WHEN THINGS GO WRONG……

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LEARNING OBJECTIVES

By the end of this session participants will be able to

1. Discuss a systems approach to adverse events in medical practice
2. Apply a frame work for managing and analysing medical errors
3. Implement peer and self support strategies and resources

CONFLICTS OF INTEREST

- Nil financial disclosures
- Chair, Doctors Health Advisory Service NSW
- Chair, Central Coast Workforce Advisory Group, HNECCPHN

TO ERR IS HUMAN

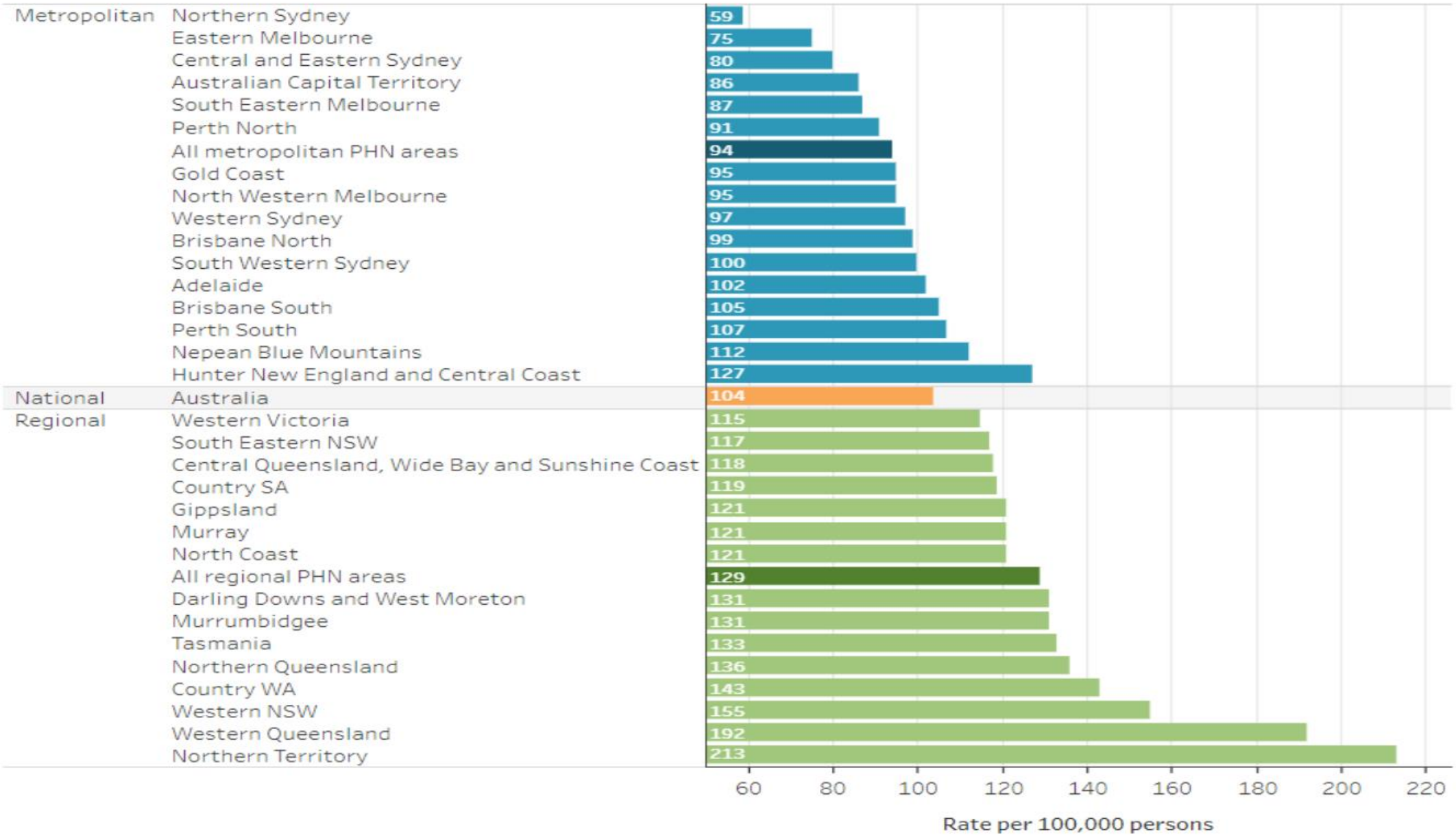
- Preventable medical errors are common
- Estimated 1/10 hospitalised patients
- Account for significant harm to patients

- Safety in health care movement

“To Err Is Human” asserts that the problem is not bad people in health care--it is that good people are working in bad systems that need to be made safer.

