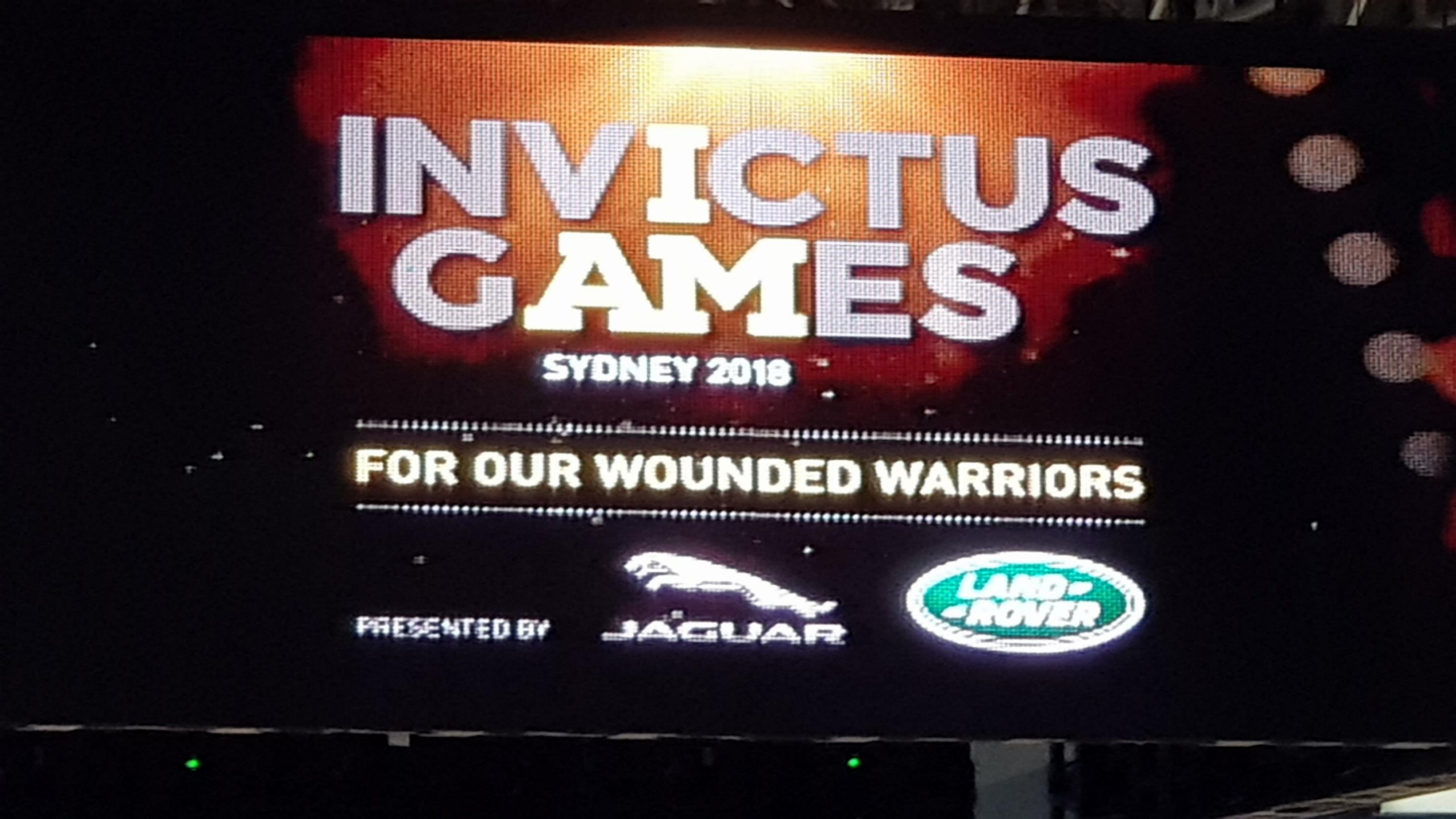
MISTAKES TO MIRACLES

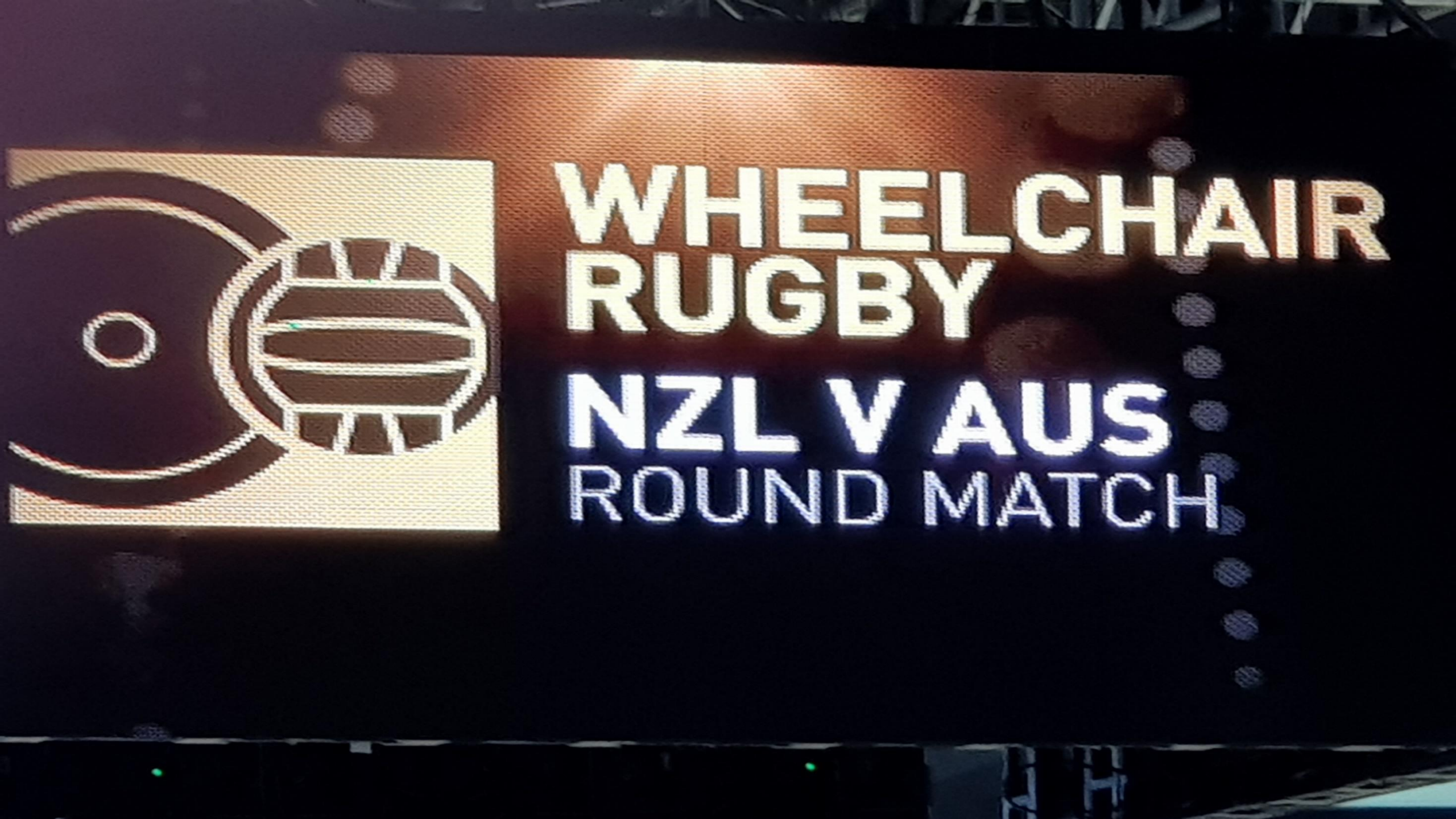
LIZ CLOUGHESSY

2018

DISCLAIMER

- The opinions expressed are those of the presenter and do not reflect any other person or agency
- Warning: I do have strong opinions
- I have no financial gain to disclose
- It is my sincere hope that this information will cause reflection and create change in how we handle being human
- .....maybe one small bias!


INVICTUS
GAMES
SYDNEY 2018
FOR OUR WOUNDED WARRIORS
PRESENTED BY
JAGUAR
LAND ROVER


WHEELCHAIR
RUGBY
NZL V AUS
ROUND MATCH


OF MY SOUL
GAME ON
INVICTUS GAMES
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GAMES
SYDNEY 2018


I AM UNCONQUERED
INVICTUS GAMES

QUESTION?

Have you ever made a medical error?

Did you report it?

"I would rather make mistakes in kindness and compassion than work miracles in unkindness and hardness."

— Mother Teresa

SOMETIMES PEOPLE DIE DESPITE THE BEST CARE

SOMETIMES PEOPLE LIVE IN-SPITE OF THE WORST CARE.

WE CALL THAT A MIRACLE

DEFINITIONS

Medical Error – preventable adverse event or near miss due to the failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim.

Adverse Event – unintended patient harm caused by medical management rather than by a disease process which results in a prolonged hospital stay, morbidity or mortality.

Near miss – an error or mishap that had the potential to cause patient

Harm, but did not, either by chance or thanks to timely intervention.

(Curing Pharm,J., Aswani,M.S., Rosen,M., Lee, H.W., Huddle, M., Weeks,K.,&Pronovost,P.J., 2011p2)

