QI TALK TIME

Building an Irish Network of Quality Improvers

Open Disclosure Webinar

05/02/2018

CARE COMPASSION TRUST LEARNING KINDNESS EMPATHY

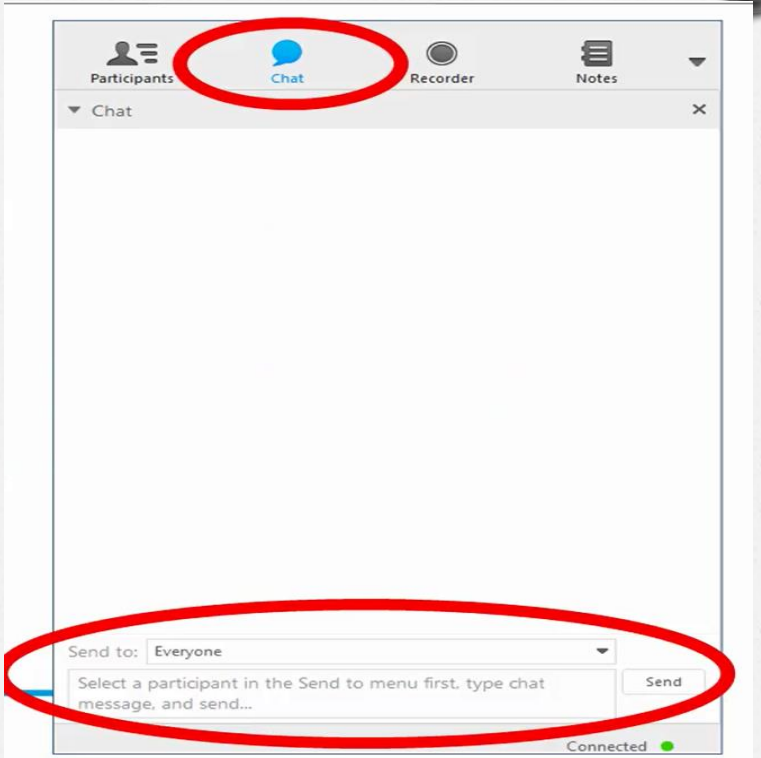
Angela Tysall: background is in general nursing and midwifery. Before joining HSE Quality Improvement Division in 2010 Angela worked for 6 years as service manager for a GP Out of Hours service in the North West. During that time worked towards and achieved quality assurance accreditation for the service.

Angela is the national co-lead on the development and implementation of the national open disclosure policy and guidelines for 7 years and more recently commenced an additional role as lead in education and training for the Assisted Decision Making Act 2015.

Mary Deasy: Quality & Risk Manager at MUH Cork, with over 15 years experience in the area of Quality & Risk Management. She is a qualified RGN. Since qualifying, she has attained Higher Diplomas in Quality & Risk Mgt; Health, Safety and Welfare at Work & MSc in Quality & Safety in Healthcare Management.

Mary successfully led the project of implementation of the Open Disclosure Programme at the MUH and continues to manage and evaluate the effectiveness of the Programme locally.

- Interactive
- Sound
- Chat box function
  - Comments/Ideas
  - Questions
- Q&A at the end
- **Twitter: @QITalktime**



Open Disclosure Webinair 06/02/2018

Open Disclosure

Communicating with service users and their families following adverse events in healthcare

people caring for people

you & your health service
people caring for people
your service, your say
you said...we did

Tús Áite do Shábháilteacht Othar
Patient Safety First

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Quality and Patient Safety Directorate

Cníomhaireacht Éileamh an Stáit
State Claims Agency

Webinair Objectives

Participants will:

- **Have an understanding of open disclosure and the national policy requirements**
- **Understand the importance of an immediate and ongoing compassionate response to all those involved in and/or affected by adverse events**
- **Be updated on the open disclosure programme and the protective provisions within the Civil Liability Amendment Act 2017**
- **Learn about putting the policy into practice - the open disclosure programme in the Mercy University Hospital Cork.**

The reality of poor communication

"Our family did not get open disclosure. We felt excluded and badly treated and none of the undertakings to give us answers were honoured. We pursued the legal route for three years but that was fraught with lack of conclusions and we feared for our financial security".

