

Patient Safety and Clinical Ethics

Restoring Trust and Safety in Healthcare:
Educating the Next Generation of Providers

Introductions

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Definition of Professionalism

AAMC & NBME:

- Altruism
- Honor and Integrity
- Caring and Compassion
- Respect
- Responsibility
- Accountability
- Excellence and Scholarship
- Leadership

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The non-principled approach

- The beginning circa 2000
 - The K.C. case, COO of sister hospital
 - Preoperative testing prior to plastic surgical procedure
 - Evening before surgery - lab tests done
 - WBC <1,000 (normal value 4-12,000)
 - Only Hgb & Hct checked on day of surgery
 - Repeated CBC (complete blood count) postop
 - WBC <600
 - Called as critical result to the unit – reported to “Mary, RN”
 - Never found out who “Mary, RN” was

The non-principled approach

- Patient discharged from hospital on post-op day 3
- Died 6 weeks later from leukemia
- Physician colleagues/friends reported death to Risk Management
- Legal Counsel & Claims Office were approached with a plan for “making it right”
- All attempts to disclose, apologize, or provide remedy were rejected by University

Condition Predicate to the “Principled Approach”

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- Courage..... and Leadership

What about a “Principled Approach”

■ Barriers

■ Benefits

A “Principled Approach”

■ Barriers

- Money
- Reputation
- “Shame and blame”
- Loss of control
- Loss of license
- Resource intense
- Uncertainty

■ Benefits

- Maintain trust
- Learn from mistakes
- Improve patient safety
- Employee morale
- Psychological well-being
- Accountability
- Money

How can institutions “encourage” care providers to be honest?

- Establish a standardized process
- Make it an expectation
- Teach it
- Hire to it
- Treat those who disclose fairly
- Establish a safe and “just culture” for the organization
- Anticipate fears of those involved in adverse events
- Add incentives; subtract disincentives
- Convince the community it is the right and smart thing to do

Linking honesty with patient safety



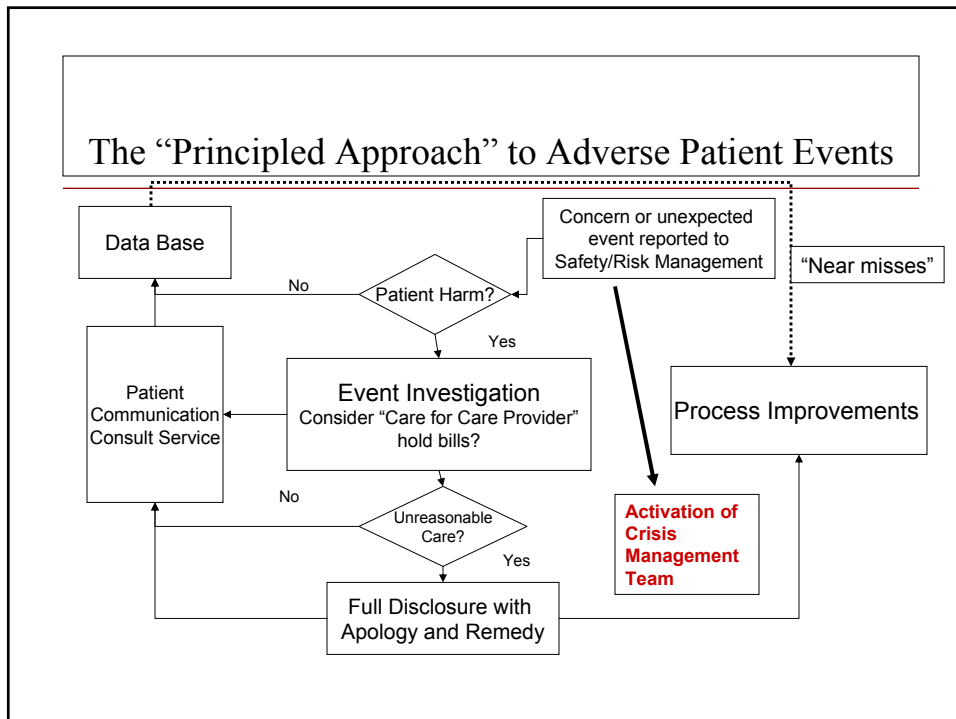
Implementing a principled approach to adverse patient events

