Management of an Open Disclosure Meeting: Quick Reference Guide and Toolkit

NATIONAL OPEN DISCLOSURE PROGRAMME

Revised August 2025

Contents

Please note this is a general guidance document to help staff prepare for and manage an open disclosure meeting. Each case must be assessed on an individual basis and managed in accordance with the specific needs of the patient/relevant person and staff affected and in accordance with the HSE Open Disclosure Policy 2025, relevant legislation and HSE Incident Management Framework.

Part A: Introduction

Context

Open disclosure discussions are often complex and sensitive and may involve many uncertainties. Guidance, training and support for staff is necessary to address the challenges that can arise and to consider the communication skills required to engage in effective open disclosure with patients/relevant persons.

This Quick Reference Guide and Tool Kit provides easily accessible information to assist staff to engage in the open disclosure process and to comply with policy and legislative requirements.

The HSE Open Disclosure Policy 2025 sets out the open disclosure requirements for **patient safety and notifiable incidents**. Notifiable incidents are a subset of incidents that are defined in the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 ['the Patient Safety Act 2023']. See Part B for information on the Patient Safety Act 2023.

This Quick Reference Guide and Tool Kit can be used to assist staff to manage open disclosure for patient safety incidents and notifiable incidents.

This resource will support staff in managing incidents in line with the provisions of the:

- HSE Open Disclosure Policy 2025
- Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023
- Department of Health National Open Disclosure Framework 2023
- Civil Liability (Amendment) Act 2017
- HSE Incident Management Framework 2020
- HSE Enterprise Risk Management Policy and Procedures and Procedures 2023

The open disclosure website includes a number of additional resources to provide practical support to those undertaking and engaging in open disclosure: www.hse.ie/opendisclosure

Please note that this resource should not be used instead of the policy or as an alternative to attending training. Additional support is available by contacting the open disclosure trainers and leads in your area.

The term **'incident'** used throughout this document refers to both a patient safety incident and notifiable incident.

Roles and Responsibilities

Clarity in relation to the roles and responsibilities of staff at all organisational levels is a fundamental governance and leadership requirement for effective incident management. Open disclosure is an integral component of the incident management process.

Please see the HSE Open Disclosure Policy 2025 for details in relation to the roles and responsibilities of staff in relation to open disclosure, with key focus on the roles of the Senior Accountable Officer (SAO), Local Accountable Officer (LAO), Principal Health Practitioners, the Designated Person, Open Disclosure Clinical and Managerial Champions, Open Disclosure Leads, and Open Disclosure Trainers.

Glossary of Abbreviations and Acronyms

Abbreviation	Full Term
ASSIST	Acknowledge, Sorry, Story, Inquire, Solutions, Travel (communication model)
CLA Act 2017	Civil Liability (Amendment) Act, 2017
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
IMF	HSE Incident Management Framework
LAO	Local Accountable Officer
MHC	Mental Health Commission
NIMS	National Incident Management System
Patient Safety Act 2023	Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023
SAO	Senior Accountable Officer

Key Terms referred to in this Document

For a comprehensive glossary of terms, please see the HSE Open Disclosure Policy 2025.

Patient	'Patient' means, in relation to a health and social care service provider, a person to whom a health service is, or has been, provided. (Patient Safety [Notifiable Incidents and Open Disclosure] Act 2023) Note: Please note that the term "patient" as used throughout this document includes patients, service users and clients of the HSE and of services funded by the HSE.
Designated Person	A person to liaise with the health and social care service provider and the patient or relevant person (or both of them) in relation to the open disclosure of the patient safety incident (CLA Act 2017) or the open disclosure of a notifiable incident (Patient Safety Act 2023).
Principal Health Practitioner	A principal health practitioner in relation to a patient means a health practitioner who has the principal clinical responsibility for the clinical care and treatment of the patient and, in the case of a cancer screening service, means the health practitioner who has the principal clinical responsibility for the cancer screening service (Patient Safety Act 2023).
Relevant Person	"Relevant person", in relation to a patient and in the context of a notifiable incident, means a person— (a) where an appointment has been made under Part 3, 4, 5, 7 or 8 of the Assisted Decision-Making (Capacity) Act 2015 in relation to health matters, to the person appointed, (b) where the patient has, under the Powers of Attorney Act 1996 , made an enduring power of attorney (within the meaning of that Act) which includes a personal care decision (within the meaning of that Act), to the attorney appointed pursuant to that Act, (c) where the patient is a ward of court, to the Committee of the Person of that ward, duly authorised in that behalf, (d) where the patient has nominated, in writing, a person to whom his or her clinical information may be disclosed, to that person, (e) where the patient is a child, to the parent or guardian of that child or where— (i) an order in respect of the child has been made under section 18 of the Act of 1991, (ii) the child has been taken into the care of the Agency under section 4 of the Act of 1991, or (iii) an order in respect of the child has been made under section 13, 17 or 20 of the Act of 1991, to the parents or guardian of the child and the Child and Family Agency (or an authorised person) or, where an order under section 23H of the Act of 1991 has been made in respect of the child, to the parents or guardian of the child and that Agency (or the social worker assigned responsibility for the child by the Agency), or (f) where the patient does not fall within the categories specified in paragraphs (a) to (e), to— (i) the spouse, civil partner or cohabitant of the patient, (ii) an adult son or daughter of the patient, or (iii) the mother, father, brother or sister of the patient. Patient Safety Act 2023, Paragraphs (a) – (f) of Section 7 (2)

Part B: Open Disclosure Legislation

The **Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023** commenced on 26 September 2024. Its purpose is to provide a legal framework for the mandatory open disclosure of notifiable incidents (NIs) and to clearly set out regulatory reporting requirements of NIs. The list of NIs is available in Appendix 5: Patient Safety Act 2023, Schedule 1 – Notifiable Incidents Part 1 and 2. It applies to public and private healthcare providers. If one of the notifiable incidents is identified then it is mandatory, by law, to action the regulatory notification requirement via the appropriate pathway e.g. National Incident Management System (NIMS), and to disclose the notifiable incident to the patient or their relevant person or both.

The **Civil Liability (Amendment) Act 2017 (CLA Act 2017)** applies to all patient safety incidents that are **not notifiable incidents**. The Patient Safety Act 2023 further amended the CLA Act 2017, and the open disclosure process is aligned for both pieces of legislation. Staff can choose to avail of the protections of the CLA Act 2017. This is a voluntary process. This means that it is not legally mandated, unlike the requirements of the Patient Safety Act 2023 as outlined above. Staff can choose to seek the protections of the CLA Act 2017 for any patient safety incident that is not a notifiable incident.