Incident Causes
The Swiss cheese model

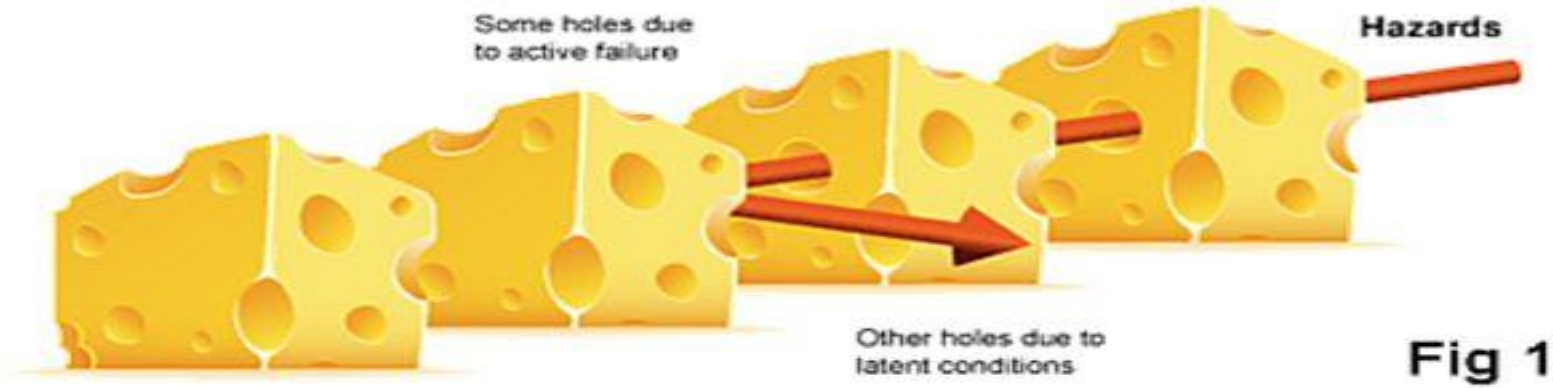


Fig 1

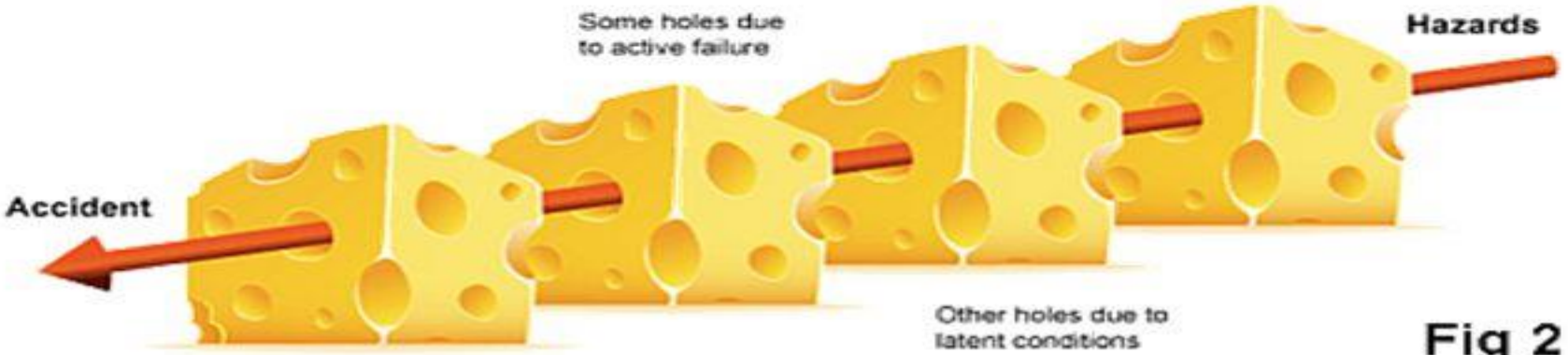
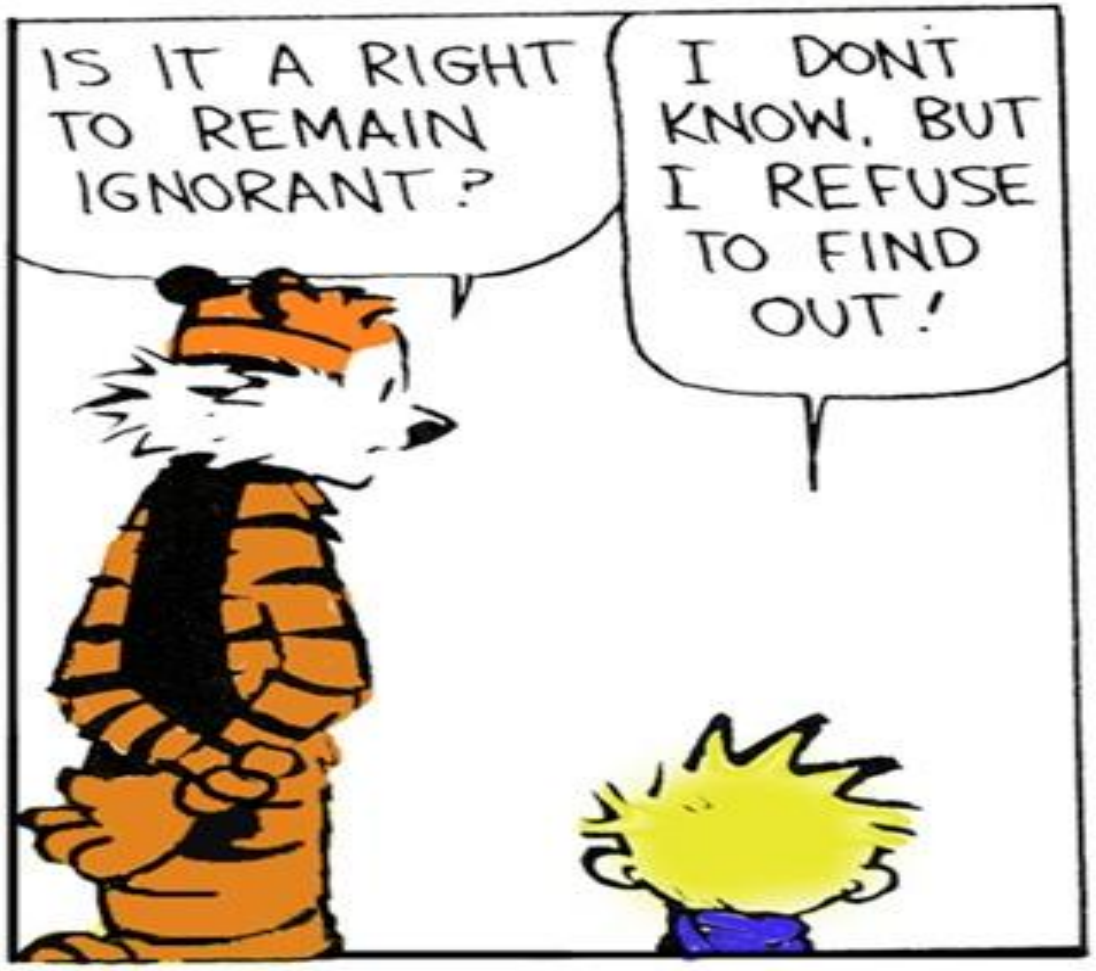


Fig 2

Adapted from Reason, J. (1990). Model: http://blogs.esa.int/astronauts/files/2013/01/swisscheese.png

PERSONNEL ISSUES

- Understanding of how errors occur
- Failure to adhere to policy and /or procedure documents
- Number of hours on shift
- Distractions
- Lack of knowledge
- Workload
- Care delivery method



CASE EXAMPLE 1

80 year old woman with a history of dementia falls at a nursing home and sustains a displaced distal radius fracture. En route EMS providers administer morphine.

She is given additional morphine and midazolam for the reduction in ED.

Post procedure the patient has a respiratory arrest requiring intubation.

Subsequent chart review reveals “allergy” to morphine

Do we define this as a mistake?


I'M NOT SAYING YOU WOULDN'T TRY TO DO THE RIGHT THING IN AN EMERGENCY, IT'S JUST... LOOK AT YOUR FREAKY LITTLE ARMS.
EMERGENCY EXIT
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CASE EXAMPLE 2

40 year old male without a medical history presents with chest pressure.

His ECG shows non specific T wave abnormalities and his discomfort is relieved by a “GI cocktail”. His troponin is normal.

He is discharged with a diagnosis of gastroesophageal reflux disease (GERD)

He returns to ED 6 hours later with an ST-segment elevation myocardial infarction

"SO — WHAT DOES IT SOUND LIKE TO YOU?"

CASE EXAMPLE 3

45 year old man sustains 60% total body surface area burn. He is intubated and a subclavian central line is inserted, without CXR confirmation.

Over the next few hours he becomes hypotensive, difficult to ventilate and hypoxic.

The clinician attributes decreased pulmonary compliance to the mans burns. IV fluids and vasopressors are administered.

