Leadership and Organisational Reliability

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Adverse Events in Healthcare

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Report exposes the hospitals of horror

Patients' lives could have been saved

EXCLUSIVE
By JOHN KIDMAN

PRELIMINARY findings of a 10-month investigation have backed up allegations of clinical malpractice linked to deaths at two Sydney hospitals.

The examination of 47 complaints that more than 60 per cent of patients whose treatment was scrutinised were subjected to "unsafe standards" of care.

However, insiders say the revelations are just the tip of the iceberg, with many further disturbing incidents yet to be explored.

A few Macarthur Area Health Service (MHS) staff, who initially reported the more than 100 claims of mismanagement, negligence and patient neglect last November, say they have received nothing but victimisation and grief over their stance.

Hospital sources say some of the casualties were "nothing short of horrific" but, despite the damning findings of their investigation, no one has been held to account.

In one case, Kearns woman Dawn Alexander was mistakenly diagnosed with the flu and twice turned away by staff at Campbelltown Hospital, a day before dying of septicaemia

She had previously been healthy and her procedure should have been "straightforward".

To make matters worse, it was also found that a letter from hospital administrators to the woman's grieving husband was "bureaucratic, cold and insensitive".

Among the most disturbing incidents reviewed concerned the early release of a female patient from Camden Hospital in October 2001. Against earlier advice that the 73-year-old remain under observation due to a history of hypertension and chest pain, she was sent home after receiving three doses of morphine.

Within an hour of being released, she collapsed and died of a massive heart attack on her front doorstep.

Elsewhere, a 72-year-old woman, who died of heart failure arising from a massive infection after having a plate inserted to repair a leg frac-

Chemotherapy under-dosing: Fears patients at two more Sydney hospitals given wrong doses

Heads roll over horror hospitals

Megan Saunders
• NSW political reporter

THE NSW Coroner will investigate 19 patient deaths in two Sydney hospitals following a shocking report into poor standards of care that has forced the Carr Government to take

Walker — met with immediate calls for the terms of reference to be widened.

Peter Bentley, who lost his wife, Marie, after what should have been a routine gallbladder operation, said the investigation should be wider "to include some politicians, because I believe what they're trying to do is to a degree still

The Sydney Morning Herald

Hospital deaths: too many cover-ups

It started with the courage and persistence of seven nurses

The harrowing trail of tragedy and incompetence

Ruth Pollard
Health Reporter

One patient died of a heart attack that had been misdiagnosed as a urinary tract infection, another died of sepsis, leaving behind a husband and four small children.

A woman with severe chest pain was discharged when a bed with a cardiac monitor could not be found. She died hours later. A perforated ulcer, internal bleeding, a post-operative infection, an asthma attack. Twenty-one deaths, 19 referred to the coroner

ency department by ambulance. She had a sharp pain down her left side, and was sweating and moaning. A locum medical officer diagnosed colic. Nursing observations were taken only once in six hours and two anomalies in blood pressure readings were not checked.

More than 10 hours after first presenting to the emergency department, the woman was discharged, with a diagnosis of urinary tract infection recorded.

Less than 16 hours later she was dead on arrival at the

unit and reviewed by a surgeon for the first time since her admission to either hospital, she had surgery for a larger perforated duodenal ulcer. "She deteriorated slowly and died six days later," the report says.

Page after page for 400 pages, stories such as these continue, spanning 47 incidents between June 1999 and February 2003.

From the emergency departments at both hospitals, to the intensive care unit and operating theatre at Campbelltown, and the medical wards at both hospitals

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External Inquiries

- Bristol, UK
- King Edward Memorial Hospital, Perth
- Canada – Paediatric Cardiac Unit reduced to 6
- Royal Melbourne Hospital
- South West Sydney AHS – Walker Inquiry
- Queensland – Dr Death
- NSW – Butcher of Bega
- North Shore – Garling Inquiry
- Mid Staffordshire's – Frances Inquiry
- St Vincent's – Off protocol chemotherapy

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Findings

Inquiries and studies showed that there were inadequate systems to monitor and respond to performance issues or serious incidents

Almost 20 years of inquiries and the recommendations remain almost the same

We need systems to monitor and measure and respond to performance issues early

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The “just world” hypothesis

Bad things happen to bad people

The real world

The worst mistakes are sometimes made by the best people

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It doesn't matter how often you do this to individuals -

It isn't a very effective way of getting the message out

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Patient Safety - Where to now?

