

Patients for Patient Safety News

September 2007



Welcome to the Autumn edition of Patients for Patient Safety News! This edition focuses on the EURO Workshop along with regional news including the exciting news about the Jakarta Declaration!

REGIONAL ACTIVITIES

EURO

WHO Regional Office for EUROPE: *Patients for Patient Safety* Workshop!

Summer was drawing to an end, but we were still blessed with some warmth and sun as 58 patients, health professionals and policymakers from 21 countries across Western, Central and Eastern Europe met in Dublin from 3 – 5 September. The aim was to build a network, partnership and strategies for the future of patient engagement in patient safety work at a national and regional level.

The first day of the workshop was for the patient participants and was an opportunity to share their personal experiences of error and harm. The power of the patient experience was evident and the passion to make a difference was felt by everyone. The second day gave an opportunity for the patients to reflect on their experiences and learning and share that with policymakers and health professionals from their own countries. The opportunities and challenges for patient engagement in patient safety were discussed across the different areas of the region and the group voiced their hopes for the future of healthcare. The meaning of patient engagement in safety, the opportunities to contribute to the other areas of the World Alliance for Patient Safety, regional and national partnerships and the building of a strong regional network were all considered. Participants created action plans for developing their work on their return home. Some of the key issues were around the need for patient reporting systems, working in partnership to create a more open and honest safety culture and raising awareness of patient safety as an issue and educating patients and health care professionals in order to strengthen the relationship and communication process.

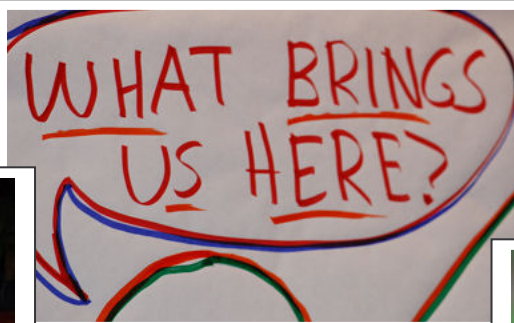
Workshop participants also attended the International Patient Safety Conference held by the Health Information and Quality Authority in Ireland in conjunction with the World Alliance for Patient Safety providing feedback and the patient perspective on the plans and scope of this new initiative.
(see page 4 for more information on this)

This workshop has created a substantial network across the region of committed, passionate and pro-active champions and the opportunities for future developments in the region are very exciting.



A look inside

- EURO Workshop, Dublin
- South East Asia Regional Committee endorse Jakarta Declaration
- PAHO raises awareness of the dangers of jaundice for babies
- EMRO Implement Patient Safety Friendly Hospital Initiative
- Medical culture about errors may be changing
- IAPO 3rd Global Patients Congress in Budapest



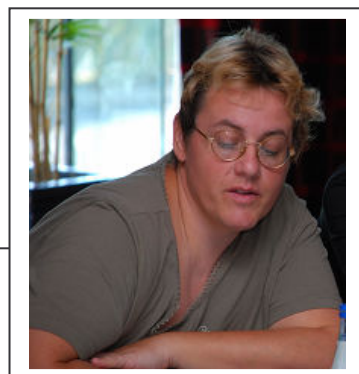
A Spiritual Journey

- Ema Gruber, PFPS Champion, Croatia

For me the Irish workshop was a kind of spiritual journey not just an intellectual and practical experience. At first, I thought I will come and learn something for the sake of my patients and users of my NGO, for all of us to pay more attention to the safety issue, but then I realized that I also came for personal reasons, to gain strength to help my grandmother to fight death. Somehow I lost my hope and faith in medicine and lost my will to open that window of opportunity.

This was my first time to participate in WHO activities and in patient safety activities, now it all makes sense to me, the things about patient safety that I found on the internet before and the London declaration that I read. It is different to hear the true, life stories than to read about it. Furthermore, I was surprised to realize how similar my country is to eastern and central European countries, we have almost the same priorities, problems, challenges and opportunities in this field. This means that we can jointly achieve things and compare efforts.

I decided to pass my knowledge gained at the workshop to my associates, colleagues, friends and patients, we will work on raising awareness of people on the patient safety issue in mental health, carry out public lectures and conferences, publish some material about it in the Croatian language. I was so inspired by the workshop that since I came back to Croatia I managed to form a web page for my NGO on patient safety, I wrote short letters and sent them to our Ministry of health, County Government, County hospital and in the Croatian Journal for Public Health, as well as to the Journal of the Croatian Medical Association. At present we are planning to do the first public lecture.



