Patient/Family Role in Patient Safety Incidents

Deborah E. Prowse, Q.C.
Patients for Patient Safety – Canada
CPSI October 2015

"You wouldn't just decide to forget about recovering the black box after an air crash. So why should it be thought so strange to want to learn from every ~~accident~~ in health care."

adverse event

Sir Liam Donaldson 2001

CALGARY HERALD
SINCE 1883
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Two patients dead in tragic error at Foothills hospital

PROWSE — Kathleen (!
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stice Hubert Prowse, passed
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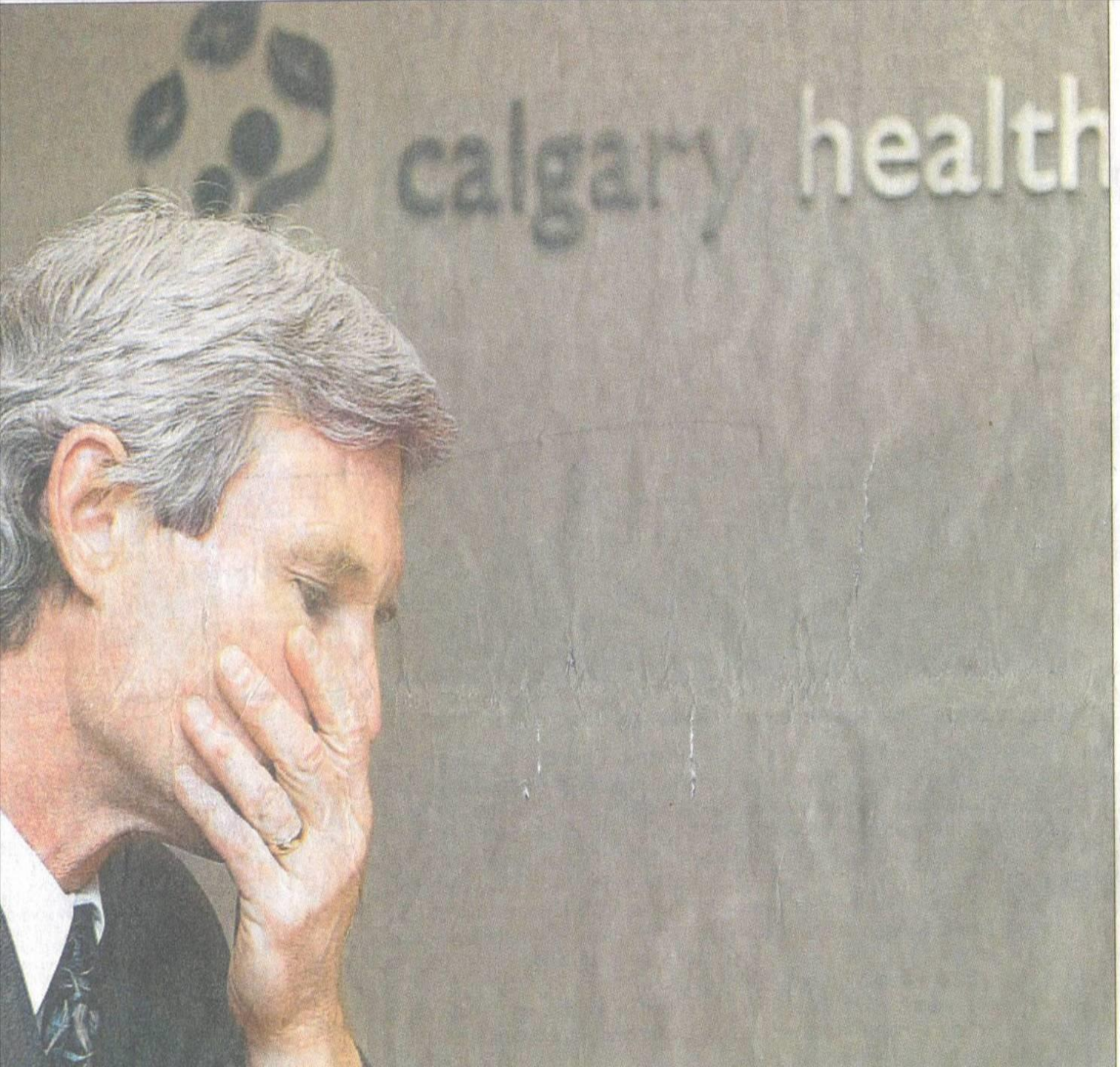
A death announcement for Kathleen Prowse ran in the Herald on March 9.



Dialysis drug mix-up traced to pharmacy

Quick-thinking doctor prevented further fatalities

MARIO TONEGUZZI
CALGARY HERALD

Two critically ill patients died recently at the Foothills Medical Centre after they were given an incorrect solution during dialysis treatment.

And Calgary Health Region officials are crediting an "astute" physician for immediately identifying the mistake, reacting quickly and preventing the possibility of many more deaths.

