

Being Open – international overview 2009



Dr Jane Cowan

Suffering -



“Involves experiencing anything subjectively unpleasant which may include: pain, malaise, nausea and/or vomiting, loss, depression, agitation, alarm, fear , grief or humiliation.”

(NPSA and ACSQHC final report)

Attitude -



“A taken-as-given way of thinking or talking, often evolved over years of socialisation and education”

(ACSQHC final report)

Culture -



“The configuration of attitude and meanings which together can be seen to be definitive of “what people are” or “where people come from”. Culture can be seen as a state or something people possess, while it appears more fruitful to regard it as a performance or process.”

(ACSQHC final report)

Open Disclosure -



“An open, consistent approach to communicating with patients when things go wrong in health care. 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.” (ACSQHC final report)

Simple Chronology



- **1990's**
 - Published work on error, adverse events
 - Vincent (UK), USA, Australia / New Zealand
 - 1995 – UK - NHS Litigation Authority established
- **2000's**
 - NPSA – England
 - 2002 CIS – Ireland
 - 2003 -ACSQHC – Open Disclosure Standard
 - 2005 - “Being Open” – Dept of Health UK



- 2007 Health Act – establishing HIQA
- 2007 WHO World Alliance for Patient Safety project with HIQA
- **2008 Building a Culture of Patient Safety**
- 2009 Minister for Health and Children – steps to implement report
- 2009 Guide to Professional Conduct and Ethics for Registered Medical Practitioners – 7th Edition 2009

Being Open and Clinical negligence



Relevant legal frameworks



National Medical Error Disclosure and Compensation (MEDiC) Act – 2005

Senator Hillary Rodham Clinton and Senator Barack
Obama Sep 28 2005

UK



Explanations should not contain admissions of liability.

For the avoidance of doubt the NHSLA will not take a point against any NHS body or any clinician seeking NHS indemnity , on the basis of a factual explanation offered in good faith before litigation is in train. We consider that the provision of such information constitutes good clinical and managerial practice.

NHSLA May 2009

Defence Organisations



“For many years we have advised our members, that if something goes wrong patients should receive a prompt, open, sympathetic and above all truthful account of what has happened.....

There are no legal concerns about taking this course of action: it is quite different from admitting liability.”

MDU, MPS, RCN, MDDUS 2009

July 2009



Section 103 of Health Act 2007

- provides for the making of protected disclosures in the Health Service

Is it working?



US Lexington Veterans' Affairs Medical Center



1987 –

Decided to investigate all cases where
medical error suspected.

High standard of disclosure set



- 1994 – Lexington in top quarter for total claims

They were disclosing too much –

BUT

Bottom quarter for total payments

3 R's programme - COPIC



- **Recognise**
- **Respond**
- **Resolve**



3 R's programme - COPIC



- For the members who practice open disclosure :
 - Malpractice claims reduced by half
 - Settlement costs reduced by 23%

Evaluation of Open Disclosure Standard



- **Victoria**
- **New South Wales**
- **South Australia**
- **Queensland**

- **154 interviews – more than 28 health facilities**
 - 131 health professionals
 - 15 patients
 - 8 family members



- **Open Disclosure is met with approval and relief on the part of health professionals and consumers**
- **Open Disclosure creates uncertainties about**
 - ✦ what triggers it
 - ✦ legal and insurance implications
 - ✦ impact on their and their organisation's reputation
 - ✦ whether colleagues will support those carrying out OD
- **Staff and consumers are concerned to integrate Open Disclosure more firmly and consistently in everyday practice.**

Safer Practice Notice 10



NPSA 2005

MK Trust - Values



- To be open and honest
- To be inclusive and involving and to listen
- To be fair
- To value and treat people with dignity and respect
- To be compassionate and caring
- To strive for excellence in all we do
- (MK Trust policy on governance 2006 -2008)

Patient charter



Staff work hard to deliver the highest standards of healthcare to all patients at...

[insert name of your organisation].

We provide safe and effective care to many thousands of people every year but sometimes, despite our best efforts, things can and do go wrong.



“If a patient is harmed as a result of a mistake or error in their care, we believe that they, their family or those who care for them, should receive an apology, be kept fully informed as to what has happened, have their questions answered and know what is being done in response.”

