A patient-centred approach to open disclosure training for junior clinical staff

Final Report

Postgraduate Medical Council of Victoria

Research Grant 2013

Clinical and consumer advisor facilitators of the '*What to do and say when things go wrong*' workshop.

Project team

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- Dr Simon Craig, Consultant Emergency Physician, Monash Health
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Research Theme: Pre-vocation Education; pre-vocational professionalism/non-technical skills

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Synopsis

Healthcare settings are dynamic workplaces where frontline doctors are expected to possess a wide range of knowledge, skills and attitudes to manage difficult clinical situations. Given the complexity of the clinical environment it is not surprising that critical incidents occur often resulting in harm to patients. Incidents not only occur during normal working hours when senior medical staff are available, but also at times when the most senior staff member is a junior medical officer (JMO). It is likely that the JMO has received some communication skills training in the undergraduate years, however, it is unlikely they have received the training required to provide open disclosure of an incident with a patient, their family or carer. Research indicates that patients and family members are often dissatisfied with the open disclosure process (White et al, 2008). This suggests there is a need for specific training in this area. Whilst it is recognised that the responsibility to disclose high level incidents rests with senior staff, it is vital that junior staff are provided with training in this area to help prepare them for this role.

This project developed, implemented and evaluated a patient focused communication skills program specifically designed for junior clinical staff about open disclosure. Recognising that staff of all disciplines may have responsibility to disclose errors, the program welcomed participants of all health professional groups. The program utilised real patients' experiences and stories in the development and delivery of the workshop. The evaluation strategy included a pre-workshop survey of participants' experience, knowledge and attitude to error and open disclosure and previous training experience. Completion of a post training survey was also invited from the participants. Additional data related to this project that will be collected in 2014 include the following;

- A repeated survey of participants' experience, knowledge and attitude to error and open disclosure at three months post workshop attendance
- A focus group for participants to gather more information about their perceptions of the workshop
- Interviews with consumer advisors who assisted with the development and delivery of the workshop

Aims

The project aims were to:

- Develop a patient-centred open disclosure training package for junior clinical staff;

- Improve the communication skills of junior staff in relation to open disclosure discussions with patients, their families and carers;
- Assist in creating positive relationships between the organisation, medical staff and patients in relation to the management of clinical incidents.

Outline of previous work

Open disclosure is defined as the open discussion of incidents that result in harm to a patient while receiving healthcare (Australian Commission on Safety and Quality in Health Care, 2008). For Australian public hospitals in 2011-12, 6.1% of separations involved an adverse event (The Australian Institute of Health and Welfare, 2013). Contained within the open disclosure standard are a range of principles, which include an expression of regret to the patient and/or family member, and openness in all communications. The standard also states that appropriate training and education should be provided to staff to ensure an informed approach to open disclosure. Despite the introduction of this standard, evidence suggests patients and family members have expressed concerns about the open disclosure processes (Iedema et al, 2011b), and that open disclosure practices fall short of patient expectations (White et al, 2011).

Junior medical officers require open disclosure training as they are fearful of these patient encounters (Sorensen, 2009) and struggle to disclose even less obvious errors (White et al, 2011). Poor communication skills associated with open disclosure have been related to negative outcomes such as patient dissatisfaction and suits for malpractice (Smith, Dorsey, Lyles and Frankel, 1999). Kachalia et al (2010) go further to report that the number of claims and liability costs may be reduced when patients receive an apology, a factual statement of what occurred and a commitment to preventing the same error occurring.

It appears that little, if any, open disclosure training is provided in the undergraduate years and in the absence of follow up training, any more general communication skills training may be lost (Hanna & Fins, 2006). Bleakley & Bligh (2008) also report that medical students may lose faith in the value of being sensitive to patients. Bombeke et al (2012) found a significant decline in patient-centred attitude scores during the clinical clerking year. All of these factors indicate a need to offer specific and relevant training for JMOs in the open disclosure process. Having greater capacity to handle strong emotions expressed by patients and being able to manage hospital stressors, Hanna and Fins, 2006 found that JMOs were better equipped to engage in this training than medical students.

There have been many approaches to open disclosure training in medical education. These include tutorial programs on clinical risk and patient safety, and simulated patient facilitated communication skills training. Whilst used widely with excellent outcomes in medical education there are still limitations to the use of simulated patients. These include costs to recruit and prepare for the teaching. They also lack the authenticity that 'real patients' offer (Hanna & Fins, 2006), particularly if not adequately trained. Incorporating simulated patients and the contributions of real patients in delivering communication skills training is considered an important step in achieving a humanistic approach to learning (Hanna and Fins, 2006).