Both Acts provide legal protections for the information and apology provided in open disclosure meetings when open disclosure is managed in accordance with the provisions of the legislation. That means that the information at the open disclosure meeting cannot be used for different purposes such as evidence of an admission of liability or evidence in court. The HSE Open Disclosure Policy 2025 highlights the conditions that must be met for both pieces of legislation.

Remit	Open Disclosure Policy	CLA Act 2017	PSA 2023
When does this apply?	Patient safety and notifiable incidents	All patient safety incidents excluding notifiable incidents	Notifiable incidents
Is it optional or mandatory?	HSE policy requirement	This is optional to follow	This is legally mandated hence a requirement in law
Is the content and apology of the open disclosure protected?	Not applicable – protections do not stem from the policy	Yes, as long as the process described in this Act (and the policy) is followed	Yes, as long as the process described in this Act (and the policy) is followed
Are there any specific requirements to be mindful of?	All requirements are clearly outlined in the policy	Prescribed process including the need for written communication which must reference the CLA and be shared within five calendar days of open disclosure meetings	Prescribed process including the need for written communication which must reference the PSA and be shared within five calendar days of open disclosure meetings

Figure 1: Policy and Legal Consideration

Part C: Principles for the Management of Open Disclosure

There are ten principles designed to assist health and social care services to create and embed a culture of open disclosure.

Figure 2: The Principles for the management of Open Disclosure – adopted from the former UK National Patient Safety Agency

The 10 Principles for the Management of Open Disclosure

1) Acknowledgement	Acknowledge what has happened (what occurred in the incident) and the impact on the patient/relevant person.
2) Truthfulness, Timeliness and Clarity of Communication	**Truthfulness:** Stick to the facts available – do not speculate – it is not necessary to know all the facts to initiate the communication process – further information can be provided as it becomes available at a later date. **Timeliness:** Open disclosure must commence as soon as practicable. This means initiating the open disclosure process within 24-48 hours of the service becoming aware of an incident, which includes considerations and planning for the open disclosure meeting. **Clarity of Communication:** Use simple language and avoid medical jargon – provide small chunks of information at a time and check for understanding before moving on. Encourage questions and provide factual answers – remember that you may not have all the answers. Use the services of an interpreter, if required.
3) The Apology	▶ Apologise for what happened and for the impact on the patient. ▶ An apology must be personal to the individual and the given situation. ▶ It must be provided by the most appropriate person and include the words "I am sorry". ▶ The apology must be sincere and delivered with empathy.
4) Recognising Patient and Carer Expectations	Be guided by what the patient wants and expects: Patients want an acknowledgement of what has happened, an explanation as to how or why it happened, a sincere and meaningful apology, reassurance in relation to their ongoing care and treatment, and confirmation of the steps being taken by the health or social care service provider to aim to prevent a recurrence of the same incident to them or to others. Explain that there was an incident and explain that this is an open disclosure meeting.
5) Staff Support	It is important to identify the staff involved in and/or affected by the incident, and to ensure that they are being supported in the immediate aftermath of the incident and on an on-going basis for as long as is required.

6) Risk management and System Improvement	Incidents are identified, managed, reported, disclosed and reviewed, and learning is derived from them. Actions are then taken to try to prevent a recurrence of the incident. Keep the patient and relevant person involved – their story and perspective is an important part of the incident management and review process.
7) Multidisciplinary Responsibility	Open disclosure involves multidisciplinary accountability and appropriate response.
8) Clinical and Corporate Governance	Health and social care services are required to have appropriate accountability structures in place which ensure that open disclosure occurs and that it is integrated with other governance systems and processes including clinical incident reporting and management procedures, systems analysis reviews, complaints management and privacy and confidentiality procedures.
9) Confidentiality	The information collated following an incident is often of a sensitive nature and therefore patient confidentiality is paramount. Disclosure to the relevant person of an adult patient should be with the consent of the patient, where this is possible.
10) Continuity of Care	▶ Maintain communication with the patient. ▶ Follow through on actions agreed. ▶ Provide or direct to relevant support services via the Designated Person.

Part D: Incidents that Trigger Open Disclosure

The first step in the process is to assess the level of response required in consideration of the level of harm that has occurred. Incidents are categorised by their level of harm to the patient in line with the HSE Incident Management Framework (IMF) and the HSE Enterprise Risk Management Policy and Procedures 2023.

Type of Incident	Open Disclosure Requirement
Notifiable Incident as defined in the Patient Safety Act 2023	Disclose, as set out under the Open Disclosure Process described in Section 5 of the HSE Open Disclosure Policy 2025
Major/Extreme harm (severe harm, permanent disability or death) defined as Category 1 Incidents in the Incident Management Framework, and as per examples in the HSE Enterprise Risk Management Policy and Procedures 2023 Risk Impact Table	Disclose, as set out under the Open Disclosure Process described in Section 5 of the HSE Open Disclosure Policy 2025
Moderate harm defined as Category 2 Incidents in the Incident Management Framework, and as per examples in the HSE Enterprise Risk Management Policy and Procedures 2023 Risk Impact Table	Disclose, as set out under the Open Disclosure Process described in Section 5 of the HSE Open Disclosure Policy 2025
Minor harm defined as Category 3 incidents in the Incident Management Framework, and as per examples in the HSE Enterprise Risk Management Policy and Procedures 2023 Risk Impact Table	Disclose, as set out under the Open Disclosure Process described in Section 5 of the HSE Open Disclosure Policy 2025

Type of Incident	Open Disclosure Requirement
No harm Examples may include, with all of the following resulting in no patient harm: medication incident, absconscion, wrong test performed, multi-patient incident (e.g. ICT failure), patient fall	There should be honest, clear, timely communication with patients involved in no harm patient safety incidents if the incident involved a patient directly (for example a bedside conversation where there was a no harm medication administration incident) which in this instance constitutes open disclosure. Good communication embodies the principles of open disclosure and fosters trust within a service. A practical, reasonable and person-centred approach should be taken. In particular, if, after consideration of the no harm incident, it is determined that: (i) there is a risk of/potential for future harm (ii) that informing the patient would assist in the prevention of future harm, then the incident must be discussed with the patient/relevant person as set out under Section 5 of the HSE Open Disclosure Policy 2025
Near Miss Examples may include: patient attending for treatment in which the wrong product is nearly administered; a near miss of wrong medication/ test that is not needed; patient was consented for wrong-site surgery and mistake identified pre-operatively.	Near miss incidents do not require open disclosure, but must be assessed on a case-by-case basis. This approach is recommended to encourage incident reporting and ensure open disclosure requirements are not a deterrent. If after consideration of the near miss incident, it is determined that: (i) there is a risk of/potential for future harm, i.e. there is potential for the “near miss” incident to become a “harm” incident in the future, and/or (ii) that informing the patient would assist in the prevention of future harm, then the near miss must be discussed with the patient/relevant person as set out under Section 5 of the HSE Open Disclosure Policy 2025

Type of Incident	Open Disclosure Requirement
Unknown Patient Harm	Where there are patient safety incidents where harm is unknown, they are often rare and complex. Health and social care staff must assess such instances on a case by case basis. Decisions not to disclose must be discussed with and agreed by the Senior Accountable Officer and must have input and agreement from a minimum of two independent patient representatives/advocates and the National Open Disclosure Office.