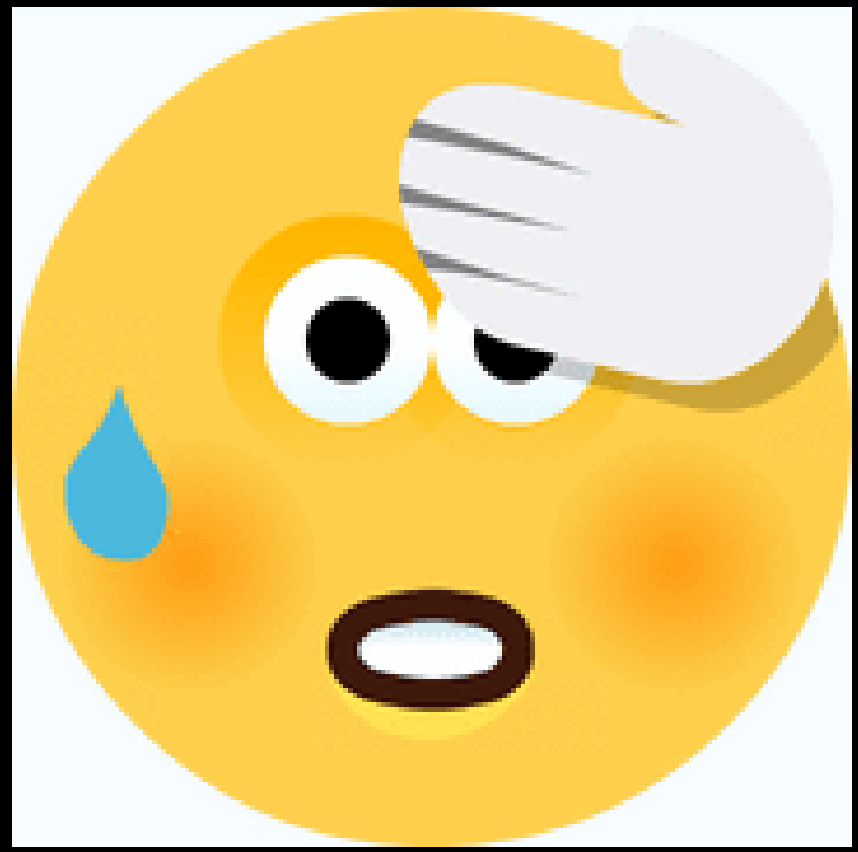
US Institutes of Health Report 1999

Figure 3: Number of potenially avoidable deaths per 100,000 people, by Primary Health Network area, 2015–17



100% Human experience

“ there for the grace of God go I”



DEFINITIONS AND EXAMPLES?

- Adverse event

- Sentinel event
- Critical incident

- Near miss

WHAT TYPES OF ERRORS?

- ACTS OF OMISSISON
- ACTS OF COMMISSION
- WHAT TYPES DO YOU KNOW?

