KARE
Founded in 1967

Promoting Inclusion for People with Intellectual Disabilities

Open Disclosures Policy.

KARE Policy Document.

Policy Owner: C.E.O.

Rev. No.	*Approved by Policy management committee*	*Approved by KARE Board*	*Launched Heads of Units*	*Operational Period*
Rev. 1	November 2022	N/A	November 2022 by email	Nov 2022 -

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”

In 2021 staff completed the HSELand module 1 on Open Disclosures and all line Managers completed Module 1: “Communicating Effectively through Open Disclosure” and Module 2 “Open Disclosure: Applying Principles to Practice”. As a result of this training, it was identified that staff need to have additional support to be able to implement Open Disclosures in practice.

The outcome of that was the development of the Open Disclosures statement which was updated to be an Open Disclosures policy.

The information below is compatible and consistent with:

- HSE Policy on Open Disclosure (2013)
- HSE and State Claims Agency Open Disclosure Guidelines -Communicating with service users and their families following adverse events in healthcare

Links to other policies:

- Complaints policy
- Incident management policy (in development)
- Safety Statement
- Safe administration and management of medication policy

Definitions:

Open disclosure is defined as an open, consistent, compassionate, and timely approach to communicating with 'people' and, where appropriate, their relevant person following safety incidents. It includes expressing regret for what has happened, keeping the 'person' informed and providing reassurance in relation to on-going care and treatment, learning and the steps being taken by the health services provider to try to prevent a recurrence of the incident. (HSE 2019)

A safety incident, in relation to the provision of a health service to a person by a health services provider, means "an incident which occurs during the course of the provision of a health service" which:

(a) has caused an unintended or unanticipated injury, or harm, to the individual

(b) did not result in actual injury or harm to the individual but was one which KARE has reasonable grounds to believe placed the individual at risk of unintended or unanticipated injury or harm or

(c) unanticipated or unintended injury or harm to the individual was prevented, either by "timely intervention or by chance", but the incident was one which KARE has reasonable grounds for believing could have resulted in injury or harm, if not prevented. (Civil Liability Amendment Act 2017).

Therefore, a safety incident includes harm events, no harm events and near miss events.

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 staff involved in and/or affected by safety incidents are met and respected, that they are communicated with in an honest, open, timely, compassionate, and empathic manner and that they are treated with dignity and respect.

The aim of this policy is also to provide support to staff in implementing an open disclosures culture within the organisation and practical steps to follow in the event of an incident that requires an open disclosure.

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.

1.3.1 Roles and responsibilities

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.

1.4 Policy Statements

1.4.1 General Statements

- 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”.
- In accordance with the HSE Policy on Open Disclosure, KARE will adhere to the following ten principles in managing open disclosure:

The Principles of Open Disclosure

- Acknowledgement: services should acknowledge to the service user that an adverse event has occurred and initiate the open disclosure process, in line with HSE Open Disclosure Policy and Guidelines

- Truthfulness: timeliness and clarity of communication: The service user should be provided with information in a timely manner - focusing on the factual information available at the time. Ideally the open disclosure process should commence within 48 hours of the event occurring or the event becoming known and as soon as the service user is physically and emotionally available to receive the information.

- Apology/ expression of regret: An apology/expression of regret, regarding the condition of the service user and for what has happened as a result of an adverse event, is important and should be forthcoming. When it is clear, following a review of the adverse event, that the healthcare provider is responsible for the harm to the service user (e.g. wrong medication) it is imperative that there is an acknowledgment of responsibility and an apology provided as soon as possible after the event.

- Recognising the expectations of service users: The service user may reasonably expect to be fully informed of the facts and consequences in relation to the adverse event and to be treated with empathy and respect.

- Professional Support: services should promote the development of a “just culture” as staff will then feel more encouraged and willing to report incidents/adverse events/near miss events. Staff can also expect to be supported by the service following an adverse event and throughout the open disclosure and incident review process.

- Risk management and systems improvement: The investigation of adverse events should be undertaken in line with the HSE’s Incident Management Framework. (Follow reporting procedures on KARE CID). Where relevant recommendations should be made, and actions taken to reduce the likelihood of a recurrence of the event.

- Multidisciplinary responsibility: Open disclosure involves multidisciplinary accountability and response. Clinical, senior professional and managerial staff should be identified to lead in and support the process.

- Governance: services should have appropriate accountability structures in place which ensure that open disclosure occurs and that it is integrated with other governance systems and processes including incident reporting and management procedures, systems analysis reviews, complaints management and privacy and confidentiality procedures.