There are many benefits of a patient-centred approach to communication skills training using real patient experiences. It provides a variety of genuine patient stories (Hanna & Fins, 2006), and takes into consideration their unique context (Bombeke et al, 2012). To acknowledge the important role patients play in this type of activity further assists the patient to develop trust in the physician (Hanna & Fins, 2006), and allows them to have a legitimate voice (Iedema et al, 2008). Iedema et al, 2011a express the view that it is a demonstration of best practice principles if an organisation involves the patient in practice improvement with one key feature of this approach being a rebalance of power. Further, Sorensen et al (2009), report that the interests of patients is playing a greater role in future policy making. In Australia, 'Partnering with Consumers' is now one of the 10 National Safety and Quality Health Service Standards.

The expectations of the medical profession today extend beyond having good communication skills. Patients also depend on sincerity and concern (Sorensen et al, 2009). For open disclosure training to be successful, addressing any negative attitudes of the trainee is essential (Smith et al, 1999). The limited amount of open disclosure education and training provided to medical staff, combined with less than ideal teaching methodologies, seem to be reflected in poor feedback from patients after an error has occurred. As stated by Iedema et al, (2011a) appropriate incident disclosure and adopting a patient centred approach may restore patients' faith. It has been suggested that educators design curricula that is consistent with national guidelines and patient expectations (White et al, 2011). The aim should be to place the patient at the centre of not only the open discussion after an incident occurs, but at the centre of education and training. Whilst challenging to design, implement and evaluate there are potentially great benefits by moving to a patient centred approach to medical education.

Background work and approvals

Approval to pursue a partnership with the Australian Patients Association (a patient advocacy group) and to offer the program to JMOs was sought and granted by relevant departments of Monash Health including Medical Executive and the Monash Health Innovation and Quality Unit. The organisation requested the program be made available to clinicians of all professional groups in keeping with their commitment to interprofessional education.

Low risk ethics approval was granted by the Monash Health Human Research Ethics Committee (Ref 13335L).

The Australian Patients Association embraced the opportunity to have their members included in the development of the program and together with the project team, recruited three members who had a desire to be involved. One consumer advisor was also recruited via a project team member. The four consumer advisors participated in training to prepare them for the role as facilitators of the open disclosure communication skills workshop, including developing skills for story-telling and giving effective feedback. The consumer advisors agreed it was pitched at an appropriate level taught in an interactive way and left them feeling confident about their skills to co-facilitate.

Program development

An advisory group of internal and external stakeholders was convened to approve the concept of consumer advisor involvement and the curriculum. These stakeholders included:

Prof. Wayne Ramsey, Senior Advisor, Medical and Quality, Monash Health (MH)	**Stephen Mason, CEO, Australian Patients Association**
Dr Annie Moulden, Clinical Director, Innovation and Quality, MH	**Prof. Rick Iedema, Director, Centre for Health Communication, UTS**
Alana Gilbee, Project Officer, Monash Doctors Education, MH	**Dr Cath Crock, Executive Director, Institute for Patient and Family Centred Care**
Debra Kiegaldie, Director, Monash Doctors Education, MH	**Liz Pryor, Communication Skills Coordinator, Monash Doctors Education, MH**
Dr Dean Everard, Director of Clinical Training, Casey Hospital, MH	**Rebecca Edwards, Consumer Participation Coordinator, Innovation and Quality, MH**

Table 1: Advisory group members

The advisory group met once to discuss the workshop content and teaching methodology, and subsequently received updates and workshop drafts for comment. The Consumer Participation Coordinator met with the existing Monash Health consumer advisor group (those previously engaged by the organisation but not involved in this particular project), who provided input into the workshop content.

The draft program was taken to the project consumer advisor group for their input and approval. Their stories, views and suggestions were incorporated into the workshop and all workshop facilitators were briefed on the program.

Implementation of the communication skills program

Titled *'What to do and say when things go wrong'*, two workshops of three hours duration were delivered in October and November, 2013. The workshops were marketed to all clinical staff via relevant education departments. One workshop was offered at Monash Medical Centre (October), and one at Dandenong Hospital (November). The workshops were facilitated by an interprofessional teaching team including medical, nursing and allied health clinicians and educators.

The workshop aims were to:

1. Distinguish low and high level responses to clinical incident management and open disclosure
2. Explore different roles and responsibilities for how to respond to low and high level incidents
3. Identify barriers to open disclosure of incidents for junior clinicians
4. Apply a framework for teams to effectively respond to clinical incidents
5. Practice principles of effective open disclosure in small group activities
6. Appreciate the impact of clinical incidents and open disclosure for clinicians, patients, their families and significant others

Teaching and learning strategies included lecture, elicitation, group discussion, use of videos and role playing with feedback.

At the completion of the October workshop all facilitators and consumer advisors discussed what worked well and areas for improvement and suggested changes, which were implemented in the November workshop.

Workshop participants: Dr Densearn Seo and Dr Hui Ting Ooi

Research Methodology

The project adopted a mixed-methods approach including before and after surveys (quantitative and qualitative data) and post training focus groups and interviews. Only survey data from junior clinician participants is contained in this report as focus groups and interviews are currently underway.