- Safety Culture
- Identification
  - Data triangulation
  - Reporting
- High reliability
- Safety II
- Human factors/team work training
- Leadership

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What is safety culture?

The complex framework of national, organisational and professional attitudes and values within which groups and individuals function that influence the safety of an organisation

Or

The way things are done around here

•(Helmreich & Merrit, 2001; Sexton, et al, 2003)

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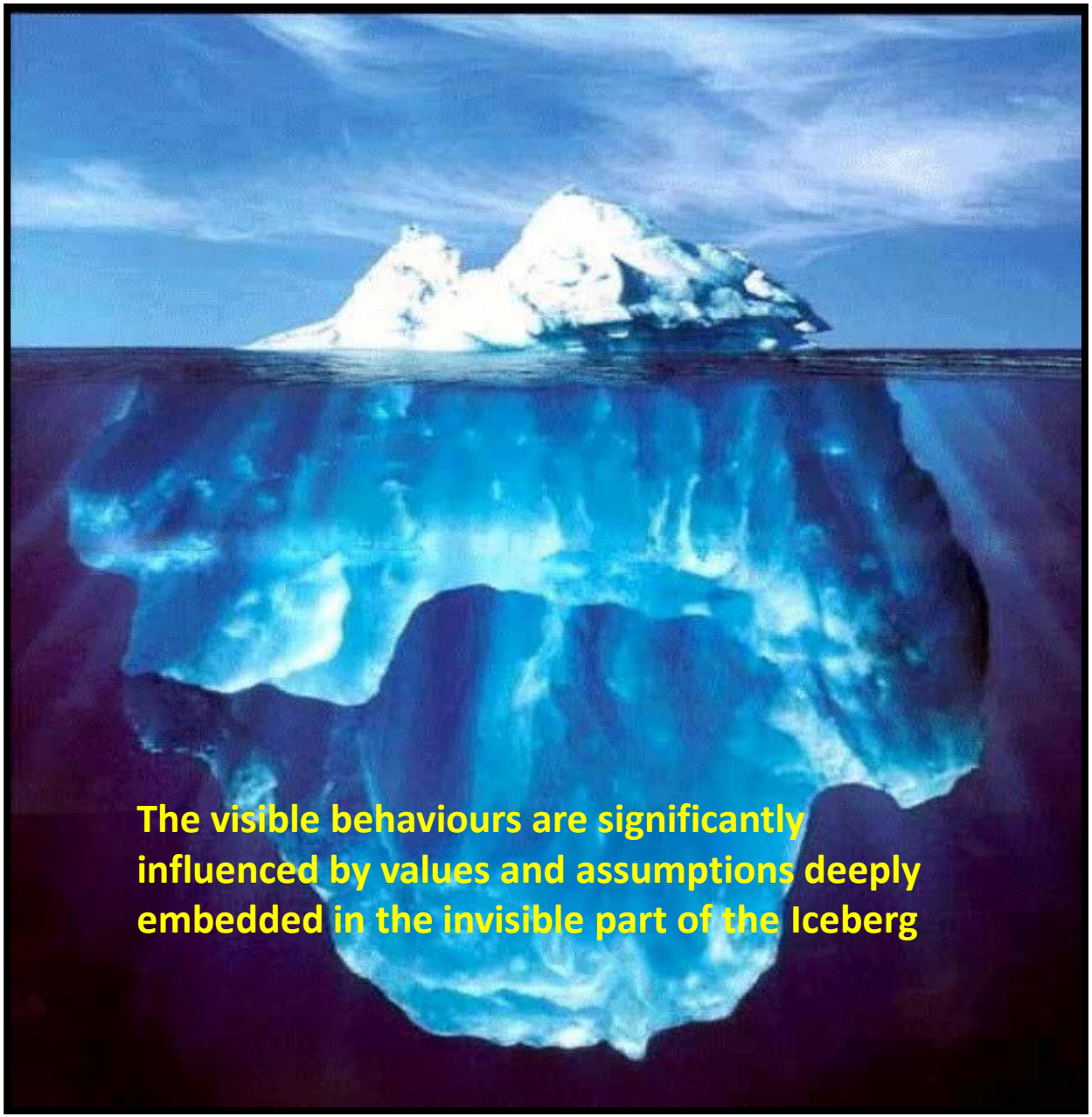