Summary Points on Open Disclosure Process

Please refer to the HSE Open Disclosure Policy 2025 for more detailed information regarding the open disclosure requirements based on the level of harm.

Level of Harm
Category 3 (minor or no harm)
A low level response to minor harm incidents, or in some instances no harm incidents, may involve one face-to-face conversation with the patient/relevant person. In the event that the patient has been discharged or has indicated a preference for same, the patient may be contacted by telephone or alternative method of communication. The conversation with the patient /relevant person should address, as appropriate: ▶ acknowledging what happened and any resulting impact or consequences for the patient; ▶ listening to and hearing the patient's story/understanding of what has happened and its impact; ▶ providing an objective explanation of the incident; ▶ responding to questions openly, honestly and factually; ▶ providing a meaningful apology; ▶ providing reassurance in relation to ongoing care and treatment and the steps being taken to try to prevent a recurrence of the incident going forward to the patient involved and to others.
Documentation Requirement Where there is a communication to disclose a minor or no harm incident, this should be documented in the healthcare record.

Level of Harm

Category 1 (severe harm, permanent disability or a reported death); or

Category 2 (moderate harm)

Where a Category 1 (severe harm, permanent disability or a reported death) or Category 2 (moderate harm) incident is reported, then the open disclosure process must be followed as described in section 5 of the HSE Open Disclosure Policy 2025.

It is referred to as a process because open disclosure may require more than one meeting or conversation. Importantly, it is a requirement of the open disclosure process and policy that there is:

- An open disclosure meeting, and that this is documented
- That the meeting is followed up in writing
- That the incident review finding (report where available) is shared with the patient/their relevant person.

To note: It is essential that a designated person is appointed to act as point of contact and support for a patient/their relevant person following a patient safety incident where it is a Category 1 incident. For Category 2 incidents on-going communication may be managed through local managers/senior health or social care staff.

Documentation Requirement

The open disclosure meeting must be followed up in writing with the patient/ relevant person as part of the open disclosure process. The written record sent to them can take the form of a letter, which is more personable. A copy of the letter must be retained in the patient's healthcare record. Sample letter and documentation templates are available on the open disclosure website (www.hse.ie/opendisclosure) to support with meeting the requirements of the policy.

IMPORTANT: the CLA Act 2017 applies to all patient safety incidents that are **not notifiable incidents**. It is voluntary, as staff can choose to seek the protections of the Act for any patient safety incident that is not a notifiable incident.

Where the protections of the CLA Act 2017 are sought in respect of a patient safety incident, then the written record must be shared with the patient/relevant person within **five calendar days** of the open disclosure meeting. It must state that: "the open disclosure was made pursuant to and in compliance with Part 4 of the Civil Liability (Amendment) Act 2017".

See the HSE Open Disclosure Policy 2025 Section 5, which outlines the requirements set out in the Patient Safety Act 2023 and the CLA Act 2017.

Level of Harm

Notifiable Incident

Notifiable incidents are a defined list of incidents that are captured in Schedule 1 of the Patient Safety Act 2023. Where a health services provider is satisfied that a notifiable incident has occurred then the requirements of the Patient Safety Act 2023 apply, and it must be reported to the relevant regulator. Importantly, it is a legal requirement to disclose the notifiable incident to the patient, their relevant person or both depending on the circumstances.

For all notifiable incidents, the open disclosure process must be followed as described in the HSE Open Disclosure Policy 2025.

Open disclosure is referred to as a process because it may require more than one meeting or conversation. Importantly, it is a requirement of the Patient Safety Act 2023 and HSE Open Disclosure Policy 2025 that:

- A notification is made to the relevant regulator (HIQA, Mental Health Commission, Chief Inspector of Social Services) within seven calendar days via NIMS.
- A notifiable incident disclosure meeting is held, and that this is documented.
- The meeting is followed up in writing within five calendar days.
- The incident review findings are shared with the patient/their relevant person.
- A designated person is appointed to act as point of contact and support for a patient/relevant person following a notifiable incident.

Refer to Appendix 5: Patient Safety Act 2023, Schedule 1 – Notifiable Incidents Part 1 and 2 for the full list of notifiable incidents.

Documentation Requirement:

The open disclosure meeting following a notifiable incident must be followed up in writing with the patient/relevant person as part of the open disclosure process. The written record being sent can take the form of a letter which is more personable. A copy of the letter must be retained in the patient's healthcare record.

IMPORTANT: As this is a notifiable incident the written record must be shared within **five calendar days** of the open disclosure meeting. It must state that: "the open disclosure was made pursuant to and in compliance with section 5(1) of the Patient Safety (Notifiable Incident and Disclosure) Act 2023." This is mandated by the Patient Safety Act 2023.

Sample letters and documentation templates are available on the open disclosure website www.hse.ie/opendisclosure to support meeting the requirements of the Patient Safety Act 2023.

Approach to Open Disclosure

Person-centred care is the approach for the management of all incidents. This means that staff should offer the level of support that is equal to the person's needs and their response to the incident. An open disclosure process is described in the HSE Open Disclosure Policy 2025 for each of the categories of incident, however, it is recognised that reasoning should be applied as to what the person at the centre of the incident needs, and a responsive and dynamic approach should be taken as a result.

For category 2 incidents in particular, it remains important to acknowledge the incident, apologise and respond compassionately in line with the process described in the policy. It is recognised, however, that a more fluid approach can be taken in some instances. For example, where a Clinical Nurse Manager apologises for a patient safety incident whereby a patient developed a pressure ulcer leading to moderate harm due to omissions in care, this may involve a meeting at the patient's bedside with their family, explaining this to them and providing them with the letter that offers a summary of the incident to which they can later refer. On the other hand where a patient has died, it is more appropriate to offer a meeting in an environment that is not on the ward.

