signed and provided to the patient/relevant person at various stages throughout the open disclosure process.

The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 has included the amendment of Part 4 of the CLA Act 2017 to bring it in line with the 2023 Act. These amendments are enacted but not yet commenced.

6.4: Preparation by the HSE for the commencement of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 and the revised Part 4 of the CLA Act 2017

6.4.1: The establishment of the Patient Safety Act HSE Implementation Working Group

The HSE established the Patient Safety Act HSE and HSE Funded Implementation Working Group in May 2023 with the first meeting of the group taking place in June 2023. This group is chaired by Dr Orla Healy, National Clinical Director for Quality and Patient Safety. 7 meetings of the group took place throughout 2023 which included a full day workshop for group members on 17th August in Dublin. This workshop was also attended by staff from the Department of Health. An Interim High Level Implementation Plan has been developed.

The working group membership includes staff from across a wide range of services and directorates in the HSE, patient representative and patient advocacy groups, legal services and the Forum of the Voluntary Hospital Group (**See Appendix C for full membership list).**

The overall purpose of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 HSE and HSE-funded Implementation Working Group is to:

- provide oversight of implementation of the legislation across the HSE and HSE-funded services and to provide clear guidance to its staff about the interpretation of the legislation, and

- develop, monitor and review an implementation plan to enable the roll out of the Act across all HSE and HSE-funded services. Key areas of development to support implementation will include:
  - Policy alignment, with specific focus on open disclosure policy, screening, audit, incident management;
  - Training and education programmes;
  - Development of resources and tools to support services;
  - Communication and engagement strategies, and
  - Supporting staffing resource and operational requirements.

The overall objective of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 HSE and HSE-funded Implementation Working Group is to:

- Develop and oversee the delivery of the implementation plan;
- Develop supporting resources to ensure staff are trained and have access to information and guidance on the Act;
- Ensure there is comprehensive risk assessment and management involving all aspects of implementation;
- Support services to implement the legislation in a way that is supportive of staff, patients and service-users and helps the development of a positive workplace culture for the delivery of healthcare;
- Ensure the delivery of a comprehensive communication plan to patient, services users, staff and the public;
- Design and embed assurance systems around implementation.

6.4.2: The establishment of 5 Work Streams

To establish and progress the deliverables relating to all parts of the Act the HSE set up 5 work streams as follows:

- The Open Disclosure and Incident Management Work Stream;
- The Legal Clarifications and Notifiable Incidents Work Stream;
- The NIMS (technical) Work Stream;
- The Part 5 Reviews Implementation Work Stream;
- The Clinical Audit Work Stream;

These work streams are tasked with the consideration of the implementation of the various parts of the Act as identified in the Work Stream titles and to project manage the same giving consideration to the following:

- Communication and engagement
- Resource development
- Training and education
- Legal Clarifications
- Risks and dependencies
- Governance
- Assurance and
- Operational Implementation

A Communications work stream was subsequently established to prepare for and manage all elements of communication pertaining to the Act.

6.4.3: Legal Clarifications

The HSE, in collaboration with legal services, established a number of legal clarifications in relation to the provisions of the ACT and these were submitted to the Department of Health in December 2023.

6.4.4: Training and Education programmes:

The open disclosure 3 hour skills workshop and train the trainer programme include high level information on the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 and Part 4 of the Civil Liability Amendment Act 2017. Information on the legislation has formed part of the content of these programmes since 2018.

Information on the legislation was also included in a number of open disclosure presentations provided across a wide range of services during 2023 including presentations to Health Managers Institute, Voluntary Healthcare Agencies Risk Management Forum, Boots Pharmacists, GPs, Irish Orthopaedic Anaesthetists Conference, NUIG Medicinal Prescribing Course, NUIG Governance course, webinar for CHO3 staff, QPS Study Day in Letterkenny General Hospital, NCHD Leads study day, Legal Aspects of Nursing and midwifery practice study day, senior management team in Dublin Midlands Hospital Group, RCSI Msc in Healthcare Management, UCD graduate diploma in Healthcare Risk Management, UCD 4th year medical students, Clinical Directors Masterclass and 221+ group.

A webinar on the Legislation was facilitated by staff from the National Patient Safety Office in the Department of Health in June 2023 as part of the open disclosure webinar series. The presentation and recording of this webinar is available on the HSE Open Disclosure Website here.

Work is planned for 2024 on the development of an E-Learning programme on the full Act and a further E-Learning programme on the role of the Designated Person. A webinar series and a roadshow on the provisions of the Act are also planned for 2024.

Section 7: The National Open Disclosure Framework 2023

The HSE Patient Safety Strategy 219-2024 Commitment 6: Leadership and Governance to improve Patient Safety

"We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance"

7.1: Background to the Framework:

"The National Open Disclosure Framework (2023) was launched by the Minister for Health, Mr Stephen Donnelly, on 19th October, 2023 at the National Patient Safety Conference.

"*The National Open Disclosure Framework (Framework) is an initiative of the Department of Health (DOH) which aims to promote a clear and consistent approach by health and social care service providers, and other organisations where appropriate, to open communication with patients/service users and any relevant support person following a patient safety incident or an adverse event. This includes a discussion about what has happened, why it happened, and what is being done to prevent it from happening again. The Framework was prepared by the National Patient Safety Office (NPSO) of the DOH and informed by recommendations from the Independent Patient Safety Council (IPSC) which were developed based on independent research and consultation undertaken by consultants during 2020.*

The Framework is designed to provide overarching principles and a national, consistent approach to Open Disclosure in health and social care in Ireland which can then be drawn from to suit the needs of the various organisations, i.e., across public and private health and social care service providers, service regulators, health and social care professional regulators, health and social care educators and other relevant bodies and organisations. It is designed to be used in the development, or upgrading, of an organisation's internal policies, processes, and practices regarding patient safety incidents and adverse events, and to facilitate open communication.

The Framework has been developed for application in a wide range of health and social care services and health and social care agencies and as such, individual organisations will need to consider implementing the process outlined in this Framework within their existing internal policies, which may need to be changed or upgraded to facilitate the Open Disclosure process.

The Framework guides the operational procedures and standards which determine how patients/service users, their families, or support persons and carers are communicated when something goes wrong in the course of their care. The Framework leads relevant health and social care service providers through the substantial culture change required to improve patient/service user outcomes and experience in this area. The Framework also recognises and guides developments in the substantial education and learning changes required to enable these improvements" **(National Open Disclosure Framework 2023).**

7.2: Ethos of the Framework:

"The Framework applies to patient safety incidents and adverse events and reflects the importance of the right of patients/service users and their support persons to have full knowledge about their health and social care, as and when they so wish, and to be informed about any failings in that care process, however, and whenever they may arise. The ethos of this Framework is to ensure that the rights of all patients/service users and health and social care staff involved in and affected by patient safety incidents and adverse events are met and respected and that they are communicated in an honest, open, timely, compassionate, and empathic manner and that they are treated with dignity and respect". " **(National Open Disclosure Framework 2023).**

7.3: Principles of Open Disclosure as set out in the Framework:

National Open Disclosure Framework 2023 Principles

7.4: What the Framework means for HSE and HSE funded services

The Framework acknowledges the significant work already undertaken across HSE and HSE funded services in relation to the development and implementation of the HSE Open Disclosure policy and programme. It supports continuous improvement and development in relation to the implementation of a fair, just, open and transparent culture across all health and social care services. The HSE Open Disclosure Policy 2019 is currently being revised to ensure that it aligns with the provisions and principles of the Framework.

It is the responsibility of each relevant organisation to adopt the Framework and to embed positive open disclosure cultures and behaviours into practice. Individual organisations will need to identify mechanisms and initiatives that

support the consistent, coherent, and sustainable implementation of open disclosure in line with the principles of this Framework.

Each relevant organisation will be required to submit an annual report to the Minister for Health regarding their implementation of open disclosure and compliance with the Framework. This annual report requirement will commence in April 2025 with the requirement for organisations to provide information on the following:

- Development and implementation of open disclosure policy.
- Development and implementation of open disclosure training for all clinical and non-clinical staff including
- agency staff.
- Evidence of the availability of support structure for all staff clinical and non-clinical including agency staff.
- The number of trained clinical and non-clinical staff including agency staff.
- The number of appointed and trained clinical and managerial Open Disclosure Champions.
- The number of open disclosure events initiated and closed.

The Framework also sets out the requirement for all health and social care service providers to comply with the requirements for mandatory open disclosure as set out in the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.

