Kare Promoting Inclusion for People with Intellectual Disabilities

Open Disclosures Policy.

Kare Policy Document.

Policy Owner: C.E.O.

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1 Contents

Section 1: Policy

1.1 Background to this Policy

Kare have had an Open disclosures statement in place in the organisation since 2013.
Kare will “fully and openly inform and support service users as soon as possible after an adverse event affecting them has occurred, or becomes known and continue to provide information and support as needed” .
Kare have created their Open Disclosures Policy which aligns to the following legislative practices:

1.1.1 The HSE Open Disclosure Policy

The **HSE** has had an open disclosure policy which sets out how staff should communicate with patients and families following safety incidents. This policy:

- Applies across the HSE and HSE-funded services.
- Establishes **principles, roles and responsibilities** for open disclosure.
- Aims to support staff and patients during the process.
- Encourages a culture of **openness, learning and improvement** following safety incidents.
- Aligns with legal protections under the Civil Liability (Amendment) Act 2017 and the later **Patient Safety Act**.

The updated HSE policy (effective **June 2025**) reinforces these aspects and places further emphasis on training, governance, and consistent implementation across services.

1.1.2 Civil Liability (Amendment) Act 2017

Before the Patient Safety Bill/Act, open disclosure was voluntary but supported by this 2017 Act. It offered a **legal framework** encouraging open disclosure by:

- Allowing healthcare providers to communicate about patient safety incidents.
- Providing legal protection so that **apologies and disclosures are not used as evidence of fault in litigation**.

This was an important step to encourage openness without fear of it being used against clinicians or organisations.

1.1.3 Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023

This is the key piece of legislation advancing open disclosure in Irish health law:

- Passed as a Bill in **2019** and signed into law in **2023**; it commenced on **26 September 2024**.
- It **legislates mandatory open disclosure** for a specified list of serious patient safety incidents (known as *notifiable incidents*).
- It requires healthcare providers — **public (HSE), community, section 38/39, private health and social care services** — to disclose those incidents to patients (or their relevant persons) and, where appropriate, external bodies.
- It sets requirements for **external notification** of such incidents to regulators like HIQA or the Mental Health Commission.
- It also covers **mandatory disclosure of completed patient-requested cancer screening reviews** in HSE National Screening Services.
- The Act amends earlier legislation — including the **Civil Liability (Amendment) Act 2017** — to align legal protections and reporting frameworks.

The purpose is to embed **openness, accountability and learning across the Irish health system**, making it clear that serious harm events must be disclosed and learned from, rather than treated as optional or internal matters.

1.1.4 Links to other policies within Kare:

- Managing Complaints policy
- Incident management policy
- Corporate Safety Statement
- Each Location Site Specific Safety Statements
- Safe administration and management of medication policy
- Safeguarding Vulnerable persons Policy
- Child Protection and Welfare Policy

1.1.5 Definitions:

Open disclosure means an open, consistent, compassionate, honest, and timely approach to communicating with a *person* (patient/service user) and, where appropriate, their *relevant person* following a safety incident or **notifiable incident**.

It emphasises openness, empathy, learning and accountability, and is grounded in the principles of the **Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023**, the **National Open Disclosure Framework 2023**, and the **HSE Open Disclosure Policy 2025**.

Open disclosure includes:

- **Expressing regret and apology** that is personalised, sincere and honest.
- **Keeping the person and relevant person informed** about what happened, the known facts, and the impact on care/treatment.
- **Providing reassurance** about ongoing care and treatment arrangements.
- **Sharing what is being done to understand and learn from the incident** and the steps being taken to try to prevent recurrence.
- **Supporting and engaging with the person and relevant person throughout the process** in a way that minimises additional distress.

The updated policy reinforces that open disclosure is **person-centred and supportive** — both for those affected by the incident and for staff involved in the process — to help prevent **compounded harm** (further emotional distress due to process or communication failures). It also strengthens **governance, roles, supports and procedures** to ensure consistent application across health and social care services.

1.1.6 Under the Civil Liability (Amendment) Act 2017, a safety incident includes:

- **Harm events** — incidents that cause unintended or unanticipated injury/harm.
- **No-harm events** — incidents that occurred but did not result in actual harm.
- **Near miss events** — incidents that could have resulted in harm but were prevented by timely intervention or by chance.

The 2025 policy continues to align with this broad definition, recognising the importance of disclosure even for incidents that did not result in harm, but where harm could reasonably have occurred.

1.1.7 Apology in the Context of Open Disclosure

An **apology** remains a core element of open disclosure and, where appropriate, must be provided. Consistent with the Patient Safety Act and HSE policy:

- An apology is defined as an **expression of sympathy or regret** in relation to the incident.
- It must be **personalised, sincere, honest and compassionate**.
- It should communicate understanding of the person's experience and distress.

The updated HSE policy emphasises that effective apologies are part of **transparent communication and emotional support**, not simply a legal or procedural formality.

