World Health Organization | Patient Safety

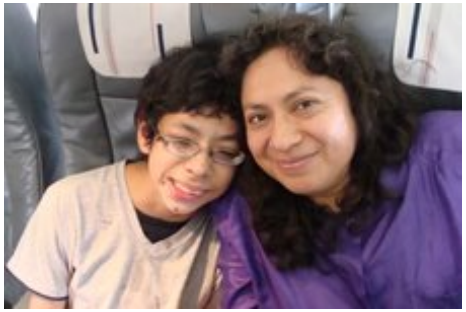
A World Alliance for Safer Health Care

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



CHKS Surveyors Update Day

London, 7th March, 2017

- 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
- Patient engagement with the next generation of professionals
- Co-creation as a sound basis for patient safety work
- Ensuring structures which learn from the raison d'etre of healthcare and provide truly patient-centred care
- The patient as the constant in the continuum of care – and having greatest vested interest in the outcome.

THE CASE FOR INVOLVEMENT
- A PATIENT SAFETY FRAMEWORK -

"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*

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

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








Patients for Patient Safety Workshops

500+ Champions in 52 Countries – Collaborating organisations

Scope for Involvement

International, National, Local arenas

Policy – Regulatory – Research -Education

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

Helen Keller

Patients for Patient Safety
- A Role in the Co-creation of Safe Care -

- PFPS – committed collaborative partners and co-producers of safe care -
- The patient experience as a catalyst for change and improvement
- Using the past to inform the present
- Using the present to influence a better future
- Partnership/Co-creation = empowerment of patients and families by enablers within the system

Leadership and the preferred Commitment

- Empowerment of patients, advocates and staffs
- The creation of meaningful partnerships by:
  - Proactively engaging patients
  - Capturing lessons from the patient experience
  - Embedding patient and family into organisational activity
- Recognising the common goal – safe healthcare

ACHIEVING THE GOAL

Synchronising Culture and Expectation

- Patient expectation of the business of healthcare – safety, openness and professionalism
- Being worthy of the trust of vulnerable patients and concerned carers

Disclosure ≠ BLAME

Disclosure = INTEGRITY, DEMONSTRATION OF TRUE PROFESSIONALISM

"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, Kaiser Permanente*

A Personal Experience

- MOTIVATION TO ENGAGE IN ADVOCACY
- The preventable nature of adverse events
- Damage limitation and its effect on learning and improvement
- The potential of adverse events to be catalysts for change

The Effectiveness of the Story to stimulate insight and reflective learning

Indian Saying:

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

"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 Monkenotte Cork	Male	Single	21 yrs.		Multi-organ failure Hypercalcaemia Parathyroid tumour certified	daniel J. Ellis occupier Cork University Hospital	Third November 1999	S. Scallegan 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 m/mol	(2.05-2.75)	5.73 (6.1)m/mol

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

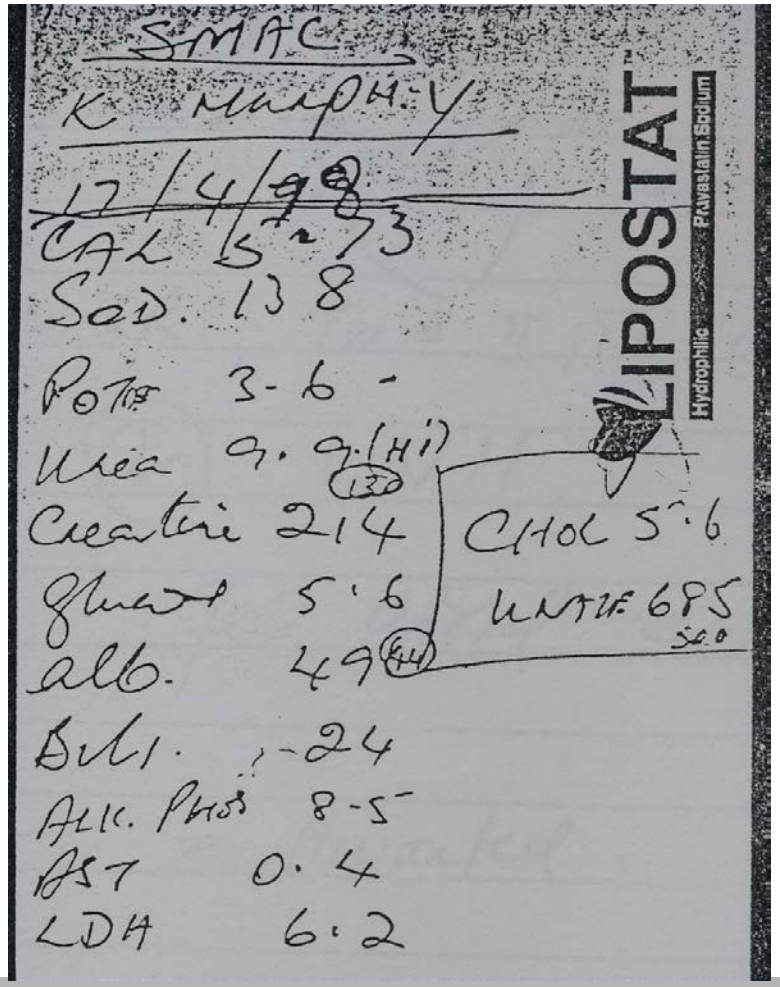
"The combination of bone pain, renal failure and hypercalcaemia in a young patient points either to a diagnosis of primary hyperparathroidism or metastatic malignancy and these ominious results should have been investigated as a matter of urgency".

