CUMMING SCHOOL OF MEDICINE

UNIVERSITY OF CALGARY

Patient Safety 101

W. Ward Flemons MD FRCPC

Professor of Medicine, U of C

Medical Director, HQCA

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Overview

1. Why I am here

2. A bit of history

3. 4 big questions about patient safety
    - why does healthcare break?
    - how do you make care safer?
    - how do you respond when healthcare breaks?
    - how do you create / promote a safety culture?

4. Putting it all together

Why I am here

Why I am here

CONTINUITY OF PATIENT CARE STUDY

December 19, 2013

http://hqca.ca/studies-and-reviews/continuity-of-patient-care-study/

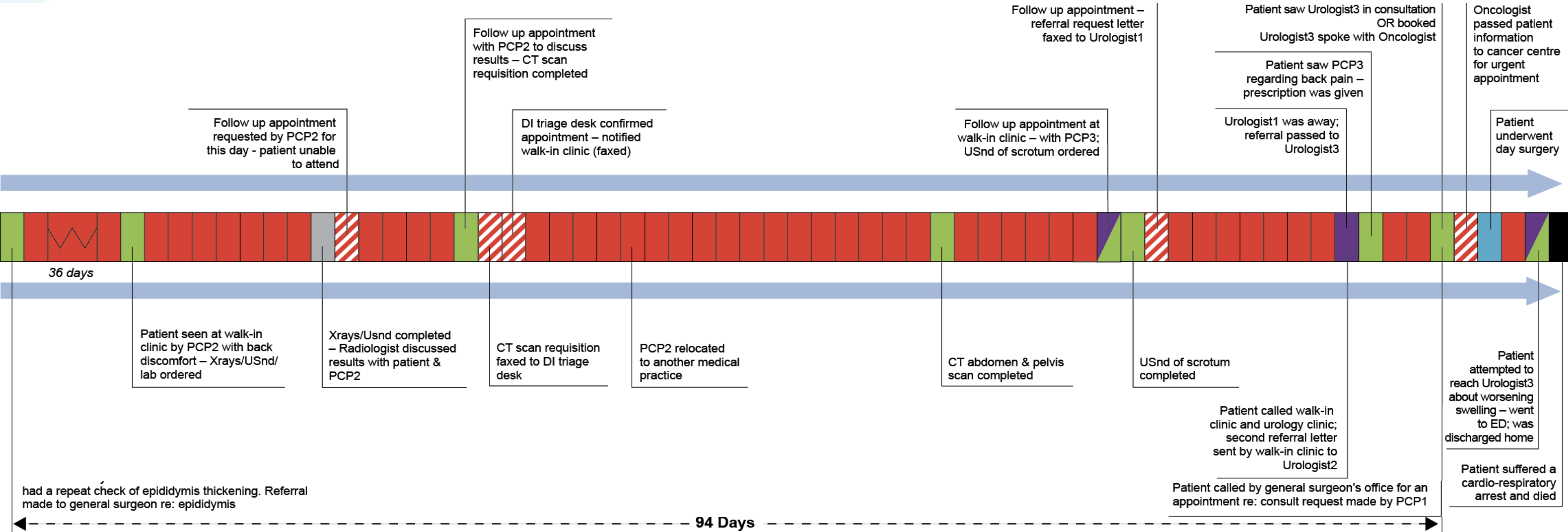
Greg’s quotes to live by

“The men who try to do something and fail are infinitely better than those who try to do nothing and succeed.”

“My best friend is the one that brings the best out in me.”

“A century from now it will not matter what kind of car I drive, what kind of house I lived in or how much money I had in the bank… but one hundred years from now the world may be a better place because I was important in the life of a child.”

Greg's Journey



Why it is an important issue now

"Medicine used to be simple, ineffective, and relatively safe.

It is now complex, effective, and potentially dangerous."

Sir Cyril Chantler.

Principal, United Medical and Dental Schools of Guy's and St Thomas's Hospitals, and Chairman of the General Medical Council's Standards Committee

