Cáilíocht Náisiúnta agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety
Office of the Chief Clinical Officer

HSE Open Disclosure Annual Report 2024

NATIONAL OPEN DISCLOSURE PROGRAMME

Reader Information

Acknowledgements	The National Open Disclosure Office of the QPS Incident Management Team would like to acknowledge the many teams and services who work with us to build capacity and capability for open disclosure, and who have contributed to the development of this report. This includes the Regional Health Area and National Service leaders, National Open Disclosure Steering Committee; Open Disclosure Leads, Trainers and Champions; HSeLanD staff; the National Doctors Training Programme; the Forum of Postgraduate Training Bodies; and our valued patient partners and colleagues who promote open disclosure across the Irish health and social care services.
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4 April 2025	1	National Open Disclosure Office	National Open Disclosure Steering Committee	HSE Senior Leadership Team

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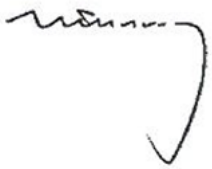
Foreword

The HSE and HSE-services take great pride in the care and services we deliver. Our staff work hard to meet the expectations of the public and to meet good quality standards of care.

When a patient safety incident occurs, it can be devastating for all the people involved. It is at such difficult times that we rely on our staff to do the right thing by meeting the needs of our patients and by responding with openness and transparency.

Patients and their families have told us repeatedly that what they want is an acknowledgement that an incident occurred and to receive an apology. It is what we would want for ourselves and our loved ones. Open disclosure is a fundamental requirement of delivering health and social care. I welcome the national developments of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 and the Department of Health's National Open Disclosure Framework 2023 for driving open disclosure across the Irish health and social care setting beyond the public sector.

This annual report reflects some of the key areas of work across the HSE and HSE-funded services in relation to open disclosure. I would like to express my gratitude to all our staff for implementing our HSE Open Disclosure Policy and to our patient partners who support, guide and positively challenge us in this important area of work.



Dr Colm Henry

HSE Chief Clinical Officer

1. Executive Summary

The HSE Open Disclosure Annual Report 2024 incorporates a summary of the key milestones achieved by the organisation in 2024 in relation to open disclosure. This area of health and social care advanced significantly in 2024 across the wider healthcare system, spanning the public and private sector, with the commencement of the Patient Safety (Notifiable Incident and Open Disclosure) Act 2023 [*hereafter referred to as the Patient Safety Act 2023*] and the launch of the Department of Health National Open Disclosure Framework [*hereafter referred to as the Framework*] late in 2023.The HSE has been at the forefront of developments in this area for a number of years. Open disclosure continues to be a priority for the HSE and HSE-funded services. This annual report is the first report of its kind incorporating the new external reporting requirements to the Minister/Department of Health.

Key developments impacting open disclosure in the HSE and HSE-funded services in 2024 include, but are not limited to, the following:

- The implementation of the Patient Safety Act 2023 and the Department of Health National Open Disclosure Framework 2023. The Patient Safety Act 2023 implementation was supported by an extensive implementation programme involving many HSE and HSE-funded staff, patient partners and external stakeholders.
- The development of the open disclosure reporting function. The Framework sets out the requirement to report on open disclosure events and their completion. It has been part of the HSE assurance programme over the last two years to develop such a reporting function using the National Incident Management System (NIMS). The implementation of the Patient Safety Act 2023, which required technical changes to be made to NIMS, provided an opportunity to develop this capability. Technical development work was completed in 2024. It is now a priority area for 2025 to determine the metrics, embed the reporting function and ensure compliance. At the outset, the HSE expects 100% compliance with open disclosure for notifiable incidents and category 1 incidents (subject to data cleansing) and will be working with services to establish and embed the reporting requirements for all incidents. Resources have already been made available to support staff such as a reporting guide, webinar and engagement events.
- The roll-out of Sláintecare and its revised governance structures.
- Revision of the HSE Open Disclosure Policy, with the updated version due to be launched in Q2 2025.
- The national developments highlighted the requirement to shape key roles necessary to embed a culture of openness and transparency:
    - The Framework identified the need for clinical champions (or managerial champions, in services where there are no clinicians employed) to provide peer-to-peer support for other staff, primarily doctors who lead out on open disclosure. This role is new and the revised HSE Open Disclosure Policy describes the requirement for each hospital or health and social care service. It will be a priority area to support and develop in 2025. The Department of Health seek assurances in relation to the establishment of this role as part of its annual reporting requirements.
    - The Patient Safety Act 2023 describes the legal requirement for a designated person (key point of contact for on-going communication for the patient/family) if there is a notifiable incident. Resources and supports have been developed for services to embed and support this role. Whilst this is well established in many services, it still warrants embedding.

This report includes responses to the relevant reporting requirements set out in the Framework. The National Open Disclosure Office provided a number of the organisational responses in relation to training compliance figures, training development, open disclosure compliance as discussed already and the policy. In 2024, the HSE developed several training programmes and resources. Particular focus was of course on targeted training development in relation to the Patient Safety Act 2023 and the Framework. Overall compliance with mandatory training requirements remained good.

HSE and HSE-funded services championed many communication and engagement events for their staff driven by local open disclosure leads, trainers and the national team, acknowledging their significant work in this area. Regional Health Areas (RHAs) and National Services were asked specifically to provide information on:

> c. Evidence of the availability of support structure for all staff clinical and non-clinical including agency staff.
>
> e. The number of appointed and trained clinical and managerial open disclosure champions.

The collated feedback from RHAs and National Services has been insightful. There is evidence of robust support mechanisms in place in certain services. That is in particular due to the established network of open disclosure leads, trainers, well established training programmes, engagement events and regular communications as well as established governance structures. Some novel approaches to supporting staff were also highlighted such as local Critical Incident Stress Management support, induction guides developed locally and multi-disciplinary integrated training on safety, risk and open disclosure. Lastly, the returns have highlighted the need for working with services to undertake a gap analysis in terms of Section 38 organisations to ensure all are included here as this was stipulated by the Department of Health in Q1 2025 as a requirement. The organisation will continue to develop its assurance programme and progress necessary steps to inform future annual reports.

2. Introduction

The HSE is committed to driving a patient safety culture that is open and transparent. It is the policy of the HSE that patients who experience harm due to a patient safety incident or notifiable incident are communicated with in an open, honest, empathic and timely manner and that an apology which is sincere and meaningful is provided.

In 2024, there was a system-wide focus on this policy area in Ireland impacting public and private health and social care service providers, academic and educational institutions as well as professional and healthcare regulators. The national developments focusing minds were the:

- launch of the Department of Health National Open Disclosure Framework 2023 toward the end of 2023 (the Framework for short)
- commencement of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 in September 2024 (the Patient Safety Act 2023 for short)

HSE and HSE-funded organisations worked with many staff and patient partners, to successfully implement the necessary requirements of both the Framework and the Patient Safety Act 2023.

The 2024 HSE National Service Plan included particular reference to open disclosure, reflecting the national developments and organisation's commitment to this area of work. It stated that in 2024, the HSE would:

> Drive quality and safety improvement through implementation of the HSE Patient Safety Strategy 2019- 2024, including implementation of improvement programmes to address the common causes of harm, development of a national quality and patient safety competency framework, **delivery and monitoring of the HSE's implementation plan for the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 with the Health Regions, implementation of the Open Disclosure policy in line with National Open Disclosure Framework,** and implementation of nationwide electronic incident reporting (HSE National Service Plan, 2024)

The HSE expanded its programme of work on open disclosure by providing a rich training programme, developing resources, supporting staff and patients, progressing its assurance programme established in 2022 and leading out on an extensive communication and engagement strategy.

This annual report provides a summary of the key developments and work of the HSE and HSE-funded services in driving a culture of openness and transparency. It is the first of its kind aligned to the requirements of the National Open Disclosure Framework 2023 which requires an annual report to be submitted to the Minister/Department for Health. Information and progress updates are included on the reporting requirements of the Framework.

3. Governance

Under the Health Service Executive (Governance) Act 2019, the Board of the Executive (the Board) is the governing body of the Health Services Executive (HSE), accountable to the Minister for Health for the performance of its functions. The HSE Chief Executive Officer is the accountable officer to the Board for the running and operation of the HSE. Accountability has been delegated to the relevant Senior Accountable Officer as stipulated in the Performance and Accountability Framework 2023[1].

Whilst open disclosure is the responsibility of all staff, key roles and governance structures have been established to help embed open disclosure. This section of the report highlights relevant developments that occurred in 2024 pertinent to open disclosure and the established governance structures. Key developments include the progression of Sláintecare, the Framework and Patient Safety Act 2023, and the revision of the HSE Open Disclosure Policy.

Sláintecare

2024 was a year of great change in the HSE. Progression of Sláintecare, the HSE and Department of Health's overall improvement plan and strategy for reforming Ireland's health and social care system, led to organisational and governance restructuring of the HSE. Moving from a bilateral operational system of acute and community care, the HSE transitioned to a model of integrated care across six HSE Health Regions. The move to a regionalised approach represented a shift in the approach to the planning, funding and delivery of health and social care services. It was envisioned that each Health Region would have the autonomy to plan and deliver the health and social care services to meet the needs of their local population. Work progressed throughout 2024 and will continue into 2025 to re-shape and re-model the required governance and assurance structures.

The HSE Accountability and Performance Framework 2023 incorporated the organisational change to Health Regions. Accountability for the implementation for open disclosure aligned with the revised structure, with the Senior Accountable Officer (SAO) of a given Health Region or National Service effectively taking on this responsibility. The integrated approach to health and social care is a positive development in terms of incident management and open disclosure because it is anticipated that the management of both will also take an integrated approach across services where necessary. Up to now, there have been instances of organisations managing such events in isolation although incidents span over multiple services or organisations with the potential of leading to an inferior response compared to a comprehensive response. Whilst there was some uncertainty in terms of roles and responsibilities whilst this significant change was progressed, open disclosure very much remained at the forefront of the organisation. A key objective in updating the HSE Open Disclosure Policy was to incorporate the emerging changes to organisational and governance structures driven by Sláintecare.

As part of the overall health reform agenda and introduction of new operating models, there was a parallel redesign of the current HSE centre. In that context, National Quality & Patient Safety function remained under the remit of the Chief Clinical Officer (CCO) to lead on policy development, procedures and assurance of quality and safety across the health system.

The Department of Health National Open Disclosure Framework 2023

The Framework was published by the Department of Health (DOH) in October 2023. The Framework aims to promote a clear and consistent approach to open communication with patients/service users and relevant support person(s) following a patient safety incident. It also

[1] As this is the 2024, the 2023 Performance and Accountability Framework applies.

further promotes the importance of a just culture. The Framework applies to both the public and private sector and must be implemented.

The Framework is closely aligned to the HSE Open Disclosure Policy, meaning that the HSE had already progressed a number of the Framework requirements. The Framework, however, has introduced some new governance requirements and roles pertinent to further help embed open disclosure.

First, the Framework introduces the new reporting requirement to the Minister/Department of Health (DoH) on a number of compliance measures. The Framework requires each health and social care service provider to submit an annual report, in the first week of April, reporting on;

a. Development and implementation of open disclosure policy.
b. Development and implementation of open disclosure training for all clinical and non-clinical staff including agency staff.
c. Evidence of the availability of support structure for all staff clinical and non-clinical including agency staff.
d. The number of trained clinical and non-clinical staff including agency staff.
e. The number of appointed and trained clinical and managerial open disclosure champions.
f. The number of open disclosure events initiated and closed.

The first annual report is to be submitted in April 2025. The HSE liaised with the DoH on the reporting requirements and approach to report submission. It was agreed that the HSE would submit one annual report incorporating information and data, where available, from the different health and social care services on the six measures described above. The DoH requested that the HSE incorporate reporting on section 38 voluntary organisations, whereas section 39 voluntary organisations were approached separately by the DoH. It was agreed that the requirements of the Framework would be streamlined into the established National Open Disclosure Annual Report, which has been produced since 2019 following the Dr. Gabriel Scally review (2018). Sections of this annual report that address Framework reporting requirements are indicated with an image of the Framework document.

Secondly, the Framework also emphasises the importance of open disclosure and managerial champions. Leadership and “champions” from both clinical staff and health and social care service provider management are required to drive a culture of open disclosure. A peer-led approach is critical as it is acknowledged that, for example, junior doctors learn from senior doctors whom they respect and emulate. Champions of open disclosure are equally important in non-clinical settings, thus necessitating the identification of managerial open disclosure champions to lead and promote open disclosure policy there. Each service (hospital, community, or national service, e.g. the National Ambulance Service, National Screening Service) should have an Open Disclosure Clinical Champion. In services where there are no clinicians working, this may be an Open Disclosure Managerial Champion. Open disclosure champions:

- Promote open disclosure policy, education, training, and practice in a service;
- Provide peer support for colleagues and role model best practice;
- Take a leadership role in open disclosure within their service by championing open disclosure as the right thing to do;
- Signpost staff to resources available to them to guide them through the open disclosure process.

The requirement for such a role is new. The HSE Open Disclosure Policy 2025 describes the role, its purpose and the requirement for one champion per hospital or service. It will be a key area of focus for the organisation in 2025.

Irrespective of the Framework, the HSE and HSE-funded services have been working towards a more robust assurance programme in relation to open disclosure compliance over the last few years to complement the positive work in this area already undertaken. There has been significant progress to achieve and meet the reporting requirements.

The Patient Safety (Notifiable Incident and Open Disclosure) Act 2023

The Patient Safety Act 2023 was enacted into law in May 2023 and commenced on the 26 September 2024. It provides a legal framework for patient safety, in particular as it relates to open disclosure. The legislation is applicable to public and private health or social care service providers, and sets out the:

- Legally mandatory requirement for open disclosure, by health and social care service providers, of certain incidents occurring in the course of the provision of a health service to a person. Specifically, the Act describes 13 different incidents, termed notifiable incidents, whereby open disclosure must take place in line with the legislation;
- Requirement for organisations to report notifiable incidents to regulators, specifically the Health Information and Quality Authority, Chief Inspector of Social Services and the Mental Health Commission (as appropriate), and it requires such notifications to be made via the National Incident Management System (NIMS);
- Legal protections in relation to the information shared at the time of open disclosure and any apologies made in the course of such disclosures where the incident is a notifiable incident;
- Provisions for procedures in respect of clinical audit, and the data obtained in clinical audits;
- Amendments to the Health Act 2007 to adapt the threshold for Health Information and Quality Authority (HIQA) to carry out statutory investigations and expansion of monitoring into private hospitals;
- Amendments to Part 4 of the Civil Liability (Amendment) Act 2017 which relates to all patient safety incidents;
- Mandatory communication by health or social care service providers of results following patient requested cancer screening reviews (specific to breast, bowel and cervical national cancer screening programmes);
- Non-compliance with the reporting of a notifiable incident to the relevant regulator or not holding the required open disclosure meeting(s) can result in a Class A fine. It is a defence to demonstrate all reasonable efforts were made to ensure compliance.

In 2024, the HSE and HSE funded services progressed a comprehensive implementation plan to prepare the organisation and its staff for its implementation. Key areas of work focused on:

- The establishment of a **HSE Patient Safety Act Implementation Working Group** under the remit of the Chief Clinical Officer with representation from HSE staff across many different services, HSE-funded organisations, patient partners and external agencies (for example the Patient Advocacy Service)
- The enhancement of the **National Incident Management System (NIMS)** to enable the reporting of notifiable incidents to the relevant regulator using the system. This technical development was supported by a collaborative project involving the Department of Health,

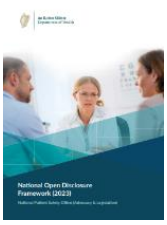
HSE, HIQA, the Mental Health Commission and the State Claims Agency. HSE staff supported the testing of the technical developments. The HSE developed numerous resources for its staff to support them. In addition to the Patient Safety Act requirements, the HSE and SCA significantly improved the reporting functionality on NIMS in relation to open disclosure for all incidents, not just notifiable incidents.

- The **development of necessary open disclosure resources and training materials,** including the production of new resources and the revision of existing resources. The HSE and patient partners developed two e-learning programmes for HSeLanD: one on the Patient Safety Act 2023 and one on the Designated Person role. The HSE further developed many templates and guidance documents for staff. This is elaborated on further in this report.
- The HSE worked with **legal services** to interpret and understand the requirements of the Patient Safety Act. A guideline on the Notifiable Incidents is in development currently and will complement the forthcoming HSE Open Disclosure Policy 2025.
- **Screening services** progressed the requirements as set out in the Patient Safety Act 2023 and aligned these with the significant work that was already underway in relation to cancer screening reviews.
- **Clinical audit provisions** were reviewed and HSE resources aligned to the Patient Safety Act 2023.

A significant communication and engagement plan supported the implementation of the Act. This is elaborated on further on in this report.

It is of note that commencement of legislation from the date of enactment is usually two years. The Patient Safety Act 2023, however, was enacted within 16 months of commencement with no additional resource. This was at a time of significant organisational change throughout the HSE, as already stated. Focus in 2025 will be on embedding the requirements of the Patient Safety Act 2023; developing reports and assurance programmes; and continuing to support staff. The Patient Safety Act 2023 can be accessed here: Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (irishstatutebook.ie)

The HSE Open Disclosure Policy



National reporting requirement:

Development and implementation of open disclosure policy

The HSE has had an open disclosure policy in place since 2013. In its first inception, the policy was written collaboratively between the HSE and the State Claims Agency. The development of the 2013 policy was influenced by international developments in this area of healthcare and emerging research and literature, highlighting the benefits of an open and transparent approach following patient safety incidents.

Following on from the Dr. Gabriel Scally Report of the Scoping Inquiry into the CervicalCheck (2018) and the 2018 commencement of the Civil Liability (Amendment) Act 2017, the open disclosure policy was significantly revised. The *HSE Open Disclosure Policy - Communicating with Patients Following Patient Safety Incidents 2019* set out policy requirements for open disclosure, emphasising a move away from 'should' undertake open disclosure to 'must' undertake open disclosure. The 2019 policy applies to all publicly funded health and social care services.

In 2024, the 2019 policy was again significantly revised following key national developments and extensive consultation with patients, patient advocates, HSE staff and leaders as well as external agencies. It is due to launch in Q2 2025.

The work of revising the policy was a key output of the National Open Disclosure Office in 2024. The National Open Disclosure Steering Committee oversaw the development of the policy and incorporated national developments such as the Patient Safety Act 2023, the Framework and international developments by the World Health Organisation. Furthermore, the revised policy incorporates learning the HSE gathered in relation to open disclosure over the last number of years to further drive improvements in this area. This learning was informed by commissioned research, a literature review of international research and best practice and feedback from patients/service users/relevant persons, patient partners, advocacy services and staff.

The draft policy was circulated for far-reaching consultation and advertised to the public in Q3 of 2024. After a six-week window, feedback was collated, analysed and mostly incorporated in the revised version.

The policy revision focused on:

- Maintaining the patient and their relevant person at the forefront of the revised policy. Underpinning the importance of good, honest, compassionate communication where all involved in an incident are supported whilst incorporating the new requirements of national developments.
- Aligning it to the requirements of the National HSE PPPG National Central Repository framework and incorporating the new requirements stemming from national developments such as the Framework, the Patient Safety Act 2023 and the Civil Liability (Amendment) Act 2017.
- Outlining the many influencing factors that clearly describe the need for open disclosure. It outlines moral, policy, professional, regulatory and legal obligations for open disclosure. The revised policy outlines roles and responsibilities in the HSE for leading and implementing open disclosure. The roles and responsibilities are all encompassing.

- Describing the importance of support for patients, their relevant person and staff. The importance of supporting those impacted by an incident will help prevent compounded harm. Supporting staff is equally important to ensure they are able to deliver on the requirements of the policy, and that they are supported by accountable officers through the open disclosure process. Many incidents span over several teams and the policy emphasises the importance of services working together to provide the patient and/or their relevant person, as well as staff, with the most comprehensive and supportive experience across health and social care services at such difficult times.
- Including information concerning the importance of meaningful involvement in incident management processes for patients/their relevant person and introducing the concept of restorative practice.
- Highlighting the need for a proportionate response whereby it is acknowledged that open disclosure is a 'process' often involving multiple interactions and conversations concerning an incident, in particular for more serious incidents.
- Incorporating and describing the new sub-set of incidents, referred to as 'notifiable incidents' which apply a legal mandate for open disclosure as set out in the Patient Safety Act 2023. In the Act there are 13 notifiable incidents listed. Importantly, the revised policy emphasises throughout that the policy applies to ALL patient safety incidents. The open disclosure process described in the revised policy applies not only to notifiable incidents, but also category 1 incidents (severe harm or death) and category 2 incidents (moderate harm) as defined in the Incident Management Framework requiring a meeting, written follow-up and sharing of incident review findings. The HSE Impact table of the HSE Risk Enterprise Policy 2022 is incorporated in the policy so that staff can apply it as an objective tool for assessing harm.
- Aligning requirements for open disclosure meetings, documentation and written follow-up with the Patient Safety Act 2023 and the amended Civil Liability (Amendment) Act 2017 requirements. A consistent approach is essential for all in terms of managing expectations, patient/relevant person experience and staff understanding as to the requirements.
- The written record as part of the open disclosure process for category 1, category 2 and notifiable incidents can take the form of a compassionate letter. Template letters were developed to ease the administrative burden for staff and read compassionately and person-centred for patients and their family. A letter is a minimum requirement. It is critical that following incidents where patients experience such harm that services follow-up in writing on the open disclosure and share the salient points discussed. Such a requirement is in line with other international jurisdictions. Whilst it was a requirement of the 2019 policy to share minutes after disclosures for category 1 and category 2 incidents, it can be a significant administrative burden that is not resourced. Healthcare staff reported that minutes were not routinely shared for category 2 incidents (moderate harm). For all these reasons and in collaboration with patient partners template letters were developed.