1.1.8 Key Enhancements in the 2025 HSE Open Disclosure Policy

The **HSE Open Disclosure Policy 2025**, effective 17 June 2025, replaced the 2019 version and introduces the following enhancements:

a) Alignment with Legislation and National Frameworks

- Implements the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 and the Department of Health's National Open Disclosure Framework 2023.

b) Greater Focus on Compassionate, Supportive Practice

- Emphasis on supporting patients/service users, relevant persons and staff affected by incidents to help prevent further harm.

c) Clearer Roles, Governance and Support Structures

- Defines governance structures, designated roles (e.g., Open Disclosure Clinical & Managerial Champions), and support mechanisms for staff and patients.

d) Standardised Processes and Templates

- Step-by-step disclosure processes, including preparation, meetings, follow-up, documentation and closure.
- Follow-up written communication is now structured as a person-centred summary letter rather than detailed minutes.

e) Training and Competency Requirements

- Mandatory training for all staff, with specific modules and workshops required for those involved in open disclosure.

f) Enhanced Incident Reporting and Audit Tools

- Tools such as the **Incident Management Framework and Open Disclosure Audit Tool** updated to align with the 2025 policy and legislative framework, supporting consistent implementation and accountability.

1.2 Aim of this Policy

The aim of this policy is to ensure that the rights of all people who use the service, and those of relevant persons and staff involved in and/or affected by safety incidents, are upheld and respected. This includes ensuring that communication following a safety incident is honest, open, timely, compassionate and person-centred, and that all individuals are treated with dignity, respect and empathy throughout the open disclosure process.

This policy aims to support a culture of openness, transparency, learning and accountability within the organisation, in line with the HSE Open Disclosure Policy (2025) and the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.

In addition, this policy seeks to:

- Provide clear guidance and practical steps for staff to follow when a safety incident occurs that requires open disclosure.
- Support staff to engage confidently and compassionately in open disclosure, recognising the emotional impact of incidents on both those receiving care and staff involved.
- Ensure that open disclosure is conducted in a consistent, supportive and structured manner, with appropriate follow-up, documentation and learning.
- Promote learning from safety incidents to support continuous quality improvement and reduce the risk of recurrence.

1.3 Scope of this Policy

This policy applies to safety incidents and reflects the primacy of the right of people using the services of Kare to have full knowledge about their support as and when they so wish and to be informed about any failings in that care process, however and whenever they may arise.

This policy is applicable to all staff, volunteers, student placements within Kare.

Open disclosure is an integral component of the incident management process.

1.4 Policy Statements

1.4.1 Kare is committed to fully, openly and promptly informing and supporting service users as soon as practicable after a safety incident or notifiable incident affecting them has occurred or becomes known. Kare will continue to provide clear, honest and timely information, appropriate support, and opportunities for ongoing communication as required.

An apology will be provided, where appropriate, as part of the open disclosure process. Any apology will be personalised, sincere and compassionate, in line with legislative and policy requirements.

1.4.2 In accordance with the Assisted Decision-Making (Capacity) Act 2015, staff will work on the presumption that every person has the capacity to make decisions about their care and participation in the open disclosure process.
A person whose decision-making capacity is in question is entitled to open disclosure on an equal basis with others and must be provided with all necessary supports, including communication and decision-making supports, to facilitate their meaningful involvement.

1.4.3 Open disclosure to a relevant person will be undertaken only with the consent of the person, unless otherwise provided for in legislation. Where consent is given, the relevant person will be involved in a manner that reflects the wishes, rights and best interests of the person.

1.4.4 Kare may assign a designated liaison person to act as a point of contact between the organisation/service and the person and/or relevant person. The role of the liaison person is to:

- Support communication and engagement throughout the open disclosure process
- Facilitate requests for information or clarification
- Ensure continuity, coordination and sensitivity in communications

Note: The designated liaison person will not be directly involved in the review or investigation of the incident, nor will they lead the open disclosure meetings, in order to maintain clarity of roles and avoid conflicts of interest.

1.4.5 Principles of Open Disclosure

In accordance with the **HSE Open Disclosure Policy (2025)**, Kare will adhere to the following **ten principles** when managing open disclosure following a safety or notifiable incident:

- **Acknowledgement**

Kare will acknowledge to the service user that a safety or adverse event has occurred and will initiate the open disclosure process in a timely manner, in line with the HSE Open Disclosure Policy and associated guidance.

- **Truthfulness, Timeliness and Clarity of Communication**

Service users will be provided with information that is **honest, factual, clear and timely**, based on the information known at the time.

Where practicable, the open disclosure process should commence **as soon as possible**, and ideally within **48 hours** of the event occurring or becoming known, taking into account the service user's **physical, emotional and psychological readiness** to receive the information.

- **Apology / Expression of Regret**

An apology or expression of regret is a core component of open disclosure and should be provided where appropriate.

When it is clear, following review, that Kare or its staff are responsible for harm caused to a service user (e.g. medication error), there must be a **clear acknowledgement of responsibility** and an **apology provided as soon as practicable**. Any apology must be **personalised, sincere and compassionate**, in line with legislative provisions.

- **Recognising the Expectations of Service Users**

Service users can reasonably expect to:

- Be fully informed of the known facts and potential consequences of the incident
- Receive explanations in a manner they can understand
- Be treated with empathy, respect, dignity and compassion
- Be supported and involved throughout the open disclosure process
- Professional Support and Just Culture

Kare is committed to promoting a **just culture**, which encourages the reporting of safety incidents, adverse events and near misses without fear of unfair blame.

Staff involved in or affected by an incident can expect to be **supported by the organisation** throughout the open disclosure and incident review process.

- **Risk Management and Systems Improvement**

The management and investigation of safety incidents will be undertaken in line with the **HSE Incident Management Framework** and Kare's internal reporting systems (including Kare CID).