Timing of Open Disclosure

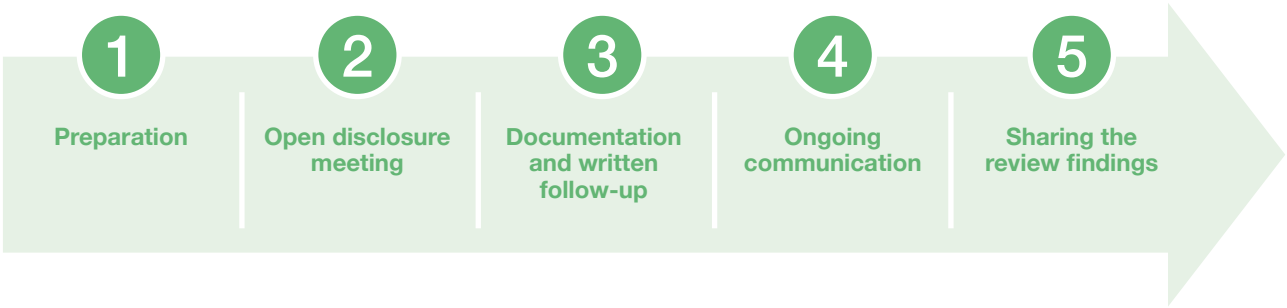
Open disclosure must commence as soon as practicable. This means initiating the open disclosure process within 24-48 hours of the service becoming aware of an incident, which includes considerations and planning for the open disclosure meeting.

There may be very reasonable considerations for delays in open disclosure. For example, a baby might have been born at one hospital and then transferred to another for treatment. It is very possible that the family may not want open disclosure initially. It is therefore appropriate to make an open-ended offer initially, acknowledging that the family can take up the invitation for open disclosure when they are ready.

Equally, there may be scenarios where delays in open disclosure are unreasonable. For example, where a health service provider becomes aware of an incident and waits a significant period of time before undertaking open disclosure, without any clear justification.

Part E: Overview of the Open Disclosure Process

This section outlines the key steps of the open disclosure process for Category 1 and Category 2 patient safety incidents, as well as notifiable incidents.



1. Preparing for an Open Disclosure Meeting

- The importance of preparation for this meeting cannot be underestimated, as open disclosure can be a highly charged and emotional process for all involved. An open disclosure meeting which is considered and well-planned will have a more positive outcome for the patient/relevant person and also for the staff members involved. Use Appendix 1: Pre-meeting checklist to guide you in the preparation for the meeting and to ensure compliance with the HSE Open Disclosure Policy 2025.
- **Identify the open disclosure team:** The principal health practitioner must undertake open disclosure unless they are unavailable, they are not in a position to make the open disclosure, or an alternative health practitioner is deemed more appropriate by the health or social care services provider. A deputy discloser will be appointed to assist the lead discloser.
- **Identify the designated person (key contact person)** who has a critical role in maintaining personal contact between the patient/relevant person and the health or social care service provider, and in providing support to the patient/relevant person at all stages of the open disclosure process.
  - The appointment of the designated person is a legal requirement for the disclosure of all notifiable incidents as per the Patient Safety Act 2023.
  - Where an incident resulted in severe harm, permanent disability or death then a designated person must be assigned to the patient/relevant person to support them throughout the open disclosure process.
  - For moderate harm incidents, on-going communication may be managed through local managers/senior health or social care staff.
  - More information on the role of the designated person and the Designated Person Checklist is available on the open disclosure website at www.hse.ie/opendisclosure.
- **Be aware of helpful words and phrases to use**, as well as those best not to use, to support and guide you in the open disclosure discussion. Appendix 6: Sample language to assist in open disclosure discussions may be helpful in this regard.

2. Managing the Open Disclosure Meeting

Patients/relevant persons generally appreciate the opportunity to meet with the healthcare team to discuss what has happened. It can be important for them to have an opportunity to tell their story, to be heard and be able to convey their thoughts/perceptions in relation to what has happened. Participating in open disclosure meetings requires the open disclosure team to demonstrate empathy and compassion towards all those involved in/affected by what has happened, including the patient, relevant person(s) and staff. Such meetings should generally be in-person unless the patient/relevant person wishes otherwise in which case alternative means should be facilitated where possible.

This HSE Open Disclosure Policy 2025 sets out the **requirements that must be met for the meeting to be deemed an open disclosure meeting**. The requirements are important to patients/their relevant person and are aligned to the Patient Safety Act 2023. This will further encourage an open and transparent culture.

The following points must be discussed with the patient/relevant person at an open disclosure meeting:

1. Introduce everyone

- Say your name and your role.
- Let the patient or their representative know who else is at the meeting and why.
- Explain that notes will be taken.

2. Say sorry

- Offer a sincere apology.

3. Listen to their story

- Give the patient or their representative time to talk.
- Let them explain what they believe happened, how it affected them, and what they hope to get from the meeting.
- Listen carefully and respond with care.

4. Explain what happened

- Tell them what is known about the incident, including the date and place if possible.
- Be honest about what you know now.
- It's okay if you don't have all the details yet – let them know more information will be shared when it becomes available.

5. How the incident was discovered

- Explain when and how the team found out about the incident.

6. Any harm caused

- If the incident caused physical or psychological harm, explain what is known about that harm.

7. Possible future harm

- If there is a chance the patient could be harmed in the future because of the incident, let them know.

8. Care and treatment

- If there was harm, explain what treatment or care is being given (or is planned) to help the patient recover.

9. What will be done to prevent it happening again

- Share what has been done or will be done to stop a similar incident happening in the future.
- Explain any changes being made to improve care and safety.

Appendix 2: Open disclosure meeting checklist outlines all of the components involved in managing the meeting effectively whilst ensuring compliance with meeting requirements outlined in the HSE Open Disclosure Policy 2025, the Patient Safety Act 2023 and the CLA Act 2017.

The ASSIST model of communication can guide the open disclosure discussion and ensure that all the key components of open disclosure are included:

The Assist Model of Communication		
A:	ACKNOWLEDGE	Acknowledge what happened and the impact
S:	SORRY	Provide a sincere apology/expression of regret
S:	STORY	Listen to the patient/relevant person's story without interruption and acknowledge your understanding of what they have said
I:	INQUIRE	Encourage questions and provide factual answers, as available
S:	SOLUTIONS	Discuss and agree solutions and next steps
T:	TRAVEL	Maintain communication and continue to provide support – Follow through on actions agreed.