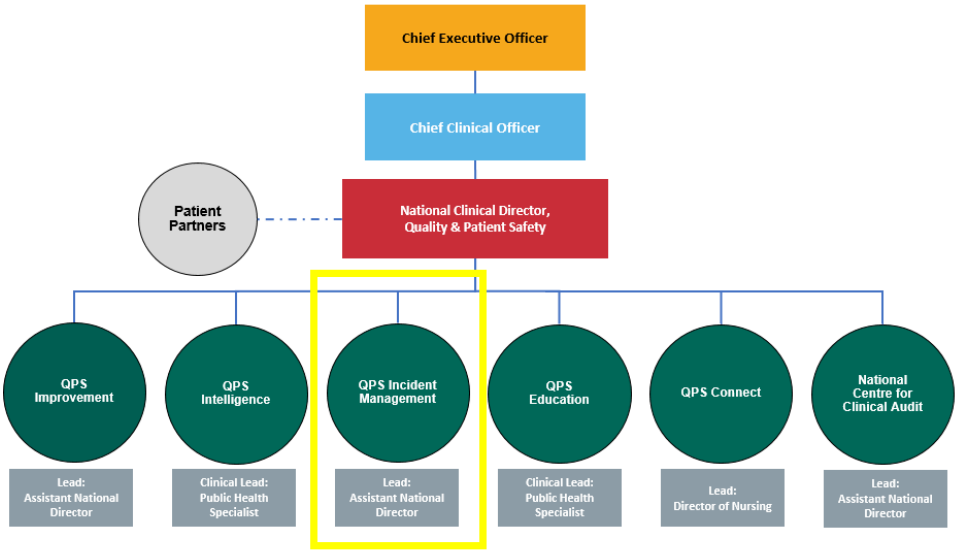
The policy is progressing through the various layers of governance and approval in early 2025. The HSE Open Disclosure Policy 2025 will be launched in Q2 2025, accompanied by communication and engagements as well as an implementation plan. The revised policy applies to all HSE and HSE-funded services.

All details on current and revised open disclosure policies can be found on the HSE open disclosure website pages.

National Open Disclosure Office, Quality and Patient Safety Incident Management

The National Open Disclosure Office is a function of the Quality and Patient Safety Incident Management (QPSIM) team as part of National Quality and Patient Safety Directorate (NQPSD), which is under the remit of the HSE Chief Clinical Officer (CCO).

National Quality and Patient Safety Directorate 2024



The QPSIM team brings together a number of functions critical to incident management, namely the National Open Disclosure Office, Incident Management, Patient Safety Together and the HSE National Incident Management System (NIMS). The HSE Open Disclosure Policy and Programme is co-ordinated via QPS Incident Management 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 team contact details can be found in the appendix of this report.

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

(i) The HSE Open Disclosure Policy;

(ii) The Department of Health National Open Disclosure Framework 2023;

(iii) The Patient Safety (Open Disclosure and Notifiable Incidents) Act 2023;

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

(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 QPSIM in National Quality and Patient Safety. The team apply a collaborative approach across the key 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 2024.

The National Open Disclosure Steering Committee (NODSC)

The HSE National Open Disclosure Steering Committee was established in April 2019 in order to strengthen corporate oversight, strategic leadership and accountability with the ongoing implementation of the national open disclosure programme and policy.

The Steering Committee is chaired by the National Clinical Lead for the Quality and Patient Safety Directorate and has representation from across a range of HSE services, the State Claims Agency and patient representatives. The Steering Committee 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 was key in developing the revised HSE Open Disclosure Policy 2025.

The committee met on a scheduled basis throughout 2024. Further information on the committee, terms of reference and the minutes of committee meetings held throughout the year are available here.

4. Supporting Patients

HSE Open Disclosure Policy 2025

As noted, the revised HSE Open Disclosure Policy, to be launched in Q2 2025, includes a chapter outlining the range of open disclosure supports available to patients and staff. On consultation, this was very well received by both.

The Designated Person

The commencement of the Patient Safety Act 2023 introduced a legal mandatory requirement for the appointment of a Designated Person in the management of notifiable incidents; this is also policy for certain patient safety incidents. The Designated Person is assigned to act as a liaison between the health services provider and the patient or relevant person (or both of them) in relation to the open disclosure of the patient safety or notifiable incident. The Designated Person has been described as a “lifeline of communication” by Mrs Bernie O’Reilly (Patients for Patient Safety Ireland).

The appointment of a Designated Person by services may be on a case-by-case basis, such that there may be many different people taking on the role rather than one person assigned to respond to all circumstances requiring a Designated Person. As such, the support offered to these individuals, and by extension their services and the patient population, needs to be ongoing, responsive and informed by practical experience of delivering the role.

As part of the HSE National Open Disclosure Team’s ongoing engagement and consultation with health and social care services, the need was identified for additional focused engagement and support around the role of the Designated Person. A range of tools were developed and shared via the open disclosure website, including a Designated Person Checklist and

- The role of the designated person (September 2024) (PDF, 216 KB, 8 pages)
- Designated person checklist (September 2024) (Word, 87 KB, 3 pages)

A workshop to support the role of the Designated Person is scheduled for early 2025, to help inform the ongoing approach to support regional QPS services and Designated Persons, whether it is through further in-person workshops or other methods / events.

An e-learning programme was developed for all staff to access and dip in and out of as needed. This was developed with patient partners and staff. It is called: ***The Role of the Designated Person in Incident Management and Open Disclosure***

The module was launched on HSeLanD in July 2024. It was designed to assist people in the role of the Designated Person, supporting patients and their relevant person(s) after an incident. The module provides clear guidance on legislation, policy, practice and the importance of self-care as it applies to incident management and open disclosure. It is accredited for CPD: 2 CEUs NMBI/2 external CPD points RCPI

Between July and December 2024, there were **464** completions of this module on HSeLanD.

Evaluations of this module indicate that it has been received well by users. Between July and December 2024, 182 evaluations were completed on HSeLanD.

Likert scale responses

- The e-learning content met my expectations: 86% (157) chose “strongly agree” or “agree”
- The content of the programme was clear and easy to understand: 85% (153) chose “agree” or “strongly agree”
- I have learned practical skills that I will apply in my area of work: 85% (150) chose “agree” or “strongly agree”
- I would recommend this programme to others: 86% (150) chose “agree” or “strongly agree”

Qualitative Feedback

- “Detailed, clear and step by step process for a designated person”
- “Excellent course, the resources were really helpful.”
- “I would be changing absolutely nothing about this programme. It is self-explanatory and easy to understand. Thank you.”
- “The e learning provides flexibility for me and also allows me to navigate through variety of courses related to my profession. Keep up the good work.”

Supporting patients throughout the open disclosure process is a key objective for HSE-staff within services. A number of resources for patients were developed and further resources are planned for 2025. In particular, revision of patient information leaflets following feedback from front-line staff.

Restorative practice

Restorative practice focuses on improving and repairing relationships and social connections among people. It is based on a set of core values and the explicit promotion and enhancement of particular skills such as the ability to empathise and to find solutions to specific problems. It has been proven to bridge communication between healthcare professionals and patients, particularly where communication has broken down, such as when patients have had a negative experience in relation to the incident review or open disclosure process.

The HSE submitted a bid for Sláintecare funding to support the development of a programme of work involving training, research, facilities and pilot to roll-out restorative practice across the HSE. The outcome of that proposal and bid is awaited in 2025.

5. Supporting Staff

National reporting requirement:

Evidence of the availability of support structure for all staff clinical and non-clinical including agency staff.

National reporting requirement:

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

Open Disclosure Training Development

Open disclosure training is essential for staff to help build their confidence and skill in open disclosure. It 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 Human Resources in July 2022 setting out the mandatory training requirements, how to access training and accountability arrangements in relation to same. It is the responsibility of each service manager (through Senior Accountable Officers and Local Accountable Officers) 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.

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 the open disclosure process and meetings 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 may include, for example, senior managers, doctors and consultants, senior nurses and midwives, health and social care professionals, quality and patient safety professionals, and staff fulfilling the role of the Designated Person. Relevant staff must be identified locally and provided with access to this training.

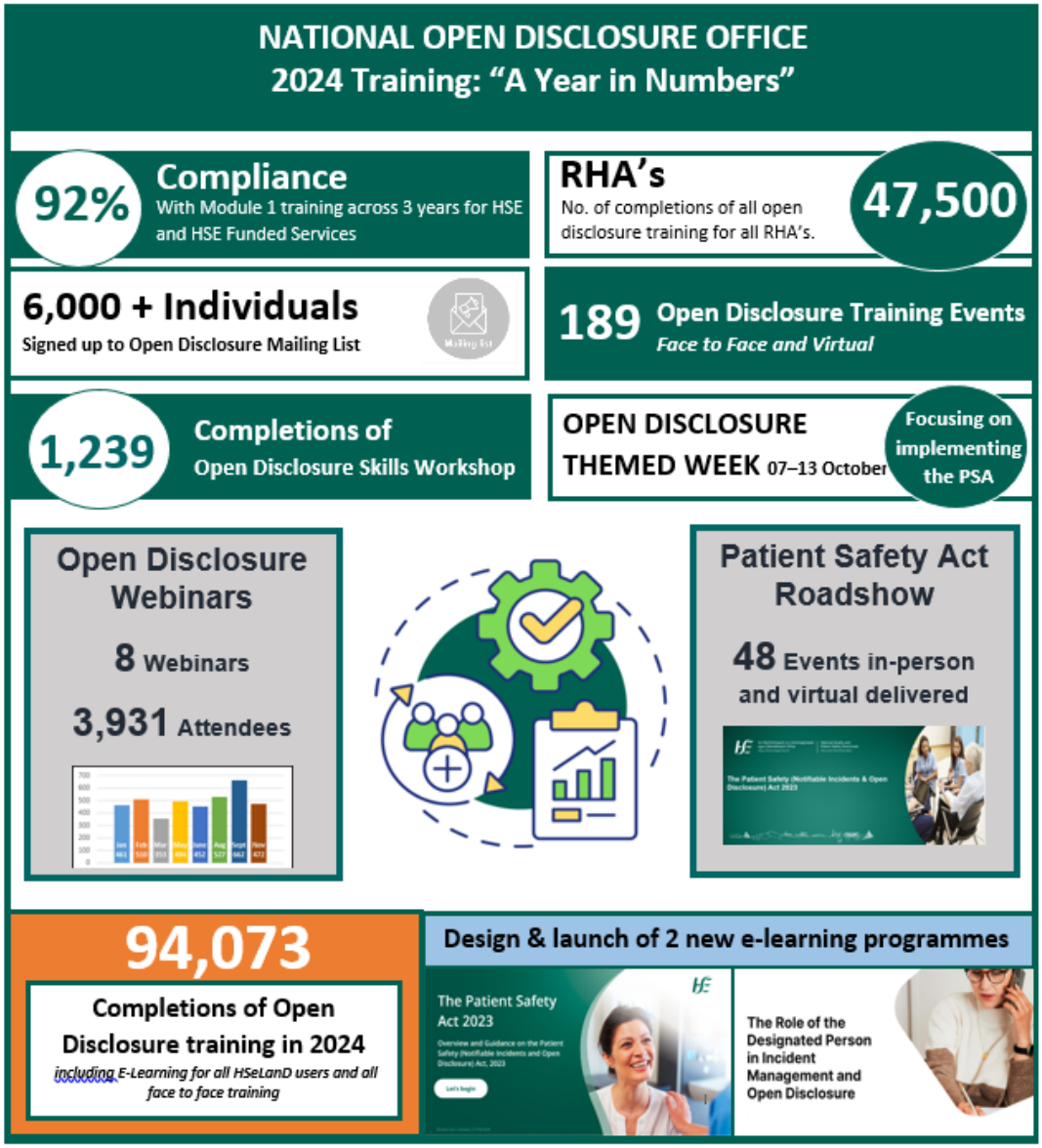
The final report of the Scoping Inquiry into the CervicalCheck Screening Programme, undertaken by Dr. Gabriel Scally in 2018, highlighted the requirement for open disclosure training. Recommendation 30 in the report identified: *"A detailed implementation programme must be developed that ensures the principles and practice of open disclosure are well understood across the health service**. In particular, medical staff must be required, as a condition of employment, to complete training in open disclosure***."

Information on the structured open disclosure training programmes is provided in the following table:

Training Programme	Delivery	Description	Target Audience
Module 1: Communicating Effectively through Open Disclosure	eLearning via HSeLanD	An overview of Open Disclosure, the principles for the management of the process, and the role of staff.	Mandatory for all staff in HSE and HSE-funded services.
Module 2: Open Disclosure: Applying Principles to Practice	eLearning via HSeLanD	Preparing for and managing open disclosure meetings following a patient safety incident or notifiable incident.	Mandatory for staff who may be involved in the open disclosure process in HSE and HSE funded services.
Module 3: Face to Face Skills Workshop	Half day in-person workshop	Enhance skills to engage in effective and meaningful open disclosure, including managing the open disclosure process and exploring policy and legislative requirements.	Mandatory for staff who may be involved in the open disclosure process in HSE and HSE funded services.
Overview of the Patient Safety Act 2023	eLearning via HSeLanD	Provides an overview of the main provisions of the Patient Safety Act and its legislative requirements, including case studies and the roles and responsibilities of staff to ensure compliance.	All staff as relevant working in health and social care services.
The Role of the Designated Person in Incident Management and Open Disclosure	eLearning via HSeLanD	Outlines the role of the Designated Person in supporting patients and their relevant person(s) after an incident. Includes guidance on legislation, policy, practice and the importance of self-care.	Staff who currently undertake the role of Designated Person, and those who may fulfil the role in the future.
Open Disclosure Train the Trainer Programme	1½ days hybrid (virtual + in-person)	Provides attendees with the appropriate skills to deliver open disclosure training and to support staff in their service. The programme is split into 2 parts: Part A (3 hour virtual) & Part B (full day workshop).	Staff as nominated by their line managers.

The HSE national open disclosure training programme is continually adapting to reflect the changing needs of services and in response to developments in open disclosure nationally including changes to policy, legislation, frameworks, and in response to feedback provided via training programme evaluations referenced below.

Image: National Open Disclosure Office Training and Education – A Year in Numbers 2024



Module 1 Evaluation (2024)

In 2024, there were 38,367 evaluations completed for Module 1.

Likert scale responses:

- The e-learning content met my expectations: 84% (32,206) chose "strongly agree" or "agree"
- The content of the programme was clear and easy to understand: 87% (32,742) chose "agree" or "strongly agree"
- I have learned practical skills that I will apply in my area of work: 84% (31,520) chose "agree" or "strongly agree"
- I would recommend this programme to others: 85% (31,668) chose "agree" or "strongly agree"

Qualitative Feedback:

- "I found the course laid out all the topics in an easy to understand and follow nature, I don't think there is anything to change."
- "Plenty of examples from different disciplines."
- "This course helped me understand better what Open Disclosure is and how to better use communication skills."

Suggested areas for improvement include minor edits to examples and case studies used, and updates to elements of the structure.

Module 2 Evaluation (2024)

In 2024, there were 10,736 evaluations completed for Module 2.

Likert scale responses

- The e-learning content met my expectations: 83% (8,827) chose "strongly agree" or "agree"
- The content of the programme was clear and easy to understand: 84% (8,917) chose "agree" or "strongly agree"
- I have learned practical skills that I will apply in my area of work: 82% (8,677) chose "agree" or "strongly agree"
- I would recommend this programme to others: 83% (8,709) chose "agree" or "strongly agree"

Qualitative Feedback:

- "The programme covered well the many situations to describe open disclosure."
- "The curriculum is excellently documented, and I really enjoyed the practical video."
- "I really appreciated the extra documentation, and links provided. It was interesting to expand upon the learning provided, and I really appreciated the blended visual, auditory, and quizzes of this programme."

Suggested areas for improvement include adding more examples of communication during open disclosure meetings and using more engaging videos in the module.

Face-to-Face Skills Workshop Evaluation (2024)

The Face-to-Face Skills Workshop is a three hour in-person workshop which focuses on the management of the open disclosure process. It was developed to support all staff who may be involved in the open disclosure process and open disclosure meetings.

In 2024, the National Open Disclosure Office delivered nine skills workshops across a range of services (149 attendees). The delivery of these face-to-face skills workshops was preparatory for new open disclosure trainers undergoing the Train the Trainer programme and were also facilitated to provide additional support to new open disclosure trainers, as required.

All open disclosure workshops are evaluated using a standardised evaluation tool. Analysis of a random sample of workshop evaluations (27) identified the following:

- 96% of respondents stated this training would change or influence their practice (4% no response).

- 93% of respondents stated their overall assessment of the training is satisfied or extremely satisfied (7% no response).
- 100% of respondents said they would recommend the training to others.

Qualitative feedback:

- “Group discussion and learnt from experts in their role play.”
- “Scenarios. They were "real life" scenarios, it was nice to hear opinions of others, their perspectives and experiences.”
- “Thought provoking, reassuring that this is a structured and supported resource to staff dealing with difficult situations.”
- Interactive component was valued.

The benefits of this format of training delivery for open disclosure has been emphasised repeatedly by open disclosure leads and participants. Clinicians in particular who are a key target group find this format the most engaging as it helps practice the skills needed. Whilst there is a suite of on-line training available, it cannot replace in person training.

Suggested areas for improvement include adding more clinical information in role play scenarios, and further clarity on what scenarios are notifiable incidents.

Train the Trainer (TTT) Programme Evaluation (2024)

The National Open Disclosure Office continued the roll-out of the revised Open Disclosure Train the Trainer (TTT) Programme throughout 2024. The purpose of the TTT programme is to refresh current trainers on the new training programme, including tenets of the Patient Safety Act 2023, and to increase the number of new trainers to the system. Open disclosure trainers are then prepared to facilitate open disclosure skills workshops across their relevant HSE and HSE-funded health and social care services.

National Open Disclosure TTT Workshop in Sligo

The TTT programme consists of a 3-hour virtual module delivered remotely over MS Teams, as well as a full-day in-person workshop. While it is preferable for participants to complete the virtual element of the training in advance of the in-person workshop, it is not mandatory to complete them in order.

In 2024, the National Open Disclosure Programme delivered:

- Five (5) virtual TTT programmes to 45 participants
- Five (5) full-day in person workshops to 58 participants.
- A total of 40 staff completed the full 1.5 day TTT programme.

All TTT workshops are evaluated using a standardised evaluation tool. Analysis of the evaluations received in 2024 (56 Reponses) identified:

- 75% of respondents rated the content of the TTT Programme as excellent, with 25% rating it as good.

Qualitative feedback:

- “Very practical, small group, friendly and comfortable atmosphere.”
- “Great peer engagement and opportunity for shared learning. Workshop facilitator very experienced and gave excellent examples.”
- “Role play gave good insight into different positions people will hold in different scenarios. Information very clearly delivered.”
- “Encourage all the groups to complete the role plays. Some guidance offered if participants get stuck or unsure how to proceed.”
- “More role plays and more time to prepare.”

Training and Resources to support staff with implementing the Patient Safety Act 2023

A core body of work in 2024 for the National Open Disclosure Office was the development of specific training resources to support HSE and HSE-funded services with the implementation of the Patient Safety Act 2023. Again, this work was collaborative with different stakeholders contributing to the development and review of resources. Final outputs were also reviewed by legal and shared with regulators and the Department of Health before publication.

In order to support staff and services in understanding and implementing the Patient Safety Act 2023, the National Open Disclosure Office, HSE-colleagues and patient partners developed two new e-Learning modules for HSeLanD. Significant work went into the build, review and launch of these modules, which both launched in Q3 2024. One of the programmes is the Designated Person training (already discussed) and the other an all-encompassing e-learning programme on the Patient Safety Act 2023, namely the **Overview of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.**

This module launched on HSeLanD in August 2024. It provides an overview of the main provisions of the Patient Safety Act, and the legislative requirements within. It is accredited for CPD: 3 CEUs NMBI/3 external CPD points RCPI.

