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

NTMA

Quality, Clinical Risk & Patient Safety Conference

29, September, 2017

- THE PATIENT EXPERIENCE AS A CATALYST FOR CHANGE -

INTRODUCTION

- Addressing the heart of the matter – the patient and family experience of care
- Considering the patient experience as a legitimate evidence base
- Recognising the potential of the 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 Basis for Learning
W.H.O. Patients for Patient Safety

- Learning to be grounded in reality
- The emergence of the ‘Patient Advocate’
- The nature of advocacy – volunteers committed to collaborative partnership in the co-production of safe care
- The advocate's motivation – seeing experiences as catalysts for change – using the past to inform the present and influence the future
- A brand of partnership that facilitates empowerment of patients by enablers within the system

FRAMEWORK AND PROCESS

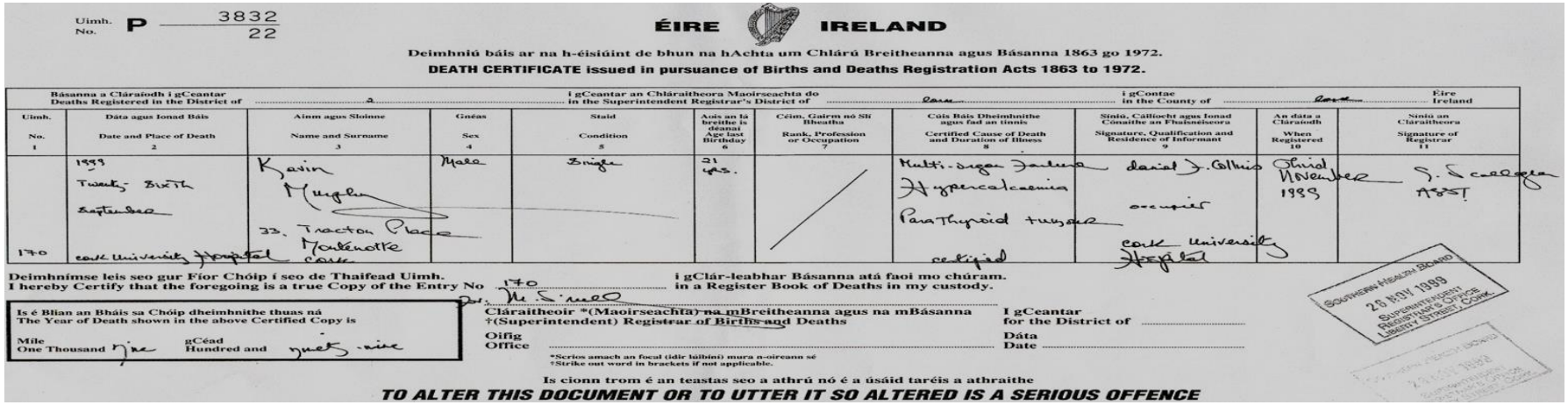
COMMITMENT

- Proactive engagement of patients in own care
- Capturing lessons learned from the patient experience
- Embedding patient and family in every aspect of healthcare

DELIVERABLE

Knowledgeable Patients receiving safe & effective care from skilled professionals in appropriate environments with assessed outcomes

THE DATA – THE RECORD



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 ..... i gCeantar an Chláraitheora Maoirseachta do in the Superintendent Registrar's District of ..... i gContae in the County of ..... 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	Sínlú, Cáilíocht agus Ionad Cónaithe an Fhaisnéiseora Signature, Qualification and Residence of Informant 9	An dáta a Cláraíodh When Registered 10	Sínlú an Cláraitheora Signature of Registrar 11
170	1999 Twenty-Sixth September cork University Hospital Cork	Kevin Murphy 33 Tracton Place Mahonette Cork	Male	Single	21 yrs.		Multi-organ failure Hypercalcaemia Parathyroid tumour certified	daniel J. Gilhis occupier cork University Hospital	Third November 1999	S. Scallagher Asst

Deimhnímse leis seo gur Fíor Chóip í seo de Thaifead Uimh. I hereby Certify that the foregoing is a true Copy of the Entry No 170 i gClár-leabhar Básanna atá faoi mo chúram. in a Register Book of Deaths in my custody.

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

Oifig Office

I gCeantar for the District of

Dáta Date

*Scrios amach an focal (idir lúibíní) mura n-oireann sé
†Strike out word in brackets if not applicable.

