“Learning from mistakes: commitment or cliche´?”

Anne Matlow MD FRCPC
Faculty Lead, Strategic Initiatives
University of Toronto
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Post MD Education
UNIVERSITY OF TORONTO

Objectives

- discuss the systems approach to medical error
- review current legislation and regulation related to communication with patients after a harmful patient safety incidents
- describe ‘just culture’ and consider the culture of safety in healthcare
- reflect on opportunities to transform healthcare organizations into true learning organizations

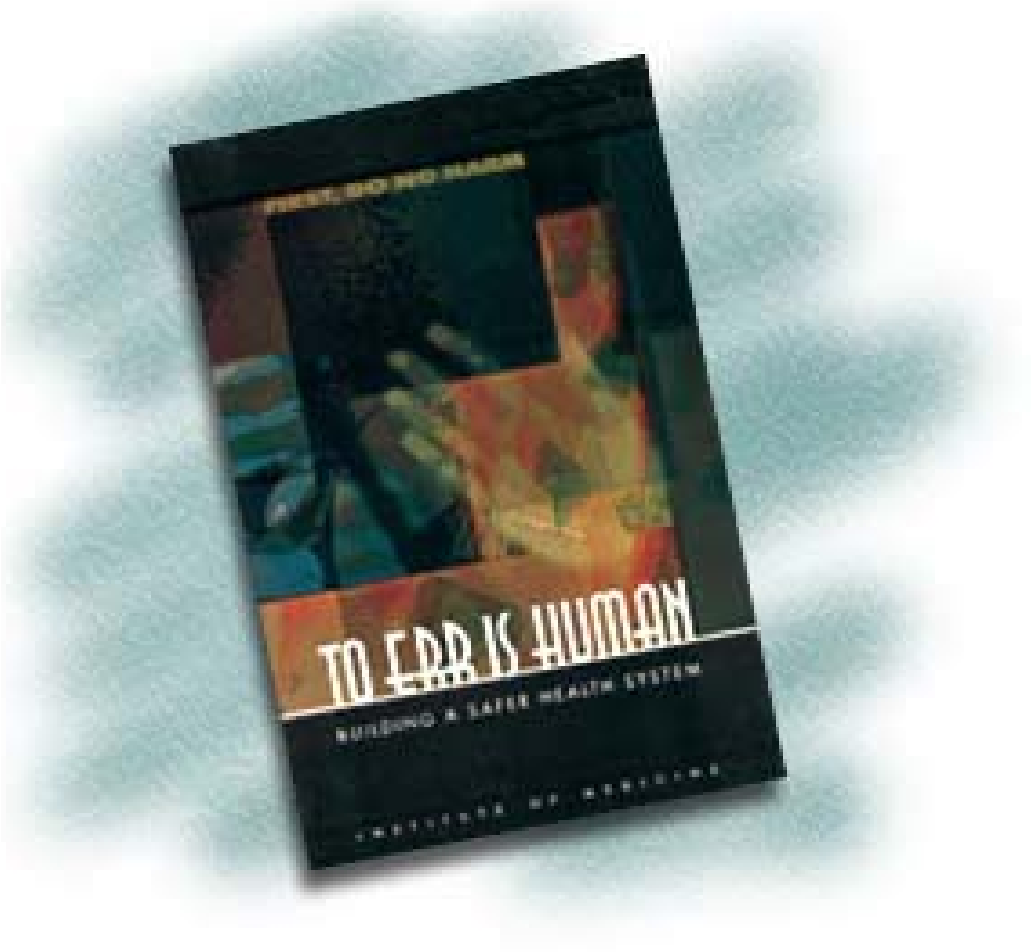
Healthcare is not always safe

www.mers-tm.net

How Common Are Adverse Events?

	AE rate	Preventable
NY *1984*	3.7%	n/a
Utah/Col *1992*	2.9%	n/a
Australia *1992*	16.6%	51%
NZ *1998*	13.1%	37%
UK *1999*	10.8%	48%
Denmark *2000*	9.0%	40%
Canada *2001*	7.5%	37%

Institute of Medicine Report 1999



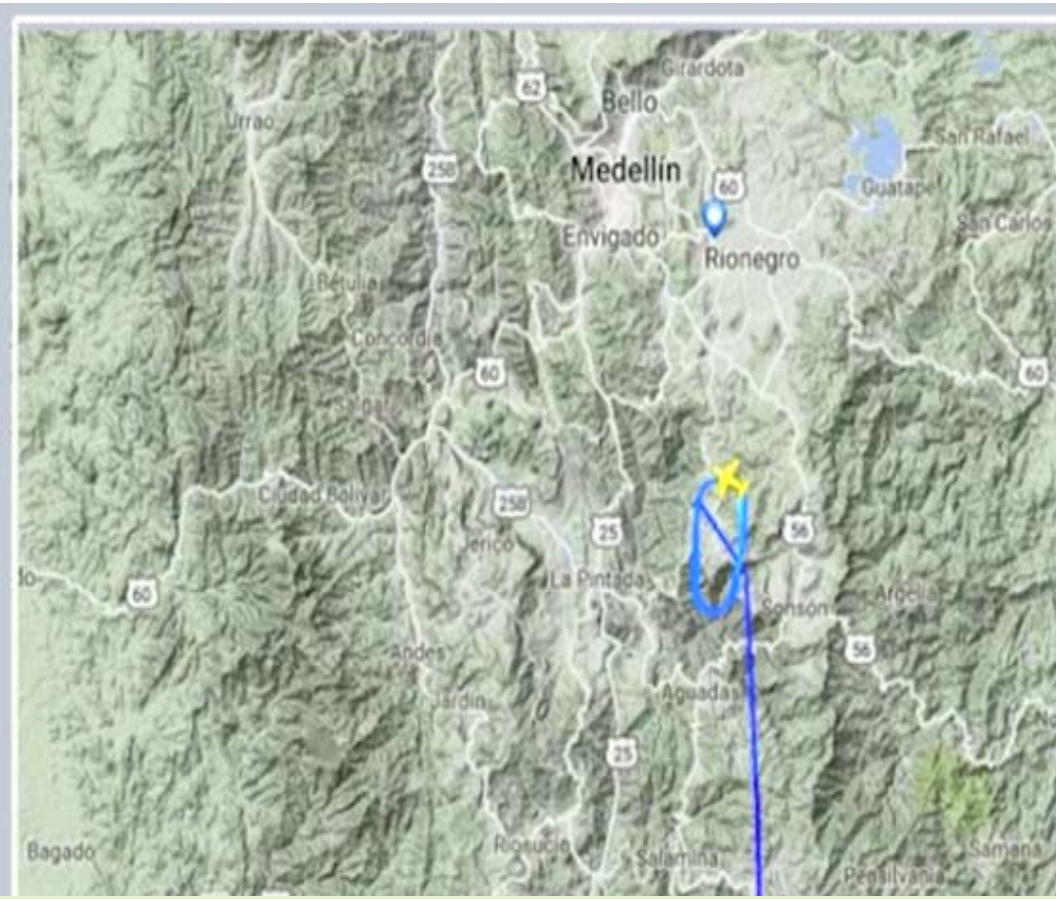
44,000- 98,000 patients die yearly from adverse events

Equivalent to 1 jumbo jet going down every 2 days

25-50% are preventable

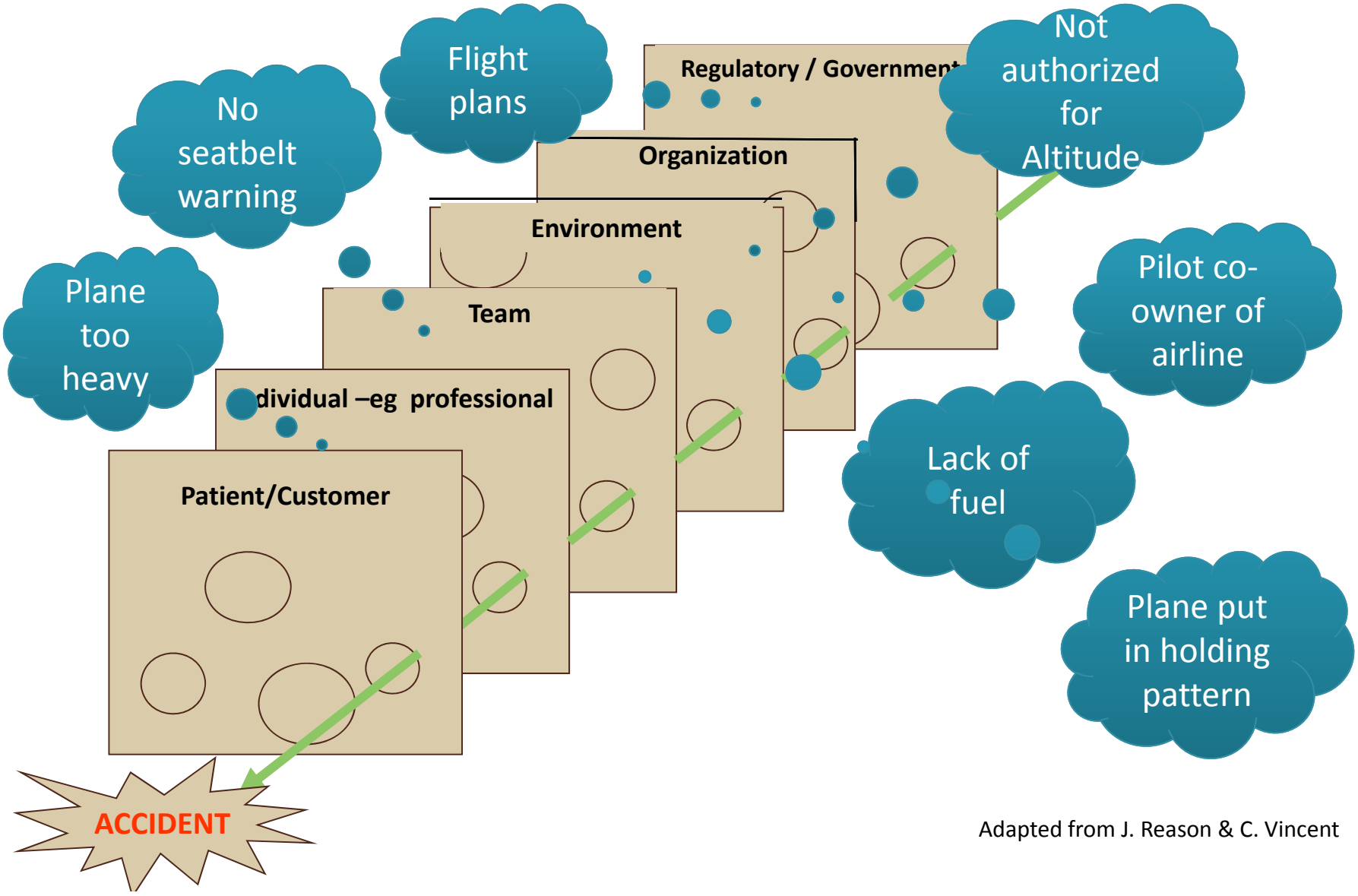
Colombia plane crash: Brazil mourns victims from Chapecoense team flight

Plane ran out of fuel before crashing



The Colombian aviation agency concluded that errors by the pilot, the small Bolivia-based charter airline LaMia Corp., and Bolivian regulators led to the crash.

