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

National Standards for Better Safer Care in Palliative Care

Our Lady’s Hospice & Care Services
Dublin 14th June 2016
INTRODUCTION & Overview of Standards

- The heart of the matter – the patient and family experience of care
- Potential to drive improvement in policy making, education, research, standard setting, regulation
- Sustainable culture change
- Standards which are relevant to both practitioner & patient
- The need for effective and uniform implementation
- Legitimate expectations and capacity to assess quality of delivery
- Responsibility and accountability
- Identifies attributes & benchmarks of a high quality & safe system
- The impact of failure to implement standards
THE BIG QUESTION

Will the Standards make a difference, WHEN IMPLEMENTED?
The Patient Experience as a Learning Tool

- The patient experience as a learning tool and catalyst for change

- Empowerment of patients and families by enablers within the system

- ‘Making the status quo uncomfortable, while making the future attractive’ – J Conway, IHI
PATIENT EXPECTATION

- Results of Irish Medical Council Survey – 90% trust doctors to tell the truth
- Expectation of a culture of openness, transparency and open disclosure
- Assuring confidence in individuals and system
- Deserving of the trust of vulnerable patients and concerned carers
- Recognising the patient as the individual with the greatest vested interest in the outcome
CULTURE AND SAFETY

“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*

“Knowledgeable patients, receiving safe and effective care, from skilled professionals, in appropriate environments and with assessed outcomes”

*Irish Commission on PS & QA*
Persistent back pain – GP Visits, X-Rays
Orthopaedic Surgeon – Bone Scan, Blood Tests
1997 1999

• Calcium 3.51 mmol (2.05-2.75) 5.73 mmol (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.”
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
THE 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
ACHIEVING THE GOAL
Synchronising Culture and Expectation

- Initial honest and humane reactions
- Corporate damage limitation

Disclosure ≠ BLAME
Disclosure = INTEGRITY, DEMONSTRATION OF TRUE PROFESSIONALISM
An Adverse Event – The Aftermath

Damage Limitation

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
“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 Better Way
Sir Liam Donaldson, Chair, WHO World Alliance for Patient Safety

The Swiss Cheese Model
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
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
A Research Perspective and the WHO Curriculum Guide

Where’s the Patients’ Voice in Health Professional Education?

Christine Farrell, Angela Towle, William Godolphin

Division of Healthcare Communication, University of British Columbia
INTERACTIONS WITH STUDENTS
FEEDBACK from Faculty & Students

- Acquiring appreciation of the value of the patient experience
- Recognising the connection – acquiring knowledge, mastering skills & appreciation patient perspective.
- Assembling core values
- Preserving the relationship of trust
- Providing care that is compassionate, quality assured and safe.
- Alignment with didactic course material
IDENTIFIED 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
More than anything, what distinguishes the great from the mediocre, is not so much that they fail less, it is that they rescue more.

- Atul Gawande

“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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