Table 1: The ASSIST Model of Communication developed by the Medical Protection Society

3. Documentation and Written Follow-up

- The open disclosure meeting must be followed up in writing with the patient/their relevant person as part of the open disclosure process. This is in line with the Patient Safety Act 2023 for notifiable incidents, and for those seeking the protections of the CLA Act 2017. This should take the form of a person-centred letter.

- The letter following the open disclosure meeting is recognised as essential correspondence for capturing the salient points discussed at the meeting, including an apology and the provision of the contact details of the health or social care service provider.
- Sample templates have been developed to support the documentation of information during the meeting, and the follow up letter to be sent. These letters can be accessed on the open disclosure website: www.hse.ie/opendisclosure.
- A copy of all letters and documentation templates used must be stored in the patient's healthcare record, unless the discussion is particularly sensitive (trust in care incident) in which case it must be saved in the health service provider's incident management/open disclosure file relevant to the incident.
- **Important for the Patient Safety Act 2023:** Where the incident is a notifiable incident, then the letter must be shared within five calendar days of the meeting. It must state that the open disclosure was made pursuant to and in compliance with section 5(1) of the Patient Safety (Notifiable Incidents and Disclosure) Act 2023.
- **Important for the CLA Act 2017:** Where the incident is a patient safety incident (not a notifiable incident) and the protections of the CLA Act 2017 are being sought, then the letter must be shared within five calendar days of the meeting. It must state that the open disclosure was made pursuant to and in compliance with Part 4 of the Civil Liability (Amendment) Act 2017.

4. Ongoing Communication

Communication will continue following on from the open disclosure meeting, and may continue over a considerable period of time. Agreed actions must be pursued, and communication maintained with the patient/relevant person through the designated person.

It is important to ensure that the patient/relevant person are afforded an opportunity to ask further questions, request further information, and seek clarification, as required. It is also imperative that an on-going treatment/care plan is discussed and agreed.

Additional open disclosure meetings may take place where new information is disclosed to the patient/relevant person. All additional relevant information, obtained subsequent to the first or preceding open disclosure meeting, including the findings and recommendations of any reviews undertaken as a result of the patient safety incident or notifiable incident, must be provided to the patient/relevant person at an additional open disclosure meeting.

The Patient Safety Act 2023 is specific as to how requests for clarifications and follow-up meetings are conducted for notifiable incidents. See Section 5.6.1 and 5.6.2 of the HSE Open Disclosure Policy 2025 for more information.

Appendix 3: Post-meeting checklist was developed to guide a comprehensive follow-up after an open disclosure meeting. It is compliant with the HSE Open Disclosure Policy 2025, the Patient Safety Act 2023 and the CLA Act 2017.

5. Sharing Review Findings

Closure of the open disclosure process occurs following honest and complete open disclosure. Where relevant, the process is closed after the review findings (preferably a report) are shared with the patient/relevant person in line with the requirements set out in the HSE Incident Management Framework.

The patient/relevant person may still require ongoing support. Health and social care services providers should try to understand what supports might be required, and help the patient/relevant persons in accessing them where possible.

Feedback from patients, their relevant persons and the staff involved in the open disclosure process should be sought and any learning incorporated into improving the process going forward.

Additional Considerations for Open Disclosure

Section 5.8 of the HSE Open Disclosure Policy 2025 outlines additional considerations for open disclosure when managing under specific circumstances. Please refer to this section of the policy for further information when managing open disclosure:

- for minor or no harm incidents
- to the relevant person
- for a patient safety incident which occurred while the patient was under the care of another team/provider
- where a patient's decision-making capacity may require support
- where a patient is a child
- following patient safety incidents affecting multiple patients

Circumstances where open disclosure cannot be facilitated

There are two circumstances when open disclosure cannot be facilitated. This is in line with the Patient Safety Act 2023. They are:

- unsuccessful attempts to contact a patient/relevant person for the purpose of open disclosure, and
- patient/relevant person declined to participate in open disclosure

The services provider must take all reasonable steps to engage in open disclosure. The rationale for not carrying out open disclosure must be documented in the healthcare record and on NIMS. A notifiable incident must still be reported to the relevant regulator, even if a circumstance where open disclosure cannot be facilitated applies.

It is important to note, where the health and social care services provider receives a request subsequently for open disclosure, the service provider must keep a note of the request in writing, specifying the date of the request and the person who made it. Where the services provider receives a request, they must hold a disclosure meeting.

Part F: Further Information and Support for Staff

Staff require support during the open disclosure process.

- The ASSIST ME Booklet has been developed to provide practical information for health and social care managers and staff in relation to:

  (a) understanding the potential impact of incidents on staff;

  (b) recognising and managing the associated signs and symptoms;

  (c) supporting staff following incidents on an immediate an on-going basis, and

  (d) providing information on the support services available to staff.

This booklet is available on the open disclosure website at: www.hse.ie/opendisclosure.

- E-Learning available: open disclosure modules on HSELanD have been developed and will assist staff throughout the open disclosure process.
  - Module 1 *"Communicating effectively through Open Disclosure"* provides the theoretical components of open disclosure.
  - Module 2 *"Open Disclosure: Applying Principles to Practice"* focuses on how to prepare for and manage an open disclosure meeting and some of the complexities that may arise.
  - *"An Overview of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023"* provides an overview of the key provisions and requirements which are mandated by the Act.
  - *"The Role of the Designated Person in Incident Management and Open Disclosure"* provides an insight into the role and responsibilities of this important role, and offers great insight into the soft skills needed for managing the requirements of the role.
- Contact the open disclosure lead for your area. The list of open disclosure leads is available on the open disclosure website: www.hse.ie/opendisclosure.
- Further information and resources for patients, staff and services are available on the open disclosure website: www.hse.ie/opendisclosure
- For additional information on the Patient Safety Act 2023, and the CLA Act 2017, please visit the open disclosure website at: www.hse.ie/opendisclosure
- If you require any additional assistance or guidance please email the National Open Disclosure Office: OpenDisclosure.Office@hse.ie

Appendix 1: Pre-meeting Checklist

Open Disclosure: Pre-Meeting Checklist	
Action	**Completed Y/N**
Ensure continued clinical care to the patient to prevent further harm and provide other supports, as required.	
Assess the incident for severity and the open disclosure requirement	
If this is a notifiable incident (NI) as defined in the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023, refer to the HSE Open Disclosure Policy for mandatory steps which must be taken to meet the requirements of the Act.	
Offer/provide support for staff involved in or affected by patient safety or notifiable incident.	
Notify appropriate personnel/agencies (as per normal policy for all incidents).	
Update patient record and ensure the incident is reported on NIMS.	
Agree team to meet the patient/relevant person ▶ Lead discloser (ideally the principal health practitioner or alternative appropriate health practitioner) ▶ Deputy discloser ▶ Designated person (key contact person)	
If a notifiable incident: Ensure documentation requirements are met as per the Patient Safety Act 2023 **If a patient safety incident:** Consider if the protections of Part 4 of the Civil Liability (Amendment) Act 2017 are being sought (optional). If yes, ensure documentation requirements are met.	
Record the details of the appointment of the designated person (key contact person). ▶ Confirm name, telephone number and email address of the designated person. ▶ Document – this designation must be made in writing and kept on record.	