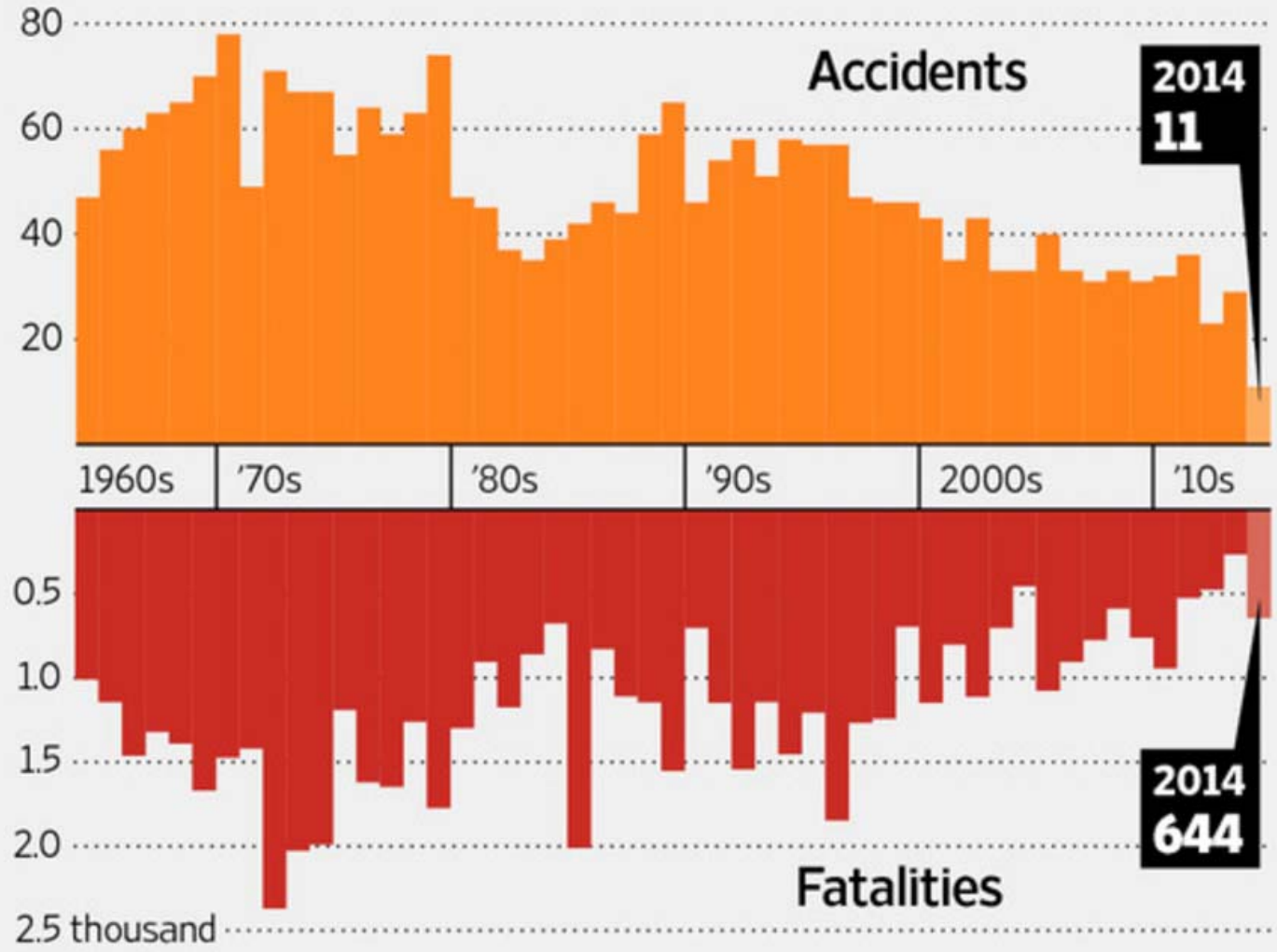
Anatomy of an accident: Swiss cheese model



Adapted from J. Reason & C. Vincent

Deadly Flights

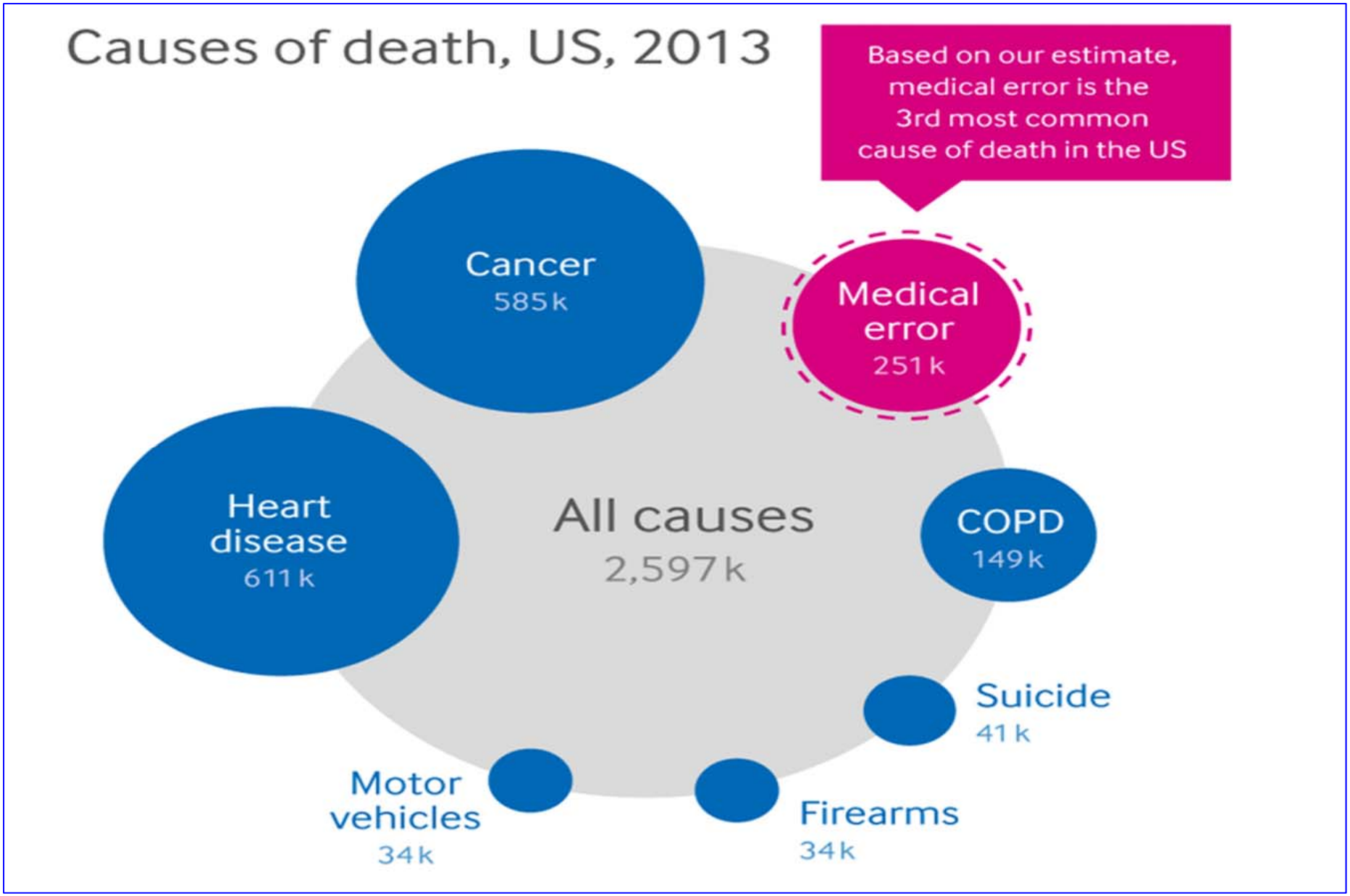
The number of fatal airliner* hull-loss accidents and fatalities



*Planes certified to carry 14 or more passengers. Note: 2014 through July 23; figures do not include corporate jet and military transport accidents/hijackings.