BMJ 1998;317:1666

Why it is an important issue now

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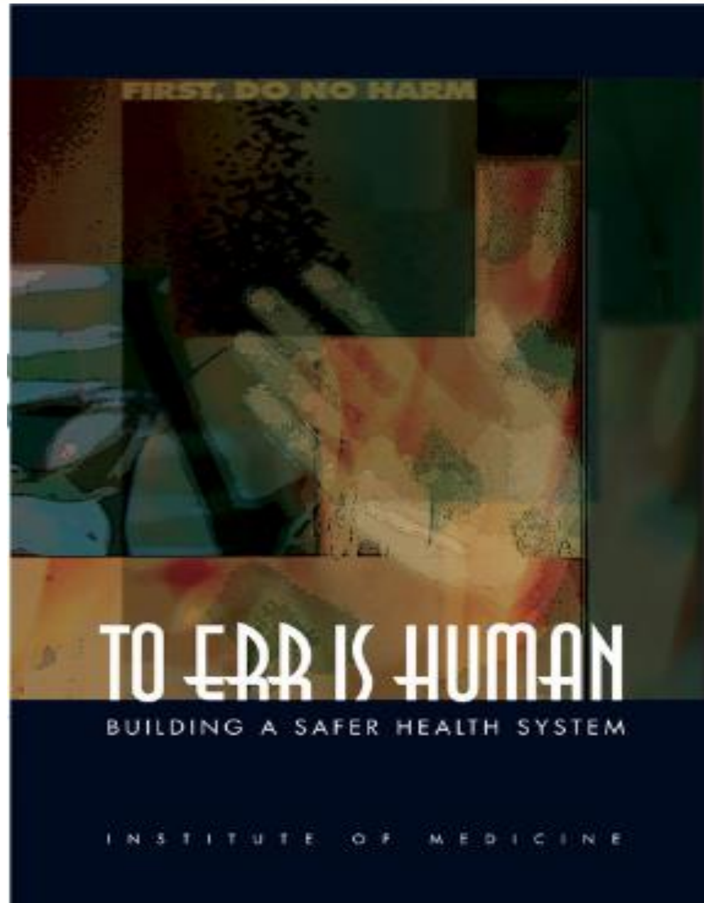

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A bit of history

SPECIAL ARTICLES

INCIDENCE OF ADVERSE EVENTS AND NEGLIGENCE IN HOSPITALIZED PATIENTS

Results of the Harvard Medical Practice Study I

Troyen A. Brennan, M.P.H., M.D., J.D., Lucian L. Leape, M.D., Nan M. Laird, Ph.D., Liesi Hebert, Sc.D., A. Russell Localio, J.D., M.S., M.P.H., Ann G. Lawthers, Sc.D., Joseph P. Newhouse, Ph.D., Paul C. Weiler, LL.M., and Howard H. Hiatt, M.D.

Abstract *Background.* As part of an interdisciplinary study of medical injury and malpractice litigation, we estimated the incidence of adverse events, defined as injuries caused by medical management, and of the subgroup of such injuries that resulted from negligent or substandard care.

Methods. We reviewed 30,121 randomly selected records from 51 randomly selected acute care, nonpsychiatric hospitals in New York State in 1984. We then developed population estimates of injuries and computed rates according to the age and sex of the patients as well as the specialties of the physicians.

Results. Adverse events occurred in 3.7 percent of the hospitalizations (95 percent confidence interval, 3.2 to 4.2), and 27.6 percent of the adverse events were due to negligence (95 percent confidence interval, 22.5 to 32.6). Although 70.5 percent of the adverse events gave rise to disability lasting less than six months, 2.6 percent caused permanently disabling injuries and 13.6 percent led to death. The percentage of adverse events attributable to negligence increased in the categories of more severe injuries (Wald test $\chi^2 = 21.04$, $P<0.0001$). Using weighted totals, we estimated that among the 2,671,863 patients discharged from New York hospitals in 1984 there were 98,609 adverse events and 27,179 adverse events involving negligence. Rates of adverse events rose with age ($P<0.0001$). The percentage of adverse events due to negligence was markedly higher among the elderly ($P<0.01$). There were significant differences in rates of adverse events among categories of clinical specialties ($P<0.0001$), but no differences in the percentage due to negligence.

Conclusions. There is a substantial amount of injury to patients from medical management, and many injuries are the result of substandard care. (N Engl J Med 1991; 324:370-6.)

How well do 'healthcare systems' do?

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The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada

G. Ross Baker, Peter G. Norton, Virginia Flintoft, Régis Blais, Adalsteinn Brown, Jafna Cox, Ed Etchells, William A. Ghali, Philip Hébert, Sumit R. Majumdar, Maeve O'Beirne, Luz Palacios-Derflingher, Robert J. Reid, Sam Sheps, Robyn Tamblyn

SPECIAL ARTICLE

The Quality of Health Care Delivered to Adults in the United States

Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H.

