Communicating in Times of Stress

WA Open Disclosure Pilot Project Evaluation

Office of Safety and Quality in Healthcare

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INTRODUCTION

"Open disclosure is the open discussion of incidents that result in harm to a patient while receiving heath care. The elements of open disclosure are an expression of regret, a factual explanation of what happened, the potential consequences and the steps being taken to manage the event and prevent recurrence."

Australian Council for Safety and Quality in Health Care 2003, Open Disclosure Standard: A National Standard for Open Communication in Public and Private Hospitals, Following an Adverse Event in Health Care.

The Western Australian (WA) health workforce is dedicated and committed to providing high quality and safe health care to patients. However, because we are human, sometimes things go wrong. In some cases the outcome can be serious.

When a patient is harmed, in a WA Hospital, by the care that is designed to help them, there is an ethical responsibility on the part of health practitioners, to inform the patient and / or their nominated carers / relatives about the clinical incident or adverse event that occurred.

It is recognised by the WA Department of Health that for many years health professionals in WA Hospitals / Health Services have routinely reported and disclosed clinical incidents that may or may not have resulted in harm to a patient. Staff are encouraged to continue this open and honest approach in line with the National Standard of Open Disclosure.

"There is no agreed universal definition of "adverse event". For the purpose of this Standard, the Australian Council for Safety and Quality in Heath Care has defined "adverse event" as "an incident in which unintended harm resulted to a person receiving health care".

Australian Council for Safety and Quality in Health Care 2003, Open Disclosure Standard: A National Standard for Open Communication in Public and Private Hospitals, Following an Adverse Event in Health Care.

In 2002, the Australian Council for Safety and Quality in Health Care ('the ACSQHC') commissioned Standards Australia to develop a National Open Disclosure Standard. Endorsed by Australian Health Ministers in July 2003, the National Open Disclosure Standard promotes a clear and consistent approach by hospitals (and other organisations where appropriate) to openly communicate with patients and their nominated relatives / carers following a clinical incident.

In July 2004 the ACSQHC established a project to pilot the National Open Disclosure Standard in Australian Health Services. The South Metropolitan Area Health Service (SMAHS) agreed to lead the Open Disclosure Pilot Project in the WA health system. The WA Pilot Project commenced in November 2004 with the formation of the Open Disclosure Project Control Group and creation of a Project Officer position. The Pilot operated at four sites - Fremantle Hospital and Health Service (including Kaleeya Hospital), Armadale Health Service, Bentley Health Service and Rockingham / Kwinana Health Service (PARK).

The Pilot Project aimed to implement the Open Disclosure Process as directed by the Australian Standard – A National Standard for Open Communication in Public and Private Hospitals, Following an Adverse Event in Health Care July 2003.

Concurrent with the pilot of the National Open Disclosure Standard, the Western Australian Council for Safety and Quality in Health Care worked in partnership with the Department of Health to develop "*Communicating in Times of Stress: Procedural Guidelines for Practicing Open Disclosure in WA Health Services".* The draft WA procedural guidelines for Open Disclosure will become a key element of the WA Clinical Governance Framework. They are currently pending endorsement with implementation anticipated in 2008.

KEY OPEN DISCLOSURE PRINCIPLES FOR WA

All WA public Hospitals / Health Services practicing Open Disclosure will do so in accordance with the following key principles:

1. An expression of regret - a patient should receive an expression of regret for any harm that they have suffered as a result of a clinical incident.

2. Disclosure of a clinical incident - a patient, and with the patient's consent, their nominated relative / carer, is to be fully informed of the facts surrounding the clinical incident and its consequence.

3. Staff support and training - the clinical team should receive appropriate support from the hospital / health service when a Clinical Incident occurs. The clinical team should also receive appropriate training in communication and the principles of Open Disclosure.

4. Patient support - the patient is entitled to be treated with respect and compassion and to receive appropriate, ongoing support.

5. Clinical Governance - Open Disclosure is a key element of the WA Clinical Governance Framework to be integrated with other Clinical Governance processes (clinical incident management and reporting processes and clinical risk management procedures).