Data collection tools

Surveys, junior clinical staff

The pre-training survey (appendix 1) aimed to explore the following areas:

1. Perceptions and experiences of medical error and disclosure
2. Previous training on error disclosure.

The pre-training survey was adapted from a previous study (White et al, 2008) and was initially piloted with incoming graduates to Monash Health early in 2013. The questionnaire asked respondents about key safety topics, such as whether medical errors are a serious problem and how frequently errors occurred. Questions about error disclosure included what types of errors should be disclosed, potential barriers to disclosure, and respondents personal experiences with medical error and disclosure. Respondent's confidence about disclosing error was also measured. Agreement was measured on a five-point Likert scale (strongly disagree, disagree, neutral, agree, strongly agree).

Free text responses were also requested to a low harm and serious harm scenario. Demographic questions measured respondent's age, gender and professional discipline.

The post-training survey (appendix 2) repeated the confidence items, free text responses and included additional questions exploring respondent's views of the training program. This survey included open-ended questions about what worked well and what needed to be improved.

An additional post-training survey, (a repeat of the training survey), will be administered at 3 months. The aim of this survey is to investigate any sustained changes in attitudes, knowledge and/or confidence.

Focus group, junior clinical staff

Participants from both workshops were invited to participate in a focus group to investigate further the impact of the communication skills training. Four individuals participated and this data is currently being analysed.

Interviews, consumer advisors

All consumer advisors (n=4) were invited to participate in an interview to explore the impact of their involvement in the process of educating junior clinicians on error disclosure. This data is currently being analysed and will be the basis of the Masters of Health Professional Education for the Chief Investigator, Alana Gilbee.

Analysis and findings

Survey respondents: Pre-training survey

A total of 37 participants attended the '*What to do and say when things go wrong*' workshops (n=23 October, n=14 November). Of these, 31 (83.8%) completed the pre-training survey. Not all respondents answered every question. The majority of participants were female (88.9%), with a reasonably balanced spread of age groups.

Age

- 37.0% 20-29 years
- 22.2% 30-39 years
- 22.2% 50-59 years
- 7.4% 40-49 years

Most of the workshop participants were doctors and nurses with a small number of Allied health professionals.

Professional Discipline:

- Medicine 46.7% (n=14)
- Nursing 40.0% (n=12)
- Allied Health 10.0% (n-=3)
- Pharmacy 3.3% (n=1)

Views on error

Most respondents agreed that medical error was a serious problem in healthcare (85.7%), however, less agreed that errors were caused by failures of healthcare systems and not failures of individuals (58.6%). The majority agreed that serious errors should be disclosed to patients and/or their families (93.3%) as should minor errors (86.7%). There was less agreement that near misses should be disclosed (31.0%). Many respondents agreed disclosing an error would damage a patient's trust in their competence (30.0%), however half of all respondents agreed that disclosing the error would make it less likely that a patient would take legal action. All participants agreed that apologising to patients and/or their family would be very difficult.

Barriers to error disclosure

Despite agreeing that serious errors should be disclosed, there were two contributing factors that resulted in the respondents being less likely to disclose a serious error. Thirty seven percent of the junior clinicians thought the patient would not understand what they were telling them and 33.3% were concerned about the risk of litigation.

Personal experience of medical error and disclosure

The majority of respondents reported experiencing minor medical error (70.4%) and subsequent open disclosure (71.4%), however only a small number (14.8%) had experienced serious error and disclosure (7.4%).

For those that had personally disclosed minor errors, satisfaction with the open disclosure conversation was high (100%). For those that had disclosed serious errors (n=2), responses were divided with one being satisfied and the other not. Both of these respondents disagreed with the statement that the disclosure conversation negatively affected the relationship with the patient.

More than half (55.2%) of respondents had observed a more senior staff member disclose a minor error and were largely satisfied with the conversation (87.5%). Fewer respondents had observed a senior staff member disclose a serious error (34.5%), however, as for disclosure of minor errors, they were satisfied with how the conversation went (87% and 80% respectively). For those respondents who observed senior staff disclose serious errors (n=10), 40% agreed the conversation negatively affected the treating team's relationship with the patient.

Reflecting organisational and best practice guidelines, where it is the responsibility of senior staff to disclose serious errors, respondents indicated few had personal or observed experience of serious error disclosure. There was some agreement that the observed disclosure conversation negatively affected the team's relationship with the patient.

Error disclosure training

Only 17.9% (n=5) of respondents had attended previous education or training on the disclosure of errors to patients, however (46.4%) had received training on steps that should be taken on recognition of an error. Whilst the survey did not ask for specific detail of this training, 75.0% of respondents had attended previous training on communication in difficult situations.