What is Open Disclosure?

An open, consistent approach to communicating with patients when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event."

(Australian Commission on Safety and Quality in Health Care)

CARE COMPASSION TRUST LEARNING KINDNESS EMPATHY

What is Open Disclosure/Open Communication?

Open disclosure describes the way staff communicate with patients who have experienced harm during health care – this harm may or may not be as a result of error/failure

Open disclosure is a discussion and an exchange of information that may take place in one conversation or

over one or more meetings

The Background

"Open disclosure represents the best of Irish healthcare. I think our instinct is to be open with patients and open disclosure guides staff to do what they know is right even in difficult circumstances when an error has occurred"

Dr Philip Crowley: National Director of Quality Improvement HSE QID

January 2018

Background

- Recommendations: “Building a Culture of Patient Safety 2008”
- Joint HSE/SCA approach supported by MPS
- Pilot October 2010- March 2013
- Launch of national documents November 2013

"*Building a Culture of Patient Safety*" 2008.

- National Standards to be developed and implemented
- Legislation to provide legal protection
- Open communication training for all healthcare professionals
- Support and counselling programmes
- Research into the impact on patients and families.

The Drivers

“At the heart of open disclosure lies the concept of open, honest and timely communication. Patients and relatives must receive a meaningful explanation following an adverse event”.

Mr Ciaran Breen: Director of the State Claims Agency 2015

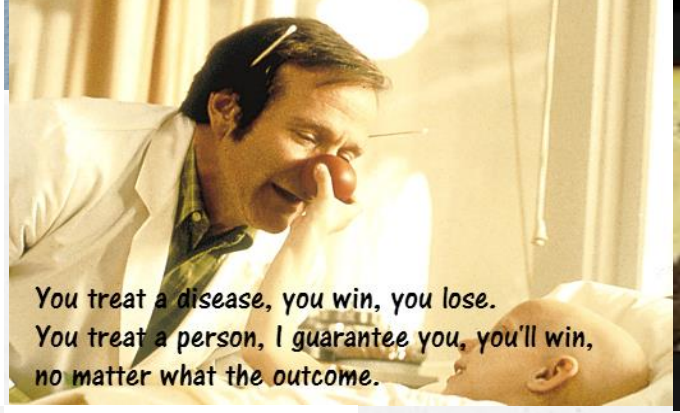
Gníomhaireacht Éileamh an Stáit
State Claims Agency

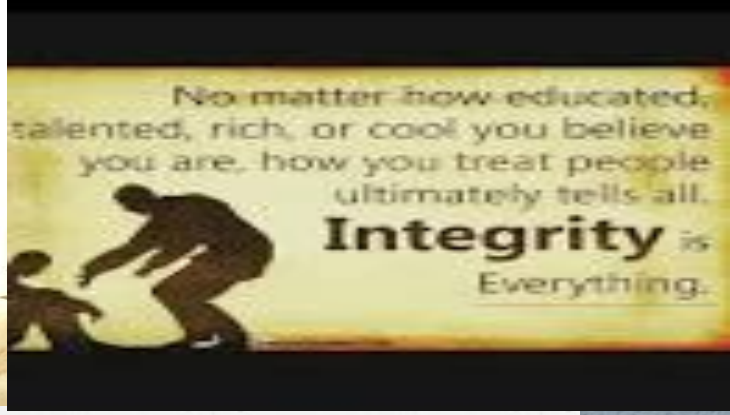
Open Disclosure: The Drivers

- "*Open disclosure is the professional, ethical and human response to patients involved in/affected by adverse events in healthcare* "

CARE COMPASSION TRUST LEARNING

Person Centred Care



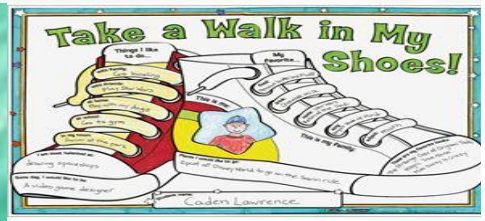


Listen to me, please!

hello my name is . . .