Between August and December 2024, there were **636** completions of this module on HSeLanD. Evaluations of this module indicate that it has been received well by users. Between July and December 2024, 197 evaluations were completed on HSeLanD.

Likert scale responses

- The e-learning content met my expectations: 88% (173) chose “strongly agree” or “agree”
- The content of the programme was clear and easy to understand: 86% (171) chose “agree” or “strongly agree.
- I have learned practical skills that I will apply in my area of work: 82% (162) chose “agree” or “strongly agree.”
- I would recommend this programme to others: 87% (169) chose “agree” or “strongly agree”

Qualitative Feedback:

- "I found it easy to understand and informative."
- "Very good content and easy to understand."
- "Very Interesting and have learned a lot. There is nothing I would like to change."
- "It is an excellent e-learning programme…not an easy task for such a big piece of legislation."

Resource development and publication on the HSE website

To align with the Patient Safety Act, changes have, and continue to be made, to the open disclosure webpages and the resources available there. Additionally, dedicated webpages were developed to offer staff an introductory overview of the Act and to provide information and resources designed to support implementation of the Patient Safety Act. The Patient Safety Act overview webpage can be accessed here: National Open Disclosure Webpage - Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023

The resources on the Patient Safety Act webpage include:

- An animated video offering an introduction to the provisions and requirements of the Act
- Guidance on recording open disclosure on NIMS and reporting notifiable incidents to the relevant regulator
- Department of Health guidance on the Patient Safety Act
- Flyer highlighting PSA commencement
- PSA e-learning poster
- Booklet of notifiable incident and open disclosure documentation templates (September 2024)
- Guide for the production of written communication for patients, service users and relevant person following open disclosure meetings (September 2024)

Additional resources that were updated include:

Staff wellbeing following an incident

- "ASSIST ME" - A model of staff support following patient safety incidents in healthcare (January 2021)

Designated person role

- The role of the designated person (September 2024)
- Designated person checklist (September 2024)

Training presentations for Open Disclosure Trainers

- Open Disclosure Face to Face Skills Workshop Presentation (December 2024)

Open Disclosure Coaching

Whilst this is discussed briefly here, it is likely one of the most significant contributions and supports offered by the National Open Disclosure Office. The team provide support to staff and services through the provision of coaching and advice on topics relating to open disclosure policy, training, application of relevant legislation and report recommendations, assurance, and the open disclosure process. The coaching augmented the team's provision of training, supports and resources in a practical and pragmatic way to meet the needs of the front line.

In 2024, structured coaching and advice was provided through:

- A regular schedule of meetings for Open Disclosure Leads to keep them informed and updated on developments relating to open disclosure;
- Drop-in coaching sessions for Open Disclosure Leads on the Patient Safety Act 2023 and implications for the open disclosure process and training;
- Timely response to email requests for advice and support, received into the open disclosure email inbox – of which several hundred emails are received per month.
- Provision of bespoke presentations to services in the context of specific topics of interest, such as medication safety or maternity services.

This timely and responsive approach to the needs of the services was a driving force for the implementation of the Patient Safety Act 2023 and a key enabler in ensuring the achievement of over 90% compliance with Module 1 training between 2022 and 2024.

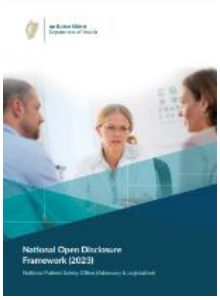
Open Disclosure Leads

There are Open Disclosure Leads in what was formerly known as hospital groups, acute hospital sites, community healthcare organisations, National Screening Service, National Ambulance Service and in many of the Section 38 and 39 voluntary agencies. The role of the Open Disclosure Lead is normally assigned to an individual who is currently working in the remit of quality and patient safety in a service or organisation, and it is not a distinct role in and of itself. Details for the Open Disclosure 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 in their remit 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 Office are engaging with services where it appears that there may be gaps emerging in light of organisational changes. The quality and patient safety model in the health regions was still being designed in 2024 and fortunately many of the extraordinary Open Disclosure Leads continued with this voluntary role.

Open Disclosure Clinical and Managerial Champions



The number of appointed and trained clinical and managerial open disclosure champions.

Clinical and managerial champions are essential to drive a culture of open disclosure across health and social care services. Such a peer-led approach is critical as it is acknowledged that, for example, junior doctors learn from senior doctors whom they respect and emulate.[2] Champions of open disclosure are equally important in non-clinical settings, thus necessitating the identification of managerial open disclosure champions to lead and promote open disclosure.

The revised HSE Open Disclosure Policy 2025 sets out the requirement that each service (hospital, community, or national service e.g. the National Ambulance Service, National Screening Service) has an Open Disclosure Clinical Champion. In services where there are no clinicians working, this may be an Open Disclosure Managerial Champion.

Open disclosure champions:

- Promote open disclosure policy, education, training, and practice in a service;
- Provide peer support for colleagues and role model best practice;
- Take a leadership role in open disclosure within their service by championing open disclosure as the right thing to do;
- Signpost staff to resources available to them to guide them through the open disclosure process.

There is a reporting requirement on the number of champions and whether or not they have been trained. As stated, the HSE has defined the role of the champion in its revised policy and will determine if they have any additional training needs in addition to what is already available.

Details of Open Disclosure Clinical and Managerial Champions has been provided for 2024, based on information returns from RHAs and National Services. It is important to note that this is a new role and only being established. This information is available in the Appendix of this document.

[2] *Recommendations on a National Policy Framework for Open Disclosure in Healthcare in Ireland (2021) Independent Patient Safety Council: https://assets.gov.ie/127396/af15e335-2c88-40a9-9571-371a978409ca.pdf*

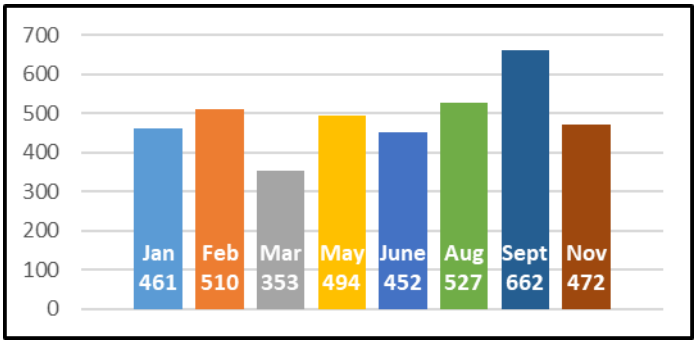
6. Communication and Engagement

The HSE has an extensive communication and engagement programme in relation to open disclosure. This takes a national and strategic approach which permeates the HSE by a well-established network of open disclosure leads and trainers.

A number of channels are used to maintain a high profile on open disclosure and influence the organisation's culture. As noted in 2024, the spotlight was particularly prominent on the Patient Safety Act 2023 and the Framework.

Open Disclosure Webinars

The National Open Disclosure Programme Webinar Series helps maintain communication with Open Disclosure leads, trainers and staff working across all our health and social care services, external agencies and patient representative / patient advocacy groups. Each webinar is allocated CPD: accredited by RCPI (2 external CPD points) and NMBI (2 CEUs).



In 2024, the National Open Disclosure Office facilitated **8 webinars to 3,931 attendees** on a range of open disclosure related topics. Numerous stakeholders from across health and social care services were involved in the delivery of the webinar programme. These webinars provide ancillary support for staff in the implementation of the HSE Open Disclosure Policy; in the management of the open disclosure process; and in identifying and responding to the impact of patient safety incidents on staff.

Details of webinars facilitated include:

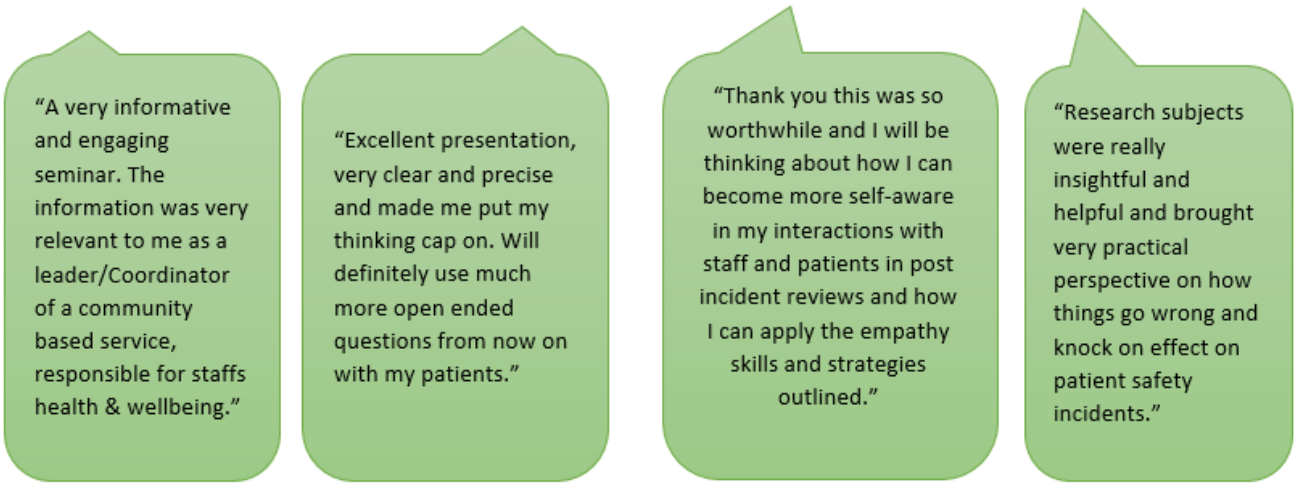
Webinar Title	Date	Total Attendees
"What does Restorative Practice in healthcare look like?" • **Catherine O'Connell**, Lecturer Mediation, Restorative Practice, Mediator, Restorative Facilitator, Conflict Management Coach, PhD Candidate, Maynooth University School of Law and Criminology.	17/01/2024	**461**
"Patient Safety (Notifiable Incidents and Open Disclosure) Act, 2023 – An Overview of the Key Provisions" • This webinar was facilitated by the National Open Disclosure Office and members of the **HSE Patient Safety Act National Implementation Working Group.**	14/02/2024	**510**
"The Patient Safety (Notifiable Incidents and Open Disclosure) Act, 2023 – What it means for me" • This webinar was facilitated by **Dr John Fitzsimmons** and **Juanita Guidera** who led the discussion on the Act with a panel of staff working in various roles across our health and social care services and a patient rep.	20/03/2024	**353**
"Caring for staff after a serious incident in healthcare delivery: Second Victim or Second Casualty" • **Professor Eva Doherty**, Director of Human Factors in Patient Safety, RCSI University of Medicine and Health Sciences.	15/05/2024	**494**
"HSE EAP Supports for Staff Following Patient Safety Incidents" • **Morgan Lucey**, Head of National Employee Assistance Services (MIACP), HSE Workplace Health & Wellbeing Unit.	12/06/2024	**452**
"Patient Safety (Notifiable Incidents and Open Disclosure) Act, 2023 - with focus on the Notifiable Incidents" • Included a **panel of speakers across various health and social care settings**, including the Patient Advocacy Service	14/08/2024	**527**

Webinar Title	Date	Total Attendees
"National Healthcare Communications Programme: Making Conversations Easier: Communication skills for disclosing errors" • **Wini Ryan** from the National Healthcare Communication Programme.	18/09/2024	**662**
"Healthcare staff experiences of adverse events and why they matter so much" • Presented by representatives from the Centre for Innovative Human Systems in TCD: **Prof. Sam Cromie, Erika Carroll, Dr. Julia Louw**	13/11/2024	**472**

Webinar attendees rated the webinar series very highly in 2024, with an average of:

- 99% of respondents stating that the webinar met or exceeded their expectations;
- 94% of respondents reporting that the content of webinars was relevant to them; and
- 96% reporting that the webinar helped them to develop their knowledge and understanding of the subject area.

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

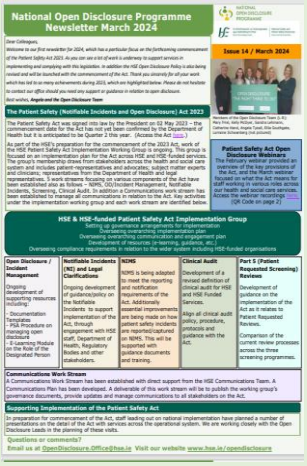


Open Disclosure Newsletters

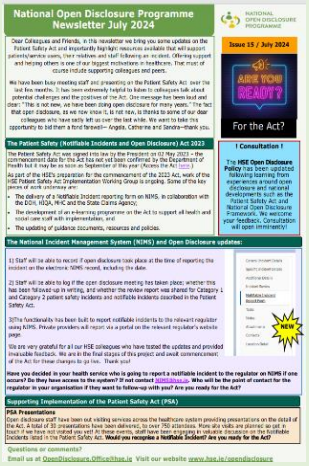
The National Open Disclosure Office published four quarterly newsletters for 2024. The newsletter is cascaded to an extensive mailing list of over 6,000 staff, patient partners and external agencies. It is also available on the HSE website pages.

The newsletter is a concise and engaging means to share relevant information and updates, key messages, educational content, as well as upcoming training, events, and networking opportunities.

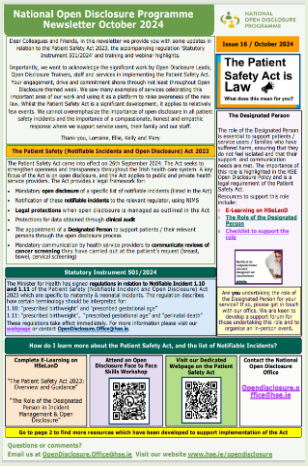
Q1 Newsletter



Q2 Newsletter



Q3 Newsletter



Q4 Newsletter

National Open Disclosure Engagements and Presentations

The National Open Disclosure Office staff delivered a range of bespoke skills workshops, training and presentations to groups as requested throughout the year, based on identified need and balanced by available capacity of the team. Some of these presentations took place outside of normal working hours, to facilitate clinical staff who are attending to patient care during the hours of 9am – 5pm.

Groups presented to include:

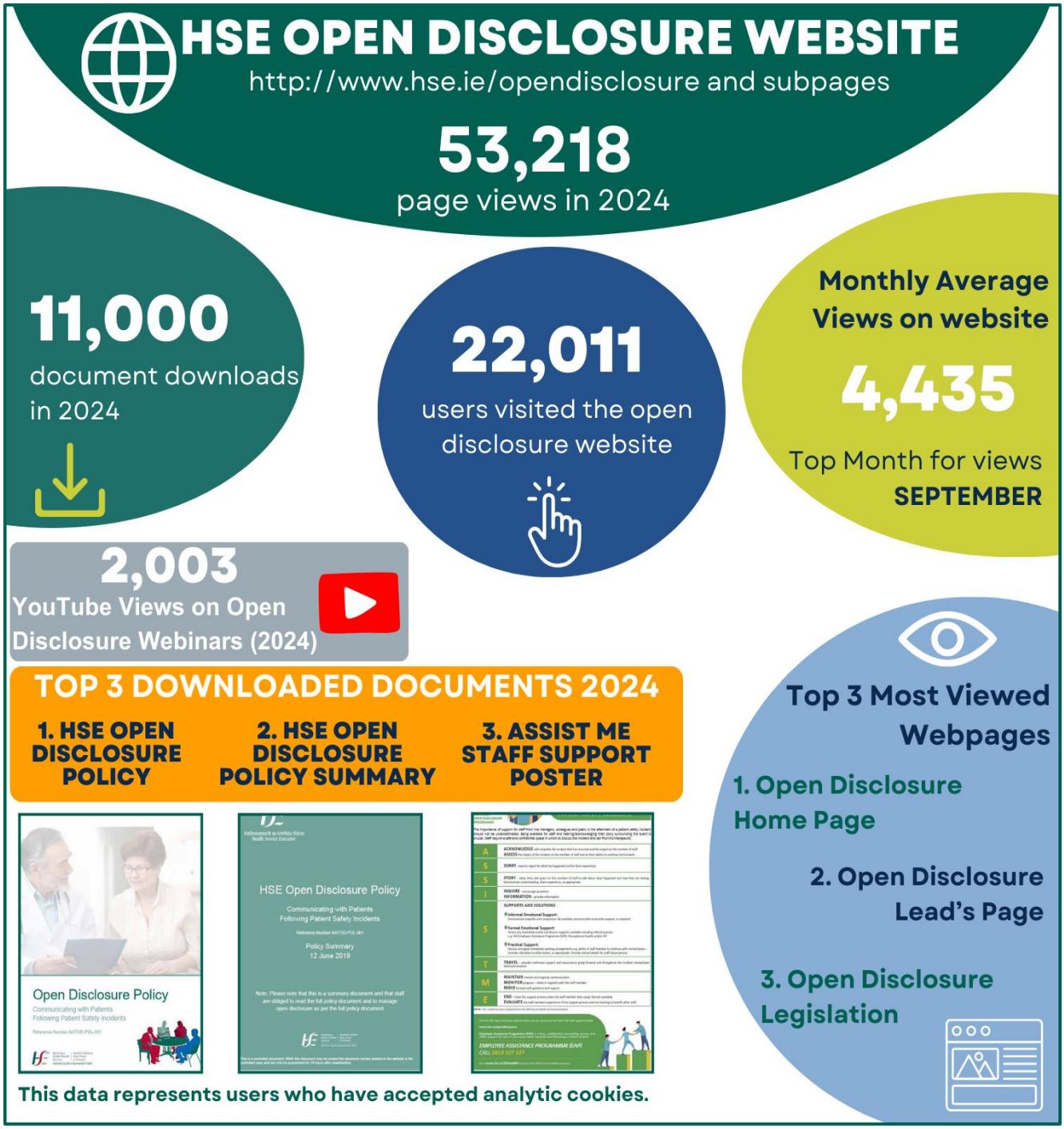
- The Nursing and Midwifery Services Director (ONMSD)
- Patients for Patient Safety Ireland (PFPSI)
- Irish Institute of Pharmacy (IIOP)
- Pharmaceutical Society of Ireland (PSI) – the Pharmacy Regulator
- Patient and Service User Engagement Officers
- Irish Medication Safety Network
- Clinical Communication Committee, St Vincent's University Hospital

In addition to the above, a pilot programme was commenced with University College Dublin in December 2023 involving the introduction of a two-hour open disclosure workshop to fourth- and fifth-year medical students. In April and December 2024, the National Open Disclosure Office

continued its delivery of lectures to fifth year medical students, facilitating a workshop to an in-person and online audience of several hundred students.

Open Disclosure Website

The HSE has produced many resources that are available online via the National Open Disclosure website. User analytics for 2024, as outlined in the figure below, demonstrate significant engagement with website pages and downloads of resources related to open disclosure.



Open Disclosure Themed Week 2024

Open Disclosure Themed Week took place from Monday 7 October to 11 October 2024. The purpose of Themed Week is to raise awareness of the importance of open disclosure for staff, patients and people who use our services, all of whom have a crucial role to play in open disclosure and in improving patient safety.

This annual event is also an opportunity for services to highlight to staff their obligations in relation to open disclosure, to ensure they are compliant with mandatory training requirements and, in particular, that they recognise the importance of providing the opportunities for patients and service-users to actively partner staff in the open disclosure and incident management process. Open disclosure leads and trainers are pivotal in this role and their activities during Themed Week create opportunities to share this information widely in their service area and engage with staff and their questions in relation to open disclosure and incident management. The dedicated Themed Week webpage offered a range of resources to support services with the delivery of their activities, which was in addition to the resources pack they received from the National Open Disclosure Office.

Themed Week in 2024 also provided a platform to engage and support staff with the implementation of the requirements of the Patient Safety Act. With the Act commencing just days before Themed Week began, the timing gave an opportunity to support staff in gaining a better understanding of how this new legislation would impact their work and care. Equally, the daily themes of the week addressed how open disclosure impacts staff and people who use our services and how to support people following patient safety incidents. The daily themes delivered through the sharing of informative videos and links to resources on social media.


Cavan & Monaghan Hospital

Royal Victoria Eye and Ear Hospital

The Mater Hospital



Bray & Wicklow Primary Care Centres & Loughlinstown Health Centre



Sligo University Hospital

Tipperary University Hospital

Poster Exhibitions and Journal Articles

The National Open Disclosure Office provides regular updates to staff working across all health and social care services via contribution to journals and publications.

Open disclosure featured in HSE *Health Matters* and the NQPSD *Quality and Safety Matters* publications with articles in editions across the year.