The routine round orders a CXR and it reveals a large tension pneumothorax.

"If we learn from our mistakes, shouldn't I try to make as many mistakes as possible?"

Publiliu Syrus, the Latin writer (born 85 BC) said: "From the errors of others, a wise man corrects his own."

Tell my mistakes to me,
not to others

Because those are
to be corrected by me,
not by them.

A WISE MAN WILL THANK YOU FOR SHOWING THEM THEIR MISTAKE AND TEACHING THEM

- Ego, pride, fear of legal reprisal are reasons we are hesitant to step-up and own the error

- Set protocols, supportive management team and encouragement for doing the right thing will help create the trust needed


Who called you a bad dog? Point them out.
I will end them...

HOW DANGEROUS IS HEALTH CARE

Less than one death in 100,000 encounters

- Nuclear power
- European railroads
- Scheduled airlines

One death in less than 100,000 but more than 1,000 encounters

- Driving
- Chemical manufacturing

More than one death per 1,000 encounters

- Bungee jumping
- Mountain climbing
- Health care

WHAT IS AN ERROR?

Definition:

- Failure of a planned action to be completed or the use of a wrong plan to achieve an aim
- Does not imply fault
- Focus is on perfecting the system to optimize performance
- Who defines a clinical error and determines its significance?
- What is the ethical responsibility for disclosing an error?

- Should clinically insignificant errors be reported?

Who should monitor error reporting?

ERROR VERSUS CRIMINAL ACT

- Neglect
- Abandonment
- Intentional Harm
- Abuse
- Assault

WHY DO ERRORS HAPPEN?

- All humans make errors: indeed, “the ability to make mistakes” allows human beings to function
- Most of medicine is complex and uncertain
- Most errors result from “the system”- inadequate training, long hours, ampules that look the same, lack of checks etc

Healthcare has not tried to make itself safe

HOW TO THINK OF ERROR?