Where appropriate, recommendations will be made and actions implemented to:

- Learn from the incident
- Improve systems and processes
- Reduce the risk of recurrence

- **Multidisciplinary Responsibility**

Open disclosure is a **shared, multidisciplinary responsibility**. Appropriate clinical, professional and managerial staff will be identified to lead, support and participate in the open disclosure process, ensuring a coordinated and consistent approach.

- **Governance**

Kare will ensure that appropriate **governance and accountability structures** are in place to support effective open disclosure. Open disclosure will be integrated with related governance systems, including:

- Incident reporting and management
- Systems analysis and review processes
- Complaints management
- Risk management
- Privacy and confidentiality procedures

- **Confidentiality**

Information arising from safety incidents and open disclosure processes is often sensitive and must be managed with the utmost care.

Service user and staff information is protected by **legal and ethical obligations of**

confidentiality, and all relevant policies, procedures and legislation relating to privacy and confidentiality will be adhered to at all times.

- **Continuity of Care**

Kare will take all reasonable steps to:

- Reassure service users regarding the management of their immediate and ongoing care needs
- Ensure that care will not be compromised as a result of the incident or disclosure
- Facilitate requests for transfer of care to another service or facility, where possible and appropriate

A designated staff member may be identified as a **point of contact** to maintain open lines of communication and keep the service user informed throughout the process.

1.5 Roles and Responsibilities

1.5.1 **The Board of Directors of Kare** have a commitment to safety that promotes a culture of openness, trust and learning between persons who may be affected by adverse events and those delivering and managing the services within where the incident occurs.

- Primary responsibility and accountability for the effective management of adverse events including the open disclosure process, remains at organisational level where the incident occurs.

1.5.2 Open Disclosure Lead – Kare

Kare will appoint an **Open Disclosure Lead** who is responsible for providing leadership, oversight and assurance in relation to the implementation of open disclosure across the organisation.

The Open Disclosure Lead will:

- Lead and oversee the **implementation, monitoring and continuous improvement** of the HSE Open Disclosure Policy within Kare.
- Ensure **clear accountability and ownership** for open disclosure at all levels of the organisation, in line with governance and legislative requirements.

- Facilitate and ensure access to **mandatory, role-appropriate open disclosure training** for all staff, including induction and refresher training as required.
- Attend and maintain competence through **specialist skills-based training** in open disclosure.
- Monitor, review and **audit compliance** with this policy and related procedures, using available audit tools and reporting mechanisms.
- **Escalate incidents of non-compliance** with this policy through appropriate governance and management structures.
- Ensure that open disclosure is fully **embedded within Kare's governance framework**, including links with incident management, risk management, quality improvement and complaints processes.
- Prepare and submit an **annual report** on the implementation and effectiveness of open disclosure within the service, including learning, trends and improvement actions.

- Ensure that managers are aware of and have access to appropriate **staff support mechanisms** following safety incidents, including the **"Assist Me" model of staff support following patient safety incidents (January 2021)**.

Note: Contact details for the Open Disclosure Lead are provided in **Appendix 7**.

1.5.3 Designated Person

A Designated Person may be appointed to support the person and/or relevant person throughout the incident management and open disclosure process. The Designated Person will not be directly involved in the review or investigation of the incident.

The Designated Person will:

- Attend mandatory, role-appropriate training on this policy, including The Role of the Designated Person in Incident Management and Open Disclosure available on HSEland.
- Act as a single, consistent point of contact for the person and/or relevant person throughout the incident management and open disclosure process.
- Ensure that the person and/or relevant person is offered immediate assistance and support following the incident, to reduce distress and ensure they do not feel isolated.

- Provide, or facilitate access to, relevant information and supports, which may include:
    - Independent advocacy services
    - Bereavement or emotional support services
    - Information on other appropriate internal or external support services, as required
- Agree clear communication arrangements with the person and/or relevant person, including:
    - Name, role and contact details of the Designated Person
    - Preferred method of communication
    - Agreed frequency and timing of updates
- Ensure ongoing, compassionate communication and support is maintained throughout the incident management, review and open disclosure process.
- Escalate concerns, questions or additional support needs raised by the person and/or relevant person to the appropriate manager or open disclosure lead, where required.

1.5.4 Managers.

It is the role and duty of all health and social care managers at all levels in the organisation to:

- Comply with this policy.
- Ensure that all employees/services under their management, supervision and responsibility are aware of and comply with this policy.
- Ensure that their services follow the clearly defined process in place for the management and recording of open disclosure.
- Ensure that all staff are clear as to their professional, ethical, regulatory and legal responsibilities and obligations in relation to open disclosure. (see appendix 6 for additional resources)
- Attend skills training on open disclosure for manager available on HSELand.
- Ensure staff are aware of supports available to them e.g. Employee Assistance Programme, the Assist Model of Communication (Appendix 2), Language to assist in Open Disclosure discussions (Appendix 3), Things to consider before a notifiable incident disclosure meeting (Appendix 4),
- Ensure staff are aware of supports available to service users; e.g. independent advocacy services, community or internal Kare clinical referral.