Source: Aviation Safety Network

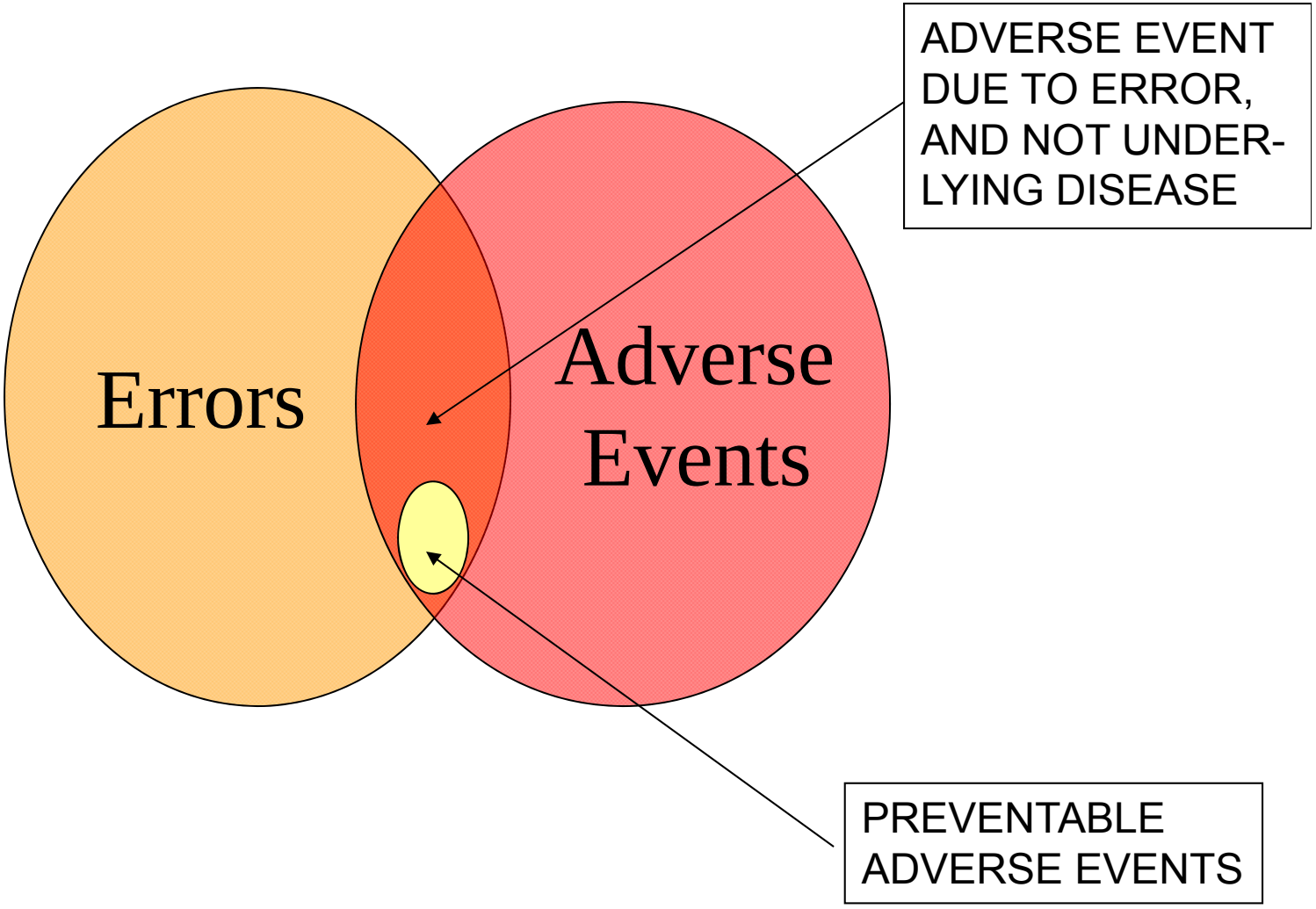
The Wall Street Journal

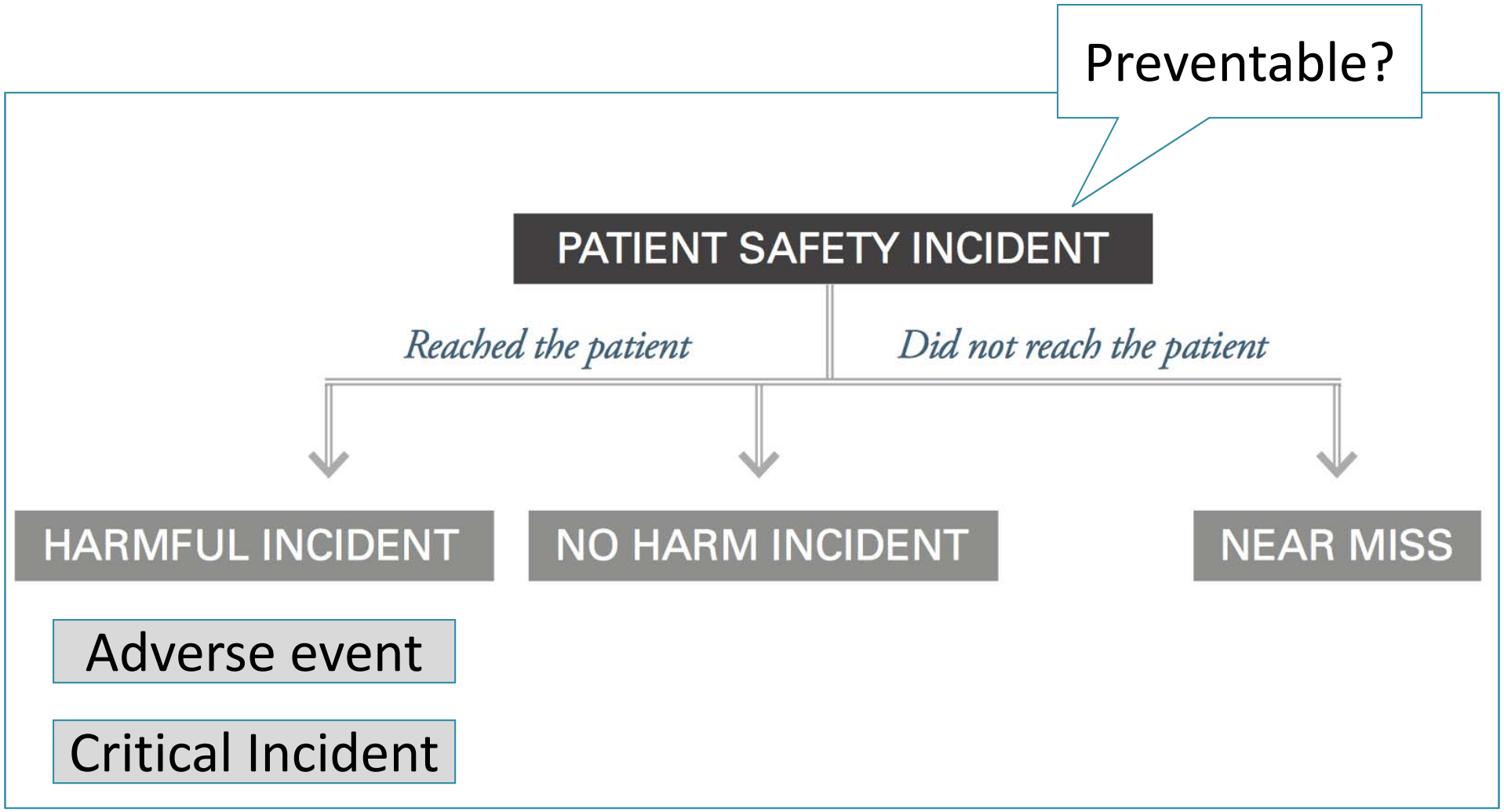

Causes of death, US, 2013
Based on our estimate, medical error is the 3rd most common cause of death in the US
Cancer
585k
Medical error
251k
Heart disease
611k
All causes
2,597k
COPD
149k
Suicide
41k
Motor vehicles
34k
Firearms
34k

CDC 2016

ERRORS vs ADVERSE EVENTS

MISTAKES vs HARM





http://www.patientsafetyinstitute.ca/en/toolsResources/IncidentAnalysis/Documents/Canadia
%20Incident%20Analysis%20Framework.PDF

http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/criticalincident/update.as
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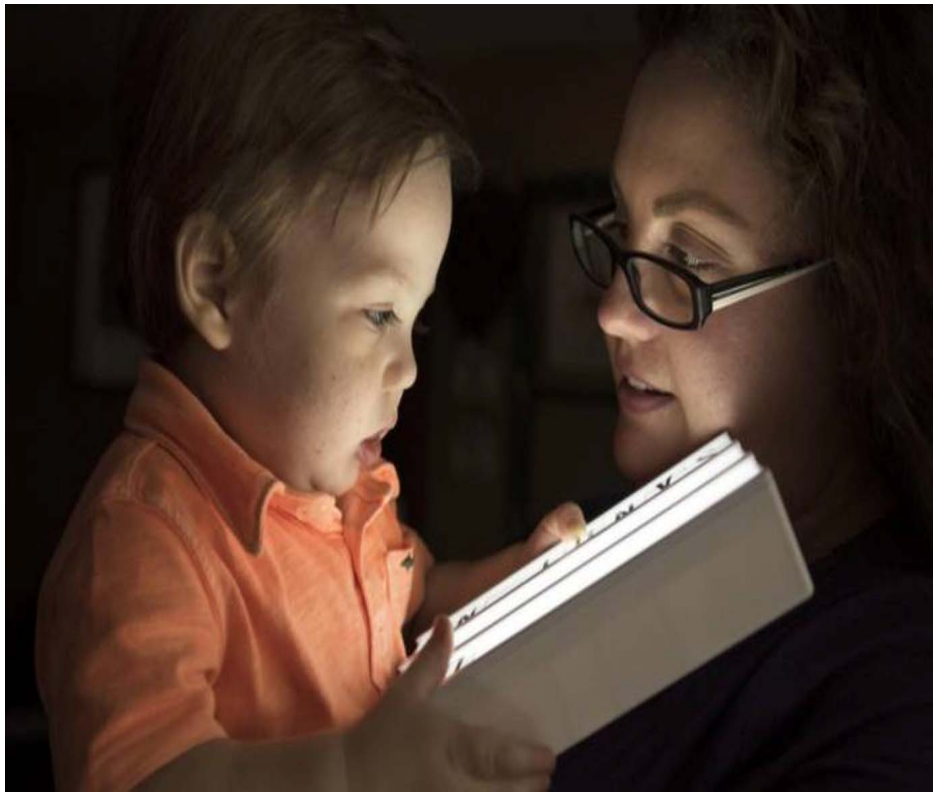
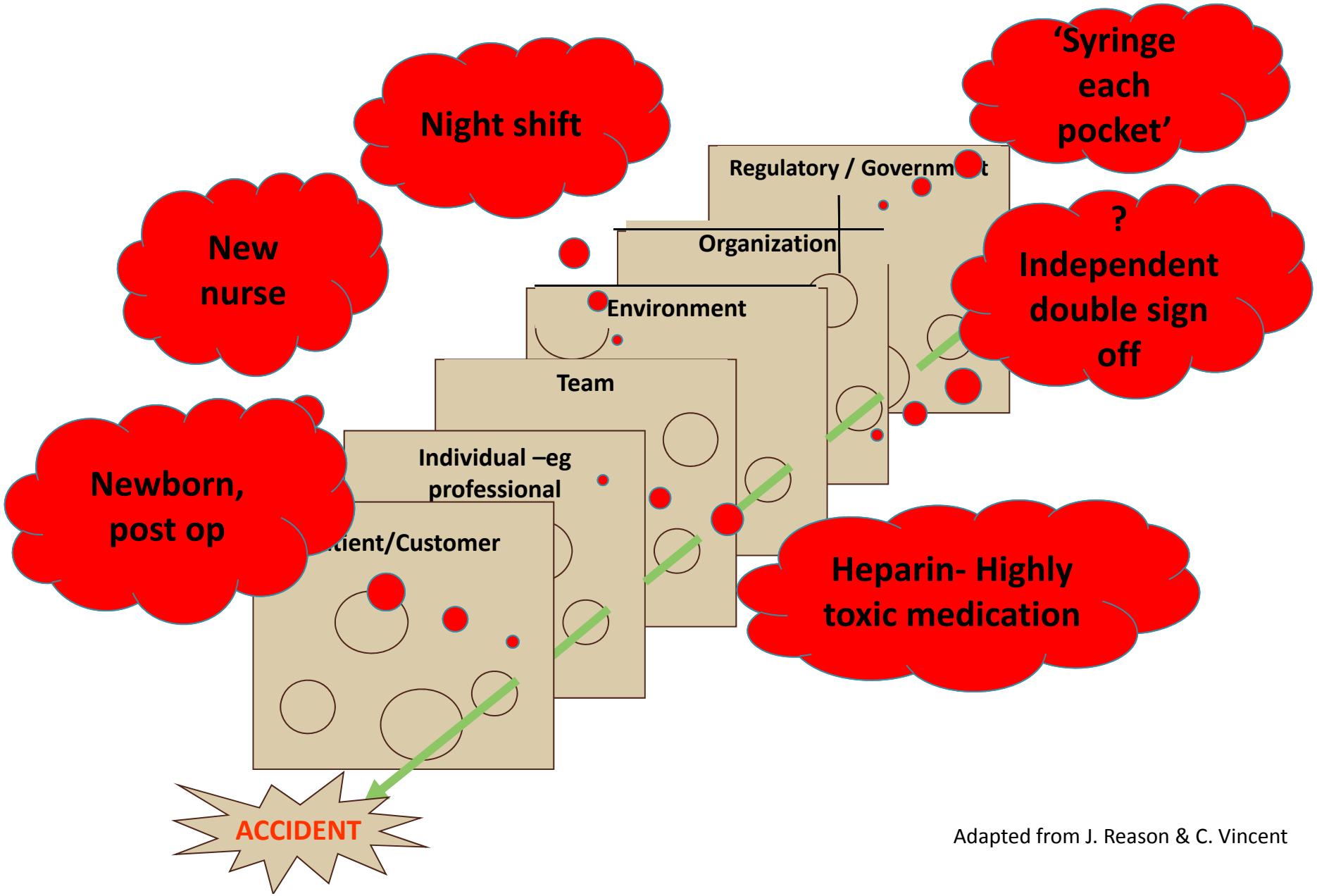


Melissa Jones and her 16-month-old son Elliott in their Toronto home on June 21, 2016. Elliott was given morphine by mistake while at SickKids Hospital after being born six week premature.

Globe and Mail, June 26, 2016

How did this happen?