Health Matters Spring Edition 2024

Spotlight

Spotlight on

Patient Safety

What does the Patient Safety Act (Notifiable Incidents and Open Disclosure) 2023 mean for me

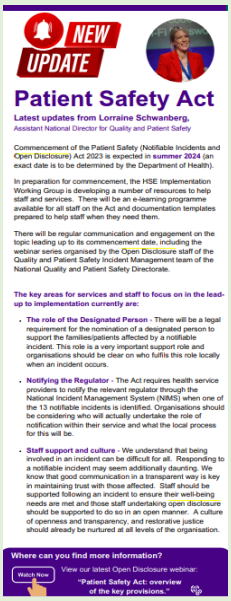
The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 is due to be commenced this summer. The exact date is to be confirmed by the Department of Health. In this article colleagues and partners share their views on the legislation.

Spotlight

THE DESIGNATED PERSON – A CRITICAL ROLE IN INCIDENT MANAGEMENT AND OPEN DISCLOSURE

Angela Tysall, National Open Disclosure Office, explains the role of the Designated Person

Quality and Safety Matters March 2024



NEW UPDATE

Patient Safety Act

Latest updates from Lorraine Schwanberg, Assistant National Director for Quality and Patient Safety

Commencement of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 is expected in summer 2024 (an exact date is to be determined by the Department of Health).

In preparation for commencement, the HSE Implementation Working Group is developing a number of resources to help staff and services. There will be an e-learning programme available for all staff on the Act and documentation templates prepared to help staff when they need them.

There will be regular communication and engagement on the topic leading up to its commencement date, including the webinar series organised by the Open Disclosure staff of the Quality and Patient Safety Incident Management team of the National Quality and Patient Safety Directorate.

The key areas for services and staff to focus on in the lead-up to implementation currently are:

- The role of the Designated Person - There will be a legal requirement for the nomination of a designated person to support the families/patients affected by a notifiable incident. This role is a very important support role and organisations should be clear on who fulfils this role locally when an incident occurs.
- Notifying the Regulator - The Act requires health service providers to notify the relevant regulator through the National Incident Management System (NIMS) when one of the 13 notifiable incidents is identified. Organisations should be considering who will actually undertake the role of notification within their service and what the local process for this will be.
- Staff support and culture - We understand that being involved in an incident can be difficult for all. Responding to a notifiable incident may seem additionally daunting. We know that good communication in a transparent way is key in maintaining trust with those affected. Staff should be supported following an incident to ensure their well-being needs are met and those staff undertaking open disclosure should be supported to do so in an open manner. A culture of openness and transparency, and restorative justice should already be nurtured at all levels of the organisation.

Where can you find more information?

Watch Now

View our latest Open Disclosure webinar: "Patient Safety Act: overview of the key provisions."

Health Matters Summer Edition 2024

The Patient Safety (Notifiable Incident and Open Disclosure) Act 2023

The legislation was enacted in May 2023 and should officially take effect this summer. The aim of the Patient Safety Act 2023 is to further embed openness and transparency across the Irish healthcare system as it applies to private and public healthcare.

In part, it sets out the legal requirement for open disclosure when one of a list of 13 Notifiable Incidents occurs. Notifiable Incidents are defined and itemised in the Act 2023 and predominantly describe events where the patient or service user sadly died.

This Act builds on current Open Disclosure policy, which is being updated to align with it. Whilst the HSE is working towards standardising requirements to make it as seamless as possible to implement the Patient Safety Act 2023, there are some elements specific to open disclosure as described in it:

- The legal requirement for open disclosure applies to one of 13 Notifiable Incidents only. The HSE Open Disclosure Policy applies to all patient safety incidents.
- The health services provider must notify the relevant regulator within 7 calendar days from when one of the Notifiable Incidents is identified. This will be in addition to other regulatory reporting requirements, for example, reporting a Serious Reportable Event to the regulator. Where the Notifiable Incident is also a Serious Reportable Event then it needs to be reported via NIMS as a Notifiable Incident and as an SRE via the current reporting mechanisms.
- Reporting a Notifiable Incident to the regulator must be via the National Incident Management System (NIMS). For users of the system, such as HSE staff, they must access the NIMS incident record and complete a form on the incident record page and submit that electronically to the regulator. This function is currently being built and will be ready for June 2024. For private providers, an electronic portal is being purpose built to enable Notifiable Incident reporting. The portal will be accessible through the relevant regulators website pages.
- The Act makes it a legal requirement to assign a designated person to support their relevant person throughout the open disclosure process of a Notifiable Incident. This is in line with current policy and adds weight to the importance of this role. A designated person is not only desirable but essential.
- The Act is specific as to what must be covered at an open disclosure meeting and within the written follow-up. This is being aligned in the HSE Open Disclosure Policy however, the Act requires that the written record following an open disclosure meeting is shared with the patient or their relevant person within 5 calendar days of the meeting.
- There are offences and penalties that apply to non-compliance with the Act, specifically when the regulator is not notified or an open disclosure meeting is not held as set out in the Act. Importantly, not undertaking open disclosure is detrimental in any situation, in particular where a patient or service user was harmed and may lead to compounded harm. It could be reputationally damaging for an organisation and lead to mistrust in the health services provider by the service user and their relevant person.

Further information on the Patient Safety Act 2023 and resources will be available on healthservice.ie/staff

Health Matters Winter Edition 2024

Patient Safety Act

Staff came together to celebrate and promote the work that is done to support open, honest and compassionate conversations between staff and people who use our services during Open Disclosure Themed Week.

Open disclosure leads and trainers in services across the country delivered a fantastic variety of engagement activities to promote the week. Performing this role in addition to their full-time job, these colleagues were nonetheless ambitious and creative in their approach to developing activities. These included information and promotional stands in public areas and visiting services to ensure that all staff can learn more about Open Disclosure, take away resources and discuss any questions they might have.

In addition to this, there was an opportunity to promote and support staff with the implementation of the requirements of the Patient Safety (Notifiable Incident and Open Disclosure) Act 2023. The act commenced on 26th September, just days before Open Disclosure Themed Week began, so the timing was perfect for supporting staff in gaining a better understanding of how this new legislation would impact their work and care.

The Patient Safety Act seeks to strengthen openness and transparency throughout the public and private Irish health care system. It aims to do this through the introduction of a legal duty to disclose key information about a specified list of incidents called 'notifiable incidents' when they are identified as having occurred in a health service.

This new act requires health services providers to be open and transparent with patients, their families, or both, depending on the patient's choice, when a notifiable incident happens while the patient is receiving care.

The act outlines a clear process for open disclosure, ensuring that patients, their families, or both, receive truthful and timely information in any health or social care setting when a notifiable incident happens.

It is essential for the delivery of safe, high-quality healthcare that we nurture a culture of openness and trust when an incident occurs. The introduction of this act builds on the HSE Open Disclosure Policy and the successes of the Open Disclosure Programme and its aim is to deliver a person-centered approach to incident management and communication.

To support services to implement the act, online resources are available. These are:

1. Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (**bit.ly/PatientSafetyAct2023**) and
2. Resources for staff and organisations (**bit.ly/OpenDisclosureResources**). There is also a module on HSeLand that offers an overview and guidance of the act. This can be found by searching the catalogue for 'Patient Safety Act' on HSeLanD.

For more information, contact **opendisclosure.office@hse.ie** or scan qr code:

In addition, in 2024 the National Open Disclosure Office participated in a poster exhibition at the RCSI Quality and Patient Safety Conference on 12 April 2024.

The poster focused on fostering a culture of openness and transparency through the development of advanced training on open disclosure for medical staff and senior managers. It identified learning from the open disclosure pilot programme in the Mater Misericordiae University Hospital and Cork University, underlining the difficulties staff can experience with open disclosure, and that approaches to open disclosure can vary from organisation to organisation.

The findings of this programme informed a three hour, accredited, face-to-face, skills-based advanced open disclosure programme developed collaboratively and piloted with the delivery of six workshops to medical staff, senior managers and quality and patient safety staff in the HSE West North West Region (Sligo University Hospital and CHO 1).

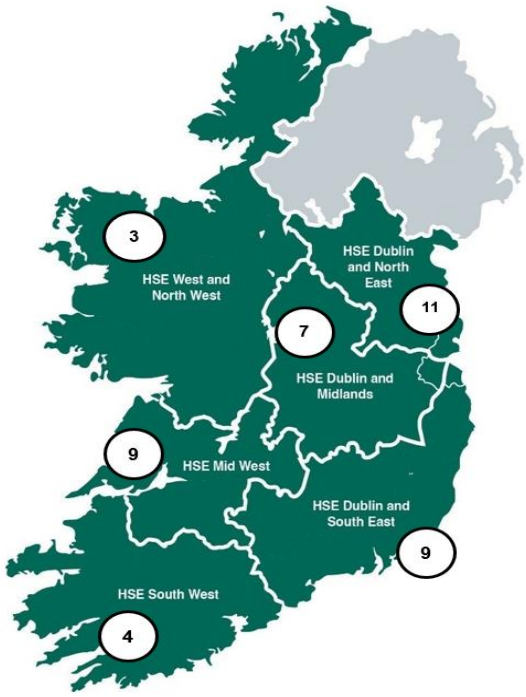
Patient Safety Act – targeted communication and engagement

With a short timeline and wide variety of stakeholders to reach, it was imperative that a robust communication and engagement plan was developed to support services in preparation for the commencement of the Patient Safety Act 2023. The plan, developed as part of the HSE-wide Patient Safety Act Implementation Plan, provided a schedule of regular informative, relevant and consistent messaging for the HSE and HSE-funded services on the Act, its implementation and expectation on the staff and healthcare providers. The content was tailored to the different stakeholder groups and general information was published to be available and accessible to all. The plan gave consideration to the use of multiple channels and a variety of opportunities as part of the stakeholder mapping and the delivery of engagement activities.

As part of the HSE-wide Patient Safety Act Implementation Plan, the National Open Disclosure Team were tasked with delivering a presentation on the new legislation to any HSE and HSE-funded service that took up the open offer.

In the eight months that followed, the team presented to over 1,200 people at 48 in-person and virtual events across the country.

The presentations were delivered to senior management teams, clinical leadership teams, patient safety forums, grand rounds, specialist services training sessions and many other engagement opportunities.



PSA presentations delivered	Number of PSA presentations delivered
HSE Dublin/Midlands	7
HSE Dublin/North East	11
HSE Dublin/South East	9
HSE Mid West	9
HSE South West	4
HSE West/North West	3
National Services (for example NAS	5
Total	**48**

The National Open Disclosure Office also ran two-weekly and then monthly update sessions throughout quarter 2, 3 and 4 for open disclosure trainers and leads, meeting more frequently around the time of commencement. This culminated in a series of comprehensive Patient Safety Act education sessions, peer support and two-way communication between services and the national team to troubleshoot and address any issues reported. This was supported with further follow-up Question-and-Answer sessions.

7. Assurance and Compliance

The HSE and HSE-funded services have progressed significant work in open disclosure over the last decade. A catalyst for change and improvement was the steep learning curve and attention on open disclosure from 2018 onwards. Since then, there has been anecdotal feedback on the improvements towards an open and transparent culture across the organisation. Still, assurance in this area has been limited. The HSE has been working on its assurance programme as a priority.

There are a number of measures the HSE determined to be important to seek assurance with open disclosure compliance. In particular, focus has been on:

- Measuring training compliance with mandatory training requirements
- Measuring compliance with key steps of the open disclosure process
- Developing key performance indicators in line with the Patient Safety Act 2023
- Understanding a patient's/relevant person's experience in relation to open disclosure (and incident management)

The HSE developments fortunately align with the recent reporting requirements set out in the DoH National Open Disclosure Framework 2023. This annual report has already explained the HSE's implementation of its Open Disclosure Policy, the development and implementation of open disclosure training for all clinical and non-clinical staff, the support structures in place for all staff and the progress with regard to rolling out the clinical champion or managerial champion role. This section of the report will incorporate the last two reporting requirements that align with the HSE assurance programme in open disclosure.

National reporting requirement:

The number of trained clinical and non-clinical staff including agency staff

National reporting requirement:

The number of open disclosure events initiated and closed

Training Compliance

Compliance with Open Disclosure Training (Module 1)

As stated, open disclosure training is mandatory for all staff working in HSE and in HSE-funded services. All staff must complete Open Disclosure E-Learning **Module 1** "*Communicating Effectively through Open Disclosure*" which is available on HSeLanD.

HSE staff working within the RHAs completed Module 1 at a steady rate throughout the year. The graph below shows the cumulative % completions of Module 1 by each RHA per quarter for 2024, based on the headcount for the RHAs at 31 December 2024.

The total completions of Module 1 for all RHAs in 2024 was **39,660.**

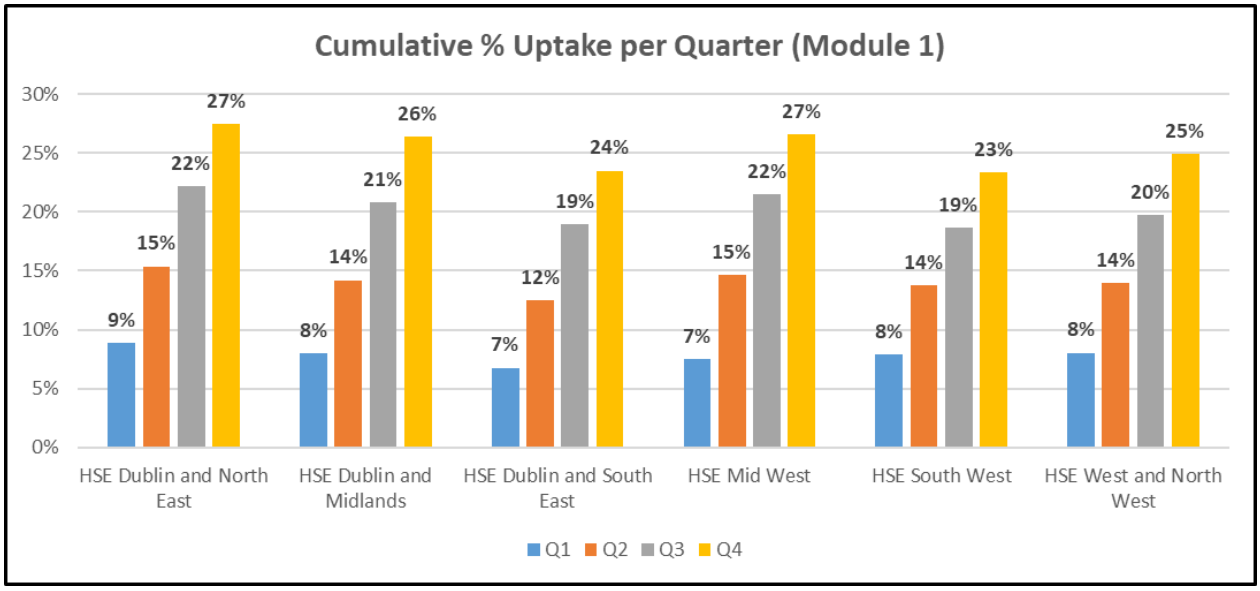


Figure: Module 1 completions per quarter for Regional Health Areas (2024)

The National Open Disclosure Steering Committee proposed a performance metric for the HSE of achieving a minimum of 90% compliance with open disclosure mandatory training over three years. This is defined by the percentage of staff across HSE and HSE-funded services who have completed Module 1 of the eLearning programme on HSeLanD. The National Open Disclosure Office alongside a significant network of open disclosure trainers in services are key enablers of this performance metric, not only in the development and revision of the training programme itself, but also in building awareness of the programme across services.

The Train the Trainer (TTT) approach has been a huge success and created significant capacity for training. Whilst trainers within services particularly focus on delivering face-to-face skills training they also promote mandatory training and highlight training reports within their service.

Data extracted from HSeLanD by the National Open Disclosure Office, as outlined in the graphs below, demonstrates that the total number of people who completed Module 1 across HSE and HSE Funded Services (S38s) is **152,690** (2022 - 2024) reflecting **a three-year compliance of 92%** for the completion of Module 1. Compliance by Hospital Group and Community Health Organisation (CHOs) is also outlined in tables to follow.

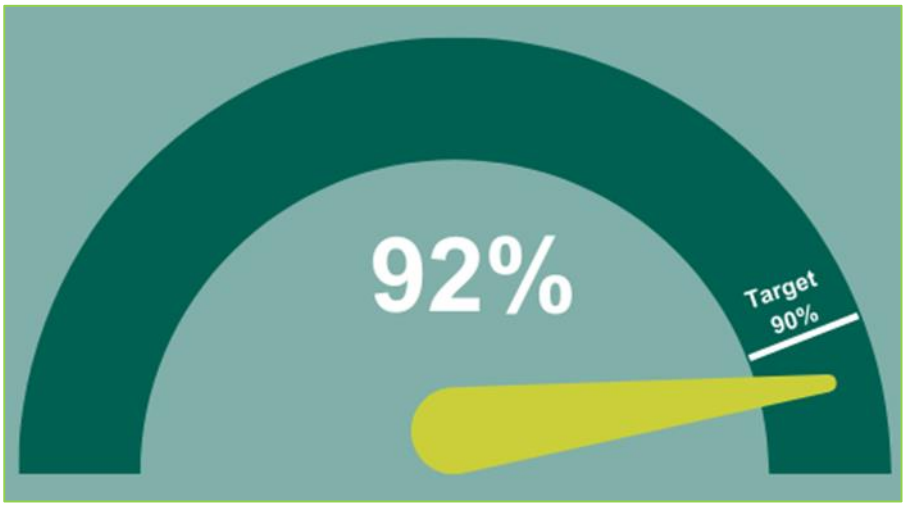


Figure: Module 1 Training Compliance for 3-year period (2022 – 2024)

Whilst the HSE and HSE-funded services benefit greatly from the HSeLanD platform, unlike any other jurisdiction, there are some data limitations in relation to the data provided:

- The data on the number of module completions is drawn down from HSeLanD. Headcount figures are provided by HSE Strategic Workforce Planning and Intelligence.
- HSeLanD statistics are dependent on staff members identifying themselves as working in the correct services /organisations/roles on HSeLanD. There is significant movement of workforce with some gaps in updating their profile.
- The data includes every individual who completed Module 1 in the three years from 01January 2022 through 31 December 2024. This includes staff that have retired, resigned from the HSE or moved post within the HSE over that period.
- The HSE underwent significant reconfiguration between 2022 and 2024, most notably with the establishment of RHAs in mid-2024. For consistency in data reporting across the three-year period, the following tables reflect the previous governance of community health areas and hospital groups / hospitals. Again, it is acknowledged that these figures are impacted by workforce movement/numbers as is evident in areas with >100% training compliance.

The National Open Disclosure Office constantly work to improve the level of accuracy of data and to provide any additional data that is of interest to services. To address some data limitations, the National Open Disclosure Office developed a data review and validation methodology which includes removal of duplicate entries and removal of known external users who work outside of HSE and HSE-funded services. The National Open Disclosure Office strongly urges services to validate their open disclosure training records to provide assurance of mandatory training completed in their organisation. This data can be cross-checked with local HR files to identify staff that have not yet completed the training module.

The following tables outline compliance with open disclosure training from 2022-2024, as defined by the completions of Module 1 training on HSeLanD.

