

AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTH CARE

Open Disclosure and Public Reporting

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23rd May, Melbourne

Australian Commission on Safety and Quality in Healthcare - Charter

- lead and coordinate improvements in safety and quality
- **report publicly on the state of safety and quality including performance against national standards**
- recommend national data sets for safety and quality
- provide strategic advice to Health Ministers on 'best practice' - quality improvement, implementation
- measurable improvement in Safety and Quality

Open Disclosure

- ...is the open discussion of incidents that result in harm to a patient while receiving health care
- Elements include:
 - expression of regret
 - a factual explanation of what happened
 - the potential consequences
 - steps being taken to manage the event and prevent recurrence

ACSQHC National Open Disclosure Standard 2003

History of OD Pilot

- Publication of Open Disclosure Standard 2003
- Australian Health Ministers endorsed national pilot 2004
- Concerns by government insurers delayed pilot
- Reendorsed national pilot Jan 2005 - National Steering Committee & pilot site funding
- Transition from Council to Commission - delay, National Steering Committee re-established mid 2006
- Pilots in 40 facilities in 7 jurisdictions & private sector
- Pilots completed mid 2007, evaluation Dec 2007

Models in use

- Majority states are piloting *clinician communication consult* models (Liebman & Hyman 2005) where pre-screened senior clinicians are trained to become experts
- Training programs - 1 hr to 2 day
- Some hi-fidelity simulation with professional actors
- Varied State governance and funding arrangements – *unit* of pilot varied from a ward to a hospital and some State-wide implementation



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Professor Rick Iedema & the Open Disclosure Evaluation Team
University of Technology Sydney, University of Melbourne, University of
Queensland

Evaluation of the Open Disclosure National Pilot

“What it is about Open Disclosure that works, for whom does it work, in what circumstances does it work, in what respects does it work, and why does it work?”

41 Ethics Approvals to HRECs

- 1 pilot site withdrew from the pilot project
- 5 HRECs did not approve
- 4 sites excluded due to legislative constraints
- 5 sites unable to progress ethics applications due to problems with identification of internal investigators or management approval
- 5 sites abandoned following ethics approval due to absence of organisational support/interest
 - leaving a total of 20 sites



Data

154 Stakeholders interviewed

- 131 staff – 34 nursing, 58 medical, 39 admin
- 23 patients/family
- (no opportunity to observe an OD session)

■ The National Open Disclosure Pilot: evaluation of a policy implementation initiative

Rick A M Iedema, Nadine A Mallock, Roslyn J Sorensen, Elizabeth Manias, Anthony G Tuckett, Allison F Williams, Bruce E Perrott, Suzanne H Brownhill, Donella A Piper, Suyin Hor, Desley G Hegney, Hermine B Scheeres and Christine M Jorm

MJA 2008; 188 (7): 397-400

Findings: What works for consumers

- **Open Disclosure is:**
- High Level for all severe adverse events
- enacted by staff proficient in 'active listening' - patients & family have the opportunity to express grief, guilt, anger
- sensitive to consumers' cultural & linguistically diversity
- conducted as much as possible by those originally involved in the patients' care
- Patients are offered an immediate, sincere (tangible) apology

Findings: What works for consumers

- OD is planned and conducted as part of an ongoing dialogue with the patient and/or family
- sharing feedback as matters come to light rather than delaying until the end of a closed-door investigation
- OD meetings are complemented with **written notes** for staff and patients (and/or families) containing:
 - a summary of what is discussed during the meeting(s)
- A summary of these OD notes are included in the clinical notes to inform other clinicians
 - medical/technical aspects of the adverse event
 - positions and responsibilities of staff involved in OD

Findings: what works for Health Care Staff

- OD is conducted in circumstances where clinicians involved in the adverse event have pre-established a good relationship with the patient
- Senior medical staff participate in and support OD
- OD is conducted (or supported) by staff who have excellent communication and listening skills
- OD is part of an established clinical governance system including: vigorous incident investigation, practice improvement and blame-free learning

“There is no going back”

“Despite the risks, uncertainties, legal constraints, insurance and indemnity concerns, limited support from colleagues, and unsuccessful disclosures, all interviewees – clinicians and consumers – regarded Open Disclosure as integral to good care”

**April 2008, Health Ministers
agreed to work towards the
implementation of the National
Open Disclosure Standard in all
health care facilities**

The Commission will support implementation by:

- Developing practical guidance - fact sheets for staff & a guide for patients & families
- Obtaining advice on overcoming legal barriers by finding legal solutions that will enable health services to fully investigate adverse events, to share information with patients and to provide clinicians with surety