6. Confidentiality - due to the sensitive nature of the information collected during the investigation and analysis of a clinical incident, Hospitals / Health Services and their staff are obliged to maintain the confidentiality of patient information.

7. Fairness - when a clinical incident occurs and the Open Disclosure process is initiated, patients and health practitioners maintain the right to be treated fairly by the institution.

THE PILOT PROJECT

Project Governance

The Open Disclosure Project Control Group was formed in November 2004 and met monthly, to assist in directing and monitoring the progress of the Open Disclosure Pilot Project.

Additional support from the WA Department of Health was made available from the Office of Safety and Quality in Healthcare which provided funding for a Project Officer position and enabled the undertaking of staff needs analysis, information dissemination and education skills development for lead clinicians.

Meetings and seminars have been conducted since the beginning of the Project to capture ideas and inform clinicians of the Open Disclosure Pilot Project.

Surveys of all clinical staff were conducted to measure the knowledge deficits in Root Cause Analysis and Open Disclosure and to provide gap analysis reporting. This was repeated mid way through the Open Disclosure Pilot Project (June / July 2006) and again at the end of the Project to evaluate the effectiveness of the education package.

Consumer groups were informed and involved throughout the implementation of the Open Disclosure process. Regular meetings were held with consumer groups including the Health Consumers' Council of WA, who have been provided with ongoing feedback. The Project Officer was regularly involved in presenting seminars on Open Disclosure to consumers.

Project Model

There were FOUR distinct components to the WA Pilot Open Disclosure Model:

1. Linkages to clinical incident reporting tools and risk management processes, by performing gap analysis. Surveys were conducted pre-education to measuring level of knowledge on Root Cause Analysis and Open Disclosure. This survey was repeated post education sessions.

2. An awareness raising campaign designed to increase awareness of the issue. This included the circulation of posters and the placement of information on the Hospital Intranet, newsletters and articles in hospital-based publications.

3. Staff briefings were conducted through team meetings, lunchtime lectures and individual appointments to provide information about the Open Disclosure Standard, the impending policy and process and the responsibilities of senior staff when dealing with high and low level incidents. Approximately 960 staff members have attended some level of education on the Open Disclosure process and Heads of Departments and team leaders are aware of how to manage the situation.

4. Communication workshops were organised to enable senior staff to practice the communication skills required when broaching difficult subjects with patients and their families. These were two-hour sessions conducted by a psychodrama therapist and approximately 100 clinicians attended.

Implications of Western Australia's Qualified Privilege Environment

The Health Services (Quality Improvement) Act 1994 governs qualified privilege in Western Australia. The purpose of the Act is to encourage health professionals to participate in quality improvement processes aimed at improving the quality of clinical care. Qualified privilege prohibits the disclosure of information that identifies, directly or by implication, individual health professionals and / or patients.

If a hospital elects to undertake an investigation of a clinical incident using State qualified privilege, or under the Commonwealth Health Insurance Act 1973 (i.e. using the Advanced Incident Management System - AIMS), then no information should be released to the patient until legal advice has been obtained, as there are a number of prohibitions on the disclosure of information arising from investigations of clinical incidents under both State and Federal legislation.

If the clinical incident has been investigated under WA's qualified privilege legislation, during the Open Disclosure process the patient and / or relatives can be informed about what events actually occurred but can not be told why the incident occurred or what is being done / has been done to prevent the incident from recurring.

The WA Open Disclosure Policy will underpin the Open Disclosure process and inform all clinicians of their rights and responsibilities. It also describes the process for use in the work arena. The clinical champions from the Pilot Project identified that it would only be possible to secure the involvement of most doctors if there is written clarification that the operation of state funded professional indemnities will not be affected when complying with the Open Disclosure Policy.

