



**World Health
Organization**

Patient Safety

A World Alliance for Safer Health Care



QI TALK TIME

Building an Irish Network of Quality Improvers

**The Patient Experience as a catalyst for
change**

Tues 26th Sept 2017

Margaret Murphy

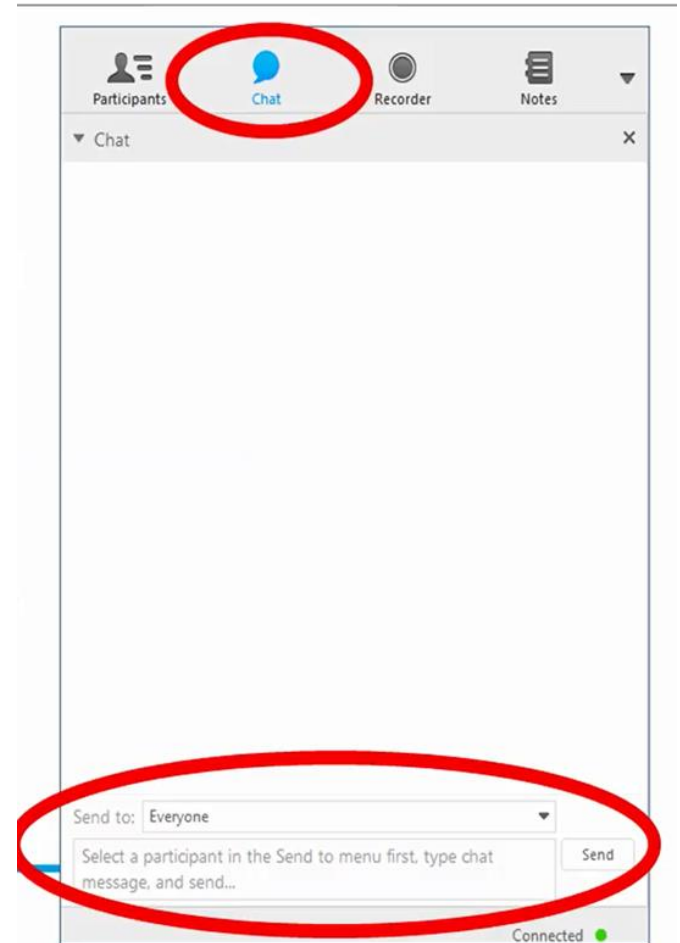
Margaret Murphy

- **Following the death of her son as a result of medical error, Margaret Murphy has been actively involved as a patient safety advocate.**
- **Margaret is the External Lead Advisor, WHO Patients for Patient Safety (400 patient safety champions from 52 countries).**
- **The focus of her work relates to seeing adverse events as having the potential to be catalysts for change as well as being opportunities for learning, identifying areas for improvement and preventing recurrence.**
- **She promotes this viewpoint at local, national and international levels as an invited presenter to conferences, hospital staffs & students.**



Instructions

- **Interactive**
- **Sound**
- **Chat box Function**
 - **Comments**
 - **Ideas and Questions**
- **Q&A at the end**
- **Twitter @QITalktime**





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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



**Quality Improvement
Talktime Webinar
26, September, 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'être* 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.

FOCUS/LOCUS FOR IMPROVEMENT EFFORTS

- Learning grounded in reality – lived experience of patient, family and healthcare staffs
- The relationship of trust – patient expectation
- Open disclosure and management of adverse events
- Recognising and responding to deterioration
- Identifying personal perceptions and experiences
- Owning the gift of being a healthcare professional
- Identifying personal resolve going forward
- THE GOOD PROFESSIONAL.....