Community Health Organisations

CHO Area	2022	2023	2024	Total	Headcount 31/12/2024	3yr Compliance Module 1
Area 1: Donegal; Sligo-Leitrim-West Cavan; Cavan Monaghan.	2,644	2,947	1,729	**7,320**	7,583	**97%**
Area 2: Galway; Roscommon; Mayo.	2,204	1,874	1,192	**5,270**	7,323	**72%**
Area 3: Clare; Limerick; North Tipperary-East Limerick.	1,363	1,808	1,155	**4,326**	6,614	**65%**
Area 4: Kerry; North Cork; North Lee; South Lee; West Cork.	2,275	2,628	2,054	**6,957**	11,226	**62%**
Area 5: South Tipperary; Carlow Kilkenny; Waterford; Wexford.	2,020	2,276	1,330	**5,626**	7,036	**80%**
Area 6: Wicklow; Dun Laoghaire; Dublin South East.	885	1,285	993	**3,163**	4,356	**73%**
Area 7: Kildare-West Wicklow; Dublin West; Dublin South City; Dublin South West.	1,916	2,657	1,768	**6341**	8,674	**73%**
Area 8: Laois-Offaly; Longford-Westmeath; Louth-Meath.	2154	2,660	1,635	**6,449**	8,049	**80%**
Area 9: Dublin North; Dublin North Central; Dublin North West.	2,078	2,432	2,232	**6,742**	8,727	**77%**
All Community Health Organisations	17,552	20,580	14,096	**52,228**	70,414	**74%**

Hospitals and Hospital Groups

Hospital Group and Hospital Site	2022	2023	2024	Total	Headcount 31/12/2024	3yr Compliance Module 1
Children's Health Ireland (CHI)	836	2,353	1,251	**4,440**	5,120	**87%**
CHI at Connolly	41	63	41	145	165	**88%**
CHI at Crumlin	643	959	676	2,278	2,739	**83%**
CHI at Temple Street	370	525	437	1,332	1,602	**83%**
Dublin Midlands Hospitals Group	4,185	5,854	4,240	**14,279**	16,421	**87%**
Coombe Womens Hospital**	183	405	289	**877**	1,169	**75%**
Midland Regional Hospital Portlaoise	572	314	223	**1,109**	989	**112%**
Midland Regional Hospital Tullamore	421	691	386	**1,498**	1,512	**99%**
Naas General Hospital	540	313	395	**1,248**	1,100	**113%**
Regional Hospital Mullingar	310	411	333	**1,054**	1,257	**84%**
St. James Hospital	719	1,743	1327	**3,789**	5,639	**67%**
St. Luke's Radiation Oncology Network	234	250	122	**606**	608	**100%**
Tallaght University Hospital	1,158	1,651	1121	**3,930**	4,071	**97%**
Ireland East Hospital Group	3,856	4,450	3143	**11,449**	14,874	**77%**
Kilcreene Regional Orthopaedic Hospital	17	44	13	**74**	79	**94%**
National Maternity Hospital	483	357	258	**1,098**	1,113	**99%**
National Rehabilitation Hospital	182	195	187	**564**	816	**69%**
Royal Victoria Eye & Ear Hospital	97	175	76	**348**	433	**80%**
St. Columcilles Hospital	151	271	99	**521**	550	**95%**
St. Lukes General Hospital Kilkenny	475	473	388	**1,336**	1,553	**86%**
St. Michael's Hospital; Dun Laoghaire	57	127	123	**307**	458	**67%**
St. Vincents University Hospital	311	618	770	**1,699**	4,091	**42%**
Tipperary University Hospital	366	485	338	**1,189**	1,331	**89%**
University Hospital Waterford	1,189	1,019	518	**2,726**	3,016	**90%**
Wexford General Hospital	448	580	315	**1,343**	1,332	**101%**
RCSI Hospitals Group	5,480	7,016	4,644	**17,140**	18,804	**91%**
Beaumont Hospital	2,193	1,742	968	**4,903**	4,923	**100%**
Cappagh National Orthopaedic Hospital	296	154	120	**570**	606	**94%**
Cavan and Monaghan Hospital Group (Cavan / Monaghan)	425	580	366	**1,794**	1,653	**109%**
Connolly Hospital	421	742	585	**1,748**	1,728	**101%**
Louth County Hospital	99	175	66	**340**	334	**102%**
Mater Misericordiae University Hospital	746	1,476	989	**3,211**	4,768	**67%**
Our Lady of Lourdes Hospital Drogheda	662	1,083	873	**2,618**	2,785	**94%**
Our Lady's Hospital, Navan	159	302	278	**739**	751	**98%**
Rotunda Hospital	331	542	294	**1,167**	1,193	**98%**
Saolta Hospital Group	4,224	5,396	3,110	**12,730**	13,111	**97%**
Letterkenny University Hospital	895	1,083	567	**2,545**	2,426	**105%**
Mayo University Hospital	579	821	474	**1,874**	1,644	**114%**
Portiuncula University Hospital	346	469	299	**1,114**	1,192	**93%**
Roscommon University Hospital	191	232	110	**533**	505	**106%**

Hospital Group and Hospital Site	2022	2023	2024	Total	Headcount 31/12/2024	3yr Compliance Module 1
Sligo University Hospital	703	942	534	**2,179**	2,375	**92%**
University Hospital Galway (including Merlin Park University Hospital)	1,479	1,825	1,116	**4,420**	4,854	**91%**
South-South West Hospital Group	2,726	4,127	2,727	**9,580**	11,301	**85%**
Bantry General Hospital	95	203	132	**430**	377	**114%**
Cork University Hospital & Cork University Maternity Hospital	1,113	1,529	1,110	**4,529**	5,873	**77%**
Mallow General Hospital	95	156	110	**361**	396	**91%**
Mercy University Hospital; Cork	260	501	496	**1,257**	1,690	**74%**
South Infirmary Victoria University Hospital	190	317	187	**694**	1,161	**60%**
University Hospital Kerry	528	1032	387	**1,947**	1,711	**114%**
University of Limerick Hospital Group	1,155	1,946	1,790	**4,891**	6,297	**74%**
Croom Orthopaedic Hospital	74	120	53	**247**	335	**74%**
Ennis Hospital	63	74	102	**239**	327	**73%**
Limerick University Hospital	770	1,241	1,110	**3,121**	4,330	**72%**
St. John's Hospital	80	155	180	**429**	442	**97%**
Nenagh Hospital	72	112	121	**305**	384	**79%**
Uni Maternity Hosp Limerick	66	155	116	**337**	462	**73%**
Hospital Group ALL	22,514	31,222	20,969	**74,705**	88,499	**84%**

**Open Disclosure Trainers at the Coombe have delivered 3 x open disclosure briefings in person (equivalent to Module 1) to an additional 38 staff members. This data is not included in the above data drawn from HSeLanD. The inclusion of this would bring the compliance rate up to 78%.

On review of the annual data, it is evident that compliance is mostly good with the target is being achieved. Acknowledging, the data limitations, specific sites that had a result of <70% were contacted for feedback. Feedback received was that:

Service	Feedback
CHO3	The area that was previously classified as CHO3 are progressing work in this area. In particular they are: 1. Initiating a working/steering group for Open Disclosure in HSE Mid-West IHA E1, E2 and Older People Services to advance the implementation of the revised HSE Open Disclosure Policy in 2025. This will include exploring monitoring of compliance in relation to Open Disclosure Training. 2. In addition, Open Disclosure Training Module 3, face-to-face workshop is now delivered by the QRPSAs directly to services within their team meetings. This is already in place to assist in staff meeting their obligation to complete Module 3.
CHO4	A number of Open Disclosure Trainers provided 5 open disclosure skills workshops to staff in CHO4 in 2024, and they have an Open Disclosure Trainers forum in place to support front line managers and staff. CHO4 will address training compliance with Module 1 in 2025.
St James's Hospital	St. James's Hospital use another training platform "Learn Together" and are validating their training data to ensure it aligns with HSeLanD data.
St Michael's Hospital, Dun Laoghaire	Training data confirmed by St Michael's Hospital, and focused efforts will be made to address any deficits in meeting training requirements in 2025. They will contact the National Open Disclosure Office if support is needed for same.

Service	Feedback
St. Vincent's University Hospital	SVUH has a strong reporting culture of incidents, this is supported when reviewed in line with incident reporting from a number of other Level 4 hospitals, via the HPSIR data. Reporting of incidents is available to all staff via the hospitals electronic incident management system, where incidents /near misses are reported and reviewed in real-time. Support is available to staff via the senior management team and onsite Occupational Health services for staff. There is also a confidential employee assistance program available for all staff. A focused effort is to increase online training figures. SVUH will also continue to work with our colleagues in the Dublin and South East Region and the National Open Disclosure Office to support this. In Quarter 2 2025 SVUH also plan to validate the HSeLanD data provided in regard to Open Disclosure training data for the hospital. Given that they appear to be an outlier this is possibly a data issue as all staff receive HSeLanD prompts when the training needs to be repeated.
South Infirmary Victoria University Hospital	Training data confirmed by South Infirmary Victoria University Hospital (SIVUH) and focused efforts will be made to address any deficits in meeting training requirements in 2025. In particular, staff from SIVUH have enrolled for the Open Disclosure Train the Trainer programme in 2025, to enable them to deliver the skills workshop onsite, which in turn supports the uptake of the e-learning modules. They will contact the National Open Disclosure Office if support if needed for same.
Mater Misericordiae University Hospital	In 2024, Open Disclosure Trainers in the Mater focused on the delivery of training on the Patient Safety Act 2023 to their staff, following its implementation September 2024. The trainers delivered approx. 30 sessions on the Act. In 2025, focused efforts will be made to address any deficits in meeting training requirements in 2025. They will contact the National Open Disclosure Office if support if needed for same.
National Rehabilitation Hospital	Training data confirmed by the National Rehabilitation Hospital (NRH). Open Disclosure Lead for NRH identified in 2025, and focused efforts will be made to address any deficits in meeting training requirements in 2025. Staff in NRH enrolled in the Open Disclosure Train the Trainer Programme for 2025, to enable them to deliver the skills workshop onsite, which in turn supports the uptake of the e-learning modules. They will contact the National Open Disclosure Office if support if needed for same.

National Ambulance Service (NAS) Training Overview (2022 - 2024)

Service	2022	2023	2024	Total	Headcount 31/12/2024	3yr Compliance Module 1
National Ambulance Service	881	1066	726	**2673**	2460	**108%**

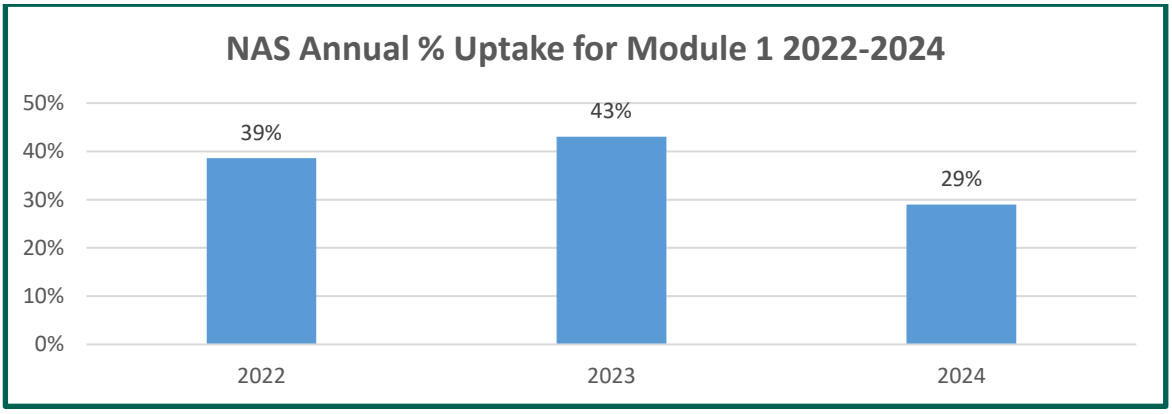
National Ambulance Service 2024 Mandatory Training Compliance for E-Learning Module 1

Total completions for online E-Learning Module 1 for NAS = 726

Total completions for online E-Learning Module 2 for NAS = 157

The chart below displays training completions of Module 1 for NAS staff as a percentage, based on the headcount (2022, 2023, 2024) respectively.

Based on a NAS headcount of 2,460, the compliance rate is approximately **108% across NAS for the 3 year period (2022 - 2024).**



The number of completions of open disclosure training by staff in the National Ambulance Service across the three-year period is as follows. **Note:** This includes **all open disclosure training** (face to face skills workshop and both E-Learning modules). The majority of training was through completion of the E-Learning modules.

2022 =	966
2023 =	1,221
2024 =	882
3 Year Total =	**3,069**

National Screening Services (NSS) Training Overview (2022 - 2024)

The NSS continues to promote and support staff in the completion of their open disclosure training requirements. From 2022 to present, there has been an incremental improvement in the completion of HSeLanD Module 1 *Communicating Effectively through Open Disclosure* training.

The NSS recognises that there are challenges for the organisation in relation to the recording of HSeLanD training data. This is due to some staff recording their HSeLanD training under their host hospital rather than selecting the NSS as their primary location.

To provide assurance of mandatory training and data validation within the NSS, the NSS record all training records on their Quality Management Information System (QMIS). Compliance is reviewed quarterly by the NSS Corporate Management Team which reviews overall compliance and compliance per programme/ department.

The QMIS reflects the current staffing levels within the NSS and is a more accurate representation of organisational compliance. The table below reflects the compliance for NSS staff with HSeLanD Module 1 *Communicating Effectively through Open Disclosure* training.

% NSS Staff completed HSeLanD Module 1 *Communicating Effectively through Open Disclosure*

2022	2023				2024			
Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
55%	61%	66%	59%	60%	62%	66%	67%	73%

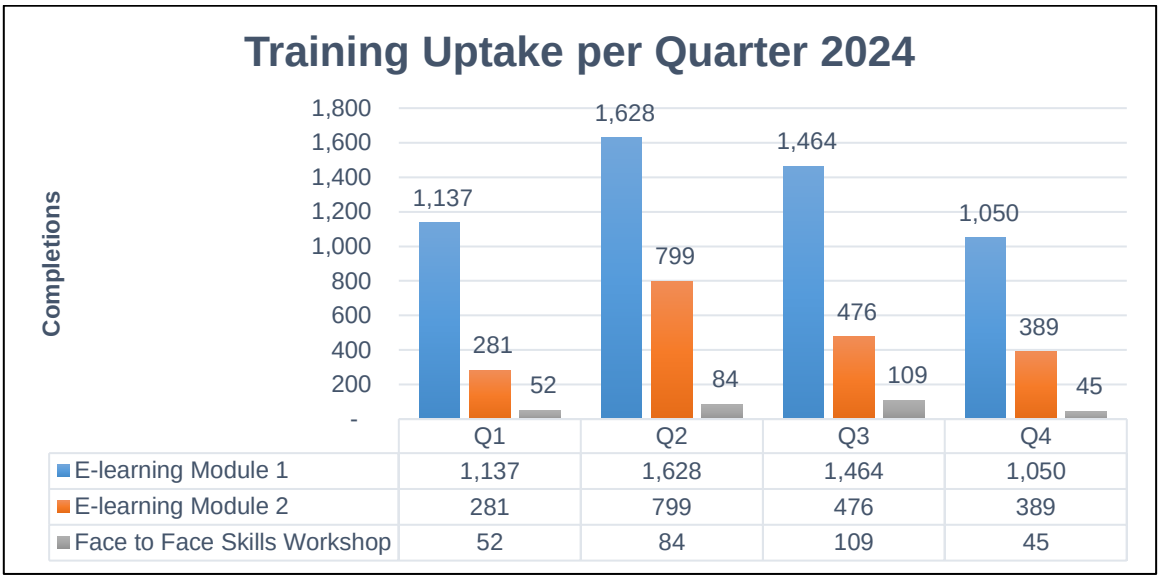
Medical and Dental Staff

The HSE Open Disclosure Policy, and the Patient Safety Act 2023, state that open disclosure will be led by the principal health practitioner involved in the care of the patient or a health practitioner deemed appropriate by the health or social care service provider. The principal health practitioner, or the lead clinician, will therefore generally always be part of the open disclosure team. This, along with the recommendation from Dr. Gabriel Scally that medical staff must complete open disclosure training, supports the mandatory requirement for all medical staff to engage in open disclosure training.

On HSeLanD reports, the Medical Dental grade group includes: Consultants, NCHDs, Other Medical Dental Grades (i.e. Dental Surgeons, Dental Examining, Orthodontics Specialists, and Dentistry Vocational Trainers).

In 2024, there were a total of **7,514** completions of open disclosure training recorded for the Medical Dental grade group. This includes Modules 1 and 2 (eLearning) and Module 3 (Skills Workshop).

Open Disclosure Training Completions – Medical and Dental Grades (2024)



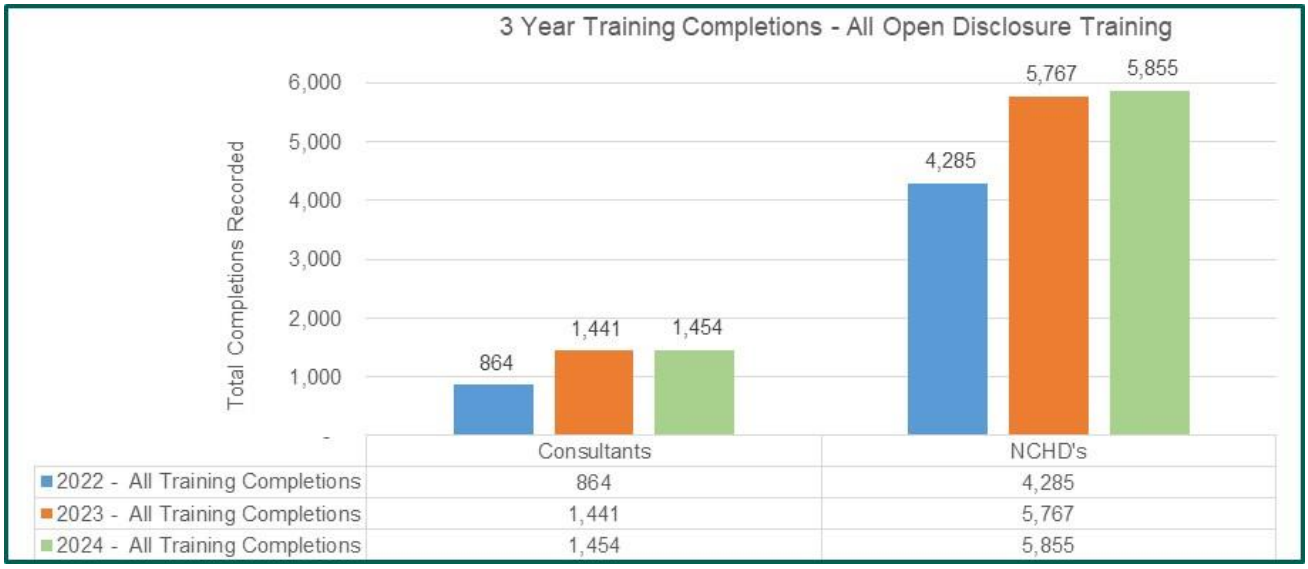
Open Disclosure Training Completions – Consultants and NCHDs (2024)

	Consultants	NCHDs	Other Medical Dental Grades
E-Learning Module 1	1,076	3,983	220
E-Learning Module 2	211	1,719	15
Open Disclosure Skills Workshop	145	145	0
Other Face to Face Training (e.g. briefings, train-the-trainer programme)	22	8	0
TOTAL	**1,454**	**5,855**	**235**

The graph below displays total completions of open disclosure training by Consultants and NCHD's for the 3 year period 2022-2024. The majority of training for all Consultants and NCHD's was through completions of the E-Learning modules.

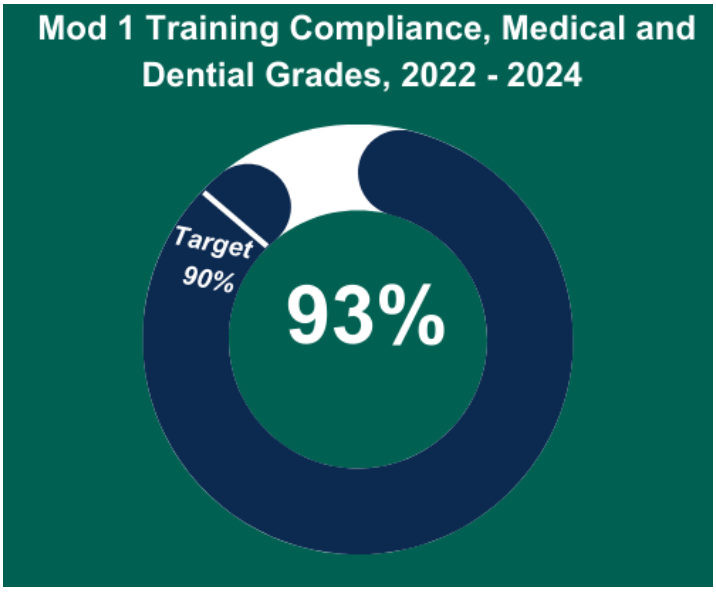
Over the 3 year period, there were a total of **3,759** completions of open disclosure training registered for Consultants, and **15,907** completions registered for NCHD's.

Open Disclosure Training Completions - Medical and Dental Grades (2022 - 2024)



In terms of compliance, the target for medical and dental grade staff is the same as that for all staff – namely, at least 90% compliance with completing training for Module 1 over three years. Using the average headcount for medical dental staff[1] over the three-year period 2022-2024 (n=14,551), the calculated compliance rate is 93% for this grade group.

Open Disclosure Training Compliance for Mandatory Module 1 Training – Medical and Dental Grades (2022-2024)



In addition to the data above from HSeLanD, data from the National Doctor's Training and Planning (NDTP) Doctors Integrated Management E-system (DIME) system has been made available to the National Open Disclosure Office to monitor open disclosure training compliance. All NCHDs have been requested to use the DIME system to upload evidence of open disclosure training.

This data in the table below 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 the previous sub-sections. This data includes NCHD's in HSE and HSE-funded services, as well as those working in private hospitals and/or Section 39's.

2024 sees an improvement in this data, with an increase in the number of verified/ submitted open disclosure documents, and a decrease in the number of open disclosure documents rejected / missing / expired.

Additionally, a significant number of medical staff attended targeted training on the Patient Safety Act 2023 which is not captured here.