An individual failing:

- Only the minority of cases amount from negligence or misconduct: so it's the wrong diagnosis
- It will not solve the problem – it will probably make it worse because it fails to address the problem
- Will hide errors

May **destroy the clinician** inadvertently (second victim)

ERRORS OCCUR- WHAT TO DO

If it is unrealistic to "make " the practice of medicine error free, do we as clinicians have an ethical responsibility to set expectations for patients

- Provide disclosures for potential errors, similar to method of informing patients of known procedural complications

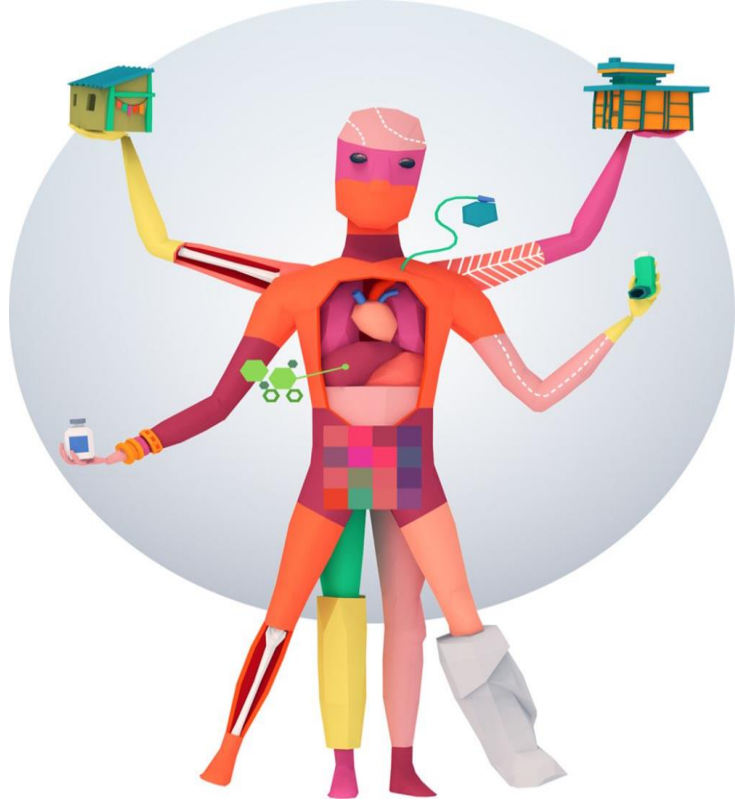
- Consider some errors which will occur (despite attempts to prevent) and others that should never occur ("never events")

POTENTIAL FOR AN ERROR

- It is estimated that clinicians make an average 5,000 decisions per shift

- If estimated error rate for clinical decision making is 1:100 – 1:1000 then 5 – 50 errors are made during an average shift

REASONS FOR MEDICAL ERROR



- Complexity and acuity of patient encounters
- Lack of complete patient information
- Non-uniformity in standardisation of care
- Inadequate supervision
- Culture of medicine:
  - Myth of clinician infallibility
  - Reluctance to discuss errors
  - Punitive approach to error discourages reporting and correction of system issues
  - Fatigue

HOW TO THINK OF ERROR'S?

A systems failure:

- This is a starting point for redesigning the system and reducing error
  - We must create an environment that feels safe to report errors
  - You should be able to report with out judgement or fear of reprisal

I am in competition with
no one. I have no desire
to play the game of being
better than anyone.
I am simply trying
to be better than
the person I was
yesterday.

WHAT IS THE ETHICAL RESPONSIBILITY FOR DISCLOSING AN ERROR

- If it is unrealistic to “make” the practice of medicine error free, do health care workers have an ethical responsibility to set expectations for patients?
- Provide disclosures for potential errors, similar to method of informing patients of known procedural complications?
- Consider some errors which will occur (despite attempts to prevent) and others that should never occur (never events)

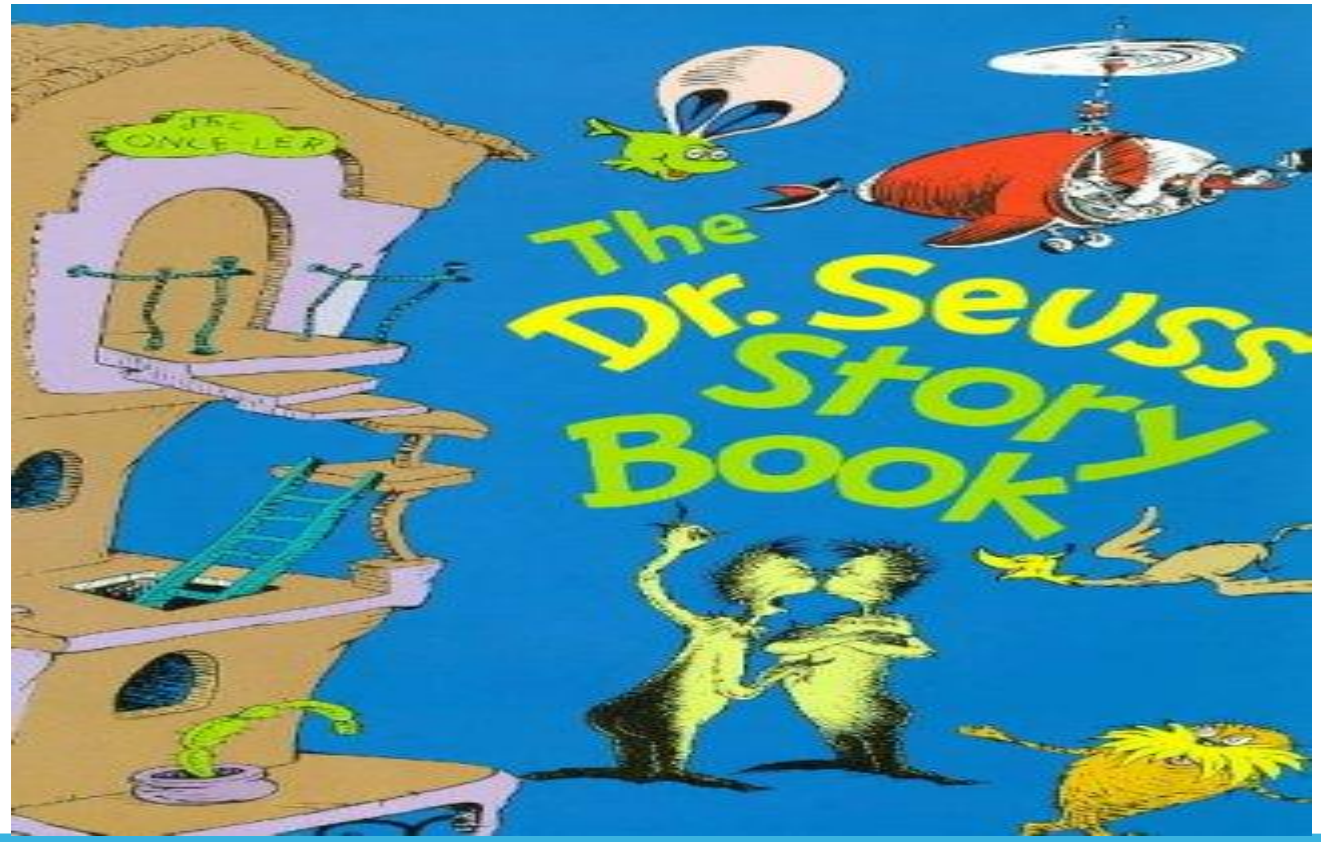
THE CASE IN YOUR MIND…

It is very likely that you have personally made an error in patient care…Think about that situation for a moment

Did you report? Were you supported in finding a resolution and identifying the cause if there was one?