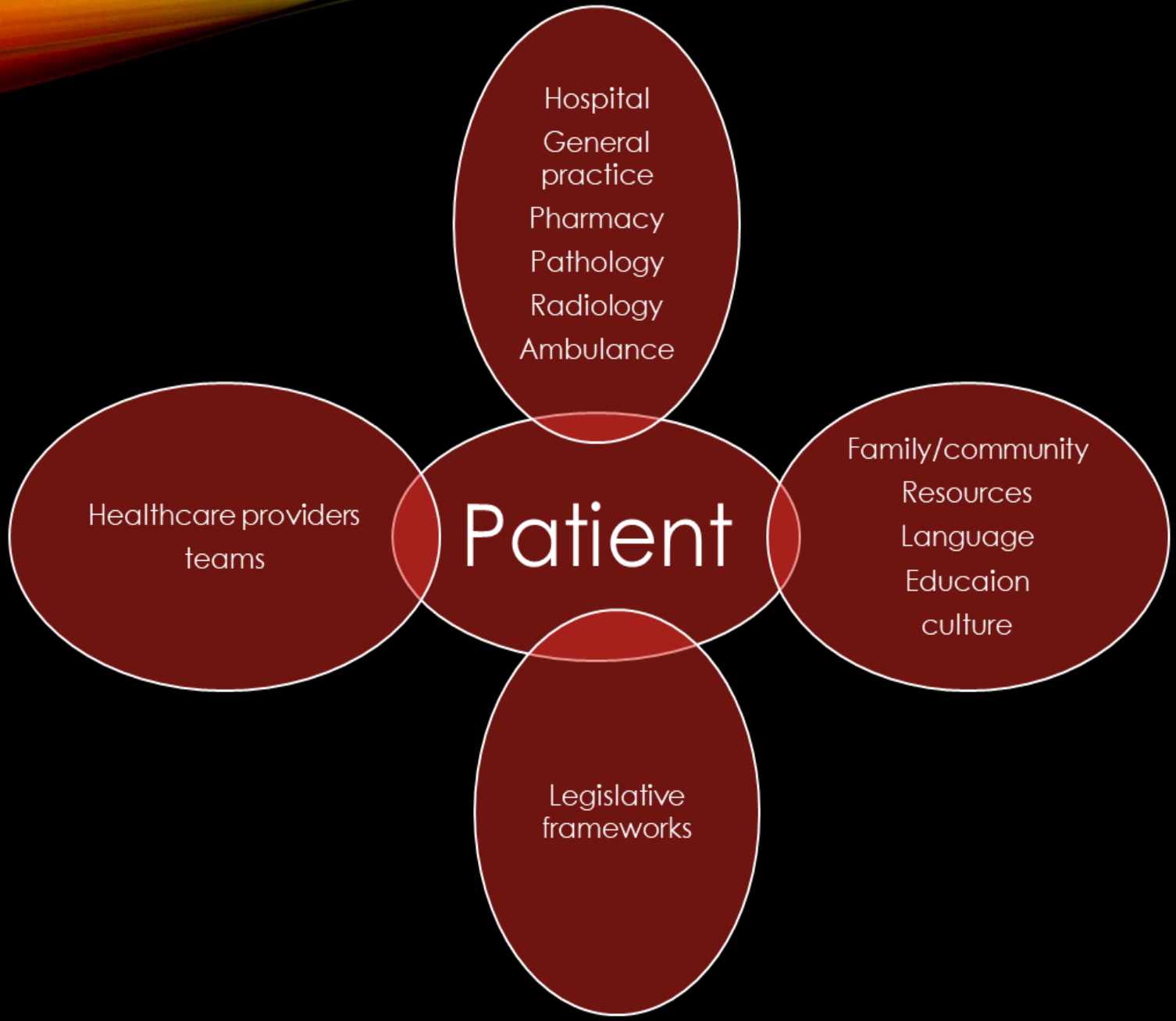
TYPES OF ERRORS?

- Diagnostic errors – half of GP malpractice claims
- Surgical errors
- Medication errors

CONSEQUENCES

- Harm and suffering
- Disability and Death
- Financial cost
- Loss of trust
- Psychological harm

Source: Adapted from the Australian Commission on Safety and Quality in Health Care 2019.


Hospital
General practice
Pharmacy
Pathology
Radiology
Ambulance
Healthcare providers teams
Patient
Family/community
Resources
Language
Educaion
culture
Legislative frameworks

WHEN IS THERE HIGHER RISK ?

