AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Australian Open Disclosure Framework

Supporting materials and resources

Staff evaluation survey template

This template should be adapted to suit your local context and setting

Health service organisation / facility logo

Open Disclosure: staff survey

What is the survey about?
This survey has been developed to enable feedback from staff about the open disclosure process. The aim of this survey is to improve the open disclosure experience for people involved in an incident that resulted in harm to a patient while receiving health care – this includes patients, their family and carers, as well as staff.

This survey is about your experience with **open disclosure**. When completing the survey please reflect on your experience of a specific open disclosure case you participated in.

Terms used in the survey. To help you complete the survey, the following terms are used:

Harmful incident	An incident that led to patient harm. Such incidents can either be part of the healthcare process, or occur in the healthcare setting (i.e. while the patient is admitted to, or in the care of, a health service organisation). Note: This term is used interchangeably with 'adverse event'.
Staff	Anyone working within a health service organisation, including self-employed professionals such as visiting medical officers.
Initial discussion	Informal, unscheduled, bedside discussion about the incident between clinician(s) and patient and/or their support person. Also referred to as **signalling open disclosure** in the *Australian Open Disclosure Framework.*
Open disclosure	An open discussion with a patient about an incident(s) that resulted in harm to that patient while they were receiving health care. The elements of open disclosure are an apology or expression of regret (including the word sorry), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure is a discussion and an exchange of information that may take place over several meetings.
Support person	An individual who has a relationship with the patient. References to 'support person' in this document can include: • family members / next of kin • carers • friends, a partner or other person who cares for the patient • guardians or substitute decision makers • social workers or religious representatives • where available, trained patient advocates. References to support person should be read with the words, 'where appropriate'.

All responses will remain confidential.

Survey Questions

1. I have participated in the following forms of open disclosure training (please tick **all** relevant answers)
   - ❑ Seminars or presentations on open disclosure
   - ❑ Interactive workshops on open disclosure
   - ❑ I have used online and/or audiovisual resources for open disclosure training
   - ❑ I have read independently about open disclosure
   - ❑ No training

2. What was your professional relationship with the patient at the time of the harmful incident and/or open disclosure? (Please tick **one**)

Doctor	❑	Speciality:
Surgeon	❑	Speciality:
GP	❑	
Nurse	❑	
Midwife	❑	
Allied health professional	❑	Speciality:
Other (please specify)	❑	
Not applicable	❑	

3. After the harmful incident, I participated in: (please tick **all** relevant answers)
   - ❑ Initial discussion with the patient and/or their family and carer(s))'Signalling open disclosure)
   - ❑ Pre-meeting discussions
   - ❑ Open disclosure discussion
   - ❑ I did not participate in patient meetings

4. On a scale from 1-10 (**1** being **least serious** and **10** the **most serious**) how serious were the effects of the harmful incident on the patient?

No effects			Mild effects		Moderate effects			Severe effects	
1	2	3	4	5	6	7	8	9	10

5. How soon did health service organisation staff speak with the patient/support person about the harmful incident? (Please tick **one**)
   - ❑ Within 48 hours
   - ❑ 1-2 weeks
   - ❑ Within 1 month
   - ❑ More than 1 month
   - ❑ The health service did not speak with the patient/support person

6. Is this timeframe acceptable for **initial** contact? (Please tick **one**)
   - ❑ Yes
   - ❑ No – it was too early
   - ❑ No – it was too late
   - ❑ Unsure

7. Did health service organisation staff inform the patient's support person about the harmful incident? (Please tick **one**)
   - ❑ Yes
   - ❑ No
   - ❑ Unsure
   - ❑ It was not appropriate

8. Was the patient/support person informed about the plan to commence open disclosure? (Please tick **one**)
   - ❑ Yes
   - ❑ No
   - ❑ Unsure

Please answer the following questions about **your experiences** of a specific open disclosure case:

		Strongly DISAGREE	Slightly DISAGREE	Neutral	Slightly AGREE	Strongly AGREE	NA or unknown
	Preparation for Open Disclosure						
9.	I had received adequate **training** in open disclosure	1	2	3	4	5	NA
10.	My **colleagues** were supportive	1	2	3	4	5	NA
11.	My **manager(s)** were supportive	1	2	3	4	5	NA
12.	I was **confident** about participating in open disclosure	1	2	3	4	5	NA
13.	The open disclosure discussion was **stressful**	1	2	3	4	5	NA
14.	The hospital **encouraged** open disclosure	1	2	3	4	5	NA
	Open Disclosure Procedure						
15.	The patient/support person were given a health service **point of contact** throughout the open disclosure process	1	2	3	4	5	NA
16.	The patient/support person were given **options** about the time and place of the open disclosure meeting/s	1	2	3	4	5	NA
17.	The open disclosure discussion was an **ongoing process**, rather than a one-off discussion	1	2	3	4	5	NA
18.	The patient was given the opportunity to have a **support person(s)** who was **not** a staff member attend the open disclosure meeting(s)	1	2	3	4	5	NA
19.	The patient/support person were given an **accurate explanation** about the harmful incident	1	2	3	4	5	NA
20.	The explanation about the incident was **clear**	1	2	3	4	5	NA
21.	Accurate information was given about **consequences** associated with the harmful incident	1	2	3	4	5	NA
22.	Information about the **timeframe** and **actions planned** to prevent similar future harmful incidents was **clear**	1	2	3	4	5	NA
23.	The patient/support person were given the opportunity to be **involved** in any **investigation** of the harmful incident	1	2	3	4	5	NA
24.	Hospital staff indicated they were willing to share **further information** with the patient/support person as it became available	1	2	3	4	5	NA
25.	The patient/support person were given the opportunity to **ask questions**	1	2	3	4	5	NA
26.	The health service organisation staff were good at **listening** to the patient/support person	1	2	3	4	5	NA
27.	I believe the patient/support person **understood** the information provided **during** open disclosure	1	2	3	4	5	NA
28.	The patient/support person received clear, **written** information about what was discussed	1	2	3	4	5	NA

		Strongly DISAGREE	Slightly DISAGREE	Neutral	Slightly AGREE	Strongly AGREE	NA or unknown
	Outcomes						
29.	An **apology** including the words 'I'm sorry' was offered during open disclosure	1	2	3	4	5	NA
30.	**Health service organisation** staff **recognised and acknowledged** the severity of harm experienced by the patient	1	2	3	4	5	NA
31.	Hospital staff were **regretful** about the harmful incident	1	2	3	4	5	NA
32.	I am satisfied with how the harmful incident was **discussed**	1	2	3	4	5	NA
33.	Appropriate **ongoing support** was offered to the patient/support person	1	2	3	4	5	NA
34.	The patient was given the option of arranging **additional meetings** if required in the future	1	2	3	4	5	NA
35.	The conclusion of the open disclosure process was **mutually agreed** between the patient/support person and the health service organisation staff	1	2	3	4	5	NA
36.	I am satisfied with the **results** of the open disclosure	1	2	3	4	5	NA
37.	The health service organisation met **its responsibility** to the patient/support person	1	2	3	4	5	NA
38.	My **professional reputation** was enhanced by open disclosure discussion(s)	1	2	3	4	5	NA
39.	My **relationship** with the patient/support person was improved by open disclosure discussion(s)	1	2	3	4	5	NA
40.	The health service organisation met its responsibility **to staff** involved	1	2	3	4	5	NA

How could this organisation improve the way harmful incidents are discussed during Open Disclosure?

41. For **staff**?

_____

_____

42. For **patients/support persons**?

_____

_____

43. For the **organisation**?

_____

_____

Thank you for completing this survey

Please return the completed survey to _____