What would you like to say to someone that finds themselves in that same situation?

A TRUE STORY



TRAUMA CASE

Scene

- Busy metropolitan ED
- Pre trauma centres or major trauma education or organised trauma care systems
- Medical Staff – predominately GPs - pre FACEMs

PATIENT

- 64 year old female - pedestrian hit by a car in a pedestrian crossing
- Brought in by Ambulance
- No pre hospital care commenced, no IV, no collar
- Fully conscious, alert and cooperative
- Haemodynamically stable

NURSING INTERVENTIONS

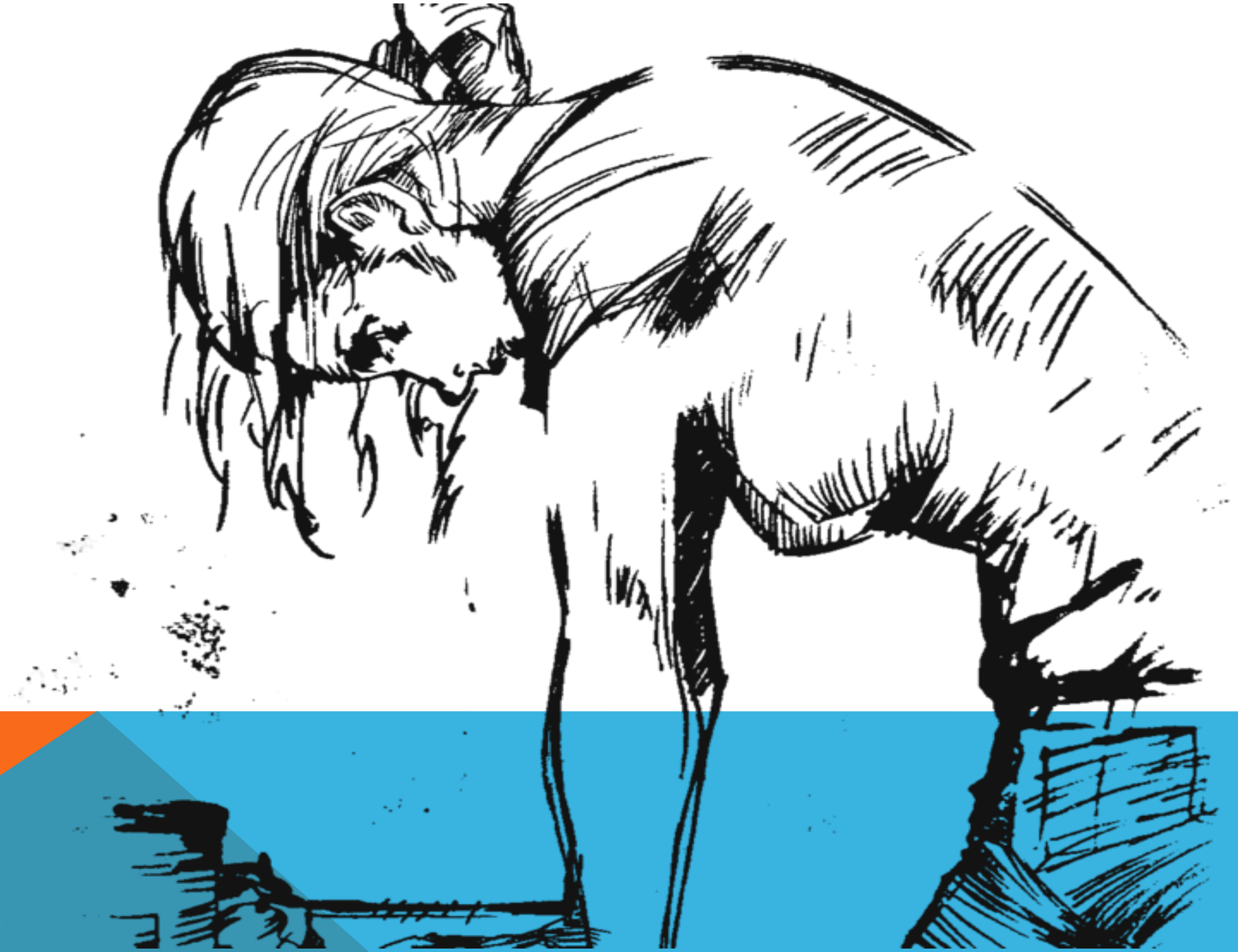
In an effort to fast track care, registered nurse asks Doctor to sign an order for x-rays where the patient hurt

- Chest,
- Pelvis,
- Right femur,
- Right humerus

No other interventions or assessment attended by nurse or doctor(Dr did not see the patient)

OUTCOME

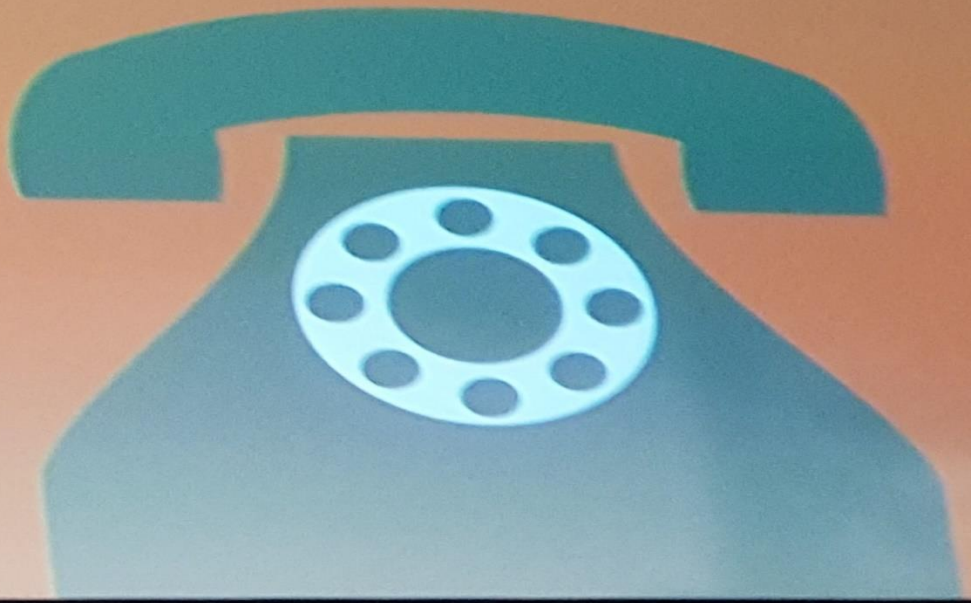
- Patient deteriorated in the x ray department
- Taken back to ED – placed in resus room
- Resuscitated and transferred to major teaching hospital
- Patient survived and ultimately discharged



THE YEAR

1982

REMEMBER THAT PATIENT YOU SAW?