Confidence disclosing medical errors

Respondents were divided in their confidence to disclose errors to patients and families (40.0% in agreement, 36.6% disagreement and 23.3% neutral). Forty three percent of respondents disagreed with the statement they were confident to manage a patient or family experiencing strong emotions as a result of error or the disclosure, and only 36.9% were confident managing their own emotions when dealing with patients/family following error. There was considerable variation in confidence disclosing errors and managing the emotions of self and patients/family in this group.

Responding to error scenarios

Using free text, participants were invited to write what steps they would take in response to two error scenarios. The first of these was a minor error and the other more serious. Responses were categorised and analysed according to themes with collation of these themes into frequencies and reported as percentages (see Figure 1).

Scenario 1 (low harm)

You have just realised that some antihypertensive medications were given to the incorrect patient. It appears that medications that were to be written up for one patient were written up for the patient in the next bed. The patient's blood pressure is monitored over the following six hours – she becomes mildly hypotensive, but does not experience any symptoms.

Most respondents reported the need to prioritise the safety of the patient in this scenario.

"Ensure patient safety and ongoing monitoring and assurance of care" (Workshop participant)

"Check the patient's vital signs, DRABCD as indicated. When satisfied the patient is safe, asymptomatic, document event in notes…." (Workshop participant)

Other actions included escalating to senior staff, disclosing the error, and making an entry into the hospital-reporting system (Riskman).

"Once I realised my error I would advise the nurse in charge and doctors…" (Workshop participant)

Only 15% identified the need to apologise to the patient for the error.

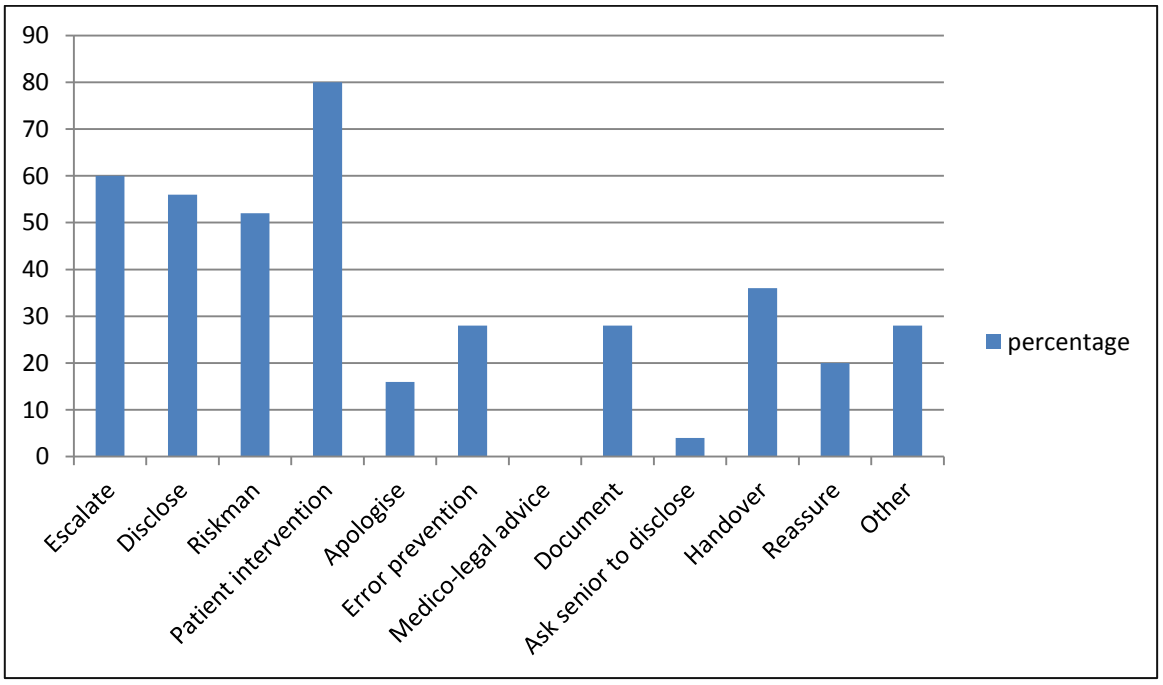

Figure 1: Actions for a low harm incident

Scenario 2 (serious harm)

A 74 year old man with Parkinson's disease is admitted to hospital with cellulitis requiring intravenous antibiotics. His usual medications are not charted initially; therefore he does not receive his anti-Parkinson therapy. The patient then sustains a fall, fracturing his hip, and later requires surgery.

Most respondents acknowledged the need to escalate this incident to more senior staff and to actively intervene for patient safety, however as for scenario 1, the need to provide an apology to the patient or family member was less of a consideration.