<u>The Framework details the following Drivers for Change:</u>

- Health and social care service providers must demonstrate that mechanisms are in place for learning and improvement in respect of patient safety incidents and adverse events and the disclosure process associated with these. It must be clear how learning from patient safety incidents and adverse events has informed policy and practice change.
- Open disclosure policies and other relevant documentation must be clearly communicated to all patients/service users, support persons, and clinical and non-clinical staff including agency staff.
- Open disclosure policies, guidelines, and any other associated documentation should be developed, updated, and reviewed in collaboration with all key stakeholders including patients/service users, support persons, and clinical and non-clinical staff including agency staff.
- Those involved in open disclosure and patient safety incidents and adverse events should be provided with an opportunity to give feedback about their experience.
- Leaders and managers in health and social care services need to ensure that open disclosure is a key part of the internal learning systems of the organisation and aligns with other organisational policies and processes.

- Health and social care service providers must ensure that all clinical and non-clinical staff, existing and new entrants, and agency staff, participate in induction, initial, and refresher training that prepares them to effectively participate in open disclosure as part of their role.
- Health and social care service providers must appoint clinical and managerial Open Disclosure Champions to lead and promote open disclosure policy, education, and training, and to monitor practice.

7.5: How to access the National Open Disclosure Framework 2023

The National Open Disclosure Framework 2023 can be accessed here

Section 8: Open Disclosure Themed Week 2nd to 8th October, 2023

HSE Patient Safety Strategy 2019-2024 Commitment 1: Empowering and Engaging Patients to Improve Patient Safety

"We will foster a culture of partnership to maximise positive patient experiences and outcomes and minimise the risk of error and harm. This will include working with and learning from patients to design, deliver, evaluate and improve care".

8.1: Overview

The HSE planned, facilitated and supported an Open Disclosure Themed Week across HSE and HSE-funded services from 2nd to 8th October, 2023.

This year's Open Disclosure Themed Week was based on the theme of the WHO World Patient Safety Day 2023 **'Engaging Patients for Patient Safety –Elevating the Voice of Patients'**, in recognition of the crucial role patients, families and caregivers play in the safety of health care. The purpose of this week was to promote and raise awareness of the crucial role held by patients, their support persons and caregivers in open disclosure and in improving patient safety generally.

This week was an opportunity for services to ensure that staff are aware of their obligations in relation to open disclosure, are compliant with mandatory training requirements and, in particular, that they recognise the importance of providing the opportunities for patients to actively partner staff in the open disclosure process.

The week provided an opportunity to increase staff and the public awareness of the forthcoming changes to open disclosure as a result of the implementation of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023, the revised Part 4 of the Civil Liability Amendment Act and the National Open Disclosure Framework 2023.

8.2: Daily Themes throughout the Week

A different theme relating to open disclosure was planned from Monday to Friday of the week as follows:

Date	Theme
Monday 2nd October, 2023	The Patient's and Service-User's Perspective
Tuesday 3rd October, 2023	Patient and service-user involvement in incident management and review process
Wednesday 4th October, 2023	Leadership in Open Disclosure and Patient Safety
Thursday 5th October, 2023	The Patient Voice in the formulation of open disclosure legislation and policy
Friday 6th October, 2023	Staff Support

In keeping with the overall theme of "Elevating the voice of patients", videos based on each of the daily themes were recorded with members of Patients for Patient Safety Ireland and with Stephen Teape from the Cervical Check 221+ Group. Each day started with posting a patient video on Twitter and LinkedIn with additional messaging to support the video content.

Additional videos were recorded with the CEO and Chief Clinical Officer supporting the importance of open disclosure and how it relates to patient safety and just culture across our health and social care services.

8.3: Examples of how HSE and HSE funded health and social care services engaged throughout the week in promoting open disclosure

The response across the system was amazing in terms of the efforts made by Open Disclosure Leads, Trainers, managers and staff across our health and social care services, patient representatives and patient advocacy services to promote the importance of open disclosure. Services and people were so creative in the ways they chose to promote open disclosure throughout the week some of which are listed as follows:

- Promotional stands in staff and public areas providing opportunities to discuss open disclosure with staff and members of the public;
- Training events;
- Promotional videos;
- Social media blogs;
- Patient stories;
- Posters and pop-up stands,
- Loop presentations on open disclosure in staff and public areas;
- Launch of documentation stickers;
- Visits to wards and services;
- Provision of resources to services;
- Competitions with prizes including crosswords, word searches, questionnaires, training completions (all with open disclosure themes);
- Social media promotions;
- Briefings at staff handovers;
- Distribution of open disclosure newsletter to departments;
- Promotion of open disclosure at events throughout the week.

8.4: Open Disclosure Themed Week in Pictures


Promotional Activities and Events
OLOL Drogheda
Tallaght Hospital
Wexford Hospital
Naas Hospital
Galway University Hospital
A number of initiatives took place to highlight the importance of Open Disclosure for patients and service-users, their support persons and caregivers - all of whom have a crucial role to play in open disclosure and in improving patient safety.
Open Disclosure Week
Dublin Midlands Hospital Group
Mayo University Hospital
Milford Care Centre


Promotional Activities and Events
Open Disclosure Week 2023
Royal Victoria Eye and Ear Hospital IEHG
Cork/Kerry Community Healthcare
CHO Dublin North City & County
National Screening Service
University Limerick HG
Letterkenny University Hospital
Clonskeagh NU
Community Healthcare CDLMS

8.5: Feedback on the Benefits of hosting an Open Disclosure Themed Week from Open Disclosure Leads across services

- I did an audit of Category and Category 2 incidents a couple of weeks previous - this highlighted gaps in documenting on NIMS and I was able to target a response for the Open Disclosure lead to speak to staff on importance of ticking OD box on paper NIMS form;
- Wider circulation of Information, able to inform staff of upcoming workshops and requesting good attendance. Reiteration of importance of Open Disclosure going forward for all departments;
- Raised awareness with staff and service users ;
- Created a focus;
- Great staff engagement opportunity to raise awareness and highlight the importance of this programme;
- Promotion and raised awareness across all specialties;
- Prepared staff groups for upcoming workshop training;
- It highlighted the launch of our sticker and newsletter, gave us a focus to work towards;
- A full week is too long given the many other themed days/weeks;
- It is hugely beneficial as it raises awareness across the group. It ensures that there is a focused effort. The t-shirts, stickers and the leaflets and posters are all ways to promote the training and helps to ensure that Open Disclosure is seen as important and to the forefront of peoples' minds;
- Spreading awareness on Open Disclosure and encouraging staff to complete the training on HSeLanD;
- Very beneficial. It is really important to keep communication and how we communicate to centre stage;
- Huge boost to promoting and informing all stakeholders of the importance of OD, the implementation of OD and associated training requirements;
- Opened the conversation around Open Disclosure.

Section 9: Open Disclosure: Share the Learning

HSE Patient Safety Strategy 2019-2024 Commitment 5: Using Information to Improve Patient Safety

"We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety."

The focus of this year's ***"Share the Learning"*** section of the report is the role of the designated person (key contact person) in open disclosure and incident management and how this role, when undertaken well, can impact so positively on the experience of patients and families who have been involved in and/or affected by patient safety incidents. This learning is also in keeping with the WHO Patient Safety Day theme of "***Engaging Patient for Patient Safety – Elevating the Voice of Patients".***

9.1: Background:

Patients who have suffered harm as a result of a patient safety incident and their relevant person(s) will need practical, emotional and psychological support and this should arrive seamlessly. The early assignment of a named designated person (also known as the key contact person) is essential to ensure that the person affected/their relevant person(s) and staff do not feel isolated. Their support and communication needs in respect of the plans for the management of the incident (including review) and open disclosure must be identified, communicated and addressed.

The appointment of a designated person is a requirement of the HSE Open Disclosure Policy 2019, the DOH National Open Disclosure Framework October 2023 and HSE Incident Management Framework 2020 and is a provision of Part 4 of the Civil Liability Amendment Act 2017 and the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.

This person should have the necessary skills and experience required to fulfil this important role. The name of the designated person must be recorded in the incident management/open disclosure record and a direct line telephone number provided to the patient/relevant person and staff members involved. The designated person will act as the liaison person between the service provider and the patient/relevant person. To avoid any conflict of interest, the designated person should ideally be impartial and sufficiently removed from the incident or its management and should not be the lead discloser in the Open Disclosure Team.

9.2: Learning together

The open disclosure webinar in October 2023 ***"Beyond disclosure: How listening to, and learning with, patients and families during incident investigations can reduce further harm"*** facilitated by Professor Jane O Hara from "Learn Together" in the UK focused on how we can improve learning by supporting the involvement of patients and families in reviews/investigations undertaken following patient safety incidents. In a review of the quality of investigation reports conducted by the Care Quality Commission in 2016 it was established that only 12% of the sample reports reviewed included clear evidence that the patient or family had been involved in the investigation process.

Learn Together supports a 5 stage process of patient/family engagement in incident review/investigation as follows:

This process ensures patient and family involvement at every stage of the management and review of the incident and the designated person plays an important role in maintaining that communication process and ensuring that the voice of the patient and family is heard and understood throughout. In an effort to develop and test new processes and guidance to support the better involvement of patients and families in serious incident investigations the Learn Together team developed 10 Principles underpinning meaningful involvement of patients and families as indicated below.