One of the patients has been identified as Kathleen Prowse, who came from a prominent Calgary legal family. She was married to Hubert Prowse, a former Court of Queen's Bench judge in Calgary.

The family

ALSO SEE
- Liberals call for inquiry A4
- Don Braid A5
- Mistakes take toll A5

High stakes

DIALYSIS DEATHS

Grit wants Klein to fire CHR boss

Health region board 'patronage playground': Taft

GWENDOLYN RICHARDS
CALGARY HERALD

Calling the Calgary Health Region a "political patronage playground," Liberal health critic Kevin Taft asked the premier Monday to fire the health authority's CEO in the wake of two deaths at the Foothills Medical Centre.

"Patronage appointments at the top level of the Calgary Health Region are getting in the way," said Taft after asking Ralph Klein to remove Jack Davis.

Davis, who earns $520,000 as CHR president and CEO, was appointed to the position more than four years ago

stead of sodium chloride, mixed at the central production pharmacy.

Families of the two victims were notified last Wednesday of the mix-up.

The central facility, staffed by two pharmacists and 33 technicians, assistants and aides, has technicians checking each other's work to guard against errors.

Davis said Saturday that those responsible for the mix-up will be held accountable.

But Taft said holding the staff accountable for the mix-up won't address larger problems within the CHR.

He noted the cases of Vince Motta and Maren Burkhart, who died in the CHR's care after long emergency waits.

"From the death of Burkhart to Motta to the two dialysis deaths, there is a deeply troubling pattern," the Liberal said. "If there wasn't a history, I wouldn't be making these demands."

Taft called for any written records

Shame and blame

Dialysis drug mix-up demands fatality probe

DON BRAID

OPINION

There's never a "right" victim in a tragedy like the CHR's lethal double blunder, but the wrong one has got to be Kathleen Prowse, widow of the late Judge Hubert Prowse.

Kathleen Prowse, 83, was the second person who died at Foothills intensive care units after being given the wrong drug.

She is the one who could have been saved, if only the CHR had realized the first person was killed by an improperly mixed medication.

This Prowse family is well known in judicial offices around town, including that of Judge Manfred Delong, who delivered last year's fatality inquiry report that blistered the health region in the death of Vince Motta.

Three years earlier, Judge Brian Stevenson, the head of DeLong's provincial court, presided over the fatality inquiry in the case of 10-year-old Maren Burkhart.

Kathleen Prowse's daughter, Sharron Prowse O'Ferrall, is a family and youth court judge in Calgary. Another daughter, Maureen Prowse, is a doctor in Rancho Mirage, Calif.

Hubert Prowse was a Court of Queen's Bench justice. Delong and Stevenson are in provincial court. But Calgary's court community is a small world with deep bonds and tight loyalties.

When a fatality inquiry into these latest deaths is inevitably held, the biggest challenge will be finding a local judge who didn't know the Prowse family.

By all accounts, Kathleen Prowse was a warm, energetic woman who certainly knew Calgary's medical and legal systems. And she died because of one of the most dreadful medical mistakes ever revealed in Alberta, or all of Canada.

A fluid was improperly mixed in the pharmacy. Two types, one lethal to these patients, one beneficial, were stored in nearly identical containers very close to each other.

That's a practice that shouldn't be tolerated in the chemical section of a hardware store, let alone a hospital pharmacy.

It took a sharp doctor to suspect what was wrong when Kathleen Prowse died.

She had too much potassium in her blood, and the physician ordered a check of the medication.

Several days before, the same batch of medication had killed a middle-aged man. No checks were done, because his

Vince Motta

Maren Burkhart

condition could have produced a high potassium level.

Dr. Bob [illegible], the CHR's chief medical officer, almost cried when he said how sorry everyone is at the CHR.

His pain was utterly genuine, but it can't begin to compare to the grief of families who lost their loved ones to incompetence.

A public fatality inquiry isn't mandatory in this case, but it's hard to see how the province could fail to call one.

The Burkhart case led to an inquiry after the girl died of septic shock resulting from complications of appendicitis.

Her family had taken her away from emergency rooms because of lineups, accusing the system of overcrowding and slow care.

Vince Motta, 23, died Jan. 2, 2001, of an asthma attack after twice leaving crowded Calgary emergency rooms before being seen.

Delong's subsequent report gave the CHR the worst scolding in its history, but not because of medical care.

The judge was furious because he thought the CHR had obstructed his inquiry by stalling and failing to produce documents.

Despite the CHR's constant public relations assurances, he said, emergency care was getting worse instead of better.

Now the CHR says that in revealing the two deaths by medication, it's being open and transparent.

It's a heck of a way to start.

A fatality inquiry into this disaster — the CHR's third major probe in six years — won't be asking if the system killed people, only how.