The Commission will support implementation by:

- Collecting and studying the experiences of 100 Australian patients with OD to develop patient centred indicators of OD
- Developing a full implementation guide for the standard to assist health care facilities and clinicians
- Conducting ongoing monitoring of the effectiveness of implementation of the standard - reporting to Health Ministers 2009

Finding the legal clear path

- “.. If you read the literature...everything out there would actually indicate that OD reduces litigation and so on but think there is a bit of trepidation of going down that path and being the exception to the rule”
- “ [privilege] is a bit like trying to drive the O and D car with someone’s foot on the break”

Finding the legal clear path

- National indemnity insurers
- National professional organisations
- National private hospital chains
- National institutional indemnity insurers

- State and Commonwealth privilege legislation
- State legislation for apology and quality improvement activities (including RCAs)
- State medical registration boards

 **CONFUSION**

Finding the legal clear path – Apology

- NSW can include an admission of fault but is “not admissible in in any civil proceedings as evidence of the fault or liability of the person” v. WA where a protected apology is defined as “an expression of sorrow, regret or sympathy by a person that does not contain acknowledgement of fault by that person”

Reform template for legislation to support open disclosure

The AHMAC Legal Process Reform Group supports the work of the Open Disclosure project and recommends the implementation of a balanced package of “open disclosure” legislation to support the broader work of that project. The package should include:

- provision that an apology made as part of an open disclosure process is inadmissible in an action for medical negligence.

Finding the legal clear path - Privilege

- “The impression the family is being left with is that there is going to be some big investigation and they get a report. And that causes problems ... so you do an investigation *but you cannot tell the family*. And that is worse. So we had circumstances where we had to do two ... and this is ridiculous.”

Finding the legal clear path - Privilege

- Standard requires: “Steps to prevent recurrence”
- There is a tension between encouraging and protecting the best possible incident investigation (RCA) and OD – but some protection also prevents dissemination of RCA findings across the system

Adverse Events

- **Are they health care data?**
- **Are the results of investigation or analysis data?**
- **Do consumers want this information?**
 - harmed individuals and their families?
 - the general public?
 - health care workers?
- **Can consumers get this information?**

<http://www.qic.health.govt.nz/moh.nsf/indexcm/qic-sentinel-and-serious-events-report-0607>

- **District Health Board Sentinel and Serious Events Data**
- **Northland DHB**[Northland DHB Sentinel Events 2005-07 \(Excel, 143 KB\)](#)
- **Waitemata DHB**[Waitemata DHB Sentinel Events 2004-08 \(PDF, 129 KB\)](#)
- **Auckland DHB**[Auckland DHB Sentinel Events 2003-07 \(PDF, 201 KB\)](#)
- **Counties Manukau DHB**[Counties Manukau DHB Sentinel Events 2003-07 \(Word, 119 KB\)](#)
- **Waikato DHB**[Waikato DHB Sentinel Events 2003-04 \(PDF, 2 MB\)](#)
- **Bay of Plenty DHB**[Bay of Plenty Sentinel Events 2005-07 \(PDF, 135 KB\)](#)
- **Lakes DHB**[Lakes DHB Sentinel Events 2004-07 \(Word, 50 KB\)](#)
- **Tairāwhiti DHB**[Contact Tairāwhiti DHB for data](#)
- **Taranaki DHB**[Taranaki DHB Sentinel Events 2005-07 \(Word, 45 KB\)](#)
- **Hawke's Bay DHB**[Hawke's Bay DHB Sentinel Events 2003-07 \(PDF, 1 MB\)](#)
- **Whanganui DHB**[Whanganui DHB Sentinel Events 2003-04 \(Word, 23 KB\)](#)
[Whanganui DHB Sentinel Events 2004-05 \(Word, 25 KB\)](#)
[Whanganui DHB Sentinel Events 2005-06 \(Word, 26 KB\)](#)
[Whanganui DHB Sentinel Events 2006-07 \(Word, 29 KB\)](#)
- **MidCentral DHB**[Midcentral DHB Sentinel Events 2006-07 \(Word, 48 KB\)](#)
- **Wairarapa DHB**[Wairarapa DHB Sentinel Events 2005-07 \(Word, 32 KB\)](#)
- **Capital & Coast DHB**[Capital & Coast DHB Sentinel Events 2006-07 \(Word, 56 KB\)](#)
- **Hutt Valley DHB**[Hutt Valley DHB Sentinel Events 2003-07 \(Word, 82 KB\)](#)
- **Nelson Marlborough DHB**[Nelson Marlborough DHB Sentinel Events 2002-2007 \(PDF, 53 KB\)](#)
- **West Coast DHB**[West Coast DHB Sentinel Events 2003-07 \(Word, 38 KB\)](#)
- **Canterbury DHB**[Canterbury DHB Sentinel Events 2004-05 \(Word, 61 KB\)](#)
[Canterbury DHB Sentinel Events 2005-07 \(Word, 95 KB\)](#)
- **South Canterbury DHB**[South Canterbury DHB Sentinel Events 2003-07 \(Word, 41 KB\)](#)
- **Otago DHB**[Otago DHB Sentinel Events 2006-07 \(Word, 69 KB\)](#)
- **Southland DHB**[Southland DHB Sentinel Events 2004-07 \(Word, 87 KB\)](#)