STAFF ENGAGEMENT

IT MATTERS TO Me



VA
VALUES IN ACTION

Our Values

Care Compassion Trust Learning

Open Disclosure: The Drivers

- **HSE Policy**
- **Professional and Regulatory**

1. NMBI and Medical Council
2. HIQA
3. CORU
4. Mental Health Commission
5. Pre Hospital Emergency Care Council
6. Pharmaceutical Society of Ireland (PSI)

Open Disclosure: The Drivers

- **The Department of Health:** Government Policy
- **Indemnifying Bodies:** SCA/MPS/MDU/MEDISEC
- **Royal Colleges:** RCSI, RCPI, ICO, ICGP, Faculty of Radiologists
- **WHO**
- **Media**

The Principles

"Open Disclosure can be viewed as an integral element of patient safety incident management and it is government policy that a system of open disclosure is in place and supported across the health system".

January 2018

An Roinn Sláinte
DEPARTMENT OF HEALTH

What is an Adverse Event?

"An incident which resulted in harm, that may or may not be the result of error"

HSE Incident Management Framework - Guidance 2018

Adverse events: How common are they?

- Studies conducted in North America, Britain, Europe, Australia and New Zealand have shown that the percentage of adverse events occurring in hospitals is between 3 and 17% with an average of 10%.
- Most medical errors are related to system problems, not individual negligence or misconduct, and are preventable.
- Fifty per cent, or one in every two, adverse events can be prevented.

The Irish National Adverse Event Study 2009 – published 2016

- 1574 patients (53% women) – 8 hospitals
- The prevalence of adverse events in admissions was 12.2%
- Over 70% of events were considered preventable.
- Two-thirds were rated as having a mild-to-moderate impact on the patient, 9.9% causing permanent impairment and 6.7% contributing to death.

Principles of Open Disclosure

1. Acknowledgement
2. Truthfulness, timeliness and clarity of communication
3. Apology / expression of regret
4. Recognising the expectations of service users
5. Professional Support
6. Risk management and systems improvement
7. Multidisciplinary responsibility
8. Clinical governance
9. Confidentiality
10. Continuity of care

Tús Áite do Shábháilteacht Othar
Patient Safety First

HSE

What do patients / service users want?

Respect

Honesty

Empathy

To be informed about their situation
by someone who is knowledgeable about it

Dedicated attention

To have their questions answered in language they understand

Professionalism

Competent, efficient service

To be listened to (and heard)

To be updated in a timely manner

Basic courtesy / friendliness

To be taken seriously

Follow-through

1. A timely and comprehensive explanation of what happened and why
2. Someone to acknowledge and apologise if things went wrong
3. A reassurance that steps have been taken to ensure the event will not happen again

Benefits for Patients/Service Users

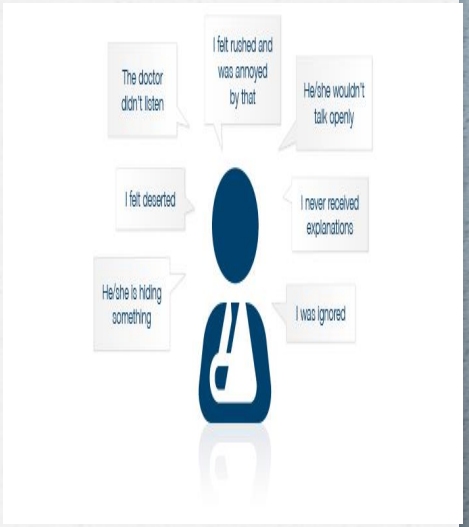
- The process can assist with providing closure for the patient/family and quicker emotional recovery.
- It can help to rebuild trust and confidence within healthcare.
- OD facilitates patient involvement in decisions relating to their ongoing care.
- OD prevents patient misconceptions in relation to the cause of the adverse event.
- Patients are more willing to continue an effective relationship with the Health Care Provider.
- Feelings of desertion after an adverse event are a major contributor to litigious intent.

Why do patients sue?

- To get answers
- The need for an acknowledgement and an apology
- Patients felt rushed
- Felt less time spent/ignored
- The attitude of staff
- Patients wanted their perceptions of the event validated

Why do patients sue?