Extract of Data from National Doctor's Training and Planning (NDTP) DIME (2024)

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
31 December 2024	5,048 (52%)	4,573 (48%)	9,621

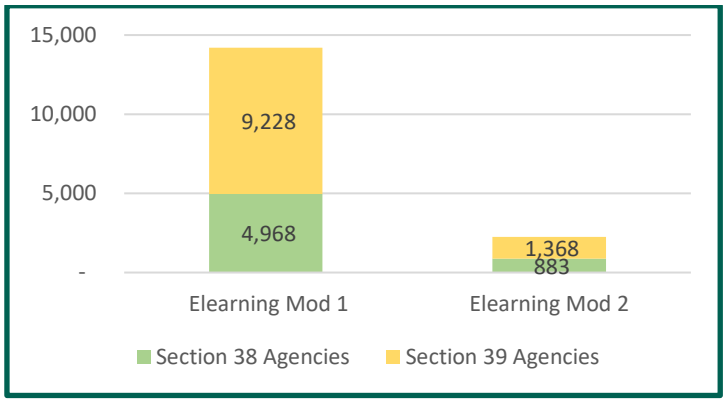
National Federation of Voluntary Service Providers (NFVSP) (2022 - 2024)

The National Open Disclosure Office engages with the National Federation of Voluntary Service Providers (NFVSP) to support the roll-out of training for service providers. The NFVSP have a number of Open Disclosure Trainers and Leads who link in with the National Open Disclosure Office for support with training roll-out. There is ongoing representation from the voluntary services at training programmes, including the Skills Workshop, the Train-the-Trainer Programme and online webinars. NFVSP members were also included in a number of Patient Safety Act presentations, which were rolled out in 2024.

The number of completions of open disclosure training by staff in the National Federation of Voluntary Service Providers over the three-year period 2022-2024 is as follows. (**Note:** This includes all open disclosure training i.e. face-to-face skills workshop and both E-Learning modules). The majority of training was through completion of the e-Learning modules. The completions for NFVSP include completions by staff working in section 38 and section 39 agencies.

2022 =	10,984
2023 =	18,493
2024 =	16,447
3 Year Total =	**45,924**

NFVSP Completions of Modules 1 and 2 (2024)



Postgraduate and Undergraduate Students

The National Open Disclosure Framework makes particular reference to open disclosure training as an essential component in undergraduate and postgraduate education programmes to promote change in workplace culture and health and social care professional practice. Educational bodies must embed communication skills, patient safety incident management, and open disclosure into all undergraduate education and training programmes with clinical components and, where relevant, postgraduate education and training programmes with clinical components for clinical professions. This will help to ensure that the programmes adequately prepare graduates to understand and participate in open disclosure as part of their professional practice. This applies to all formal education and training programmes with clinical/practical components, not just programmes that are subject to accreditation or approval and monitoring by a professional regulator.

While education bodies and regulators will report separately to the Department of Health on these requirements annually, as outlined in the National Open Disclosure Framework, the following information is provided as part of the training, monitoring and oversight conducted by the National Open Disclosure Office.

Completions of Module 1 e-Learning on HSeLanD

Data from HSeLanD indicates that there were 2,770 completions of Module 1 by students in third level education in 2024. This is across a number of grade groups such as Nursing & Midwifery, Patient and Client Care, Management and Admin, Health and Social Care, General Support.

Other Education Sessions facilitated for Postgraduate and Undergraduate Students

The National Open Disclosure Office supports and delivers training and programme updates to undergraduate and postgraduate training programmes. During 2024 the following was facilitated:

- Two “Mastering Adverse Events Simulation Training” days (co-facilitation), RCSI
- Two open disclosure workshops, Nursing Medication Prescribing Programme, NUIG
- Open disclosure presentation to “Legal and Clinical Risk Aspects of Maternity and Nursing Care” study day, Centre for Midwifery Education, The Coombe
- Open disclosure workshop, Graduate Diploma in Quality and Risk Management, UCD
- Two open disclosure lectures to fifth year medical students, UCD

Agency Staff

The Framework outlines the requirement for health and social care services to report on the number of clinical and non-clinical staff trained in open disclosure, including agency staff. Data drawn-down from HSeLanD in respect of Module 1 completions indicates that **7,297 agency staff** completed the online training programme between 2022 and 2024.

HR Shared Services has advised that the Service Level Agreements (SLAs) are in place for the national supplier panels for agency workers, which include detailed pre-placement clearance requirements to the standard of HSE recruitment. All SLAs list open disclosure training as mandatory. The SLA stipulates that "the Agency will furnish the Agency Staff with a Clearance Pass which evidences how the Agency Staff is compliant with the placement clearance requirement, this should include key dates e.g. Gard Vetting Report Form, expiry date of Mandatory Training, date of most recent reference etc. Agency Staff must be able to access their Clearance Pass while on the Contracting Authority premises". Therefore, a receiving line manager can request to see this when the agency worker presents for duty.

Members of the national supplier panel inform their employees of their obligations under the Department of Health Code of Conduct. This includes taking personal responsibility for their own fitness to work, behaviour and continuing competence in their professional activities at all times as well as adhering to policies, procedures and guidelines relevant to their employment. In addition, sample audits are conducted of the personnel records of agency workers placed by national supplier panel members to ensure compliance with SLA obligations.

Quantification of open disclosure training of agency staff will be reviewed in 2025.

Open Disclosure Compliance: Measuring compliance with key open disclosure steps

The Framework sets out the requirement to report on open disclosure events and their completion. This has been part of the HSE trajectory in developing such a function using the National Incident Management System (NIMS). The implementation of the Patient Safety Act 2023, which required technical changes to be made to NIMS so that the HSE and HSE-funded services could report notifiable incidents to the relevant regulator, provided an opportunity to develop this capability. Development work was completed in 2024 and is a priority area of work for 2025. The HSE expects 100% compliance with open disclosure for notifiable incidents and category 1 incidents (subject to data cleansing) and will be working with services to develop and set the necessary metrics for all incidents Resources have been developed to support staff with this requirement such as a reporting guide, webinar and engagement events.

Developing key performance indicators (KPI) in line with the Patient Safety Act 2023

As stated previously, a key priority area for the HSE is to be assured that the HSE and HSE-funded services are compliant with key legal requirements of the Patient Safety Act 2023.

The developments made to the NIMS system will enable the organisation to monitor the identification of notifiable incidents; the reporting of notifiable incidents to the relevant regulator; and the stages of progressing open disclosure, as mandated. A national service plan KPI for this reporting requirement is being considered.

Open disclosure events initiated and closed

The number of open disclosure events initiated and closed is a reporting requirement, as already stipulated, and necessary developments progressed in 2024 to support this reporting function. Whilst the technical changes were implemented toward the latter part of 2024, the change and

practice require embedding in services. The reporting requirements for all patient safety incidents (not only notifiable incidents) are clearly set out in the revised HSE Open Disclosure Policy, to be launched in Q2 2025.

The patient's experience of open disclosure and incident management

Whilst the HSE recognises the benefits in relation to measuring training compliance and measuring the key steps of the open disclosure process, real success in this priority area will stem from the patient and/or their relevant person reporting a positive experience in as much as is possible and can be expected when a patient safety incident occurs. The HSE commissioned research to examine and help design a patient experience tool to be used to gain such insight. A working group was established that included patient partners, HSE-staff, the advocacy service and HIQA representatives.

The mixed methods research approach included a literature review and qualitative interviews. A workshop was held where the insight gathered was presented and a patient experience tool was developed accompanied with recommendations. Findings were shared at the National Open Disclosure Committee and further work in this area is planned for 2025. Additionally, HIQA and the Department of Health have been approached by the National Open Disclosure Office to ask that open disclosure questions (related to patient safety incidents) are included in national patient experience surveys.

Whilst the emphasis of the work was on the patient/relevant person's experience, researchers identified lessons learned from the experience of staff partaking in open disclosure. This supported the fact that gaps in open disclosure are not generally because staff do not want to partake in open disclosure but rather that it is difficult. Further insight was shared by the CervicalCheck screening programme regarding the staff's experience in relation to open disclosure and the importance and impact of good preparation for the open disclosure meeting for the patient's/their relevant person's and staff's experience.

8. Shared learning from services: organisational readiness for the Patient Safety Act

Each year in the HSE Open Disclosure Annual Report, the National Open Disclosure Office provides learning and insights to inform good practice in open disclosure and incident management. This short piece below reflects learning shared by services prior to the commencement of the Patient Safety Act, as organisations across the health and social care system worked to implement the requirement of the Act.

An organisational readiness survey was shared with services prior to the Act's commencement. It also provided a prompt to services of the questions they should be asking themselves about their preparations. Services were asked to provide a traffic light rating indicating local readiness in key operational areas.

Responses were heard from a range of sizes of organisations and highlighted specific considerations for different services. The exercise demonstrated the need to engage with services frequently, to support them with the implementation of the Act and to listen to their feedback to understand the effectiveness of different interventions.

The designated person role

The area on which most feedback was received was the designated person role. In some services this was well established and in others it had not been embedded prior to the enactment of the Patient Safety Act 2023.

There was an indication that the designation of the designated person may only happen at the point of identification of a notifiable incident, because of resources capacity. Some services indicated that it would be the manager of the particular area where the notifiable incident took place that would be adopting that role. Some services chose to issue an expression of interest for this role.

In light of this feedback the National Open Disclosure team progressed the planning for the in-person training event to provide training, networking opportunities and peer-to-peer support for persons new to the role. The National Open Disclosure Office has published an outline of the role of the designated person, alongside further detail about this responsibility.

Management of the notifiable incident

Some respondents indicated that management of a notifiable incident would be through pre-existing governance, escalation, and communication lines.

One robust approach developed by a commissioning body was the development of a dedicated pathway for its section 38/39 services through which to escalate notifiable incidents.

Some services indicated that at the time of the survey they had not yet defined how they will meet documentation record keeping requirements of the Act. Again, it should be noted that the National Open Disclosure Office has since published documentation templates for standardisation of this aspect of the management of notifiable incidents and the open disclosure process.

Training and learning on the Patient Safety Act

It was reported that training and engagement had been well received. Feedback suggests that in some instances resources and e-learning programmes had not yet reached the 'right staff' which was addressed.

9. Summary and Conclusion

The 2024 HSE Open Disclosure Annual Report highlights the continued commitment of health and social care services to foster transparency and accountability through open disclosure practices. These efforts to provide clear, accessible information to staff, patients / service users and their families not only continues to strengthen trust but also creates new opportunities for collaboration and improvement.

Whilst there have been significant strides in embedding open disclosure across all health and social care services, there are still opportunities to enhance processes. All health and social care services are committed to achieving compliance metrics as set out in HSE's assurance programme of work and the Framework; and, equally, if not more so importantly, services are dedicated to ensuring open disclosure continues to be a key driver in the pursuit of organisational excellence and the achievement of a just, open and transparent culture.

In compiling and reflecting on this Annual Report, the National Open Disclosure Office, as a function of the QPS Incident Management team in National Quality and Patient Safety, has identified key priorities to continue with as well as a number of opportunities for further development and improvement in 2025. These include: the promotion of mandatory open disclosure training through awareness campaigns and communication strategies with open disclosure leads and trainers; progressing the development of assessing the patient or relevant person's experience in relation to open disclosure, increased oversight and monitoring of incident data on NIMS as relates to open disclosure, followed-up by coaching conversations with services; building local competency and capability to deliver open disclosure training through the provision of targeted TTT programmes; developing new and enhanced resources to support services in enabling open disclosure locally, including the co-design of informational resources for patients with our valued patient partners; and engaging with clinical and managerial open disclosure champions.

Appendix 1: National Open Disclosure Framework – Annual Report Submissions from HSE Services

The Framework requires that all health and social care service providers submit an annual report on their compliance with open disclosure measures. April 2025 is the first time that all health and social care service providers must meet this requirement. The 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 annual compliance reports from all HSE services have been collated in this report. In the below, the responses from RHAs and National Services are shared, as were provided to the National Open Disclosure Office following CCO request.

The Department of Health advised that the HSE annual open disclosure report should include section 38 voluntary organisations' information on open disclosure. It is important to note that whilst all HSE services responded, the response from section 38 organisations was variable. This was likely due to a short turn-around-time in seeking responses and the new change being introduced. In 2025, the National Open Disclosure Office will be working with the RHAs and National Services to undertake a mapping exercise of all the section 38 organisations that need to contribute here and liaising with them

In this HSE Open Disclosure Annual Report 2024, the National Open Disclosure Office has already provided detail and progress updates regarding:

a. Development and implementation of the HSE Open Disclosure Policy 2025.
b. Development and implementation of open disclosure training for all clinical and nonclinical staff including agency staff
d. The number of trained clinical and non-clinical staff including agency staff (training data from HSeLanD, and data submitted from the network of Open Disclosure trainers nationally).
e. The number of open disclosure events initiated and closed

This appendix covers RHA and National Services responses specific to:

c. Evidence of the availability of support structure for all staff clinical and non-clinical including agency staff.
e. The number of appointed and trained clinical and managerial open disclosure champions.

1A: Responses Received and Gap Analysis

	Response Received
	Response Pending

Regional Health Area / Site	Staff Support	Clinical Champions
HSE Dublin and North East		
Beaumont Hospital		
Cappagh National Orthopaedic Hospital		
Cavan and Monaghan Hospital Group		
Connolly Hospital		
Louth County Hospital		
Mater Misericordiae University Hospital		
Our Lady of Lourdes Hospital Drogheda		
Our Lady's Hospital Navan		
Rotunda Hospital		
CHO1		
CHO8		
CHO9		
HSE Dublin and Midlands		
CHI at Connolly		
CHI at Crumlin		
CHI at Temple Street		
Coombe Women's Hospital		
Midland Regional Hospital Portlaoise		
Midland Regional Hospital Tullamore		
Naas General Hospital		
Regional Hospital Mullingar		
St. James Hospital		
St. Luke's Radiation Oncology Network		
Tallaght University Hospital		
CHO7		
CHO8		
HSE Dublin and South East		
National Maternity Hospital		
National Rehabilitation Hospital		
Royal Victoria Eye & Ear Hospital		
St. Columcille's Hospital		
St. Luke's General Hospital Kilkenny		

Regional Health Area / Site	Staff Support	Clinical Champions
St. Michael's Hospital Dun Laoghaire		
St. Vincent's University Hospital		
Tipperary University Hospital		
University Hospital Waterford		
Wexford General Hospital		
CHO5		
CHO6		
HSE South West		
Bantry General Hospital		
Cork University Hospital		
Cork University Maternity Hospital		
Mallow General Hospital		
Mercy University Hospital; Cork		
South Infirmary Victoria University Hospital		
University Hospital Kerry		
CHO4		
HSE Mid West		
Croom Orthopaedic Hospital		
Ennis Hospital		
St. John's Hospital		
Nenagh Hospital		
University Maternity Hospital Limerick		
University Hospital Limerick		
CHO3		
HSE West and North West		
Letterkenny University Hospital		
Mayo University Hospital		
Portiuncula University Hospital		
Roscommon University Hospital		
Sligo University Hospital		
University Hospital Galway		
CHO1		
CHO2		

1B: National Screening Service (NSS) – Support Structures

Support structures for All Staff

The Framework requires that all staff (clinical and non-clinical), including agency staff, have access to support structures regarding Open Disclosure. What support structures are available for all staff?

- The NSS supports a fair, open and just culture in the management of incidents.
- Provision of training and education lead by QSR staff in open disclosure and communication skills via regular promotion of open disclosure and open disclosure training in the staff newsletter, regular Open Disclosure Programme Skills Workshops held across NSS sites.
- Module one Open Disclosure HSeLanD Training is mandatory for all staff and compliance is reviewed quarterly by line managers and NSS Corporate Management Team.
- Managerial and clinical open disclosure champions in place and details communicated to staff
- The “ASSIST” model of communication used to support all staff in the discussion of patient safety incidents with patients / relevant persons.
- The “Assist Me” model of staff support is used to assist managers and staff.
- After Action Review (AAR) training has been arranged for Q2 2025 to support debriefing in the aftermath of an incident.
- Named staff liaison person identified, as required, to act as a designated person for patient /families impacted by the incident- three staff attended recent Designated Person Training Workshop in February 2025.
- Named staff liaison person identified, as required, to act as a single point of contact for staff directly impacted by the incident.
- Details of Employee Assistance Programme and HSE Occupational Health made available to staff
- Three open disclosure trained trainer/lead staff available for advice and support.
- Regular attendance by Open Disclosure Lead at Open Disclosure Leads’ meetings.
- Two NSS staff members are part of the HSE Open Disclosure Steering Committee.
- Events to increase awareness of open disclosure organised annually for Open Disclosure Themed Week across NSS locations.

1C: National Ambulance Service – Support Structures

Support structures for All Staff

The Framework requires that all staff (clinical and non-clinical), including agency staff, have access to support structures regarding Open Disclosure. What support structures are available for all staff?

- QPS Advisor in each RHA is designated to support managers and staff.

1D: Dublin and North East Regional Health Area – Support Structures

Support structures for All Staff

The Framework requires that all staff (clinical and non-clinical), including agency staff, have access to support structures regarding Open Disclosure. What support structures are available for all staff?

Please note the following;

- The data for CHO8 has also been submitted to HSE Dublin Midlands Region and may be included in their returns. It is included here for completeness.
- Data for Monaghan Hospital is included in the response for Cavan & Monaghan Hospitals
- Data for Louth County Hospital is included in the response for Our Lady of Lourdes Hospital, Drogheda.

Dublin and North East Regional Health Area - Community services

CHO1

- Community Healthcare Cavan, Donegal, Leitrim, Monaghan and Sligo (CDLMS) has facilitated a wide range of Open Disclosure Training which is available to all staff. It has provided face-to-face training jointly with the National Open Disclosure Office and has also piloted joint training with Letterkenny University Hospital.
- All Quality Patient Safety Advisors provide support directly and indirectly to staff affected by these incidents.
- In the provision of multi-disciplinary training on risk management and incident management, open disclosure forms an integral part of those on-line and face-to-face training sessions.
- The National Open Disclosure Office have also presented at the CDLMS Governance for Quality Meeting which is chaired by the former Chief Officer and is attended by all the heads of service.
- The training is aimed at all levels of staff, and senior managers in particular are encouraged to attend and also to disseminate the principles of open disclosure and staff responsibility under the Patient Safety Act.
- Likewise all training encompasses the need to support patients/service users and their family and advocates where appropriate where open disclosure takes place.
- CDLMS has proportionally one of the highest rates of incident reporting in the HSE.

CHO1 (Cavan and Monaghan Disability Services)

- Open disclosure discussed at staff meetings
- Staff provided with open disclosure information
- Line Manager provides leadership and support to staff in the event of open disclosure meeting
- De-briefing sessions provided where necessary
- Open Disclosure training completed by staff

CHO8 (potentially included within Dublin Midlands submission)

- Access to Open Disclosure Lead for CHO 8.
- Incident management training delivered through QPS Department which supports staff in recognising and reporting patient safety incidents. The training also discusses the importance of open disclosure and directs staff to the training and resources online.

IHA Dublin North County and Dublin North City & West - HSE Services

The service actively promotes a culture of open disclosure throughout IHA Dublin North County and Dublin North City & West. All staff in in IHA Dublin North County and Dublin North City & West currently have access to support structures regarding open disclosure; this includes the points outlined below.

Education

- There is a programme of education in place for staff (clinical and non-clinical), in IHA Dublin North County and Dublin North City & West.
- This includes a requirement for all staff to complete mandatory training in open disclosure (Open Disclosure E-Learning Module 1: Mandatory for all staff in HSE and HSE-funded services) and additional training available.
- A programme of local in-person training is also in place, whereby an open disclosure in-person, Module 3 Face-to-Face Skills Workshop is offered at monthly intervals to all senior staff, managers and clinicians in IHA Dublin North County and Dublin North City & West by our QPS advisors.
- The service have held multiple open disclosure education events throughout 2024 in preparation for changes in open disclosure procedures in 2024/2025. This included an Open Disclosure Masterclass for 60 clinicians, managers, and senior staff which took place on Friday 07 June 2024, at the Clayton Hotel, Stockhole Lane. This event provided an excellent platform for senior staff to gather and learn about the upcoming changes which were due to take place regarding open disclosure requirements in 2024 and 2025.

Attendance at staff education days and events:

- The QSSI Department has supported services across the IHAs throughout 2024, also including attending education days and events such as the Public Health Nurses, Annual Education Event on 19 September 2024. This focused on Open Disclosure Policy, Framework and legislation, including the upcoming changes arising in 2024/2025. In addition, the session highlighted an overview of open disclosure training available, both e-learning and in-person, for all IHA staff.
- Annual Open Disclosure Themed Week: Each year the IHAs host Open Disclosure Themed Week in October, in which education events take place across the week with focus on open disclosure matters. This took place from 07 to 11 October 2024. This included engagement with the HSE National Open Disclosure Office, who attended the Launch Event in St. Mary's Lecture Hall on 07 October 2024. In addition, the QPS Team held 9 open disclosure promotional stands across the IHAs throughout Open Disclosure Week, to engage staff in all areas and promote the importance of open disclosure.