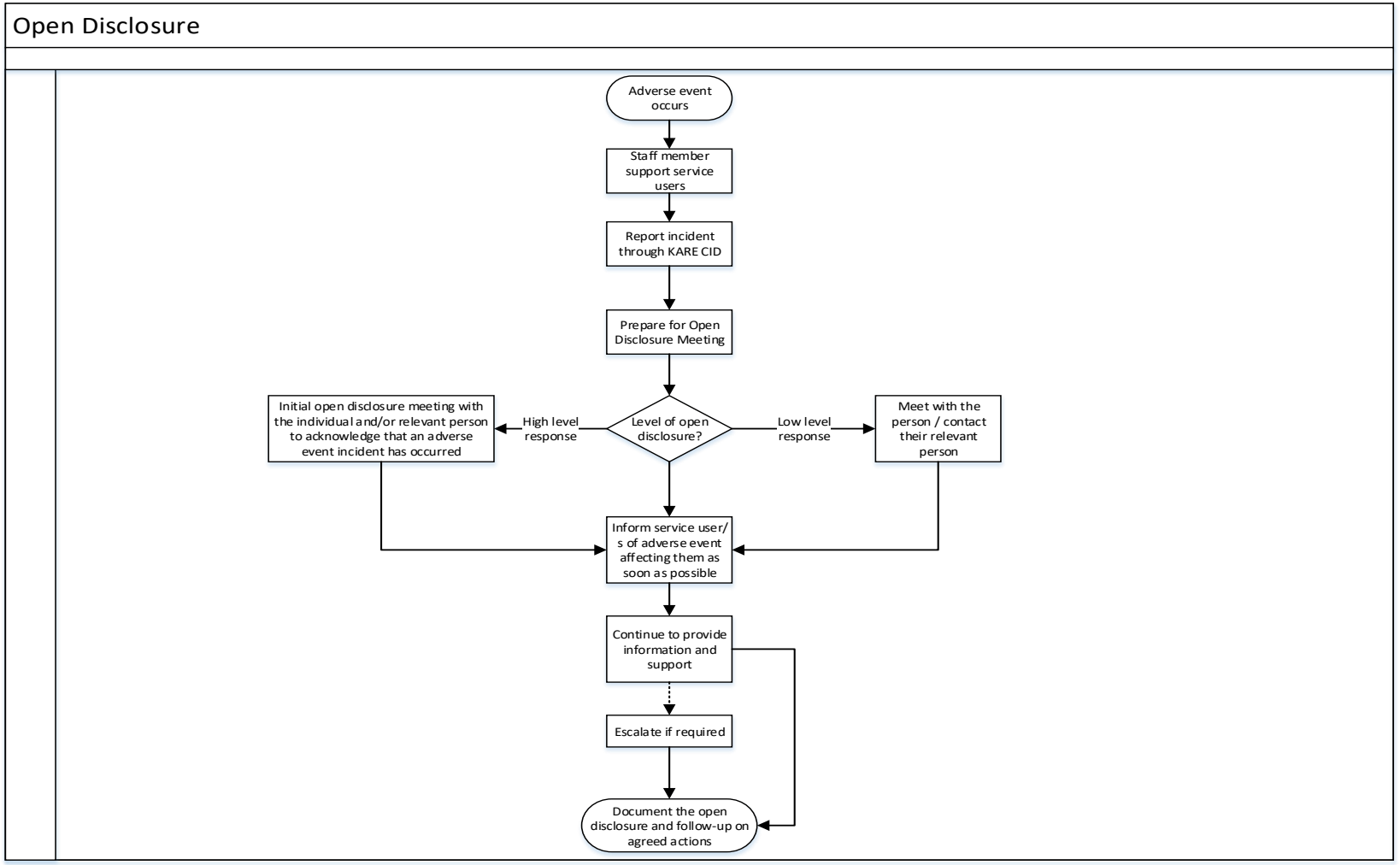
- Incidents will be notified to the appropriate regulatory body in line with the relevant legislation (See Appendix 5)

1.5.5 All Staff .

It is the role and duty of all staff to:

- read this policy and to understand their professional, ethical, regulatory and legal responsibilities/obligations in relation to open disclosure.
- comply with this policy.
- attend mandatory role appropriate training on this policy available on HSEland and keep training up to date.
- report all safety incidents on CID Database to facilitate timely open disclosure.
- participate in open disclosure discussions, as required.
- promote a culture of openness, honesty and transparency in the workplace.
- communicate with individuals and their relevant person involved in and/or affected by safety incidents in a manner which is compassionate, caring, kind and empathic.
- comply with their professional codes of conduct and ethics as they relate to open disclosure.
- notify non-compliance of this policy to their line manager.

Section 2: Process



Section 3: Procedure

3.1 Levels of Open Disclosure.

Type of Event	Disclose Yes/No
Harm event	Always disclose
Suspected harm event (harm is suspected but not confirmed)	Always disclose
No Harm event*	Generally disclose – It is important to be sure that harm has not occurred as a result of an incident and the best way to ensure this is to discuss the incident with the patient. This approach is recommended for most no-harm events.
Near Miss event*	Near Miss events generally do not require open disclosure but must be assessed on a case by case basis, depending on the potential impact the event could have had on the patient. If, after consideration of the near miss event, it is determined that (i) there is a risk of/potential for future harm i.e. there is potential for the "near miss" event to become a "harm" event in the future and/or (ii) that informing the patient would assist in the prevention of future harm this must be discussed with the patient.

- The level of open disclosure required will be determined following assessment of the safety incident and in line with the HSE Open Disclosure Policy and the HSE Incident Management Framework.
- The appropriate level of response will be guided by:
    - The degree of harm experienced by the person
    - Any additional interventions, treatment or supports required as a result of the incident
    - The needs, preferences and expectations of the person and/or relevant person
- The open disclosure process may involve:
    - A single open disclosure meeting, or
    - A series of meetings and follow-up communications, depending on the complexity and severity of the incident.
- Open disclosure is required for harm events, no-harm events and near-miss events, where appropriate.