NEW CHAMPIONS – Workshop Perspectives

EURO Perspectives

- Fedir Petkanych PFPS Champion, Ukraine

I feel that in the world in general states are spending funds for patient safety without the involvement of patients to the decision-making process. In the overwhelming majority of the countries, the medical community decides by itself what the most important problem for the patients' safety is; even not considering as necessary discussing those decisions with patients. That is to say the medical community assumes that the patient agrees beforehand with any decision made by them. As a result the healthcare systems not taking into account those components of the treatment process and of patient safety that are very important to the patients themselves.

During the workshop in Dublin patients from all over Europe exchanged their own experiences of interaction with the healthcare systems of different European countries which had caused great injury to themselves or their relatives. Patient-leaders also shared different approaches to the protection of their abused rights. At the workshop in Dublin live witness accounts of the medical errors were so numerous that it became evident that without involvement of the patients to the decision-making process the problems of patients will remain their personal problems and medical systems of European countries will continue not to learn from patients and their families, making the same mistakes, which will be perceived only as statistics.

The European Regional Workshop "Patients for Patients' Safety" in Dublin united patients from different countries of Europe. It allowed the basis for the dialogue between European medical policy makers and between patients from this region to begin. The results of the workshop are not finished despite its closure because as a result of the workshop personal contacts were established between patient-leaders from different countries of the region allowing in the future the coordination of their efforts and exchanging experiences on patients' safety, patients' rights and protection, as well as on different approaches to solving actual medical problems in different countries of Europe.



EURO Workshop – Big Strides Forward

- Rebecca O'Malley, PFPS Champion, Ireland

On the first day of the conference, we each introduced ourselves and told our story. We heard almost 30 individual stories from 21 different countries. Each participant had suffered a different trauma or tragedy arising from a medical error. But what made the experience so special for me was the incredible strength and determination that filled the room - the strength to rise from the devastation that had hit each participant and the determination each person felt to improve their health service so that others wouldn't have to suffer in the way they did. For me, it was a very humbling and moving experience.

In May 2007 the breast cancer misdiagnosis that resulted in a 14 month delay in the commencement of my treatment hit the media headlines. I was very vocal, resisted the pressure to accept what was unacceptable and took every opportunity to speak out on issues of patient safety. The Workshop, however, forced me to consider wider issues of patient safety, gave me some tools and in so doing, has made me more confident and determined. Now, more than ever, I feel that I have an important role to play in making the health service more open, more honest and more transparent.



International Patient Safety Conference Dublin 2007

The Health Information and Quality Authority hosted its first International Patient Safety Conference on the 6th of September 2007. The conference marked the official launch of the patient safety project which, the Health Information and Quality Authority is leading on behalf of the World Health Organization's World Alliance for Patient Safety. The project aims to drive learning while supporting patients, families and clinicians in the aftermath of a patient safety incident and will:

- Identify the best and current Irish and international practice;
- Determine the outcomes that patients, families, clinicians and relevant key stakeholders desire;
- Develop an International Consensus Guidance that will identify best practice for communicating with and supporting patients, their families and clinicians in order to facilitate more responsive, positive outcomes for all parties.

The aim of the conference was to listen, take on board views, challenge prevailing culture and draw from experiences that will support the development and implementation of best practice to facilitate more responsive, positive outcomes for patients, families and clinicians following a patient safety incident.

The Health Information and Quality Authority were delighted to welcome the EURO Regional Patients for Patient Safety Group to the conference. The Authority recognises that patient safety is a priority shared by all stakeholders and any guidance must be developed with the involvement, engagement and consultation of patients, clinicians, providers, members of the public and other stakeholders. The presence and contribution of the members of the EURO Regional Patients for Patient Safety Group contributed to the overall success of the conference. The conference included a 'on the couch' interview session with patients and clinicians and three representatives from the group, Mrs Mary Vasseghi, Ms Sara Yaron and Mr Vasyl Kvartiuk participated in this session describing their experiences with different healthcare systems across Europe. This was an innovative and powerful session as it was patients telling their own stories and highlighting the patient safety issues across Europe. This feedback from delegates was very positive and the Health Information and Quality Authority believe that this session contributed to the overall success of the event.

'Very powerful session listening to patient / clinician experiences'

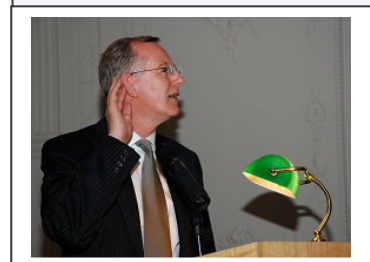
'It is always good to hear the experience of patients, patient stays with us. Overall the conference excellent...'