- The experience of “second harm”
- To seek financial compensation
- To enforce accountability
- To correct deficient standards of care
- To try to prevent a recurrence of the event



University of Michigan Health System

2002, Adopted full disclosure policy-

Moved from, “Deny and defend” to

“Apologise and learn when we’re wrong, explain and vigorously defend when we’re right and view court as a last resort”

August 2001-August 2007

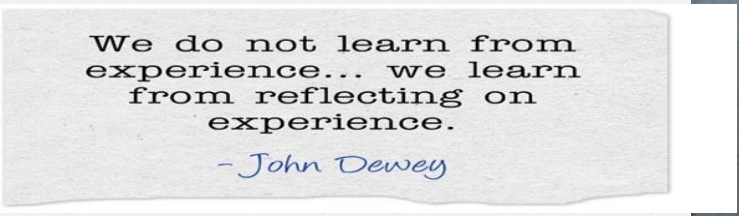
- Ratio of litigated cases : total reduced from 65-27%.
- Average claims processing time reduced from 20.3 months to 8 months.
- Insurance reserves reduced by > two thirds.
- Average litigation costs more than halved.

Barriers for Staff

- **Institutional Barriers: "Blame and Shame" approach – no institutional support or mechanisms to facilitate disclosure**
- **Fear of litigation**
- **Fear concerning professional advancement/Fear with regard to reputation**
- **Fear of being reported to professional body**
- **Fear of the Media**
- **Fear of the patient's/family response**
- **Lack of training and guidance for healthcare professionals**

Benefits for staff

- Improved staff recovery.
- It encourages a culture of honesty and openness.
- Staff are more willing to learn from adverse events.
- It enhances management and clinician relationship.
- It leads to better relations with patients and their families.
- Maintains personal and professional integrity
- Lightens the burden of guilt
- Allows for reflective learning



The Open Disclosure Process using the MPS A.S.S.I.S.T Model of Communication

A – Acknowledge – problem and impact

S – Sorry – express regret

S – Story – hear patient's story and summarise back to them

I – Inquire – seek questions to be answered, provide answers, give information,

S – Solution – seek patient's ideas on the way forward - agree a plan

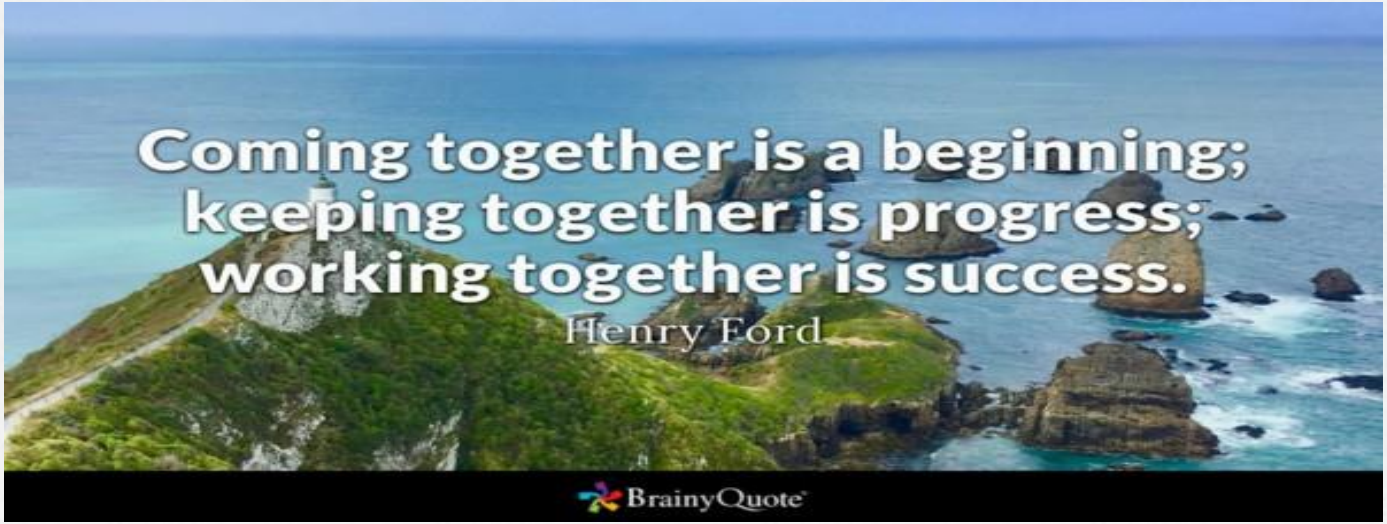
T – Travel – avoid abandonment – continued care – increased contact.