Patient factors

- frailty, multimorbidity (Duke et al, MJA Feb 2022)
- Language, culture, education, family
- Dirty/smelly /unkempt

Physician factors

- knowledge deficit (low) ; cognitive errors
- Fatigue, stress, personal stressors, burnout
- Distractions (noise, devices)

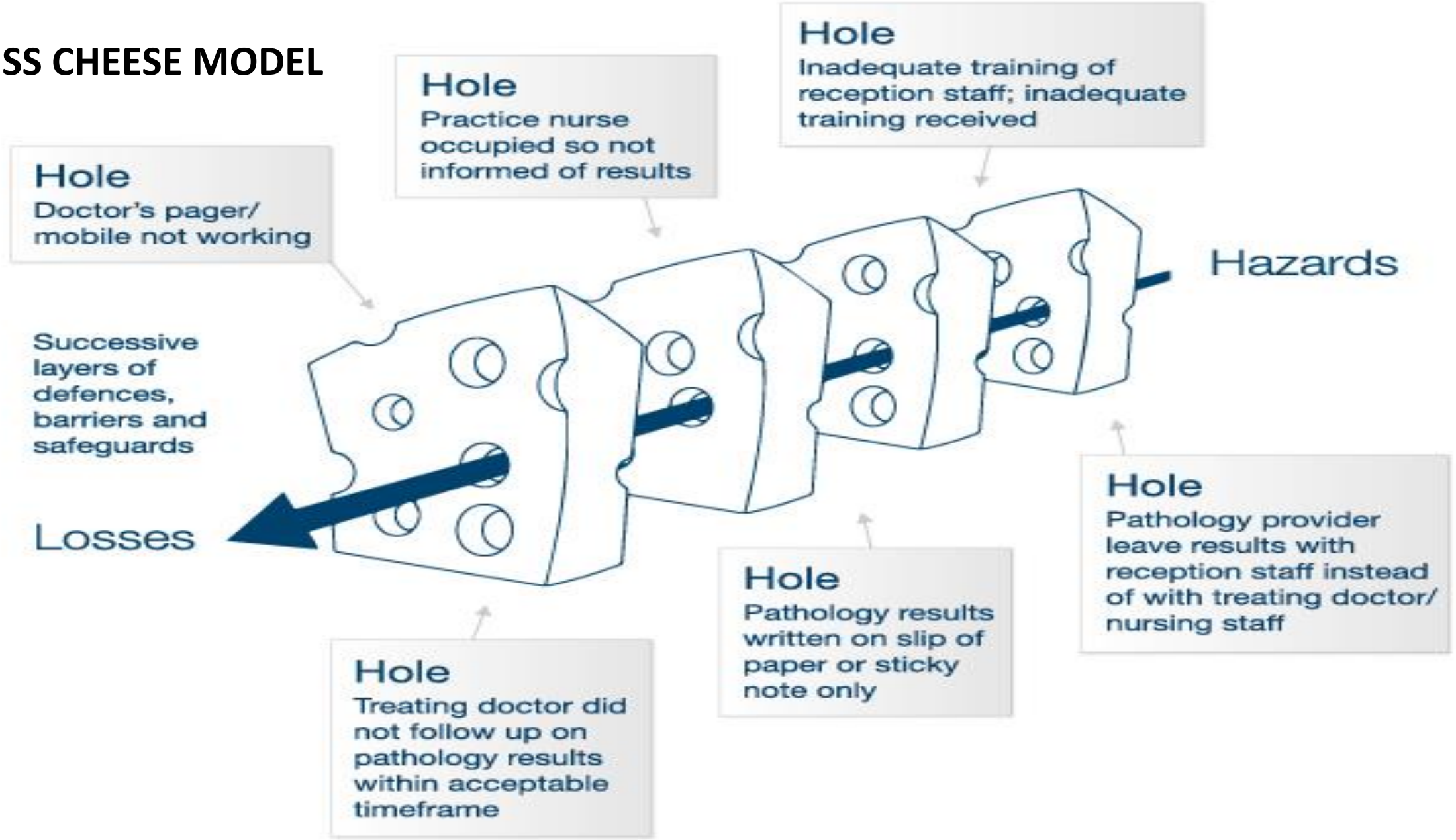
SYSTEMS

- Understaffed, blame culture, clinical governance, IT, supervision, HANDOVER

WHAT DO YOU DO NEXT?