'Excellent to have actual examples of patient experiences'

Other members of the group promoted dialogue and discussion by contributing to the questions and answers sessions at the conference. This was another aspect that was appreciated by conference attendees.

'This conference was truly ground breaking in the way it incorporated dialogue among patients, providers and policy makers...'

'The conference was 'different', bringing together patients, patient groups and clinicians...'



SEARO

Regional Committee in South East Asia endorse Jakarta Declaration!

We are very excited to announce that at the end of September the Regional Committee of the World Health Organization in South East Asia endorsed the Jakarta Declaration which was created by the patients, health professionals and policymakers that met at the South East Asia Regional Patient Safety Workshop on *Patients for Patient Safety* which we held in July this year.

This endorsement is recognition of the vital role that patients can play in creating safer health care systems in the Region. The Declaration is an official addendum to the Resolution on "Promoting Patient Safety in Health Care" that was adopted by member states at the 59th session of the Regional Committee in Bangladesh last year. Henceforth, patients, health care providers and policy makers will work as partners in all aspects of patient safety in the Region."



JAKARTA DECLARATION

On Patients for Patient Safety in Countries of South-East Asia

We, the patients, consumer advocates, health care professionals, policy-makers and representatives of nongovernmental organizations, professional associations and regulatory councils having reflected on the issue of patient safety in the regional workshop on "Patients for Patient Safety", 17-19 July 2007, in Jakarta, Indonesia

Referring to Resolution SEA/RC59/R3 on Promoting Patient Safety in Health Care, adopted at the 59th Session of the Regional Committee for South-East Asia Region, which notes "with concern the high human and financial toll of adverse events" and the vicious cycle of adverse events, law-suits, and the practice of defensive medicine which contributes to the rising cost of the health care, and urges Member States to "engage patients, consumer associations, health care workers, and professional associations, hospital associations, health care accreditation bodies and policy-makers, in building safer health care systems and creating a culture of safety within the health care institutions",

Considering the recommendations in the proceedings of the first Regional Workshop on Patient Safety, 12-14 July 2006, in New Delhi, India,

Inspired by the WHO World Alliance for Patient Safety, Patients for Patient Safety London Declaration (March 2006),

We,

1. Declare that no patients should suffer preventable harm;
2. Agree that patients are at the centre of all patient safety efforts;
3. Acknowledge that fear of blame and punishment should not deter open and honest communication between patients and health care providers;
4. Recognize that we must work in partnership in order to achieve the major behavioural and system changes that are required to address patient safety in our Region;
5. Believe that:
 - transparency, accountability and the human touch are paramount to a safe health care system;
 - mutual trust and respect between health care professionals and patients are fundamental;
 - patients and their carers should know why a treatment is given and be informed of all risks, big or small, so that they can participate in decisions related to their care;
 - patients should have access to their medical records;
6. Recognize that when harm does occur:
 - there should be a system in place whereby the event can be reported and investigated with due respect to confidentiality;
 - patients and their families should be fully informed and supported;
 - providers involved in unintentional harm should also receive support;
 - corrective actions should be taken to prevent future harm and widely share lessons learnt;
 - there should be a mechanism to fairly compensate the patient and their family;
7. Commit to:
 - consumer empowerment through frank and candid education;
 - partnering with the media to encourage responsible reporting and seize opportunities to educate the public;
 - active consumer participation in adverse event reporting;
 - two-way communication among patients and health care providers that encourages questioning;
 - meaningful patient representation on patient safety committees and forums;
8. Pledge to achieve through sustained efforts the following goals:
 - functioning quality and patient safety systems in every health care facility, both public and private, starting with the establishment of a patient safety committee and of an adverse event reporting and response system;
 - adherence to guidelines that are evidence-based and ethical and avoidance of irrational treatments such as unnecessary medicines, investigations and surgical procedures;
 - continuing medical education for health care professionals;
 - integrate patient safety concepts into pre- and in-service training of allied health care professionals;
 - rational load of patients in each health care facility;
 - adequate resources devoted to patient safety;
 - motivated and competent health care professionals;
 - satisfied patients and providers.

PAHO

Recent Activities for one Champion in Argentina

PFPS Champion Professor Jorge César Martínez – Argentina

September 6:

One of the most important News Papers in Argentina – La Nacion, published an interview with me. In the article, I explain the importance of the neonatal screenings that have been implemented by law in Argentina.

