An Roinn Sláinte
Department of Health

Explanatory Leaflet

Report and Recommendations for a National Policy Framework for Open Disclosure in Healthcare in Ireland

February 2021

Introduction

In 2019, the Independent Patient Safety Council was set up to give advice to the Minister for Health on how to improve patient safety for everyone in Ireland. One of the first areas the Council was asked to look at was *open disclosure in healthcare*.

Open disclosure in healthcare is the open discussion that the healthcare provider has with patients or service users, their families or support people when something goes wrong that has harmed or had the potential to cause harm to a patient or service user. An example would be where a mistake was made that resulted in harm to a patient. This means that health and social care staff and the organisations who provide health and social care must make sure that patients/service users and their families get all the information about what happened.

In 2020, the Department of Health asked Crowe to do a report to gather important information to help the Council in their work. Crowe is a consulting practice that provides advice and information.

The consultants from Crowe did research to find out what happens in other countries when it comes to open disclosure. They looked at policies and guidelines that relate to open disclosure in healthcare in Ireland at present. They spoke to a wide range of people and organisations to get their views, including patients/service users and families, healthcare workers, health and social care providers, healthcare professional regulators, healthcare education providers, and many others.

Crowe did a survey of patients/service users and families to find out what they thought about open disclosure, and how they wanted it to work in future. Crowe then worked with and helped the Council to develop its recommendations for the Minister on a National Policy Framework for Open Disclosure in Healthcare in Ireland. The policy framework, which the Department of Health will work on in the coming months, will set out principles and guidelines for how open disclosure should work in health and social care.

Report Findings

The findings in the Crowe report set out a number of things that were important in relation to how open disclosure is working and might work in future. The findings include:

- Open disclosure practice in health and social care in Ireland has been getting better in the past few years but there are still times when patients/service users and families do not get all of the right information about something that has not gone according to plan with their care, or when nobody seems to take responsibility or say they are sorry about what happened.
- When something doesn't go the way it was supposed to in health and social care, most patients/service users and families want:
    - to get the right information at the right time, so that they can clearly understand what happened;

  - someone to say sorry about what happened in a sincere way; and
  - to know what has been done and that the services have taken action to make sure that the chances of it happening again are reduced.
- Patients/service users and their families can find it difficult to get the right information or to understand what happened and they need help and support to do this.
- People who work in health and social care are fearful about what might happen if they tell patients/service users or families all the details, or if they say sorry, when something went wrong in their care. They worry about whether they will be taken to court, whether they might lose their job, whether patients/service users will trust them again, or whether the people they work with will not respect them.
- In health and social care in Ireland, people believe there is a tendency to try to blame a single person when something goes wrong, rather than look at whether there was a set of circumstances that made a mistake or a problem more likely. The people who were consulted as part of the project said they would prefer to see a system where mistakes and problems are openly talked about and dealt with in a fairer way that helps patients and families and makes sure that everyone can learn how to make sure it doesn't happen again.
- When something goes wrong with a patient or service user's care, this can also be very difficult for the health and social care staff involved. It is important to make sure that the staff have support and help to deal with the situation and give the right information to the patient/service users and their families.
- If the organisations providing health and social care do not make sure that the right things happen in relation to open disclosure, then there should be consequences.

Recommendations of the Independent Patient Safety Council

Having discussed the findings of the Crowe report, the Independent Patient Safety Council has made a number of recommendations to the Minister for Health to help with the development of a national policy framework on *open disclosure in healthcare* in Ireland. The recommendations are based on a set of principles that will be used as the basis for the framework. These are as follows:

- **Open, Honest, Compassionate, and Timely Communication**

  This means that patients/service users and families must be told all the right information at the right time when something has gone wrong in relation to their care, that nothing should be held back, and that they should be treated with respect and compassion by the health and social care staff and organisations involved.

- **Patient/Service User and Support Persons' Entitlements in Open Disclosure**

  This principle says that patients/service users and families are entitled to be told something has happened, have it explained clearly, receive an apology, and be told what has been done to try to put it right. They should be able to get help to understand what happened and to deal with the open disclosure process.

- **Supporting Health and Social Care Staff**

  This says that as well as supporting the patient/service user and their family when something has gone wrong in their care, the staff members involved should be helped and given support to deal with what has happened in the best way – for the patient/service user and family and for themselves. Staff should have the information they need so that they know how to discuss what happened with patients/service users and families in the best way.

- **Promoting a Culture of Open Disclosure**

  This principle says that the health and social care system needs to work on the problems that make it difficult for health and social care staff to provide the right information at the right time to patients/service users and their families. It means that organisations providing health and social care must encourage their staff to do this the right way and not make them fearful of what might happen if they tell someone that something has gone wrong.

- **Open Disclosure for Improving Health and Social Care Policy and Practice**

  When things go wrong in patient/service user care, there is an opportunity for the way things are done to be improved, so that this problem does not happen again or as often in future. Organisations who provide health and social care must have systems in place to learn from when things go wrong, and encourage staff to be open about mistakes or problems so that things can be improved.

- **Clinical and Corporate Governance for Open Disclosure**

  This principle sets out what should be done to make sure that open disclosure is happening in the right way and what should happen if it is not. Organisations who provide health and social care must have systems in place to be able to track what is happening with open disclosure and to report on this regularly. It must be clear to all staff what should happen with open disclosure and what the consequences for not giving the right information to patients/service users and families will be. Organisations where this is not happening may have penalties.

What Happens Next?

Following the recommendations of the Council to the Minister, the Department of Health will work on the national policy framework to provide guidance and principles for organisations providing health and social care, health and social care staff, and other relevant organisations, to improve how open disclosure works so that patients and families will have the right information available to them at the right time if and when something does not go as expected in their care.