- Patients hospitalized in Canada
- 7.5% of patients had an adverse event
- 1/3 judged 'preventable'

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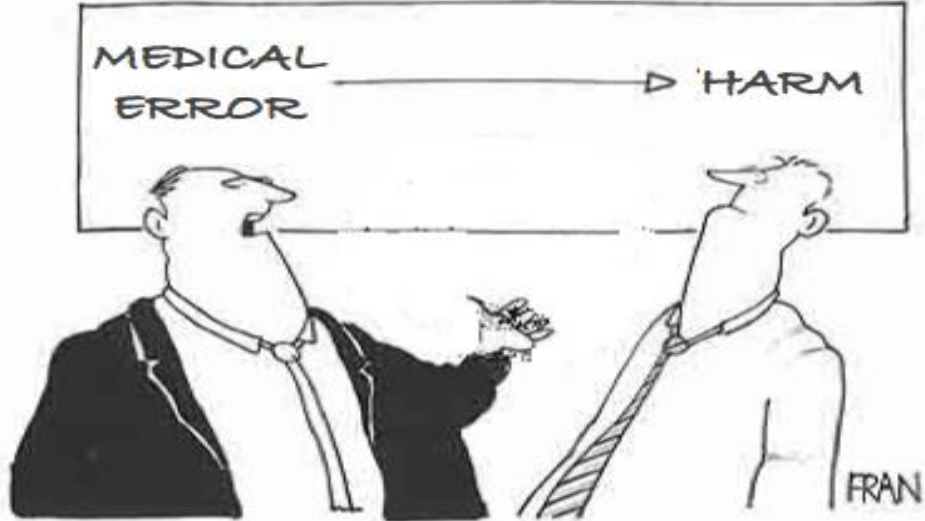
- Adults living in 12 US metropolitan centres
- Evaluation of 439 indicators of quality of care for:
- 30 acute / chronic conditions
- preventative care
- 54.9% received recommended care

Big questions about patient safety

1 Why does healthcare break?



"It's a simple model... but it works for me..."

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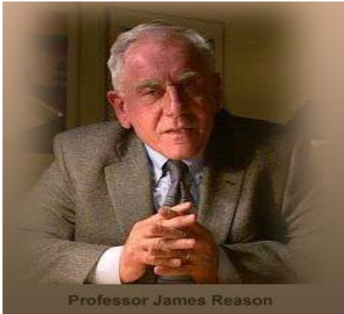

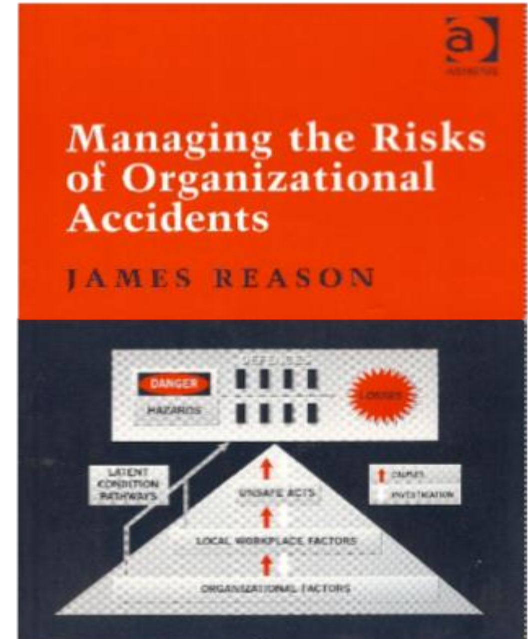

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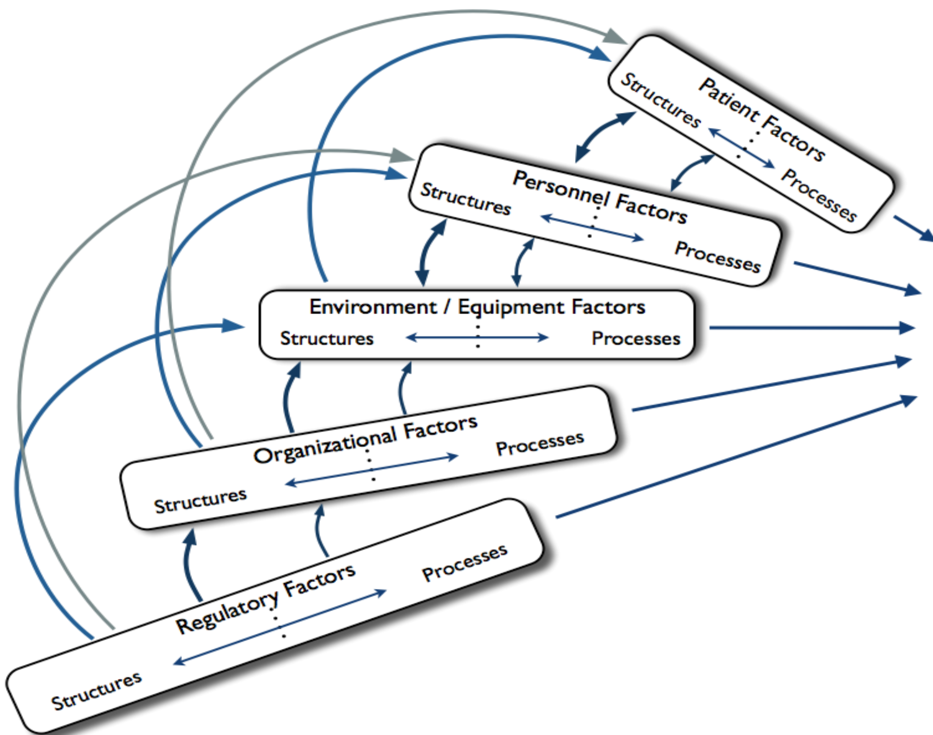
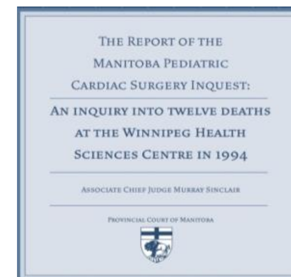
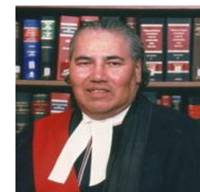



