Deteriorating Patient Condition Across the Healthcare Spectrum

Canada's Virtual Forum on
Patient Safety & Quality Improvement
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Polly Stevens
VP, Risk Management
pstevens@hiroc.com

Disclosure

http://www.tashachawner.com

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  - MDs in leadership
  - Regulatory colleges,
  - National associations
- We are not-for-profit
- We are **passionate** about patient safety

Failure to Detect Deteriorating Patient Condition…

http://www.scireq.com

- Why so Important?
- …so challenging?
- Learning from failures
- Promising ideas

November 2014

Los Angeles Times

Joan Rivers death: Clinic committed errors, report finds

NBC NEWS

State: Joan Rivers' Doctors 'Failed to Identify Deteriorating Vital Signs'

Failure to Detect Deteriorating Patient Claims

Sector	Claims Costs
Acute Care	#2
Home Care	#2
Community Health	#3
Mental Health	#10
Nursing/Personal Care Homes, Long Term Care	#11
Chronic/Complex Continuing/Rehab	#12

Case 1

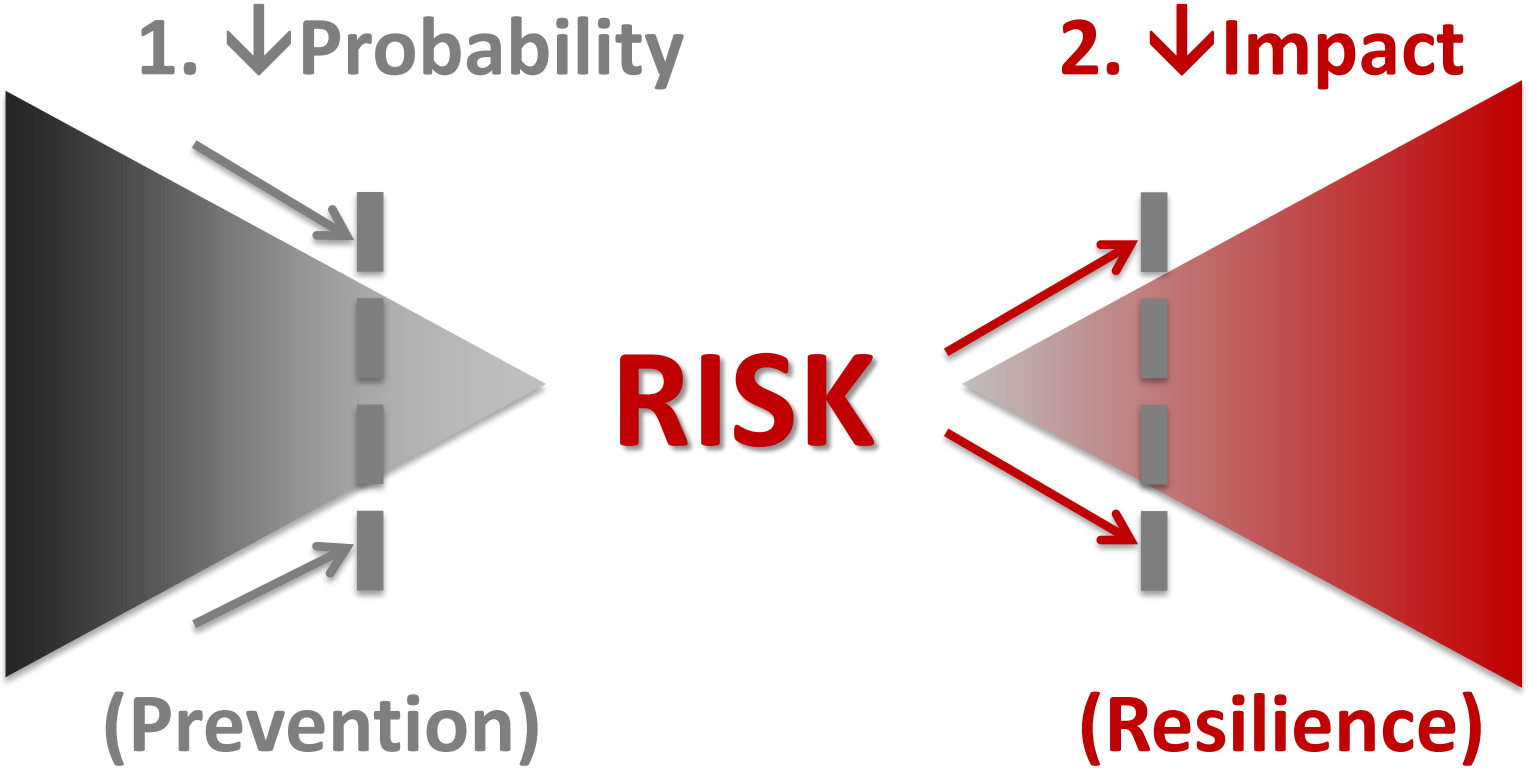
- Elderly patient for a lap chole
- Post op orders did not include higher level of observation (required due to age/history)
- Vital signs were not recorded for an extended period of time
- When recorded, deteriorating vital signs not reported to the attending physician
- Patient suffered a hemorrhage
- Cardiac arrest, ICU, death