I made a special mention that a bilirubin test should be added to the list and explain the importance of making this proper control in order to avoid neurological disfunctions.

This was an important step to raise awareness of the dangers of jaundice for babies.

September 20:

The University del Salvador held a Pediatric Meeting in honor of the 50th Anniversary of its Foundation.

Pediatricians as well as other disciplines as psychologists, nurses, and students were invited to attend, and a large amount of Parents were included too.

I presided the Meeting and one of the main issues I proposed and discussed, was the World Alliance for Patient Safety mission and potential.

The audience was invited to join PAHO's philosophy and action.

EMRO

Follow up from EMRO on the PFPS Meeting

Dr Riham Elasady - Eastern Mediterranean Regional Office of WHO

Following the first PFPS meeting in the Eastern Mediterranean Region (26th-28th March, 2007), several activities have been initiated by champions as well as by the Patient Safety Team at EMRO. A proposal for the "Patient Safety Friendly Hospital Initiative" (PSFHI) was submitted to international organizations to secure funding. The project entails the implementation of several guidelines related to patient safety, part of which is the engagement of patients in the healthcare setting.

We are looking at ways of developing further support for several activities initiated by Champions who were identified in the Regional PFPS workshop. For example, the Champion from Lebanon, Dr. Mohammed Hamandi, has been diligently working on the introduction of PSFHI and other concepts of patient safety in hospitals in Lebanon, building on the economic burden inflicted by medical errors on healthcare expenditure.

Furthermore, efforts in Egypt, lead by Dr. Mahmoud El-Damaty, Dr. Mahmoud El-Tayeb and Mrs Nagwa Metwally, have been focused on implementation of PSFHI and the introduction of Patient Safety in the medical and nursing school curricula. Other countries have requested support for advocacy and introduction of the PSFHI and the concept of patient engagement in Jordan, Morocco and Tunisia. A report detailing the proceedings, outcomes and recommendations of the PFPS meeting is currently in being edited.

Finally, in an attempt to link all strands of the work done on patient safety, it is proposed that patient engagement and patient education will form a major component of the upcoming regional meeting (tentatively February, 2008) for the first global Patient Safety Challenge, Clean Care is Safer care.

WORLD ALLIANCE FOR PATIENT SAFETY



Patient Safety Research - shaping the European agenda

A major international conference to set the future agenda for patient safety research in Europe took place in Porto, Portugal, in September 2007. The conference was organised by the WHO World Alliance for Patient Safety, the UK Faculty of Public Health and University College London, and funded by the European Commission. The conference helped promote discussion between researchers and policy-makers.

Silvana Simi, Patients for Patient Safety Champion, Italy, represented our programme on the organizing committee for this event and took part in several of the sessions to bring the voice of the Patients for Patient Safety programme to discussions.

Press release from the event:

For me, the most important question is when do we meet next time?' said Chair of the German Coalition for Patient Safety, Günter Jonitz, in the final day's session on The way forward.

Knowledge was more than research, he said. It was based on the experience of everyone in healthcare, which is why all those involved in patient safety should come together and share their experiences through weblogs and electronic libraries of information. 'If we want to reach the hearts of healthcare staff we have to sell patient safety to the people who provide the healthcare,' he said. 'Patient safety is a win-win situation - for patients, for doctors and for those who pay for healthcare systems. So why don't we start now?'

'Most people in healthcare don't make mistakes very often,' said Immediate Past President of the Faculty of Public Health, Rod Griffiths, 'and when they do it's upsetting for them, and for the patients.' Culture change required patience, and for people to work together over a long period of time, without politicians trying to force the agenda and apportioning blame, he said.

It would be a pity if patient safety research was totally isolated, Director General of Research and Development at the Department of Health in the UK, Sally Davies, told delegates. 'It's multi-disciplinary. We need to collect data locally and get some young Turks to mash that data.'

Patients were an incredibly under-used resource in judging the quality of care, said Patients for Patient Safety Champion in Italy, Silvana Simi. 'Patient-centred healthcare is also the most cost-effective healthcare,' she said. 'We need to overcome the arrogance of technical knowledge and make sure patients are not intimidated and feel able to speak out. We need to hear the patient's voice – not what other people think patients want.'