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Characteristics of Safety Culture

- Leadership commitment
- Open & frequent communication (trust)
  - Open about failures
- A just culture
- Robust systems
- An obligation to act
- Organisational learning
- Team work

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Patient Safety II

- High reliability
  - *An organisational structure and team-work based safety culture so that inevitable human mistakes do not lead to patient harm. This methodology differs from previous quality and safety efforts, in that it simultaneously emphasises interprofessional interventions, behavioural changes, structured leadership, and culture shifts towards a culture of safety as a core value…*

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High performing health care

- **Organisational design**- standardise practice, reduce complexity, learn from mistakes
- **Organisational work**- commitment to safety, blame free, resources, encourage collaboration
- **Organisational focus**- preoccupation with potential failure, focus on near miss, teams, deference to frontline expertise

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Priorities

Leadership, culture, partnerships

- Leadership programs
- Coaching
- Increase focus/awareness
- Best practice examples
- Universities
- Consumers

Outputs of high reliability

- Exec walkrounds
- Safety huddles
- Handover/communication
- Team based training
- Target local programs

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Leadership is about taking people to a place they would not go on their own

True? Adequate?

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A better definition

The exercise of **influence** to bring about the **willing consent** of others in the **ethical** pursuit of a mission

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A true story

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FOUNDATION TRUST KILLED OUR LOVED ONES
WHERE NEXT
WHY HAS IT TAKEN SO LONG
400 DEATHS
theguardian


Mid Staffordshire NHS
NHS Foundation Trust
Stafford Hospital


RESIGN
"The Man With No Shame"
© PA


DAILY Mirror
FREE BOOKS
Celebs flip-tuck secrets
++NHS IN CRISIS++
1,200 DIED IN THEIR CARE
..yet one was promoted and now runs the NHS ..the other is enjoying his £400,000 pay-off


THE MID STAFFORDSHIRE
NHS FOUNDATION TRUST
PUBLIC INQUIRY
Robert Francis QC
© Getty Images


Report of
the Mid Staffordshire
NHS Foundation Trust
Public Inquiry
Executive summary

The hospital culture

- There was no culture of trust and respect
- There was an atmosphere of fear
- Poor standards were accepted
- Senior medical staff disassociated themselves from management
- Staff morale was low

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Administration

- Thinking was dominated by financial pressures
- Lack of transparency about problems
- Statistics and reports were preferred to patient experiences
- A culture of self promotion rather than critical analysis and openness

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Administration

- Leadership was expected to focus on financial issues
- The impact of proposed savings on patient safety was not considered
- Targets were seen as an end, not as a step on the way to good patient care
- There was no focus on the patient