For incidents where there has been no harm or minimal harm to the person, the level of

open disclosure will generally be proportionate and may involve one open disclosure meeting, supported by follow-up communication as needed.

- This level of response typically applies to Category 3 incidents, as defined in the HSE Risk Impact Table (see Appendix 1).

3.1.1 A low-level response

The conversation with the person/their relevant person should address, as appropriate:

- acknowledging what happened and any resulting impact/consequences for the patient;
- listening to and hearing the patient's story/understanding of what has happened and its impact;
- providing an objective explanation of the incident;
- responding to questions openly, honestly and factually;
- providing a meaningful apology;
- providing reassurance in relation to on-going care and treatment and the steps being taken to try to prevent a recurrence of the incident going forward to the patient involved and to others.

This should be documented in the CID electronic record using the open disclosure button within the documented adverse event. The details of a contact person will be provided to enable and support further contact should the patient/relevant person have any further questions/concerns that they would like addressed at a later stage. This may be the only discussion that is required and, with the agreement of the patient/relevant person, open disclosure may be concluded at this stage.

3.1.2 A high-level response

A high-level response involves the full open disclosure process and will be initiated for safety incidents where the person has suffered a moderate or higher level of harm (i.e. Category 1 and Category 2 Incidents as per HSE Risk Impact Table – (See Appendix 1).

This level of response may involve an initial open disclosure meeting with the individual and/or relevant person to acknowledge that an adverse event incident has occurred followed by a further meeting(s) to update the individual and/or relevant person as additional information becomes available.

Occasionally people we support and/or relevant person may expect or request a high-level response to a low-level event.

3.2 Timing of Open Disclosure

When a safety incident occurs, the open disclosure process must be initiated as soon as practicable after the incident has occurred or becomes known to Kare.

Open disclosure should ideally commence within 24–48 hours, taking into account:

- The person's physical, emotional and psychological readiness to participate
- The availability of a support person, if requested or deemed appropriate
- The need to ensure that accurate, factual information is available

Where immediate open disclosure is not possible, the reasons should be documented, and the process commenced at the earliest appropriate opportunity.

3.2.1 Open disclosure of an adverse event involves:

3.3 Deciding Who Will Make Initial Contact

The decision regarding who will make the initial contact with the person and/or relevant person will be based on the category, severity and complexity of the incident.

In most circumstances, the staff member(s) who identified or were involved in discovering the incident will make the initial contact and will follow the ASSIST Model of Communication (see Appendix 2), with appropriate support from their line manager.

3.3.1 Leadership Involvement

On a case-by-case basis, it may be determined that the Leader/Manager is the most appropriate person to make the initial contact.
Alternatively, the Leader/Manager may make a follow-up call or attend subsequent open

disclosure meetings once additional information is available regarding the causes of the incident and actions taken or planned.

3.3.2 On-Call Situations

Where a safety incident occurs outside of normal working hours, the On-Call Manager will:

- Liaise with staff and the relevant line manager where possible
- Provide support to staff involved
- Make or facilitate contact with the person and/or relevant person where they are the most appropriate person to do so at that time

3.3.3 Components of Open Disclosure

Open disclosure of a safety incident involves a structured, compassionate and person-centred process, which includes:

(a) Open, honest, transparent and timely communication with the individual and/or their relevant person following a safety incident

(b) Acknowledgement of what has happened and recognition of the impact of the **incident**, which may include physical, psychological, emotional, financial and/or social effects

(c) A factual explanation of what is known about what happened and, where possible, how and why it happened

(d) Listening to and hearing the individual's perspective, including their understanding of the incident and its impact

(e) Demonstrating empathy, kindness and compassion towards all those involved in and/or affected by the incident, including the individual, their relevant person(s) and staff

(f) An apology or expression of regret, where appropriate, which must be sincere, personalised and relevant to the situation

(g) Shared decision-making in relation to ongoing care, treatment and the management of the safety incident

(h) Providing opportunities for the individual and/or relevant person to ask questions, and responding honestly and factually to any concerns raised

(i) Provision of immediate and ongoing support to the individual and/or their relevant person, as appropriate

(j) Provision of immediate and ongoing support to staff involved in and/or affected by the safety incident, as appropriate

(k) Reassurance regarding learning arising from the safety incident, where available

(l) Provision of information on the actions taken or planned by Kare to reduce the likelihood of a recurrence of the incident

3.4 Open disclosures checklist for managers

Managers have a key role in ensuring that open disclosure is managed appropriately, consistently and in line with this policy and governance requirements.

3.4.1 Understanding the Incident

- Meet with staff involved, as required, to establish a clear factual understanding of the incident.
- Determine whether further review or investigation is required and ensure appropriate linkage with relevant policies and processes, including:
    - Incident Management
    - Trust in Care
    - Complaints Management
    - Safeguarding or other relevant organisational policies

3.4.2 Incident Documentation

- Ensure that the incident is recorded accurately and in a timely manner on the Kare CID system, in line with reporting requirements.