RECRUITMENT, EDUCATION AND TRAINING EVALUATION

Recruitment, Education and Training

Clinical champions were identified at the beginning of the Pilot, and were fully informed about the National Open Disclosure Standard and processes. A total of 96 clinical champions were recruited from the four pilot sites from various disciplines. The clinical champions included a number of medical physicians and nursing staff from a range of specialties in addition to representatives from mental health, social work, staff development, allied health, aged care, and clinical governance.

It was acknowledged that should clinicians move on from their current position the valuable resource of the clinical champion would be lost to the Pilot. To address this risk, clinical champions agreed to hand over their responsibility to another clinician if they left. In addition, the valuable knowledge gained by the clinical champions during the pilot project would be taken with them to their next position.

A flow chart on the Open Disclosure process (Appendix A) was used during the Pilot Project.

The purpose of the Open Disclosure training was to educate key clinical champions on effective communication strategies to enable them to provide support and encouragement to other clinicians to communicate effectively following an adverse event. The object of the workshops was to prepare senior clinicians for their role as "champions" for the Open Disclosure process.

An initial communications skills workshop was held for clinical champions, over two three-hour evening sessions presented by an external consultant with the assistance of the Project Team.

In addition, the communication workshop entitled *Delivering Difficult News*, was presented to senior clinicians by a psychodrama / psychotherapist consultant and counsellor using the model of sociometry – group relations and reflectiveness.

The communication skills workshops conducted for senior clinicians further expanded on the principles for the Open Disclosure process and allowed personal experiences and issues to be addressed. Posters, brochures and lanyard cards were also developed to inform and support staff with the Open Disclosure process. These resources featured important process points to remember and information on how to access further information from the Area Health Service Intranet website.

The education / training package (Figure 1) implemented for the WA Pilot Project was developed using the National Open Disclosure Standard literature as the basic framework. Guidance from local staff surveys, evidence from international programs, State legal advice and the endorsed WA Pilot Open Disclosure Policy were all used to structure the integral content of the education program, which was presented across the four pilot sites.

Figure 1. Education / Training Package of the WA Open Disclosure Pilot Project

Type of Training / Education
1. Delivering Difficult News Workshop Each session 2 hours / Open to all senior clinicians
2. Communication Skills Workshop – PDT 2 x 3 hour sessions – attended by the same group of clinicians
3. Lunch time lectures Open to all staff at Fremantle and Bentley Hospitals.
4. 15 minute 'handover sessions' Clinicians and Heads of Departments
5. 'One on one' sessions All pilot sites
6. Open Days
7. Staff Orientation

More broadly, information on the WA Pilot Open Disclosure Process and Policy was disseminated to the wider clinical population informing them of the National Open Disclosure Standard via the Area Health Service website, presentations, lunchtime seminars and individual team meetings.

Approximately 960 staff in the Pilot were provided with education or training in the Open Disclosure process at the following facilities:

- Armadale Health Service;
- Bentley Health Service;
- Fremantle Hospital and Health Service (including Kaleeya Hospital); and
- Peel and Rockingham / Kwinana Health Service.