Engaging in a meaningful way through continuous communication and involvement in the incident management and review process can prevent the occurrence of the "second harm" or "compounded harm" that can be created after a patient safety incident due to the processes that follow.

9.3: The Role of the Designated Person (Summary)

The appointment must take place as soon as possible following the patient safety incident (predominately following Category 1 and Category 2 incidents) to maintain a seamless line of communication between the patient / service user and the service.

The role of this person is to:

- ensure that the person directly affected or their relevant person(s) do not feel isolated and that their support and communication needs are met both in the immediate aftermath of the incident, in planning for open disclosure and the review of the incident and throughout the conduct of the review;
- act as a liaison between the patient, service user, family and service;
- build rapport and trust;
- listen to the story of those affected and acknowledge any concerns they may have;
- provide contact details and identify how and what frequency the patient/service user /relevant persons wish to be kept updated of the progress of the review and open disclosure process e.g. telephone call, letter;
- facilitate the arrangement of an opportunity for the patient/service user/relevant persons to meet the review team at the outset of the review process;
- facilitate feedback between the patient/service user /relevant persons and the review team (as appropriate) during the review process;
- provide information and offer assistance as appropriate;
- assist the patient / relevant person with preparing for and attending an open disclosure meeting and meetings with the review team;
- provide support during and after these meetings;
- provide information on support services and/or other services available;
- follow up on any actions agreed or clarification requests;
- inform the patient/service user/relevant persons when the report is finalised and agree with them the arrangements required to provide them with a copy of the report.

The person identified should have the necessary skills and experience required to fulfill their role.

- More detailed information on the role of the designated person in supporting patients and their relevant persons in preparation for, during and post open disclosure meetings is available here.
- The designated person checklist is available here.

- The National Open Disclosure Office facilitated a webinar on the Role of the Designated Person in 2023, which provided and overview of the role, and explored some key aspects of this role in various healthcare settings. A recording of this webinar can be watched here.

9.4: Sharing the learning from staff fulfilling the role of the Designated Person

The follow are examples of the role of the designated person in various healthcare settings as shared by staff fulfilling this role.

9.4.1: Examples of the Role of the Designated Person In Acute Hospital Services

9.4.1.1: Case Scenario 1 (Anonymised)

A 70 year old woman "Mary" had been discharged and was awaiting a lift home when she fell in the bathroom on the ward. She sustained a fracture to her left femur. Mary had multiple co-morbidities. All care and support was provided to Mary, everything that happened was explained and she asked for her husband to be contacted. Mary's husband was contacted by telephone and the Senior Doctor and Clinical Nurse Manager spoke to him using the ASSIST model of communication. A formal open disclosure meeting was carried out when the incident was reviewed and the facts established.

The role of the Designated Person in supporting Mary and her family.

	PALS Directorate Referral for Designated Liaison Person	
Name of Patient		
Date of Birth:		
Contact Details for Patient		
Name of NOK		
Contact Details for NOK		
Name of Designated Contact Person if different to NOK		
Contact Details for Designated Contact Person (if known)		
Date of Incident		
Incident Outcome		
Commissioner		
QPS Case Officer		
Contact details of Case Officer		
NIMS/QPULSE NUMBER		
Incident Review Leaflet & Consent Form	Yes ☐	No ☐
Terms of Reference completed (if applicable	Yes ☐	No ☐
Initial Meeting	Yes ☐	No ☐
Open Disclosure Initiated	Yes ☐	No ☐

A Designated Liaison Referral Form was completed by the Risk Advisor.
When asked to assist the designated person visited Mary on the ward and offered support and reassurance.
She contacted Mary's husband by phone introducing her name, role and explaining why she was making contact.
She checked if this was a good time for him to take the call.
She offered an open disclosure meeting with him and Mary together and offered for him to bring an additional support person.
He agreed to meet face to face on the ward with Mary and to bring his daughter as additional support.
The designated person arranged a date and time for the Open Disclosure Team to meet with them and they were advised as to who would be in attendance at the meeting.
The team met with Mary, her husband and their daughter and discussed what happened using the ASSIST model of communication.

The apology was indicated as an important part of this meeting for all of them.

9.4.1.2: Acute Services: Case Scenario Two - The role of the Designated Person in supporting a vulnerable person.

A Designated Person referral form was received from the peri-operative directorate regarding a lady "Jo" who has an Intellectual Disability and is non-verbal. Jo was diagnosed with a ruptured ovarian cyst.
Jo became very upset and there was a delay in making her diagnosis due to communication challenges in the ED.
Jo's relevant person is her Mum who is in her 80s and is in good health. Jo lives in residential care full time.

The designated person arranged the contact with both Jo, her Mum and the manager of the residential unit by teleconference due to logistical challenges.
The designated person discussed the reason for the open disclosure meeting using the ASSIST Model of communication while Jo was provided with the information using visual aids.

The open disclosure meeting was attended by Jo, her mum and the manager of the residential service.
Jo used her health passport to support communication.
The Designated Person helped coordinate the meeting and ensured that Jo and her mother were supported.

Recommendations at the open disclosure meeting:

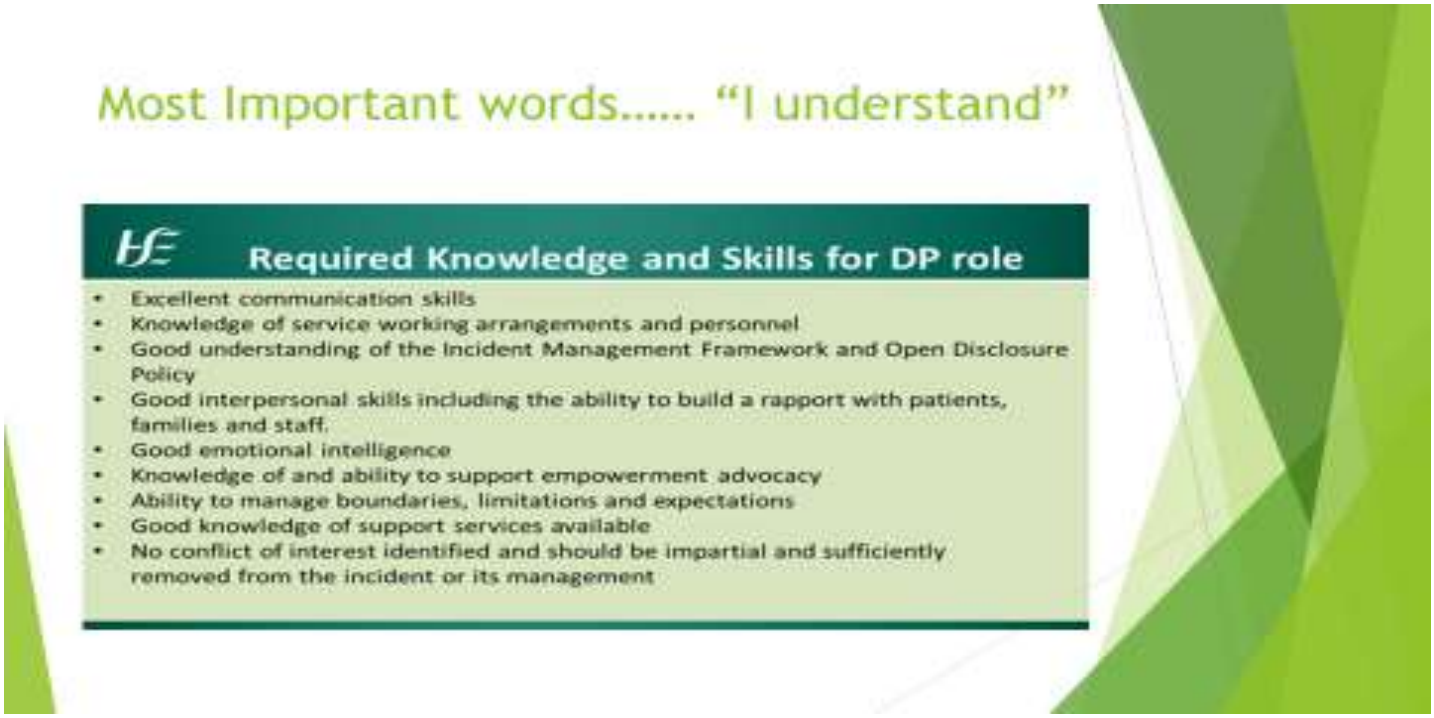
- Staff to be aware of Jo's needs using her health passport
- Training was arranged for staff on non-verbal communication skills and also ASD and ID training.
- The ED department is undertaking an Autism and ID care pathway including a designated parking space, a sensory sensitive cubicle available, signage and sensory boxes for all age groups .