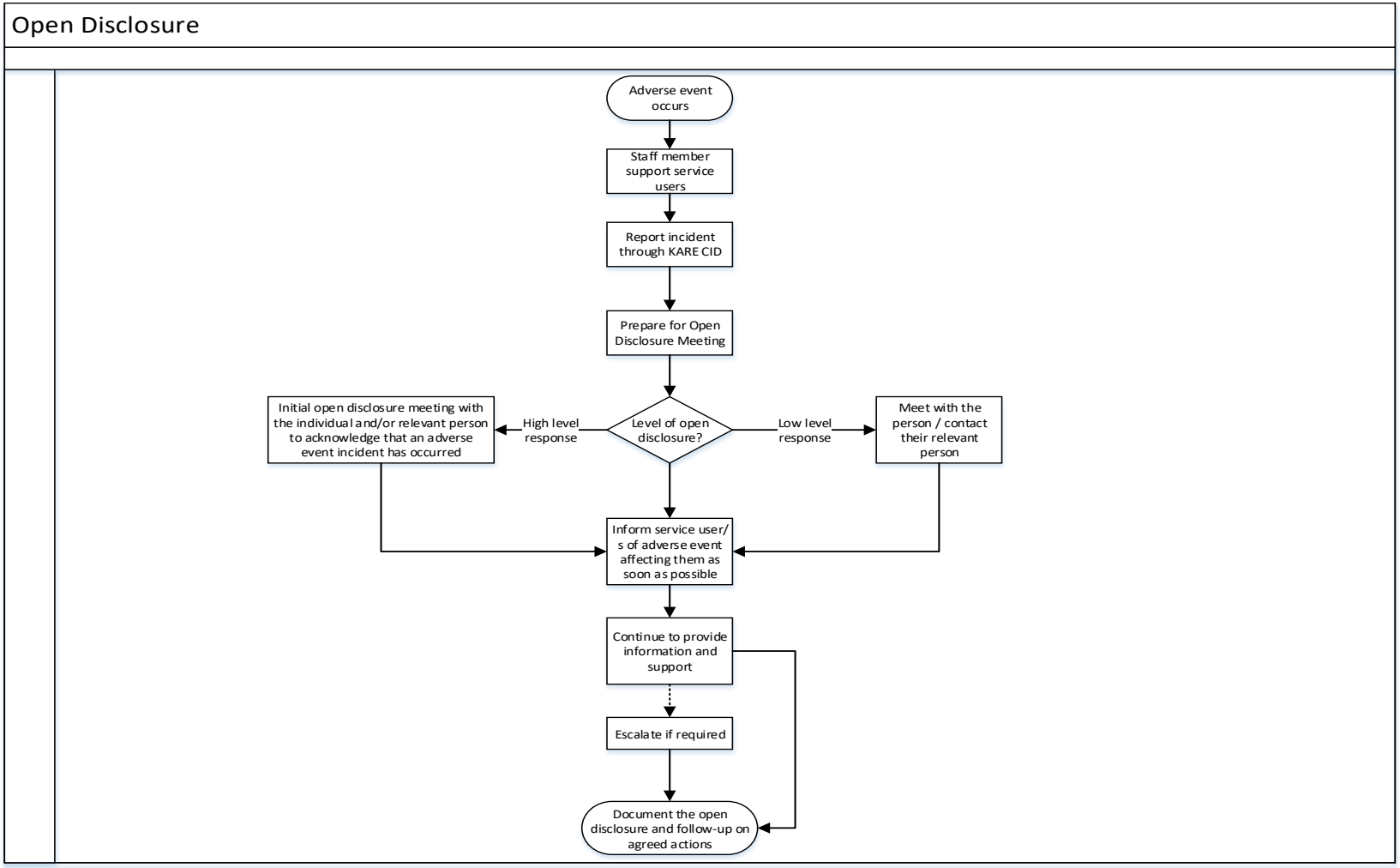
- Confidentiality: The information collated following an adverse event is often of a sensitive nature and therefore confidentiality is paramount. Service user information is generally held under legal and ethical obligations of confidentiality. All health and social care policies, procedures, and guidelines in relation to privacy and confidentiality for service users and staff should be consulted with and adhered to.

- Continuity of care: Steps need to be taken to reassure the service user in relation to the management of their immediate care needs and to also reassure them that their care will not be compromised going forward. Transfer of care to another facility may be

  requested by the service user and should be facilitated when it is possible to do so. A member of staff should be identified who will act as a contact person for the service user to keep them informed of the situation and to maintain open channels of communication between the service user and the service.