THE REPORT OF THE MANITOBA PEDIATRIC CARDIAC SURGERY INQUEST:

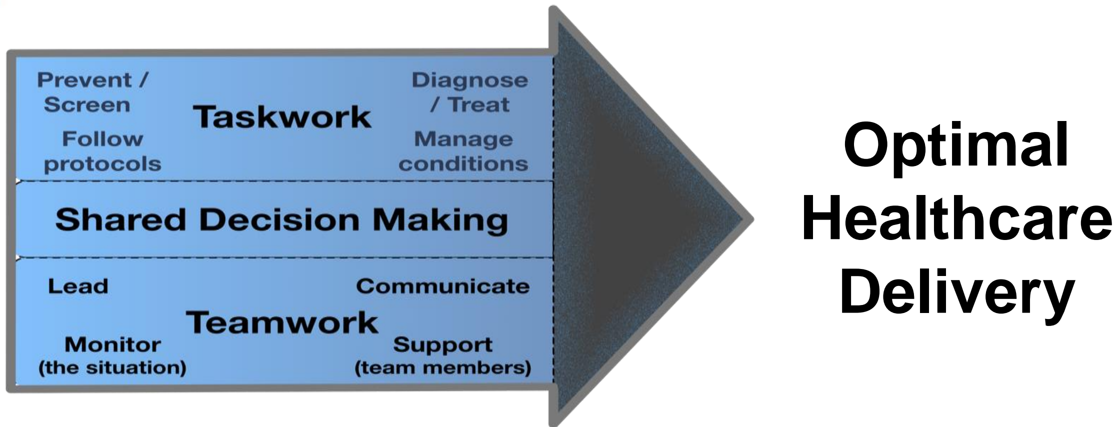
AN INQUIRY INTO TWELVE DEATHS AT THE WINNIPEG HEALTH SCIENCES CENTRE IN 1994

ASSOCIATE CHIEF JUDGE MURRAY SINCLAIR

PROVINCIAL COURT OF MANITOBA



2 How do you make care safer?



Optimal Healthcare Delivery

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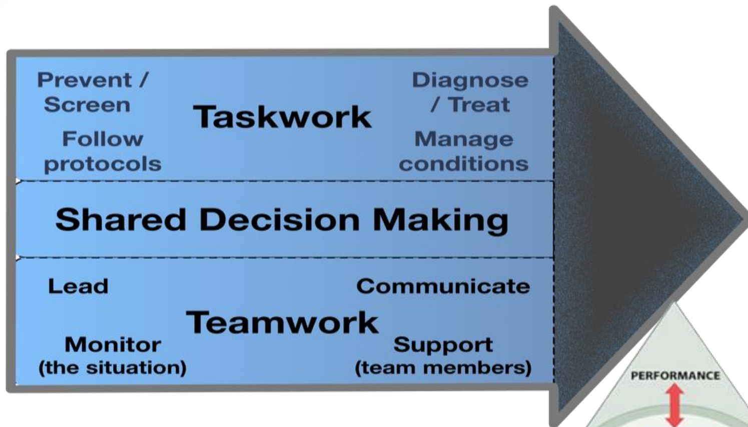

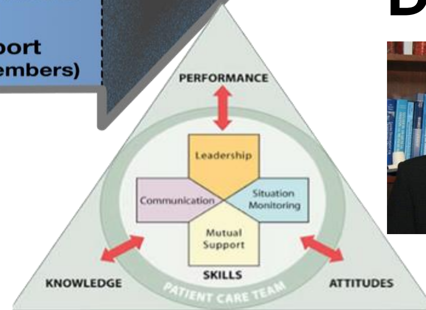

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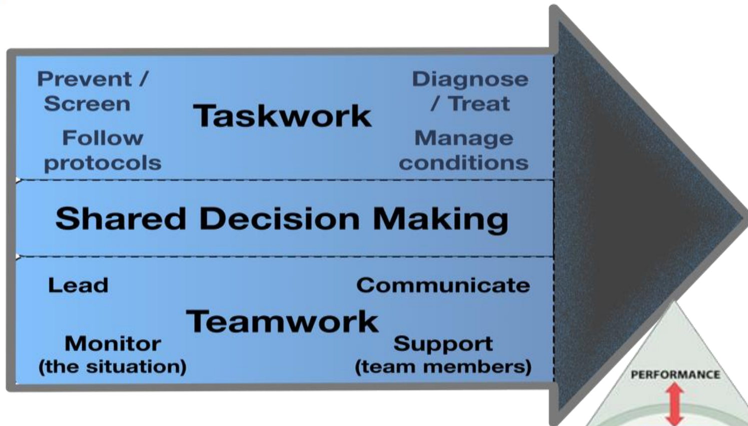