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A little more shaming

Medication error 'very hard to make'

DON BRAID

A medical technician who has given thousands of safe doses of potassium chloride says a hospital employee would have to be "blind and illiterate" to confuse it with sodium chloride.

"Potassium chloride is labelled purple and sodium chloride is yellow, and it's been like that from time immemorial," says Peter Burrows, 65, a retired cardiovascular perfusionist who worked in operating rooms for more than 30 years.

"It's a very, very hard mistake to make, because the labelling is also as distinct as the colours.

"So you have to both not see and not read in order to make this error."

He feels that any CHR worker who had confused the drugs must be "so stressed, overworked or distracted that they simply aren't paying attention."

Burrows, who worked in Ontario and Saskatchewan hospitals, said he decided to speak out because "this has happened too many times in one city to be ignored or shuffled under the counter."

ALSO SEE
■ Pharmacists' review will be public B1

SEE BRAID, PAGE A14

DON BRAID

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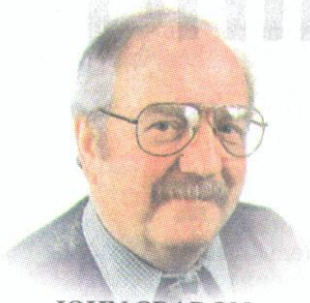
ALSO SEE
■ Pharmacists'

Blame and Punish

Facing up to double jeopardy



JOHN GRADON

OPINION

He, she or they is or are out there, somewhere in Calgary or its immediate environs, today suffering agonies and despair, the depth of which the rest of us can only guess.

The after-the-fact remorse and sense of guilt, whether those suffering the emotions are singular or plural, must be simply overwhelming.

And so, simply because we are fellow human beings, there is sympathy for those involved in two unfortunate, unnecessary deaths at Foothills Medical Centre in addition to that for the bereaved families.

After all, no one, except maybe professionals in other far darker areas of life, sets out to work in the morning to deliberately cause death.

Nevertheless ....

The lab technician or technicians involved in the fatal errors that led to 83-year-old Kathleen Prowse and, as the Herald learned Sunday, 53-year-old Bart Wassing of Strathmore, being given a deadly fluid containing potassium chloride instead of sodium chloride must — and, according to Calgary Health Region chief Jack Davis, will — be held accountable.

The degree of that accountability is clear.

A head or heads have to roll. It's simply a matter of justice, of public safety and public confidence.

In an interview with Herald columnist colleague Don Braid during the paper's coverage of the awful affair that is a tragedy for all concerned, the University of Calgary's Dr. Norm Schachar, a surgeon and leading authority on patient safety, makes some fascinating points on that issue.

He asks: "What are we going to do? Hang a pharmacist?

"Somebody else would take over and the bottles would still be the same and eventually it would happen again.

"If the focus is on finding someone to blame, someone to hang, the systems won't be fixed."

Ah, there's the rub.

SEE GRADON, PAGE B4

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Relationships

- Patient family centred care is a building block of a safety environment
- Build the relationship between patients/family and providers lets patient/family members be active partners
- Having patient/family partners involved in designing policies, processes, education etc to help determine and carry out incident management


CLOSE THE LOOP
Share learning (internally and externally)
FOLLOW THROUGH
Implement recommended actions
Monitor and assess the effectiveness of actions
BEFORE THE INCIDENT
Ensure leadership support
Cultivate a safe and just culture
Develop a plan including resources
ANALYSIS PROCESS
Investigate what happened
Understand how and why it happened
Develop and manage recommended actions
IMMEDIATE RESPONSE
Care for and support patient/ family/providers/others
Report incident
Secure items
Begin disclosure process
Reduce risk of imminent recurrence
PREPARE FOR ANALYSIS
Preliminary investigation
Select an analysis method
Identify the team
Coordinate meetings
Plan for/ conduct interviews
INCIDENT MANAGEMENT
PATIENT SAFETY MANAGEMENT
SYSTEM FACTORS

When things go Wrong

- Disclosure: timely, compassionate and simple words (avoid second harm)

- Acknowledge
- Apologize
- Act to make changes

- "*In time they might forget the words you said, but they will never forget how it made them feel.*"

Maya Angelou

Include the patient/family

- Family members are likely to be with the patient at bedside more than staff.
- They will be able to provide information on what happened between the provider contacts, changes in data, etc.
- They will need preparation and support through the fact finding

Engage them as Advisors

- The time is right to consider putting a trained patient representative on the investigation team
  - Training in systems theory, human factors and patient safety concepts
- They will bring a patient perspective that the others will likely not
  - It's not enough to say, "we are all patients, we can address that perspective"

Provide Support Services

- Patient and family members
- Providers (prevent second victims)

"*Together we cried with each other, we taught each other things we didn't know and we are now friends*."

Eugenio Martinez

"A smart man learns from his own mistakes... a wise man learns from the mistakes of others."

Chesley B. 'Sully' Sullenberger
Miracle on the Hudson

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