The HSE and State Claims Agency Open Disclosure Guidelines -Communicating with service users and their families following adverse events in healthcare, should be referred to for guidance in managing complex open disclosure situations.

Section 2: Process



Section 3: Procedure

3.1 Levels of Open Disclosure.

- It is necessary to determine the level of Open disclosure required.
- The level of response required will be defined by the degree of harm the individual has experienced, the level of additional interventions/treatments required as a result of this harm and/or the expectations of the individual or their appropriate person.
- This response may vary from one open disclosure meeting to a number of meetings.
- **A low-level response** is usually initiated for adverse events where there has been no harm to the individual or the harm is minimal – this level of response may involve just one meeting with the person (i.e., Category 3 incidents as per the HSE Risk Impact Table – (See Appendix 1).
- **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 something goes wrong the open disclosure process must be initiated as soon as possible and as is practicable (ideally within 24 - 48 hours after the incident occurs or becomes known to the health services provider or as soon as the person is available both physically and emotionally to take part in the discussion and, if deemed necessary, to have a support person present).

3.3 Open disclosures preparation

3.3.1 Decide who is going to make the call – this may depend on the category/severity of the incident. Generally, staff who are involved in discovering the incident make the initial contact.

3.3.2 On a case-by-case basis it may be determined that the Leader is more appropriate to make the phone call. Or the leader may make a follow up call when further information is available on the causes or actions following the incident.

3.3.3 If the situation occurs during on call hours on call responsibility is to link with the staff and line manager of possible and provide support. They may be the best person placed at that time to make the contact with family.

3.3.4 Open disclosure of an adverse event involves:

(a) a process of open, honest, transparent, and timely communication with individuals and/or their relevant person following a safety incident

(b) an acknowledgement of what has happened and of the impact of the safety incident on the individual – impact includes physical, psychological, financial and/or social

(c) a factual explanation in relation to what has happened and how/why it happened

(d) listening to and hearing the individual's story i.e. their understanding of what has happened and their description of the impact of the safety incident

(e) demonstrating empathy, kindness and compassion towards all those involved in and/or affected by the safety incident that has occurred to include the individual, their relevant person(s) and staff

(f) an apology/expression of regret (as appropriate to the situation) – this must be sincere and personal to the individual and/or their relevant person and to the given situation

(g) shared decision making in relation to on-going care and treatment and the management of the safety incident that has occurred

(h) affording the individual and/or their relevant person the opportunity to ask questions and responding honestly and factually to any questions/concerns arising

(i) the provision of immediate and on-going support for the individual and/or their relevant person, as appropriate

(j) the provision of immediate and on-going support for staff involved in and/or affected by the safety incident, as appropriate

(k) reassuring the individual and/or their relevant person in relation to any learning that has occurred as a result of the safety incident and

(l) providing information on the steps being taken or planned by the health services provider to try to prevent a recurrence of the incident.

3.4 Open disclosures checklist for managers

3.4.1 May need to meet with staff involved to understand the incident fully. As a result of further investigation, it may be necessary to refer to other policies, trust in care, incident management, complaints etc

3.4.2 Ensure incident is documented on CID.

3.4.3 If families want to make complaint complete the process or escalate if required.

3.4.4 Ensure family communication plan is updated if required.

3.5 Record Keeping

3.5.1 Documentation of open disclosure: The salient points discussed with individual and/or their relevant person during open disclosure meetings, including the details of,

(i) who was present at the open disclosure meeting,
(ii) the information provided,
(iii) the apology provided
(iv) agreed care/treatment plan and actions, must be documented in the record.

3.5.2 Open disclosure must be recorded on the National Incident Management System (NIMS) indicating if open disclosure has occurred and the date open disclosure occurred. If open disclosure has not occurred, the reason must be provided.

3.5 Roles and Responsibilities

Open disclosures lead for KARE:

- Lead and oversee the implementation of the HSE Open Disclosure Policy.
- Ensure accountability and ownership for open disclosure at every level in the organisation.
- Facilitate role appropriate training for employees on this policy.
- Attend skills training on open disclosure.
- Monitor and audit compliance with this policy.
- Escalate incidences of non-compliance with this policy.
- Ensure that open disclosure is embedded in the service's governance programme/framework.
- Prepare an annual report on the implementation of open disclosure within the service.

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 have a 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.
- Attend skills training on open disclosure.

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 role appropriate training on this policy.
- report all safety incidents 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.

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