Case 2

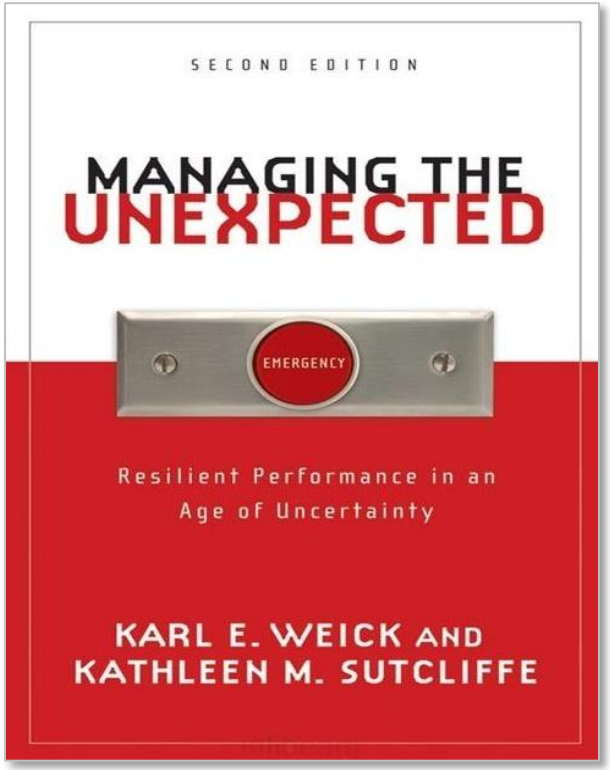
- Patient with a PEG feeding tube
- Family observed stomach distension and notified the healthcare team
- Concerns not immediately investigated
- Tube found to have displaced from the stomach
- Feeds entered the peritoneal cavity over several days
- Patient suffered septic shock
- Coma for several months, death

The Risk “Molecule”