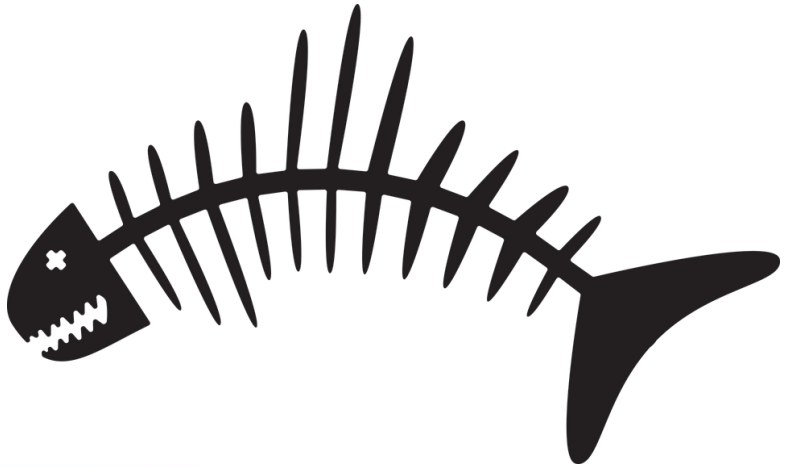
- Identify the incident
- Acknowledge to the patient, offer empathetic regret (Open disclosure)
- Provide a factual honest explanation and commit to finding out what happened
- Review adverse event/analyse
- Involve the team, take QI approach, offer support
- Implement safety plan to prevent recurrence
- Follow up with patient
- **REGAINING TRUST – patient, in the team, in oneself**

SWISS CHEESE MODEL

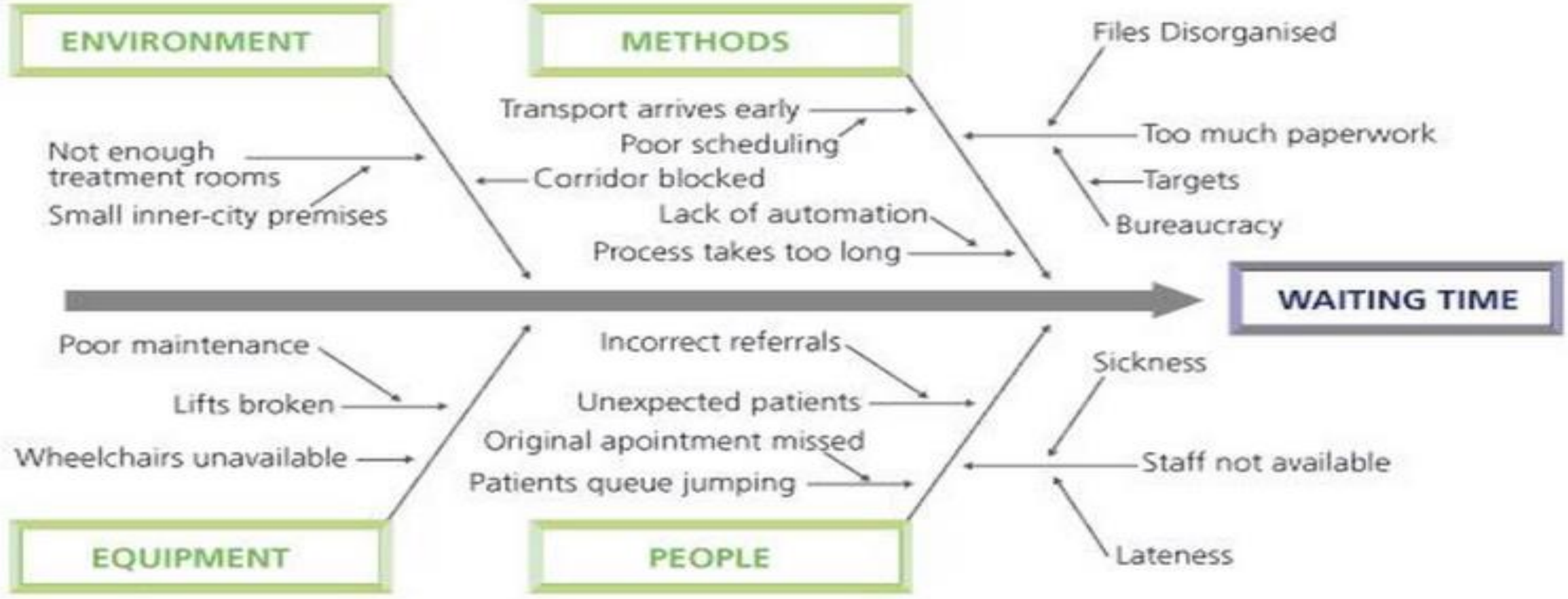


Some holes due to active failure. Other holes due to latent conditions (resident "pathogens").