Communication

- There is a programme of communication in place for staff in IHA Dublin North County and Dublin North City & West in relation to open disclosure updates and open disclosure matters, including email communication cascades, broadcasts, local events, QPS stands in service locations. All communication received in relation to open disclosure is circulated accordingly.

Dedicated QPS Advisor

- All services have a dedicated QPS Advisor contact who supports services locally with open disclosure matters.

Open Disclosure Lead:

- There is an Open Disclosure Lead (Quality and Safety Manager) in IHA Dublin North County and Dublin North City & West. The Open Disclosure Lead provides leadership and direction for the IHAs, manages the QPS Advisors regarding open disclosure matters, and drives the importance of open disclosure matters, including all aspects of the National Open Disclosure Framework. The Open Disclosure Lead sits on the HSE National Open Disclosure Leads Group which meets at minimum quarterly.
- The Open Disclosure Lead has also supported and participated in National Open Disclosure Working Groups throughout 2022-2025, supporting excellence in Open Disclosure Matters across the HSE.

Governance

- Open disclosure is tabled on agendas for the IHA management team by the Head of QSSI.

- In addition, open disclosure is tabled on agenda's for the IHA QPS Committee and local service level QPS Committees.

IHA Dublin North County and Dublin North City & West - Section 38 Services

Avista CLG

- Training is available to all staff via HSeLanD.
- Avista are identifying further internal resources to support in-house training for staff.
- A number of senior managers have attended training to support staff within their area in relation to the requirements and implementation of open disclosure in line with policy, framework and legislation.
- An Avista Open Disclosure Policy aligned to the national policy which provides guidance and support to Avista staff and an understanding of their role is in the final stages of development and will be rolled out across the organisation to create further awareness and guidance on the open disclosure process.
- Avista's Incident Management Policy clearly refers to the requirement for open disclosure and the principles of a just culture and a positive reporting culture when incidents or near misses occur.
- Service user safety and incidents is a standing agenda item at all governance meetings and is reviewed at all levels from local level to board level.
- All Avista staff have access to the Employee Assistance Programme and Critical Incident Stress Management which has been utilised to support staff in the aftermath of significant incidents. Staff liaison person is assigned to staff in the aftermath of significant incidents.
- A specific information session on Open Disclosure and the Patient Safety Act for senior managers was completed on 06/09/2024.
- Information leaflets are available to staff.
- A number of managers have been supported to attend relevant webinars and to bring back any relevant learning to areas.
- A number of Avista-specific resources are in development including templates and posters; some amendments identified for existing resources including shared learning templates.

St. Michael's House

- Information resources and tools are available to staff.
- SMH Open Training College (OTC) provides training reminders for HSeLanD training, with all certificates recorded by the OTC Training and Development Department.
- In-house eLearning currently being developed to include face-to-face training, and the E Levels online training.
- Quality Safety and Risk Department support provided across SMH Services.
- Easy-read document used by the OD office was developed with the Quality Safety and Risk Department in SMH.

St. Francis Hospice, Dublin

- The service actively promote a culture of open disclosure throughout the organisation.
- Support is available from the Director of Nursing, Medical Director, Medical Consultants and line managers in line with the organisation's Open Disclosure Policy.

Dublin and North East Regional Health Area - Acute services

Beaumont Hospital

- Open Disclosure Education and Awareness Committee established
- Recognised OD Champion across Nursing, Business; Medical; QPS
- Bi-Monthly Module 3 Training
- Module 1 and 2 accessible to staff via hospital online learning platform
- Dedicated OD Intranet Page for staff
- Bespoke training at local level regards, documentation; low level meetings etc.

- Active participation in OD awareness weeks
- Newsletters / publication from National Office disseminated hospital wide.

Cavan & Monaghan Hospitals

The resources CMH provide are as follows:

- Access to HSeLanD
- Face-to-face training being rolled out to each directorate with support from the Clinical Lead for each area.

Access to in-house:

- OD Team/champions,
- QPS Team for support /mentor staff,
- AAR facilitators,
- Critical Incident Stress Management available if required,
- Open Disclosure Policy accessible to all staff,
- Training for the role of designated person (HSeLanD),
- Regular Open Disclosure Training sessions throughout the hospital,
- Communication Training is continuous throughout each Directorate, and
- OD Train-the-Trainer programme can be facilitated for staff who wish to become a champion.

Connolly Hospital

Training

- Open Disclosure training available on HSeLanD and promoted with staff:
  - Module 1; Communicating Effectively through Open Disclosure
  - Module 2; Open Disclosure, Applying the principles to practice
  - The Role of the Designated Person.
- Total of five open disclosure trainers in Connolly Hospital;
- Face-to-face training takes place twice monthly.

Additional Support Structures in place:

- Quality and Safety Patient Liaison Officer (PLO) is available to provide support and guidance to all staff undertaking open disclosure.
- Events were held to celebrate National Open Disclosure Week in October 2024.
- All clinical areas have been supplied with information pertaining to the Patient Safety Act and Open Disclosure Policy. Updates are also shared periodically through the Q&S Newsletter.
- There is oversight of training compliance by each Executive Team Member, Hospital compliance data is discussed at EMT and QSE Committees.
- Connolly Hospital Guideline for Reporting and Management of Incidents (updated 2024) is available for staff with practical guidance on incident management including open disclosure.
- Incident report training is available via HSeLanD, and support is provided in the use of NIMS by the Quality and Safety Team.
- EAP programme available for staff involved in serious incidents.
- PPPGs are available on CHB shared drive for all staff to avail of and reference.

Mater Misericordiae University Hospital

- The MMUH has a policy in place entitled Supporting Staff after an Adverse Incident, Claim or Attending an Inquest. The aim of this policy is to provide guidance to senior staff, supervisors and managers in supporting employees involved in a stressful or traumatic incident, complaint or claim or those who may be required to appear as a witness at a coroner's inquest.
- Within this policy we offer staff the services of EAP and Occupational Health.

Internal Support Available:

- The Director of Quality and Safety - provides advice and support to staff and their managers regarding this policy on a case by case basis.
- Risk Manager - advises staff involved in a traumatic incident, complaint or claim including advice regarding written statements or appearing as a witness at an external venue e.g. Coroner's Court.
- Quality Manager - Advise staff involved in an traumatic incident, complaint or claim including advice regarding written statements or appearing as a witness at an external venue e.g. Coroner's Court.
- Occupational Health Department - advises on coping strategies for staff experiencing difficulties at work including advice following a staff accident.
- Patient Services Manager / Patient Liaison Team - provides support and advice to staff involved in a complaint. Advice and support staff on preparing statements.
- Psychology Team – called-upon when a traumatic incident takes place and support is needed for either individual members of staff, or a group (team, ward, or department). Offer a timely response consultation where indicated, usually involving 1 but up to 3 meetings, when members of staff are in serious distress.
- Human Resource Department - support managers in identifying staff support needs and finding appropriate sources of support once identified. Providing support where appropriate.
- Department Manager - provides support and advice to staff involved in a traumatic incident, complaint or claim event. On a 1:1 basis or arranging debriefs etc.
- External Support Available: GP resource for support for staff. Staff should self-refer.

National Orthopaedic Hospital Cappagh

- Currently training three staff to facilitate module 3 on site.
- In week 17/03/2025 we are launching open disclosure sticker to assist staff in the process and for clear documentation.
- These will be complemented by an Open Disclosure Toolkit in all clinical areas with national and local resources to assist staff.
- Incident Report Forms updated to reflect changes to reporting of open disclosure on NIMS.
- All national newsletters and webinars are circulated to staff.
- Annual open disclosure day with stand in canteen and education in-house.
- Clinical Risk Manager follows-up with staff on patient safety incidents requiring open disclosure and provides support and resources for this process.
- Clinical Risk Management Training includes a component on open disclosure and is part of regular NOHC staff induction schedule and is mandatory for clinical staff.
- Open Disclosure Policy is available on internal document control system (Q-Pulse) and is accessible to all staff.
- AAR can be facilitated by the QSR department on request. Local teams are encouraged to debrief after patient safety events and relevant patient safety information is communicated in safety huddles in clinical areas.
- Staff have access to EAP and this is promoted widely across the hospital.

Our Lady of Lourdes Hospital, Drogheda & Louth County Hospital

- Open Disclosure Lead in place
- On-going face-to-face workshops
- E-learning modules
- Discussed at Clinical Specialist Governance Meetings
- Discussed at Quality and Safety Executive Meetings
- Discussed at monthly Performance meetings with SMT

Our Lady's General Hospital, Navan

- OD Leads in place and provide support to staff
- All staff are encouraged to complete Modules 1 & 2 on HSeLanD
- In person workshops are held bimonthly

Rotunda Hospital

- Induction and Orientation Programme,
- Managerial and Peer Supports,
- After Action Reflections,
- Staff Debriefing,
- Patient Safety Meetings,
- Occupational Health Department,
- Employee Assistance Programme, and
- Open disclosure policy and training - HSeLanD and onsite.

1E: Dublin and Midlands Regional Health Area – Support Structures

Support structures for All Staff

The Framework requires that all staff (clinical and non-clinical), including agency staff, have access to support structures regarding Open Disclosure. What support structures are available for all staff?

Dublin and Midlands Regional Health Area - Community services

CHO7 Health and Wellbeing

- Open Disclosure Policy;
- Nominated Champion;
- Clinical Leads & DPHN to offer guidance to staff, and
- HSeLanD training:
  1) Open Disclosure modules 1 & 2
  2) Overview of the patient safety & role of designated person on HSeLanD
  3) 0.5 day face to face skills workshop
  4) 1.5 days train the trainer programme

- Induction training incorporates open disclosure and continued professional development within the services for open disclosure, if identified.
- Open disclosure discussed at weekly clinic/ops meetings in vaccinations.
- Adverse events discussed and findings are integrated into ongoing staff training and operational improvements.
- Proactiveness in lessons learned processes following each vaccination programme.
- Open communication approach enables continuous quality improvement and helps maintain the highest standards of safety and care.

CHO7

- Open disclosure is included as an agenda item on the QSSI Caregroup Meetings within the Community.
- Services are directed to mandatory training of Module 1 Communicating Effectively through Open Disclosure and Module 2 "Open Disclosure: Applying Principles to Practice" for staff involved in formal open disclosure meetings on HSeLanD.
- Services are advised on the templates available to assist the services in documenting/ managing open disclosure.
- Three QPS Advisors have attended Open Disclosure TTT and will be providing face-to-face workshops with services in 2025.

- QPS support Open Disclosure Week with the priority in 2024 to support the legislative requirements associated with notifiable incidents under the Patient Safety Act.

CHO8 (Some of the following is also included within Dublin and North East submission)

➢ Older Persons
- Open Disclosure e-learning Modules 1 and 2 on HSeLanD.
- Access to Open Disclosure Lead for CHO 8.
- Incident Management training delivered through QPS Department which supports staff in recognising and reporting patient safety incidents.
- Training also encompasses the principles of OD and directs staff to the training and resources online.
- E-learning programme on 'The role of the Designated Officer' and 'The Patient Safety Act' on HSeLanD which are promoted at the various governance forums in OPS.

➢ Disability Services
- QPS incident management training emphasises open disclosure
- Access to open disclosure lead
- HSeLanD training module 1 and 2, Patient safety Act, designated officer training

➢ Midlands Dental Service
- HSeLanD

➢ County Manager Longford
- Longford County Manager for PCC Services

➢ Chronic Disease LW
- Chronic Disease Manager

➢ Psychology LW
- Line management structures

➢ Public Health Nursing LW
- Line management support

➢ Network 8
- Yes the CHO8 lead.
- CHN Manager supports open disclosure in all meetings and with staff in PA.

➢ DPHN
- HSeLanD On Line Modules
- MAPS Portal (electronic portal) for access to National Policy
- All staff in LO PHN service receive the quarterly National Open Disclosure Office Newsletter Programme

➢ Psychology
- Line Management Structures

➢ Social Work
- Social Work provides regular supervision where this can be discussed

➢ Co. Manager Laois
- Support from Management and HSeLanD

➢ Network 12
- South Laois Manager

- Network 11 North Laois and East Offaly Manager
- Open Disclosure Lead for CHO 8

- CDM
- Staff supported to report incidents and engage in open communication
- Staff all up to date with mandatory training
- Item on team meetings

Our Lady's Hospice & Care Services (*data collated relates to 2 RHAs across which the service operates - HSE Dublin and Midlands and HSE Dublin and South East*)

- Open Disclosure policy
- Three onsite trainers/champions provide guidance and support in the event of Open Disclosure meetings
- An MDT approach to facilitating Open Disclosure through collaborative Serious Incident Management Teams meetings
- Awareness raising OD campaigns
- OD audit showcase held
- OD webinars promoted
- Governance reporting pathway established at Executive level to support local OD Leads,
- Information resources repository locally available for SIMT members, senior clinicians or those who may be involved in OD events
- Trained AAR facilitators from within the service available to assist with staff debriefing if required.

Muiriosa Foundation (*data collated relates to 2 RHAs across which the service operates - HSE Dublin and Midlands and HSE Dublin and South East*)

- Module 1 HSeLanD is a mandatory training course for staff of all levels with the Muiriosa Foundation.
- We are enabling staff to communicate effectively through our delivery of open disclosure training.
- Local training reports provide a picture of compliance levels across each region. This is also monitored by our centralised training department.

Dublin and Midlands Regional Health Area - Acute services

Children's Health Ireland at Temple Street, Crumlin, Tallaght and Connolly
Support structures available to staff:

- Information, resources, documentation available to support and assist staff and trainers with open disclosure via CHI Intranet.
- Guidance documents (Open Disclosure Framework and Policy) available and access to HSE Open Disclosure webinars and HSE training modules via CHI Intranet.
- Open disclosure champions appointed and trained.
- CHI weekly online NIMS Q&A sessions facilitated by CHI Incident Management Team and support to staff following incidents.
- All staff memos regarding Open Disclosure updates on NIMS and Open Disclosure training/skills workshops, and additional information to include the designated person in Incident Management and Open Disclosure.

The Coombe Hospital
The Coombe Hospital has established structures to support all staff.

- Two QRPS staff have trained as Open Disclosure leads and a designated person has been identified.

- Information on the ASSIST and ASSIST-ME models and the EAP are available on the hospital intranet.
- Module 1 was demonstrated to staff with no computer access on three occasions in 2024 and a Module 3 workshop ran in October.
- Open Disclosure forms part of the mandatory training document sent to all staff (includes how to access modules on HSeLanD).
- National Open Disclosure Week - stand outside the canteen provided staff with information on Open Disclosure and the Patient Safety Act.
- Coombe Incident management Policy displayed in clinical areas as a reference guide for staff.

MRH Mullingar

- Internal staff in risk and legal services provide some support to clinicians during open disclosure meetings.

MRH Portlaoise

For Staff:

- Access to HSeLanD Modules 1 & 2 and Module 3 Face-to-Face Workshop.

For Staff including Agency:

- Access to QPS and OD trainers for support and guidance;
- Access to HSE Website for OD Resources;
- Access to National OD Office; at Senior Management Team (SMT) meeting on 11/2/25,
- SMT approved the facilitation of training/education by QPS Staff re OD, PSA and Incident Management at Grand Rounds;
- Clinical Audit Meetings;
- Departmental Meetings;
- Lunch Meetings and other fora (as required).

MRH Tullamore

MRHT has the following structures in place to support staff:

- "ASSIST ME" Model of staff support,
- Employee Assistance Scheme,
- QPS Department,
- Regular open disclosure face to face training (including Simulation),
- HSeLanD training,
- National Open Disclosure Policy.

Naas General Hospital

NGH has effective structures in place to enable all staff, clinical and non-clinical, access to open disclosure resources and supports. These structures include but are not limited to:

- A Quality, Risk and Patient Safety Department,
- An Open Disclosure Committee,
- Open disclosure training (face-toface training),
- Open disclosure face to face simulations where requested by clinical staff,
- Training information available on NGH sharepoint,
- NGH also has an Open Disclosure Policy, available via SharePoint;
- The ASISST ME model,
- Employment Assistance Programme available for all staff,
- Incident Management training to NCHDs at induction and Nursing, AHP and HCA staff on orientation,
- NGH has a named designated staff support person to liaise with patients /relevant persons following a Category 1 and Notifiable Incident, and
- Information will be made available on digital screens throughout the hospital in relation to open disclosure.

St. Luke's Radiation Oncology Network

- Training - HSeLanD and in-person, local policies, and access to the national policy.

St James's Hospital

- SJH's Patient Safety & Risk Team and Quality & Safety Improvement Director provide open disclosure support to all staff.
- Open disclosure practice and assurance is integrated within the hospital's patient safety incident management procedures.
- Support is also available from the hospital's legal advisor, clinical directors and professional leads.
- Training and support materials are available on the hospital's electronic learning platform.
- The hospital has a Just Culture: Balanced Accountability Policy in place and embeds its principles in all patient safety work in the hospital.

Tallaght Hospital

- Member of the PALS Team, who are currently acting designated liaison persons for initial notifiable incident cases, attended the Designated Person Workshop.
- Risk and Incident Team available in working hours to discuss any queries in regards to open disclosure and the process.
- Guidance and information given on individual cases.
- Module 3 Face to Face training provided monthly for all senior management staff, including additional bespoke training provided for groups of consultants on request.
- Open disclosure training extended to external organisations also, e.g. nursing homes.
- Training on NIMS ongoing and frequent reminders and education on completing the open disclosure question fields on the NIMS page.
- Provide open disclosure stand annually to highlight open disclosure and how it impacts staff and patients.

Peamount Healthcare Newcastle Co Dublin

- Staff training provided face-to -face and HSeLanD
- Mandatory training tracker
- Serious Incident Management Team meetings as required
- Policies and procedures in place
- Open Disclosure Lead and trainers in place

1F: West and North West Regional Health Area – Support Structures

Support structures for All Staff

The Framework requires that all staff (clinical and non-clinical), including agency staff, have access to support structures regarding Open Disclosure. What support structures are available for all staff?

West and North West Regional Health Area - Community services

CHO1

- Community Healthcare Cavan, Donegal, Leitrim, Monaghan and Sligo (CDLMS) has facilitated a wide range of open disclosure training which is available to all staff. It has provided face to face training jointly with the National Open Disclosure Office and has also piloted joint training with Letterkenny University Hospital.
- All Quality Patient Safety Advisors provide support directly and indirectly to staff affected by these incidents.
- In the provision of multi-disciplinary training on risk management and incident management, open disclosure forms an integral part of those on-line and face to face training sessions.

- National Open Disclosure have also presented at the CDLMS Governance for Quality Meeting which is chaired by the former Chief Officer and is attended by all the Heads of Service.
- The training is aimed at all levels of staff, and senior manager in particular are encouraged to attend and also to disseminate the principles of open disclosure and staff responsibility under the Patient Safety Act. Likewise all our training encompasses the need to support patients/service users and their family and advocates were appropriate were Open Disclosure takes place.
- CDLMS has proportionally one of the highest rates of incident reporting in the HSE.

CHO2

- HSeLanD Training Modules.
- Face-to-face facilitated workshops.
- On-going support and guidance from QPS Advisors at local QPS Governance Committees and presentations of the Patient Safety Act have been provided at local and senior management team level.
- Key staff have attended the Designated Persons Training with a plan to establish a local forum to support these staff going forward.

West and North West Regional Health Area - Acute services

Letterkenny University Hospital

- Open disclosure training sessions have been provided on the new act and notifiable incidents. Guidance on open disclosure has also been included in the recently developed Staff Induction Guide and the How to Report and Manage an Incident
- Comprehensive Open Disclosure Guidance and resources available via LUH Sharefile

Merlin Park University Hospital

- Linked with UHG for OD training

Sligo University Hospital

- Dedicated resources available via the QPS Department and a targeted open disclosure training programme has been in place for senior medical staff.

University Hospital Galway

- An open disclosure programme for consultant medical staff has been developed with the first scheduled workshops earmarked for 28th April and 1st May at UHG. The programme will be delivered by Medical and QPS Trainers.

Portiuncula University Hospital Galway

- Open Disclosure Awareness included in all staff induction programmes at PUH.
- Multidisciplinary training sessions provided and information widely available on how to access both online and face to face training.

Roscommon University Hospital

- Specific training and awareness provided on provisions of Patient Safety Act.
- Information provided on open disclosure and the Patient Safety Act can be accessed online.

Mayo University Hospital

- Renewed focus in Q4 2024 and Q1 2025 on providing face-to-face training on the Patient Safety Act with the availability of additional trainers.
- Staff induction includes guidance on how to access open disclosure online training and availability of in room sessions throughout the year.

1G: Dublin and South East Regional Health Area – Support Structures

Support structures for All Staff

The Framework requires that all staff (clinical and non-clinical), including agency staff, have access to support structures regarding Open Disclosure. What support structures are available for all staff?

