LAUNCH: 12 November 2013
Workshop Programme

- Open Disclosure: The Drivers
- Update on national programme
- A review of the Principles of Open Disclosure
- The Patients Perspective – A Patient Story
- The ASSIST Model of Communication
- Applying the ASSIST Model
- The Staff Perspective
- The ASSIST Me Model of Staff Support
You treat a disease, you win, you lose. You treat a person, I guarantee you, you'll win, no matter what the outcome.
What is Open Disclosure?

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.
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)
What is an Adverse Event?

An undesired patient outcome that may or may not be the result of an error.

Or

An incident which resulted in harm

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 percent, 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.
The Irish National Adverse Event Study 2009 – published 2016

- A mean of 6.1 added bed days was attributed to events, representing an expenditure of €5550 per event.

- The adverse event rate varied substantially (8.6%–17.0%) when applying different published adverse event eligibility criteria.

- Adverse events in adult inpatients were estimated to cost over €194 million.
Open Disclosure: The Drivers

"Open disclosure is the professional, ethical and humane response to patients involved in/affected by adverse events/adverse outcomes in healthcare."

Open disclosure is HSE Policy.
Open Disclosure: The Drivers

Professional and Regulatory

1. NMBI
2. Medical Council of Ireland
3. HIQA
4. CORU
5. Mental Health Commission
6. Pre Hospital Emergency Care Council

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Open Disclosure: The Drivers

- **Indemnifying Bodies:** SCA/MPS/MDU/MEDISEC
- **Royal Colleges:** RCSI, RCPI, ICO, ICGP, Faculty of Radiologists
- **WHO**

**Values:**
- Care
- Compassion
- Trust
- Learning
- Kindness
- Empathy
Update on National Programme

Coming together is a beginning; keeping together is progress; working together is success.

Henry Ford
Update on National Programme

- Pilot 2010-2012
- Launch of National Documents Nov 2013
- Training Programmes:
  1. Briefing: 12,910 staff attended
  2. Half day workshop: 4,233 staff attended
  3. 2 day train the trainer programme: 300 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
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
- International recognition of Irish programme – in particular The ASSIST ME model

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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
Apologising effectively to Patients- Prof Lucian Leape

https://www.youtube.com/watch?v=kDfoJXq8BRA

“Quote”

“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.” (Leape 2009)

Dr. Lucian Leape is a professor at Harvard School of Public Health, he is a health policy analyst whose research has focused on patient safety and quality of care.
In our work we promote:

- Care, Compassion, Empathy, Trust and Learning for all involved in adverse events
- HSE Values in Action
- #Hellomysnameis
- What matters to you
- Person Centred Care
The Patient’s Perspective

Our Story
Mrs Bernie O’Reilly
What are patients saying?

They want:

- A truthful discussion
- To have their story heard, acknowledged and validated
- Information to their level of satisfaction
- An expression of regret or sorrow – an apology
- Information on how similar outcomes will be prevented in the future
- An agreed plan for ongoing care and follow-up

What do patients / service users want?

- Respect
- Honesty
- Empathy
- Dedicated attention
- Professionalism
- Competent, efficient service
- To be informed about their situation by someone who is knowledgeable about it
- To have their questions answered in language they understand
- 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
Why do patients sue?

- Patients felt rushed
- No explanations given
- Felt less time spent
- Felt ignored
- Patients wanted their perceptions of the event validated
- The need for an apology

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Why do patients sue?

- Desire for financial compensation
- To correct deficient standards of care
- To enforce accountability

- 91% wanted to prevent a recurrence.
- 90% wanted an explanation.
- 68% wanted the doctor to know how they felt.
- 45% due to attitude of hospital staff following the error.

George Bernard Shaw

“The single biggest problem in communication is the illusion that it has taken place.”
The Staff Perspective

Sidney Dekker on The Second Victim

https://www.youtube.com/watch?v=YeSvCEpg6ew
The 6 recognised staff reactions to adverse events


2. Intrusive reflections: Re-evaluate the event. Haunted re-enactments of the event. Self isolation.

3. Restoring personal integrity: Managing gossip Questioning trust. Fear.
The 6 recognised staff reactions to adverse events

4. **Enduring the inquisition:** Realisation of seriousness. Wonder about repercussions. Who can I talk to?

5. **Obtaining emotional first aid:** Seeking personal and professional support. Where can I turn to for help?

6. **Moving On—Dropping Out, Surviving or Thriving:**

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The 6 recognised staff reactions to adverse events

- Despite a desire to move on, many professionals find it difficult to do so. This stage has three potential paths:
  - Dropping Out—changing professional role, leaving the profession or moving to a different practice location.
The 6 recognised staff reactions to adverse events

- **Surviving**—performing at the expected performance levels (“doing OK”) but continue to be affected by the event.
- **Thriving**—making something good out of the adverse event.
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
The Open Disclosure process

- assists patients that have experienced harm
- guides and supports staff and organisations in supporting patients that have experienced harm
- guides and supports staff and organisations in supporting those staff involved in and/or affected by adverse events
- ensures that health service organisations learn from adverse events.
DVD:
“And you weren’t even going to tell me”

https://www.youtube.com/watch?v=UgxXPhb9zl
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.

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Role Play using the MPS ASSIST Model

Scenario:
Mary Gallagher is a healthy 72 year old lady who has full capacity. Mary is an inpatient in Bay 1 on the surgical ward 3 days post a right hip replacement and is making a good recovery. During the 0800hr medication round Mary was administered AMLODIPINE 5mgs (an anti-hypertensive medication) in error. The nurse quickly realised her error and informed the nurse in charge immediately. There are two patients on the ward with the name Mary Gallagher – the other Mary Gallagher is in Bay 2 and on AMLODIPINE.
Role Play using the ASSIST Model

Setting:
Family Room on surgical ward

Cast:
Ms Bernie O’Reilly as Mary Gallagher
Ms Angela Tysall as Sister Bridget Kelly (CNM2)
In summary

- Open disclosure team – key contact
- Prepare well – establish the facts – consider type of apology required and language
- Consider time, venue, support persons, additional requirements
- Introductions
In summary

- Acknowledge – event and impact
- Apologise – Story – Questions – Care plan – Learning – agreed actions
- Document
- Follow up
- Keep in touch

“If it’s not documented it was not done”

To avoid litigation, health care providers must comply with established standards of care.
Legislation to support Open Disclosure

Protective legislation will appear in the Civil Liability Amendment Bill 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 continued

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
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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"We were heartened by the efforts made by administrators and clinicians in the Mater to accept responsibility and embrace the need for change. We are grateful for those people in the Mater who helped us along the way, those people who admitted that failings had occurred and agreed to right them in the future, those who showed us compassion and treated us as human beings rather than potential litigants.

Financial compensation was never on our agenda. Money would never have compensated us for losing our wonderful and precious son. Instead we simply wanted answers, information, explanations, solid reassurances that what went wrong would never happen again. We wanted a proper and meaningful apology”. 

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

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