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Leadership involves

Strategic vision

Moral courage

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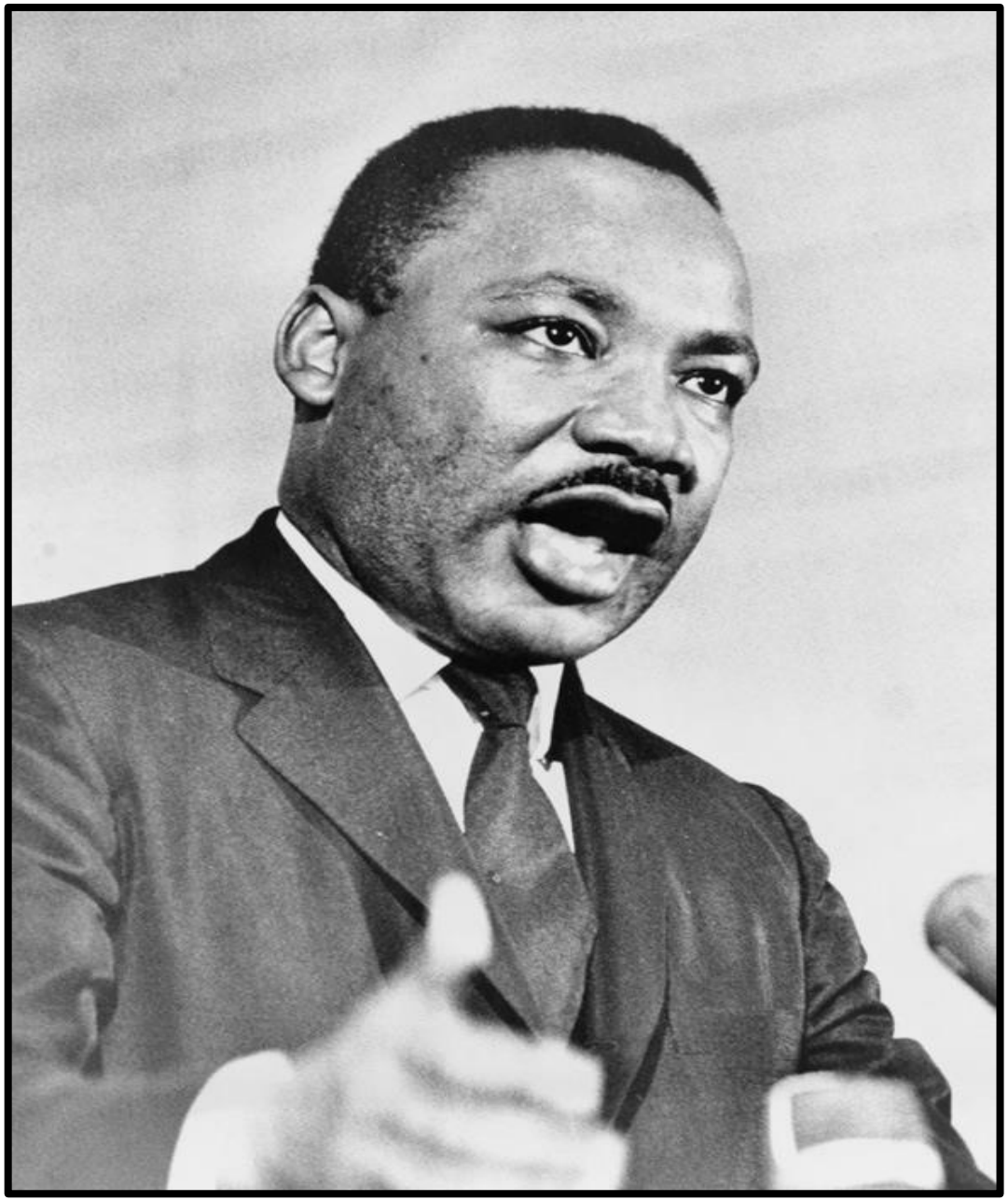

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Good leaders exercise moral courage

1. Ask “why do we do it like this?” “Is there a better way?”
2. Courage to admit and learn from our own errors
3. Fearless but not foolish
4. The right balance between being subversive and constructive

