Apologizing with H.E.A.R.T®: An Innovative Simulation to Increase Confidence in Disclosing a Patient Safety Incident

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Introduction

•Effective disclosure discussions of patient safety events are a hallmark of patient-centered care and safety.[1]
•Hospital staff must accept accountability when safety incidents transpire and take necessary steps to mitigate.[1]
•The Canadian Disclosure Guidelines (2011) recommend staff attain ongoing education, mentoring and coaching to help facilitate effective disclosure discussions.
•Accreditation readiness and consultations with Quality & Patient Safety, Patient and Family Partners, and Interprofessional Practice teams highlighted inconsistencies in disclosing patient safety incidents to families.
•A training was developed to help staff practice making apologies using the H.E.A.R.T® communication model and discussing safety incidents with patients, families, and clients in a safe, supportive environment.

Learning Objectives

The learning objectives of the training are to:
1.Describe the CAMH Quality and Adverse Event Process requiring a disclosure
2.Develop a plan for a disclosure conversation
3.Communicate a disclosure to a family member using the H.E.A.R.T.® model

Methods

•Using the H.E.A.R.T.® communication model,[2] staff compose a script for disclosure and practice it with a simulated participant (SP) who plays the role of a family member.
•Engaging with the SP helps staff learn how to foster a collaborative environment where all parties involved feel heard and their contributions are valued.
•This simulation training combines didactic teaching, simulation with a simulated family member, observation, and a facilitator and lived experience advisor debrief.

Results

•Data was collected through self-reported pre-and post-training surveys guided by Moore's Outcome Evaluation Framework, focusing on levels one (participation/engagement), two (satisfaction), and three (learning/knowledge).[3]
•Quantitative Likert-scale questions and qualitative open-ended questions were used to assess changes in confidence from pre- to post-training, intention to change practice, and learners' overall experience with the training.
•24 healthcare providers have participated in the training to date.
•Data was collected from 16 clinicians (nurses, social workers, physicians, behavior therapists, recreation therapist, occupational therapist, other) between Mar-Nov 2024.

100% Intention to Change Practice

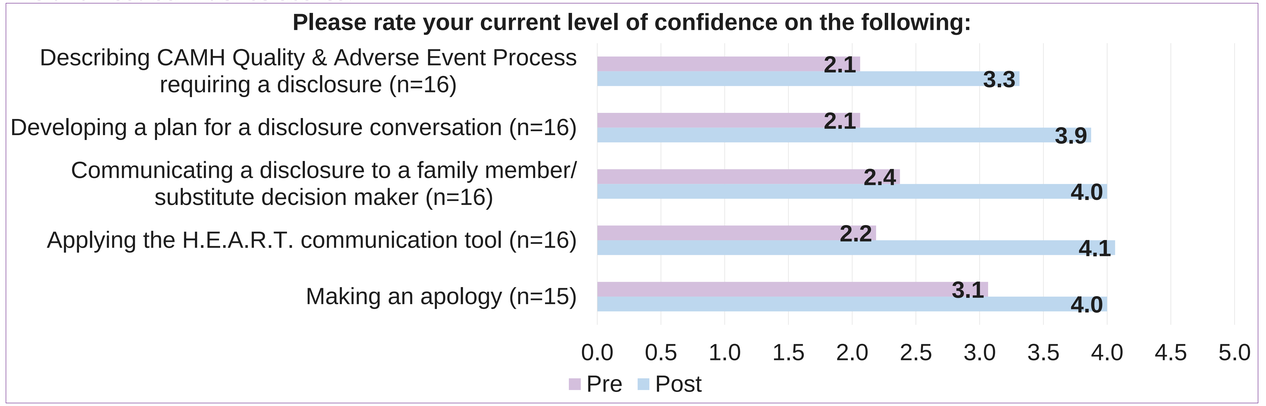
94% Satisfaction with Training

100% Recommend to Others

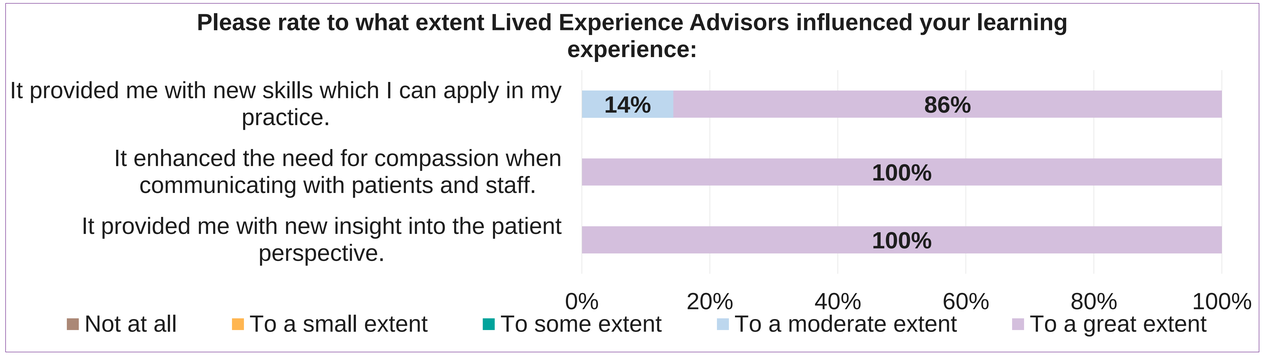
"It was amazing to get all of the different perspectives in the room. The SP was an excellent resource."

"Provided real-life responses that resembled an actual clinical settings."

Pre and Post Confidence Scores:



Lived Experience Advisor Feedback:



Conclusion

•Evaluation results highlight the value of this simulation on learner's confidence in disclosing a safety event.
•The inclusion of lived experience advisors in the debrief provided a unique opportunity for staff to hear and learn from different perspectives.
•This novel training, based on an evidence-based model, contributes to the understanding of how CPD training, can increase skills in quality processes, e.g. disclosure discussions, which can contribute to professional resilience.

References

1. Disclosure Working Group. Canadian disclosure guidelines: being open and honest with patients and families. Edmonton, AB: *Canadian Patient Safety Institute;* 2011.
2. Cleveland Clinic. Communicate with H.E.A.R.T. 2024. Accessed February 25, 2024. https://my.clevelandclinic.org/departments/patient-experience/depts/experience-partners/licensed-programs/communicate-with-heart
3. Moore DE Jr, Green JS, Gallis HA. Achieving desired results and improved outcomes: integrating planning and assessment throughout learning activities. *J Contin Educ Health Prof.* 2009;29(1):1-15.