

South Health Campus steps up to say "Sorry" . . . really, really well

Dr. Kobus Stassen MBChB, Jodi Ploquin, MSc, Maryann Kusmirski RN, MN

What are we talking about?

Disclosure is a formal process involving open and honest conversation between a Patient and/or Family and members of the healthcare organization about the events leading to harm and/or a close call. Alberta Health Services Disclosure of Harm Policy/Procedure 2011



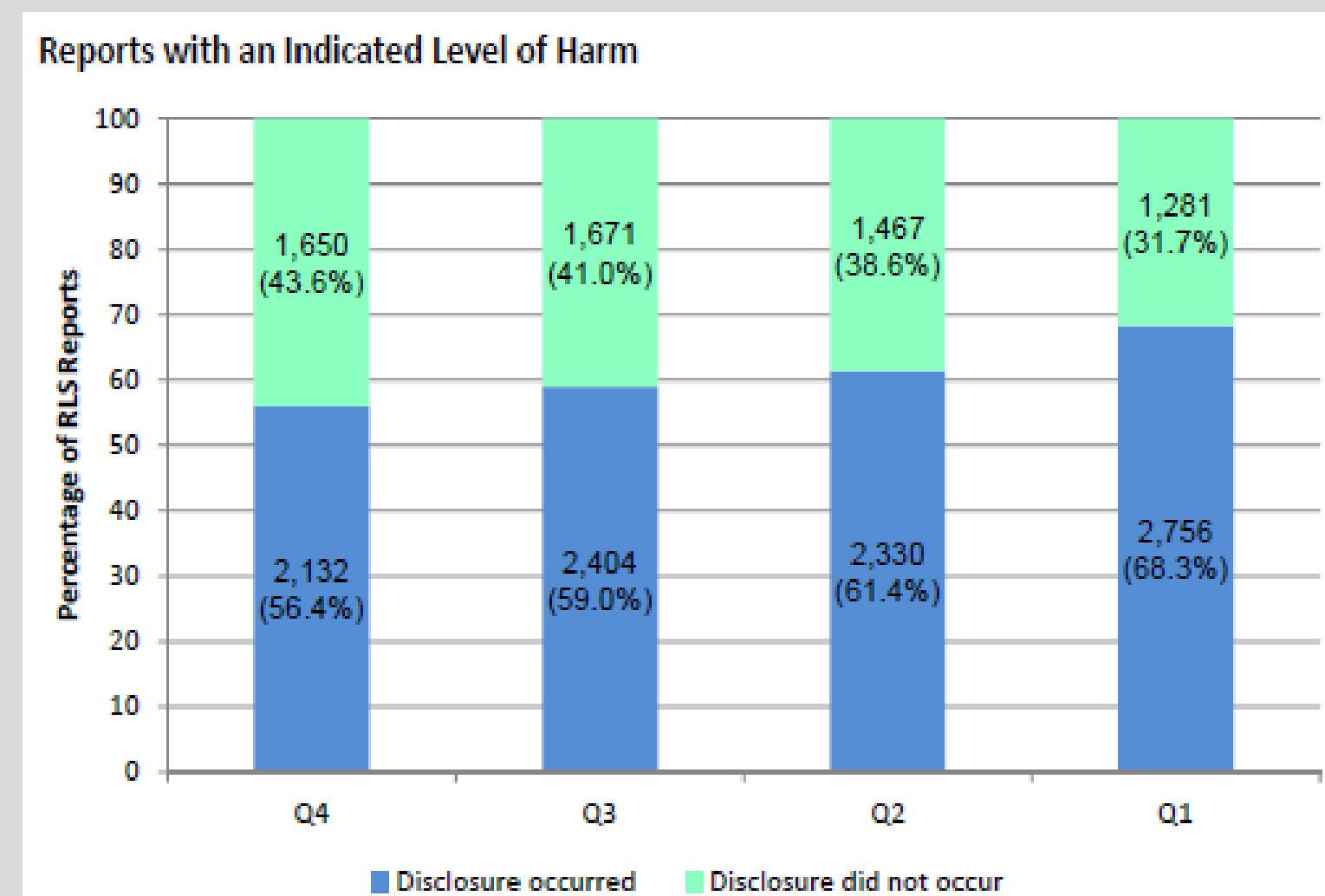
When patients experience an unanticipated medical outcome, they experience two types of disappointment

1. the disappointing medical outcome
2. the disappointing way the healthcare providers behave after the unanticipated outcome

Research suggests patients are more forgiving of the first disappointment than of the second

(not to mention we are legally required to disclose if our care has resulted in harm or a change to monitoring/treatment)

So how is AHS doing with disclosure?



