World Health Organization | Patient Safety

A World Alliance for Safer Health Care

Patients for Patient Safety

Margaret Murphy,
Patient Advocate
External Lead Advisor
Patients for Patient Safety
WHO Patient Safety

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

Person Centred Health and Care
Learning Session
Glasgow, 28th May 2014

- THE PATIENT EXPERIENCE AS A CATALYST FOR CHANGE -

INTRODUCTION

- The heart of healthcare – the patient experience
- The significance of the professional in the life of the patient
- The responsibility and privilege attaching to being a healthcare professional
- The patient as a resource
- The case for involvement
- Patient and Family – constant in continuum of care – with greatest vested interest in the outcome
- The Report Safety First 2006

INTERNATIONAL INSIGHTS
- Patient Safety and Safety Culture -

"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

The time is Now. If health and/or healthcare is on the table, then the consumer (public, patient, family member) must be at the table, every table. NOW. *Lucian Leape*

"Knowledgeable patients, receiving safe and effective care, from skilled professionals, in appropriate environments and with assessed outcomes" *Irish Commission on PS & QA*

THE EMPOWERING AND ENABLING PARTNERSHIP
The Patient Experience as a Catalyst for Change

Making the Status Quo Uncomfortable

while

Making the Future Attractive

J Conway, Senior VP, IHI

There is one thing worse than being blind

And that is having sight but no vision

J Conway, Senior VP, IHI

The Business of Care
- The Expectation -

- Culture of openness, transparency, true professionalism
- Aiming for trustworthiness
- Results of Medical Council Survey
- The Doctor-Patient Relationship

PERSONAL MOTIVATION
- THE BURNING QUESTION -

A Patient Journey

Can a Tragic Outcome

be a Catalyst for Change?

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)

The Effectiveness of the Story

"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 Mahonotte Cork	Male	Single	21 yrs.		Multi-organ failure Hypercalcaemia Parathyroid tumour certified	daniel J. Gillis occupier Cork University Hospital	Third November 1999	S. Scallagher 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 Bliain 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 NOV 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 Mag PH: V
12/4/98
CAL 5.73
Sod. 138
Pot 3.6
Urea 9.9 (Hi)
Creatin 214
Gluc 5.6
alb. 49
Bili. 24
Alk. Phos 8.5
AST 0.4
LDH 6.2
LIPOSTAT
Hydrophilic Pravastatin Sodium
CHOL 5.6
UNTR 685

Every Point of Contact Failed Him…

The Shortcomings
Primary Care

- 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

The Shortcomings
Secondary Care

- 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

- Initial humane reaction from individuals
- Damage limitation
- Absence of transparency, disclosure, honest dialogue

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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

Open Disclosure

- Disclosure ≠ BLAME – accepting blame, apportioning blame.
- Disclosure = INTEGRITY, DEMONSTRATION OF TRUE PROFESSIONALISM

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!
For Individual Practitioners

- Observe existing guidelines, best practice and SOP's.
  Be prepared to challenge each other in that regard
- Listen to and respect patients and families
- Know your personal limitations
- Keep impeccable records and refer constantly to those records
- Communicate effectively within the medical community
  and with patients

