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.
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

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

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<tr>
<td><strong>Calcium</strong></td>
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<tr>
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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

Confidence in ascertaining the truth shattered

Closing ranks
Lame excuses
Muddying waters

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
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
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