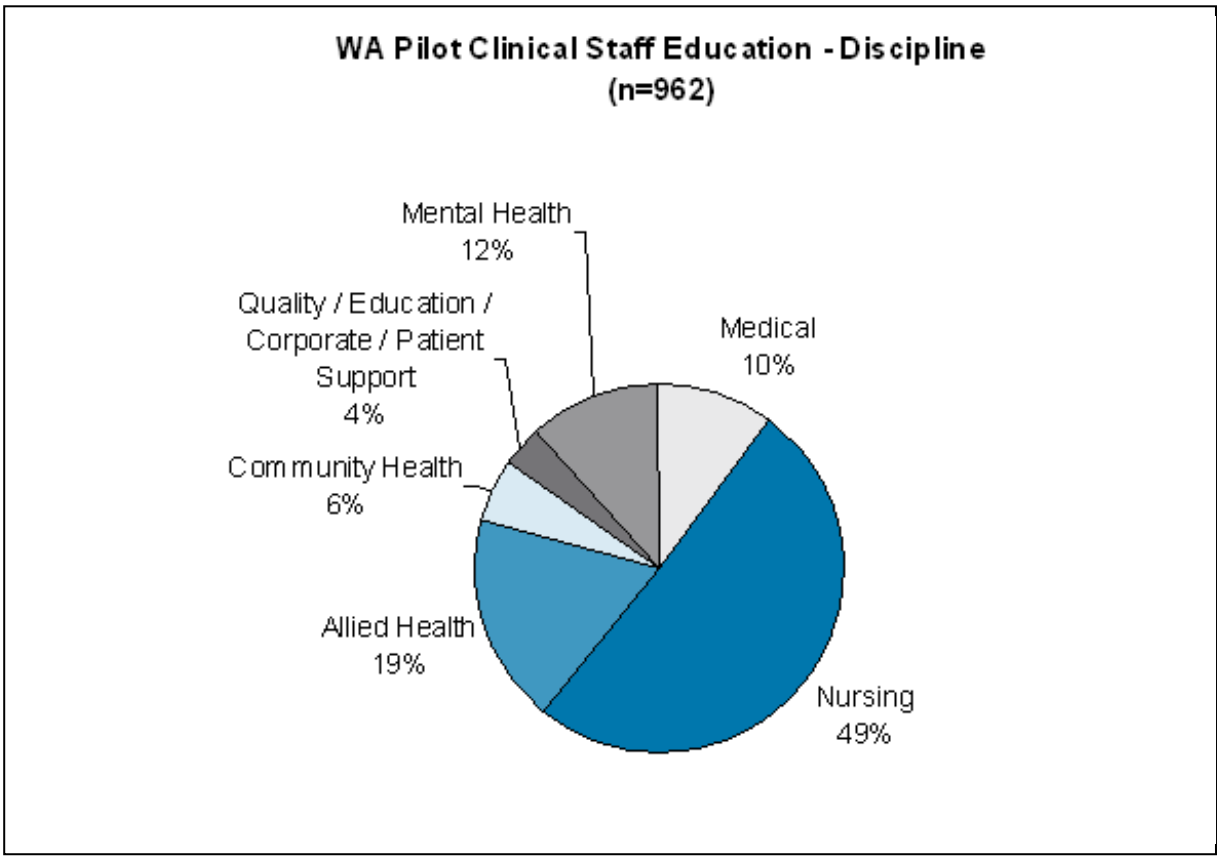
All education sessions focused on:

- Definition of Open Disclosure;
- Open Disclosure policy principles;
- Clarification of legal issues;
- Documentation requirements;
- Open Disclosure process;
- Policy guidelines;
- Local examples; and
- Identification of area-specific clinical champions.

Initiatives to maintain staff skills were put in place and were reviewed and evaluated on a regular basis. Staff Development was allocated responsibility for maintaining the flow of information through orientation processes. The Medical Education Officer allocated time for information sharing at each new intake, and teams assisted in the orientation of new staff members on hospital policy and procedure.

In many areas the issue of education in regards to Open Disclosure has been placed on the agenda of Quality Committees, Complaints Management and Heads of Department Meetings. Awareness has been raised of the need for comprehensive education on communication skills to facilitate the Open Disclosure process.