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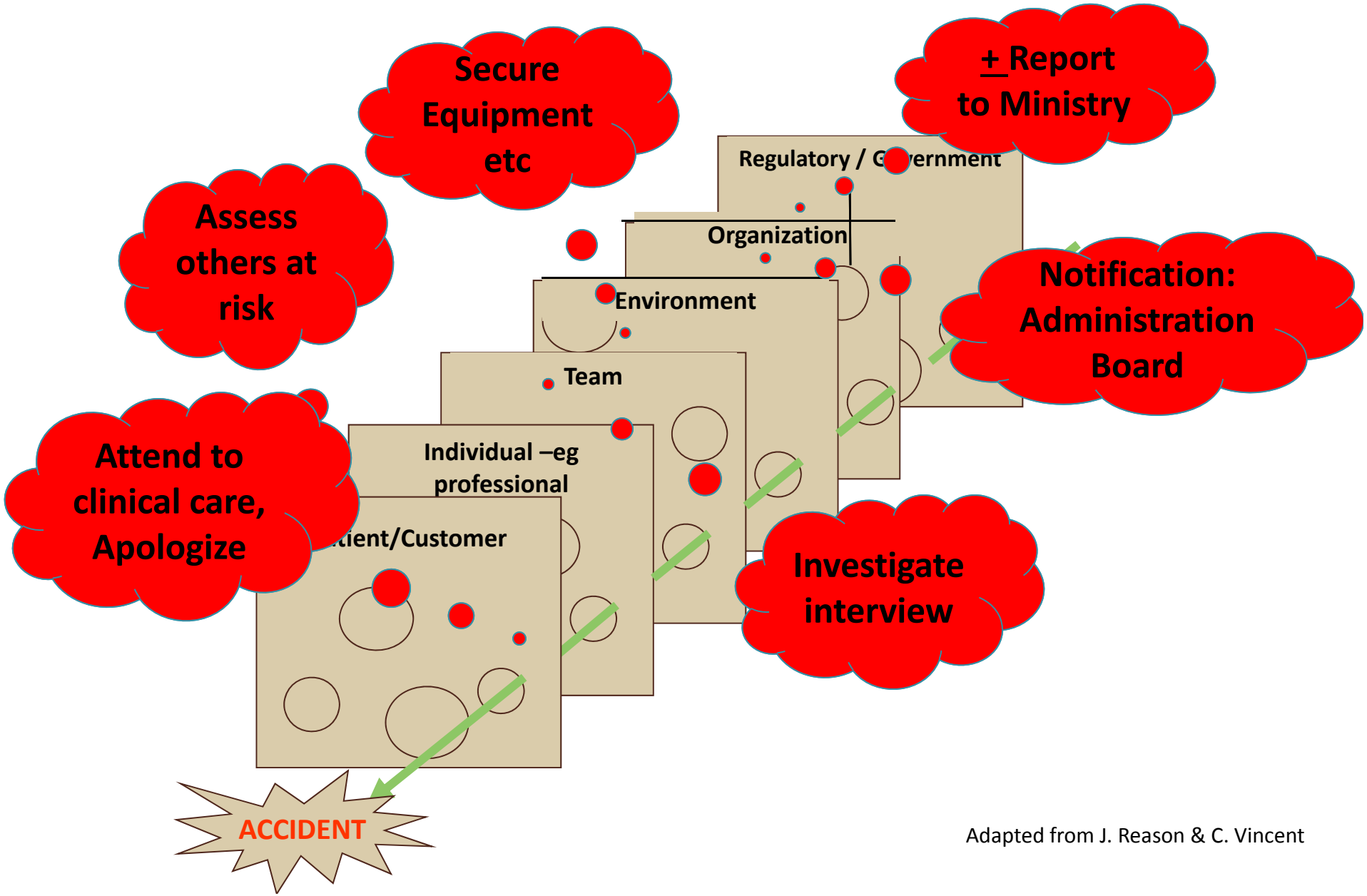
Response to harmful event



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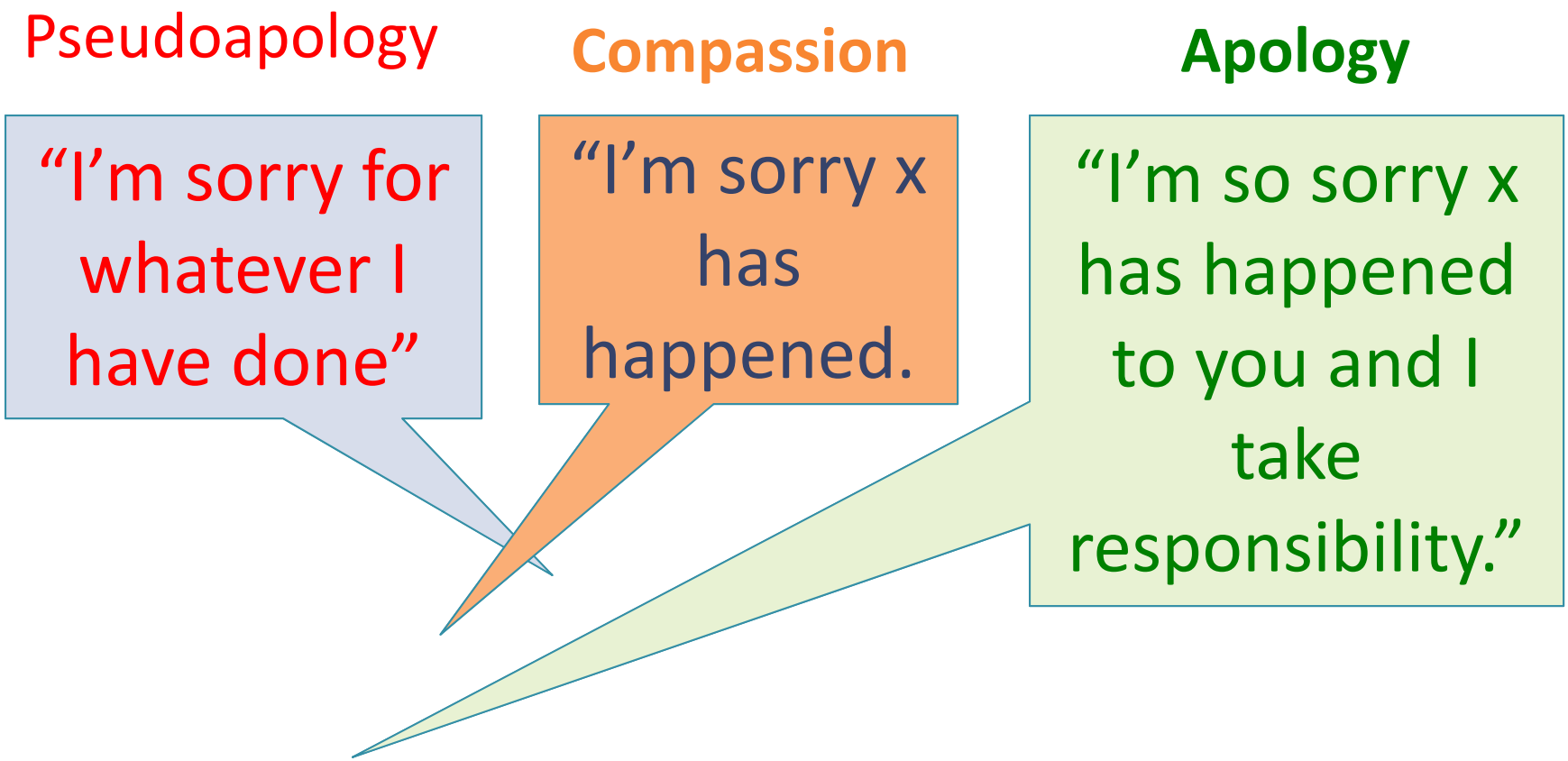
Response to a harmful event- What patients want

- an acknowledgement that something has gone wrong;
- the facts that are known about what happened;
- an understanding of the recommended next steps in clinical care;
- a genuine expression of concern and regret;
- reassurance that appropriate steps, if possible, are being taken to prevent a similar occurrence from happening again to themselves and to others.

- https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/adverse_events/Disclosure/what_is_disclosure-e.html

“Learning from mistakes: commitment or cliché ?”



Based on “On Apology’ by Aaron Lazare

GLOBE EDITORIAL

Truth and Reconciliation (2): First apologize, then act

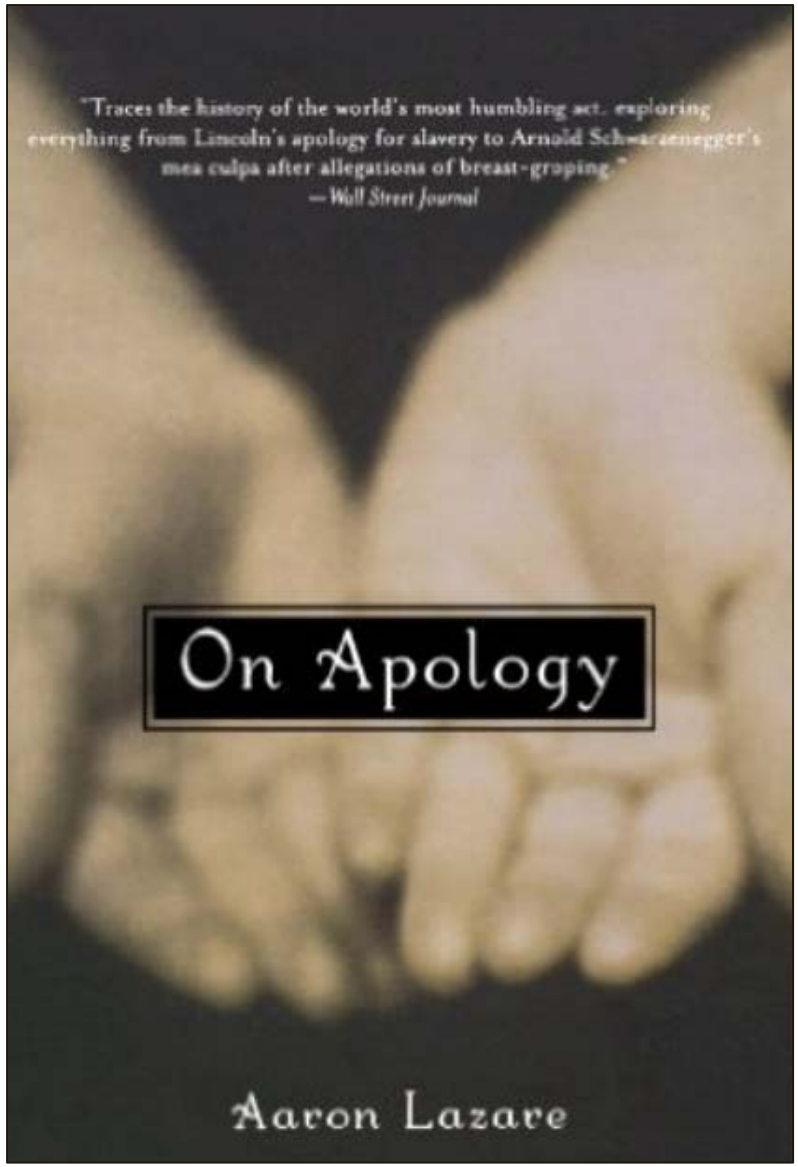
The Globe and Mail

Published Friday, Jun. 05, 2015 5:30PM EDT

Last updated Friday, Jun. 05, 2015 5:30PM EDT

"The government recognizes that the absence of an apology has been an impediment to healing and reconciliation. Therefore, on behalf of the government of Canada and all Canadians, I stand before you, in this chamber so central to our life as a country, to apologize to aboriginal peoples for Canada's role in the Indian residential schools system."