For more information about this event you can visit the website at: www.patientsafetyresearch.org or contact Silvana on s.simi@ifc.cnr.it

Interview of the Month - Professor Lucian Leape

Each month on the World Alliance for Patient Safety website Sir Liam Donaldson interviews a selection of individuals on issues around Patient Safety. This month he talks with Professor Lucian Leape. To find out more and to watch the interview you can visit the WHO World Alliance for Patient Safety website and follow the link from the Patient Safety home page or visit:

http://www.who.int/patientsafety/information_centre/interviews/leape/en/index.html

Other Patient Safety News Around The World

RISK: A Primer on Health Risk Communication - Comments Please!

We have recently been having many conversations amongst the Patients for Patient Safety team and Patients for Patient Safety Champions in different regions regarding how risk is communicated most effectively and appropriately in Healthcare. In the recent Regional PFPS Workshops several patients have said it was important to them that Health professionals communicated ALL risks to patients, no matter how small.

An interesting website to visit around this issue is: www.atsdr.cdc.gov/risk/riskprimer where there are several materials considering risk communication in healthcare.

We would like to seek your comments, thoughts and feedback about this issue of risk communication with regard to patient safety. We will share some of these in the next PFPS News issue at the end of November. Please email Rachel on safety@patientsorganizations.org

Medical Culture about errors may be changing

Adapted from 3 September 2007 The Herald Tribune, By David Gulliver

By his count, Dr. Douglas A. Dorsay has performed nearly 2,000 angioplasties, a procedure where a surgeon threads a catheter through the bloodstream to clear blockages. By state officials' count, he did so flawlessly -- until one morning in March 2006. The Florida Board of Medicine disciplined Dorsay in August for his surgical error. He was one of six Southwest Florida doctors, and 73 statewide, with cases before the body in August. What makes him different is that he is willing to talk about it. The Sarasota vascular surgeon said he agreed to discuss his case in depth with the Herald-Tribune because both doctors and the public harbor misconceptions about medical errors. "I'm not trying to hide from it," Dorsay said. "All of us have made mistakes." State records show about 40,000 active, licensed physicians in Florida. Some 1,750 had at least one disciplinary action. Hundreds more have lost their licenses, given them up or moved out of state.

Experts say that countless more errors and near-misses never get reported to state medical boards. Doctors and hospitals worry that disclosing their errors will draw lawsuits and drive away patients -- fears that are unfounded, some studies have found. That culture of silence creates an unrealistic image of health care and ultimately means worse care, experts said. "Medicine has the mirage of perfection," said Dr. Harlan Krumholz, a cardiologist, professor of medicine at Yale University's medical school and a national leader in quality of care and accountability. "The truth is, no one's perfect, and no one can go through a medical career without making a mistake, the way the current system is organized." Two major advances that have improved health care -- abundant, specialized medications and powerful new technology -- also create new possibility for errors. "The likelihood of error goes up with the more steps there are," said Frances Griffin, a director of the Institute for Healthcare Improvement.

Pauses and paradoxes

Board of Medicine investigators termed it a "wrong-site surgery," a case where the doctor operated on the wrong part of the patient. Such mistakes as Dorsay's error are rare -- about one in every 100,000 surgeries, nationally, and one-tenth as often as doctors leaving foreign objects, like sponges or surgical tools, inside patients. The board has heard 151 wrong-site surgery cases in the past three years, or about 16 percent of its caseload. Most wrong-sites leave no lasting harm: The doctor usually catches the mistake early and then performs the procedure in the right place.

But the incidents are shocking, like a Florida hospital's amputation of the wrong leg in 2003. That incident triggered a state law, passed the next year, known as the "pause rule." It requires physicians and their surgical teams to stop before surgery, verify the patient's identity, the procedure and the site being operated on. In an apparent paradox, the number of reported wrong-site cases has risen since the law was passed -- in Florida hospitals, doubling from 2004 to 2005. But it had little or nothing to do with doctors making more mistakes. "There hasn't been a rush of adverse incidents," said Jay Wolfson, a University of South Florida professor and co-author of a 2006 report on Florida's system for reporting mistakes. Instead, hospitals are now more likely to report the mistakes that have been happening all along, he said. He credited the passage of the pause rule and three other changes around the same time.

Wolfson's study also found wide variation between hospitals, a side effect. Hospitals took one of two attitudes, he said: " 'We're not going to report anything,' or, 'We're going to report everything because we don't want to get caught not reporting.' " Dorsay told his patient and her family of his mistake immediately after the surgery. The board's investigative report found that he followed all the mandatory precautions, including marking and verifying the surgery site. "In complex situations, sometimes people make mistakes," Dorsay said. "That's what happened in this case." The report outlined how a seemingly routine procedure went awry.

