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

NATIONAL OPEN DISCLOSURE OFFICE PROGRAMME NEWSLETTER

Issue 19 | July 2025

Dear Colleagues and Friends,

Welcome to the Q2 2025 issue of the National Open Disclosure Office newsletter.

This is an especially significant edition, as it follows the official launch of the updated HSE Open Disclosure Policy 2025 in June. The new policy marks an important step forward in our collective efforts to strengthen a culture of openness, compassion, and learning across health and social care. It reflects both legal developments and deep engagement with patients, staff, and services over recent years. We are proud of the work that has gone into shaping it—and deeply grateful to all of you who are working to bring it to life on the ground.

In this issue, you'll find updates on the supports and resources available to help implement the policy, highlights from recent webinars and training sessions, and real-world examples of how services are applying open disclosure principles in practice. These stories continue to demonstrate the difference that honest, empathetic communication can make—for patients, for families, and for staff.

Thank you for your continued engagement and commitment. Together, we are shaping safer, more transparent care for all.

With Best wishes,

Lorraine, Róisín, Ellie, Kelly, Mary and Killian

NATIONAL OPEN DISCLOSURE PROGRAMME

NEW

Launch of the HSE Open Disclosure Policy 2025

On Tuesday 17 June, HSE Chief Clinical Officer Dr Colm Henry launched the Open Disclosure Policy 2025. The updated policy reinforces our commitment to open, honest and compassionate communication with patients following safety incidents.

Open disclosure is the open, honest and empathetic communication with patients or their relevant person after a patient safety or notifiable incident. This includes acknowledging what happened, offering a sincere apology or expression of regret, explaining the impact and the steps being taken to support ongoing care, and sharing what is being learned to prevent recurrence.

Speaking at the launch, Dr Henry emphasised the cultural importance of open disclosure:

> *Through open disclosure, we honour the trust that patients place in us. We support our staff in doing the right thing. And we move, step by step, towards a health system where learning and improvement are continuous, and where safety is not just an aspiration, but a lived reality. And through this new policy and the wider work of National Quality and Patient Safety, we are not only responding better to incidents—we are building safer services for the future.*

The 2025 policy builds on the foundations of the 2019 policy, but reflects significant developments in legislation and national standards. It now incorporates the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023, which introduces statutory obligations for open disclosure of notifiable incidents, and the Department of Health's National Open Disclosure Framework 2023. These changes place a legal requirement on services to disclose, while providing enhanced protections for staff under both the 2023 Act and the Civil Liability (Amendment) Act 2017.

The updated policy offers greater clarity on roles and responsibilities; places more emphasis on leadership and governance; and reinforces the importance of timely, compassionate communication to reduce further harm. It also provides detailed process guidance, and outlines supports available to patients, staff and services. This policy applies to all HSE and HSE-funded services and aims to embed a culture of openness, learning and accountability at every level.

Open Disclosure training is mandatory for all staff to ensure they are equipped to meet these requirements confidently and compassionately.

Scan the QR code or visit this link to download the HSE Open Disclosure Policy 2025: www2.healthservice.hse.ie/files/220/

This newsletter is an interactive PDF. When you click on a hyperlink, it will bring you to the website or other resource mentioned. To access, just hover and click on the text. This is the symbol you will see beside a hyperlink:

Training and Education

Updates on our National Open Disclosure Office Training and Education

Tools and resources to support the launch of the HSE Open Disclosure Policy 2025

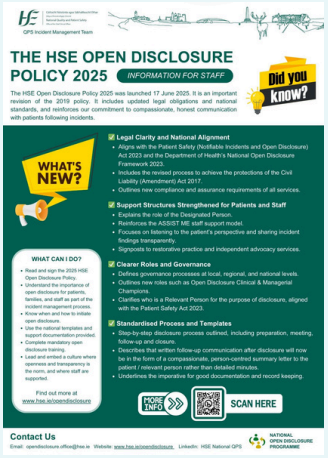
The National Open Disclosure Office is designing a range of tools and resources to support services and individuals in understanding and implementing the new HSE Open Disclosure Policy 2025.

These include:

- An A4 Poster announcing the HSE Open Disclosure Policy 2025
- An A4 Leaflet outlining key information on the HSE Open Disclosure Policy 2025 for staff
- A Checklist for the implementation of the HSE Open Disclosure Policy 2025, which also acts as an audit tool

The team will be launching additional resources in the coming weeks, including updated patient information leaflets and sample open disclosure letter templates for Category 2 incidents.
We would encourage you to include these in your open disclosure training materials, and to share widely with staff in your organisation.

Poster announcing the Open Disclosure Policy 2025



Information Leaflet for Staff

Policy Implementation Checklist and Audit Tool

Upcoming training, events, and networking opportunities

Open Disclosure Leads Meeting (online)

- 7 Aug 2pm - 3pm

Open Disclosure Webinar (online)

- 13 Aug Time TBC

We are currently finalising our training programme for Q4 2025. If you are interested in the Open Disclosure Train-the-Trainer programme for your service, please contact us at opendisclosure.office@hse.ie

Contact us for information on CPD (RCPI) and CEU (NMBI) for our training and events.