Don't judge me
for things I did a
few seconds ago,
I've changed since then.

SYSTEMIC APPROACH

Proper case review conferences

- Interactive, nonjudgmental forum for discussion of clinical care improvement
- Must involve frank discussion of error, with focus on correction of systematic factors that put patients at risk
- Anonymity (of patient and provider) to promote faculty interaction and assessment

SYSTEMIC APPROACHES

Supervision

- Ready access to senior clinicians for patient care activities
- Culture of patient safety should encourage all caregivers to ask for help when needed
- Direct patient care observation

Team based care

- Open communication
- Everybody has a say

Concern for patientcare aids in conflict resolution among team members

Feedback and debriefing manages to improve care for subsequent patients

ERRORS AND VIOLATIONS

Violations are deliberate deviations from proper procedures or rules

Most violations are used as shortcuts and do not arise from harmful intentions

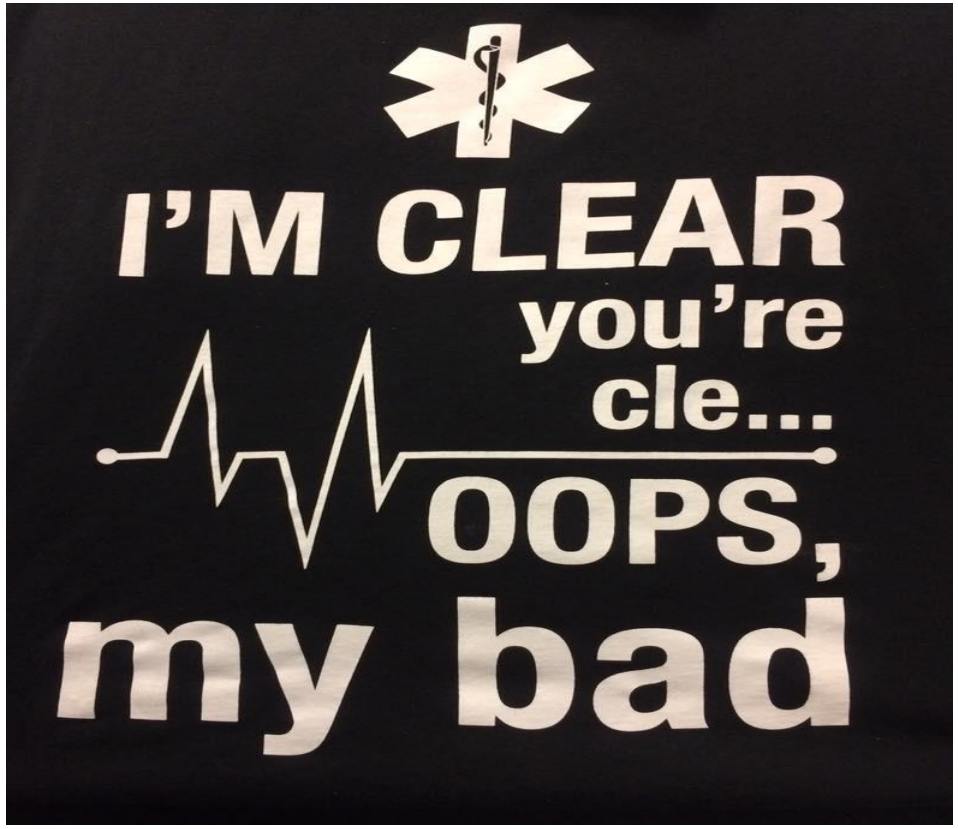
Errors are unintentional deviations

Active failures are immediate causes of safety incidents

Latent failures rest in the systems, procedures and culture of the organisation

JAMES REASON BOTTOM LINE

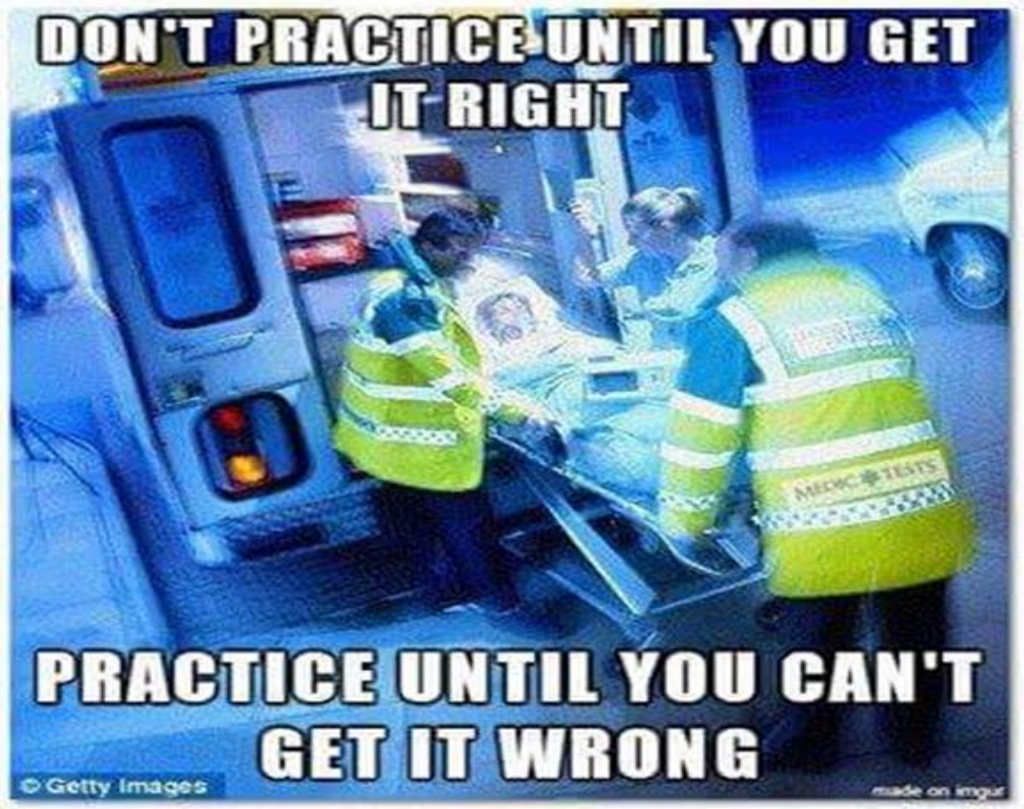
- Fallibility is part of the human condition
- We can't change the human condition
- We can change the conditions under which people work



BUILDING A SAFE HEALTHCARE SYSTEM

James Reason concepts:

- Principles
- Policies
- Procedures
- Practices
- Safety is everybody's business



WHAT ABOUT MIRACLES?