3.4.3 Complaints Management

- Where the person and/or relevant person wishes to make a complaint:
    - Ensure they are informed of the complaints process

- Facilitate completion of the complaint process or escalate appropriately, in line with Kare's Complaints Policy

3.4.4 Communication Planning

- Ensure that a family/person communication plan is in place and updated as required, reflecting:
  - Agreed communication arrangements
  - Key contacts
  - Frequency and method of communication

3.5 Record Keeping

3.5.1 Documentation of Open Disclosure

- The key elements ("salient points") of all open disclosure communications with the person and/or their relevant person must be clearly, accurately and contemporaneously documented. This documentation must include:
  i. The date of the open disclosure meeting and the names and roles of all attendees
  ii. The information provided, including how and when the incident became known
  iii. Details of any apology or expression of regret provided
  iv. Any agreed care, treatment or support plans, actions, and follow-up arrangements
- Note: This information will be recorded within the Open Disclosure section of the incident report.

3.5.2 Recording on the National Incident Management System

Open disclosure activity must be recorded on the National Incident Management System (NIMS) (or Kare's designated reporting system, as applicable), including:

- Confirmation that open disclosure has occurred
- The date open disclosure took place

Where open disclosure has not occurred, the reason must be clearly documented in the incident record.

3.5.3 Refusal to Participate in Open Disclosure

Where a person chooses **n**ot to participate in the open disclosure of a notifiable incident:

- The refusal must be documented in writing, including the date of refusal
- The record must be retained for a period of five years

This ensures that the person, or a relevant person, may reconsider their decision within five years of the date of refusal and request that the service provider undertake open disclosure in accordance with legislative requirements.

3.6 Monitoring of Open Disclosure

Open disclosure practices are monitored through multiple governance and assurance mechanisms within Kare to ensure compliance, effectiveness, and continuous improvement.

3.6.1 Annual Reporting

- Open disclosure activity, trends, outcomes, and improvement actions are reported annually
- Kare complete the necessary annual revew template and return to the HSE as part of organisational governance reporting.

3.6.2 Open disclosure processes are embedded within the organisation's:

  - Risk management framework, ensuring incidents triggering open disclosure are identified and managed appropriately.
  - Complaints management system, enabling alignment between consumer concerns and disclosure responses.
  - Quality and safety improvement framework, ensuring insights from open disclosure inform service improvements, staff education, and system redesign.

Data from open disclosure activities is used to identify trends, mitigate risks, and strengthen patient safety culture.

3.6.3 Escalation Processes for Non-Compliance

- Instances of non-compliance with open disclosure requirements are identified through audits, incident reviews, complaints, or staff reporting.

- Persistent or serious non-compliance may result in:
    - Targeted education or retraining.
    - Performance management processes.
    - Further investigation in line with organisational policies and regulatory obligations.
- Outcomes of escalation processes are documented and monitored to ensure accountability and sustained improvement.

Appendix 1 - Risk rating table

1. IMPACT TABLE	Negligible	Minor	Moderate	Major	Extreme
Harm to a Person	Adverse event leading to minor injury not requiring first aid. No impaired Psychosocial functioning.	Minor injury or illness, first aid treatment required <3 days absence < 3 days extended hospital stay Impaired psychosocial functioning greater than 3 days less than one month	Significant injury requiring medical treatment e.g. Fracture and/or counselling. Agency reportable, e.g. HSA, Gardai (violent and aggressive acts). >3 Days absence 3-8 Days extended hospital Stay Impaired psychosocial functioning greater than one month less than six months	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling Impaired psychosocial functioning greater than six months.	Incident leading to death or major permanent incapacity. Event which impacts on large number of service users or member of the public Permanent psychosocial functioning incapacity.
Service User Experience	Reduced quality of service user experience related to inadequate provision of information	Unsatisfactory service user experience related to less than optimal treatment and/or inadequate information, not being to talked to & treated as an equal; or not being treated with honesty, dignity & respect - readily resolvable	Unsatisfactory service user experience related to less than optimal treatment resulting in short term effects (less than 1 week)	Unsatisfactory service user experience related to poor treatment resulting in long term effects	Totally unsatisfactory service user outcome resulting in long term effects, or extremely poor experience of care provision
Compliance (Statutory, Clinical, Professional & Management)	Minor non-compliance with internal PPPG's. Small number of minor issues requiring improvement	Single failure to meet internal PPPG's. Minor recommendations which can be easily addressed by local management	Repeated failure to meet internal PPPG's. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Failure to meet national norms and standards / Regulations (e.g. Mental Health, Child Care Act etc). Critical report or substantial number of significant findings and/or lack of adherence to regulations.	Gross failure to meet external standards Repeated failure to meet national norms and standards / regulations. Severely critical report with possible major reputational or financial implications.
Objectives/Projects	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significant project over – run.	Inability to meet project objectives. Reputation of the organisation seriously damaged.
Business Continuity	Interruption in a service which does not impact on the delivery of service user care or the ability to continue to provide service.	Short term disruption to service with minor impact on service user care.	Some disruption in service with unacceptable impact on service user care. Temporary loss of ability to provide service	Sustained loss of service which has serious impact on delivery of service user care or service resulting in major contingency plans being involved	Permanent loss of core service or facility. Disruption to facility leading to significant 'knock on' effect
Adverse Publicity/ Reputation	Rumours, no media coverage. No public concerns voiced. Little effect on staff morale. No review/investigation necessary.	Local media coverage – short term. Some public concern. Minor effect on staff morale / public attitudes. Internal review necessary.	Local media – adverse publicity. Significant effect on staff morale & public perception of the organisation. Public calls (at local level) for specific remedial actions. Comprehensive review/investigation necessary.	National media/ adverse publicity, less than 3 days. News stories & features in national papers. Local media – long term adverse publicity. Public confidence in the organisation undermined. HSE use of resources questioned. Minister may make comment. Possible questions in Dail. Public calls (at national level) for specific remedial actions to be taken possible HSE review/investigation	National/International media/ adverse publicity, > than 3 days. Editorial follows days of news stories & features in National papers. Public confidence in the organisation undermined. HSE use of resources questioned. CEO's performance questioned. Calls for individual HSE officials to be sanctioned. Taoiseach/Minister forced to comment or intervene. Questions in the Dail. Public calls (at national level) for specific remedial actions to be taken. Court action. Public (independent) Inquiry.
Financial	0.33% of budget deficit	0.33 – 0.5% of budget deficit	0.5 – 1.0% budget deficit	1.0 – 2.0% of budget deficit	> 2.0% of budget deficit
Environment	Nuisance Release.	On site release contained by organisation.	On site release contained by organisation.	Release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc.)	Toxic release affecting off-site with detrimental effect requiring outside assistance.