Two Options for Managing Risks

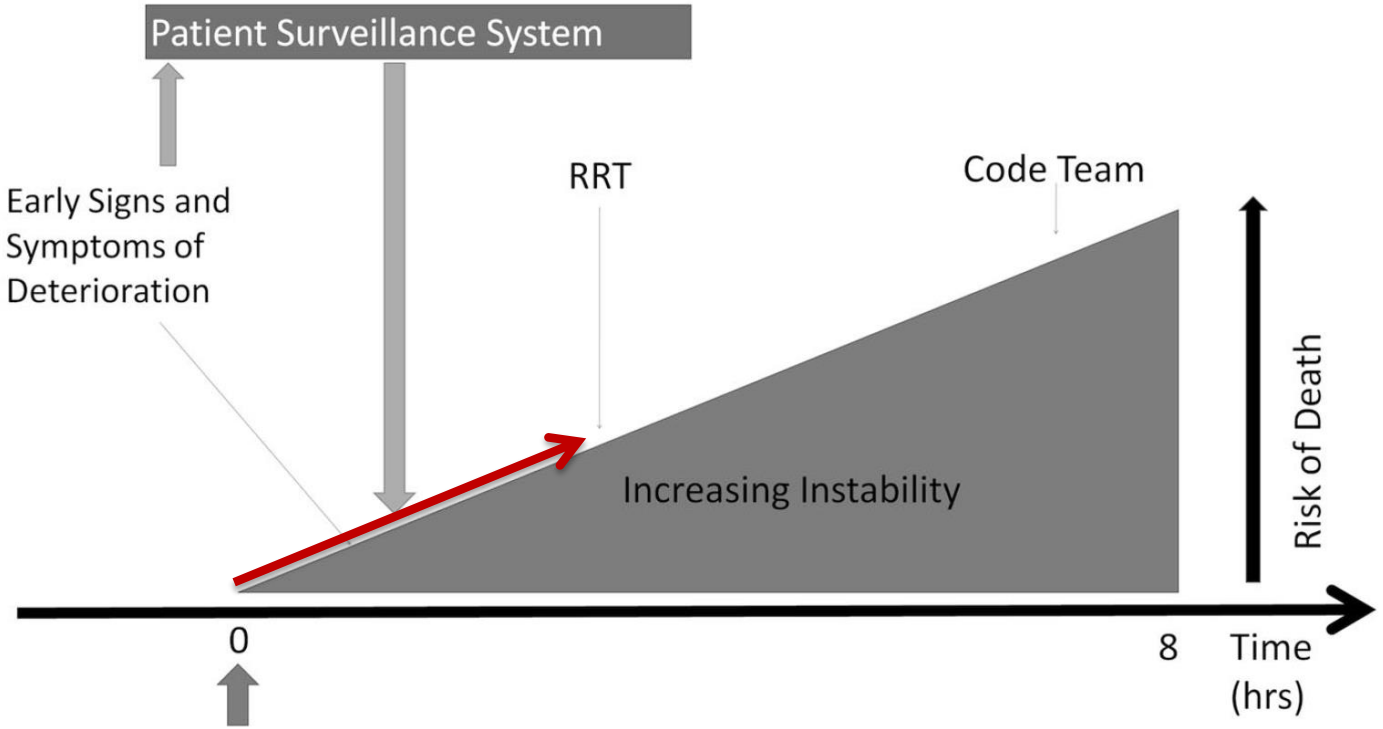


Second Option – Key to High Reliability



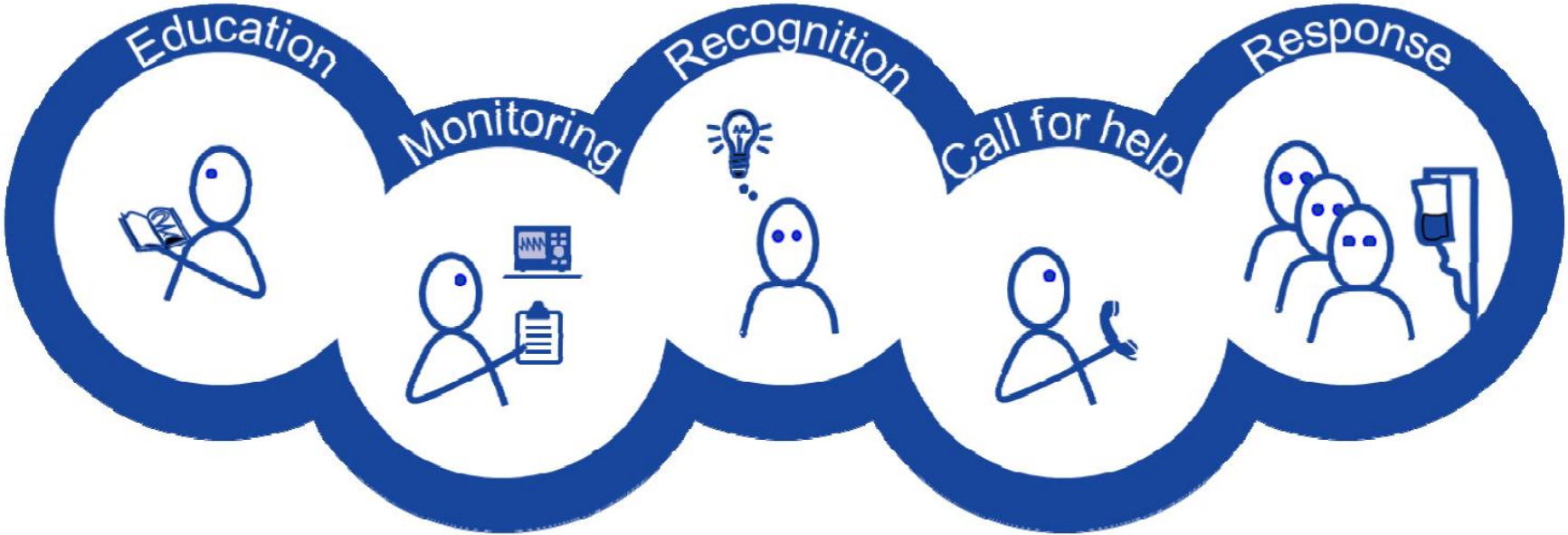
"The only realistic goal is **resilience** - to develop a maximum capability to catch, correct, and learn from surprises as they arise"

Deteriorating Patient Condition – the Plan



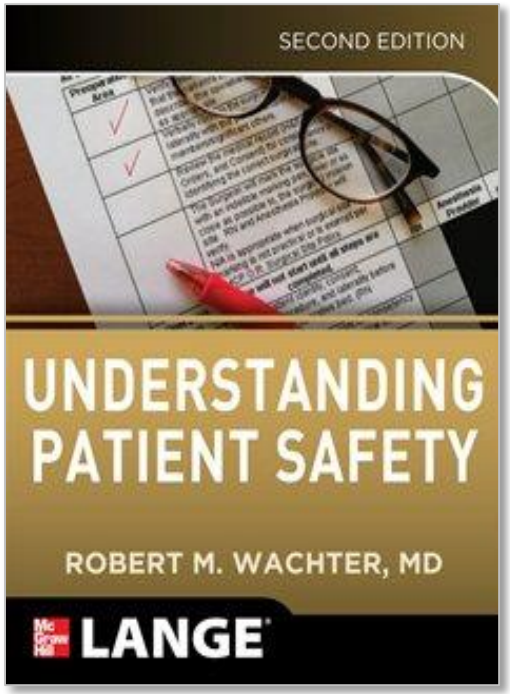
Taenzer. Anesthesiology (2011).

Simple, Yet Surprisingly Complex…



Smith. Resuscitation (2010).
"Chain of Prevention"

Learning From Claims

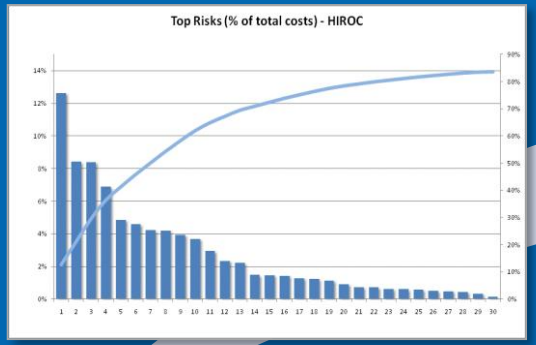


Wachter (2012).

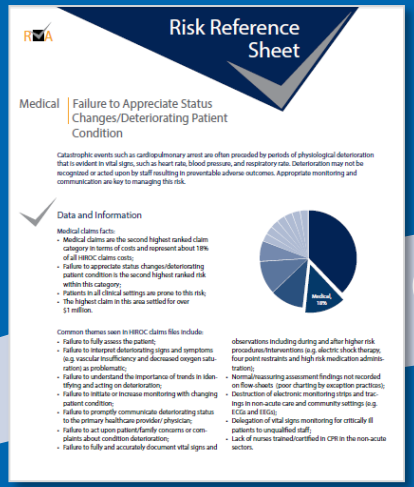
"…A maddening aspect of the malpractice system: it is so politically charged that its potential as a **rich source of patient safety knowledge and wisdom** generally goes untapped."