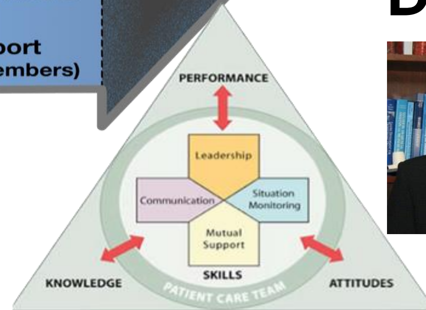

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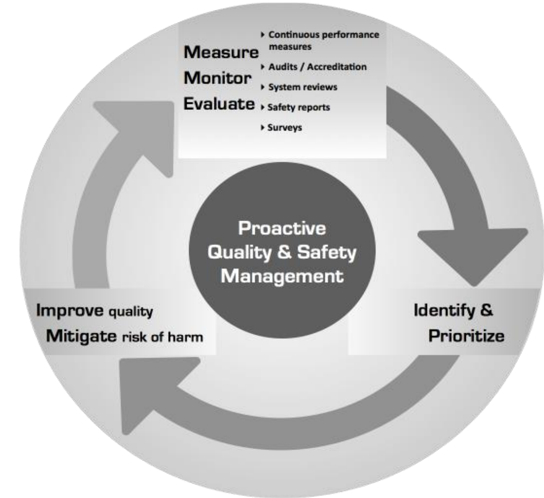


Big questions about patient safety

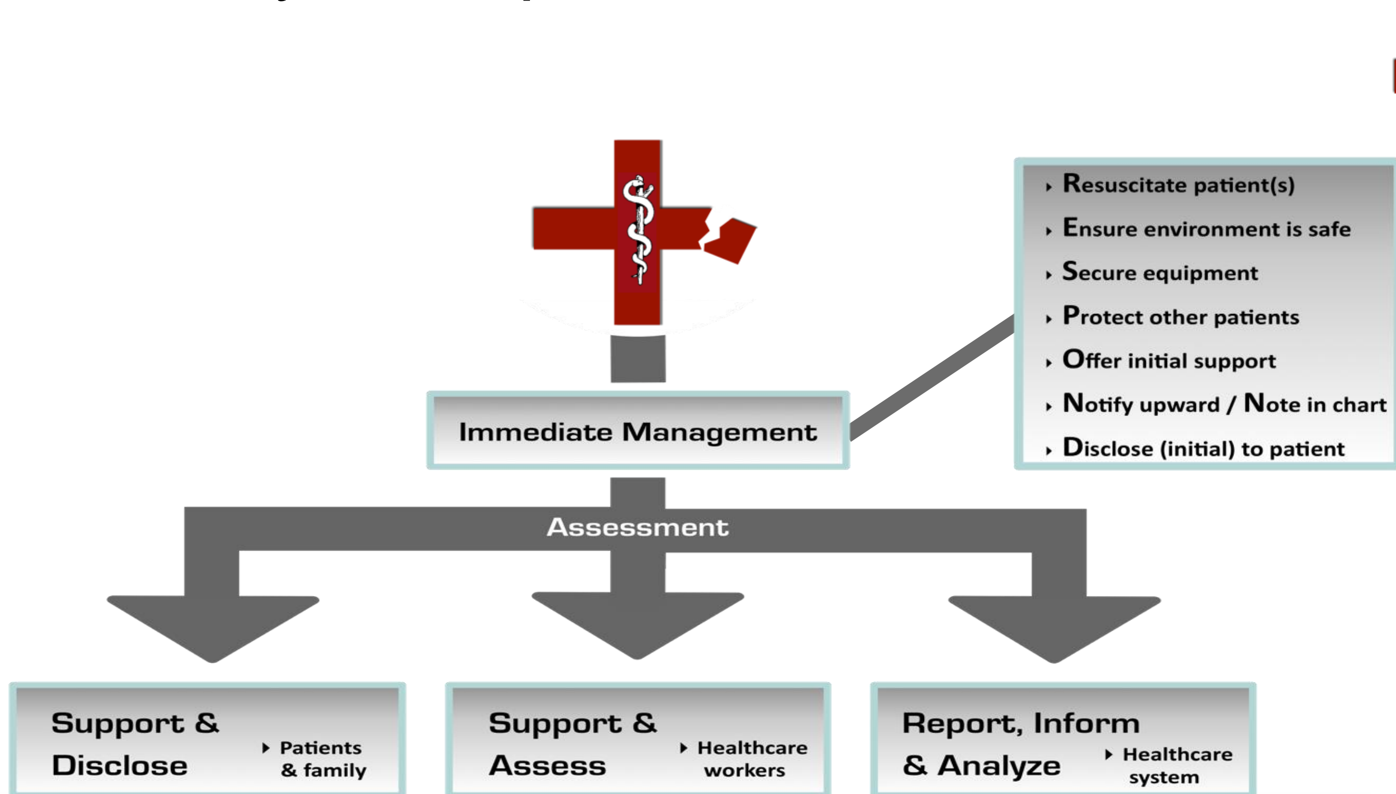
3 How do you respond when healthcare breaks?