ACKNOWLEDGE ERROR AND ALLOW LEARNING TO OCCUR

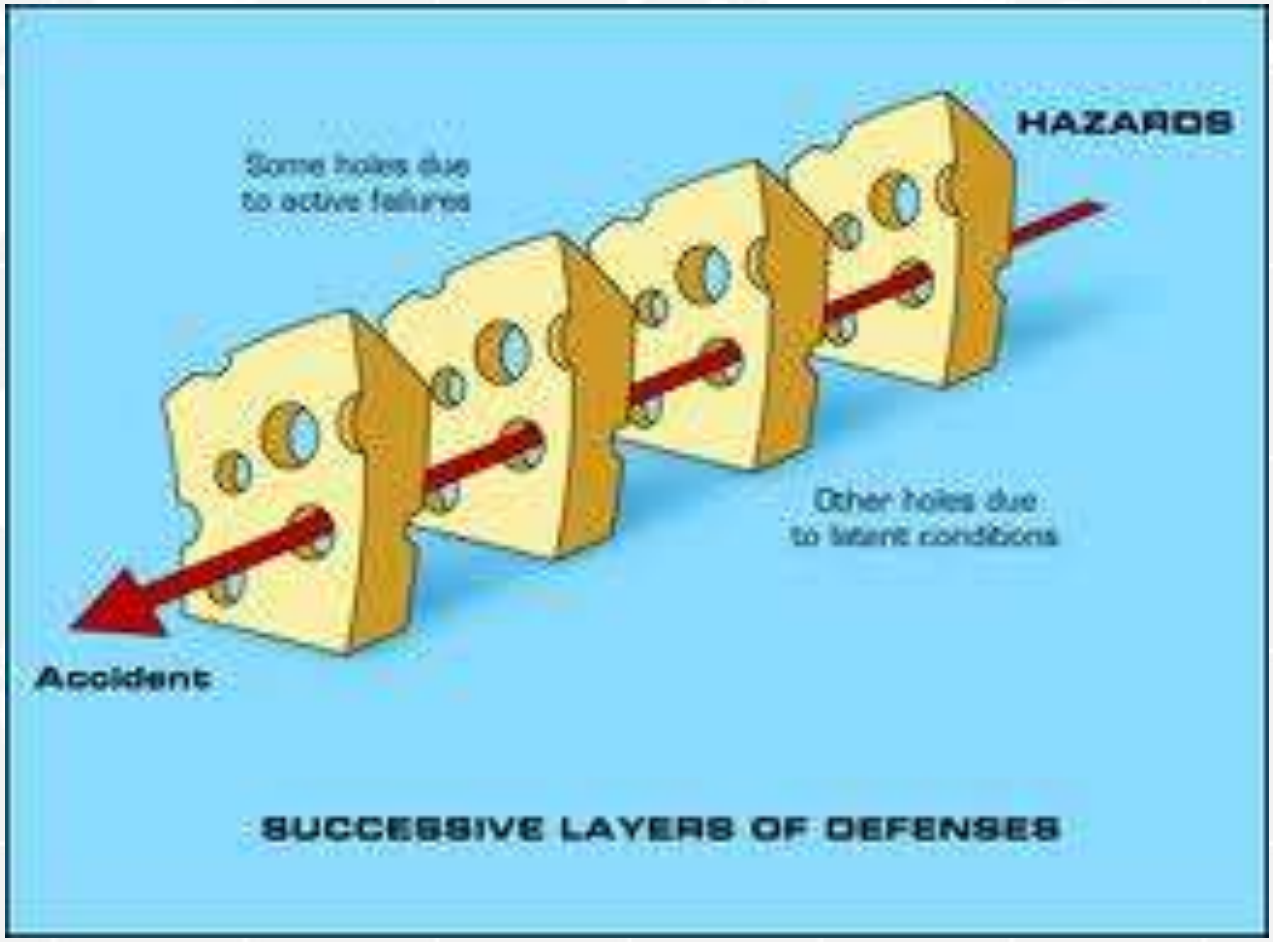
A Wish List
For Individuals, Organisations & System

- Following adverse outcomes undertake “root cause analysis” "system failure analysis"/"critical incident investigation”.
- Replicate what is good and identify opportunities to improve.
- 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

A Better Way

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



The Swiss Cheese Model

Systems and Culture

Personal Responsibility

System Failure

The role of the individual

Who designs, maintains and can change the system?

An effective safety culture – adherence to protocols, commitment to hipocratic oath and ethical guides, practice inclusively, transparent, open culture which allows learning and healing to occur.

Partnership and Collaboration

DIALOGUE

=

POWERFUL CONVERSATION

Patient Safety – A Final Reflection

Addressing the challenge of translating Aspiration into Reality

"Safety is a core value,

not a commodity that can be counted.

Safety shows itself only

*by the events that **do not** happen*

Erik Hollnagel

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