"Given ISR1, severity escalate to senior staff to initiate appropriate open disclosure and investigation" (Workshop participant)

"Apologise to the patient. Make sure the patient is safe and comfortable. Report to the team leader and doctor in charge about the incident. Disclose and discuss with patient, with team leader and doctor. Work according to a plan to treating injury. Keep patient informed of treatment and allay fear…." (Workshop participant)

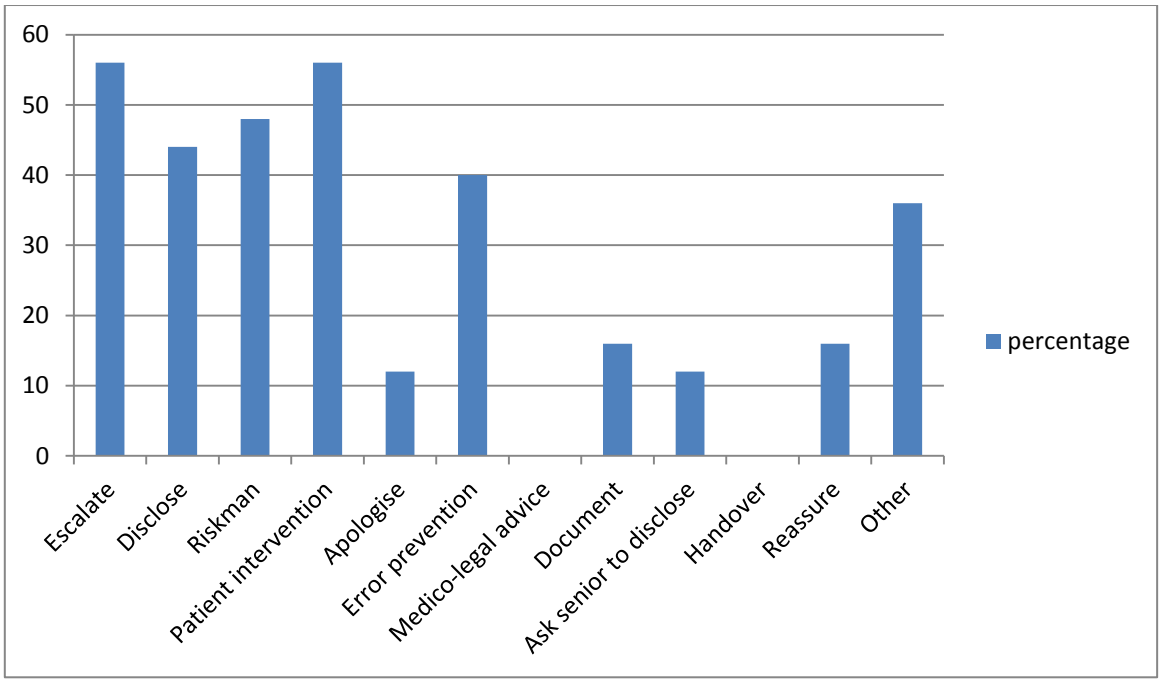

Figure 2: Actions for a serious harm incident

Post-training survey

Of the 37 workshop participants 32 (86.5%) completed the post-training survey. Not all respondents answered every question.

Satisfaction with workshop

The respondents indicated strong agreement that the workshop met their expectations (90.0%), was well designed (90.0%) and delivered to a high standard (93.3%). There was also strong agreement that it was taught in an interactive and engaging manner (96.7%). The contributions of the consumer advisors were valued (96.7%) and most agreed that their knowledge about communicating error had improved as a result of the workshop (93.3%).

Aspects of the workshop that worked well for respondents included;

- Involvement of consumer advisors
- Level of interaction
- The practicality and relevance of the workshop
- That it provided a useful framework for responding to and disclosing errors

"Great to hear the real story from someone who has experienced the situation" (Workshop participant)

"Hearing about a patient's experience with being a long term patient and learning from all of it. " (Workshop participant)

"Background information re definitions, classification etc. Useful templates to apply to clinical scenarios. Multiple disciplines interacting to reflect clinical situations…" (Workshop participant)

Suggestion for improvement included more time for role-plays and group feedback and more examples of 'go to' phrases and words for disclosing errors.

Overall there was a high level of satisfaction with the workshop and self-reported improvement of knowledge about communicating errors.

"Best seminar attended so far…Excellent PowerPoint presentation. Inviting patient to share his experience to show us that it's not just theoretical…." (Workshop participant)

Confidence disclosing medical errors:

	Pre Training (n=30) %A/SA (n)	Post Training (n=26) %A/SA (n)	Relative risk (95% CI)	P value
I feel confident about disclosing an error to a patient/their family/significant other	40% (12)	92.3% (n=24)	6.67 (1.75 – 25.4)	<0.0001
I feel confident about my ability to elicit worries or concerns from a patient/ their family/ significant other	53.4% (16)	92.3% (24)	4.8 (1.28 – 17.9)	0.002
I feel confident about my ability to manage a patient/their family/ significant other who is experiencing strong emotions as a result of an error or the disclosure	23.3% (7)	84.6% (22)	5.12 (2.03 – 12.95)	<0.0001
I feel confident about managing my own feelings when dealing with a patient/their family/ significant other following an error	36.6% (11)	76.9% (20)	2.68 (1.27 – 5.67)	0.003
Statistically significant at p < 0.05 *Calculated using Fisher's Exact Test (GraphPad Instat v 3.1)*				

Table 2: Comparisons for pre and post the intervention

Post the educational intervention; respondent's confidence levels in all four items had greatly improved, particularly in relation to disclosure of error which was statistically significant. Overall respondents reported being more confident to disclose errors, manage their own the emotions and the emotions of patients/family following an error compared to that indicated on the pre-training survey.

