Co-designing of Patient Safety Incident Disclosure Process in Primary Healthcare System in Qatar

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Co-designing of Patient Safety Incident Disclosure Process in Primary Healthcare System in Qatar

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ABSTRACT

The importance of disclosing a patient safety incident to the patient involved is recognized. In Qatar, there is no legal requirement for disclosure. The primary health care system in Qatar includes 30 health centers located around the country, managed by the Primary Health Care Corporation (PHCC). Over 63 nationalities of staff deliver care in the health centers, many coming from countries where a disclosure policy is not implemented, and staff would be reluctant to disclose an incident to a patient for fear of reprimand. Many patients who receive care in the health centers come from countries where the health system culture is not open and transparent with patients. PHCC seeks accreditation of the health centers by Accreditation Canada, which has a required organizational practice of disclosure of patient safety incidents. To maintain accreditation, and consistent with PHCC’s strategy to deliver patient and family-centered care, PHCC needed to develop and implement a disclosure policy and process. The policy and process were co-designed by clinical staff working in the health centers and patients, through a focus group and individual interviews. The resulting policy and process focused on communicating disclosure quickly by a multidisciplinary team, providing for quick access to healthcare services by the patient, and fully documenting the disclosure, using a newly developed electronic record. Staff training, coordination with incident reporting and analysis, and ongoing evaluation were key stages of the implementation. The disclosure process has been in place for five years, with only positive feedback from patients and no legal implications.

Keywords: Disclosure, Patient safety incident, Patient-centered care, Patient engagement, Consumer engagement, Patient experience, Patient satisfaction

1. Introduction

Patient safety is a defining characteristic of quality health care. The Institute of Medicine’s (IOM’s) Committee on Data Standards for Patient Safety regarded patient safety and delivering quality care as indistinguishable. However, unexpected or unplanned events can occur during the provision of health care, some possibly resulting in harm to a patient. These events are typically referred to as patient safety incidents. Patients can experience physical, psychological, or financial trauma because of a patient safety incident, which can make it challenging for practitioners to disclose the event to patients and their families.

The public is becoming more aware of the impact of patient safety incidents, and the demand on health policymakers to respond to incidents, particularly those that cause serious harm, is intensifying. When an incident happens, patients and their families have the right to know what happened; therefore, it is ethically appropriate to disclose the occurrence of a patient safety incident. Open disclosure to patients...
involved in incidents requires practitioners to apologize to a patient for the occurrence of an incident and discuss with the patient what s/he should know about the implications of the incident for the patient’s health.

Disclosure of patient safety incidents is being implemented in several countries. In the United States and Canada, the mandate for disclosure began through accreditation of healthcare organizations. In Australia, disclosure was endorsed for implementation by the Australian Commission on Safety and Quality in Health Care. In the United Kingdom, healthcare providers are required by law to inform patients of incidents that have caused or could still cause moderate or severe harm, apologizing for the incident and being open and transparent with patients about the incident.

The benefits of open disclosure policies include that transparency in communication with patients involved in incidents and their families demonstrates respect, compassion, and commitment. Disclosure improves the reputation of a healthcare organization, promotes potential legal benefits, and demonstrates the organization’s trustworthiness. Disclosing incidents to patients and their families helps to build a better physician-patient relationship, improves patient satisfaction and increases the credibility of medical profession. It also prevents media, regulators, and the public from becoming hostile toward the organization, thereby avoiding misjudgment and humiliation. Patients often react positively to open communication about adverse outcomes. On the other hand, providers can face barriers when attempting to disclose a patient’s condition. Some believe that reporting a side effect is unnecessary if the patient is unaffected or has minimal harm. Also, disclosing an inaccuracy in care to certain patients may cause them to lose trust in their doctors. Other challenges to disclosure from healthcare providers have been concerns about apologizing for an incident, lawsuits or an expectation by the patient of compensation.

2. The context for introduction of a disclosure policy in Qatar

The healthcare system in Qatar makes a determined effort to inculcate patient and family-centered care in the provision of its healthcare services. PHCC manages 30 health centers that offer a wide variety of medical services suited to their communities, in accordance with PHCC’s mission of sustaining the population’s health and providing safe, timely healthcare to patients and their families. To contribute to fulfilling its mission, PHCC sought accreditation from Accreditation Canada (AC), which requires implementation of a policy and process for disclosing patient safety incidents.