Figure 2. Percentage of WA Pilot clinical staff educated by discipline

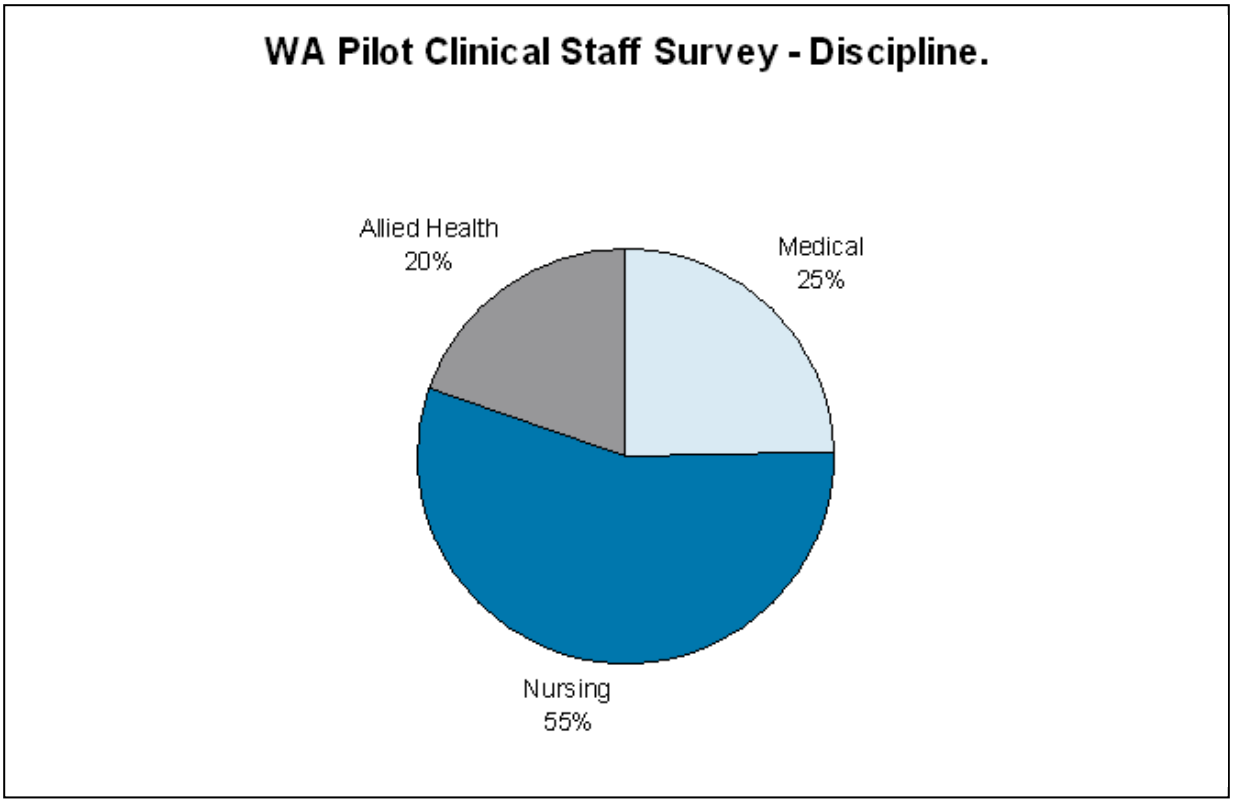


WA Pilot Clinical Staff Survey - evaluation of education and training

- Surveys (Appendix B) of clinical staff at each site were performed to measure the knowledge deficit in Root Cause Analysis (RCA) and Open Disclosure and provide gap analysis reporting. This was repeated mid way through the process implementation phase (June / July 2006) and again at the end of the project to evaluate the effectiveness of the education package.

- A survey of randomly selected staff was conducted across the pilot sites to assess the level of staff knowledge on the Open Disclosure process. Medical, nursing and allied health staff were included in the survey (see figure 3).

Figure 3. Percentage of WA Pilot clinical staff surveyed by discipline



Learnings from the WA Pilot Clinical Staff Survey

1. The majority of staff interviewed pre-training were not familiar with the Open Disclosure process.

2. In WA, the issue of expressing regret creating legal liability showed mixed results both pre and post education / training. This reflects the current uncertainty and anxiety of health care professionals in regards to providing patients and their family members with an apology following an adverse event. This finding further supports the need for comprehensive staff training and support when involved in the Open Disclosure process.

3. A considerable number of staff have been involved in expressing regret to a patient / carer following an adverse incident and were comfortable with this process.

4. Overall, the majority of staff when briefed on the WA Pilot Open Disclosure Policy showed a motivation to embrace the guidelines.

5. Extra training in the Open Disclosure process has been requested by staff, in particular development of communication skills.

    - Feedback indicated that staff wanted clear information as to the process of Open Disclosure and knowledge on how to communicate with patients and / or their families following an adverse event. Staff also indicated the benefit of having a step-by-step guide to the Open Disclosure process, clarification of legal implications and a definition of what constitutes an apology and will not infer liability.