HIROC's Approach

"Learning from Failures"



Risk Ranking



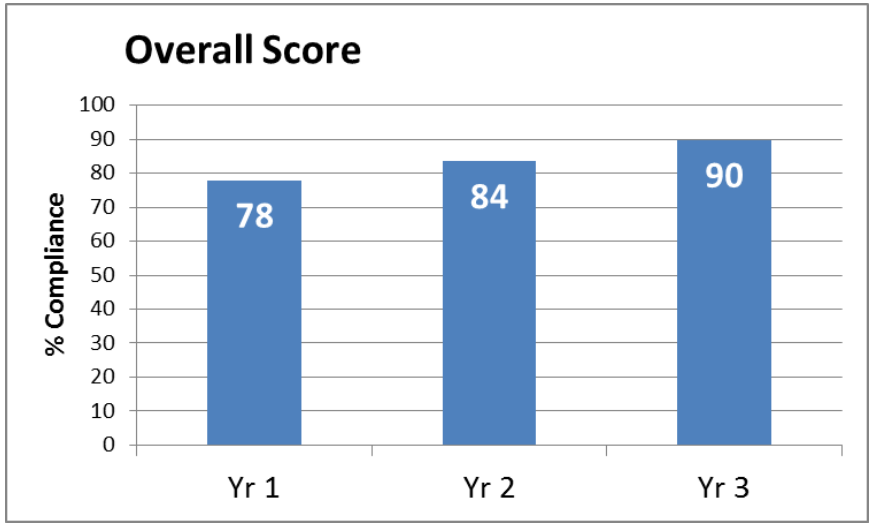
Risk Reference Sheets

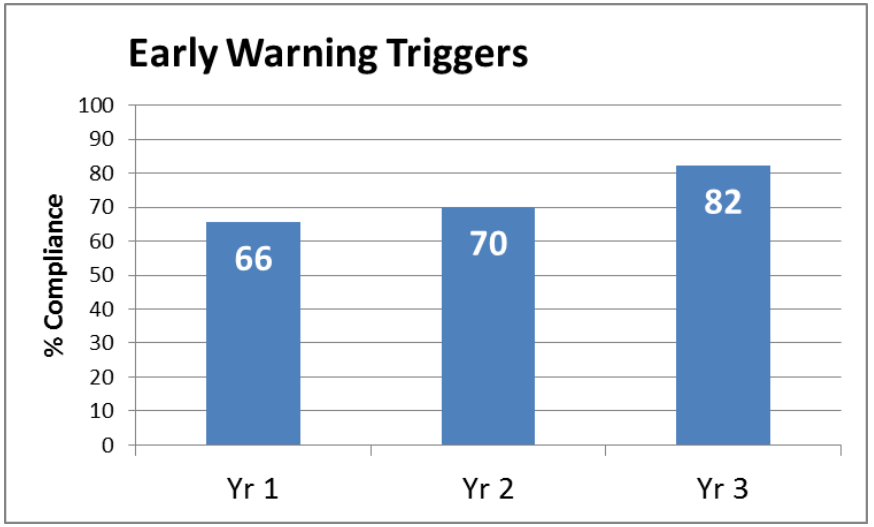
Risk Assessment Checklists

"Scale and Spread"

Risk Assessment Checklists Results – 1

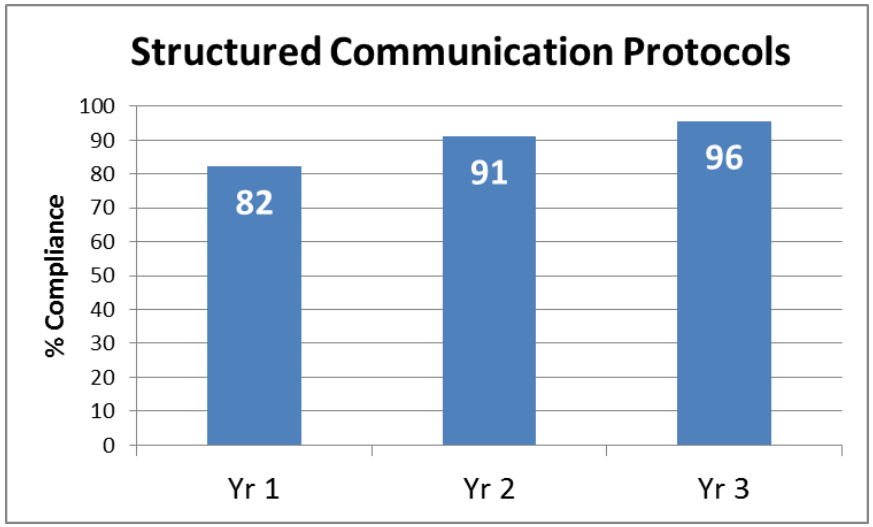
Failure to Detect Deteriorating Patient Condition