Stephen Harper June 2008



Psychological needs of offended party

- Restore dignity
- Demonstrate shared values
- Affirm not their fault
- Assure safety in relationship
- See offender suffer
- Reparation
- Meaningful dialogue

Why disclose?

Ethical

autonomy, beneficence, non-maleficence; justice

Professional Obligations

CPSO, ONA, CMA, CMPA

Legal Duty

Policy

Safety Culture

Transparency, learning

Healing: Second victim

Legislation, Regulation etc

- Public Hospitals Act
  - Critical incident
  - Disclosure
- Apology Act
- Quality of Care Information Protection Act (QCIPA)
- Excellent Care for All Act (ECFAA)

- CPSO
- CMPA
- CMA

- Canadian Patient Safety Institute

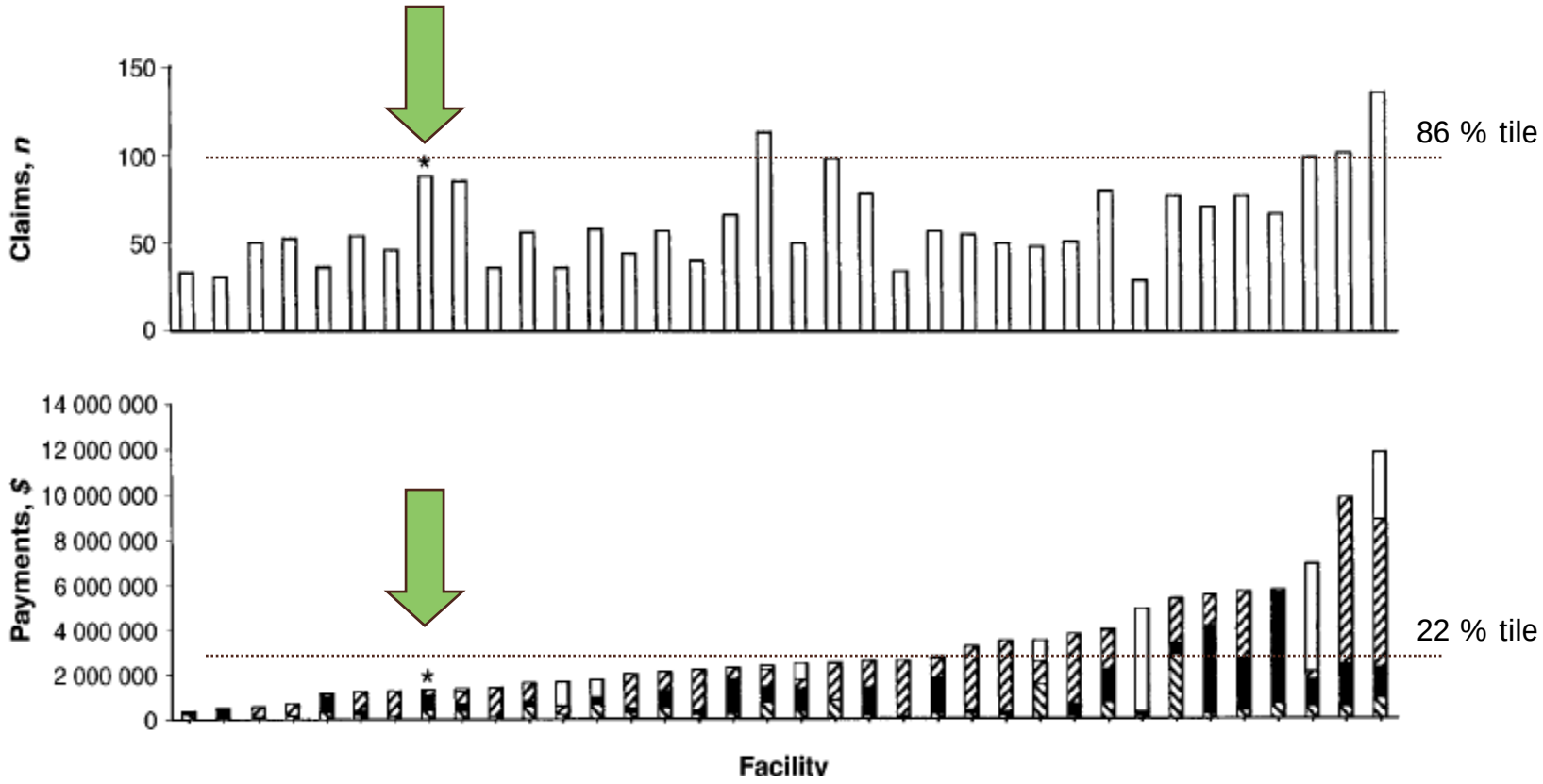
Barriers to Error Disclosure from Physician Perspective

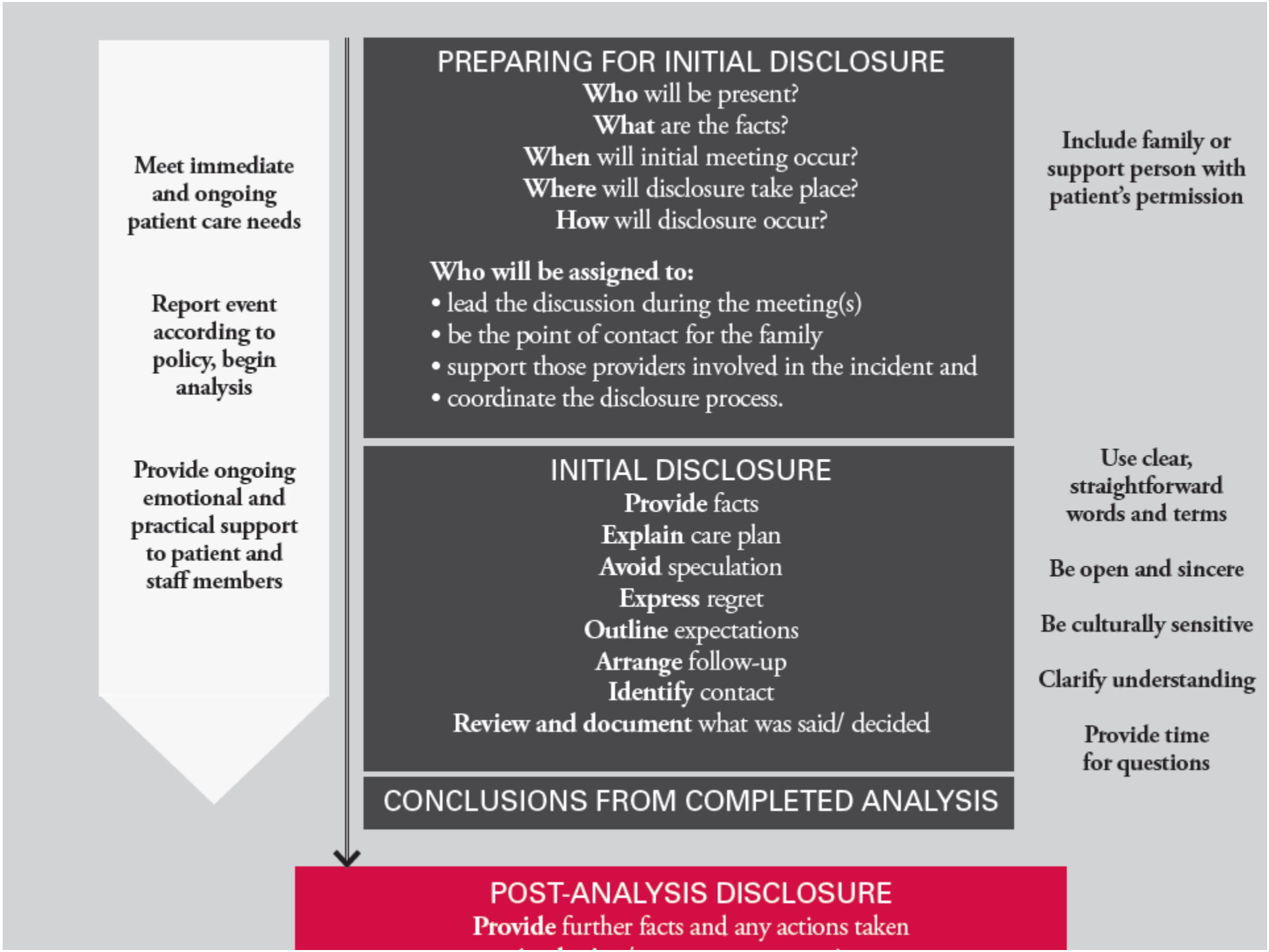
- Concern that disclosure could precipitate a lawsuit
- Fear that disclosure could harm patient
- Worry that disclosure would be awkward and uncomfortable
  - Difficulty in admitting to personal failure
  - No formal training in error disclosure

Extreme Honesty May Be the Best Policy Lexington VA

Kraman & Hamm, AIM 1999; 131:963

- Proactive full disclosure to patients who have been injured




Meet immediate and ongoing patient care needs
Report event according to policy, begin analysis
Provide ongoing emotional and practical support to patient and staff members
PREPARING FOR INITIAL DISCLOSURE
Who will be present?
What are the facts?
When will initial meeting occur?
Where will disclosure take place?
How will disclosure occur?
Who will be assigned to:
• lead the discussion during the meeting(s)
• be the point of contact for the family
• support those providers involved in the incident and
• coordinate the disclosure process.
Include family or support person with patient's permission
INITIAL DISCLOSURE
Provide facts
Explain care plan
Avoid speculation
Express regret
Outline expectations
Arrange follow-up
Identify contact
Review and document what was said/ decided
Use clear, straightforward words and terms
Be open and sincere
Be culturally sensitive
Clarify understanding
Provide time for questions
CONCLUSIONS FROM COMPLETED ANALYSIS
POST-ANALYSIS DISCLOSURE
Provide further facts and any actions taken