- Comments post education also reflected the complexity of communicating with a patient and / or their family following an adverse event and that continued education for staff in managing this sensitive task would be welcomed. Staff commenting in this area identified that role-play and case studies of various possible Open Disclosure scenarios would complement their knowledge of the process and assist in putting the theory into practice.

6. The provision of education and training in advanced communication skills for health professionals to facilitate the Open Disclosure process is vital. However, this necessity represents significant resource and time costs for health services.

KEY LEARNINGS FROM THE WA PILOT PROJECT

- The majority of staff briefed on the WA Pilot Open Disclosure Policy showed a willingness to support the guidelines.

- The introduction of education in the pilot sites initiated robust conversation on best practice regarding communication with patients and / or relatives following an adverse event in health care.

- Evaluation of the educational component of the Open Disclosure Pilot Project showed evidence that staff found the training to be very beneficial and relevant to their position.

- Significant education / training is required to increase health professionals' communication skills given the inherent complexities of communicating with patients and / or relatives following a clinical incident.

- Prior to participating in the Open Disclosure process, health professionals require clarity and certainty regarding the matter of expressing regret and legal liability.

- Health professionals require adequate education, training, resources and support to comfortably participate in the Open Disclosure process.

- Anecdotal evidence from the Pilot Project identified that staff welcome the 'formalised' Open Disclosure process that for many clinicians reflects current practice when communicating with patients and / or relatives following an adverse event.

- The Open Disclosure process complements the WA Department of Health's existing clinical incident and risk management strategies.

- Western Australia's qualified privilege legislation, the Health Services (Quality Improvement) Act 1994 limits the ability of health professionals to complete the Open Disclosure process according to the National Open Disclosure Standard. The Act limits health professionals providing patients and / or their relatives with information as to why the adverse event occurred and what steps are being taken to prevent a recurrence. A future review of this legislation will hopefully address this limitation in regards to the Open Disclosure process.

- Consumer participation and feedback of the Open Disclosure process will be vital to its success in the WA health system.

RECOMMENDATIONS

1. Rollout of Open Disclosure across WA.

2. Support for the implementation of Open Disclosure through comprehensive education strategies and implementation resources.

3. Integrate the collection and reporting of data related to the Open Disclosure process.

4. Consideration of nationally consistent Qualified Privilege legislation given the challenges for WA from the Health Services (Quality Improvement) Act 1994 limiting the release of information.

THE FUTURE OF OPEN DISCLOSURE IN WA

Following the conclusion of the WA Pilot Project, momentum for the Open Disclosure process to be implemented continues. WA Health continues to work towards ensuring best practice in communicating with patients and / or their relatives following an adverse event in line with the National Standard for Open Disclosure.