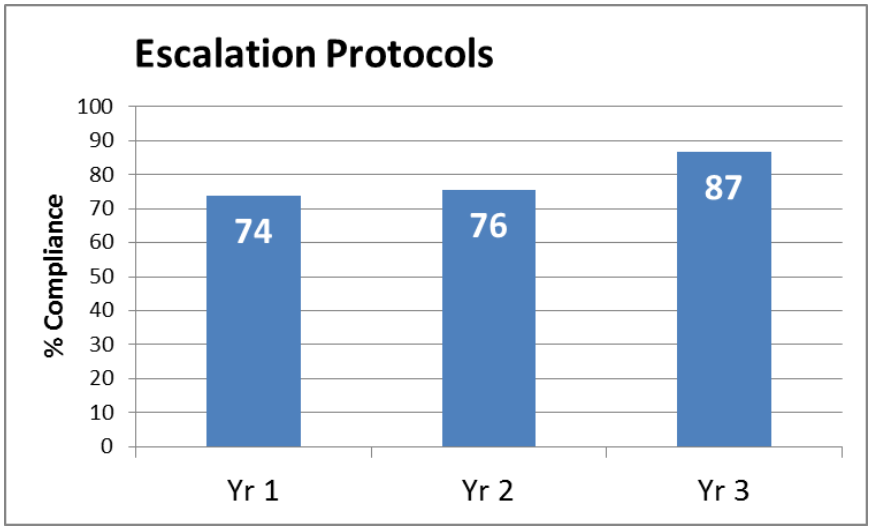




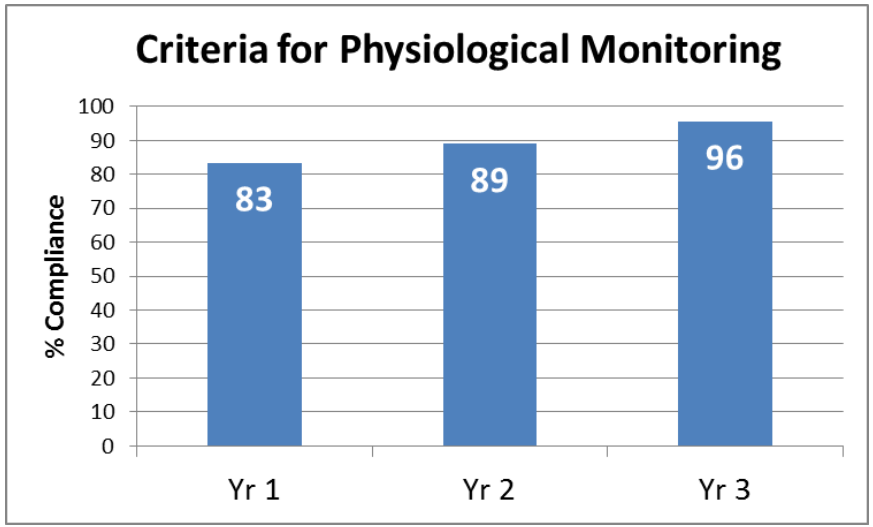
N= 41 hospitals

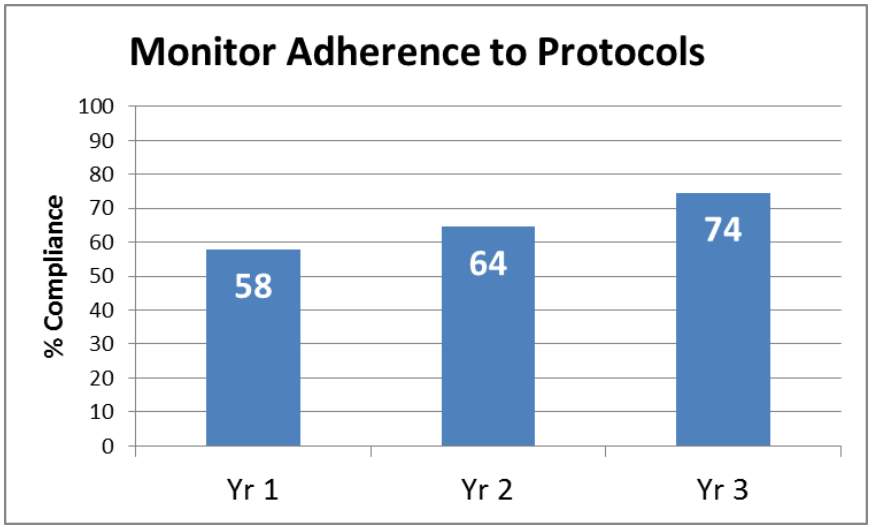
RAC Results – 2





RAC Results – 3





RAC Results – Top "Areas of Focus"

Risk	Rank
Failure to Provide Adequate Discharge/Follow-up Instructions	#1
Failure to Detect Deteriorating Patient Condition	#2
Patient Falls	#3
Medication Adverse Events	#4
Healthcare Acquired Pressure Ulcers	#5

Promising Idea: **Listening to Patients & Families**

EDITORIAL

The wisdom of patients and families: ignore it at our peril

Liam J Donaldson

Correspondence to
Professor Liam Donaldson, Department of Surgery and Cancer, Imperial College London, St Mary's Campus, London W2 1NY, UK; l.donaldson@imperial.ac.uk

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CrossMark

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PATIENT-REPORTED INCIDENTS HELP TO UNDERSTAND AND REDUCE HARM

Health system leaders, and those managing healthcare organisations, are increasingly trying to find the right way to use the views and experience of patients to make the services that they provide better and safer. The traditional path is to start with data. But the days when a provider of care could pride itself as being patient-centred purely by capturing patient feedback on its services have long gone. Today, the emphasis is on outcomes defined by patients: so-called patient-reported outcome measures.[1] For example, *The International Consortium for Health Outcomes Measurement*[2] defines outcome as: 'The results people care about most when seeking treatment, including functional impairment and the ability to live normal, productive lives'.