Open Disclosure Webinars

We facilitate regular webinars on open disclosure related topics with a variety of guest presenters. We welcome all staff to attend these webinars. Each webinar is CPD accredited by RCPI and NMBI for those who attend the live event. Recordings are available if you wish to listen back or for those of you who cannot attend on the day.

May 2025 | Communication & care: How does culture shape quality in health and social care?

Our May webinar focused on the forthcoming HSE Culture Framework: "Enabling Framework for Organisational Culture". Developed through considerable co-creation and consultation, the framework represents a significant moment in the HSE's culture journey. We examined:

- What has been learned from the engagement with teams, patients, the public and academia about culture in the HSE as part of the development of the Culture Framework.
- How the Culture Framework will enhance working environments to support openness and transparency with patients.
- How open disclosure fits into the framework, and its ambition to measure cultural improvement.

Featuring:
Joe Ryan, National Director, HSE Public Involvement, Culture and Risk Management
Margaret Stone, Culture Lead, HSE Organisational Culture Group
JP Swaine, Organisational Culture Transformation Manager, HSE Organisational Culture Group

WATCH NOW

322 Attendees

98% of survey participants felt the webinar met or exceeded their expectations

June 2025 | Launch of the HSE Open Disclosure Policy 2025

This webinar formally launched the HSE Open Disclosure Policy 2025.
The revised policy incorporates much learning from the last few years, and also national developments such as the Patient Safety (Notifiable Incident and Open Disclosure) Act 2023 and the Department of Health National Open Disclosure Framework 2023. The revised policy focuses on the importance of support for patients, families and staff.

Featuring:
Bernie O'Reilly, Chair, Patients for Patient Safety Ireland
Dr Colm Henry, HSE Chief Clinical Officer
Dr Orla Healy, National Clinical Lead, HSE National Quality and Patient Safety
Lorraine Schwanberg, Assistant National Director – QPS Incident Management, HSE National Quality and Patient Safety

WATCH NOW

1,056 Attendees

96% of survey participants felt the webinar met or exceeded their expectations

Sharing The Learning

We are often requested by health and social care services to provide coaching and support on the open disclosure process in relation to incidents, particularly notifiable incidents. We work with the services to unpack nuances of the Patient Safety Act and how to manage incidents and open disclosure. At a recent Open Disclosure Leads meeting, we committed to seek new ways to share our learning across services, including through this newsletter.

The case studies below, although fictional, were inspired by real-world examples of how notifiable incidents have been managed by services. They offer relatable issues that services may learn from in the context of improving quality and patient care.

NOTFIABLE INCIDENT WHICH OCCURRED IN A S39 AGENCY

An incident occurred in a Section 39 agency, and the service user supported in the agency was transferred to hospital for medical care. Sadly, the service user died in hospital following the incident. The incident was determined to be a notifiable incident.

The service provider (i.e., the Section 39 agency) was fully aware of the incident and led out on the open disclosure process. The agency notified the incident to HIQA using the notifiable incident portal on the HIQA website. A Designated Person within the agency was appointed to liaise with the service user's relevant person. The agency documented the disclosure process and ensured it complied with the HSE Open Disclosure Policy and the Patient Safety Act 2023.

Importantly, there was good communication across the teams in both the S39 agency and the hospital to ensure a coordinated, person-centred approach that avoided duplication and confusion. The services held a brief internal coordination meeting to agree facts and timelines; clarify roles and responsibilities; and prevent conflicting or repeated messages to the relevant person. This helped to ensure consistent and compassionate messaging and support to the relevant person.

NOTFIABLE INCIDENT 1.6

(Unintended and unanticipated death directly related to medical treatment)

A healthy 45-year-old received a corticosteroid injection to a shoulder tendon under ultrasound in hospital. Shortly after, he developed an embolic stroke and sadly died.

This incident was determined by the hospital to be a NI 1.6 as:

- his death was unintended and unanticipated.
- the cause (embolism from the medical procedure) was directly related to the therapeutic treatment provided.
- it was not attributable to a pre-existing illness.

The hospital addressed the incident as a NI 1.6. It was reported as a notifiable incident to HIQA through NIMS within 7 calendar days. The hospital undertook the open disclosure process as outlined in the HSE Open Disclosure Policy, including appointing a designated person. Following a preliminary assessment, the hospital commenced a systems analysis review in line with the HSE Incident Management Framework, to help determine if the incident related to multiple systems failures including communication breakdowns and process errors.

To note, the National Open Disclosure Office has received a number of queries relating to NI 1.6. Ongoing collaboration between clinical, legal and patient safety teams will help offer greater understanding of when this NI is applicable, and case scenario libraries will further offer examples for learning into the future.

Connect with Us!

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QPS Incident Management Team

Incident Management | National Open Disclosure Programme | Patient Safety Together: learning, sharing and improving | NIMS

National Open Disclosure Office

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