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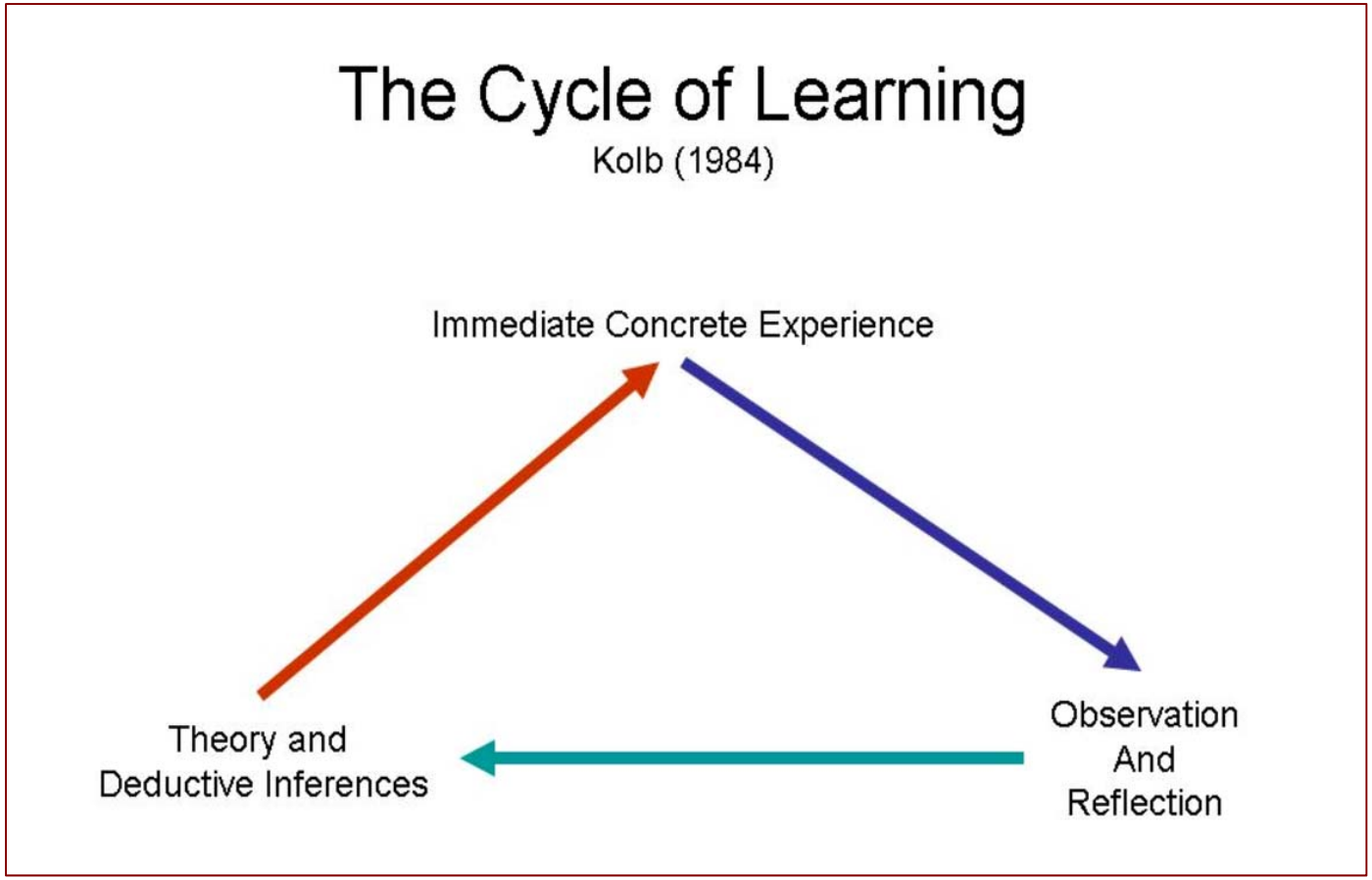
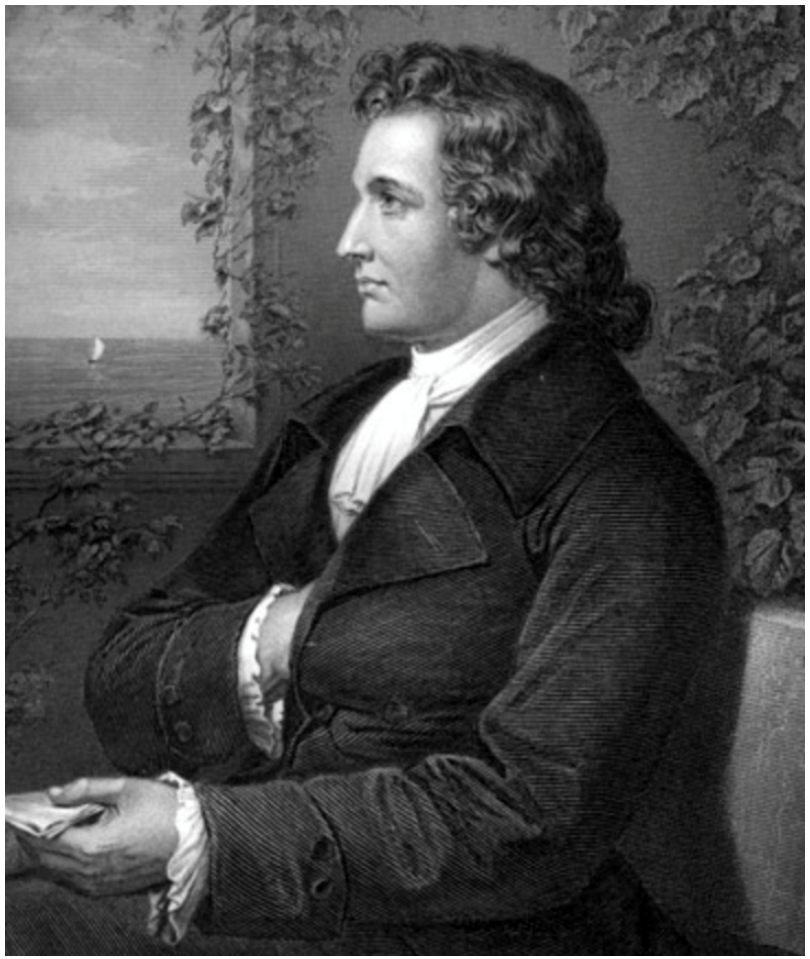




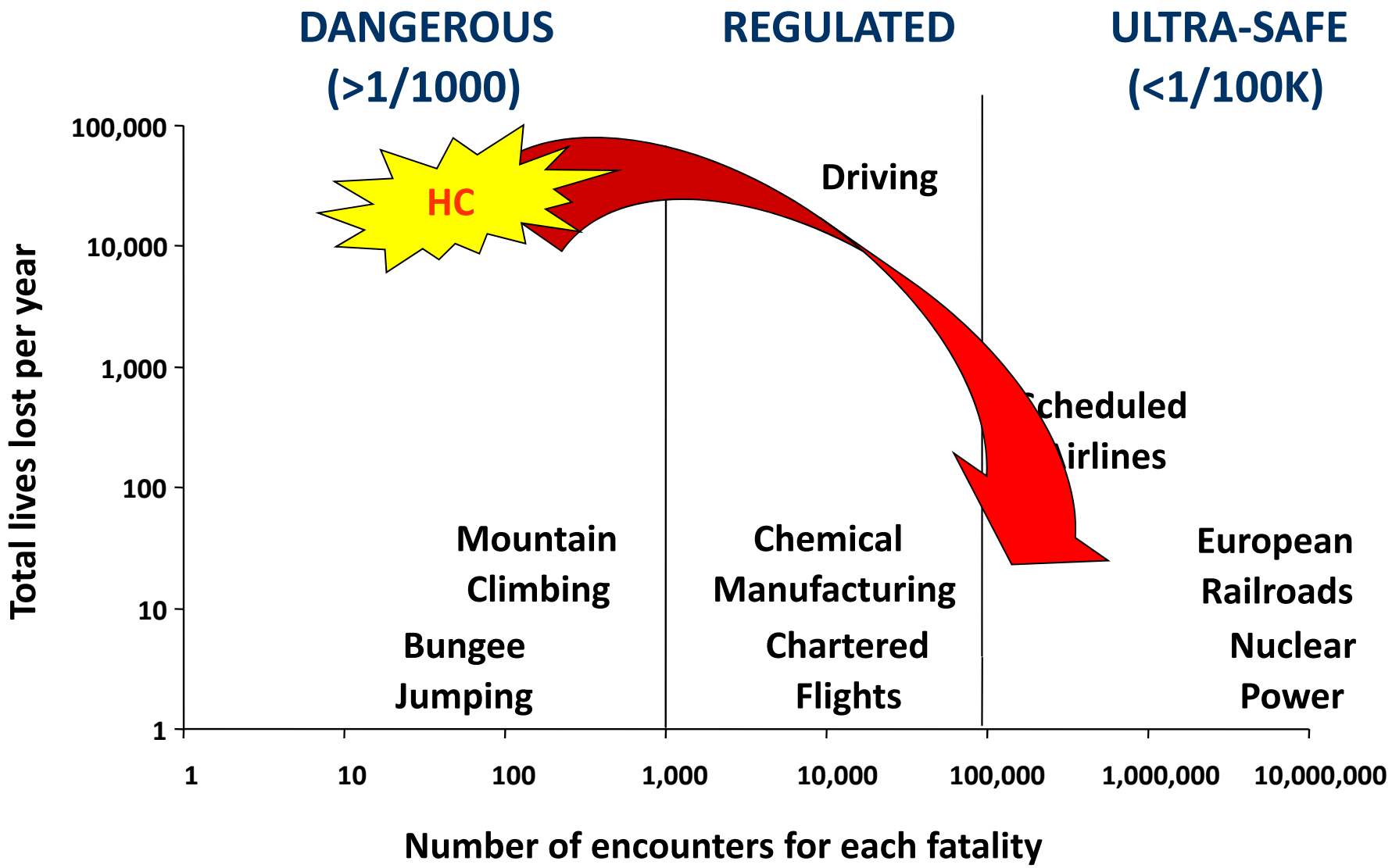
"By seeking and blundering,
we learn."