There can be no area that people receiving health services should care more deeply about than being protected from the risk of avoidable harm. For the past decade, governments, health systems, providers of care and professional bodies around the world have placed a great deal of faith in incident reporting systems as the main route to safer care. Large volumes of such reports have been accumulated: in England and Wales, for instance, the database of patient safety incidents stands at 12 million.[3] Yet, taking a global perspective, there are too few examples of where a sustained reduction in risk can be unambiguously attributed to the fruitful analysis of incident data. Some question the purpose of continuing to invest time and money in this endeavour, while others believe that the potential can still be realised.[4]

Frontline healthcare professionals submit the majority of all incident reports; the narrative elements describing the failure of care are based on their insights. Understandably, such accounts are generally factual, clinical and technical. Feelings and emotions play little part in conveying what can be dramatic and life-changing events for patients and families. This latter aspect of harm tends to be captured in what the patient safety world terms 'patient stories', first-hand accounts by those who have been the victims, communicated in papers, in books and at conferences,[5] but which are separate from the routine, daily flow of incident reports.

A study based on patient-reported adverse event data,[6] gathered on a voluntary basis, provides a comparison with research reports based on traditional patient safety incident data.[7] There are limitations: under-reporting, selectivity and lack of a reliable denominator—but these are also present in many studies based on reporting by clinical staff. What is remarkable about the analysis of these patient-initiated reports is that it shows broad consistency with the major categories of harm captured in established patient safety reporting systems (eg, healthcare-associated infection, medication error, misdiagnosis, wrong-site surgery) while also capturing the psychological, social and economic impact. The relatively small sample size and limited geographical coverage mean that caution is necessary in claiming universality of the messages, but the findings will ring many bells with those in the field of patient safety.

For those of us who have listened with deep concern to many individual accounts by patients and family members in conference presentations or during private conversations, it is particularly chilling to see how the aggregated experience of this study is so similar to the poignant individual accounts. It confirms the very strong impression that too many healthcare organisations espouse the goal of safer care while regarding harm as the cost of doing business. A failure of providers to respond appropriately to the suffering that they have caused, a sense of

Donaldson. BMJ Qual Saf (2015).

Promising Idea: **"Quadruple Aim"**

EDITORIAL

The Quadruple Aim: care, health, cost and meaning in work

Rishi Sikka,[1] Julianne M Morath,[2] Lucian Leape[3]

[1]Advocate Health Care, Downers Grove, Illinois, USA
[2]Hospital Quality Institute, Sacramento, California, USA
[3]Harvard School of Public Health, Boston, Massachusetts, USA

Correspondence to
Dr Rishi Sikka, Advocate Health Care, 3075 Highland Avenue, Suite 600, Downers Grove, IL 60515, USA; rishi.sikka@advocatehealth.com

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CrossMark

To cite: Sikka R, Morath JM, Leape L. BMJ Qual Saf 2015;24:608–610.

In 2008, Donald Berwick and colleagues provided a framework for the delivery of high value care in the USA, the Triple Aim, that is centred around three overarching goals: improving the individual experience of care; improving the health of populations; and reducing the per capita cost of healthcare.[1] The intent is that the Triple Aim will guide the redesign of healthcare systems and the transition to population health. Health systems globally grapple with these challenges of improving the health of populations while simultaneously lowering healthcare costs. As a result, the Triple Aim, although originally conceived within the USA, has been adopted as a set of principles for health system reform within many organisations around the world.

The successful achievement of the Triple Aim requires highly effective healthcare organisations. The backbone of any effective healthcare system is an engaged and productive workforce.[2] But the Triple Aim does not explicitly acknowledge the critical role of the workforce in healthcare transformation. We propose a modification of the Triple Aim to acknowledge the importance of physicians, nurses and all employees finding joy and meaning in their work. This 'Quadruple Aim' would add a fourth aim: improving the experience of providing care.

The core of workforce engagement is the experience of joy and meaning in the work of healthcare. This is not synonymous with happiness, rather that all members of the workforce have a sense of accomplishment and meaning in their contributions. By meaning, we refer to the sense of importance of daily work. By joy, we refer to the feeling of success and fulfilment that results from meaningful work. In the UK, the National Health Service has captured this with the notion of an engaged staff that 'think and act in a positive way about the work they do, the people they work with and the organisation that they work in'.[3]

The evidence that the healthcare workforce finds joy and meaning in work is not encouraging. In a recent physician survey in the USA, 60% of respondents indicated they were considering leaving practice; 70% of surveyed physicians knew at least one colleague who left their practice due to poor morale.[2] A 2015 survey of British physicians reported similar findings with approximately 44% of respondents reporting very low or low morale.[4] These findings also extend to the nursing profession. In a 2013 US survey of registered nurses, 51% of nurses worried that their job was affecting their health; 35% felt like resigning from their current job.[5] Similar findings have been reported across Europe, with rates of nursing job dissatisfaction ranging from 11% to 56%.[6]

This absence of joy and meaning experienced by a majority of the healthcare workforce is in part due to the threats of psychological and physical harm that are common in the work environment. Workforce injuries are much more frequent in healthcare than in other industries. For some, such as nurses' aides, orderlies and attendants, the rate is four times the industrial average.[7] More days are lost due to occupational illness and injury in healthcare than in mining, machinery manufacturing or construction.[7]

