World Health Organization | Patient Safety

A World Alliance for Safer Health Care

Patients for Patient Safety

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Patients for Patient Safety Programme
WHO Patient Safety

Canada's Forum
On
Patient Safety & Quality Improvement
- CPSI Turns Ten -
29th October, 2014

The Patient Experience as a Catalyst for Change

INTRODUCTION

- Addressing the heart of the matter – the patient and family experience of care
- Recognising the potential of patient experience to drive improvement in all aspects of care
- Ensuring structures which learn from the raison d'etre of healthcare and provide truly patient-centred care
- Need for reflection on important issues at a time of celebration – leadership, partnership, medication safety, responding to the deteriorating patient and considering frontline staff
- Courage – being prepared to put our heads above the parapet

DEMONSTRATING COURAGE

"There is one thing worse than being blind
and that is having sight but no vision"

Helen Keller

- Motivations to strive for healthcare improvement, e.g. (i) a negative experience of care (the patient); (ii) awareness of the gaps between the safety measures that are possible and those actually being experienced by patients (the healthcare professional)

Patients For Patient Safety (PFPS)

- The emergence of the ‘Patient Advocate’
- The nature of advocacy – volunteers committed to collaborative partnership in the co-production of safe care
- The advocate's motivation – seeing experiences as catalysts for change – using the past to inform the present and influence the future
- A brand of partnership that facilitates empowerment of patients by enablers within the system

Addressing the Challenges

- Ensuring productive engagement
- Balancing the different commitments
- Role of leadership to provide a robust culture together with systems and supports to enable staffs and empower patients

In honour of
those who have died,
those who have been left disabled,
our loved ones today,
we will strive for excellence,
so that all people receiving healthcare
are as safe as possible,
as soon as possible.

This is our pledge of partnership

FRAMEWORK AND PROCESS

COMMITMENT

- Proactive engagement of patients in own care
- Capturing lessons learned from the patient experience
- Embedding patient and family in every aspect of healthcare

DELIVERABLE

Knowledgeable Patients receiving safe & effective care from skilled professionals in appropriate environments with assessed outcomes

ACHIEVING THE GOAL

Synchronising Culture and Expectation

"No one is ever hesitant to speak up regarding the well being of a patient and everyone has a high degree of confidence that their concern will be heard respectfully and acted upon"

- *Michael Leonard, Physician Leader for PS at Kaiser Permanente*

"Around the world, healthcare organisations that are most successful in improving patient safety are those that encourage close cooperation with patients and families"

- *Safety First, 2006*

88% of Survey Respondents trust their doctor to tell the truth

- *Irish Medical Council 2012*

THE ACID TEST
DISCLOSURE and the LIVED EXPERIENCE

- Disclosure = ?
- Blame vs Integrity and Professionalism
- Learning?
- Preventing recurrence?
- The need to understand and resolve the disconnect between humanity, compassion and inappropriate responses in the aftermath of events

A Personal Experience

- Using a negative experience as a learning tool
- Awareness raising and providing insight and motivation for reflective learning
- Appreciating and owning the gift of being a healthcare professional
- Accepting engagement as a requirement for safe care which enhances staff safety and satisfaction

"Making the status quo uncomfortable, while making the future attractive " *J. Conway, IHI*

"The time is NOW. If health an/or healthare are on the table, then the consumer must be at the table, every table – NOW! "– Lucien Leape

Tell me a fact

...and I'll learn

Tell me a truth

…and I'll believe

Tell me a story

…and it will live in my heart forever

(Indian Proverb)

What Patients Want....

- To experience Openness, Transparency and Inclusion
- To see evidence of Professionalism and Trustworthiness

The Effectiveness of the Story
Examples of Feedback

"Facts do not change feelings and feelings are what influence behaviours. The accuracy, the clarity with which we absorb information has little effect on us; it is how we feel about the information that determines whether we will use it or not".

- Vera Keane, 1967

SIMPLE
MEASURES
SAVE
LIVES

Official Data : An Example

Uimh. No. P 3832 / 22

ÉIRE **IRELAND**

Deimhniú báis ar na h-éisiúint de bhun na hAchta um Chlárú Breitheanna agus Básanna 1863 go 1972.