Discussion

There is a community and organisational expectation that all clinicians are well versed in the management of complex and difficult clinical situations, particularly when things go wrong in health care delivery. Disclosure of errors to patients and their families presents unique challenges for junior clinical staff. Our study, of a mostly female and interprofessional group of junior clinicians, revealed that this group viewed errors seriously and believed errors were largely due to systems failure (not the individual). Our findings also showed there is still a prevailing anxiety amongst junior clinicians

that they are at risk of litigation or at very least their competency will be questioned if something goes wrong. These findings concur with much of the literature and needs to be explicitly addressed in any training program. Aligning with principles of best practice and effective open disclosure, respondents agreed that errors should be disclosed to patients and families.

Low levels of confidence in disclosing errors were observed in this cohort prior to training but there was strong evidence that the teaching intervention increased confidence. The repeat survey planned for three months post-training will shed additional light as to whether this confidence is sustained.

Key principles of open disclosure, including apologising to the patient and engaging in error prevention strategies, were noted by less than half of respondents when presented with two error scenarios. This indicates that error management and open disclosure training is necessary to adequately prepare clinicians for these challenging conversations. Further in-depth analysis of responses to explore changes post the intervention will provide greater clarity on whether the actions are in accord with best practice principles and improve as a result of the training. This data has not been presented in this report.

Few participants of our study had received specific prior training on open disclosure. Even fewer had personal experience with serious errors and not all had seen senior staff disclose errors to patients and/or their family. Whilst participants of our study were largely satisfied with an observed disclosure of errors to patients, the literature reports patients are often dissatisfied with these conversations. This does indicate a potential gap between open disclosure practices and how they are perceived by patients. Given that errors and disclosure have the potential to cause distress for the patient and clinicians, specific training on managing the emotions of self and others may also be of value.

Conclusion

Disclosure of medical errors to patients and family members is difficult. The Australian Open Disclosure Standard recommends that clinicians receive training on how to have these challenging conversations. With considerable numbers of respondents having disclosed minor errors already, and with an expectation that they are to disclose more serious errors as they become more senior, there is a considerable training gap.

Given the frequency at which errors occur, and the variation in confidence and emotional distress experienced, this small pilot study reinforces the value of training provision to our junior clinical staff. Of most significance is the observed increase in knowledge and confidence levels.

The high level of participant satisfaction with the '*What to do and say when things go wrong*' workshop for junior clinicians at Monash Health has demonstrated that consumer advisors can be recruited and trained to co-facilitate communication skills training. This study has shown it is feasible and highly valued by learners. Incorporating the 'patient voice' in health professional education provides a unique, authentic and powerful learning experience. The value of this cannot be underestimated.

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LEARNING ABOUT ERROR – A SURVEY OF JUNIOR HEALTH PROFESSIONALS (Survey 1 Pre-training)

Dear colleague,

Monash Doctors Education is conducting a study about junior clinicians' experiences relating to adverse events, and the impact of a training program titled 'What to do and say when things go wrong'. The study aims to collect information on clinicians' experience before and after participating in the training. There are 3 voluntary, anonymous surveys in all; pre-training, immediately post-training and 3 months post- training. The final survey will be emailed to you. These surveys will be analysed to determine if there is any change in your experiences and attitudes about error in the healthcare setting. You may also be invited to attend a focus group in the weeks following training to discuss in more detail your thoughts about the training. Consumer advisors involved in developing and facilitating the training will also be invited to an interview to explore how participation impacted them.

The study results will also be used to evaluate the 'What to do and say when things go wrong' training program, and may be used for research purposes, including publication and presentation at scientific meetings.

It is impossible for us to identify you from the responses you provide. All 3 completed surveys will be tracked by the ID code you provide. All data will be de-identified and collated prior to analysis. If all 3 surveys are completed, you will automatically go in the draw for an iPad Mini and Zouki vouchers. To be eligible for the draw you must provide your name and contact number on the 3rd and final survey. Your name will be removed prior to collation and analysis.

This project has been assessed as a low risk project by the Monash Health Human Research Ethics Committee

Thank you very much for your participation.