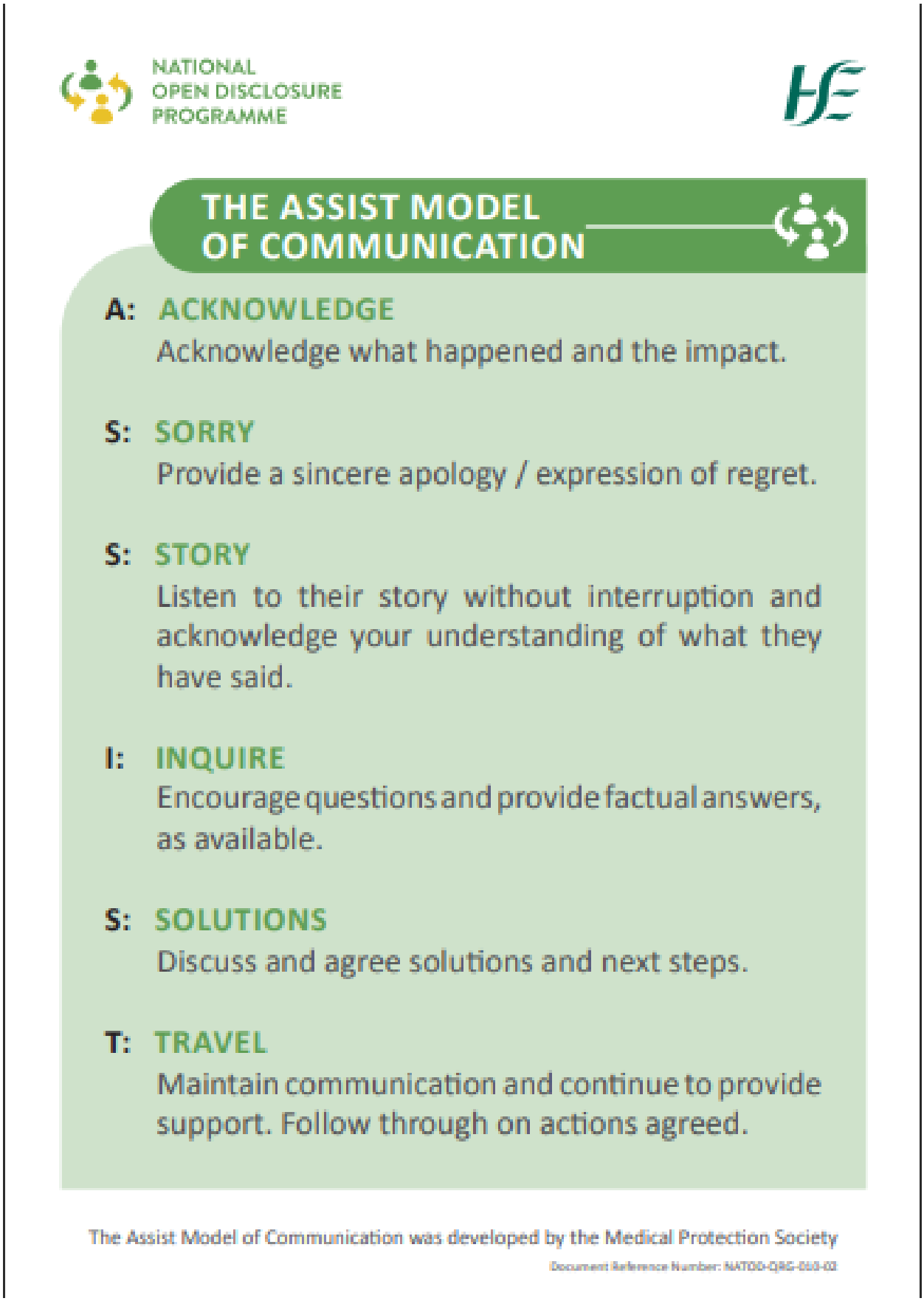
2. LIKELIHOOD SCORING

Rare/Remote (1)		Unlikely (2)		Possible (3)		Likely (4)		Almost Certain (5)	
Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability
Occurs every 5 years or more	1%	Occurs every 2-5 years	10%	Occurs every 1-2 years	50%	Bimonthly	75%	At least monthly	99%