Changing plans

His patient was a 91-year-old woman who was having severe pain when walking even a few feet. She agreed to an angiogram and angioplasty of the right leg. An angiogram is a test that uses dye to produce images of obstructed blood vessels. Angioplasty is a procedure to remove the obstructions. A catheter is threaded into the groin, through blood vessels to the blockage. The patient arrived at Sarasota Memorial Hospital on March 26 for the procedure. That morning she began experiencing pain, even at rest, in her right leg. Dorsay had planned to perform the angioplasty retrograde, meaning against the direction of blood flow. It allows exploration of the iliac arteries, which form a "wishbone" off the abdominal aorta and continue into the femoral arteries of the legs. The doctor inserts a needle in the upper thigh of the leg opposite the suspected blockage. He then threads the catheter up the femoral artery, across and through the wishbone and back down into the target femoral artery. But the patient had arrived in pain and it was rapidly becoming more severe, Dorsay said. Angioplasty patients normally are only lightly sedated and remain conscious during the procedure. Dorsay prescribed painkillers but, with a small, elderly patient, was wary of administering too much. He decided to change his plan: "I felt if I could get the blockage open, it would relieve the pain." Dorsay chose to perform the procedure antegrade, or with the blood flow. In that method, the incision is on the same side as the blockage, for a shorter and quicker path. Before starting, the four-person team had to perform a series of safety checks required under the pause rule. One check is verifying that the surgery site is properly marked with a "yes." For angioplasty, the mark goes on the leg to Health Department investigators found that the team performed the check, and the mark was in the proper place -- on the right leg. But the patient was positioned for easy access to the initial site, on the left leg. Before he began, Dorsay asked the patient where she felt pain. She slapped her left leg. Dorsay made the puncture on that leg and threaded the catheter antegrade, the right direction but in the wrong leg. He still found and opened a blockage in that leg. During the procedure, a team member noted he was in the wrong leg. He completed the angioplasty, then moved to the right leg and performed the procedure as planned, opening three blockages. That immediately relieved the woman's pain, he said. The medical staff notified the family and patient immediately, and reported it to the Health Department, which triggered the citation for a wrong-site surgery.

The Board of Medicine, which met Aug. 10-11 in Fort Lauderdale, fined him \$5,000, half the amount normally assessed in wrong-site surgery cases, plus the board's legal costs. It also issued a letter of concern, required him to take a continuing medical education course in risk management, perform 50 hours of community service and give a lecture on wrong-site surgeries.

'A more closed environment'

Neither the play-by-play report nor the board's ruling surprised Griffin, the director of the Institute for Healthcare Improvement. Complications arose from the outset, making an error more likely:

- The patient showed up in severe pain, and was hard of hearing. That made miscommunication -- like the leg slap -- more likely.

- The pain and miscommunication pushed the doctor to alter his plans on the fly.
- Repositioning the patient spun his field of work 180 degrees, and moved the final incision site further away.

News continued

"The surgeon didn't screw up," Griffin said. "Lots of things went wrong all the way down." She faulted the Florida board's traditional response of punishing the physician. "How does fining the surgeon reduce the chances of that happening again tomorrow?" What might work, experts said, is more openness and a change in how the health care community views mistakes. "Medicine has historically been a more closed environment," Krumholz said. "There's been a lack of recognition that some of these are system errors." He recalled a July 2001 case at Westchester Medical Center in New York. A boy undergoing an MRI scan was killed when a technician brought an oxygen tank into the room. The MRI machine, which generates tremendous magnetic force, yanked the metal tank into the machine, striking the boy in the head. State authorities found 11 safety violations and fined the hospital \$22,000. What happened next was unusual and significant, Krumholz said. "They could have just said, 'We'll fire the person.' Instead they said, 'This is our fault as an institution.'" The hospital analyzed its processes and made dozens of safety improvements, he said. But doctors and hospitals have long had a deep aversion to openness. "We've got to get over this. Fear is incompatible with learning, and safety can't be achieved without learning. Safe systems are open transparent systems."

Krumholz has led a major step toward transparency: Medicare's disclosure of hospitals' mortality rates for heart attack and heart failure. In that, baseball players and hospitals have something in common, he agreed: Those making the fewest errors often are not the best in the field. "I always say, when you're looking at error rates, the better hospital has the higher rate," Krumholz said. "Proactive hospitals will seem worse than a place that pretends it doesn't have errors and doesn't look for them." For now, only the very best and very worst hospitals' names are disclosed, but he expects that to broaden over time as the culture changes. Disclosures like Dorsay's are a step, he said. "All doctors make mistakes. Any doctor who's willing to talk about it should be commended."