9.4.2: Feedback from Mental Health Services on the Role of the Designated Person in Mental Health Settings

Where, How and When do I start Open Disclosure?

- Always assume the person affected has capacity to understand you might need to tailor your information, so it's understood
- Open disclosure is a journey – remember this if you don't have all the answers be open, transparent and honest
- Don't make it up….
- ASSIST model and more ASSIST but remember that it doesn't have to be linear… don't make it robotic.
- If families or persons affected become upset offer to reconvene- remember open disclosure is a journey.
- Expect anger, frustration, sadness- offer counselling.

Required Knowledge and Skills for the Designated Person (DP) Role



9.4.3: The Role of the Point of Contact in Screening Reviews:

The Point of Contact is largely drawn from the role of the Designated Person in open disclosure. It is sometimes easier to talk about the role of the Point of Contact by looking at the ways it differs to the role of the Designated Person as follows:

- The Point of Contact is provided to all review participants;
- Unlike open disclosure, a Point of Contact is provided to everyone before the possibility that something has gone wrong;
- Reviews are difficult journeys even when they go right;
- The Point of Contact plays an important role in supporting participants through a challenging journey regardless of whether an adverse event took place.

The role of the Point of Contact is to communicate meaningfully with every participant through their review journey.

How we do that:

- By relying on the best practice principles of open disclosure;
- By being prepared to take every journey with every participant;
- By building strong relationship with participants before, during and after their journey.

<u>Before: Every review journey starts at home</u>

Preparing for the Reviews and the Role of the Point of Contact

- Series of in-person training sessions for staff by subject matter experts (Open Disclosure Office & National Healthcare Communications Team).
- Review of previous audit feedback from participants to incorporate learning opportunities.
- Development of training videos in collaboration with the National Healthcare Communications Team to provide always accessible training to staff delivering reviews
- Suite of documentation developed to support participants & guide staff on best practice all based on open disclosure resources

The Journey Begins – The Role of the Point of Contact

- Interaction Logs – identifying concerns, understanding context and circumstances
- Review of relevant screening history records to understand their screening journey so far.
- Early relationship building with dedicated Point of Contact for every participant.
- Early information resources provided.
- Early signposting to independent advocacy services

During: Taking the journey together – the Role of the Point of Contact

- Continuous contact (scheduled and ad hoc) throughout the process ensure continue participant engagement and trust.
- Series of PCSR Team sessions to ensure full awareness and shared understanding of every participant's journey so far, before and after every participant meeting.
- Dedicated PCSR & Point of Contact details and pathway information provided in multiple formats (soft/hardcopy)
- Introductory Meeting: to listen to participant story & questions, to introduce members of PCSR team, to give an overview of PCSR process, to prepare participants for results meeting
- Results Discussion Meeting: to deliver and discuss review findings with a focus on participant needs, questions, and concerns
- Robust documentation, sign-posting materials, and resources provided at relevant pathway milestones to support information given to participants at meetings

After: Ensuring safer, better outcomes – the Role of the Point of Contact

- Follow-up check in call scheduled with all participants following results discussion meeting
- Participant experience evaluation conducted with willing participants for continuous improvement
- Team of Complaints & Feedback Officers independent of PCSR process available to support all participants
- Sign-posting to community support services for all participants and onward referral and safeguarding if required

9.4.4: Learning about the Role of the Designated Person in a Community Multiple Disclosure situation:

Undertaking the role of the designated support person for multiple disclosures was both a challenging and rewarding role. It is advantageous to have previous experience in open disclosure communications and meetings before undertaking this role. The initial contact with families in this role was via telephone with follow-up meetings with family members and the Open Disclosure Team.

It is important to have someone with subject matter expertise to assist in the preparation for the initial communication, such as clinical input into FAQ's, potential questions, language used and explanations given to families is key to building a rapport and trust in the relationship. Consistency in the message is important to families and advising of the HSE policy on communicating with service users and families, known as open disclosure was really important to explain in this communication. Clinical expertise participating in the open disclosure meetings and

having the ability to offer the "T" (Travel) in the ASSIST model of communication is paramount to the experience for families too. No additional request from families was too much and offers of additional referral/reviews from the clinician was the right thing to do and was greatly appreciated by the families involved.

The impact of the Designated Person role on the outcomes and experience of the patients and families (as described by the Designated Person involved).

- Once a rapport with a family is established by the same person, the setting up and participation in an open disclosure meeting becomes easier for families.
- Being clear in commitment to communicating with the families, having agreed timelines and adhering to them, and always explaining the process and the different steps is important.
- Using the various resources created by the National Open Disclosure Team and their expertise was invaluable in supporting colleagues who had never engaged in formal open disclosure meetings.
- When the duty of this role is carried out correctly trust is established and can be maintained throughout, which is of huge importance for families who have received a less than optimal service and their person has been harmed.

Challenges Encountered by the Designated Person.

When initial communication was made with a family, a follow-up call was agreed but the family did not engage further and retreated from the process.

It is hard to know when enough communication and reaching out to a family is enough. We tried to provide a number of opportunities for a family to meet with us after the initial conversation, such as being present in a service at the same time an OPD clinic was underway. This ultimately resulted in the family not attending their appointment which did not benefit anyone.

The learning was that if a family does not respond to two phone calls then a follow-up letter advising of contact details and invitation to engage at a time suitable to them is sufficient.

We were overly eager to comply with policy requirements to the point that it affected the families' treatment as they did not attend.

Section 10: Partnering with Patients and Service Users

HSE Patient Safety Strategy 2019-2024 Commitment 1: Empowering and Engaging Patients to Improve Patient Safety

"We will foster a culture of partnership to maximise positive patient experiences and outcomes and minimise the risk of error and harm. This will include working with and learning from patients to design, deliver, evaluate and improve care".

10.1: Background:

"The HSE is committed to changing how we invite people to participate in health and social care. Our intention is to place people at the heart of our practices, our processes, our programmes, our policies, our systems, and our organisations. We are committed to exploring how we involve them in co-design, co-decision-making, co-implementation, and co-evaluation. We are focused on listening to the patient experience and partnering with those with this experience. We are focused on building better, together". **(HSE website)**

"Developing a more collaborative relationship with patients, service users and individuals is important to:

- *give us a more rounded view and depth of understanding of health policy and leadership;*
- *help to ensure our work resonates with the issues people feel are important in health and care;*
- *model the values that we encourage in the health and care system".* **(Kings Fund UK)**

Some of the steps involved in building effective patient-partnership models include:

i. Educating: Patient education is the basic requirement for patient engagement - helps patients better understand their condition(s) and available treatment options.

ii. Engaging: Effective engagement deepens understanding of overall health and wellness and motivates patients to take a greater role in their health and healthcare services.

iii. Activating: Better informed and better engaged patients become more active in their care and are more likely to participate in preventive care and wellness activities.

iv. Coaching: Coaching helps facilitate the transition from transactional to longitudinal care and helps patients adhere to their treatment and wellness plans, and addresses barriers to adherence.

v. Partnering: Partnership is the final, aspirational step of the patient-provider relationship. Patients become valued partners of the care team who are incentivized to improve health outcomes. Partnership supports whole-person care through real-time, personalized interaction throughout the customer lifecycle. (Medical Economics: Beyond Patient Engagement: How to Effectively Partner with Patients to Optimize Care

10.2: The National Open Disclosure Programme approach to Partnering with Patients and Service Users.

The mission of the National Open Disclosure Programme is to promote and support a culture of honesty and transparency through compassionate and empathic communication with our patients, service users, their families and staff. Central to achieving our mission is our engagement and partnership with patients, service users, patient representative and patient advocacy groups. The overall philosophy and approach of the programme is based on the patient voice and patient rights, needs, expectations and preferences.

10.3: Examples of the involvement of Patients, Patient Representatives and Patient Advocacy services in the work of the National Open Disclosure Programme during 2023

10.3.1: National Open Disclosure Steering Committee:

There are two patient representative members on the National Open Disclosure Steering Committee, one representative from Patients for Patient Safety Ireland and one representative from the CervicalCheck 221+ Patient Support Group. They are very active members on the committee and have input into the actions and decisions made by the committee.

10.3.2: Patient Representatives on Work Streams and Working Groups:

The National Open Disclosure Team and Incident Management Team aim to have patient representatives/patient advocacy representatives on all relevant work streams and working groups. See list below of the working groups/work streams with patient representative/patient advocacy representation during 2023.