DEATH CERTIFICATE issued in pursuance of Births and Deaths Registration Acts 1863 to 1972.

Básanna a Cláraíodh i gCeantar Deaths Registered in the District of 2 — i gCeantar an Chláraitheora Maoirseachta do in the Superintendent Registrar's District of Cork — i gContae in the County of Cork — Éire Ireland

Uimh. No. 1	Dáta agus Ionad Báis Date and Place of Death 2	Ainm agus Sloinne Name and Surname 3	Gnéas Sex 4	Staid Condition 5	Aois an lá breithe is déanaí Age last Birthday 6	Céim, Gairm nó Slí Bheatha Rank, Profession or Occupation 7	Cúis Báis Dheimhnithe agus fad an tinnis Certified Cause of Death and Duration of Illness 8	Síniú, Cáilíocht agus Ionad Cónaithe an Fhaisnéiseora Signature, Qualification and Residence of Informant 9	An dáta a Cláraíodh When Registered 10	Síniú an Cláraitheora Signature of Registrar 11
170	1999 Twenty-Sixth September Cork University Hospital	Kevin Murphy 33 Tractor Place Monkenotke Cork	Male	Single	21 yrs.		Multi-organ failure Hypercalcaemia Parathyroid tumour certified	daniel J. Gillis occupier Cork University Hospital	Third November 1999	S. Scallagh Asst

Deimhnímse leis seo gur Fíor Chóip í seo de Thaifead Uimh. 170 i gClár-leabhar Básanna atá faoi mo chúram.
I hereby Certify that the foregoing is a true Copy of the Entry No 170 in a Register Book of Deaths in my custody.

Dr. M. Sinnott

Is é Blian an Bháis sa Chóip dheimhnithe thuas ná
The Year of Death shown in the above Certified Copy is

Míle One Thousand nine gCéad Hundred and ninety-nine

Cláraitheoir *(Maoirseachta) na mBreitheanna agus na mBásanna
†(Superintendent) Registrar of Births and Deaths

I gCeantar for the District of .....

Oifig Office .....

Dáta Date .....

*Scrios amach an focal (idir lúibíní) mura n-oireann sé
†Strike out word in brackets if not applicable.

SOUTHERN HEALTH BOARD 26 MAY 1999 SUPERINTENDENT REGISTRAR'S OFFICE LIBERTY STREET, CORK.

Is cionn trom é an teastas seo a athrú nó é a úsáid taréis a athraithe

TO ALTER THIS DOCUMENT OR TO UTTER IT SO ALTERED IS A SERIOUS OFFENCE

Kevin The Person

8 Days
before admission
to hospital

The Questions

Simple questions…..

Why did Kevin die?

What went wrong?

We need to know and we need to understand

Every Point of Contact Failed Him…

The Unfolding Story 1997-1999

Persistent back pain – GP Visits, X-Rays

Orthopaedic Surgeon – Bone Scan, Blood Tests

		1997	1999
•Calcium	3.51	(2.05-2.75)	5.73 (6.1)

Described as 'inconsistent with life'.

•Creatinine	141	(60-120)	214
•Urate	551	(120-480)	685
•Bilirubin Direct	9.9	(0-6)	
•Alk Phosphate	489	(90-300)	