This is something that we call *being open* and we make a commitment to our patients to:



- apologise for the harm caused;
- explain, openly and honestly, what has gone wrong;
- describe what we are doing in response to the mistake;
- offer support and counselling services that might be able to help;
- provide the name of a person to speak to;
- give updates on the results of any investigation.



“if you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems,

you should put the matter right if that is possible.....



you must record your concerns and the steps you have taken to try and resolve them”



“you must protect patients from risk of harm posed by another colleague’s conduct, performance or health.

if you have concerns that a colleague may not be fit to practice you must take appropriate steps without delay.”

Good Medical Practice 2006

Adverse Events – 18.3



Patients and their families are entitled to honest, open and prompt communication with them about adverse events that may have caused them harm.

Therefore you should:

- ❖ acknowledge that the event happened
- ❖ explain how it happened
- ❖ apologise, if appropriate, and
- ❖ give an assurance as to how lessons have been learned to minimise the chance of the event happening again in the future.

Barriers

- No knowledge of policy or practice in organisation
- Insufficient positive feedback from adverse events
- Lack of training.



Barriers



- **Concerns about litigation**
- **Concerns about professional practice and reputation**
- **Time**
- **Communication skills and qualities**
- **Letting colleagues down**
- **Dealing with difficult people**

- **Lacking managerial or clinical support**

London Declaration 2006



Patients for Patient Safety

**WHO World Alliance for
Patient Safety (WAPS)**



“There is a right to safe healthcare and we will not let the current culture of error and denial continue.

We call for honesty openness and transparency.”

Taken from:

Conclusions and recommendations to National Health Authorities



When establishing the appropriate regulatory framework for reporting systems these must be supported by open disclosure programmes which protect both health professionals and patients without affecting accountability. (Dublin 2007)

AvMA and the NPSA – November 2008



- **Being Open should be on the core curriculum for all healthcare professional training**
- **Being Open should be adopted by senior clinicians and throughout clinical services**
- **Being Open should be on corporate induction training for all staff of all trusts.**
- **The proposed Being Open re-launch should be high profile and should involve patients**
- **Information packs for patients admitted to hospital should include information on Being Open**



- **House of Commons Session 2008-09**
Health Committee Publications
- Health Committee - Sixth Report - Patient Safety

18 June 2009.



“Beth was admitted to hospital. Everything was going, so far as we knew, well. She went down to surgery and the next thing we knew the doctors came back up and told us that they had cut a major blood vessel and Bethany had bled to death on the operating table. Subsequently, a lot of information came to light because we fought for it.”



“The hospital were very reluctant to give us any information; we had to ask for everything we were given. Their story changed considerably over time. We found out that the blood vessel they were talking about was her aorta. That they could not have cut through her aorta, that it must have been a problem with her heart—even though she had two cuts in her aorta and cuts to her stomach and her bowel.”



“We found out that a trainee was using a brand new piece of equipment called a morcellator on Beth. This bit of equipment had never been used in paediatrics in the UK before. It is used widely in gynaecology.”

A motorized morcellator simultaneously excises and evacuates the tissue to be removed without your having to change instruments. The device works by suction, which pulls the tissue into its tip where it is minced by a rapidly rotating blade.



- They had not received any new training on this. Actually, they decided to use this equipment after the consent form was signed. The additional risks just were not told to us [...]"

“But motorized morcellation requires sterling surgical skills and nerves of steel.

This is a very aggressive instrument,” Dr. McCarus admitted.



“[O]n the day in the room when they told me Beth had died they told me the truth, I know they did, they were very emotional and they told me the truth. They told me they had cut a blood vessel and she had bled to death. It changed within two days.”



“They came back and they said, I will read it from here: "We cut the aorta in two places, probably the morcellator, but the resulting blood loss not significant. We do not know what killed her." About six months later: "The aorta was certainly not damaged by the morcellator, the cuts did not have any explanation and the blood loss was insignificant. We do not know how she died." [49]

Health Select Committee and response



“ Harmed patients and their families or carers must receive honest information, a full explanation, an unequivocal apology, and an undertaking that harm done will not be repeated.

While the NHS has made progress in this regard, there is still too often a lack of frankness on these counts”

We agree that progress has been made but



There is a
great deal
more to do