Action	Completed Y/N
The designated person will contact the patient/relevant person to: ▶ Arrange and agree meeting date and time (a patient may be an inpatient or resident and wish to have the meeting in the care setting). ▶ Provide an overview of what to expect at the meeting and who will be attending. ▶ Sensitively communicate with the relevant person in the event of the death of a patient. Communication must also take into consideration and be led by the grieving process of the relevant person/family. ▶ Discuss any venue requirements, an off-site location or access requirements. ▶ Encourage them to have a support person present with them at the meeting (discuss the number of people attending). Offer the services of an independent advocate, if required. ▶ Consider the need for interpreting services. ▶ Ask about any specific questions or concerns the patient/relevant person may have. ▶ Provide information regarding transport to venue and car parking arrangements. ▶ Send patient information leaflet.	
Book suitable venue based on the needs of the patient/relevant person or check with ward/residential staff where open disclosure can be facilitated.	
Arrange a pre-meeting of the open disclosure team. ▶ Agree the flow, content and structure of the open disclosure meeting. Use the documentation template to ensure key information is covered during the meeting to meet policy and legislative requirements. ▶ Identify a note taker. ▶ Consider any concerns/questions raised by the patient or relevant person to the designated person. ▶ Establish the facts and discuss any anticipated questions. ▶ Consider the timeframe involved in any review or other processes that are on-going as a result of the incident so that realistic timescales may be provided to the patient/relevant person. ▶ Consider and agree the wording of the apology and expression of regret to be provided at the meeting.	

Action	Completed Y/N
Prepare the room for meeting: ▶ "Do not disturb" sign on door. ▶ Refreshments available. ▶ Tissues available (discreetly). ▶ Room set up in a non-confrontational, relaxed style. ▶ Bathroom facilities nearby and checked.	

Additional notes/considerations

Checklist completed by:	
Date:	

Appendix 2: Open Disclosure Meeting Checklist

Open Disclosure: Meeting Checklist		
Action		**Completed Y/N**
Introductions	Designated person to meet, greet, and welcome patient/relevant person and their support person at agreed location and time and accompany them to the meeting room.	
	On arrival at meeting room, the patient/relevant person and support person are welcomed and thanked for attending this meeting.	
	Introductions must include the names, job title and role of all persons present.	
Housekeeping	Offer refreshments, ensure comfort.	
	Provide information regarding facilities, toilets etc.	
	Offer breaks – e.g. “If at any stage you feel that you need a break/refreshments or you need time out to discuss anything we have said please let us know and we will facilitate that for you”.	
	Explain note taking e.g. “We will be recording the key points discussed in this meeting today in writing and a copy of these meeting notes will be sent to you after the meeting”.	
Using the ASSIST model to structure the meeting		
Acknowledgment	Acknowledge what has happened and the impact on the patient/relevant person.	
	Demonstrate understanding for example. “I know that this has been a very difficult time for you”.	
Sorry	Provide a sincere and meaningful apology and expression of regret, for example “I would like to express my sincere apologies to you for what has happened and for how this has affected you”.	
Story	Encourage them to talk about what has happened from their perspective and how it has affected them.	
	Listen attentively and actively without interruption.	
	Summarise their story with empathy and understanding.	
Inquire	Pause regularly to check understanding and provide clarification e.g. “If at any stage you are unsure about anything or don’t understand anything we have said please stop us and ask for clarification”.	
	Encourage questions and provide factual answers for example. “What questions do you have?”	

Action		Completed Y/N
Solutions	Agree next steps and the proposed plan for their on-going care – involve the patient/relevant person in decisions made and ensure their understanding.	
	Provide information about appropriate supports available to them.	
Travel	Provide reassurance to the patient/relevant person in relation to the on-going communication process – agree communication arrangements via the designated person – confirm contact details.	
	Offer further meetings, if required.	
	Agree the action points.	
	Ensure that adequate time is provided for the closure of the meeting.	
	Check if the patient/relevant person has any further questions.	
	The designated person accompanies the patient/ relevant person to the exit of the premises. They check in with them immediately following the meeting and confirm a follow up call.	
Note: it is important that the team meeting with the patient/relevant person are aware of the information that must be provided at an open disclosure meeting, to meet policy and legislative requirements. The sample documentation template can assist with this.		
Documentation	The salient points of the open disclosure meeting are documented in the healthcare record including the names of persons present, information and apology provided, agreed care/treatment plan and any actions agreed.	
	Consider using the documentation template to support this, to ensure key information is covered during the meeting.	
After meeting review	The team discuss the meeting and reflect on the outcome, what went well, any unanticipated matters that arose and reflect how they are feeling following the meeting.	

Checklist completed by:	
Date:	

Appendix 3: Post-meeting Checklist

Open Disclosure: Meeting Checklist	
Actions	**Completed Y/N**
Follow-up call by the designated person to ▶ Establish the patient/relevant person's experience of the open disclosure meeting using the Patient Experience Questionnaire. ▶ Provide an update on any actions taken since the meeting. ▶ Check if any further assistance is required. ▶ Confirm frequency and means of regular communication and adhere to this.	
Circulate the summary letter to all relevant parties for timely verification and signature by lead discloser.	
Send summary letter to patient/relevant person after the meeting and keep a copy of the record in the patient's healthcare record. **Note documentation requirements for the Patient Safety Act 2023:** For notifiable incidents the written record must be shared within five calendar days of the meeting. The written record must state that: "the open disclosure was made pursuant to and in compliance with section 5(1) of the Patient Safety (Notifiable Incidents and Disclosure) Act 2023." **Note documentation requirements for the CLA Act 2017:** If protections are being sought under the CLA Act 2017, the written record must be shared within five calendar days of the meeting. It must state that: "the open disclosure was made pursuant to and in compliance with Part 4 of the Civil Liability (Amendment) Act 2017."	
Ensure a copy of all written records is held on the patient's healthcare record.	
Document actions pertaining to the continued care/treatment of the patient in the patient's healthcare record.	
Follow up on agreed actions.	
Involve the patient/relevant person in the review process, as appropriate and as indicated in the Incident Management Framework.	