Dublin and South East Regional Health Area - Community services

CHO5

- Mandatory open disclosure training and QPS Advisors - last year we had 2.8 QPS Advisors and this year we have 3.8 QPS Advisors.
- CHO5 provide training to all staff in CHO5 and are working on providing training to NCHDs working in Mental Health with the first session already completed in the first quarter of this year.
- CHO5 have five train the trainers currently in CHO5, three of which are in QSSI.
- CHO5 are looking to increase this number and will be working on that for 2025.

CHO6

- Open Disclosure Awareness Week organised annually by QSSI
- Annual QSSI Training Prospectus - developed and shared with all divisions annually.
- Each division is aligned with a QPSA
- QPSA review NIMS regularly to ensure incident close off including open disclosure.
- Open disclosure is imbedded in SIMT process
- QSSI led open disclosure project underway
- Open disclosure, as part of training, is highlighted at all QSECs

Our Lady's Hospice & Care Services (*data relates to 2 RHAs across which the service operates - HSE Dublin and Midlands and HSE Dublin and South East*)

- Open Disclosure policy
- Three onsite trainers/champions provide guidance and support in the event of Open Disclosure meetings
- An MDT approach to facilitating Open Disclosure through collaborative Serious Incident Management Teams meetings
- Awareness raising OD campaigns
- OD audit showcase held
- OD webinars promoted
- Governance reporting pathway established at Executive level to support local OD Leads,
- Information resources repository locally available for SIMT members, senior clinicians or those who may be involved in OD events
- Trained AAR facilitators from within the service available to assist with staff debriefing if required.

Muiriosa Foundation (*data relates to 2 RHAs across which the service operates - HSE Dublin and Midlands and HSE Dublin and South East*)

- Module 1 HSeLanD is a mandatory training course for staff of all levels with the Muiriosa Foundation.
- We are enabling staff to communicate effectively through our delivery of open disclosure training.
- Local training reports provide a picture of compliance levels across each region. This is also monitored by our centralised training department.

Dublin and South East Regional Health Area - Acute services

National Maternity Hospital

- HSE online and in-person resources.
- Local champions also provide education.

National Rehabilitation Hospital
- Managerial and clinical open disclosure leads in place, open disclosure champions in place, Open Disclosure Policy and information leaflets available to all staff including agency staff.
- Presentation to all heads of department in November 2024 on the Patient Safety Act (2023).

Royal Victoria Eye and Ear Hospital
- EAP Programme is available for staff.
- Staff debrief held after patient safety incidents.

St. Columcille's Hospital
- Implementation of the IMF at St. Columcille's Hospital where staff are supported through the incident management process and open disclosure.
- Provision of national information leaflets to staff involved in incident.
- Open disclosure trainers on site.
- Promote Open Disclosure Awareness week

St Luke’s Hospital, Kilkenny
- EAP and Occupational Health available to all staff.
- AAR events are also available to staff as required.

St. Michael's Hospital, Dun Laoghaire
- 5Fivestaff members trained in facilitating Module 3 Workshops
- Open Disclosure Policy updating ongoing
- Promotion of Just Culture
- EAP available for staff
- Regular communications via Newsletter, Open Disclosure Information Stands, discussed at all forums (Town Halls, HOD meetings etc.)

St. Vincent’s University Hospital
- HSeLanD
- Open disclosure documentation accessible via Q-Pulse the hospitals document management system
- Information sessions and stands in 2024

Tipperary University Hospital
- Information resources e.g. templates for OD meetings, ASSIST model of communication. Open Disclosure awareness week with support from IEHG.
- Access to HSeLanD training for Module 1 & 2.
- Workshops provided locally onsite.
- Local OD trainers
- Local champions
- Training provided on Patient Safety (Notifiable Incidents & Open Disclosure) Act onsite by National OD Manager & Assistant National Director QPS Incident Management (Open Disclosure, Incident Management and NIMS).

University Hospital Waterford
- Local support via Risk Management Department
- Local support via line management structures
- Access to resources via local Information systems
- Part of RM local training programme
- Communication systems

- Active local promotion of OD
- Engagement with National Open Disclosure Office

Wexford General Hospital

- Information resources e.g. templates for OD meetings, ASSIST model of communication. Open Disclosure Awareness week with support from IEHG.
- Access to HSeLanD training for Module 1 & 2.
- Workshops provided locally on site.
- Local OD Trainers.
- Training provided on Patient Safety (Notifiable Incidents & Open Disclosure) Act onsite by QPS Teams

1H: South West Regional Health Area – Support Structures

Support structures for All Staff

The Framework requires that all staff (clinical and non-clinical), including agency staff, have access to support structures regarding Open Disclosure. What support structures are available for all staff?

South West Regional Health Area – Community services

CHO4

- Open Disclosure Lead in place.
- Open Disclosure Trainers Forum in place to support frontline managers and staff preparing for and undertaking the open disclosure process.

South West Regional Health Area – Acute services

Bantry General Hospital

- HSeLand Open Disclosure Training
- Quality, Risk and Patient Manager will provide practical and regulatory guidance and support following a patient safety incident and assist senior medical and nursing personnel to support their staff through the open disclosure process.(No Mandatory OD Case in BGH since commencement of act)
- Line Manager Structure
- Occupational Health- EAP
- Relevant National PPPG's available on Q-Pulse for all staff

Cork University Hospital

- Availability of the following on Q-Pulse:
  - Open Disclosure policy
  - Incident Management Framework
- Local information sessions on open disclosure with staff facilitated by Quality & Patient Safety Department
- HSELand training
- After Action Review approach to the review of incidents
- Employee Assistance Programme
- CUH Staff Wellbeing Officer
- Quality & Patient Safety Department
- Discipline specific management, e.g. Assistant Director of Nursing; Speech & Language Therapy Department Manager

Cork University Maternity Hospital

- HSeLanD
- Line management structure
- QPS Department

Mallow General Hospital

The support structures available for staff for open disclosure are:

- HSeLanD
- Line management structure
- QPS and Risk Department

Mercy University Hospital

- Staff enabled to complete open disclosure modules on HSeLanD
- Dedicated open disclosure resource repository on hospital Intranet including a section for staff support
- MUH Quality, Risk and Patient Safety Director provides practical and regulatory guidance and support following a patient safety incident and assists senior medical and nursing personnel to support their staff through the open disclosure process.
- Three open disclosure trainers provide training in how to carry out open disclosure
- Comprehensive ePOE NIMS training provided to enable to staff to recognise and report patient safety incidents and to encourage a culture of openness and transparency at MUH by highlighting the importance of open disclosure and of completion of open disclosure section of NIRF
- Open disclosure trainers enabled to attend open disclosure webinars and other training as appropriate
- Access to HSE EAP

South Infirmary University Hospital

- Positive reporting culture for incident reporting in a large elective surgical setting
- Information resources available
- HSeLanD training
- Open Disclosure Lead
- Next steps include in-person training, 3-minute initiatives to raise awareness

University Hospital Kerry

- EAP
- Occupational Health
- Dignity at Work
- HSE Policy for Prevention and Management of Stress in the Workplace 2018
- Medical Council (Staff support resources)
- The HSE Open Disclosure Policy and resources
- Open Disclosure HSeLanD training
- IMF 2020
- The HSE Just Culture Guide
- Line Manager support
- QRPS Department support
- National Healthcare Communications training locally
- After Action Review facilitated process.

1I: Mid-West Regional Health Area – Support Structures

Support structures for All Staff

The Framework requires that all staff (clinical and non-clinical), including agency staff, have access to support structures regarding Open Disclosure. What support structures are available for all staff?

Mid-West Regional Health Area – Community services (CHO3)

- Training available on HSeLanD.
- QRPS Department facilitate Module in person skills workshop.

- Quality, Risk & Patient Safety Advisors & Manager provide support for managers in preparation of open disclosure meetings and the associated documentation.
- Staff support structure include: EAP, Crisis Intervention, and Occupational Health.
- Open Disclosure Themed Week: All OD Champions hold awareness events within the Care Groups across the region. Activities include quizzes, Q & A sessions, short presentations. This is shared on the social media channels.

Mid-West Regional Health Area – Acute services

There are a number of supports in place across the acute sites:

- Formal debrief after a serious incident (AAR).
- Line manager support is provided immediately following an incident.
- EAP/ Inspire is offered to all staff involved as well as a formal debrief by a principal psychologist if necessary. These supports are also promoted throughout the coronial and legal processes.
- Designated Patient Advocacy and Liaison (PAL) staff are appointed for all CAT1s and SREs.
- PALS staff are available to support all staff on the open disclosure process. Designated PALS staff take a lead and ensure that staff are fully briefed and prepared for the completion of Open disclosure for CAT1s and SREs. Formal prep meetings are arranged.
- Open disclosure form developed for the recording of the open disclosure meeting, which also acts as a guide to ensure that staff follow the process in line with the policy and the act.
- The QPulse system is available on all PCs across the acute sites.
- ePOE is available for direct entry in St John's Hospital.
- Training on how to raise an incident is provided on a monthly basis.
- QPS Risk advisors are available to further support staff on raising incident and on open disclosure.
- Open Disclosure training and communication training being rolled out on a monthly basis. There are trained open disclosure staff available on all sites.
- HSeLanD training available on all PCs and work phones, which is promoted.

1J: Open Disclosure Champions

Open disclosure champions

How many clinical and managerial open disclosure champions have you appointed and trained in your organisation?

National services

Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
National Ambulance Service	7
National Screening Service	Three in total (one clinical open disclosure champion and two managerial open disclosure champions)

Mid West Regional Health Area

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
Community total (CHO3)	Open Disclosure Champions: All of the Quality, Risk and Patient Safety Advisors (6) are the nominated champions for their assigned Care Groups and work with the Clinical champions in each service. The Clinical Champions change year on year.
Acute Hospitals	17 staff trained of which 6 are clinical

South West Regional Health Area

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
Community total (CHO4)	8 formal champions comprising of Open Disclosure Lead and Open Disclosure Trainers. In addition, the ask is that anyone who attends the Open Disclosure face-to-face workshop to become an "informal" champion going forward.
Bantry General Hospital	To secure nominations for Open Disclosure Champions
Cork University Hospital	CUH is in the process of seeking nominations for further open disclosure champions per directorate, with a focus on Clinical Directors and Assistant Directors of Nursing.
Cork University Maternity Hospital	3
Mallow University Hospital	There is one designated person / open disclosure champion currently in the hospital.
Mercy University Hospital	Awaiting nominations from the directorates within the hospital to take on positions of clinical and managerial open disclosure champions.
South Infirmary University Hospital	2 just trained with another currently in training. Next step of plan is to focus on consultants first aiming for a trained champion in each specialty.

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
University Hospital Kerry	2

Dublin and Midlands Regional Health Area

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
Community	
CHO7 Health and Wellbeing	No of clinical open disclosure champions: 1 No of managerial open disclosure champions: 1 (NTC DPHN is both managerial and clinical)
CHO7	We are continuing to work to develop clinical champions with the services in Community.
CHO8	Disability Services - Module 1 (everyone) and 2 (predominately managers are on HSeLanD and form part of the mandatory training records of the service. Older Persons - No designated Open Disclosure Champions currently in Older Persons Services including Community Nursing Units, Home Support Services or Community Specialist Teams.
CHO8 - County Manager Longford	One - Longford County Manager Grade VII is Open Disclosure Trainer and Champion
CHO8 Services for: • Chronic Disease LW • Psychology LW • Public Health Nursing LW • Network 8 • DPHN • Psychology • Social Work • Co. Manager Laois • Network 11 – North Laois and East Offaly Manager • CDM	None at this time
Section 38 community services	
Our Lady's Hospice & Care Services (*data collated relates to 2 RHAs, across which the service operates - HSE Dublin and Midlands and HSE Dublin and South East*)	3
Muiriosa Foundation (*data collated relates to 2 RHAs, across which the service operates -*	• We do not have expressly titled Open Disclosure Champions within the organisation, as yet. • All managers and area directors are well versed in the Open Disclosure Policy and its application and are

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
HSE Dublin and Midlands and HSE Dublin and South East)	considered the equivalent of Open Disclosure Champions within our organisation. • There are 8 area directors and 40 managers.
Acute services	
Children's Health Ireland at Temple Street, Crumlin, Tallaght and Connolly	Open Disclosure Champions -Train the Trainer (total CHI 5), staff members who completed workshops (total CHI 32)
The Coombe Hospital	The Coombe Hospital have 2 open disclosure leads and the QRPS Department manage all queries regarding Open Disclosure. Our Designated Person is also a member of the QRPS Department.
MRH Mullingar	0
MRH Portlaoise	No Clinical Champion as yet. Matter was raised at Senior Management Team meeting on 11/3/25. Awaiting details regarding the 'role' of Clinical Champion before nominating a Clinical Champion. 2 x Trainer (QPS Staff) are Administrative/Managerial Champions.
MRH Tullamore	MRHT do not have formal Open Disclosure Champions, as yet. However it is been championed by our open disclosure trainers in the QPS Department and at senior level by the Clinical Director, Director of Nursing and Open Disclosure Lead.
Naas General Hospital	Although NGH has not formally appointed Open Disclosure Champions, open disclosure is currently championed by the Clinical Director and all members of the Senior Incident Management Team. We also have an NCHD Lead who has been trained as a trainer. This is all supported by the QRPS department.
St. James's Hospital	12 clinical and managerial leaders have been invited to serve as open disclosure champions. Level 3 training planned for completion by end Q2 2025.
St. Luke's Radiation Oncology Network	3
Tallaght Hospital	Currently TUH does not have any clinical champions. There are 5 trainers who currently provide open disclosure education currently.
Additional s. 38 services	
Peamount Healthcare Newcastle Co Dublin	3

West and North West Regional Health Area

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
Community	

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
CHO1	Community Healthcare Cavan Donegal Leitrim Monaghan Sligo (CDLMS) is awaiting proposed training for Clinical and Managerial Open Disclosure Champions and when available those people already identified will participate and take on this role. It is anticipated that the role out of the champions will be underway by Q2 2025.
CHO2	Mental Health Services have identified a lead clinician as a champion. QPS Advisors promote role within Community Service areas. Due to the current restructuring of the Regional Health Areas collaboration will be required in developing the role of champions in partnership with acute and community services.
Acute services	
Letterkenny University Hospital	Multidisciplinary trainers available and provide training at departmental, classroom and seminar level. A number of consultant medical staff have indicated their willingness to become Trainers in OD and Notifiable Incidents.
Mayo University Hospital	OD Lead has returned to employment at MUH and is leading the open disclosure training with PALS and QPS support.
Portiuncula University Hospital	Onsite Champion and wide awareness of requirements for open disclosure and the reporting of Notifiable Incidents following targeted training.
Roscommon University Hospital	Onsite Open Disclosure Lead/Champion
Sligo University Hospital	Open Disclosure Trainers available in QPS and also consultant in ED, consultant anaesthesiologist
University Hospital Galway	Open Disclosure Champions onsite in QPS and within the consultant medical staff in medicine and haematology.

Dublin and North East Regional Health Area

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
Community	
CHO1	Community Healthcare Cavan Donegal Leitrim Monaghan Sligo (CDLMS) is awaiting proposed training for Clinical and Managerial Open Disclosure Champions and when available those people already identified will participate and take on this role. It is anticipated that the role out of the champions will be underway by Q2 2025.
CHO1 (Cavan Monaghan Disability Services)	0 - Clinical and Managerial Open Disclosure Champions to be appointed following the launch of the reviewed and updated Open Disclosure Policy.

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
CHO8 (Also included within Dublin Midlands Submissions)	Not at this time
CHO9 - IHA Dublin North County and Dublin North City & West HSE Services	The following roles which are provisionally assigned as Open Disclosure Champions: o General Manager Disability Services; o Principal Medical Officer; o Head of Primary Care; o Consultant Ophthalmologist; o Head of Department for Psychology; o Principal Dental Surgeon and Senior Dental Surgeon; o Principle Clinical Lead and Operational Manager for Vaccination Services; o Director of Nursing Management Team.
Section 38 Services	
Avista CLG	6 managers are acting as champions within their respective areas - this is an area identified for further development in 2025. Clinical champions among senior clinical staff including the Clinical Director and Director of Nursing will develop in 2025.
St. Michael's House	Three (3) Clinical Staff and (2) Service Support/Management
St. Francis Hospice Dublin	Director of Nursing Training is planned for other key staff
Acute services	
Beaumont Hospital	Open Disclosure Champions recognised: · 2 Nursing; · 1 Business Manager; · 2 PALS Managers; · 1 HSCP; · 1 Risk & Legal (QPS); · 1 Clinical Governance / Clinical Audit (QPS), and · 1 Medical (Director Clinical Governance).
Cavan & Monaghan Hospitals	7
Connolly Hospital	· Associate Clinical Directors - 4 · Clinical Director - 1 · Open Disclosure Lead - 1 · Executive Management Team - 5 · Open Disclosure Trainers - 5 · Quality & Safety Team (excluding members of EMT and Open Disclosure Trainers) - 3 Total: 19
Mater Misericordiae University Hospital	· QPS Clinical Lead Champion, · Risk Manager, · Claims Manager, · Quality Manager
National Orthopaedic Hospital Cappagh	· 16 members of the Open Disclosure Committee, 9 of whom are clinical managers, and · 2 additional clinical staff identified for training.

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
Our Lady of Lourdes Hospital, Drogheda & Louth County Hospital	6
Our Lady's General Hospital, Navan	· Three: the QPS Manager, the Risk Manager and the Scheduled Care Manager.
Rotunda Hospital	· Medical = 4; · Midwifery/Nursing = 6, and · Admin = 1 Total = 11

Dublin and South East Regional Health Area

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
Community	
CHO5	• Our 5 Trained Trainers and (3.8 WTE) QPS Advisors will act as Open Disclosure Champions for clinical and managerial staff until there is more information available about the role of the champions and how to recruit and train staff for these roles.
CHO6	• As part of the Open Disclosure Project being led by QSSI – Open Disclosure Champions have been identified and attend working groups aligned with Open Disclosure Project. • A total of 6 Open Disclosure Champions have been identified. • Currently, no formal training has been provided as there is no training readily available pertaining to the role of Open Disclosure Champion. • Open Disclosure Champions have completed Module 3 Face to Face OD Training.
Section 38 community services	
Our Lady's Hospice & Care Services (*data collated relates to 2 RHAs, across which the service operates - HSE Dublin and Midlands and HSE Dublin and South East*)	3
Muiriosa Foundation (*data collated relates to 2 RHAs, across which the service operates - HSE Dublin and Midlands and HSE Dublin and South East*)	• We do not have expressly titled Open Disclosure Champions within the organisation, as yet. • All managers and area directors are well versed in the Open Disclosure Policy and its application and are considered the equivalent of Open Disclosure Champions within our organisation. • There are 8 area directors and 40 managers.
Acute services	

Regional Health Area / Service	How many clinical and managerial open disclosure champions have you appointed and trained in our organisation?
St. Vincent's University Hospital	Senior staff continue to champion open disclosure in the hospital
National Maternity Hospital	6
National Rehabilitation Hospital	4
Royal Victoria Eye & Ear Hospital	None
St Columcille's Hospital	4 staff - 2 clinical, 2 managerial
St. Luke's General Hospital, Kilkenny	3
St. Michael's Hospital, Dun Laoghaire	Clinical Lead appointed (Clinical Director). 5 Staff trained to facilitate Workshops.
Tipperary University Hospital	Clinical lead - Clinical Director. Training lead - Quality Manager, Support trainers - ADOM, IPC CNS
University Hospital Waterford	1 Managerial Champion
Wexford General Hospital	Champions not appointed to date. Three Trainers in place in 2024

Appendix II: The National Open Disclosure Office

As at 31 December 2024, the National Open Disclosure Office is comprised of the following team members:

Name	Role	Contact
Dr Orla Healy	National Clinical Lead – National Quality and Patient Safety	NQPS@hse.ie
Lorraine Schwanberg	Assistant National Director, QPS Incident Management (Incident Management / Open Disclosure / NIMS / PST)	Opendisclosure.office@hse.ie
Róisín Egenton	General Manager, Incident Management (Open Disclosure)	
Ellie Southgate	National Open Disclosure Office Manager (Gr VIII)	
Mary Friel	National Open Disclosure Educator and Trainer (Gr VII)	
Kelly McDyer	National Open Disclosure Educator and Trainer (Gr VII)	

References

- HSE National Service Plan 2024
- HSE Performance and Accountability Framework 2023
- The Department of Health National Open Disclosure Framework (2023)
- The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023
- HSE Incident Management Framework 2020
- Sláintecare Implementation Strategy & Action Plan 2021-2023
- HSE Patient Safety Strategy 2019-2024
- The Civil Liability (Amendment) Act 2017 [CLA Act 2017] Part 4