3. RISK MATRIX

	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare/Remote (1)	1	2	3	4	5

Appendix 2: The Assist Model of Communication



Appendix 3: Sample Language to assist in Open Disclosure discussions

Stage of Discussion	Sample Phrases
Acknowledgement Discussing what has happened and the impact	– "I realise that this has caused you great pain/distress/anxiety/worry" – "I can only imagine how upset you must be"
Sorry Saying Sorry / Expressing Regret Managing the Apology	– " I am so sorry that this has happened to you" – "A review of this event has indicated that there were certain failings in the care provided to you. (List failings identified)… I am so sorry about this and I would like to offer you my sincere apologies on behalf of myself and my team. We are planning the following actions to try to prevent this happening again in the future…"
Story Listening to the patient's/relevant person's story and summarising	**<u>Establishing their Story</u>** – "How are you since we last met?" – "Can you tell me your understanding of what has happened?" **<u>Demonstrating your understanding of their Story: (Summarising)</u>** – "I understand from what you have said that you are very upset and angry about this" "You think that …… Is this correct?" (I.e. summarise their story and acknowledge any emotions/concerns demonstrated) **<u>Relating your understanding of the story to date</u>** – "We are not sure at this stage about exactly what happened but we have established that … We will remain in contact with you as more information unfolds"
Inquire Encouraging questions and providing factual answers	– "What questions do you have in relation to what we just discussed?" – "We may not be able to answer all of your questions until we have completed our review of the incident." – "How do you feel about this?" – "Is there anything we talked about that is not clear to you?" – "Do you understand what has happened?"
Solutions Establishing and agreeing the plan of care together	– "What do you think should happen now?" – "Do you mind if I talk you through what I think we could do and you can let me know if you are happy with this? "
Travel Moving forward with the patient/relevant person. Providing reassurance and on-going support	– "It is important to us that we find out why this happened. We have already commenced a review of the incident to establish the facts." – "We expect the review to take xx time." – "We will keep you up to date on what is happening."

Appendix 4: Things to consider before a notifiable incident disclosure meeting

- Who from the organisation is already in contact with the patient and/or family?
- Has a designated person been appointed and what contact have they had?
- What discussions or information exchange has already taken place?
- What is the patient and/or family's current understanding of the incident and organisational response to this?
- Where the conversation takes place? A quiet room should be used, free from distraction and where the meeting will not be interrupted. It may not be appropriate to host the meeting close to where the incident happened as this could be emotionally difficult for the relevant person.
- Who should be part of, and who should lead that conversation?
- Staff should try to avoid the use of jargon or explain technical terms when speaking with relevant persons.
- What support should be available to the patient and/or relevant person during the conversation and afterwards?
- Who will be the single point of contact following the discussion with the patient and/or family?
- Are there linguistic needs or reasonable adjustments that might need to be made for someone who has a disability? In some circumstances it will be necessary to have an interpreter or any other appropriate support person present

Appendix 5: List of notification requirements

Report to Whom	Report about what	Who makes the report
Gardai	Events of an allegedly criminal nature	Leader/ Operations Manager
Health Information and Quality Authority (HIQA)	As a registered provider or person in charge of a designated centre for people with disabilities, you are legally required to notify HIQA within certain time frames about certain incidents. Notification Forms (DCD) | HIQA	The registered Provider to the Person in Charge of the designated centre
Health and Safety Authority (HSA)	Under the Safety, Health and Welfare at Work (General Application) Regulations 2016 all employers and self-employed persons are legally obliged to report the injury of an employee as a result of an accident while at work. Injuries must be reported if your employee is unable to carry out their normal work for more than three consecutive days, excluding the day of the accident	Human Resources (HR)
Health Service Executive	Microsoft Word - SRE Guidance January 2015 _reissued_ v1.0 30 01 15.doc (hse.ie)	See guidance document to the left.
TUSLA – sessional preschool	Death of a child while attending the service Accident resulting in service closure Unplanned closure of the service Injury to a child that requires immediate medical attention Child goes missing Diagnosis of notifiable infectious disease	Leader
National Incident Management System (NIMS)	All incidents related person/s, property, crash/collision or dangerous occurrences.	NIMS administrator

Appendix 6: Additional Resources:

Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023
Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023

PATIENT SAFETY (NOTIFIABLE INCIDENTS AND OPEN DISCLOSURE) ACT 2023: GUIDANCE
Department of Health Guidance on the Patient Safety Act

National Open Disclosure Programme "Assist Me" A Model of Staff Support following Patient Safety Incidents in Healthcare
assist-me-a-model-of-staff-support-following-patient-safety-incidents-in-healthcare-january-2021-.pdf

National Open Disclosure Programme Management of an Open Disclosure Meeting: Quick Reference Guide and Tool Kit
management-of-an-open-disclosure-meeting-quick-reference-guide-and-tool-kit.pdf

HSE Open Disclosure Policy
hse-open-disclosure-full-policy.pdf

HSELand - Irish Health Service's national online learning and development portal.
HSELand | The Irish Health Service's portal for online learning

The Role of the Designated Person in Incident Management and Open Disclosure
The Role of the Designated Person in Incident Management and Open Disclosure

HSE: **Resources for staff and organisations**
Resources for staff and organisations - Corporate

Appendix 7: Contact Details for Open Disclosure Lead

Open Disclosure Lead	Sandra Burke Kare Newbridge Ind. Est. Newbridge Co. Kildare Email: sandra.burke@kare.ie Telephone: 045 448700