

The Patient Experience as a Catalyst for Change and Improvement

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Kevin The Person



**8 Days
before
admission
to
hospital**



The Questions

- **Simple questions.....**

Why did Kevin die?

What went wrong?

Please tell us the truth

– we need to know and we need to understand

Court Ruling

“It is very clear to me that Kevin
Murphy should not have died.”

Judge Roderick Murphy at High Court Ruling
May 2004

The Unfolding Story 1997-1999

Persistent back pain – GP Visits, X-Rays

Orthopaedic Surgeon – Bone Scan, Blood Tests

		1997	1999
•Calcium	3.51	(2.05-2.75)	5.73 (6.1)

Described as ‘inconsistent with life’.

•Creatinine	141	(60-120)	214
•Urate	551	(120-480)	685
•Bilirubin Direct	9.9	(0-6)	
•Alk Phosphate	489	(90-300)	

Peer Review

“The combination of bone pain, renal failure and hypercalcaemia in a young patient points either to a diagnosis of primary hyperparathyroidism or metastatic malignancy and these ominous results should have been investigated as a matter of urgency”.

“All evidence indicates that the patient was suffering from a solitary parathyroid adenoma and removal would have been curative with a normal life expectancy”

“Kevin would have had surgery to remove the over-active parathyroid gland. He would have been cured and would still have been alive today.”

Research : 96% Success; 1% Complication

The Post-It

SMAc
K. Murphy
~~17/4/98~~
CAL 5.73
Sod. 138
Potas 3.6 -
Urea 9.9 (Hi)
Creatin 2.14
gluc 5.6
alb. 4.9 (Hi)
BUN 2.4
ALK. Phos 8.5
AST 0.4
LDH 6.2

LIPOSTAT
Hydrophilic Pravasatin Sodium

CHOL 5.6
UNTR 685
5.0

The Shortcomings

- Inability to recognise seriousness of Kevin's condition
- Appropriate interventions not taken
- Selective and incomplete transmission of information.
- Non receipt of vital information
- Absence of integrated pathways
- Link between behaviour and test results not made
- Developing neurological problems ignored

ABSENCE OF DIRECT COMMUNICATION
WITH THE PATIENT

Shortcomings Contd...

- Treatment at Registrar level
- The team dynamic
- The impact of a weekend admission
- Patient asked to accommodate system?
- System intended to accommodate patient?
- Expectations of a Tertiary Training Hospital

**Every Point of Contact
Failed Him...**



The Response of Doctors

- **Defensive**
- **‘Loyalty to colleagues’**
- **Muddying the waters – dissembling**
 - e.g. **Claims of inability to understand ‘layspeak’**
- **Attempts to shift responsibility**
- **Confidence in any hope of ascertaining truth shattered**
- **Excuses offered were unsustainable to the point of being offensive**
- **Expectation of professional and honourable conduct betrayed**

Legal Route to Finding Answers

- ‘System favours defendants
- Disempowerment of plaintiff
- Plaintiff takes huge personal risks
- “David and Goliath” experience
- Wearing-down process
- Lack of compassion

A Wish List : Do it Right!

- Observe existing guidelines, best practice and SOP's. Be prepared to challenge each other in that regard**
- Following adverse outcomes undertake “root cause analysis” "system failure analysis"/"critical incident investigation”.**
- Communicate effectively within the medical community and with patients**
- Listen to patients and families**
- Respect patients and families**
- Keep impeccable records**

**ACKNOWLEDGE ERROR
AND ALLOW LEARNING TO OCCUR**

A Wish List Continued

- **Know your personal limitations**
- **Replicate what is good and be always vigilant for opportunities to improve.**
- **Learn and disseminate that learning**
- **Practice dialogue and collaboration – meaningful engagement with patients and families**
- **Create a coalition of healthcare professionals and patients**

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Speak Up

- **Speak up if you have questions or concerns. It is your right to know.**
- **Pay attention to the care you are receiving.**
- **Educate yourself about your diagnosis, tests and treatment**
- **Ask a trusted family member or friend to be your advocate**
- **Know what medications you take and why you take them**
- **Use a health-care provider that rigorously evaluates itself against safety standards**
- **Participate in all decisions about your care**

The Way Forward

- Accepting the challenge to learn.
- Recognising barriers to healing.
- Providing signposts to partnership
- Identifying and removing barriers to engagement.
- Recognising the value of patients as partners.

Kevin's experience as a Learning Tool

- Opportunities for Involvement -

- Globally – WHO and World Alliance
- Internationally.
- Nationally
- Locally

World Alliance for Patient Safety

- **In 2004 the 57th World Health Assembly supported the creation of an international Alliance to support Patient Safety**
- **The World Alliance was launched in October 2004**
- **Aim is to coordinate and accelerate international improvements in patient safety**
- **The Alliance brings together ministries of health, patient safety experts, national agencies on patient safety, health care professional associations and consumer organizations**
- **Patients for Patient Safety is one of 6 major priority action areas**

Patients for Patient Safety

- To ensure perspective and viewpoint of patients, families and health care consumers from all corners of the globe is infused in the work of all six strands of the World Alliance.

Patients for Patient Safety Workshop 2005

- **Held in the UK in November 2005 in conjunction with the UK Government's EU Summit on Patient Safety**
- **Brought together 21 patient champions from 19 countries to build a global voice of patients**
- **The Patient Champions developed a collective vision that expresses the deeper aspirations the group shared**
- **Exposure to experts in patient safety both as part of the larger EU Summit and in the more intimate setting with the workshop**
- **EU Summit Delegates were exposed to the perspective of a global team of Patients all committed and passionate about forming a partnership to bring about change aiming to reduce harm from medical error.**

The PFPS Champions



World Alliance for Patient Safety

- Action Areas -

- Patients for Patient Safety
- Taxonomy for Patient Safety
- Research for Patient Safety
- Reporting and Learning for Patient Safety
- Solutions for Patient Safety
- Global Patient Safety Challenge

**Patients and Families
– the untapped resource –**

EXPLORE and EXPLOIT

**ENGAGE
IN
POWERFUL CONVERSATION**

THANK YOU

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