After The Storm – Stories of Harm and Learning

By Helen Haskell, Tanya Lord, Carolyn Canfield, Laura Townsend, and Lisa and Kirsten Morrise

Objectives

- Analyze different kinds of patient safety events as a way to drive the design and implementation of solutions.

- Identify ways to work with patients and families to change culture and develop a system of co-production of health care.
Presenters

- **Helen Haskell**, MA, President, Mothers Against Medical Error and co-author of *Case Studies in Patient Safety: Foundations for Core Competencies*
- **Carolyn Canfield**, Independent Citizen Patient, University of British Columbia
- **Tanya Lord**, PhD, MPH, Patient Safety and Quality Improvement Consultant, Co-Founder The Grief Toolbox
- **Laura Townsend**, President and Co-Founder, Louise H. Batz Patient Safety Foundation
- **Lisa Morrise**, MA, Past Patient Co-Chair Patient and Family Engagement Affinity Group Partnership for Patients 1.0

Agenda

- **Sharing Our Stories – Part One**
  - Helen Haskell
  - Carolyn Canfield
- **Connecting Stories to Core Competencies – Part One**
  - Moderated Discussion
- **Refreshment Break (approximately 1:55-2:05)**
- **Sharing Our Stories – Part Two**
  - Tanya Lord
  - Laura Townsend
- **Connecting Stories to Core Competencies – Part Two**
  - Moderated Discussion
Agenda (continued)

- Sharing Our Stories – Part Three
  - Lisa Morrise and Kirsten Morrise
- Connecting Stories to Core Competencies – Part Three
  - Moderated Discussion
- Refreshment Break (approximately 3:00-3:10)
- Using the Patient Voice to Collaborate to Improve Quality and Safety in Healthcare
  - Patient Panel – Competencies, Culture, and Co-production
  - Attendee Stories: Do you have a story to share? We want to hear your story and how it may impact quality and safety.
- What has been helpful? What else would you like to cover?

Why do we tell our stories?

- To make it real
- To connect with others
- To make a change by
  - Inspiring
  - Informing
  - Improving
Medical Harm

HHS Office of Inspector General, 2010
- 27% of hospitalized Medicare beneficiaries experience adverse events

Landrigan et al, NEJM 2010
- 18.1% rate of medical harm across 10 NC hospitals
- No improvement from 2002 to 2007

Classen et al, Health Affairs 2011
- 33% of patients in 3 large tertiary care centers suffer medical harm
- Many patients experience multiple events

Looking for Consistent Themes

- Communication
- Diagnostic issues
- Patient experience
- Patient satisfaction
- Lessons learned
- Obstacles and challenges
- Mistakes and failures
- Inspirational events
Evolution of Patient Voice in Healthcare Improvement

Elements of change
- Competencies
- Culture change
- Collaboration
- Co-production
Developing the Book

- Case Studies in Patient Safety: Foundations for Core Competencies
- Co-Authors:
  - Julie Johnson
  - Helen Haskell
  - Paul Barach

Linking Patient Stories to Core Competencies for Health Professions

- Patient Care
- Knowledge for Practice
- Practice Based Learning & Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems Based Practice
- Interprofessional Collaboration
- Personal and Professional Development
Sharing Our Stories – Helen Haskell

The Lewis Blackman Story

Lewis’ Story – “It’s Hard to Kill a Healthy 15-Year-Old”

Thursday, November 2

Lewis and his family arrive at the hospital at 6 a.m., for the 7:30
surgery.

Lewis is taken to the operation room. Nurses remove clothes
from the patient.

The nurse tells Lewis and his mother that after the
surgery, “they’ll be able to go home.”

Lewis is prepped for the surgery.

Friday, November 3

4:30 a.m., another nurse checks on Lewis. “He’s not,
saying anything,” she tells the nurse.

The nurse says Lewis is scheduled to be discharged
that day.

Saturday, November 4

6:30 a.m., Lewis is discharged. Getting out of bed.

On Saturday night, Lewis begins to feel a little better.

Sunday, November 5

12:00 a.m., a ball rolls after another transplant.

Lewis gains weight.

Nurses instruct Helen to give Lewis pain killer
for breakfast.

Lewis takes his pills. He’s going to be
asleep.

Lewis has his blood pressure
checked.

Monday, November 6

5:30 a.m., Lewis’ heart rate is 142.

Lewis is discharged.

Lewis’ blood pressure is 90/65.

Lewis’ heart rate is 120.

Lewis’ mother asks for the
doctor’s advice.