Name of Working Group or Work Stream	Patient Representatives	Patient Advocacy Representatives
Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 HSE and HSE-funded Implementation Working Group	Yes x 2	Yes x 1
Patient Safety Act Open Disclosure / Incident Management Implementation Work Stream	No - Patient representative request submitted New Resources for the Act submitted to PFPSI for review and input.	Yes x 1
Patient Safety Act Part 5 Reviews Implementation Work Stream	Yes x 1	No
Patient Safety Act Clinical Audit Work Stream	Yes x 1	No
Open Disclosure Performance Measurement Work Stream 1 – Developing a KPI for the Patient Safety Act	Yes x 2	Yes x 1
Open Disclosure Performance Measurement Work Stream 3 – Measuring the Patient Experience of Open Disclosure	Yes x 2 plus x 1 PALS representative	Yes x 1

10.3.3: Patient Involvement in the Open Disclosure webinar series during 2023

Invitations are sent to members of Patients for Patient Safety Ireland (PFPSI), the National Patient Forum, staff from the Patient Advocacy Service, National Advocacy Service, SAGE and other advocacy services to attend the webinars facilitated by the National Open Disclosure Office. These webinars are regularly attended by representatives from all of these groups who engage proactively in the chat and question and answer sections of the webinars.

In addition to attendance, patient representatives and patient advocacy representatives have been involved in the facilitation of some of the webinars in the panel discussions as follows:

- Learn Together: Patient Involvement in the Incident Management Process
- The Role of the Designated Person in Incident Management and Open Disclosure

The Learn Together webinar had a strong focus on how we can improve learning by supporting the involvement of patients and families in reviews/investigations undertaken following patient safety incidents.

10.3.4: Patient Involvement in Open Disclosure Themed Week 2nd to 8th October 2023.

Given the theme for Open Disclosure Themed Week 2023 ***"'Engaging Patients for Patient Safety – Elevating the Voice of Patients"*** the National Open Disclosure Team wanted to ensure that the important messaging throughout this week came from the voice of patient representatives and patient advocates.

This involved a lot of planning and preparation with patient representatives and patient advocacy services including the recording of a number of videos and agreeing the daily messaging.

Each day of the Open Disclosure Themed Week (Monday to Friday) included videos and messaging from patient representatives and patient advocates as follows:

Date	Theme	Examples of Patient and Patient Advocacy Involvement
Monday 2nd October, 2023	The Patient's and Service-User's Perspective	Video from PFPSI with supportive messaging released on social media. Video produced with members of PFPSI on the importance of open disclosure for patients and their loved ones. Video produced by Patient Advocacy Service and released on Social Media called **"Open Disclosure and the Patient Advocacy Service – The Advocates Role"** National Screening Service published a video by their Patient and Public Partnership (PPP) about listening and responding to create a safer, more inclusive service. "**Open Disclosure is the right thing to do"** video produced with PFPSI released on social media.

Date	Theme	Examples of Patient and Patient Advocacy Involvement
Tuesday 3rd October, 2023	Patient and service-user involvement in the incident management and review process	Video from PFPSI with supportive messaging released on social media. Video produced with members of PFPSI on the importance of patient involvement in the incident management process and the early appointment of a key contact person. Social media messaging by PFPSI. "**Open Disclosure is the right thing to do"** video produced with PFPSI reposted on social media.
Wednesday 4th October, 2023	Leadership in Open Disclosure and Patient Safety	Video from PFPSI with supportive messaging released on social media. Video produced with members of PFPSI on how all staff have a role as leaders in implementing open disclosure. Video developed by Patient Advocacy Service and shared on social media about Leadership in Open Disclosure and Patient Safety "**Open Disclosure is the right thing to do"** video produced with PFPSI reposted on social media.
Thursday 5th October, 2023	The Patient Voice in the formulation of Open Disclosure legislation and policy	Video by Bernie O'Reilly (Patient Advocate and member of PFPSI) and Stephen Teape (221+ Group) with supportive messaging on the importance of the patient voice in the formulation of policy and legislation released on social media. National Screening Service patient story shared on social media. "**Open Disclosure is the right thing to do"** video produced with PFPSI reposted on social media.
Friday 6th October, 2023	Staff Support	Video from PFPSI with supportive messaging released on social media. Video produced with members of PFPSI on how the support provided by managers and teams can significantly impact on how staff respond to and recover from patient safety incidents.

Date	Theme	Examples of Patient and Patient Advocacy Involvement
		Video shared on social media by National Screening Services as part of Themed Week emphasising how patient and public representatives are equal partners in the work that we share and decisions that we make. "**Open Disclosure is the right thing to do"** video produced with PFPSI reposted on social media.

Members of Patients for Patient Safety Ireland with the HSE Open Disclosure Team

10.3.5: Performance Measurement Work Stream 3: The Development of an Open Disclosure Patient Experience Survey or other assessment tool involving contribution from patient representatives and patient advocates.

This is considered to be a critical piece of work in relation to developing an open disclosure performance measurement programme as ultimately it is the lived experiences of patients and families that will inform the HSE on the impact of the implementation of the HSE Open Disclosure Policy, legislation, training programmes and resources.

This work stream is tasked with

(i) the development of a patient experience survey or other assessment tool to measure patient's/relevant persons' experience following the open disclosure process to be designed and implemented and

(ii) the agreement of governance processes for the management of the patient experience survey process, data collection and analysis.

See Section 5 for more information on this programme of work.

10.3.6: Presentation to members of the 221+ Group

The National Open Disclosure Lead was invited to provide an update to the group on developments in the National Open Disclosure Programme since matters arising in CervicalCheck in 2018 and how the 221+ evaluation report has informed these developments /changes. This update was provided on 17th October, 2023.

10.3.7: Patient Advocacy:

The National Open Disclosure team continued to work very closely with and maintain very positive working relationships with patient advocacy services throughout 2023.

Patient Advocacy Service (PAS): Regular meetings were held with senior staff in PAS, the Assistant National Director (AND) for Incident Management and the General Manager of the National Open Disclosure Office. The purpose of these meetings is to (i) provide updates on the work of the Incident Management and Open Disclosure team and PAS, (ii) discuss trends or concerns arising in the complaints and incident management process and (iii) work together in an effort to address any issues arising.

An open disclosure 3 hour workshop was facilitated by the Open Disclosure Training Team for members of PAS in February 2023.

Meetings were arranged with PAS to plan and agree how they would support the Open Disclosure Themed Week 2023 and significant contribution was made by PAS during the week as demonstrated in **10.3.4** above.

PAS staff have been actively involved in the open disclosure webinar series in both attendance and in facilitation of panel discussions.

PAS is promoted in the "Resources for Patients and Service Users following an Incident" booklet developed by the National Open Disclosure Office – available here.

National Advocacy Service (NAS): Representatives from NAS are invited to and attend the open disclosure webinar series. NAS is promoted in the "Resources for Patients and Service Users following an Incident" booklet developed by the National Open Disclosure Office – available here

Training: The role of patient advocacy is included in open disclosure training programmes and it is included in the programme content for the planned training on the Role of the Designated Person which will be rolled out during 2024.

10.3.8: Patients for Patient Safety Ireland:

Patients for Patient Safety (PFPS) is a World Health Organisation (WHO) initiative aimed at improving patient safety. Networks of PFPS exist in many countries.

PFPSI is a group of committed individuals representing, patients, their families, service users, healthcare providers, and health services executives. Some members have experienced harm to themselves or their loved ones. All are dedicated to using these unique experiences to bring about improvements in the healthcare system.

They advocate for person centred care through collaboration with all stake holders, including the patient, across all levels of policy development, implementation, evaluation, design and delivery of services.

PFPSI work very closely with and are hugely supportive to the National Open Disclosure Team and Programme. Their level of engagement and support for the programme throughout 2023 is highlighted in 10.3.2-10.3.5 above.

This group continually engage in and promote open disclosure activities and events.

Section 11: Stakeholder Involvement

HSE Patient Safety Strategy 2019-2024 Commitment 2: Empowering and Engaging Staff to Improve Patient Safety
"We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety".

11.1: Introduction

"Stakeholders are the key component of any project and organisation. Their contribution and engagement ensure the success of any project. Stakeholders are people interested in the results, affected by the deployment and results and operational users of the business processes and tools.
Effective engagement with stakeholders translates the needs and requirements of the business into goals and ensures every one related and relevant to the project is on board. Each stakeholder has a unique perspective on how the project and organisational success can be achieved. Shared understanding and consensus are vital for building positive momentum and vision for the project.

Some of the effective techniques of stakeholder engagement include:

- *Clear consistent communication*
- *Outlining the engagement required from stakeholders*
- *Building the project around the engagement*
- *Identifying the benefits and wins for each stakeholder*
- *Identifying the major ways in which the project can help the business*

Creating an effective process of engagement enables us to foster lasting, mutually beneficial relationships that will improve organisational morale, reputation, and business outcomes". (**Khan S, 2020, Importance of stakeholder engagement in projects).**

11.2: Stakeholder Involvement in the National Open Disclosure Programme

Ensuring that all the right stakeholders have been included and timely, informed communications and collaborations with these stakeholders has been an integral part of the implementation of the HSE Open Disclosure Policy and Programme to date. From the outset the National Open Disclosure Team have engaged with a number of stakeholders and have steadily extended the collaboration with various stakeholders as the project has progressed. These stakeholders include HSE services, HSE funded services, professional and regulatory bodies, indemnifying bodies, trade unions, patient representative and patient advocacy groups, royal colleges, training bodies, the Department of Health and other government agencies.