Root cause analysis



- Contributing factors



What to do?

Confess or Hide it?

Apologise or never say sorry?

OPEN DISCLOSURE

Quality Improvement

The value of patient forgiveness and understanding

RVTS
REMOTE VOCATIONAL TRAINING SCHEME LTD

HOW DOES IT FEEL?

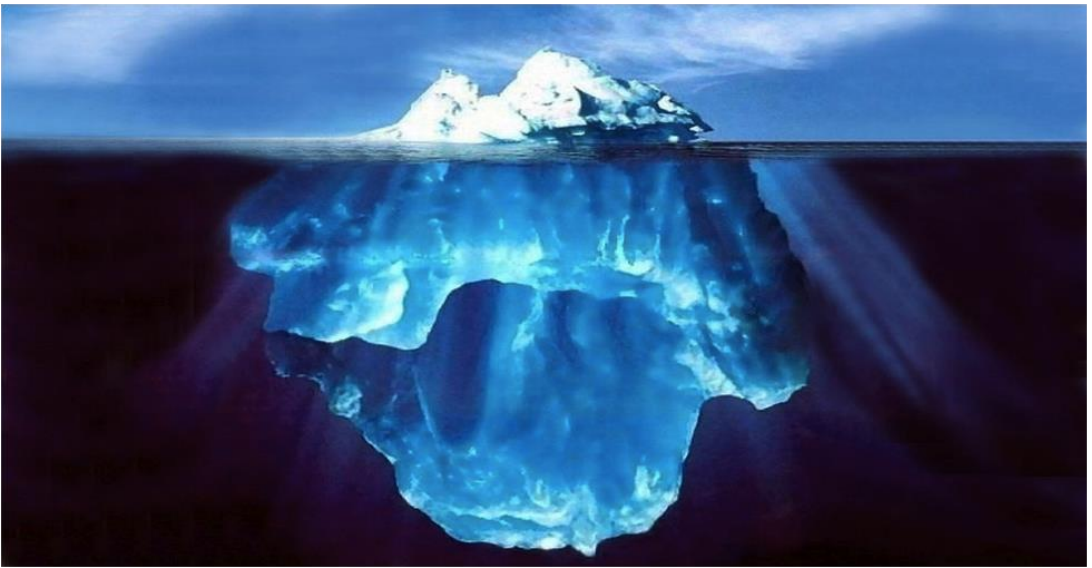
- Shame ; Guilt
- Anxiety and Fear – AHPRA, registration, reputation
- Failure and Self worth
- Identity crisis
- Anxiety, depression, substance use, suicide
- Alters practice
- **Impact on your performance**
- **Impact on patient care**