Immediate Management

Assessment

- **Support & Disclose**
  - Patients & family
- **Support & Assess**
  - Healthcare workers
- **Report, Inform & Analyze**
  - Healthcare system

3 How do you respond when healthcare breaks?



3 How do you respond when healthcare breaks?

Support & Disclose

- Patients & family

Second Harm

3 How do you respond when healthcare breaks?

Patients experience two types of disappointment:

- the disappointing unanticipated medical outcome
- the disappointing way that healthcare providers and organizations behave after the fact

Research suggests that patients and their families are more forgiving of the first type of disappointment then they are about the second

3 How do you respond when healthcare breaks?

What do patients and their families need?

- Acknowledgment / Investigation
- Disclosure (what / how / why)
- An apology
- Support for the patient / family
  (including possible reimbursement for out-of-pocket expenses)
- Future healthcare plan
- A plan to protect other patients

[establish a point of contact who is always available]

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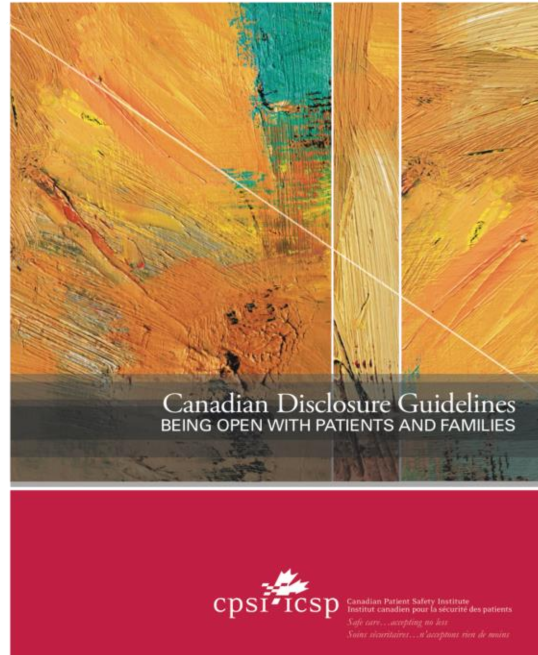
❸ How do you respond when healthcare breaks?



3 How do you respond when healthcare breaks?

"If you take my pen and say you are sorry, but don't give me the pen back, nothing has happened."

Bishop Desmond Tutu

3 How do you respond when healthcare breaks?

Service Recovery:

The process used to “recover” dissatisfied members or patients by identifying and fixing the problem or making amends for the failure in customer or clinical service.

Reimbursement:

The act of paying someone for expenses with or without an admission of fault

Innovation Series 2011

Respectful Management of Serious Clinical Adverse Events

Second Edition

Authors:
Jim Conway, MS, FACHE, *IHI Senior Fellow*
Frank Federico, RPh, *Executive Director, IHI*
Kevin Stewart, MB, BCh, FRCP, *Health Foundation/IHI Fellow 2009-2010*
Mark J. Campbell, MEd, *Adjunct Instructor, Harvard School of Public Health*

Compensation:

A financial remedy accorded to an individual who has sustained an arguably avoidable loss in order to replace the loss caused by the arguably inappropriate act, with the intention of making the injured party whole.

3 How do you respond when healthcare breaks?

Support & Assess

- **Healthcare workers**

3 How do you respond when healthcare breaks?

Support & Assess

- **Healthcare workers**

Second Victim

3 How do you respond when healthcare breaks?

Medical error: the second victim

The doctor who makes the mistake needs help too

Personal view p 812

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that "doctors are only human," technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that "it will never happen again." Paradoxically, this approach has diverted attention from the kind of systematic improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient's anger. You may become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you haven't told them, wondering if they know.[1-3]

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming. While there is a norm of not criticising,[4] reassurance from colleagues is often grudging or qualified. One reason may be that learning of the failings of others allows physicians to divest their own past errors among

BMJ 2000;320:726–7

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Big questions about patient safety

3 How do you respond when healthcare breaks?

Human

~~Medical~~ error: the second victim

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3 How do you respond when healthcare breaks?