The relationships established with these stakeholders has been critical in driving the importance of open disclosure, embedding open disclosure in ways of working, improving the uptake of open disclosure training and the implementation of the HSE Open Disclosure Policy.

11.3: Stakeholder Engagement during 2023

The HSE National Open Disclosure Team continued to work proactively with many internal and external stakeholders, on an on-going basis throughout 2023 as part of the implementation strategy for the National Open Disclosure Policy and Programme. The type of collaboration varied from provision of training, attending meetings, engaging in and supporting various work streams, presentations at study days/conferences/webinars, providing and receiving data, embedding open disclosure in policies, curriculums, systems and programmes, responding to queries, providing support and guidance, supporting local policy development and sharing learning.

The following is a list of *some* of the engagements during 2023 with various internal and external stakeholders:

Organisation	Summary of engagement
HSE Services	• National training programme supported across all HSE and HSE funded services. • Quarterly update meetings with Open Disclosure Leads across all service areas. • Quarterly newsletters circulated to all service areas. • Quarterly and annual training reports circulated to all service areas. • The National Open Disclosure Programme Annual Report for 2022 was published on the open disclosure section of the HSE website and provides an update of the work of the office. • Open disclosure webinar series – there are currently **5401** persons on the invitation list to the webinar series from across all HSE, HSE funded services, patient advocacy and patient representative groups and external agencies. Staff circulate these invitations further to members of their teams. 8 webinars were facilitated during 2023. • There is representation from HSE services on the National Open Disclosure Steering Committee (NODSC) and the Performance Measurement works streams. • There are Open Disclosure Leads in all service areas and site leads in acute hospitals. • There are Open Disclosure Trainers in all service areas. • There is a designated open disclosure office email address from which the office staff respond to queries, invitations, feedback, requests for advice, requests for training and requests for resources for all HSE and HSE funded services. • Onsite consultation was provided by the National Open Disclosure Team for staff in 2 service areas to support them in preparing for and managing complex open disclosure meetings. Telephone/email consultation is regularly provided for staff in relation to the management of open disclosure in various healthcare settings and situations. • Staff from the open disclosure team are involved in supporting 3 national workgroups. • The Open Disclosure Themed Week was organised and facilitated to support and deliver key messaging in relation to open disclosure across all service areas. Staff from the National

Organisation	Summary of engagement
	Open Disclosure Office and wider Incident Management Team were out in sites supporting promotional and training events. • Two workshops on open disclosure were facilitated at the National Safeguarding Office Learning and Development Seminar in October 2023.
Department of Health (DOH)	• There is ongoing communication between the National Patient Safety Office (NPSO) and the HSE Incident Management/Open Disclosure Team. • There is representation from the National Patient Safety Office (NPSO) on Work stream 1 of the Open Disclosure Performance Measurement Programme (development of a KPI for the Patient Safety Act). • The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 was signed into law on 3rd May 2023. There are regular meetings with the Department of Health on matters pertaining to preparation for the implementation of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 including providing legal clarifications on the provisions of the Act. Key staff from the NPSO in the DOH attended a face to face workshop on preparation for implementation of the Act 0n 17th August, 2023. • The DOH launched the National Open Disclosure Framework on 19th October 2023 at the NPSO Conference and there was a strong focus on the topic of open disclosure at this event. This included a facilitated panel discussion on open disclosure developments by Dr Orla Healy on the afternoon of the conference. Panel members included staff from the HSE Incident Management/Open Disclosure Team.
Voluntary Agencies	• The Federation of Voluntary Bodies are included in all general communications from the National Open Disclosure Office and staff working in these services are invited to training/ information/educational events. • There are Open Disclosure Leads identified in many of the voluntary agencies with a list of these leads available on the open disclosure website here. • Training programmes are supported and train the trainer programmes provided for staff working in HSE funded services. • Funded services engaged in promotional activities during Open Disclosure Themed Week. • A 1 hour webinar on open disclosure was facilitated by the AND for Incident management and the HSE Open Disclosure Lead for the Voluntary Healthcare Agencies Risk Management Forum's (VHARMF) Risk Managers Advisory Group in December, 2023.

Organisation	Summary of engagement
State Claims Agency(SCA)	• There is representation from the SCA on the National Open Disclosure Steering Committee and Work Stream 1 of the Open Disclosure Performance Measurement programme. • Staff from the SCA regularly attend open disclosure webinar events. • There are staff representatives from the State Claims Agency Clinical Indemnity Scheme on the Patient Safety Act NIMS work stream with a focus on the technical changes required on NIMS to support the provision of data on compliance with the Act. • Key staff from the SCA attended a face to face workshop on preparation for implementation of the Act on 17th August, 2023. • The SCA actively promoted open disclosure during Open Disclosure Themed Week.
Royal College of Physicians Ireland (RCPI)	• The National Open Disclosure Team promote the RCPI "Gateway to Communication" programme in training and education events. • The RCPI award CPD for the open disclosure E-learning programmes, face to face skills training, webinars and train the trainer programme.
Royal College of Surgeons Ireland(RCSI)	• The National Open Disclosure Steering Committee included representation from the RCSI*. • x 2 webinars were facilitated by staff from the RCSI during 2023 as part of open disclosure webinar programme as follows: o "*Managing Conflict - Tips and tools for resolving conflict with colleagues*" by Professor Eva Doherty on 13/09/2023 and o "Positive Health and Wellbeing: What does the science tell us"? by Professor Ciaran O'Boyle on 15/03/2023. • The National Open Disclosure Lead supported x 3 full day Mastering Adverse Events simulation training events in the RCSI during 2023 with further days planned for 2024. • The Incident Management and Open Disclosure Team facilitated a 2 hours presentation on the RCSI MSc Healthcare Management - Contribution to Quality & Risk Management Module. ***The NQPSD wishes to acknowledge the significant contribution made by the late Professor Sean Tierney (RIP) to the work of the National Open Disclosure Steering Committee and National Open Disclosure Programme generally. He is fondly remembered and sadly missed by committee members.**
Royal College of Anaesthetists	• The National Open Disclosure Lead facilitated a presentation on Open Disclosure at the Irish Orthopaedic Anaesthetists' Association Conference on 01/12/2023.

Organisation	Summary of engagement
General Practice	• Open disclosure is included in training programmes for GP trainees and GP Principals. • An open disclosure workshop was facilitated for GP Tutors at their masterclass in January 2023.
University College Dublin (UCD)	• Open disclosure workshop and assessments of candidates facilitated on the Graduate Diploma in Quality and Risk Management. • Pilot project commenced with UCD medical training programme on the inclusion of a 2 hour open disclosure workshop for 4th and 5th year medical students, the inclusion of open disclosure in their MCQ examinations and the inclusion of open disclosure in 5th year OSCEs. A workshop was delivered on 04/12/2023 to **296** medical students with inclusion of open disclosure related questions in their MCQ examination on the same week. Further work is planned for 2024.
National University of Ireland, Galway (NUIG)	• A 2 hour open disclosure overview and update was facilitated by a member of the Open Disclosure Training Team on the NUIG Advanced Nurse Practice and Medicinal Prescribing Course. • A 2 hour open disclosure overview and update was facilitated by a member of the Open Disclosure Team on the NUIG Clinical Governance Course.
The National Doctors Training Programme (NDTP)	• Dr Brian Kinirons, Medical Director of the NDTP is a member of the National Open Disclosure Steering Committee. • Dr Kinirons is also a member of Open Disclosure Performance Measurement Programme Work Stream 4 (Training). • The NDTP continues to support the National Open Disclosure Team in promoting mandatory open disclosure training arrangements for NCHD's through the Doctors Integrated Management System / National Employment Record (DIME / NER). • The NDTP provide reports to the National Open Disclosure Office on a quarterly basis on the number of NCHDs who have uploaded evidence of attendance at open disclosure training to the Doctors Integrated Management E-portal/National Employment Record. • The NDTP actively promoted open disclosure prior to and during Open Disclosure Themed Week.
The Forum of Postgraduate Training Bodies	• Professor Martin McCormack, (Secretary of the Forum of Postgraduate Medical Training Bodies of Ireland) is a member of Open Disclosure Performance Measurement Programme Work Stream 4 (Training). • Work with the Forum on providing data on the uptake of open disclosure training provided by the colleges, exploring the inclusion of open disclosure training in medical