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Alice Stewart 1906-2002

British epidemiologist

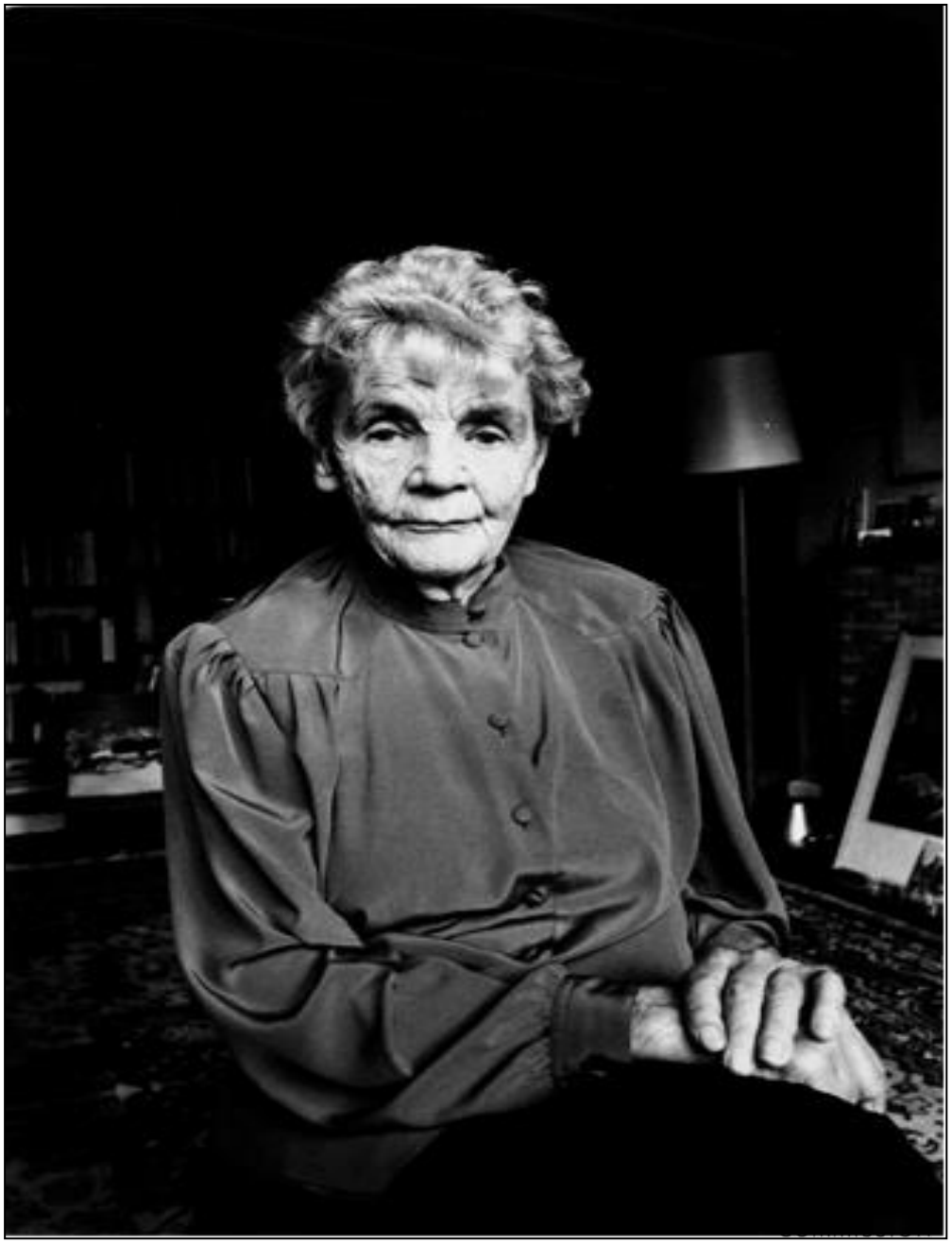
Noted more leukaemia in children from rich families

Talked with the mothers

Found that well-off mothers had foetal X-rays during pregnancy

Her call to cease foetal X-rays was met with resistance, opposition, and derision

Alice Stewart had moral courage. She drew a line in the sand.



Don Berwick's five radical proposals

1. When responsibility is diffused, it is not clearly owned: with too many in charge, no one is
2. **Fear is toxic** to safety and improvement
3. **Abandon blame as a tool**. Trust the goodwill and good intentions of staff
4. Use quantitative targets with caution. Targets have an important role *en route* to progress, but **targets should NEVER replace the goal of better care**
5. **The voices of patients must be heard**

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Traps for leaders and administrators

1. Not listening to the patient voices.
2. Not having the patient at the centre, always, every time
3. Being seduced by their own importance
4. Seeing targets as the end, instead of the means to an end

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Patient Safety Leaders

- Understand risk
- Take action to mitigate patient risk
- Are proactive
- Report
- See a problem and don’t ignore it
- Don’t blame individuals
- MAKE CHANGES to transform the workplace

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Good health leaders

- Do not resist change
- Are always willing to learn
- Understand that communication involves listening as well as talking
- Resolve conflict
- Collaborate within and beyond
- Are clinically competent.
- Use data to drive change

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Questions?

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