W. Goethe

Improving Health Care

Safety
Efficiency
Patient centered
Timely
Equitable
Effective

The Challenge



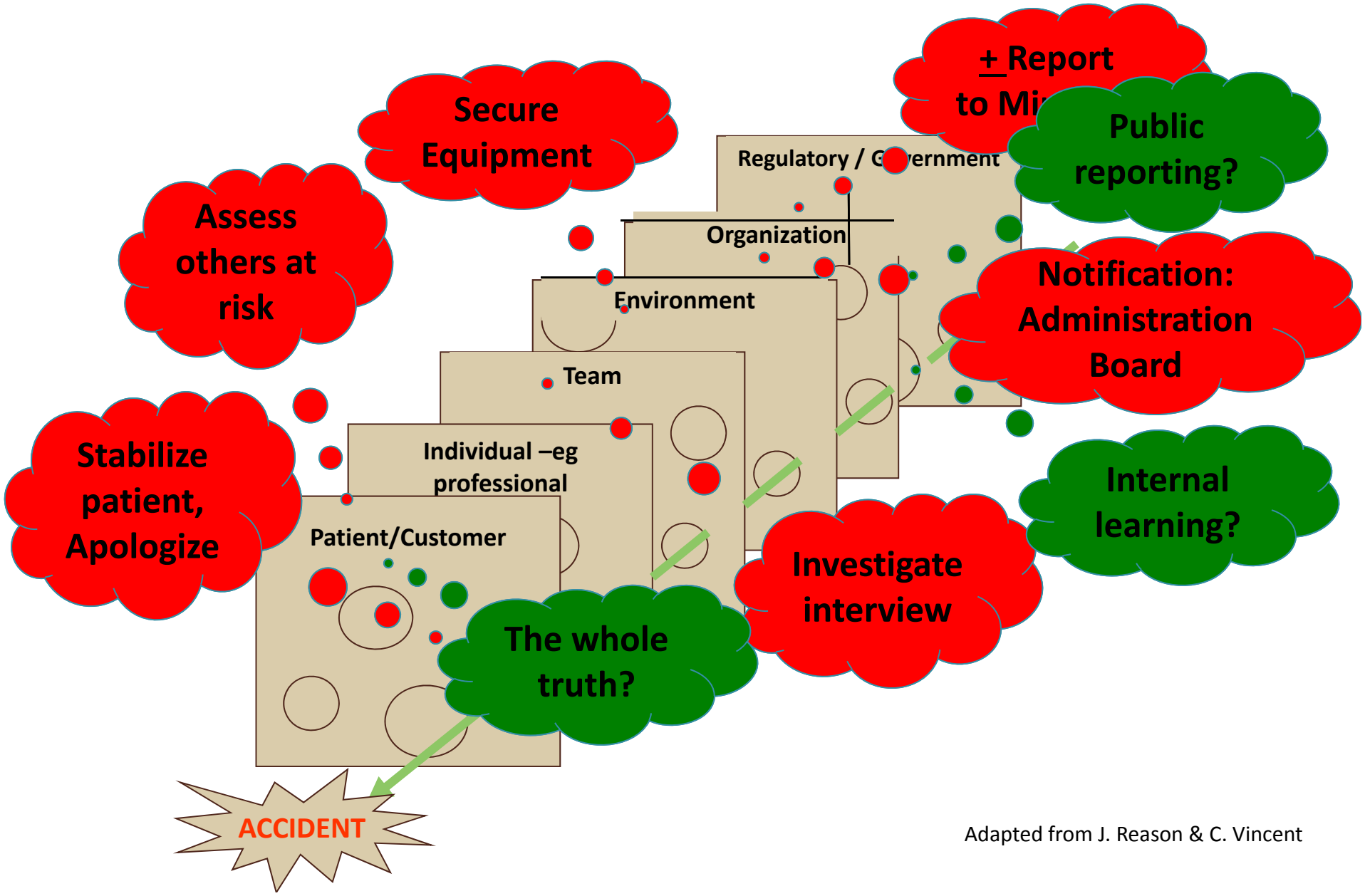
Key Elements of a Culture of Safety

Singer S. Qual Safety Health Care 2003; 12:112-118

- Commitment of leadership to safety → shared values, beliefs, behaviour
- Resources, rewards, incentives offered/allocated
- Safety valued as primary priority
- Communication at all levels frequent and candid
- Openness about errors and problems, and they are reported
- Organizational learning valued, focus in on improvement, not blame

→ Unsafe acts are rare

Response to harmful event

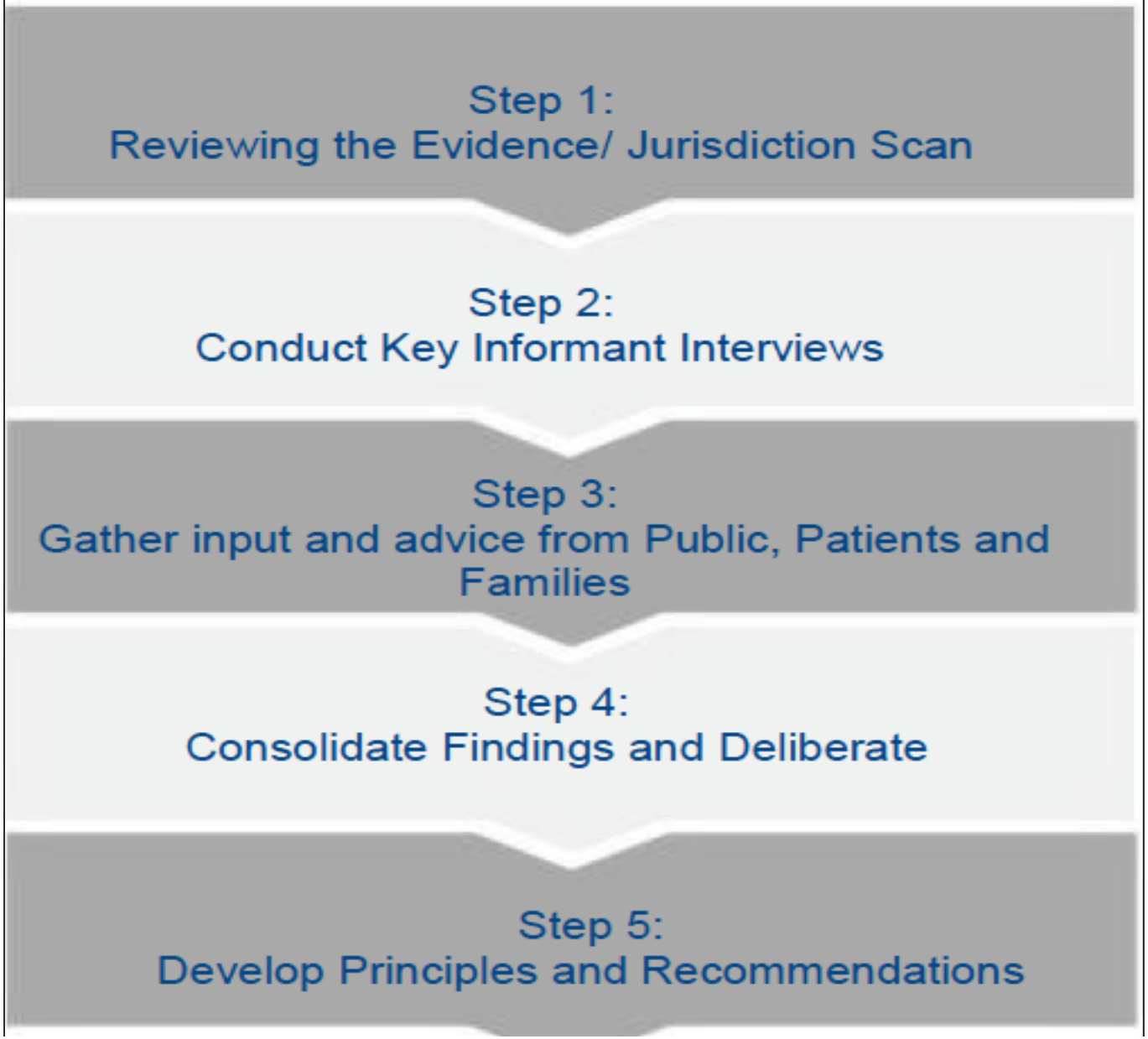


Adapted from J. Reason & C. Vincent

Quality of Care Information Protection Act, 2004 (QCIPA)

- The Act is designed to encourage health care professionals to share information and have open discussions about improving the quality of health care delivered. This includes learning from critical incidents in their organizations that involve the delivery of patient care without fear that information will be used against them.
- QCIPA ensures that information specifically prepared by or for a QCC, subject to various exclusions discussed below, is shielded from disclosure in legal proceedings and from most other disclosures.

Figure 1: QCIPA Review Committee Approach



The intent of QCIPA remains valid and QCIPA should be retained, with recommended amendments..

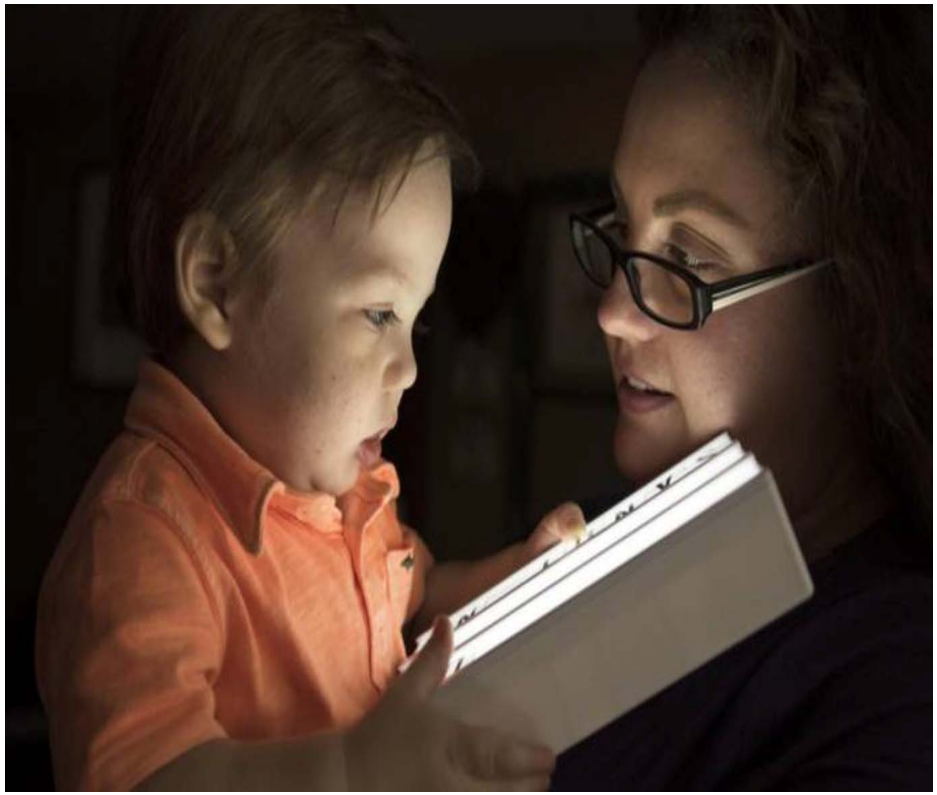
Develop clear guidance on when / how to use QCIPA

Amend QCIPA to ensure appropriate disclosure to patients/families following a CI investigation

Establish an appeal mechanism for the investigation of CIs

Establish a mechanism for hospitals to share what they have learned from their CI investigations and recommendations to prevent future incidents

Patients and families must be interviewed as part of the process of investigating the CI and be fully informed of the results



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SickKids: “… administrators will not disclose the actual number of safety events that occur at the hospital. According to [CEO], going public with error rates could backfire by making various departments look bad. Even if the hospital could provide context for the error rates, public reporting could deter employees from reporting mistakes. “It’s a tough balance,” he said.

UHN: “…will publish data on various categories of medical errors, and the rate of mistakes/patient in the coming months.“I think the information belongs to.. the public and our patients,” said Emily Musing, the patient safety officer at UHN/. The risk, she says, is that if UHN is the only organization publishing such figures, it may imply “we are the only ones with a problem with regards to safety” when in fact, “we are a microcosm of what is out there in health care. It’s just that we are very willing to talk about it.”

Globe and Mail, June 26, 2016

QCIPA Review Committee 2014

Recommendation 1: Strive for a just culture.

'The Ontario health care system must strive to achieve a 'just culture' and must have a firm commitment to quality improvement, part of which is the identification, investigation and learning from critical incidents.'