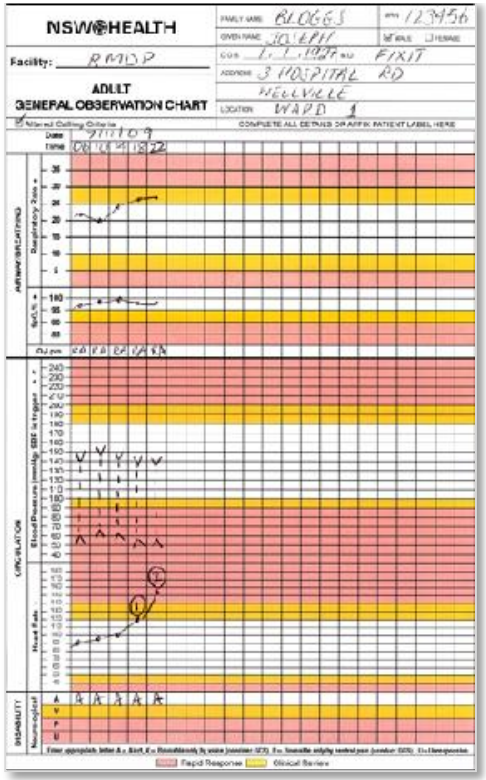
The risk of physical harm is dwarfed by the extent of psychological harm in the complex environment of the healthcare workplace. Egregious examples include bullying, intimidation and physical assault. Far more prevalent is the psychological harm due to lack of respect. This dysfunction is compounded by production pressure, poor design of work flow and the proportion of non-value added work.

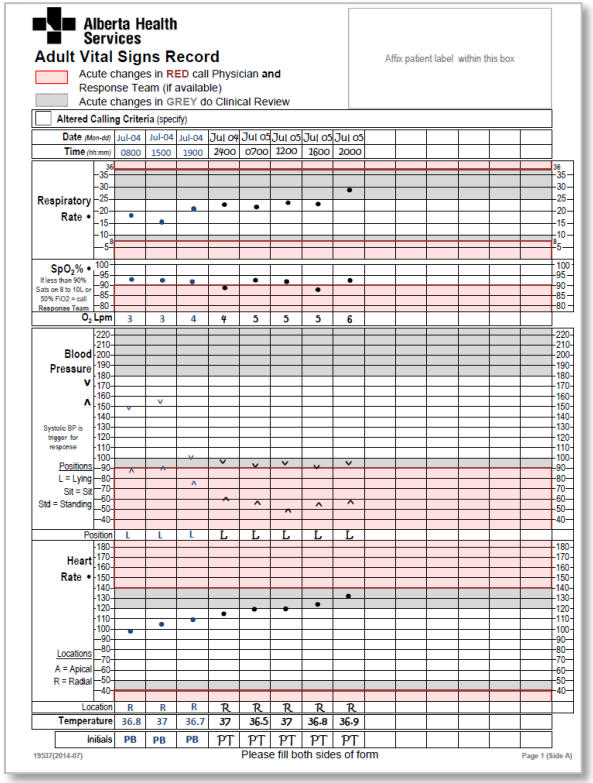
The current dysfunctional healthcare work environment is in part a by-product of the gradual shift in healthcare from a public service to a business model that occurred in the latter half of the 20th

Sikka. BMJ Qual Saf (2015).

Promising Idea: **Vital Signs Charting Visual Cues**

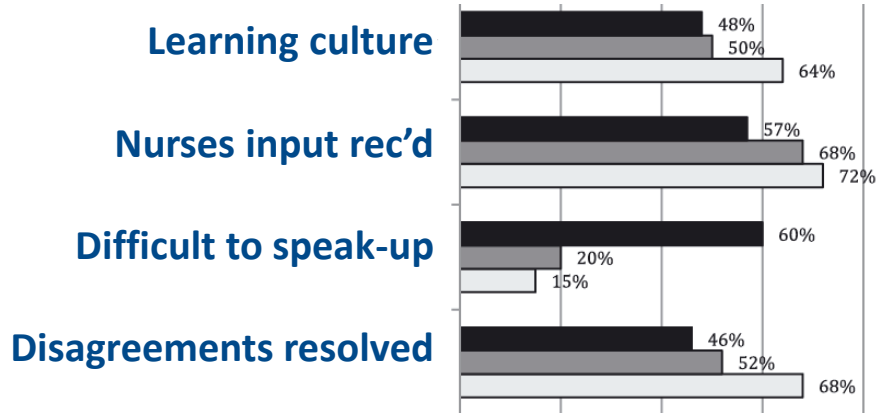
Between the Flags
Keeping patients safe

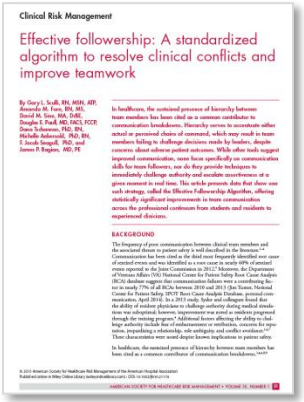




jason.laberge@ahs.ca

Promising Idea:
“Effective Followership” (AKA Escalation)