Fair Assessment

System-focused Performance Assessment

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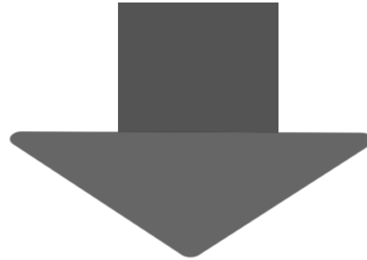
Fair Assessment

System-focused Performance Assessment

❸ How do you respond when healthcare breaks?



Report, Inform & Analyze

- Healthcare system

Second Chance

Big questions about patient safety

3 How do you respond when healthcare breaks?

Reporting

Learning

Improve

THE CULTURE OF PATIENT SAFETY

Reporting, Learning and the Culture of Safety

W. Ward Flemons and Glenn McRae

Abstract

Systems that provide healthcare workers with the opportunity to report hazards, hazardous situations, errors, close calls and adverse events make it possible for an organization that receives such reports to use these opportunities to learn and/or hold people accountable for their actions. When organizational learning is the primary goal, reporting should be confidential, voluntary and easy to perform and should lead to risk mitigation strategies following appropriate analysis; conversely, when the goal is accountability, reporting is more likely to be made mandatory. Reporting systems do not necessarily equate to safer patient care and have been criticized for capturing too many mundane events but only a small minority of important events. Reporting has been inappropriately equated with patient safety activity and mistakenly used for "measuring" system safety. However, if properly designed and supported, a reporting system can be an important component of an organizational strategy to foster a safety culture.

Healthcare is not as safe as it should or could be: rates of adverse events, defined as situations where patients suffer harm from the healthcare they receive (or not receiving care that would have helped), in acute care have been shown to be high. For example, the Canadian Adverse Events Study found that 7.5% of patients admitted to a Canadian hospital suffered an adverse event (Baker et al. 2004). The National Steering Committee on Patient Safety listed the comprehensive identification and the reporting of hazards as one of "nine key principles for action" that served as a foundation for the committee's recommendations to make Canadian patients safer (National Steering Committee on Patient Safety 2002). Further, the committee recommended the adoption of non-punitive reporting policies within a quality improvement framework. Recently, the *National System for Incident Reporting* (Canadian Institute for Health Information 2011) was established by the Canadian Institute for Health Information, whose focus at the present time is incidents regarding hospital-based medication and intravenous fluids. The development of reporting systems to enhance patient safety has been proposed as a strategy in other countries; examples include the Australian Incident Monitoring System (Runciman 2002) and the National Reporting and Learning System in England and Wales (Williams and Osborn 2006).

Reporting Defined

Reporting is described in *The Canadian Patient Safety Dictionary* as "an activity where information is shared with appropriate responsible individuals or organizations for the purposes of system improvement" (Davies et al. 2003). Reporting is sometimes confused with disclosing, informing and notifying. *Disclosing* is the imparting of information, by healthcare workers

Healthcare Quarterly Vol.15 Special Issue 2012

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3 How do you respond when healthcare breaks?

Informing - why do it?

1. **protect** other patients
2. maintain or restore **reputation**
3. **empower** the public or a population of patients to make an informed decision about an actual or potential hazardous situation
4. **normalize** ‘open discussion’ of system vulnerabilities

CULTURE

GUIDELINES FOR INFORMING THE MEDIA AFTER AN ADVERSE EVENT

3 How do you respond when healthcare breaks?

"to err is human,

to cover up is unforgivable,

and to fail to learn is inexcusable"

Sir Liam Donaldson Former CMO for England and Chair of World Alliance Patient Safety

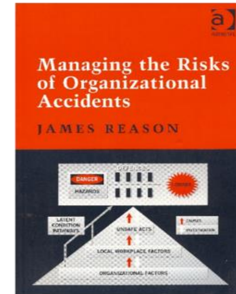
3 How do you respond when healthcare breaks?

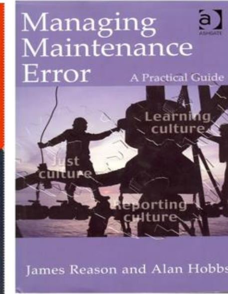
Systems analysis

http://hqca.ca/health-care-provider-resources/systematic-systems-analysis/

4 How do you create / promote a culture of safety?

JUST
REPORTING
LEARNING
IMPROVE

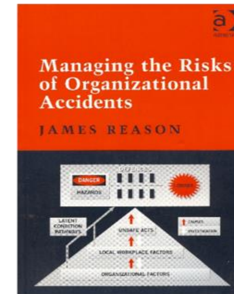


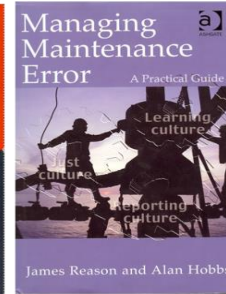


just culture - an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information - but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour.