YOU IGNORE AT YOUR PERIL

THE CONCERNS OF A MOTHER

Peer Review

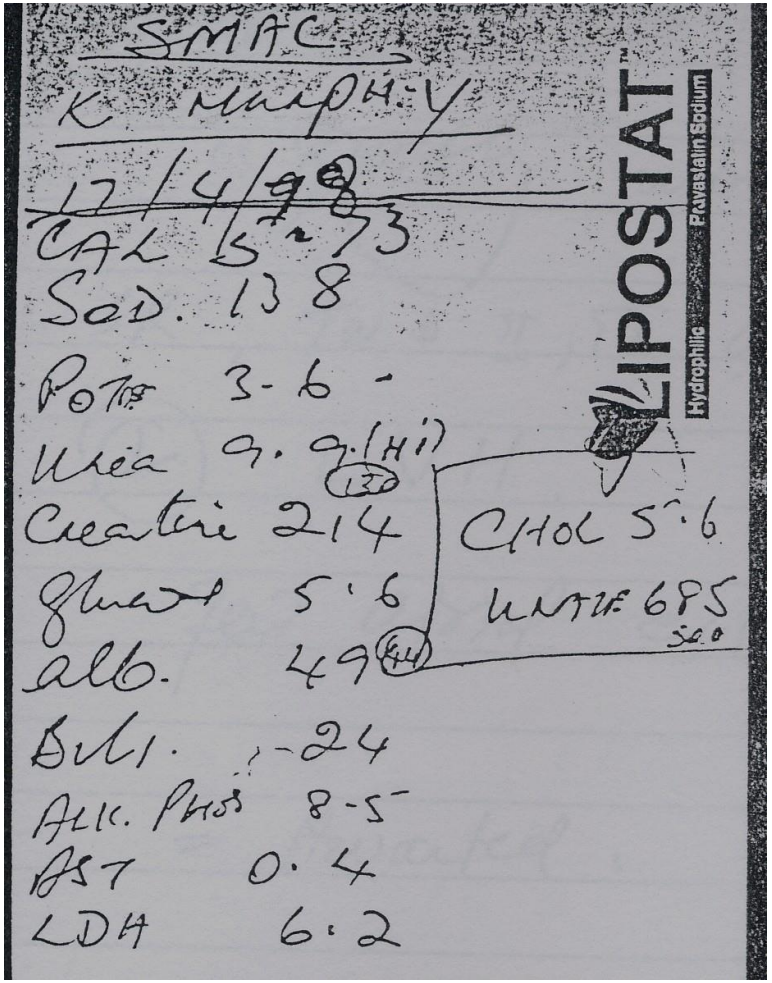
"The combination of bone pain, renal failure and hypercalcaemia in a young patient points either to a diagnosis of primary hyperparathroidism or metastatic malignancy and these ominious results should have been investigated as a matter of urgency".

"Kevin would have had surgery to remove the over-active parathyroid gland. He would have been cured and would still have been alive today."

"All the evidence indicates that the patient was suffering from a solitary parathyroid adenoma at the time, removal would have been curative with a normal life expectancy"

Research 96% Success; 1% Complication Rates

The Post-It


SMAC
K MMOL/L
12/4/98
CAL 2.73
SOD. 138
POT 3.6
Urea 9.9 (H)
Creatin 214
Gluc 5.6
alb. 49
BILI. 24
ALK. PHOS 8.5
AST 0.4
LDH 6.2
CHOL 5.6
TRIG 685
LIPOSTAT
Hydrophilic Pravastatin Sodium

Every Point of Contact Failed Him…

The Shortcomings

- Inability to recognise seriousness of Kevin's condition
- Appropriate interventions not taken
- Selective and incomplete transmission of information.
- Non receipting of vital information
- Absence of integrated pathways
- Link between behaviour and test results not made
- Developing neurological problems ignored
- No evidence of tracking of his deteriorating condition