The ASSIST Me Model of Staff Support

Information for staff on:

- **The potential normal reactions to what is an abnormal event**
- **How to help yourself**
- **How to support a colleague /peer using the ASSIST ME model**
- **Advice on when to seek professional assistance i.e. GP/EAP/OH**

Update on National Programme



Update on National Programme

- **Pilot 2010-2012**
- **Launch of National Documents Nov 2013**
- **Training Programmes:**
  1. Briefing: 16,000
  2. Half day workshop: 4,300
  3. 2 day train the trainer programme: 320 trainers
- **National database of trainers and training**

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Update on National Programme

- Service user/Patient representative involvement
- Multi-stakeholder involvement: Royal colleges, professional and regulatory bodies,

  Office of the Ombudsman, HSE divisions,

  DOH, colleges and universities
- Integration with other PPPGs

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Update on National Programme

- Independent evaluation of pilot programme 2015-2016
- Audit of x 4 early adopter sites 2016/2017
- Identification of leads in CHOs, HGs and NAS
- Development of numerous resources and website www.hse.ie/opendisclosure or www.opendisclosure.ie
- International recognition of Irish programme – in particular The ASSIST ME model of staff support

Legislation to support Open Disclosure

Protective legislative provisions in Part 4 of the the Civil Liability Amendment Act 2017

1. Open disclosure:

(a) shall not constitute an express or implied admission of fault or liability

(b) shall not, notwithstanding any other enactment or rule of law, be admissible as evidence of fault or liability and

(c) shall not invalidate insurance or otherwise affect the cover provided by such policy

Provisions of legislation

2. Information provided, and an apology where it is made, shall not

(a) constitute an express or implied admission, by a health practitioner, of fault, professional misconduct, poor professional performance, unfitness to practise

(a) be admissible as evidence of fault, professional misconduct, poor professional performance, unfitness to practise, in proceedings to determine a complaint, application or allegation

Legal Services Regulations Act 2015

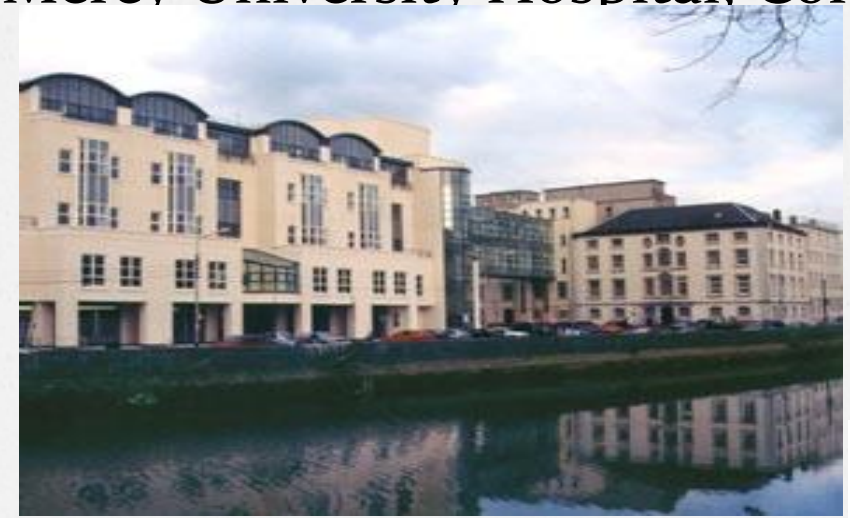
This act contains the following protections for an apology in clinical negligence claims:

(1) An apology made in connection with an allegation of clinical negligence—

- ***(a) shall not constitute an express or implied admission of fault or liability, and***
- ***(b) shall not, despite any provision to the contrary in any contract of insurance and despite any other enactment, invalidate or otherwise affect any insurance coverage that is, or but for the apology would be, available in respect of the matter alleged.***

2) Despite any other enactment, evidence of an apology referred to in subsection (1) is not admissible as evidence of fault or liability of any person in any proceedings in a clinical negligence action.”.