"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 Rate

The Post-It


SMAC
K. Murphy
12/4/98
CAL 5.73
SOD. 138
POTS 3.6
Urea 9.9 (Hi)
120
Creatin 214
Gluc 5.6
alb. 49
44
Bili. 24
ALK. PHOS 8.5
AST 0.4
LDH 6.2
CHOL 5.6
LIPOSTAT
Hydrophilic
Pravastatin Sodium

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

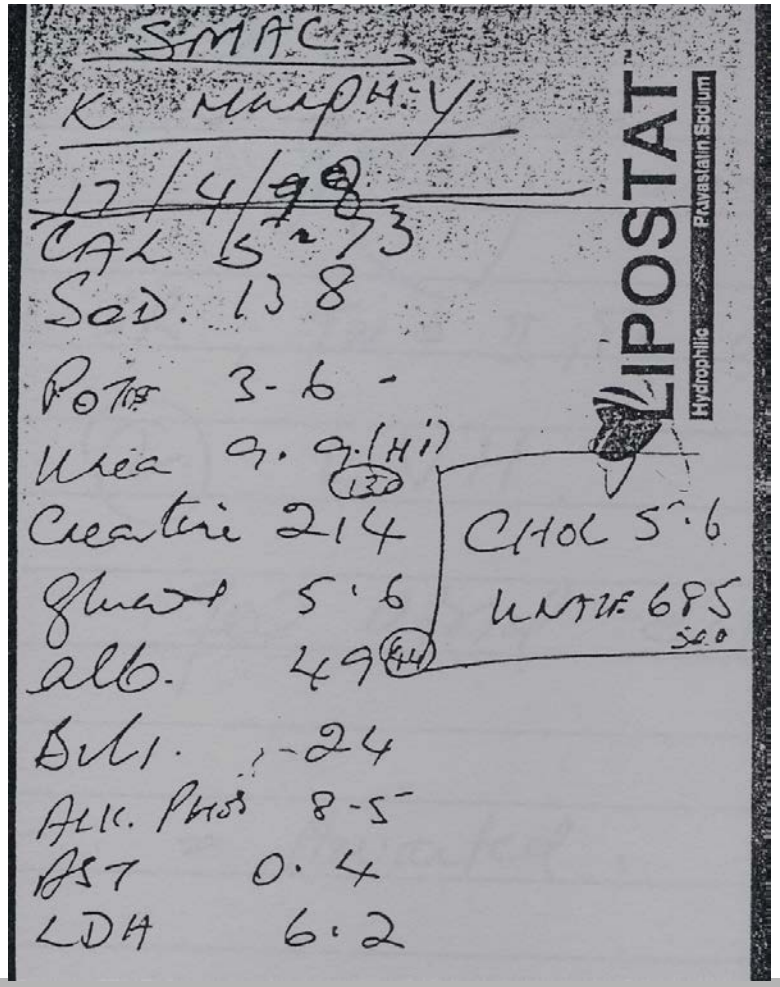
The Response

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

An Adverse Event – The Aftermath

Reluctance to be open and transparent

Closing ranks
Lame excuses
Muddying waters



Confidence in ascertaining the truth shattered

Forced to reluctantly pursue the litigation route

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
- Focus needs to be on learning rather than on blame

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 STAFF??