At the Board of Medicine meeting, unlike almost all his peers, Dorsay brought no attorney. He did not contest the board's findings -- Dorsay has always supported the pause rule, he said -- and he accepts what happened. What matters to him is that the woman remains his patient, and that her family approves: "They continue to place their trust in me." Full story on -:

<http://www.heraldtribune.com/article/20070903/BUSINESS/709030527>

Can Your Nurses Stop a Surgeon?

(Adapted from 9 September 2007 Hospital and Health Networks on hospitalconnect.com)

The patient was prepped. The surgical team was ready. The equipment tray was loaded, the devices cleaned. The surgeon asked for the scalpel. "No," said Clarita Distor, R.N. The team at Advocate Illinois Masonic Medical Center was taking a "time-out"—something they do before every surgery to make sure they are operating on the right patient and the right body part with the right equipment.

The doctor refused to participate. Again he asked for the scalpel. This time, Leonard Arnold, a surgical technician, spoke up. He was Distor's wingman—a term borrowed from Tom Cruise's 1986 hit movie "Top Gun" to describe people who watch each other's backs. Arnold declined to hand over the knife and reiterated that the doctor had to complete the time-out before cutting into the patient.

Visibly—and vociferously—irritated, the doctor reached over and grabbed the knife handle off the surgical tray. To his chagrin, it was empty—Arnold had pre-emptively removed the blade.

"Why can't I have the [expletive] knife?" the doctor shouted as he threw the handle down and stomped to the door. Distor was already on the phone to the operating room manager explaining the situation. That set off a chain reaction that led all the way up to the chief of medicine, who immediately came down and told the surgeon in no uncertain terms that he couldn't operate at Illinois Masonic—or any other of Advocate Health Care's 10 Chicago-area hospitals—unless he abided by the so-called red rule. The physician returned to the OR and hasn't missed a time-out since that day in June 2006.

"We don't want to embarrass doctors," Arnold told an audience of more than 600 managers and senior-level officials at Advocate's quarterly leadership meeting in June, where he and Distor, along with several other Advocate employees, were honored for their commitment to patient safety. **"But patients trust us. We can't take that trust for granted."**

"Culture of safety" is a popular term, tossed around at health care conferences, medical staff meetings and boardrooms, and championed by the National Quality Forum, the Joint Commission, the Institute for Healthcare Improvement and others. While many hospitals pay lip service to the notion, few have defined exactly what it means in their operations and fewer still have established specific processes to make it a reality. Advocate is among those few.

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At Advocate, a culture of safety means all employees have the power to speak up and stop an action that they think may harm a patient or co-worker. More importantly, it means creating a work environment in which critical thinking is as routine as breathing.

And the system has put some real meat on the bones of its safety efforts, launching an ambitious, systemwide training program in 2004 for every employee who walks through the door—from back-office staff to janitors to nonemployed physicians to the chief executive officer. All of Advocate's acute care hospitals participate; ditto for the 140 outpatient centers, the home health agency and the five ambulatory surgery centers. More than 200 sites, 25,000 employees and 4,500 affiliated physicians are involved. And the system's health plan will soon join the mix.

Failure to comply is not an option. "This has my 150 percent commitment," says Advocate CEO Jim Skogsbergh. "The truth is, I love this stuff. If we had any pushback, it wouldn't have mattered. We were going to do it anyway."

What is Culture?

A definition of "culture of safety" that satisfies everyone is hard to come by. A lot of people say it's an error-free environment. That's wrong, according to James Bagian, director of the Department of Veterans Affairs National Center for Patient Safety. The goal isn't eliminating errors, it's ensuring that patients are not harmed. There's a big difference, Bagian says.

A 2001 Agency for Healthcare Research and Quality white paper, *Making Health Care Safer*, offers a slightly more academic view. Noting that an exact definition does not exist, AHRQ researchers cite four common traits among institutions with a culture of safety:

- Acknowledgement of the high-risk, error-prone nature of an organization's activities
- Blame-free environment where individuals are able to report errors and close calls without punishment
- Expectation of collaboration across ranks to seek solutions to vulnerabilities
- Willingness on the part of the organization to direct resources to address safety concerns.