Open Disclosure
From Policy to Practice
Mercy University Hospital, Cork



6th February 2018
QI Talktime

Mercy UNIVERSITY HOSPITAL
Compassion Excellence Justice Respect Team Spirit

Open Disclosure – Policy to Practice

- Building on our culture
- Values led organisation
- Patient-centred model of care
- High level of support
- Support of the National Programme and Leads
- Broad collaboration – give it time
- Work through the barriers

Mercy University Hospital
Compassion Excellence Justice Respect Team Spirit

Project

- Project Management Framework
- Board and Leadership commitment
- Committee
- Identify stakeholders
- Policy development and integration of OD into other policies
- Broad collaboration
- General Awareness sessions

Training

- Identify trainers & build a team
- Train-the-Trainer Programme
- Stakeholder analysis – Mandatory group
- Training model & training plan
- Workshop series 2014-present
- Awareness sessions

National Audit of Open Disclosure Policy

- Leadership commitment & effective governance processes
- Training programmes for staff & responsibility for managing the OD process.
- An acknowledgement, apology or expression of regret and an explanation of the circumstances of the incident to the patient.

Mercy UNIVERSITY HOSPITAL
Compassion Excellence Justice Respect Team Spirit

National Audit of Open Disclosure Policy

- Information and support to patients, their families and the staff involved in the incident.
- Quality improvement and learning outcomes from the adverse incidents examined.

Local Audit of Open Disclosure Policy

- Local Audit Programme for OD-methodology
- Training Evaluation
- Developed a quiz – National OD Leads
  - 25 true/false questions
  - Sent to all workshop participants from 2014-2016 – 46% response rate
  - 93% pass rate
  - Areas with low scores – actioned
  - Enhance training

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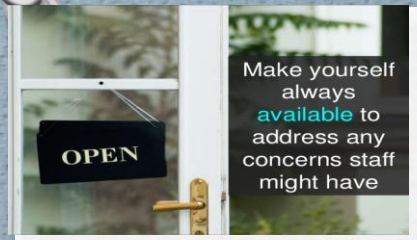
Compassion Excellence Justice Respect Team Spirit

Local ownership of OD

- Trainers - Building the team
- Tool-box talks
- Assigned trainers to each clinical area

Future considerations

- Succession Planning
- Audit Tools & measurement – in collaboration with the National Team and QID
- National Guidance/Policies on OD in special circumstances – HCAI



Summary of Policy

- Disclose – harm events, suspected harm events
  - No Harm events – generally disclose
  - Near Miss events – assess on case by case basis
- Apologise – compassion, empathy.
- Document
  - salient points and apology
  - rationale for non disclosure (remember open disclosure is the norm)
- Provide supportive environment and training
- Review, learn and take action

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Resources and further information

- www.opendisclosure.ie
- National documents
- Resources for clinicians, organisations and trainers
- Open disclosure site leads/group leads/CHO leads/NAS Leads
- Yammer.com support forum

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Fact: Things go wrong and will continue to go wrong ……..

- Adverse events happen to the best people in the best places – none of us are immune.
- We must be honest with our patients, our colleagues and with ourselves.
- Open Disclosure involves empathy towards all involved/affected