- Decide upon and adopt “full disclosure” principles
 - We will provide effective and honest communication to patients and families following adverse patient events
 - We will apologize and compensate quickly and fairly when inappropriate medical care causes injury
 - We will defend medically appropriate care vigorously
 - We will reduce patient injuries and claims by learning from the past

Credit to Rick Boothman, CRO, University of Michigan

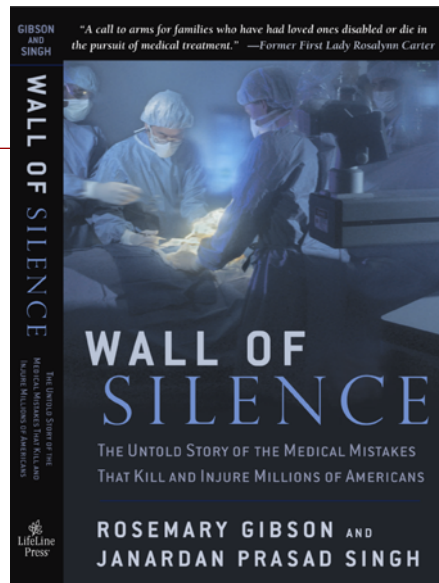
This is NOT a “Sorry Works” program.
Because, sorry does NOT work, alone.

- What about all those situations in which unexpected adverse outcomes are not caused by “clear medical error”?



Key elements

- Reporting
- Investigation
- Communication
- Apology & remedy, when indicated
- Process improvements
- Data tracking



Core elements in full disclosure

- What patients want to hear:
 - The truth
 - Recognition: investigation
 - Regret: apology
 - Responsibility: accountability and prevention
 - Remedy

Effective Communication Skills Training

Core Philosophies:

- Patients help us design and teach our curriculum
- Incorporate real medical error cases
- Standardized Patients & experiential learning to improve effective communication skills

A case demanding “a principled”, investigation and process improvements

- 8 y.o. with asthma, pneumonia
- Rx'ed with O₂, bronchodilators, antibiotics
- CXR ordered
- Transported to radiology
- Transported with venti-mask: O₂ - 15L/min
- Upon return to floor, oxygen tank empty
- Patient cyanotic, admitted to PICU
- What next? **Report!**
- What do you tell the family?

Investigation and process improvement: Oxygen cylinder hand-off



How long before the tank is empty?

- 1650 psi
- 8 Liters/minute
- If the trip to radiology and back may take an hour, do you have enough oxygen for the trip?

Investigation findings & source of process improvements

- Profound lack of knowledge re: oxygen cylinders
- Except for respiratory therapists and anesthesiologists
- Inadequate hand-offs between med-surg units and diagnostic areas
- Need for standardized reliable methodology regardless of training, experience

Oxygen Tank Assessment Tool

University of Illinois Medical Center
at Chicago

Oxygen Cylinder Assessment Tool
Duration of transport based on O₂ liter flow and fullness of E Cylinder oxygen tank
(Total liters in a full E cylinder = 620)