ABSENCE OF DIRECT COMMUNICATION WITH THE PATIENT

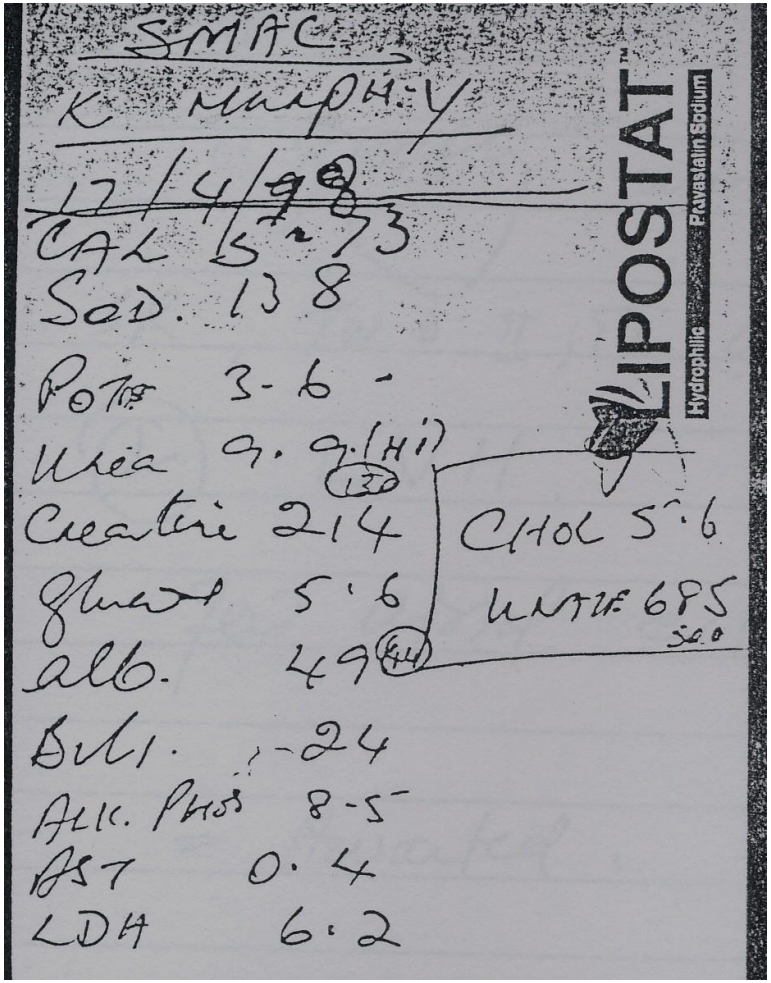
Shortcomings *Contd…*

- Treatment at Registrar level
- The team dynamic
- The impact of a weekend admission
- Patient asked to accommodate system
- Expectations of a Tertiary Training Hospital

The Response

- Defensive
- 'Loyalty to colleagues'
- Muddying the waters – dissembling
- - e.g. Claims of inability to understand 'layspeak'
- Attempts to shift responsibility
- Confidence in any hope of ascertaining truth
- shattered
- Excuses offered were unsustainable
- Expectation of professional and honourable
- conduct betrayed

The Post-It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Legal Route to Finding Answers

- System favours defendants
- Disempowerment of plaintiff
- Plaintiff takes huge personal risks
- “David and Goliath” experience
- Wearing-down process
- Lack of compassion

Court Ruling

"It is very clear to me that Kevin

Murphy should not have died."

Judge Roderick Murphy at High Court Ruling
May 2004

Adverse Events and Healthcare Staffs???

A Wish List : Do it Right!

- Observe existing guidelines, best practice and SOP's.
  Be prepared to challenge each other in that regard
- Following adverse outcomes undertake "root cause analysis" "system failure analysis"/"critical incident investigation".
- Communicate effectively within the medical community
  and with patients
- Keep impeccable records and refer constantly to those records
- Listen to and respect patients and families
- Know your personal limitations
- Replicate what is good and be always vigilant for opportunities to improve.

ACKNOWLEDGE ERROR AND ALLOW LEARNING TO OCCUR

A Wish List Contd

- Learn and disseminate that learning
- Practice dialogue and collaboration – meaningful engagement with patients and families
- Create a coalition of healthcare professionals and patients
- Be honest and open and seize the opportunity to give some meaning to tragedy
- It could not happen here
  – **5 most dangerous words**