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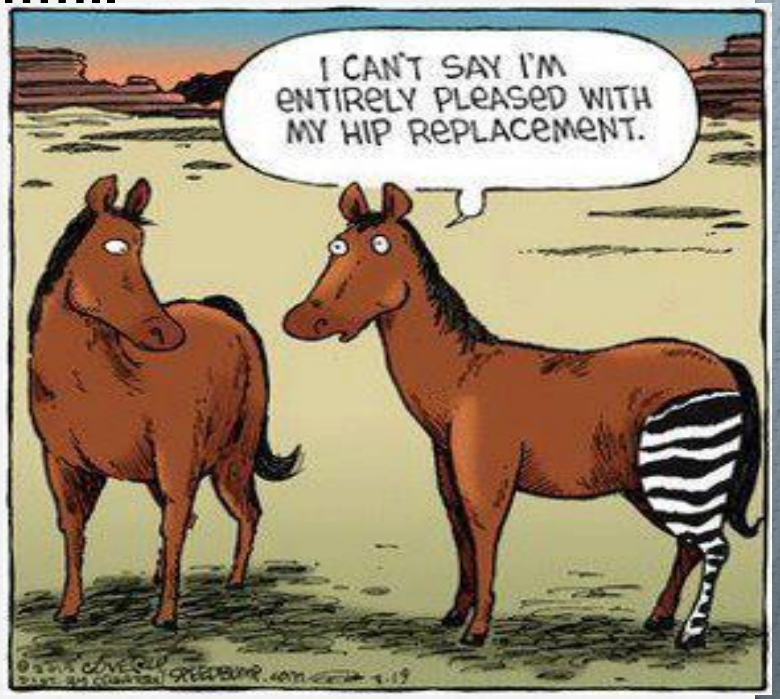

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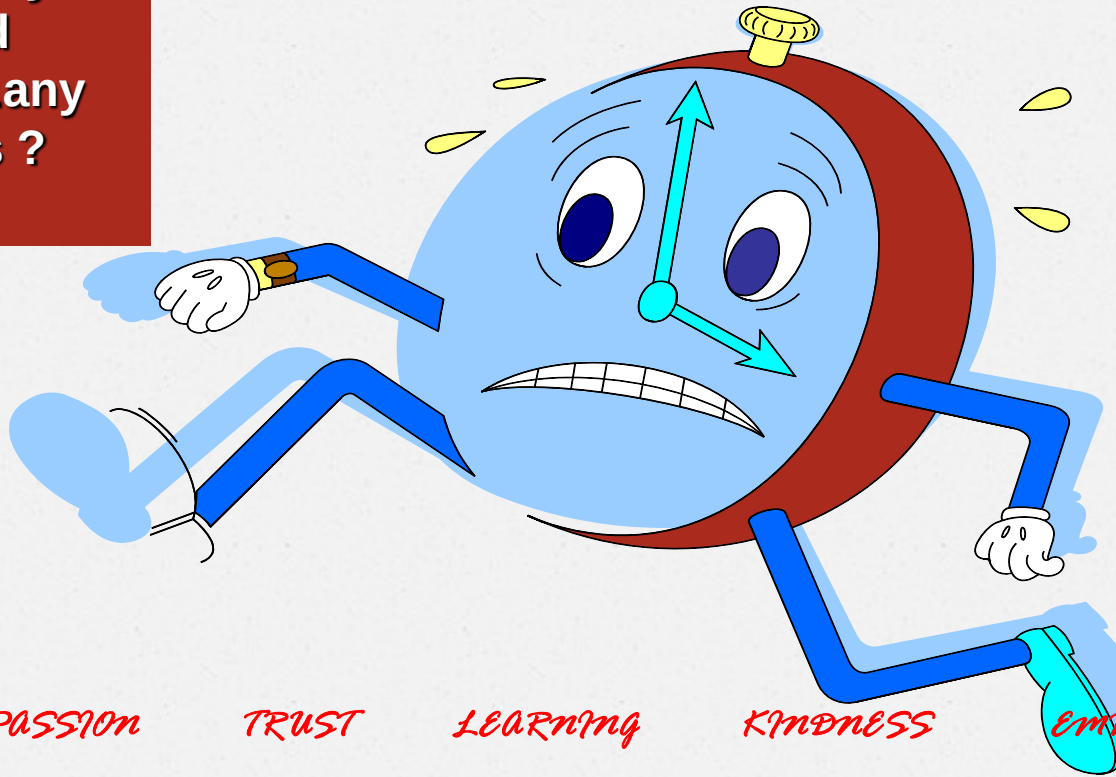
Thank you for your time and attention….any questions ?



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Follow us on Twitter @QITalktime

Watch recorded webinars at your convenience on HSEQID QITalktime page

Next Webex –Tuesday February 20th 1pm

Schwartz Rounds live from Conference Dublin Castle

Thank you from the team @QITalktime
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