The future of Open Disclosure in WA

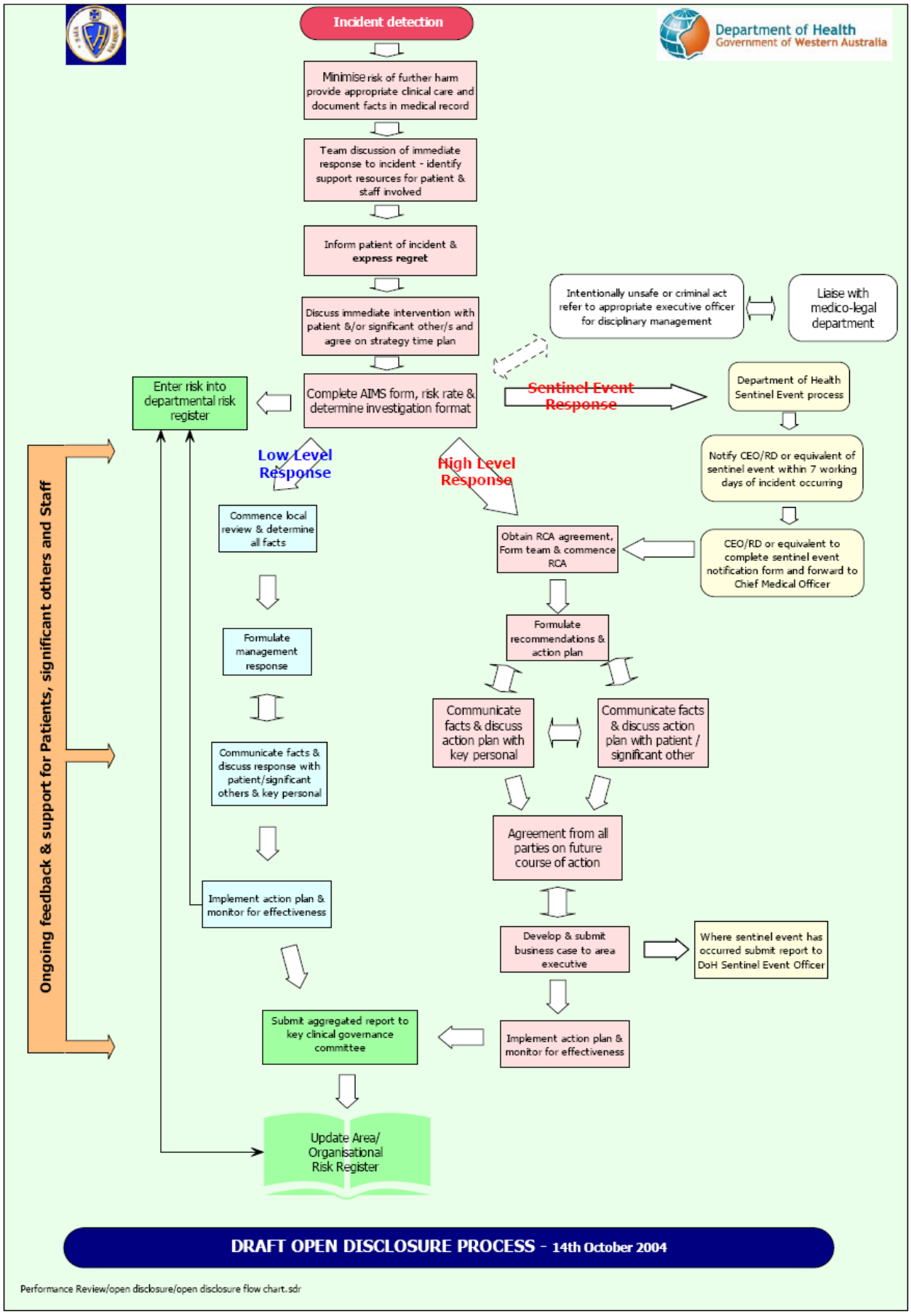
1. "Communicating in Times of Stress: Procedural Guidelines for Practicing Open Disclosure in the WA Health Services" has been drafted and is awaiting endorsement prior to implementation across the WA health system.

2. Comprehensive education / training and resource information is required to ensure that health professionals have a clear understanding of Open Disclosure and possess the advanced interpersonal communication skills required to effectively participate in the Open Disclosure process.

3. Consumer participation and feedback is required in regards to the implementation of Open Disclosure.

4. Ongoing evaluation of the Open Disclosure process for consumers and health professionals will be vital for the future success of this valuable initiative for the WA health system.

APPENDIX A – WA PILOT OPEN DISCLOSURE FLOW CHART



APPENDIX B – WA PILOT CLINICAL STAFF SURVEY

Survey questions included the following;

- Are you familiar with the Open Disclosure process?
- Have you ever been involved in expressing regret to a patient / carer for an incident that has occurred?
- If yes, did you feel comfortable / confident with the process?
- Do you believe expressing regret creates legal liability?
- Were you happy with the outcome?
- What support, if any was offered to you in this instance?
- What resources / support / training do you feel will be required to assist you in learning about the Open Disclosure process and assisting you in discussing emotionally charged topics with patients and their relatives?

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