Organisation	Summary of engagement
	staff induction and pre-induction programmes and calling out open disclosure in the "Memorandum of Agreement" with Training Bodies and in site accreditation standards.
Irish Hospital Consultants Association (IHCA)	• An update on developments in open disclosure (provided by the National Open Disclosure Office) was included in the IHCA Annual Report 2023.
HIQA and Mental Health Commission(MHC)	• There is representation from HIQA on Open Disclosure Performance Measurement Work Stream 3 (Patient Experience). • Preparation for commencement of the Patient Safety Act has involved meetings and collaboration with HIQA and the MHC.
Medical Council	• Input was provided by the Open Disclosure Team to the revision of the Guide to Professional Conduct and Ethics for Registered Medical Practitioners. • A presentation on open disclosure was facilitated at the Medical Council launch of the 2024 Guide to Professional Conduct and Ethics for Registered Medical Practitioners. • There is Medical Council representation on Work Stream 4 of the Open Disclosure Performance Measurement programme (Training).
Nursing and Midwifery Planning and Development Unit (NMPDU) Centre of Nursing and Midwifery Education (CMME)	• The National Open Disclosure Steering Committee includes representation from the NMPDU. • Open Disclosure training is delivered in various CNME's across the country. • There is representation from the CNME on Work Stream 4 of the Open Disclosure Performance Measurement Programme (training). • There is representation from NMPDU on the Patient Safety Act National Implementation Working Group.
Patient representatives and patient advocacy groups	• See Section 10 for details
National Screening Services (NSS)	• There is representation from NSS on the National Open Disclosure Steering Committee and Work Stream 1 of the Open Disclosure Performance Measurement Programme. • There are two members of the National Open Disclosure team on the CervicalCheck implementation group. • There is an Open Disclosure Lead for screening services.

Organisation	Summary of engagement
	• The National Open Disclosure Team supported the development of a training programme for the communication of personal care reviews and facilitated 4 workshops during 2023 on the management of the various stages of the personal care review process.
Pharmacy	• A 1.5 hr presentation on open disclosure was facilitated at the Boots Supervising Pharmacists Conference in February 2023. • A 2 hour open disclosure overview and update was facilitated by a member of the Open Disclosure Training Team on the NUIG Advanced Nurse Practice and Medicinal Prescribing Course.
Health Managers Institute	• A 1 hour webinar on open disclosure was facilitated for HMI by the AND for Incident Management and the HSE Open Disclosure Lead. • An article on Open Disclosure was submitted to the HMI Journal.

Section 12: Supporting staff in the implementation of the HSE Open Disclosure Policy and following patient safety incidents.

HSE Patient Safety Strategy 2019-2024 Commitment 2: Empowering and Engaging Staff to Improve Patient Safety

"We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety".

12.1: Background

Commitment 2 of the HSE Patient Safety Strategy (2019-2024) outlines our ambition for a compassionate, just, fair and open culture in the HSE and states that *"Staff must be actively encouraged to speak up for safety, feel psychologically safe, be involved in decisions which affect the safe delivery of care and be provided with the skills, support and time to engage in patient safety improvement initiatives"*.

The HSE Incident Management Framework (2020) defines "Just Culture" as one which refers to *a* values based supportive model of shared accountability. It states that individual staff should not be held accountable for system failings over which they have no control. Instead, organisations need to encourage staff to report such incidents and near-misses and apply system-learning to improve patient safety.

The HSE Incident Management Framework (2020) also acknowledges that within a just culture, acts of deliberate harm and complete disregard of policies and procedures without due consideration by staff are not acceptable which is equally important to maintain patient safety. A just culture approach is key in gaining a shared understanding of how safety is achieved within any complex organisation. (HSE website)

12.2: HSE Commitment:

The HSE is committed to creating an environment within the HSE that encourages staff to speak up whether this involves the reporting of incidents or raising issues that pose a risk to the safety of service users, without fear of reprisal. It is essential that our staff feel confident to report incidents so that there is learning from such events and the healthcare system is improved. (HSE website).

12.3: HSE Just Culture Guide:

The HSE Just Culture Guide was developed to support consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents. The purpose of the guide is to support a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

Consultation on the development of the National Open Disclosure Framework by the DOH demonstrated that 97% of respondents agreed that organisations should promote a "just culture"

12.4: The Principles of Open Disclosure:

The principles of open disclosure in the HSE Open Disclosure Policy 2019 and in the National Open Disclosure Framework 2023 include the requirement for health care providers to provide immediate and ongoing support to all those involved in and/or affected by patient safety incidents and adverse events which includes patients/service users, their relevant persons and staff.

Principle 3: Supporting Health and Social Care Staff

• While patients/service user and their support person must be at the heart of the open disclosure process following a patient safety incident or adverse event, it is important that staff involved and affected by these incidents are identified and supported on an ongoing basis.

• Staff should be encouraged, empowered, and obliged to recognise and report patient safety incidents and adverse events. Staff should be supported and prepared to take part in open disclosure through easily accessible information, communication skills training and education, and supportive procedures. Staff should be fully supported through the open disclosure process.

• Open disclosure involves multi-disciplinary accountability and responses and relates to all staff groups and not just clinical staff. Staff at managerial, clinical, and non-clinical levels must be identified to lead the process and all staff have a role in supporting patients/service users, their support persons, and other staff after a patient safety incident or adverse event.

• Staff must recognise and understand their obligations in relation to open disclosure and that a failure to disclose may result in consequences. Providers must include in their policies, mechanisms to empower staff to report patient safety incidents or adverse events and communicate openly with patients/service users when patient safety incidents or adverse events occur. (National Open Disclosure Framework 2023 DOH)

As part of the National Quality and Patient Safety Incident Management team, the National Open Disclosure Programme works with the wider team to raise awareness of, promote and support the provision of timely and ongoing support for staff involved in/affected by patient safety incidents. The team focuses on the provision of training, support and resources for organisations and staff to assist them in preparing for and engaging in effective open disclosure discussions with patients, service users and their relevant persons.

12.5: Examples of how the National Open Disclosure Programme supported staff throughout 2023

The following are examples of the support provided to staff and organisations during 2023 in relation to the implementation of the HSE Incident Management Framework and open disclosure programme, in preparing for and managing open disclosure meetings and promoting the support of staff involved in/affected by patient safety incidents.

12.5.1: Training:

- The development and delivery of training programmes for all staff to increase their confidence and to provide a structured approach to engaging in open discloure meetings. Various training progammes are provided to meet the needs of different staff groups and roles. Scenarios used in face to face skills training are selected carefully so that the group can relate to them in relation to their role and workplace and oportunities are provided to practice open disclosure discussions in these sessions.
- All training programmes include education on staff support and the “ASSIST ME” Model of staff support is discussed and promoted.
- The national training team provide support to local trainers and develop and providing access to a wide range of training and implementation resources.
- Training programmes are continualy evlauated and updated.
- All training programmes are CPD/CEU accredited.
- A Train the Trainer programme is facilitated to enable improved access to open disclosure training at local level.
- A full range of training resources is available here.

12.5.2: Resources:

- The National Open Disclosure Office develop and provide access to a number of resources to support staff and organisations in managing open disclosure meetings. The open disclosure Quick Reference Guide and Toolkit is a particularly helpful document to support organisations and staff when preparing for, facilitating and following up on an open disclosure meeting and this resource is utilised across the system.
- There is constant engagement with Open Disclosure Leads and staff across the system to identify and develop resources that will assist them in the implementation of the policy;
- An archive of these resources is maintained;

- Staff are made aware of the resources available via regular communications e.g. newsletters, training events, Open Disclosure Themed Week.

- The National Open Disclosure Office developed a resource outlining the resources available to support staff following incidents "List of Support Services and Resources for Staff following an Incident 2022" available here;

- The National Open Disclosure Office developed its own "ASSIST ME" staff support booklet which is available on the website and which is provided during open disclosure training. The programme has also developed a summary"ASSIST ME" poster which is also available on the website. These are promoted via communications and on social media.

- The Open Disclosure Implementation Toolkit was completed and launched in 2023. This tool guides services on how to approach implementation and includes an in-built quality improvement plan and annual report guidance. This toolkit is available here

- There is a page dedicated to staff support on the website and linking to all of the support services and resources available for staff – view webpage here.

- A full range of staff support resources is available here.

12.5.3: Webinars:

- The National Open Disclosure Office facilitate webinars on open disclosure related topics based on feedback from attendees. These webinar are recorded and the recordings and power point presentations are published on the open disclosure section of the HSE NQPSD website so that they may be accessed at a later date. Webinar powerpoInt presentations and recordings are available here;

- Two webinars were facilitated during 2023 which were specific to staff health and wellbeing as follows:

  - Positive Health and Wellbeing: What does the science tell us? - Professor Ciaran O'Boyle, RCSI.
  - Managing Conflict - Tips and Tools for Resolving Conflict with Colleagues – Professor Eva Doherty, RCSI.