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

SOUTHERN HEALTH BOARD 26 NOV 1999 SUPERINTENDENT REGISTRAR'S OFFICE LIBERTY STREET, CORK

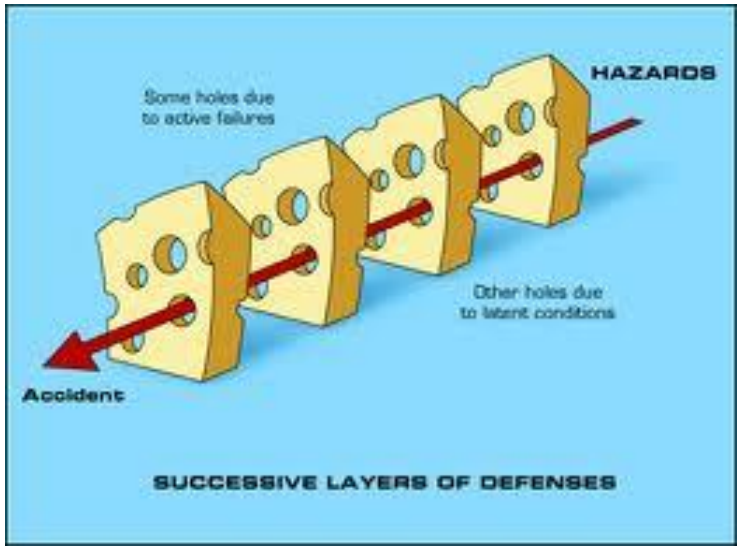
Persistent back pain – GP Visits, X-Rays
Orthopaedic Surgeon – Bone Scan, Blood Tests

		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)	

Every Point of Contact Failed Him...



Research

96% Success Rate; 1% Complication Rate

Peer Review

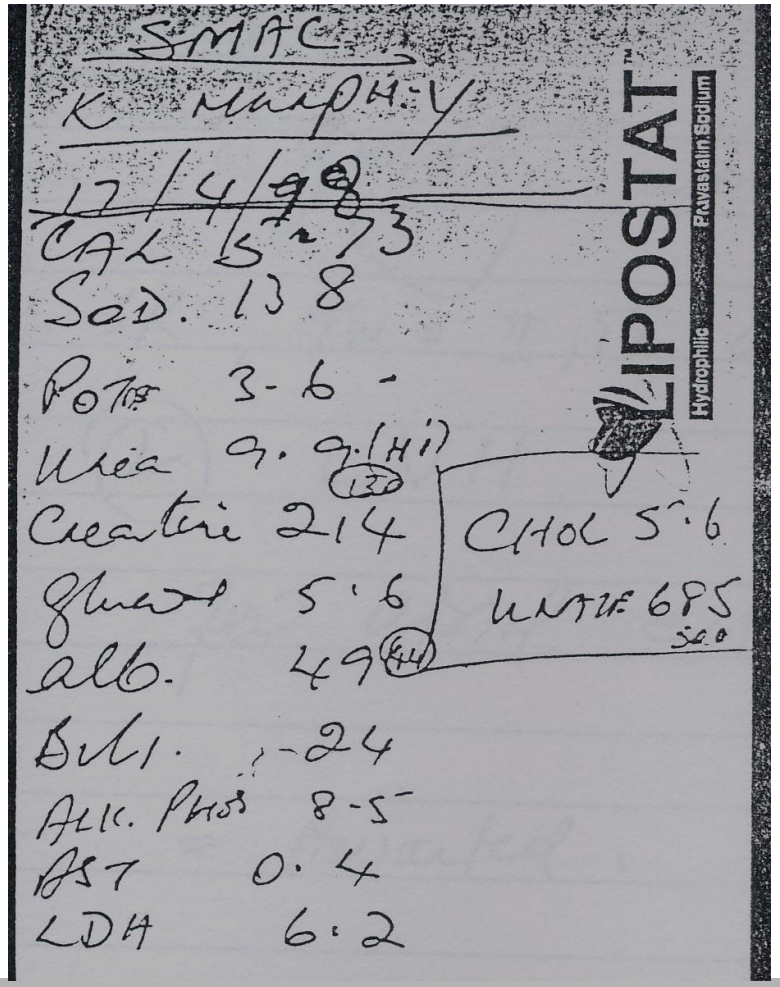
"All the evidence indicates that the patient was suffering from a solitary parathyroid adenoma at the time, removal would have been curative with a normal life expectancy"

"Kevin would have had surgery to remove the over-active parathyroid gland. He would have been cured and would still have been alive today."

Response to Error – The Lived Experience

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

ACHIEVING THE GOAL

Synchronising Culture and Expectation

- Medical Council Survey
- 90% responding trust their doctor to tell the truth
- Patients want to be able to old their doctor in high regard
- High level of trust sometimes betrayed

Disclosure ≠ BLAME

Disclosure = INTEGRITY, DEMONSTRATION OF TRUE PROFESSIONALISM

"Respectful Management of Serious Clinical Events"

IHI White Paper

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???

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

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

Preserving The Trusting Relationship

DIALOGUE = POWERFUL CONVERSATION

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 from protracted court proceedings. Why an absence of humanity?
- 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 - *IHI*
- 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