Advocate embraces those notions. Key among them is stopping the blame game. At Advocate, the focus is on five behavior-based expectations, or BBEs: pay attention to detail, communicate clearly, have a questioning attitude, hand off effectively, and be a good wingman. For each one of these, there's a prescribed code of conduct. For instance, to encourage attention to detail, staff are taught the STAR technique:

Stop: Pause for one or two seconds to focus on what you are about to do.

Think: Is what you are about to do correct?

Act: Concentrate and perform the task.

Review: Check to see if the task was done correctly.

"It gives your brain a chance to catch up with your hands," Kate Kovich, director of quality and regulatory compliance and patient safety officer at Advocate Christ Medical Center and Advocate Hope Children's Hospital, told 12 new employees undergoing training in early June. "We do this when we go to the vending machine. We see that the Snickers is B-12. We press B and then wait a few seconds to check and make sure that it's 12."

The Journey Begins

By the late 1990s, Advocate's board of trustees identified patient safety as a system wide priority. A task force was established to explore ways to improve performance.

The Assessment

Most of Clapper's early health care clients dipped their toes into the culture of safety experience, trying it at one hospital at a time. Advocate jumped in systemwide all at once. "We tend to be pretty audacious," Sacks says. "We want our lowest common denominator to be world class."

The first step was to conduct a cultural assessment. In 2005, staff members were surveyed about their perception of the organization's commitment to safety. In addition, one-on-one interviews were conducted of 900 employees representing every part of the organization. Finally, Clapper's team reviewed two years' worth of root cause analyses, looking for "human factors" that led to the errors.

They found that staff was committed to safety but wanted assurances from leaders that problems would be addressed. They also identified the top five causes of sentinel events: lack of critical thinking, inattention to detail, inadequate knowledge of established procedures, poor communication between caregivers, and noncompliance with policies. PII's program was then modified to fit Advocate's needs.

The Rollout

To start, staff had to be selected and trained to lead the effort. There were some challenges. Finding the right leaders was critical, Elia says. If the appropriate person in a division didn't step up, it was more of a challenge to get line employees to buy into the concept.

Nonclinical staff wondered why they needed the training—a question that continues to crop up. During a break at the recent training session for new employees at Christ Medical Center, some attendees, who asked not to be identified, questioned if three hours of training was worthwhile when they don't care for patients.

Kovich told them about a mix-up at Duke University hospitals in which an elevator maintenance crew stored hydraulic fluid in a canister similar to one for sterilization liquid used in surgery. Spotting the canister in the hall, a housekeeper moved it to the surgical suite. Medical equipment soaked in it for several days before someone noticed. Surgeries had been performed with the equipment that had soaked in it.

"Most people eventually make the tie on how they fit in," Willeumier says.

No End in Sight

Advocate has made significant strides since embarking on its safety program two years ago. Staff clearly understands the need to report problems and is more comfortable doing so. Reports of sentinel events and near-misses climbed to 336 in 2006, up from 109 in 2005. However, such reports are projected to hit only 174 this year, and Sacks is certain that errors haven't dropped that steeply. To keep up the momentum, Advocate will roll out a computerized error reporting system later this year. Perhaps the biggest challenge for Advocates and others is making the culture stick for the long haul. Once the initial wave of training is finished, peer pressure and active leadership are critical. The VA's Bagian says it is in people's competitive nature to jump on board when they see others following established procedures.

For the full story please visit -:

<http://www.hhnmag.com>

IAPO

3rd Global Patients Congress



20 – 22 February, Budapest , Hungary – Registration is now open!

The International Alliance of Patients' Organizations (IAPO) is delighted to announce that registration for the 3rd Global Patients Congress is now open. This event offers a fantastic opportunity to meet with other patient leaders from all over the world as well as a wide range of other healthcare stakeholders including healthcare professionals, researchers, academics and industry representatives.

IAPO's Congress is open to IAPO members and invited guests. Please contact IAPO for further information: membership@patientsorganizations.org

The overarching focus of the event will be IAPO's vision of patient-centred healthcare worldwide with a special focus on patient involvement in patient safety, patient information and access to healthcare.

For more information, please see IAPO's website, www.patientsorganizations.org/congress2008 where you can download the preliminary programme. **Book before 30 November 2007 to save up to 20%.**

A Look Ahead

An international **Patient Safety Trek to the base camp of K2** will be organized in 2008. Patients for Patients safety Champions will be invited from all around the world to participate in this trek to raise funds and create awareness internationally and also to show international solidarity on Patients safety. For more information contact:

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Memories of Dublin