Actions	Completed Y/N
Requests for clarification from the patient/relevant person can be directed to the designated person, who will follow up with the lead disclosure to follow up. A record of the request for clarification and the response must be retained by the health or care services provider. For Nis and where the Patient Safety Act applies the clarification must be followed up in writing within 5 calendar days.	
Provide relevant updates to the patient's GP.	
Organise further meetings as required using above process.	
Record the open disclosure meeting on NIMS and ensure NIMS record is kept updated.	

Checklist completed by:	
Date:	

Disclaimer: Please note this is a general guidance checklist to help staff prepare for and manage open disclosure meetings in an informed, empathic, compassionate and effective manner. Each case must be assessed on an individual basis and managed in accordance with the specific needs of the patient and family affected.

Appendix 4: Documentation Template for Recording the Open Disclosure Meeting

Documentation Template: Open Disclosure Meeting

This sample template can be used to guide documentation of an open disclosure meeting. A number of different templates are available on the open disclosure website: www.hse.ie/opendisclosure.

Essential requirements as per the HSE Open Disclosure Policy 2025

The following points are important to include:

- Persons present/date/time.
- Summary of the incident shared.
- Known impact/harm of the incident on the patient and any potential future harm that could reasonably be considered to occur.
- Care/treatment plan in response to any known harm (physical/psychological).
- Any steps being taken in response to the incident (immediate actions/incident review process).
- Questions/concerns by the patient/their relevant person.
- Sincere apology.
- Ongoing agreed contact person patient/relevant person.
- Ongoing agreed contact person heath service provider/designated person.
- Actions agreed and next step.
- Supports offered (i.e. independent advocacy).
- It should be signed, dated and kept on record.

Open disclosure meeting/additional disclosure information meeting documentation			
Date:		Incident Reference Number (NIMS):	
		Date of incident (if known):	
Add patient sticker			
Name of Patient/ Service User:		Contact details Relevant Person:	Address:
Patient Identification Number (if applicable):			Phone Number:
Date of birth:			Email:
Name of Relevant Person:		Contact details Relevant Person:	Address:
			Phone Number:
			Email:
Mode of communication face to face/telephone/other: Please highlight if interpreter was present			
Persons at the meeting (role/relationship):			
Is this the first open disclosure meeting or an additional open disclosure meeting?			
Designated person:			

Information discussed at the meeting
Description of the incident:
If it is an additional disclosure information meeting, please outline the additional and new information disclosed:
Known impact/harm of the incident on the patient and any potential future harm that could reasonably be considered to occur:
Care/treatment plan in response to any known harm (physical/psychological):
Steps taken in response to the incident (immediate actions/incident review process):
Questions/concerns by the patient/their relevant person:
Details of the apology provided:
On-going agreed contact person for patient/relevant person:
On-going agreed contact person for heath service provider:
Actions agreed and next step:
Supports offered (for example independent advocacy):
Any further comments from persons attending the meeting:

Signature of Principal Healthcare Practitioner:	
Print name:	
Date:	

Appendix 5: Patient Safety Act 2023, Schedule 1 – Notifiable Incidents Part 1 and 2

Item	Notifiable Incident
1.1	Surgery performed on the wrong patient resulting in unintended and unanticipated death which did not arise from, or was a consequence of, an illness, or an underlying condition, of the patient, or having regard to any such illness or underlying condition, was not wholly attributable to that illness.
1.2	Surgery performed on the wrong site resulting in unintended and unanticipated death which did not arise from, or was a consequence of, an illness, or an underlying condition, of the patient, or having regard to any such illness or underlying condition, was not wholly attributable to that illness.
1.3	Wrong surgical procedure performed on a patient resulting in an unintended and unanticipated death which did not arise from, or was a consequence of, an illness, or an underlying condition, of the patient, or having regard to any such illness or underlying condition, was not wholly attributable to that illness.
1.4	Unintended retention of a foreign object in a patient after surgery resulting in an unanticipated death which did not arise from, or was a consequence of, an illness, or an underlying condition, of the patient, or having regard to any such illness or underlying condition, was not wholly attributable to that illness.
1.5	Any unintended and unanticipated death occurring in an otherwise healthy patient undergoing elective surgery in any place or premises in which a health services provider provides a health service where the death is directly related to a surgical operation or anaesthesia (including recovery from the effects of anaesthesia) and the death did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient.
1.6	Any unintended and unanticipated death occurring in any place or premises in which a health services provider provides a health service that is directly related to any medical treatment and the death did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient.
1.7	Patient death due to transfusion of ABO incompatible blood or blood components and the death was unintended and unanticipated and which did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient.
1.8	Patient death associated with a medication error and the death was unintended and unanticipated as it did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient.

Item	Notifiable Incident
1.9	An unanticipated death of a woman while pregnant or within 42 days of the end of the pregnancy from any cause related to, or aggravated by, the management of the pregnancy, and which did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the patient.
1.10	An unanticipated and unintended stillborn child where the child was born without a fatal foetal abnormality and with a prescribed birthweight or has achieved a prescribed gestational age and who shows no sign of life at birth, from any cause related to or aggravated by the management of the pregnancy, and the death did not arise from, or was a consequence of (or wholly attributable to) the illness of the patient or an underlying condition of the child.
1.11	An unanticipated and unintended perinatal death where a child born with, or having achieved, a prescribed gestational age and a prescribed birthweight who was alive at the onset of care in labour, from any cause related to, or aggravated by, the management of the pregnancy, and the death did not arise from, or was a consequence of (or wholly attributable to) the illness of the child or an underlying condition of the child.
1.12	An unintended death where the cause is believed to be the suicide of a patient while being cared for in or at a place or premises in which a health services provider provides a health service whether or not the death was anticipated or arose from, or was wholly or partially attributable to, the illness or underlying condition of the patient.

Part 2

Item	Notifiable Incident
2.1	A baby who— (a) in the clinical judgment of the treating health practitioner requires, or is referred for, therapeutic hypothermia, or (b) has been considered for, but did not undergo therapeutic hypothermia as, in the clinical judgment of the health practitioner, such therapy was contraindicated due to the severity of the presenting condition.