Initially in 2015, the accreditation requirement was simply for the organization to have a disclosure policy; there was no requirement to implement or evaluate implementation of the policy. In 2018, AC updated criteria on patient-centered care, and disclosure of patient safety incidents became a Required Organizational Practice (ROP) under the leadership standards. At that time, PHCC reviewed its disclosure policy and process and incorporated a comprehensive framework to redesign the physician-patient relationship and process to disclose patient safety incidents to patients and their families.

Implementation of a new disclosure process needed to acknowledge the context of primary care services in Qatar. PHCC provides services to diverse cultural communities through its 30 health centers located around the country. More than 63 nationalities make up the patient population and the health centers’ staff. Many staff working in the health centers come from countries where a disclosure policy is not implemented, and staff would be deeply reluctant to disclose an incident to a patient for fear of the consequences to the staff member involved. Similarly, many patients relying on the health centers come from countries where the health system’s culture is not open and transparent with patients.

In this cultural context, the new disclosure policy and process had to be co-designed with patients and staff. In addition, the benefits and barriers to implementation of disclosure with patients and staff needed to be continuously evaluated to identify learning opportunities and inform adjustments to the policy and process.

2.1. How the disclosure policy was developed

Disclosure of patient safety events to the patient and their families is not a legal requirement for healthcare providers in Qatar. In view of the need to demonstrate compliance with Canadian accreditation requirements, PHCC’s Risk Management and Patient Safety Department was designated as the owner of disclosure process and policy and charged with updating the PHCC disclosure policy and process, consistent with PHCC’s strategy on patient and family-centered care.
Clinical staff and patients were included in the development process, starting from review of the existing policy. Individual patients who had experienced a patient safety incident in one of the health centers were interviewed about their experiences. A multidisciplinary clinical team focus group, including physicians, nurses, and pharmacists, was carried out to learn about staff experiences with the disclosure policy. The major themes emerging from the focus group and patient interviews were: direct access to care; who provides the disclosure; the method of communication; and documentation of the disclosure. Table 1 provides comments made by patients or staff about each theme and how the theme was subsequently handled in the policy update. Generally, the patients’ views were consistent with patient expectations of disclosure in other countries.17

2.2. Purpose and content of the new disclosure policy document

The purpose of having the new policy document on the disclosure of patient safety incidents was to guide PHCC leaders and clinicians on the process of disclosure and help staff approach disclosure confidently when a patient safety incident occurs. The contents of the policy after the updates based on the staff focus group and patient interviews is in Table 2. The updates focused on the timeliness and mode of communication to the patient involving a multidisciplinary team, the apology, documentation of the disclosure, and access to immediate care for the patient.

2.3. How the disclosure policy was implemented in all health centers

Implementing the process to disclose patient safety incidents to patients and families involved addressing two different needs while maintaining the trust relationship between a patient and a provider:

- Patients and families have the right to know about what happened to them and what to expect after a patient safety incident has occurred.
- Breaking unpleasant news is not an easy task for healthcare providers or for the organization, with concerns about fear by staff, trust in staff and the organization, and the reputation of a health center and PHCC.

Considering the challenges in disclosing a patient safety incident to a patient and family, the clinical staff focus group requested guidance and support for frontline staff as the primary action in implementing the disclosure process in all PHCC health centers.

Organizations in countries in which disclosure has been implemented have commented on the implications for implementation of a disclosure policy, referring to the following considerations: informing patients of their right to full disclosure; support for patients and families involved in disclosure; the need for clear policy; training that prepares healthcare providers to provide what might be bad news, aligning incident reporting and analysis with disclosure; preparing the team involved in the incident; and providing detailed guidance for healthcare providers.18–20 Table 3 describes the key steps in implementation of the patient safety incident disclosure process.