Ms Alana Gilbee

Ms Debra Kiegaldie

Dr Dean Everard

Dr Simon Craig

Ms Elizabeth Pryor

If you have any queries regarding the conduct of this research, please contact Alana Gilbee on 9594 3743 or by email at alana.gilbee@monashhealth.org

Complaints

If you have any questions or concerns about your rights as a participant in this study, or if you have any complaints you may contact:

Name: **Ms. Malar Thiagarajan**
Position: **Director, Research Services, Monash Health**
Telephone: **(03) 9594 4611.**

Please turn over to commence the survey

Please enter today's date_____

Your ID code: (develop your own 'personal code' by using the first 3 letters from your first name and last 3 letters from your last)
For example, Julie Smith, J U L I T H

First 3 letters from your **first name**: ☐ ☐ ☐ **Last 3 letters** from your **last name:** ☐ ☐ ☐

What is your age? 20-29 30-39 40-49 50-59 60+

What is your gender? Male Female

Are you…

(please tick)

	A nurse
	A doctor
	A pharmacist
	A midwife
	An allied health professional (please specify discipline)_____

What is your classification/grade_____

Please list all other prior degrees / qualifications you hold

ERROR DEFINITIONS
Serious error: *"an error that causes permanent injury or transient but potentially life-threatening harm"*
Minor error: *"an error that causes harm that is neither permanent nor potentially life-threatening"*
Near miss: *an error that did not cause harm*

For every 100 hospitalised patients, please estimate how many will experience a

Near miss	
Minor error	
Serious error	

Which medical errors, if any, have you <u>personally</u> been involved with? (Please circle ALL that apply)

Near miss Minor error Serious error

ERROR DEFINITIONS
Serious error: *"an error that causes permanent injury or transient but potentially life-threatening harm"*
Minor error: *"an error that causes harm that is neither permanent nor potentially life-threatening"*
Near miss: *an error that did not cause harm*

Please indicate your level of agreement / disagreement with each of the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Medical error is one of the most serious problems in health care					
Most errors are caused by failures of care delivery systems, not failures of individuals					
A near miss should be disclosed to patients and/or their family					
A minor error should be disclosed to patients and/or their family					
A serious error should be disclosed to patients and/or their family					
Disclosing a serious error would damage a patients' trust in my competence					
Disclosing a serious error would make it less likely that a patient would take legal action					
Disclosing a serious error would be very difficult					
Apologising to patients and/or their family should be avoided, as it increases the risk of legal action.					

Please indicate your level of agreement / disagreement with each of the following statements:

"It might make me less likely to disclose a serious error if I think…."

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The patient would not understand what I was telling him/her					
The patient would not want to know about the error					
I might get sued					
The patient is unaware an error has happened					
The patient would be angry with me					
I didn't know the patient very well					

ERROR DEFINITIONS
Serious error: *"an error that causes permanent injury or transient but potentially life-threatening harm"*
Minor error: *"an error that causes harm that is neither permanent nor potentially life-threatening"*
Near miss: *an error that did not cause harm*

Have you ever **personally** disclosed the following types of error to a patient?

Near miss Yes No

If yes….

Were you satisfied with how the conversation went? Yes No

Did the disclosure discussion negatively affect your relationship with the patient? Yes No

Minor error Yes No

If yes….

Were you satisfied with how the conversation went? Yes No

Did the disclosure discussion negatively affect your relationship with the patient? Yes No

Serious error Yes No

If yes….

Were you satisfied with how the conversation went? Yes No

Did the disclosure discussion negatively affect your relationship with the patient? Yes No

ERROR DEFINITIONS
Serious error: *"an error that causes permanent injury or transient but potentially life-threatening harm"*
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Near miss: *an error that did not cause harm*

Have you ever had the opportunity to **observe a more senior staff member (medical or nursing)** disclose the following types of error to a patient?

Near miss Yes No

If yes….

Were you satisfied with how the conversation went? Yes No

Did the discussion negatively affect the treating team's relationship with the patient? Yes No

Minor error Yes No

If yes….

Were you satisfied with how the conversation went? Yes No

Did the discussion negatively affect the treating team's relationship with the patient? Yes No

Serious error Yes No

If yes….

Were you satisfied with how the conversation went? Yes No

Did the discussion negatively affect the treating team's relationship with the patient? Yes NoPlease enter

Have you ever received education or training in the following topics?

Communication in difficult situations	Yes	No
Disclosure of errors to patients	Yes	No
Steps that should be taken on recognition of an error	Yes	No
Legal responsibilities of health practitioners	Yes	No
Error prevention / Risk management	Yes	No
Error reporting procedures	Yes	No

Please indicate your level of agreement / disagreement with each of the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I feel confident about disclosing an error to a patient/ their family/significant other					
I feel confident about my ability to elicit worries or concerns from patients/family/ significant others about error					
I feel confident about my ability to manage a patient or family member who is experiencing strong emotions as a result of an error or the disclosure					
I feel confident about managing my own feelings when dealing with patients/their family/significant other following an error					

Please write down the steps <u>you</u> would take in each of the following scenarios:

<u>SCENARIO ONE:</u>

You have just realised that some antihypertensive medications were given to the incorrect patient. It appears that medications that were to be written up for one patient were written up for the patient in the next bed. The patient's blood pressure is monitored over the following six hours – she becomes mildly hypotensive, but does not experience any symptoms.