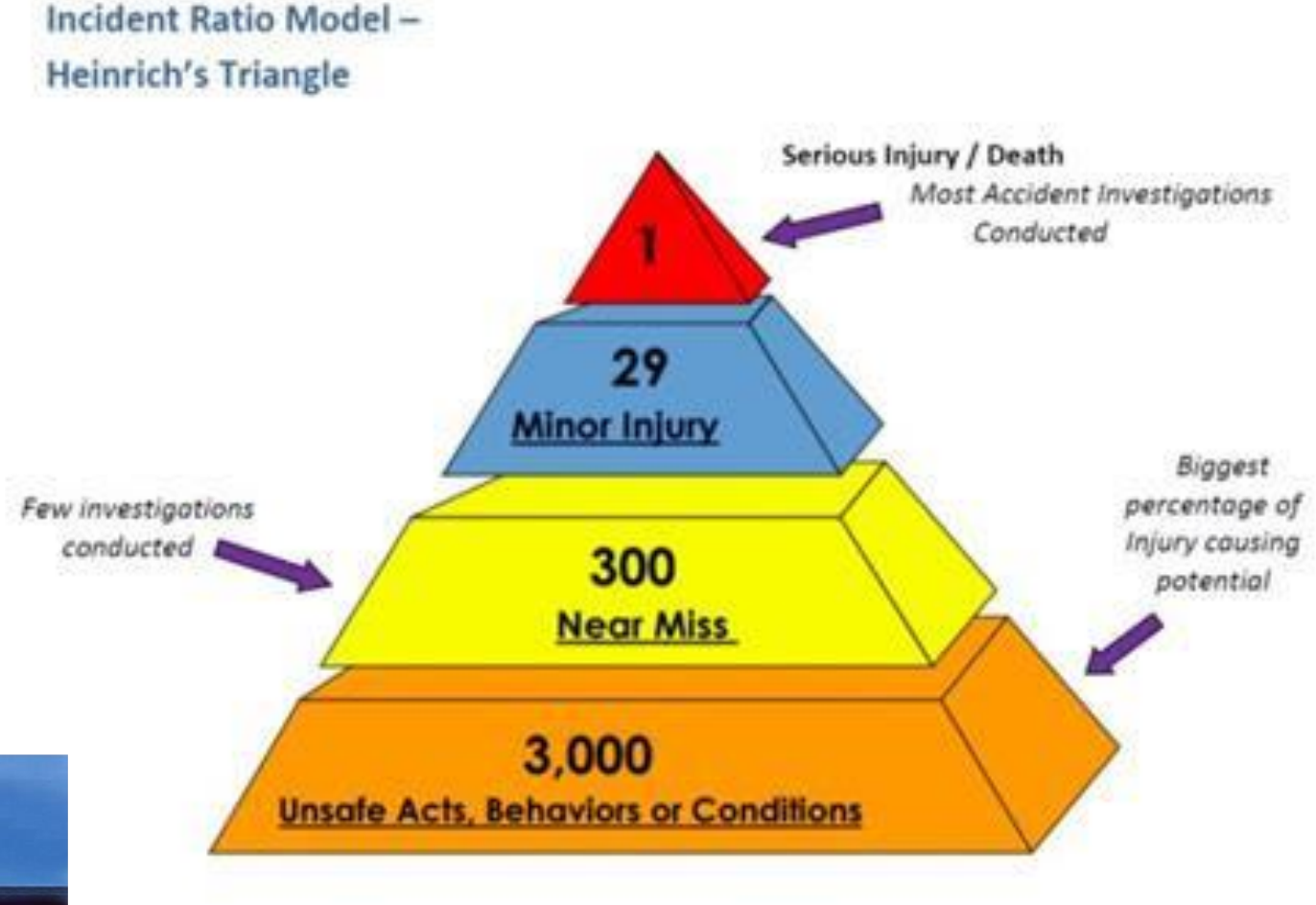
Primum non nocere

NEAR MISSES

- Didn’t reach the patient, or if it did, didn’t cause harm
- Detected or prevented – analyse WHAT factors provided the safety net?
- Easier to talk about openly – after all it was a “SAVE”

Near Misses





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BREAKOUT SMALL GROUP

- Think of a near miss or critical incident
- Share briefly with your colleagues
- Apply the “swiss cheese” / fishbone models
- How did you feel?
- What was the outcome?

PROCESSING - REFLECTION

1. TALK TO YOUR MDO
2. Talking - “get it off your chest”
3. Peer support
4. Writing exercises
5. Medico Legal advice
6. Counselling - Drs4Drs
7. Implement quality improvement
8. Time

RESOURCES

- World Health Organization. Towards eliminating avoidable harm in health care. Global patient safety action plan 2021–2030. 3 Aug 2021. https://www.who.int/teams/integrated-health-services/patient-safety/policy/global-patient-safety-action-plan
- Duke GJ, Moran JL, Bersten AD, et al. Hospital-acquired complications: the relative importance of hospital- and patient-related factors. Med J Aust2022; 216: 000–000
- Scott, I.A. and Crock, C. (2020), Diagnostic error: incidence, impacts, causes and preventive strategies. Med. J. Aust., 213: 302-305.e2. https://doi.org/10.5694/mja2.50771
- Australian Open Disclosure Framework
- Annette Braunack-Mayer Yishai Mintzker . General practice ethics: Disclosing errors .Volume 44, Issue 12, December 2015