Based on reporting in RLS, a voluntary reporting system, therefore is to be taken as a sample rather than true incidence.

Video	Clinical scenario	Status
1. Intro	Dr. Bruce Macleod overview of disclosure interjected with reflections from Lori Anderson, Dr. Colin DelCastilho and Citizen Advisory Team member	Editing – target Oct.30
2. Care is not reasonable	Nurse administers medication which is not signed off in the patient chart, a second nurse administers another dose	Editing – target Oct.30
3. Care is reasonable	Known complication (perforated bowel) following a procedure (colonoscopy)	Filming - Nov.10
4. Unsure if care is reasonable	Patient presents a second time to Emergency with abdominal pain, imaging reveals ruptured appendix.	Filming - Dec.15

Target date for provincial release on AHS YouTube – Mar.31, 2018

KEEP CALM AND DISCLOSURE ON

Act to Improve

We have a policy, we have training, but we need to **show** staff examples of disclosure done well, and these examples need to be accessible 24/7 from any AHS site.

Coming soon to a theatre near you..

Video examples of disclosure done well to support frontline staff in early disclosure conversations (AHS YouTube)

Act to Improve

Clinical Safety Leader and Physician Safety Lead dressed up as "AHS never events"

SHC training blitz

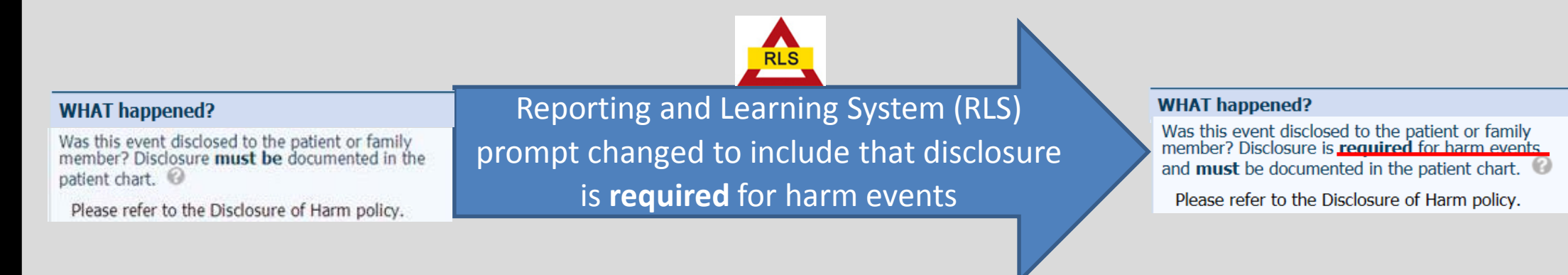
1 hour
Oct 2016 – 90 physicians

4 hour
May 2017 – 15 nurse practitioners, physicians, Executive Directors

June 2017 – 20 Unit managers

Oct 2017 – 24 Clinical Nurse Educators, Nurse Clinicians, Unit managers

A nudge in the right direction (provincial level)...



Getting meaningful metrics to the frontlines (unit level)...

RLS TREND OF THE MONTH

SHC ED - July 2017

Review of 6 months of harm events reported in the ED indicate 43% were confirmed to be disclosed to the patient and/or family.

As RLS is a voluntary reporting system, true incidence may be higher.

Action:

- Disclosure must occur if there has been any harm, if there is a risk of potential future harm, or if there is any change in care or monitoring. (AHS policy PS-01)
- See Disclosure – Employee Tools (insite page 3212)

Initial disclosure meeting

- Can be done by anyone on the care team, not just the attending physician
- Timely contact
- Acknowledge what has happened, offer a genuine apology, and listen
- Avoid speculation
- Future meetings to provide more information

Currently state: manual tabulation from RLS

Future state: Tableau "disclosure dashboard" (under construction)

Are we improving disclosure at SHC?

Target – 20% decrease in disclosure status "no" or "not applicable" for harm events reported in RLS at South Health Campus by March 31, 2018