..... THE GREAT PROFESSIONAL

BASIC ISSUES FOR CONSIDERATION

- Leadership
- Harnessing collaborative partnerships
- Prevention better than cure – intuitive vigilance and search for excellence
- Tensions experienced at the frontline
- Trustworthiness

THE ACID TEST

DISCLOSURE and the LIVED EXPERIENCE

- Disclosure = ?
- Blame vs Integrity and Professionalism
- The Question – Why? in relation to inappropriate responses to adverse events

“Respectful Management
of Serious Clinical Events”

IHI White Paper

Patients For Patient Safety (PFPS)

- 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
- PFS London Declaration



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

ACHIEVING THE GOAL

Synchronising Culture and Expectation

“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, Physician Leader for PS at Kaiser Permanente*

“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*

The patient as the constant in the continuum of care

The patient having the greatest vested interest in the outcome

Addressing the Challenge

*"Making the status quo uncomfortable,
while making the future attractive "*

J. Conway, IHI

PERSONAL MOTIVATION

Using the Patient Experience as a Catalyst for Change

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 *(Indian Proverb)*

“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. **P** 3832
No. 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 <u>2</u>		i gCeantar an Chláraitheora Maoirseachta do in the Superintendent Registrar's District of <u>Carr</u>					i gContae in the County of <u>Carr</u>		Éire Ireland	
Uimh. No.	Dáta agus Ionad Báis Date and Place of Death	Ainm agus Sloinne Name and Surname	Gnéas Sex	Staid Condition	Aois an lá breithe is déanaí Age last Birthday	Céim, Gairm nó Sli Bheatha Rank, Profession or Occupation	Cúis Báis Dheimhniithe agus fad an tinnis Certified Cause of Death and Duration of Illness	Síniú, Cálíocht agus Ionad Cónaithe an Fhaisnéiseora Signature, Qualification and Residence of Informant	An dáta a Cláraíodh When Registered	Síniú an Cláraitheora Signature of Registrar
1	2	3	4	5	6	7	8	9	10	11
170	1999 Twenty-Sixth September Cork University Hospital	Kavin Mugha 33, Tractor Place Mankenotte Cork	Male	Bríge	21 yrs.	/	Multi-sigam Failure Hypercalcaemia Parathyroid tumour certified	David J. Collins occupier Cork University Hospital	Thrid November 1999	S. S. Coolegan 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 Bliain an Bháis sa Chóip dheimhniithe thuas ná
The Year of Death shown in the above Certified Copy is

Míle one gCéad hundred and ninety-nine

Cláraitheoir *(Maoirseachta) na mBreitheanna agus na mBásanna
†(Superintendent) Registrar of Births and Deaths

Oifig
Office

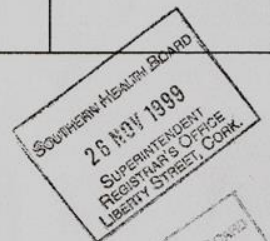
I gCeantar
for the District of

Dáta
Date

*Scríos 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



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	(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)	

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 ominous 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 Rates

The Post-It

SMAC
K. MURPHY
12/4/98
CAL 5.73
SOD. 138
POT⁺ 3.6 -
Urea 9.9 (Hi) (130)
Creatine 2.14 CHOL 5.6
glu⁺ 5.6 UAT⁺ 6PS
alb. 49 (44) 500
BUN. -24
ALK. Phos 8.5
AST 0.4
LDH 6.2

LIPOSTAT
Hydrophilic Evastatin Sodium

Every Point of Contact Failed Him...



The Shortcomings

- 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

Shortcomings *Contd...*

- 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

- Defensive
- ‘Loyalty to colleagues’
- Muddying the waters – dissembling
 - - e.g. Claims of inability to understand ‘layspeak’
- Attempts to shift responsibility
- Confidence in any hope of ascertaining truth
- shattered
- Excuses offered were unsustainable
- Expectation of professional and honourable
- conduct betrayed

The Post-It

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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**