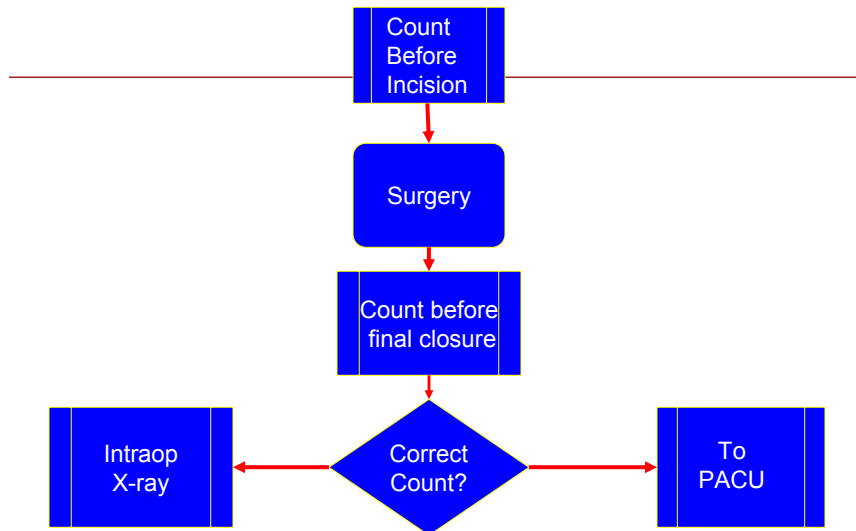
O ₂ Liter Flow	2200 psi (100%)	1650 psi (75%)	1100 psi (50%)	550 psi (25%)
1	10h+20min	7h+45min	5h+10min	2h+35min
2	5h+10min	3h+30min	2h+35min	1h+18min
3	3h+27min	2h+35min	1h+43min	52min
4	2h+35m	1h+56m	1h+18m	39m
5	2h+4m	1h+33m	1h+2m	31m
6	1h+43m	1h+18m	52m	26m
7	1h+29m	1h+6m	44m	22m
8	1h+18m	58m	39m	19m
9	1h+8m	52m	34m	17m
10	1h+2m	47m	31m	16m
11	56m	42m	28m	14m
12	52m	39m	26m	13m
13	48m	36m	24m	12m
14	44m	33m	22m	11m
15	41m	31m	21m	10m

For questions please contact Respiratory Services at 3-4499

Scope of the Problem

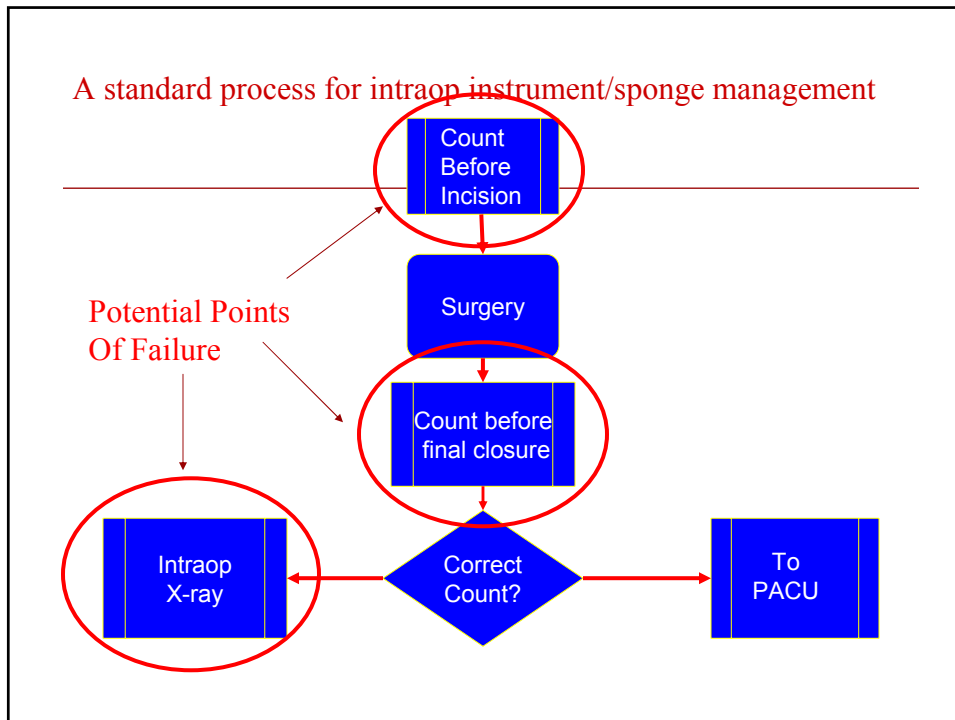
- 1 in 1000 vs 1 in 5000 surgical cases
- Potentially catastrophic
- Res Ipsa Loquitur: “the thing speaks for itself”
- Media Nightmare
- JCAHO sentinel and CMS “never event”