Miracles in medicine are events that have no scientific explanation

I have witnessed miracles, they are everywhere in medicine

Do not try to project your actions into the cause

Miracles do help us pause and consider why…

They have humbled me, I think that is their purpose


I NEVER LOSE.
EITHER I WIN
OR I LEARN.

CONCLUSIONS

- Human beings will always make errors
- Errors are common in medicine, killing tens of thousand world wide
- We are beginning to know something about the epidemiology of error but we need to know much more
- Naming, blaming and shaming have no remedial value
- We need to design health care systems that put patient safety first (First do no harm)
- We need to create a safe place where we can look at causes and find ways to prevent the errors
- We know a lot about how to do that
- It’s a long never ending job

IS IT OKAY TO ADMIT WHAT YOU DON'T' KNOW?

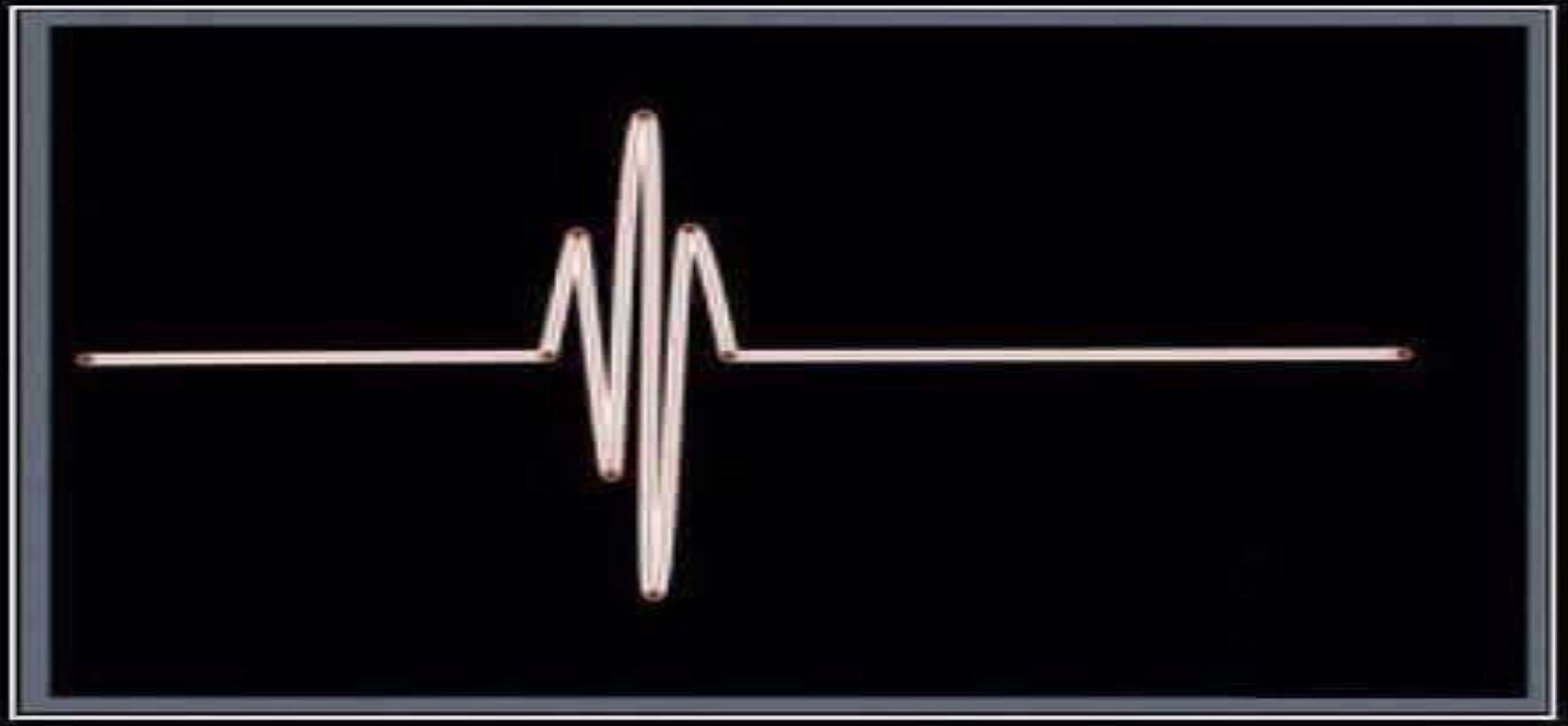
Medicine requires practitioners to be:

- Self Aware
- Self Directed
- Lifelong learners.

- It is crucial that providers not only understand the limits of ones knowledge and skills

- But: also recognise when it is important to convey genuine expertise to provide the best care and comfort to our patients


Oh, yes, the past
can hurt. But the way I see
it you can either run from it
or learn from it.
Rafiki
BRIGHTSIDE.ME
© UNASHOOK