Lewis is discharged.

Lewis is recovering well.

Lewis is doing great.

Lewis is going to be
released.

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Finishing the story

- What are the lessons?
- What needs did you identify?
- What positive changes have resulted?

Morrise, L and Stevens KJ. Training Patient and Family Storytellers and Patient and Family Faculty. Perm J 2013 Summer; 17(3): e142-145

The Lewis Blackman Act
Sharing Our Stories – Carolyn Canfield

A Cascade of Small Events
Learning from an Unexpected Postsurgical Death

IHI National Forum
December 6, 2015

a cascade of small events…

OR ➔ surgical ward ➔ isolation ward

MRP-GS OT AtP-S GE Urol Endo GE RN
Connecting Stories to Core Competencies

- Thinking of Helen’s story about Lewis Blackman, hypothesize the effect of professional hierarchy on communication patterns, patient care, and patient safety.

- How do we learn from this incident to proactively prevent similar events in the future?

- Which of the core competencies for health professionals are most relevant for this case?

Connecting Stories to Core Competencies

- Thinking of Carolyn’s story – how can a “cascade of small events” be prevented in an in-patient setting?

- Which of the core competencies for health professionals are most relevant for this case?

- How can patient involvement in care help limit “burnout?”
TEN MINUTE BREAK

Sharing Our Stories – Tanya Lord

The Story of Noah Lord
My Mom

My Mom’s Story

1. **Lack of Teamwork** – She had a great doctor, great nurse, and a great family. But great players don’t make a great TEAM.

2. **Lack of Knowledge** – The family and the patient didn’t have the tools they needed to become informed active members of the team. We asked tons of questions; we just didn’t get LUCKY and ask the right ones.

3. **Lack of Technology** – The only machine she was hooked up to was the PCA therapy machine; she had no oxygen or heart monitors on her at all. The hospital standard of care was to check on her every four hours.
The Louise H. Batz
Patient Safety Foundation

Our mission is to prevent medical errors by ensuring that patients and families have the KNOWLEDGE they need to promote a safe hospital experience for their loved ones, and to support innovative advancements in patient safety. Our greatest hope is that families, patients, and caregivers will work together as a TEAM to improve safety in our hospitals.

www.louisebatz.org

Connecting Stories to Core Competencies

- Thinking of Noah and Tanya’s story, again we see fragmentation in health care leading to a sentinel event. How could the system have been designed to prevent this from happening?

- Which of the core competencies for health professionals are most relevant for this case?
Connecting Stories to Core Competencies

- Thinking of Louise Batz and Laura Townsend’s story, what level of monitoring should be in place for a patient receiving opioid analgesics?

- To what degree should the patient’s designated caregivers be responsible for monitoring and involved in decision making for the patient?

- Which of the core competencies for health professionals are most relevant for this case?

Sharing Our Stories – Lisa Morrise
Sharing Our Stories – Lisa Morrise

[Image of a family]

Sharing Our Stories – Lisa Morrise

[Image of a family]

11/23/2015
Sharing Our Stories – Kirsten Morrise

Connecting Stories to Core Competencies

- Evaluate the implications of routine training for special circumstances in neonatal resuscitation.
- Have you ever been in a position where you stepped in to rescue a patient? Should hospitals have a “Speak Up” policy for all allied health professionals as part of their Quality and Safety plan?
- Which of the core competencies for health professionals are most relevant for this case?
Ten Minute Break

Patient Panel
and audience discussion

- Collaborating with patients: using the patient voice to change healthcare culture
- Lessons learned: linking your own stories to core competencies and healthcare improvement
Stories from Case Studies in Patient Safety

- It’s Hard to Kill A Healthy 15-Year-Old: The Story of Lewis Blackman / Helen Haskell (p. 5)
- A Cascade of Small Events: Learning from an Unexpected Postsurgical Death: The Story of Nick Francis / Carolyn Canfield (p. 117)
- Not Considered A Partner: A Mother’s Story of a Tonsillectomy Gone Wrong: The Story of Noah Lord / Tanya Lord (p. 143)
- Unmonitored: A Postsurgical Narcotic Overdose in the Hospital: The Story of Louise Batz / Laura Townsend (p. 287)
- The Trial Meant For You: The Lifelong Medical Journey of a Child with a Complex Congenital Condition: The Story of Kirsten Morrise / Lisa Morrise and Kirsten Morrise (p. 261)

Closing

- What was helpful?
- What else should be discussed?

Thank you for participating in our session!