A standard process for intraop instrument/sponge management



Pitfalls associated with the “standard process” for managing intraop instruments/sponges

- Relies entirely on human counting processes
 - The human factor
- Lack of consistency in count vs. no need to count
- Inability to count: emergencies
- Count was correct or not done in most claims related to retained foreign objects
- Some procedural objects not routinely counted (OR towels ect)



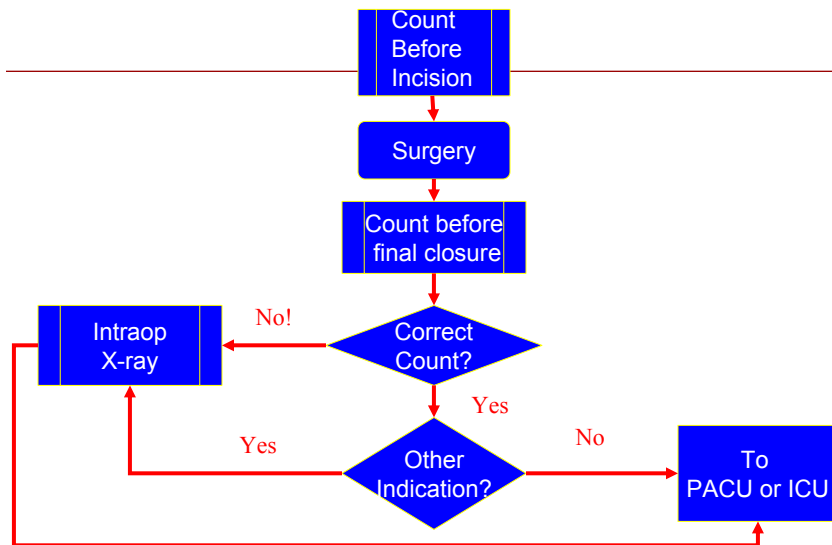
Risk factors for retained objects

- Emergency open cavity surgery
- Unexpected change in surgical procedure
- BMI > 35
- No count of sponges or instruments
- “Case-controlled analysis of medical malpractice claims may identify and quantify risk factors...”

UIMC's data for additional risks

- Extending beyond change of shift
- Greater than 6 hours in duration
- Multiple (>1) surgical services involved