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

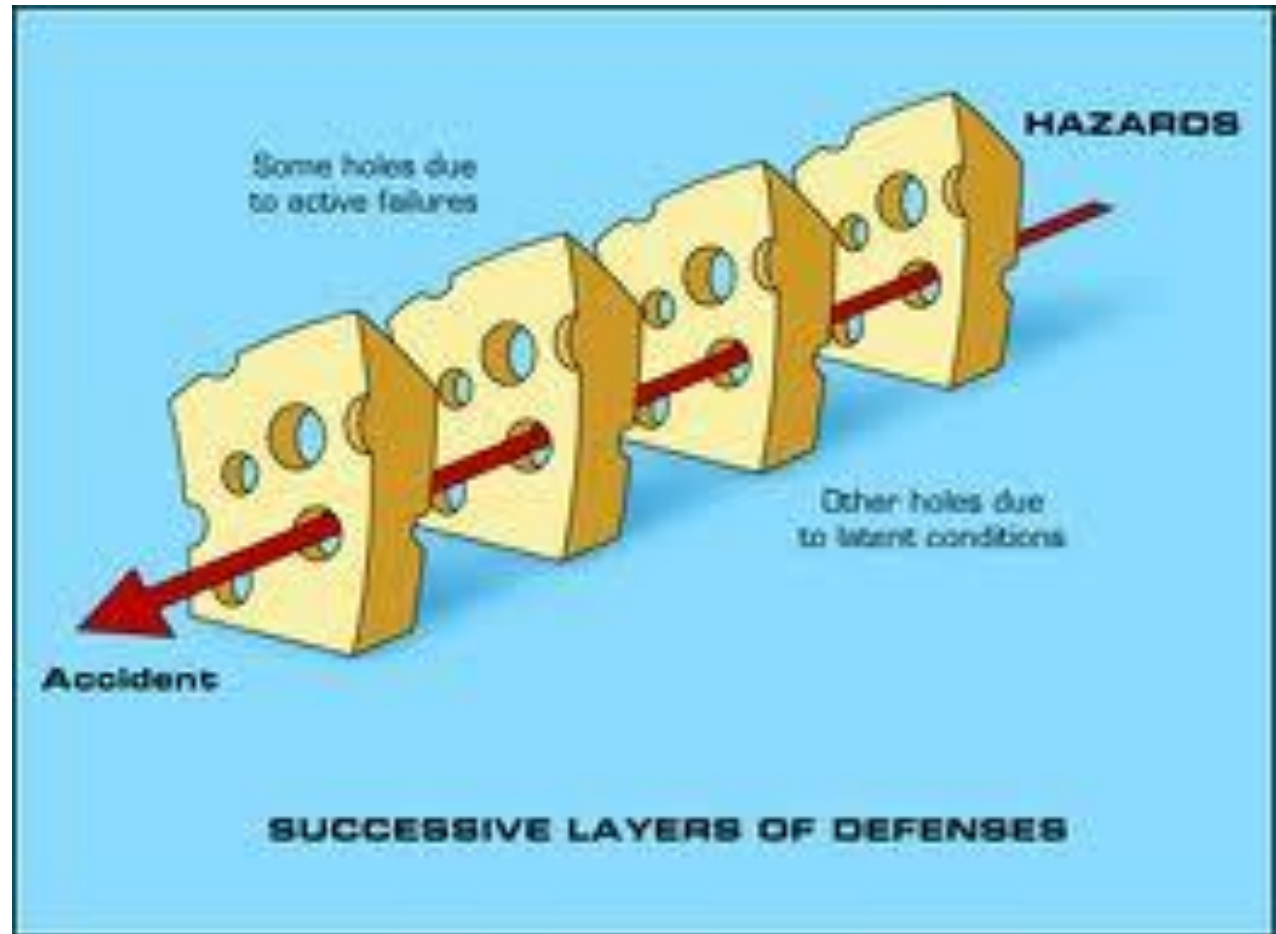
The Way Forward

- Barriers to Progress -

- **Inappropriate responses and their role in relation to fuelling confrontation?**
- **Inaccessibility of partnership and collaborative opportunities to ordinary patients and families**
- **The culture of medical practice - a perception of infallibility and faultless performance**
- **Fears relating to litigation and loss of reputation.**
- **Excluding the patient and family from the change process.**
- **Neglecting to learn from industry**

A Better Way

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



The Swiss Cheese Model



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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

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**Next Webex – October 10th: Dr David Vaughan:
Director of Quality and Patient Safety, Childrens Hospitals
Team work**

Thank you from all the team
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