ACKNOWLEDGE ERROR

AND ALLOW LEARNING TO OCCUR

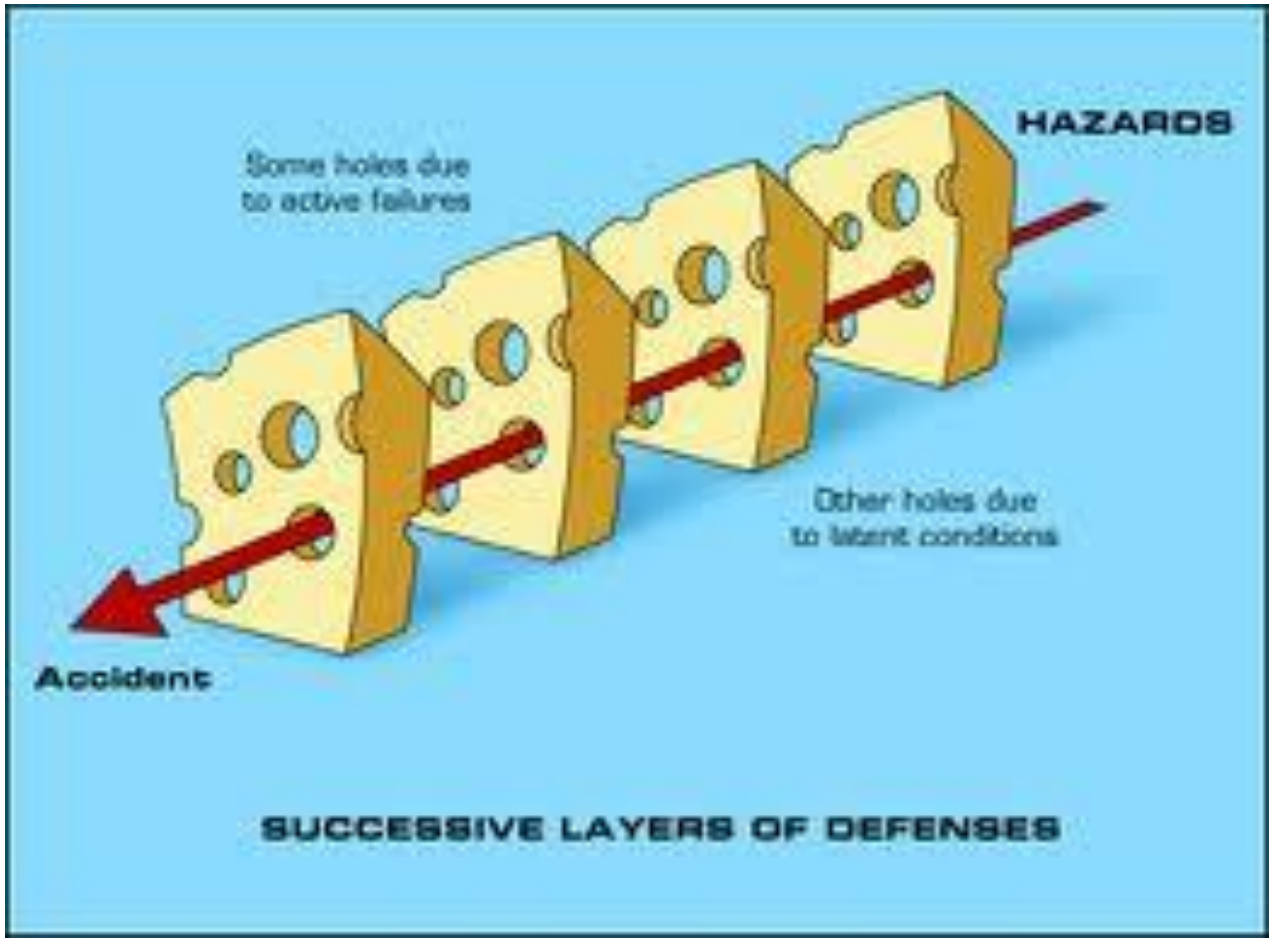
The Way Forward
- Barriers to Progress -

- Inappropriate responses and their role in relation to fuelling confrontation?
- Inaccessibility of partnership and collaborative opportunities to ordinary patients and families
- The culture of medical practice - a perception of infallibility and faultless performance
- Fears relating to litigation and loss of reputation.
- Excluding the patient and family from the change process.
- Neglecting to learn from industry

A Better Way

Sir Liam Donaldson, Chair, WHO World Alliance for Patient Safety

The Swiss Cheese Model



Preserving The Trusting Relationship

DIALOGUE = POWERFUL CONVERSATION

Responding to the Deteriorating Patient
- A Resolution Going Forward -

More than anything,
what distinguishes
the great from the mediocre,
is not so much that they fail less,
it is that they rescue more.

- Atul Gawande

"To err is human,
to cover up is unforgivable
but to fail to learn is inexcusable."

-Sir Liam Donaldson,Chair, WHO Patient Safety