Implementing a modified process



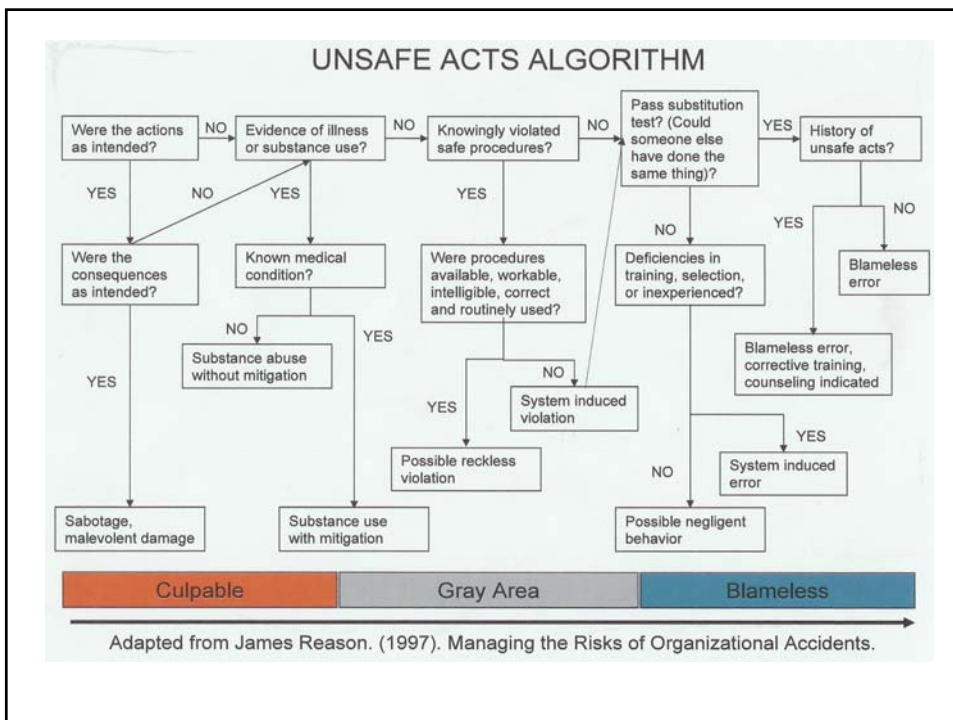
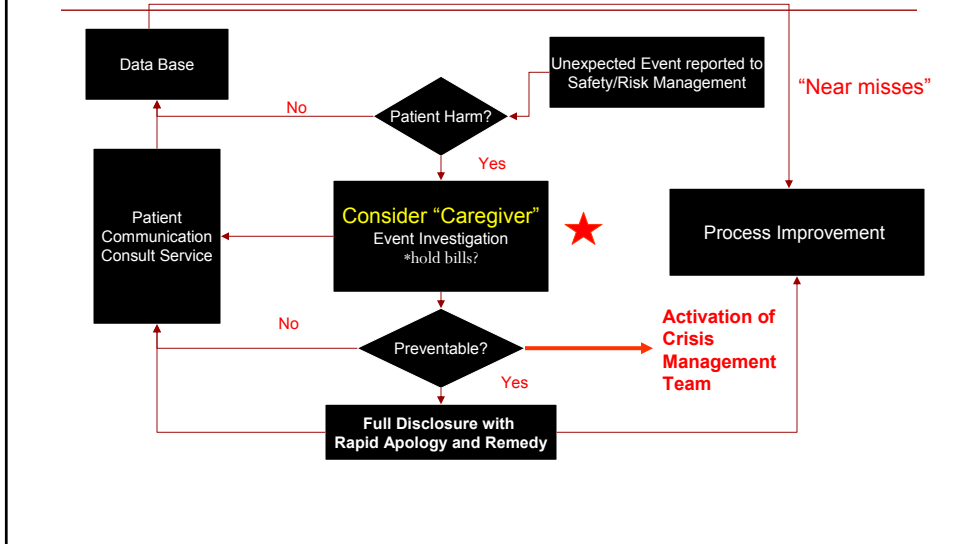
Lessons learned in past 36 months

- 9 objects identified in “correct count” cases
- 2 neck case
- 1 OB case
- 1 ortho case
- 1 chest
- 4 abdominal cavity
- No claims since implementation

A “near-miss” in OB

- 28 year old primigravid
- Worrisome FHR; scalp electrode placed
- 2 hours later emergent c-section
- ‘Unable to count’ indication for x-ray
- Intraop x-ray taken after closure of abdomen
- Patient taken to PACU

The University of Illinois Patient Communication Process



Data to date: 36 months

- > 200 Patient Communication Consults
- 52 Preventable errors with apology
- 51 cases settled in under seven months
- Several cases [6] with \$ added to waiver of bill
- Higher percent of funds going to patients/families
- Decrease of defense counsel costs
- No increase in payment to self-insurance fund or payment for excess coverage
- Close to 200 process improvements