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

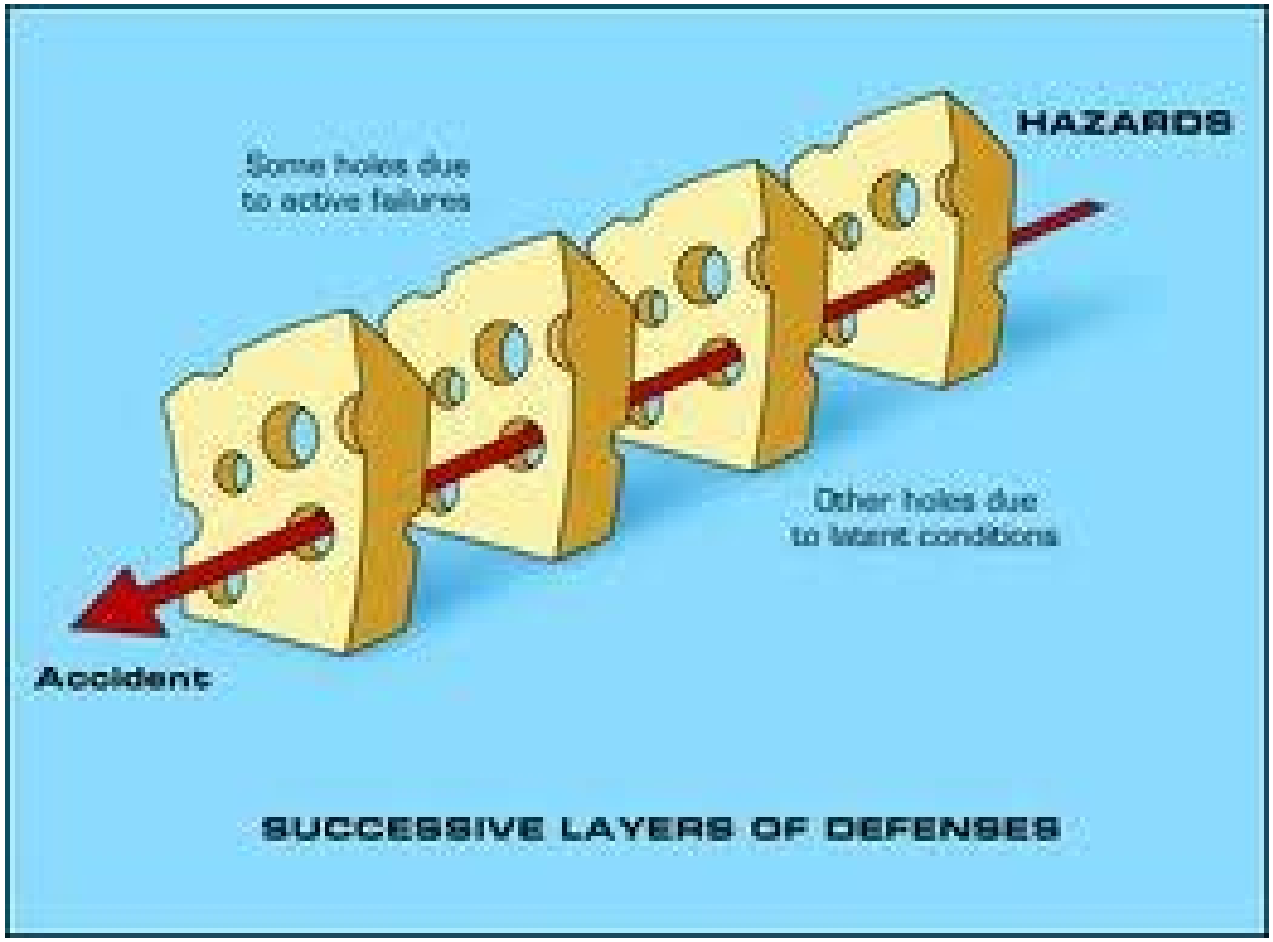
- Learn and disseminate that learning
- Practice dialogue and collaboration – meaningful engagement with patients and families
- Create a coalition of healthcare professionals and patients
- Be honest and open and seize the opportunity to give some meaning to tragedy
- It could not happen here
  – **5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

ACKNOWLEDGE ERROR

AND ALLOW LEARNING TO OCCUR

A Better Way

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



The Swiss Cheese Model

Patient Safety Issues

- Communication
- Viewing Patient holistically
- Family Advocacy
- Experience vs Tunnel Vision
- Patient as Partner
- Danger times in patient journey
- Care Team
- Professionalism and Integrity
- Supports for Patients and Family – adverse events
- Supports for Clinicians – adverse events

A Resolution going Forward
- RESCUE and CO-PRODUCTION -

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

- Atul Gawande

- Rescue
- A role for patient, family, advocate
- Role of healthcare to invite partnership
- Role of patients, advocates and civil society in rising to the challenge to be critical friends in meaningful collaborations

My Call for……

- Care delivered with Head, with Heart, with Hand - *BMA*
- Reporting and Learning
- Transparency, Accountability, Open Disclosure
- Patient engagement/involvement as a ‘right’

“To err is human,
to cover up is unforgivable
but to fail to learn is inexcusable.”
-Sir Liam Donaldson,Chair, WHO Patient Safety