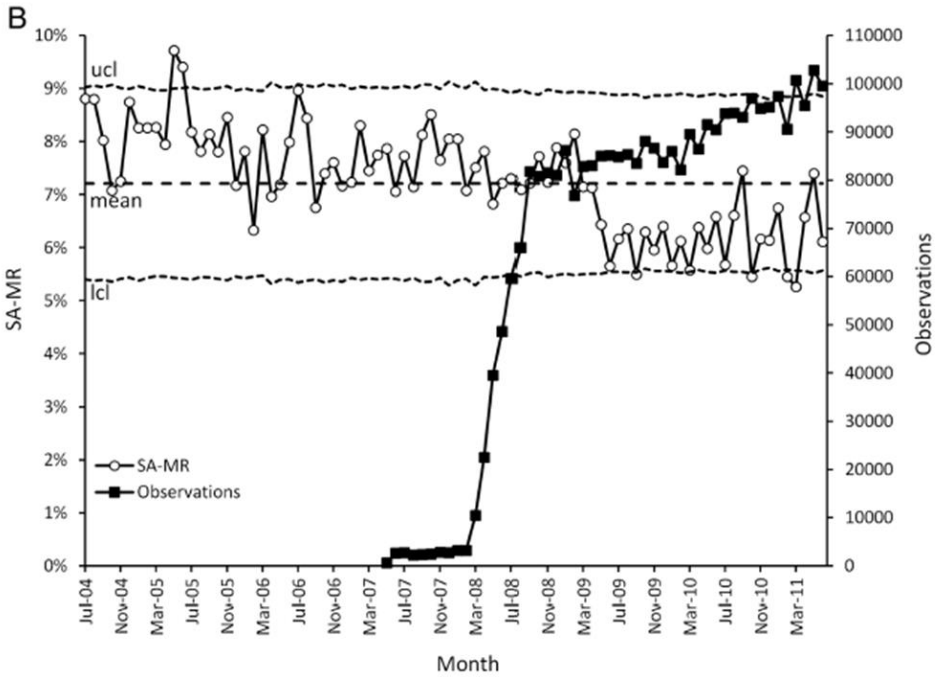



Clinical Risk Management

Effective followership: A standardized algorithm to resolve clinical conflicts and improve teamwork

Sculli. J HC RM (2015).

Promising Idea: **Electronic Physiological Surveillance Systems (EPPS)**



Impact of introducing an electronic physiological surveillance system on hospital mortality

Schmidt. BMJ Qual Saf (2015).

Knowledge Brokering

RISK WATCH – October 2015

HIROC

Selected research, publications, and resources to promote evidence-informed risk management in Canadian healthcare organizations. Prepared by Healthcare Risk Management staff at the Healthcare Insurance Reciprocal of Canada (HIROC). Titles with an open lock icon ( ) indicate that a publication is open access. For all others a subscription or library access is required; the librarian at your organization may be able to assist you. Please contact riskmanagement@hiroc.com for assistance if required.

Hot Off the Press

STAFF ENGAGEMENT/BURNOUT **The Quadruple Aim: care, health, cost and meaning in work**

Sikka R, Morath J, Leape L. *BMJ Qual Saf.* 2015 (October);24(10):608-10.

Editorial proposing that "improving the experience of providing care" be added to the triple aim – "improving the individual experience of care"; "improving the health of populations"; and, "reducing the per capita cost of healthcare".

"This absence of joy and meaning experienced by a majority of the healthcare workforce is in part due to the threats of psychological and physical harm that are common in the work environment... Complex, intimate caregiving relationships have been reduced to a series of transactional demanding tasks, with a focus on productivity and efficiency, fuelled by the pressures of decreasing reimbursement" (p. 608-09).

SECOND VICTIMS **Wisdom in medicine: what helps physicians after a medical error?**

Plews-Ogan M, May N, Owens J, et al. *Acad Med.* 2015 (September online):1-9.

Article examining factors helping physicians gain wisdom after a harmful error. Using 'posttraumatic growths' as a model, semi-structured interviews of 61 physicians in the US who made serious mistakes were conducted. Results showed: a mean elapsed time since the error of 8 years; 60% participated in disclosure; only 10% received disclosure training prior to the error; 21% reported that lawsuit was filed; and 74% of the physicians scored as 'wisdom exemplars'. Exemplars were more likely to report disclosing the error and strongly identified with the statement, "My experience of coping with a medical error has made me a wiser person". Eight key coping strategies from the exemplars are provided in narrative/ vignette and tabular format.

HAND HYGIENE **Why even good physicians do not wash their hands**

Redelmeier D, Shafir E. *BMJ Qual Saf*, 2015 (July online):1-4.

Article by Canadian lead author, highlighting the behavioural factors that explain ongoing non-compliance with hand hygiene among well-intentioned physicians. Factors are described in three ways: affective, cognitive, and social. Affective factors include: lack of positive reinforcement; recurring inconvenience; and hardly any sense of accomplishment or sense of certainty. Cognitive factors include: recurrent monotony; divided attention (e.g. focusing on a demanding situation at the same time hand washing should be completed); and faulty memory. Social factors include: insufficient prestige including the inadequate enforcement of norms. The authors present practical recommendations to help improve hand hygiene programs.

The content does not necessarily reflect HIROC's views. For queries contact riskmanagement@hiroc.com 1

riskmanagement@hiroc.com

“Harm is the tuition paid on a safer healthcare system.” Berwick, 2012

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