Waikato DHB Response to Official Information Act Requests received from:

- Ruth Hill, Dominion Post, 10 December 2007
- Errol Kiong, Science and Health Reported, New Zealand Herald, 11 December 2007

Waikato DHB Serious and Sentinel Events occurring between July 2003 and June 2004

Event Severity	Description	Review Findings	Recommendations / Actions	Follow-up
Sentinel	<p>Equipment used incorrectly Irrigation fluid was left running during the final stages of eye surgery, instead of being clamped off. Further surgery required and the outcome for sight or improved sight is poor</p>	<ul style="list-style-type: none"> • No written procedure for use of the equipment • The equipment design is not fail safe • Low lighting in the eye theatre due to surgical needs 	<ul style="list-style-type: none"> • Written procedure for using this equipment to be developed to include an alert warning staff that there have been previous operating problems with the design of the equipment • An education programme to be developed to ensure all staff are competent to use all eye theatre equipment • Product supplier to be involved in staff training sessions • A culture of learning to be developed within eye theatre through regular inservice training • Investigate the provision of continuous lighting for the theatre nurse 	<ul style="list-style-type: none"> • Procedure for use of the equipment has been completed • Concerns regarding equipment discussed with supplier • Education programme on eye theatre equipment implemented, involving product suppliers • Regular staff education sessions held in eye theatre • Continuous lighting has been provided for the theatre nurse.

Learning from incident investigation

- Patient admitted with pneumonia & severe cardiac failure
- Patient was administered 2 doses of a medication instead of 1 due to a prescription error
- Later the patient was administered another medication without prescription
- Patient's condition deteriorated and despite active interventions died 2 days later

Waikato DHB response to Official Information Act Request on Serious events 2006-2007

Review Findings

- Guideline for treatment of Community Acquired Pneumonia not followed
- Non-compliance with medicines management policy (medication not prescribed for the correct date)
- X-ray not sent for reporting by radiologist, as this results in X-ray not being available for ward staff)
- Inadequate clinical record documentation

Follow-up

- Medical officers have had the Pneumonia Guidelines reiterated to them by both the Clinical Director and the medical Consultant
- Staff reminded to comply with medication policy
- Staff agreed to approach patient's GP if queries
- **Electronic X-ray reporting being introduced**
- **The ward round structure has improved significantly to ensure full handovers are occurring at the end of every shift**

Doctors Say 'I'm Sorry' Before 'See You in Court'



- She rejected her sister's advice to call a lawyer.
- Ms. Valdez said she was gratified that the hospital quickly acknowledged its mistake, corrected it without charge and later improved procedures for keeping track of electrodes.
- **“They took the time to explain it and to tell me they were sorry,” she said. “I felt good that they were taking care of what they had done.”**

- David M. Studdert, an authority on patient safety in the United States who teaches at the University of Melbourne in Australia, said the focus on disclosure reflected a lack of progress in reducing medical errors.
- “If we can’t prevent these things, then at least we have to be forthright with people when they occur,”

- “Quality improvement committees openly examine cases that once would have vanished into sealed courthouse files. **Errors become teaching opportunities rather than badges of shame.**”
- “I think this is the key to patient safety in the country,” Dr McDonald said “If you do this with a transparent point of view, you’re more likely to figure out what’s wrong and put processes in place to improve it.”

OD is patchy in Australia

- Not all those harmed get all the information they would like
- Not all clinical staff feel able to give all the information they would like to give to those harmed
- Access to information for research is limited
- Adverse event information has extremely limited circulation
 - to health professionals
 - to consumers
 - to the public
- **Limited reporting on adverse event information means limited learning**