4 How do you create / promote a culture of safety?

JUST
REPORTING
LEARNING
IMPROVE



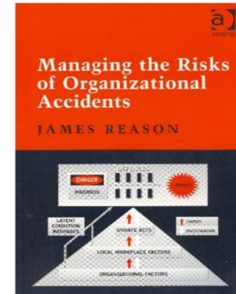


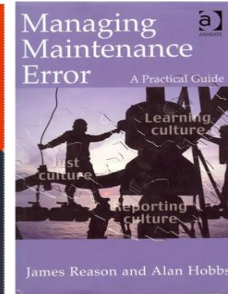
Any safety information system depends crucially on the willing participation of the workforce, the people in direct contact with the hazards. To achieve this, it is necessary to engineer a ***reporting culture*** - an organizational climate in which people are prepared to report their errors and near-misses.

4 How do you create / promote a culture of safety?

JUST
REPORTING
LEARNING

IMPROVE





Finally, an organization must posses a ***learning culture*** - the willingness and the competence to draw the right conclusions from its safety information system, and the will to implement major reforms when their need is indicated.

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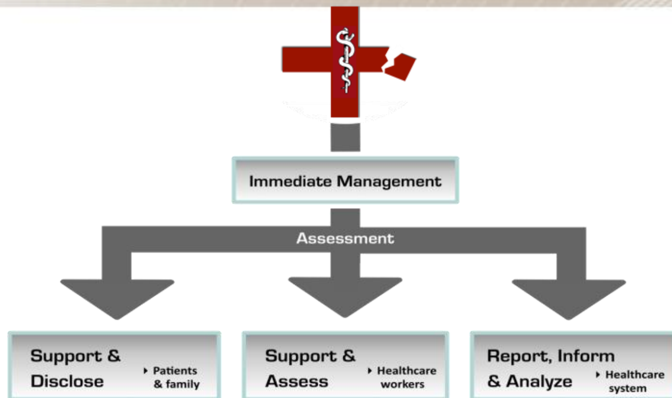
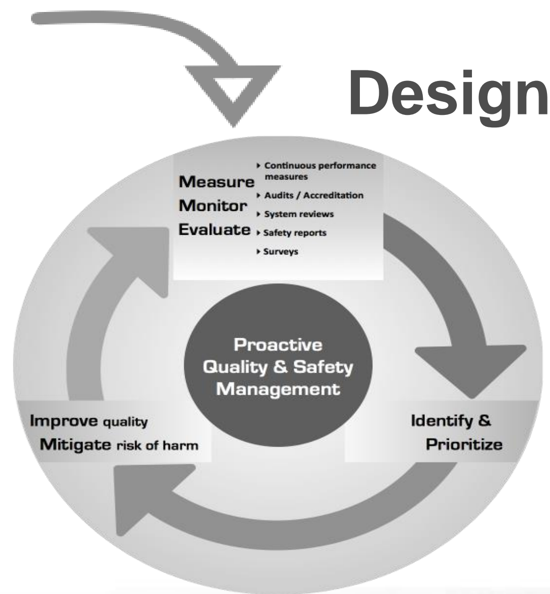
Putting it all together

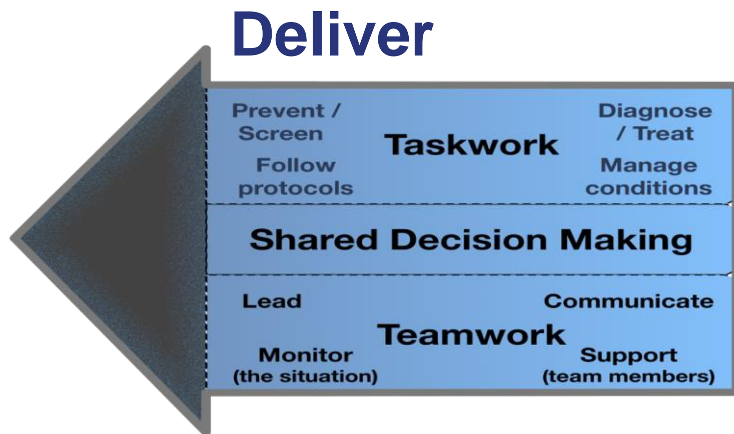


Respond
(Reactive Safety Management)

Design



Deliver



Patient-care Management

Optimal Healthcare Delivery

Putting it all together

A safe organization is a prepared organization

- **prepared (a plan) for success**
- **prepared for failure (a plan for responding)**