- All webinars are CPD/CEU accredited.

12.5.4: Communications and publications

The National Open Disclosure Office provide regular updates to staff working across all health and social care services via:

- The development, cirulation and publication of quarterly programme newsletters avalable here;

- The publication of the programme annual report available here;

- The development and cirulation of quarterly training reports and publication of an annual training report available here;
- Quarterly meetings and updates provided to Open Disclosure leads;
- Abstract and poster display at the RCSI Patient Safety Conferrence;
- The publication of open disclosure related articles in various journals – see Section 13 for a list of 2023 publications;
- Responding to all email queries and requests via individual email addresses and the dedicated open disclosure office email address opendisclosure.office@hse.ie;
- Providing on-site consultation/training, telephone and written advice relating to all open disclosure topics and particulary in supporting staff in preparing for and engaging in complex open disclosure meetings.

12.2.5: Events

- Facilitating and supporting the Open Disclosure Themed Week which included a day focused on the theme of staff spport. See section 8 of this report for more details.

Section 13: Publications during 2023

The following is a list of publications by the HSE National Open Disclosure Programme during 2023.

- Open Disclosure Programme Annual Report 2022 available here
- Open Disclosure Programme Annual Report 2022 Executive Summary available here
- Open Disclosure Programme Annual Training Report 2022 available here
- Open Disclosure Programme Quarter 1 2023 Training Report
- Open Disclosure Programme Quarter 2 2023 Training Report
- Open Disclosure Programme Quarter 3 2023 Training Report
- Open Disclosure Programme Quarter 1 2023 Newsletter available here
- Open Disclosure Programme Quarter 2 2023 Newsletter available here
- Open Disclosure Programme Quarter 3 2023 Newsletter available here
- Open Disclosure Programme Quarter 4 2023 Newsletter available here
- Open Disclosure Submission to IHCA Annual Report 2023
- Open Disclosure Submission to Radiocht Newsletter 2023 (available to members only)
- RCSI Patient Safety Conference Abstract and Poster
- Open Disclosure Themed Week 2022 raises awareness - Health Matters Spring Edition 2023 – available here
- Patient Safety Act Embeds Culture of Open Disclosure – Health Matters Autumn Edition 2023 available here
- Open Disclosure Themed Week 2023 sees an uptake of training - Health Matters Winter Edition 2023 available here
- Open Disclosure Themed Week 2023 NQPSD Quality and Safety Matters Newsletter Nov 2023 available here
- Insights on the Patient Safety Act and National Open Disclosure Framework NQPSD Quality and Safety Matters Newsletter, Nov 2023 available here
- Open Disclosure Resources - Win Magazine Quality and Safety Column Dec 2022/Jan 2023 (available to members)
- Roles and Responsibilities of Managers in Open Disclosure and Incident Management - Health Manager Journal September 2023 available here
- Developments in relation to Open Disclosure - Health Manager Journal available here
- Open Disclosure 'The Right thing to do" NQPSD Quality and Safety Matters Newsletter available here

Appendix A: Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023: List of Notifiable Incidents

SCHEDULE 1 NOTIFIABLE INCIDENTS PART 1

1.1: Surgery performed on the wrong patient resulting in unintended and unanticipated death which did not arise from, or was a consequence of, an illness, or an underlying condition, of the patient, or having regard to any such illness or underlying condition, was not wholly attributable to that illness.

1.2: Surgery performed on the wrong site resulting in unintended and unanticipated death which did not arise from, or was a consequence of, an illness, or an underlying condition, of the patient, or having regard to any such illness or underlying condition, was not wholly attributable to that illness.

1.3: Wrong surgical procedure performed on a patient resulting in an unintended and unanticipated death which did not arise from, or was a consequence of, an illness, or an underlying condition, of the patient, or having regard to any such illness or underlying condition, was not wholly attributable to that illness.

1.4:Unintended retention of a foreign object in a patient after surgery resulting in an unanticipated death which did not arise from, or was a consequence of, an illness, or an underlying condition, of the patient, or having regard to any such illness or underlying condition, was not wholly attributable to that illness.

1.5: Any unintended and unanticipated death occurring in an otherwise healthy patient undergoing elective surgery in any place or premises in which a health services provider provides a health service where the death is directly related to a surgical operation or anaesthesia (including recovery from the effects of anaesthesia) and the death did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient.

1.6: Any unintended and unanticipated death occurring in any place or premises in which a health services provider provides a health service that is directly related to any medical treatment and the death did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient.

1.7: Patient death due to transfusion of ABO incompatible blood or blood components and the death was unintended and unanticipated and which did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient.

1.8: Patient death associated with a medication error and the death was unintended and unanticipated as it did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient.

1.9: An unanticipated death of a woman while pregnant or within 42 days of the end of the pregnancy from any cause related to, or aggravated by, the management of the pregnancy, and which did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient.

1.10: An unanticipated and unintended stillborn child where the child was born without a fatal foetal abnormality and with a prescribed birthweight or has achieved a prescribed gestational age and who shows no sign of life at birth, from any cause related to or aggravated by the management of the pregnancy, and the death did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the child.

1.11: An unanticipated and unintended perinatal death where a child born with, or having achieved, a prescribed gestational age and a prescribed birthweight who was alive at the onset of care in labour, from any cause related to, or aggravated by, the management of the pregnancy, and the death did not arise from, or was aconsequence of (or wholly attributable to) the illness of the child or an underlying condition of the child.

1.12: An unintended death where the cause is believed to be the suicide of a patient while being cared for in or at a place or premises in which a health services provider provides a health service whether or not the death was anticipated or arose from, or was wholly or partially attributable to, the illness or underlying condition of the patient.

SCHEDULE 1 NOTIFIABLE INCIDENTS PART 2

2.1: A baby who—

(a) in the clinical judgment of the treating health practitioner requires, or is referred for, therapeutic hypothermia, or

(b) has been considered for, but did not undergo therapeutic hypothermia as, in the clinical judgment of the health practitioner, such therapy was contraindicated due to the severity of the presenting condition.

Appendix B: Patient Safety Act HSE Implementation Working Group Membership as at 08/11/2023

Name	
Dr Orla Healy (Chair)	National Clinical Director, National Quality and Patient Safety Directorate (NQPSD)
Alan O'Gorman	Director of Nursing, University of Limerick Hospitals Group
Angela Tysall	GM NQPSD Incident Management/Open Disclosure Team
Aideen Quigley	Quality & Safety Manager, National Women and Infants Health Programme (NWIHP)
Bernie O'Reilly	Chairperson: Patients for Patient Safety Ireland
Bríd Moran	Information Manager, National Office of Clinical Audit (NOCA)
Carole Broadbank	Chief Officer, CHO 8
Colette Brett	National Screening Services (NSS), Head of Quality, Safety and Risk
Colette Tully	Executive Director, NOCA
Dara Purcell	Solicitor and Chartered Secretary, HSE Board
Dr Alan Smith	NSS Specialist in Public Health Medicine
Dr Cliona Murphy	Clinical Lead NWIHP
Ellie Southgate	QPS Open Disclosure Manager
Fidelma Browne	AND HSE Communications
Fiona Melia	Health and Social Care Professionals Development Manager, NHSCP Office
Fiona Murphy	CEO, NSS
Florina Rizoaica	QPS Incident Management
Georgina Cruise	National Manager, Patient Advocacy Service
Grace Turner	NSS Head of Strategy, Business and Projects
Irene O'Hanlon	General Manager, QPS Community
Loretta Jenkins	GM QPS Incident Management
Lorraine Schwanberg	AND NQPSD IM – Deputy Chair
Lucy Nugent	CEO Tallaght University Hospital
Margaret Brennan	AND QPS Acute Services
Marie Kinsella	Philip Lee, Legal Services
Mary Gallagher	QPS NIMS Project Lead
Stephen Teap	Patient Representative
Susan Moloney	Q&S Manager, RCSI Hospital Group
Frances Ni Fhlannchadha	Acute Hospital, TUH.
Maureen Flynn	Office of the Nursing and Midwifery Services Director (ONMSD)
Ronan Buckley (for Maria Lordan Dunphy)	Clinical Audit Facilitator, National Centre for Clinical Audit, HSE
Majella Daly	AND, National Centre for Clinical Audit
Gerry Clerkin	Head of Service Quality Safety & Service Improvement CH CDLMS
Mary Friel	NQPSD Incident Management/Open Disclosure Team
Catherine Hand	NQPSD Incident Management/Open Disclosure Team
Kelly McDyer	NQPSD Incident Management/Open Disclosure Team
Sandra Lehman	NQPSD Incident Management/Open Disclosure Team

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar

Oifig an Phríomhoifigigh Cliniciúil

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Office of the Chief Clinical Officer

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