2.4. Outcomes of implementation of the disclosure policy

Accreditation Canada has recognized PHCC with an award as an organization committed to its patient-centered care approach.21 The disclosure process co-designed with the patients and staff was a demonstration of PHCC’s commitment. Disclosure of a patient safety incident has become standard practice in the organization, and implementation of the policy is continuously monitored and evaluated. From each disclosure episode, the process is evaluated through review of the patient file, disclosure documentation, staff interviews, and a patient interview. From the evaluation, additional improvements in the process have included adding structured support to staff, such as critical incident stress debriefing,22 and providing communication channels to patients to report incidents.

Feedback both from patients and staff demonstrates that transparency increases trust and positive relationships between the patient and staff. Staff are more confident in disclosing incidents to the patient and patient experience ratings are improved.

2.5. Implications for further practice

The development of the disclosure process illustrates the role of co-designing and co-evaluating processes with the people involved in the process – for this subject, the clinical staff and patients – in providing efficient and effective health care. Without the direct involvement of both staff and patients, assumptions can be made that may risk failure to achieve the intended outcome of a process. This experience shows that involving patients and staff sheds light on the real issues about disclosure that are faced by both groups and provides context-relevant and context-sensitive
### Table 1. Themes about disclosure of a patient safety incident from staff and patients and how the theme was handled in the disclosure policy.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Engagement method</th>
<th>Patient and staff comments</th>
<th>Subsequent policy update</th>
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<tbody>
<tr>
<td>Direct access to care</td>
<td>Patient interviews</td>
<td>I need the consultation and need care to be provided to me.</td>
<td>Patient involved in disclosure is to be provided with immediate direct care based on the nature of incident, and urgent quick access for all needed care related to that incident</td>
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<td>Need access to urgent care, I do not need to wait for any registration, appointment, or referral. I am considering this as important for you as the organization as well as for me. In my case as an example, I accept the apology because I was very well consulted, I have been immediately seen by the needed physician, I was assured of my health and I did not get any further impact. But this can be turned into a legal case by any patient at any time if there is any major impact for any patient.</td>
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<td>Staff focus group</td>
<td></td>
<td>All participants agreed on the patient need to have quick access to the subsequent care process. The team suggested that quick access is to be provided through the physician lead as he/she can provide the care directly to a patient without a need to refer to another clinic.</td>
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<tr>
<td>Disclosure team</td>
<td>Patient interviews</td>
<td>I think it should be the supervisor or the head or any responsible person for sure, not the person who made the mistake as for me as a patient I already lose the trust of that person, so will not accept his further communication.</td>
<td>Disclosure needs to be done with the team to include but not be limited to:</td>
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<td></td>
<td>All participants agreed on the importance of having the disclosure done through a team with emphasis of including the team involved in the situation. Also, the importance of having a physician as mandatory in all disclosure teams. As s/he will be the most aware of the impact of the incident on the patient’s health and treatment plan, s/he will be the person to answer all clinical questions related to what to expect next based on the patient’s clinical status and to provide the patient with an immediate checkup on his/her clinical situation and decide whether any other consultation and referral or follow up is needed. At the same time, the staff from the area involved in the incident will be the most appropriate persons to explain what happened to the patient and to answer any clarification from the patient that might relate to the specific incident.</td>
<td>• Physician lead or his/her designee</td>
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<td></td>
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<td>• The section lead of the incident location</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Any other specialties required based on the nature of the incident</td>
</tr>
<tr>
<td></td>
<td>Staff focus group</td>
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<tr>
<td>Method of communication</td>
<td>Patient interviews</td>
<td>I want the information to be given to me as early as possible, if I am in the health center or outside the health center, I need to get the information very quickly. Remember that I may have already been affected with that mistake. So I expect even sometimes from you to send me an ambulance if my case required. On the other hand, even if I am not affected, if you called me without giving me any details over the phone and just ask me to visit the health center to see the staff who want to talk to you, I may not feel the importance, relevance or urgency of the visit, and meanwhile I may continue taking any medication at home which might have worse impact on me.</td>
<td>1. Patient to be contacted as soon as possible</td>
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<td></td>
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<td>2. If the patient is outside the health center, the patient is to be contacted by phone and given details about the following: • what happened • what the patient needs to do • when the patient needs to visit the health center • who to contact when s/he visits the health center if s/he needs any further details • If the patient is in the health center (or when he visits the health center), disclosure needs to be done by the team</td>
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### Table 1. (cont.)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Engagement method</th>
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<tr>
<td>Documentation</td>
<td>Patient interview</td>
<td>The most important information I want to know is the impact of this mistake to me as patient and what to expect. Also, I want to know if there is any test or investigation which may be required to rule out any of the expected impact of this mistake. I will be keen to know also if there are any other patients had been impacted by this error or not.</td>
<td>Disclosure information to include the following: • Facts around what happened without an explanation of why it happened • Clear acknowledgement and apology of what happened • Commitment that this incident will be considered for investigation to find the cause/s • Promising the patient that s/he will get an update on the outcome of the investigation and the improvements made following the investigation • Details of a contact person assigned to follow up in case any further clarification or need arises</td>
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<tr>
<td>Staff focus group</td>
<td></td>
<td>All participants agreed on the importance of documentation of disclosure as this is the only evidence of the details of what exactly was communicated to the patient. The team agrees on the importance of having clear documentation of the disclosure including a guide to the staff on all the information that needs to be documented, including either a checklist or forms with fields to be filled by the staff to ensure that no information is missed. The staff emphasized having this documentation approved by the PHCC legal department.</td>
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Table 3. Key steps in implementation of the patient safety incident disclosure process by PHCC.