Additionally, Regulation S.I. No. 501/2024 – Patient Safety (Notifiable Incidents and Open Disclosure) Regulations 2024 describes that for the purposes of Schedule 1 of the Patient Safety Act 2023 (No. 10 of 2023) and notifiable incident—

(a) 1.10 and 1.11 thereof—

(i) "prescribed birthweight" means a birthweight of not less than 2500 grammes; and

(ii) "prescribed gestational age" means a gestational age of at least 37 weeks, commencing on the first day of the 37th week

(b) 1.11 thereof, a "perinatal death" means a death which occurred within 7 days of birth.

Appendix 6: Sample Language to Assist in Open Disclosure Discussions

Sample Language to Assist in Open Disclosure Discussions Based on the ASSIST Model	
Stage of Discussion	**Sample Phrases**
Acknowledgement Discussing what has happened and the impact	▶ "We are here to discuss the harm that you have experienced/the complications with your surgery/treatment." ▶ "I realise that this has caused you great pain/distress/ anxiety/worry." ▶ "I can only imagine how upset you must be." ▶ "I appreciate that you are anxious and upset about what happened during your procedure – this must have come as a big shock for you." ▶ "I understand that you are angry/disappointed about what has happened."
Sorry Saying Sorry/ Expressing Regret Managing the Apology	▶ "I am so sorry that this has happened to you." ▶ "I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital for an extra few days for observation." ▶ "I truly regret that you have suffered xxx. While this is unfortunately a recognised complication associated with the xxx procedure/treatment, we do understand that this has caused you anxiety". ▶ "A review of your care has indicated that an error occurred – I am truly sorry about this." ▶ "A review of this event has indicated that there were certain failings in the care provided to you. (List failings identified)… I am so sorry about this and I would like to offer you my sincere apologies on behalf of myself and my team. We are planning the following actions to try to prevent this happening again in the future…"

Story Listening to the patient's/relevant person's story and summarising	▶ "How are you since we last met?" ▶ "Tell me about your understanding of your condition." ▶ "Can you tell me what has been happening to you?" ▶ "Can you tell me your understanding of what has happened?" ▶ Demonstrating your understanding of their Story: (Summarising). ▶ "I understand from what you have said that you are very upset and angry about this" "You think that… Is this correct?" (i.e. summarise their story and acknowledge any emotions/concerns demonstrated). ▶ "Am I right in saying that you…?" ▶ "From what you have told me it is your understanding that..., is this correct, have I missed anything?" ▶ Relating your understanding of the story to date. ▶ "Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned?" ▶ "Do you mind if I tell you what we have been able to establish at this stage?" ▶ "We have been able to determine at this stage that…" ▶ "We are not sure at this stage about exactly what happened but we have established that… We will remain in contact with you as more information unfolds." ▶ "You may at a later stage experience xxx – if this happens you should…"
Inquire Encouraging questions and providing factual answers	▶ "What questions do you have in relation to what we just discussed?" ▶ "We may not be able to answer all of your questions until we have completed our review of the incident." ▶ "How do you feel about this?" ▶ "Is there anything we talked about that is not clear to you?" ▶ "Do you understand what has happened?" ▶ "Do you understand what is happening in relation to your care now?" ▶ "Have we addressed all of your questions and concerns?" ▶ "Is there anything that you would like me to explain again?" ▶ "You will likely think of other questions following this discussion. Please write them down and I can try to answer them for you when we meet next or you can contact your designated person who will let me know."

Solutions Establishing and agreeing the plan of care together	▶ "What do you think should happen now?" ▶ "What is important to you?" ▶ "Do you mind if I talk you through what I think we could do and you can let me know if you are happy with this?" ▶ "I have reviewed your condition and this is what I think we need to do next… What do you think about that?" ▶ "These are your options now in relation to managing your condition, do you want to have a think about it and I will come back later to talk about it with you?" ▶ "I have discussed your condition with my colleague Dr X. We both think that you would benefit from xxx. What do you think about that?"
Travel Moving forward with the patient/relevant person. Providing reassurance and on-going support	▶ "It is important to us that we find out why this happened. We have already commenced a review of the incident to establish the facts." ▶ "We expect the review to take xxx time." ▶ "We will keep you up to date on what is happening." ▶ "We will be taking steps to learn from this incident so that we can try to prevent it happening again in the future" ▶ "I will be with you every step of the way and this is what I think we need to do now -" ▶ "We will keep you up to date in relation to our progress with the review of the incident and you will receive a report in relation to the findings and recommendations of the review team." ▶ "Would you like us to contact you to set up another meeting to discuss our progress with the review? ▶ "I will be seeing you regularly and will see you next in… days/weeks." ▶ "You will see me at each appointment." ▶ "Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by…" ▶ "XXX your designated person will be in contact with you and continue to support you during this time. Please let them know if you need any assistance or have any further questions for us." ▶ "If you think of any questions write them down and bring them with you to your next appointment." ▶ "Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services."

Language to avoid when apologising to the patient/relevant person

Certain phrases should be avoided during an apology or expression of regret. This is to ensure that only known facts are communicated to the patient/relevant person and also to ensure that the apology is sincere and meaningful. Hearing the word 'sorry' in an apology or expression of regret can be very important to the patient who has been harmed and also to their relevant persons/support persons. However, any insincerity, real or perceived, can have the opposite effect. It is important to realise that people harmed during care are likely to have a heightened emotional sensitivity.

Some examples of **wording to be avoided**:

So-called apologies that are vague, passive or conditional:

- "I apologise for whatever it is that happened."
- "Mistakes were made… mistakes happen."
- "These things happen to the best of people…"
- "If I did anything wrong, I'm sorry."
- "We are sorry… but the mistake certainly didn't change the outcome…"
- "I know that this is awful for you... but believe me, for me it is shattering."

Any speculative statements and apportioning of blame:

- "I would say that the night staff probably neglected to write down that you were given this medication…"
- "I am sorry that this has happened – I don't know what they were doing/how they could have missed this at xxx Hospital."
- "I don't really know what happened… it was probably due to…"

Try to avoid the words "but" and "however" as they often negate the first part of the sentence and can come across as defensive

- "I am sorry that you feel that way but…"
- "I am sorry if you feel that XXX was rude to you, however…"

Avoid the use of legal terminology:

- "It is all my fault – I am liable."
- "I made a mistake – I was negligent in my actions."

NOTE: Negligence and liability are matters that are established in a court of law and therefore these terms should be avoided when communicating with patients/relevant persons.

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