

LAUNCH: 12 November 2013



Open Disclosure

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



people caring for people

Tús Áite do
Shábháilteacht **1**Othar
Patient Safety **1**First



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality and Patient Safety Directorate



Background



- **Recommendations by Patient Safety Commission 2008 – Building a Culture of Patient Safety**
- **Pilot Programme 2010-2013**
- **Launch of HIQA National Standards for Safer Better Healthcare June 2012**
- **Development of national policy and guidelines and supporting documents**
- **Launch of policy and guidelines 12th November 2013 following wide national consultation**

What's Happening Now?



- **Implementation of National Policy and Guidelines**
Phased Implementation:
 - Phase 1: Acute Hospitals :
 - Phase 2: PCCC services:
 - Phase 3: Undergraduate and post graduate programmes
- TTT programme
- Development of additional resources to assist services
- Evaluation of pilot sites
- Engaging with key stakeholders: NAS, Colleges, Professional Bodies, Regulators
- Increasing awareness

Phase 1 and Phase 2: Acute Hospitals and PCCC Areas



No of Acute Hospitals engaging: 47

No of PCCC areas engaging: 5

National Approach to implementation:

Level 1: Change management proposal provided followed by meeting with senior management team.

Level 2: Staff briefing sessions: 40 minute sessions for all staff. 1 hour grand rounds session – approximately 250 staff briefing sessions to date

Level 3: 4 hour CPD accredited skills workshops. – approximately 95 workshops to date

Phase 3: Undergraduate and Post graduate programmes



- RCSI
- RCPI
- UL
- LYIT
- St Angela's College

Local approaches to implementation



- **Organisational readiness prior to engagement with NPT**
- **OLOL Drogheda: Rolled out by directorate and lead by clinical directors for each directorate**
- **Site Lead and cross directorate roll out.**
- **Group Approach: DML and UL**

Evaluation of Pilot /Early Adopter Sites



- Current and Independent
- Initial Themes emerging:
 - 77% of staff see no difficulties or barriers in implementing open disclosure in their work
 - Pilot has had a positive impact in giving staff confidence to engage in open disclosure.
 - Pilot widely viewed as something positive in the organisation.
 - Positive feedback on the support and expertise provided by the national leads and also the local support from the site leads.
 - Formal procedures introduced and implemented for the management of critical incidents and open disclosure
 - Ripple down effect across the organisation

Recurrent themes arising in training



Barriers to Open Disclosure identified in international studies:

- Fear of litigation
- Fear concerning professional advancement
- Fear with regard to reputation
- Fear of the emotional reaction of the patient and their family
- Uncertainty with regard to the extent of information to be disclosed
- Lack of training and guidance for healthcare professionals

Additional Barriers identified in ROI:

- Absence of legislation to protect clinicians – cart before the horse!
- Fear of the Media
- Fear of being reported to Fitness to Practice
- Blame and shame culture still exists
- Concerns re corporate and medical manslaughter cases in other countries e.g. UK
- Inadequate resources particularly poor staffing levels – leading to increased likelihood of adverse events
- Poor staff support arrangements in many services

Feedback from Midwives October 2014



Barriers Identified:

- Lack of “buy in” from managers
- Too much emphasis on “legal”
- Media damage – staff not defended
- Fear – what will happen to me? Fitness to practice
- What about us – the staff involved – who cares for us?
- Anxiety regarding access by the public to reflective practice documentation

Feedback from 7 Early Adopter sites



- ⌘ There has been positive buy in by organisations to date
- ⌘ Training programmes critical – shorter training programmes required for doctors – difficulties identified releasing staff for training due to staff resource issues
- ⌘ The process works
- ⌘ Positive feedback regarding national implementation strategy and support offered to services – “*making open disclosure real – a living entity*”.
- ⌘ National guidance required re use of tape recordings and video recordings in HSE services
- ⌘ Protective legislation will increase confidence in the process
- ⌘ A change in culture required.



- Recommendations of the Commission for Patient Safety and Quality Assurance (2008) and the Law Reform Commission (2008)
- Ireland currently does not have any legislation in place to protect the open disclosure process
- DOH: Protective legislation expected in the upcoming Health Information Bill – to allow medical practitioners to apologise and explain (when a patient has suffered harm as a result of their care) without these being construed as an admission of liability.
- Department of Justice and Equality: Work continuing on pro action protocols for the early settlement of liability and on periodic payment options for catastrophic injury cases which will provide enhanced options for resolution of such liability cases, some of which will involve medical negligence (October 2014)

Next steps



- **Continue work on Phases 1,2 and 3 of National Implementation Programme and engagement with other relevant stakeholders.**
- **Increased emphasis on TTT programme in hospital groups and Community Healthcare Organisations.**
- **Specific pieces of work to be undertaken e.g. radiology QA programme, staff support programmes.**
- **E- learning module**
- **Development of additional resources to assist implementation**
- **Sharing our experience and resources**
- **Increasing awareness.**

Resources: www.hse.ie/opendisclosure



Key messages



Open Disclosure is about:

- Doing the right thing
- Improving patient experience
- Improving patient safety
- Improving staff experience
- Increasing public confidence in our services
- Professionalism, Integrity, Empathy and Respect

Essential components:

- Leadership and organisational buy in and support
- Training including introduction to undergraduate and post graduate programmes
- Staff support
- Requires a change in culture
- Phased implementation

Final thought:



“Transparency and honesty are powerful tools to improve patient safety”

(Jeremy Hunt Health Secretary UK- this week at a presentation in St Thomas’s Hospital, London)



Angela Tysall: Lead for the HSE in Open Disclosure

angela.tysall@hse.ie

Ann Duffy: Lead for the SCA in Open Disclosure

aduffy@ntma.ie