If there are no ups and downs in your life

It means you are dead

WHEN YOU HAVE THAT TEAM

AND YOU KNOW YOU'RE GOING TO HAVE A GOOD SHIFT

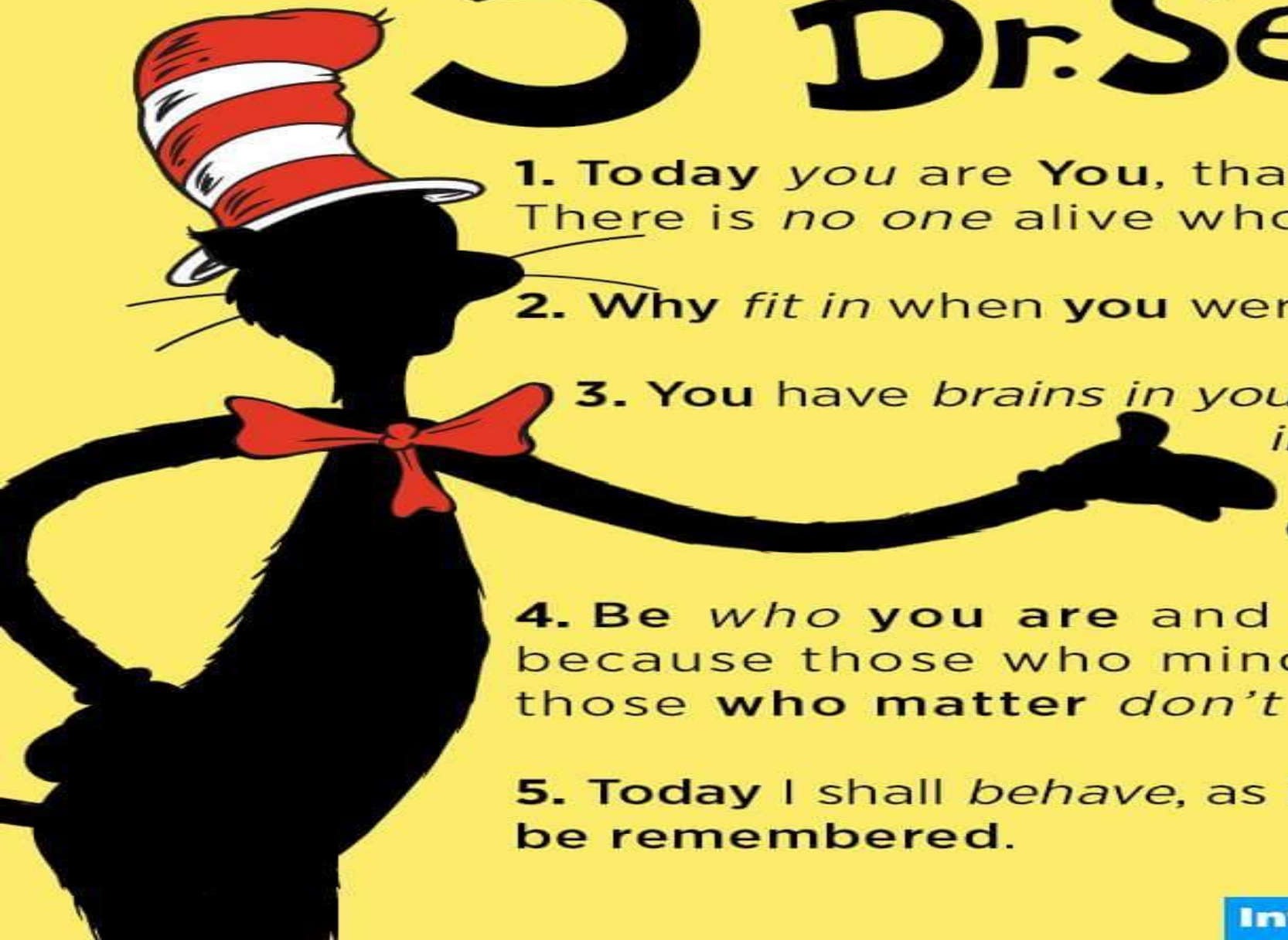
MY 3 RULES TO LIVE BY

1. At the end of the day you go to bed with yourself

2. Let all my mistakes be new ones

3. Only take notice of people whose opinion you respect

5 Lessons in life from Dr. Seuss



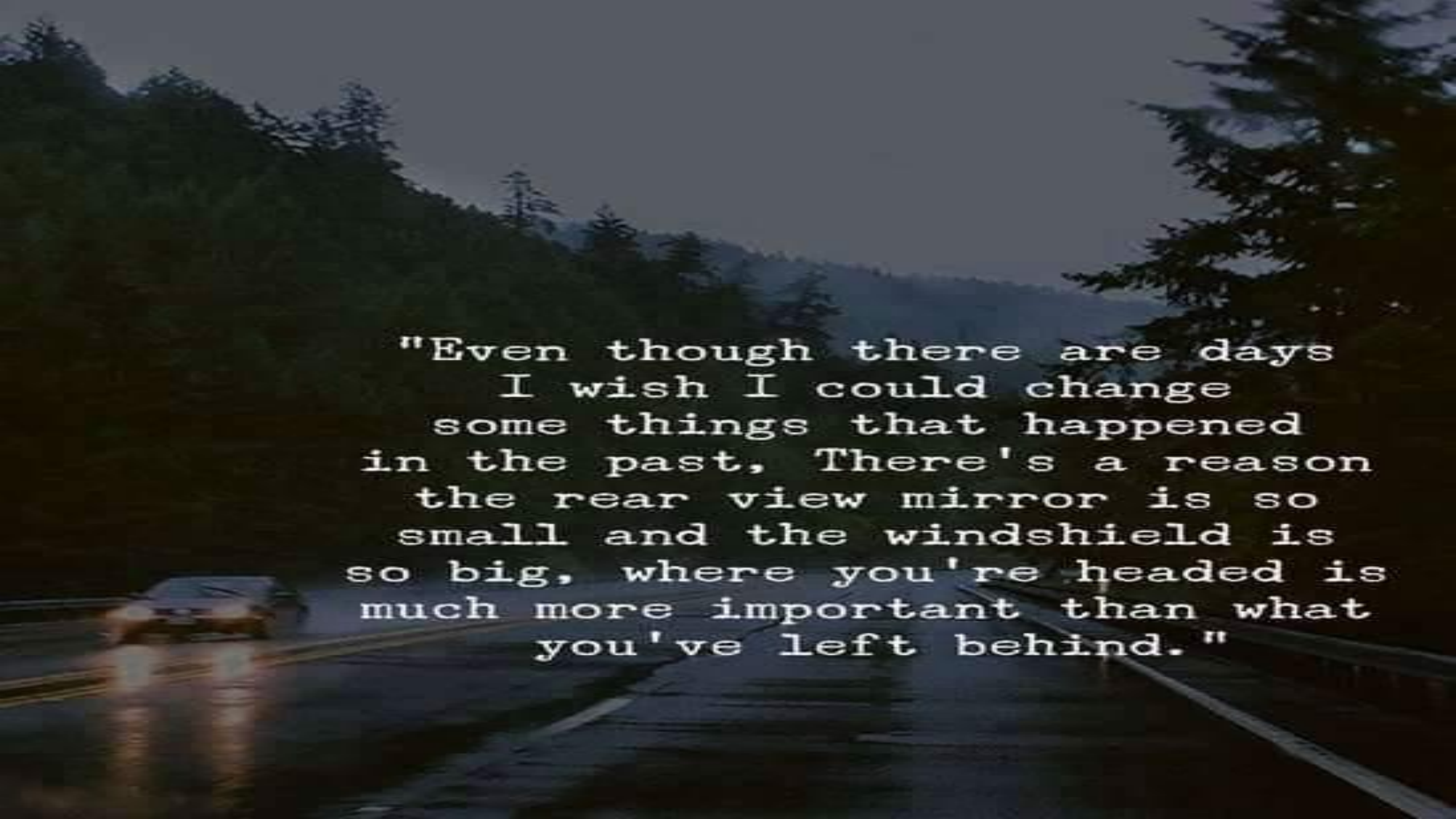
1. **Today** *you* are **You**, that is *truer* than **true**. There is *no one* alive who is *Youer* than **You**.

2. **Why** *fit in* when **you** were born to **stand out**?

3. **You** have *brains in your head*. **You** have *feet in your shoes*. **You** can **steer yourself** any **direction you choose**.

4. **Be** *who* **you are** and *say* **what you feel** because those who mind *don't matter* and those **who matter** *don't mind*.

5. **Today** I shall *behave*, as if *this is the day* **I will be remembered**.


"Even though there are days
I wish I could change
some things that happened
in the past, There's a reason
the rear view mirror is so
small and the windshield is
so big, where you're headed is
much more important than what
you've left behind."

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