SCENARIO TWO:

A 74 year old man with Parkinson's disease is admitted to hospital with cellulitis requiring intravenous antibiotics. His usual medications are not charted initially, therefore he does not receive his anti-Parkinson therapy. The patient then sustains a fall, fracturing his hip, and later requires surgery.

Thank you for completing this survey.

LEARNING ABOUT ERROR – A SURVEY OF JUNIOR HEALTH PROFESSIONALS

(Survey 2 training evaluation)

This is a voluntary, anonymous survey of junior health professional staff to assist in evaluating the 'What to do and say when things go wrong' training module, and may be used for research purposes, including publication and presentation at scientific meetings.

Please enter today's date:_____

Your ID code: (develop your own 'personal code' by using the first 3 letters from your first name and last 3 letters from your last)
For example, Julie Smith, J U L I T H

First 3 letters from your **first name**: ☐ ☐ ☐ **Last 3 letters** from your **last name:** ☐ ☐ ☐

Please indicate your level of agreement / disagreement with each of the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
My expectations for this module were met					
The module was well designed					
It was pitched at the appropriate level					
It was delivered to a high standard					
It was taught in an interactive and engaging manner					
I valued the contribution of the consumer advisors in the module					
My knowledge about communicating error has improved as a result of today's session					

What worked well in this module and why?

What needs improvement?

Please indicate your level of agreement / disagreement with each of the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I feel confident about disclosing an error to a patient/ their family/significant other					
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I feel confident about managing my own feelings when dealing with patients/their family/significant other following an error					

Thank you for completing this survey.

LEARNING ABOUT ERROR – A SURVEY OF JUNIOR HEALTH PROFESSIONALS (Survey 1 Pre-training)

Dear colleague,

Monash Doctors Education is conducting a study about junior clinicians' experiences relating to adverse events, and the impact of a training program titled 'What to do and say when things go wrong'. The study aims to collect information on clinicians' experience before and after participating in the training. There are 3 voluntary, anonymous surveys in all; pre-training, immediately post-training and 3 months post- training. The final survey will be emailed to you. These surveys will be analysed to determine if there is any change in your experiences and attitudes about error in the healthcare setting. You may also be invited to attend a focus group in the weeks following training to discuss in more detail your thoughts about the training. Consumer advisors involved in developing and facilitating the training will also be invited to an interview to explore how participation impacted them.

The study results will also be used to evaluate the 'What to do and say when things go wrong' training program, and may be used for research purposes, including publication and presentation at scientific meetings.

It is impossible for us to identify you from the responses you provide. All 3 completed surveys will be tracked by the ID code you provide. All data will be de-identified and collated prior to analysis. If all 3 surveys are completed, you will automatically go in the draw for an iPad Mini and Zouki vouchers. To be eligible for the draw you must provide your name and contact number on the 3rd and final survey. Your name will be removed prior to collation and analysis.

This project has been assessed as a low risk project by the Monash Health Human Research Ethics Committee

Thank you very much for your participation.

Ms Alana Gilbee

Ms Debra Kiegaldie

Dr Dean Everard

Dr Simon Craig

Ms Elizabeth Pryor

If you have any queries regarding the conduct of this research, please contact Alana Gilbee on 9594 3743 or by email at alana.gilbee@monashhealth.org

Complaints

If you have any questions or concerns about your rights as a participant in this study, or if you have any complaints you may contact:

Name: **Ms. Malar Thiagarajan**
Position: **Director, Research Services, Monash Health**
Telephone: **(03) 9594 4611.**

Please turn over to commence the survey

Please enter today's date_____

Your ID code: (develop your own 'personal code' by using the first 3 letters from your first name and last 3 letters from your last)
For example, Julie Smith, J U L I T H

First 3 letters from your **first name**: ☐ ☐ ☐ **Last 3 letters** from your **last name:** ☐ ☐ ☐

What is your age? 20-29 30-39 40-49 50-59 60+

What is your gender? Male Female

Are you…

(please tick)

	A nurse
	A doctor
	A pharmacist
	A midwife
	An allied health professional (please specify discipline)_____

What is your classification/grade_____

Please list all other prior degrees / qualifications you hold

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Near miss: *an error that did not cause harm*

For every 100 hospitalised patients, please estimate how many will experience a

Near miss	
Minor error	
Serious error	

Which medical errors, if any, have you <u>personally</u> been involved with? (Please circle ALL that apply)

Near miss Minor error Serious error

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