“Just” culture

Principles of a Just Culture [16]

For Patients

- Organizational commitment to deliver & monitor quality care
- Organizational commitment to investigate and remediate adverse events or concerns about quality of care
- Openness, honesty and support if things go wrong

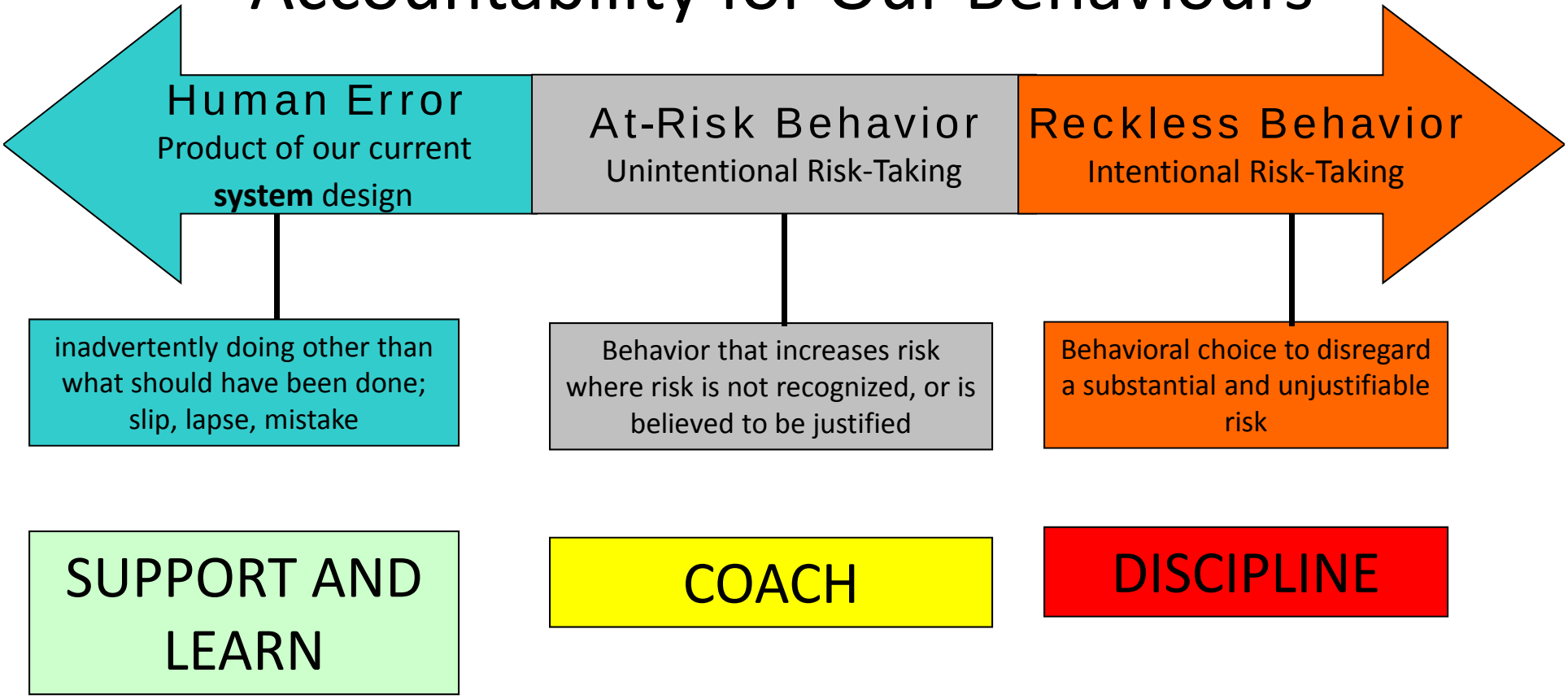
For health care providers

- Safe systems in which to work
- Support to participate
- A presumption of competence
- Unbiased assessment of competence
- Support if things go wrong, not blame
- Support for education and training with action taken if provider does not meet standards
- Transparent, evidence-based investigation of adverse events

For Organizations

- A professional culture that supports organizational efforts to improve quality and address adverse events
- A professional commitment to self-regulation
- Professional compliance with reasonable policies/procedures

Just Culture:
Assessing Unsafe Acts
Accountability for Our Behaviours



Children's Hospital of Philadelphia. Adapted from: "The Just Culture", David Marx, JD, and Missouri Baptist Medical Center

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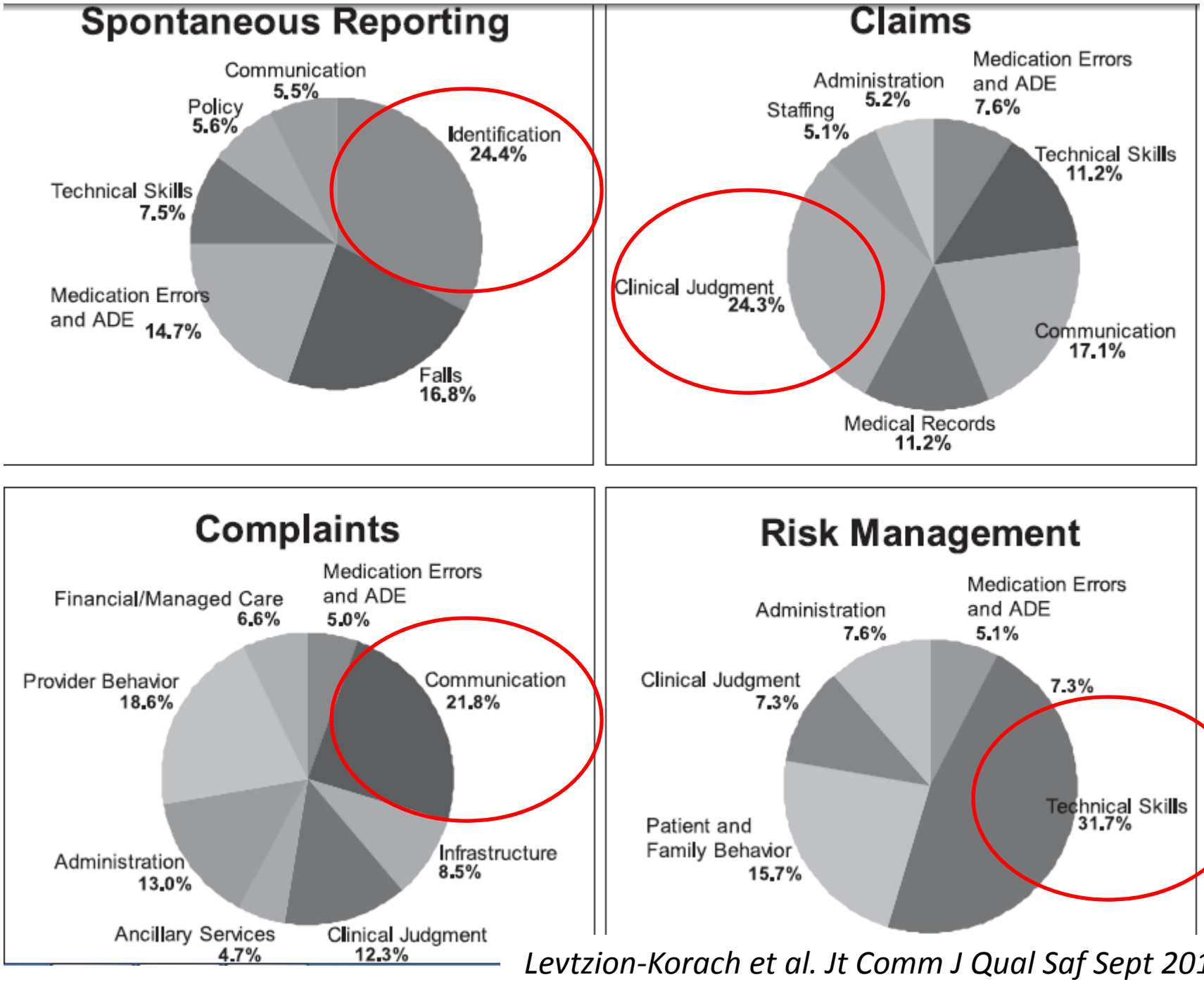
Learning Organizations

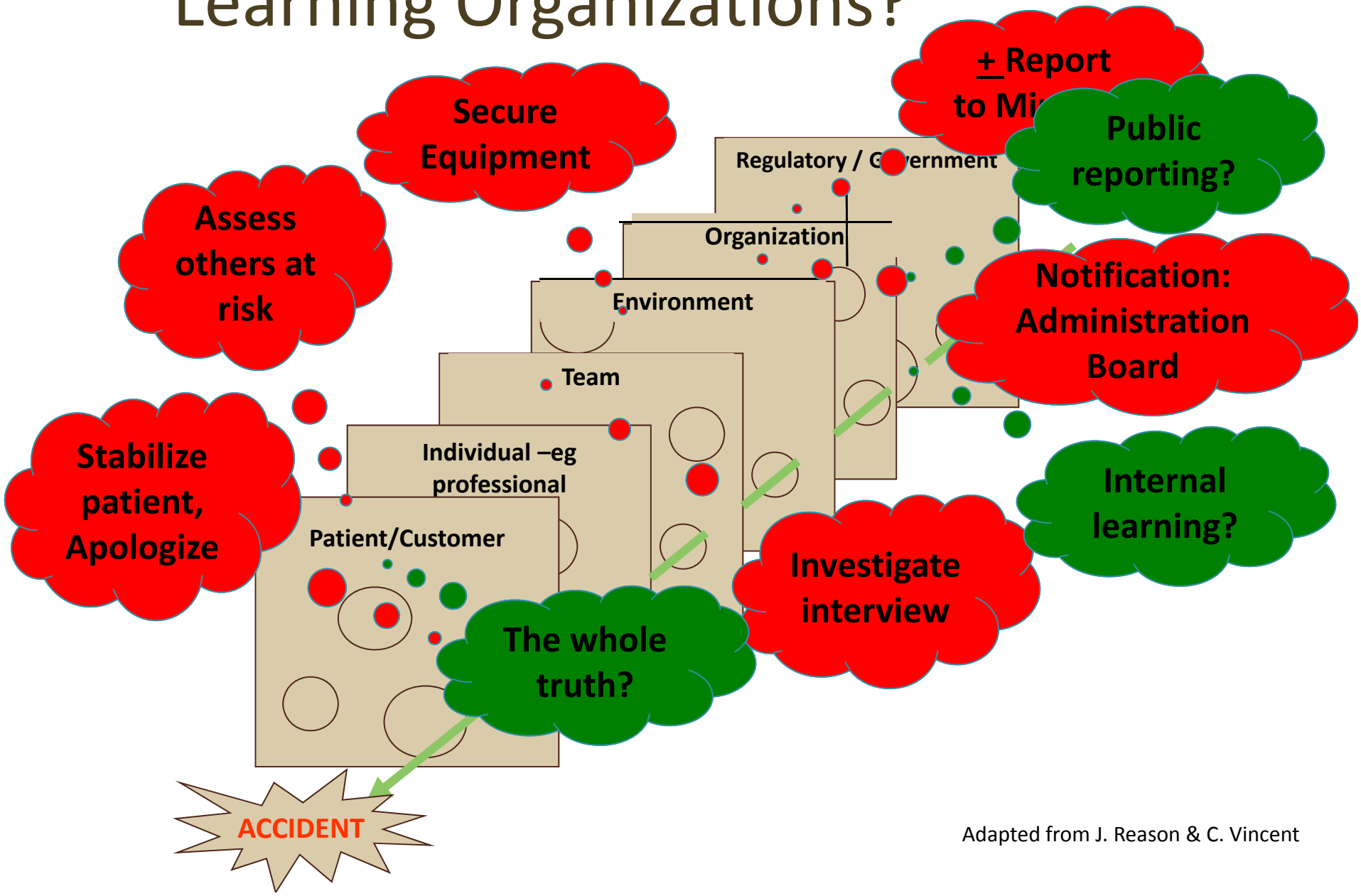
The Fifth Discipline, Peter Senge.

- a learning organization is a group of people working together collectively to enhance their capacities to create results they really care about
  - Systems thinking
  - Personal mastery
  - Challenge mental models
  - Shared vision
  - Team learning



Levtzion-Korach et al. Jt Comm J Qual Saf Sept 2010

How can we create true Learning Organizations?



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Thank you

anne.matlow@utoronto.ca