<table>
<thead>
<tr>
<th>Implementation step</th>
<th>Description</th>
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<tr>
<td>Training staff</td>
<td>The disclosure training was conducted in two phases.                                                                ---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>• Phase I consisted of in-house training targeted at all clinical staff focused on an introduction to the disclosure process and its implementation at health center level. In this training, clinical staff practiced a disclosure and shared their feedback.</td>
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<td>• For Phase II, an external expert in the field of disclosure was sourced by PHCC to introduce further the implementation of disclosure with the clinical leads of specific departments of the health centers. This training focused on the importance of patient-provider communication throughout the disclosure process using role play. This training aimed to build capabilities among the clinicians and health center leaders in open communication and disclosure of patient safety incidents to patients and families in order to support health center staff in the disclosure process.</td>
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<td>In addition, disclosure was added as one of the main subjects to be covered annually as part of the regular patient safety training programs.</td>
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<td>Read and sign and competency tests</td>
<td>To ensure that the disclosure policy reached all staff, staff were required to activate the Read and Sign feature in the Policy Portal of PHCC. This feature requires a staff member to declare that s/he has read and understood the disclosure policy. Following the Read and Sign feature, a staff member needs to answer a set of questions related to the disclosure process to assess the staff member’s understanding of the policy.</td>
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<tr>
<td>Disclosure of patient safety incident form</td>
<td>A disclosure form was developed in the electronic medical record to help healthcare providers to systematically complete the documentation of the incident and the details of disclosure discussions with a patient and family. Staff were trained to use this form to document disclosure.</td>
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<tr>
<td>Notification system</td>
<td>A new field was added to the PHCC Incident Report form available in the Safety Management System to document the disclosure status at the time of reporting the incident. The field has been used as a trigger point to notify the patient safety team of any disclosure that happened at a health center in order to be able to extend support to the staff and complete verification of the disclosure process.</td>
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<tr>
<td>Awareness posters</td>
<td>Awareness posters on disclosure were shared with the staff to remind staff and ensure compliance with the policy. The posters also could be used as a reference on what disclosure is, which incidents require disclosure, who should disclose, where to document, and learning and improvement from patient safety incidents.</td>
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</table>

Patients appreciate the transparency despite being involved in an incident. They particularly appreciate follow up calls checking on them. Some patients involved in the disclosure process became patient advisors to the health center and joined the patient and family advisory group in PHCC. Staff needs and concerns are equally important and reflecting them in the policy updates and implementation activities enhances their trust and buy-in.

The updated disclosure process has now been implemented in PHCC health centers for five years. The disclosure policy has not increased liability for PHCC, but rather increased trust by the patients concerned. Because disclosure of a patient safety incident is not a legal mandate in Qatar, staff frequently ask about potential liability associated with disclosure. Approval of a process at national level, such as the legal duty of candor process adopted in the UK, could contribute to a sense of security by staff.

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References


