PReP 14 — Adverse Events, Disclosure, and Apology

Lesson 5 — Quality Improvement

Reporting

Pam:
Every organization has a reporting expectation. Reporting is sort of an internal mechanism that we use to identify and keep stats and data on incidents that happen. The most important thing, I think, for new professionals going into organizations to know is that reporting is important, not just because it's required or because it's a policy. It's important because it actually does help us to make things better. If we know that things are going wrong, or almost went wrong, that's the importance of reporting. Reporting isn't because we have to tell the Ministry or we have to tell Health Quality Ontario—those are reasons too. The main reason is because as professionals, we're accountable for our piece of the puzzle to make things better. Change is completely slow in healthcare. It takes a long, long time. What changes things is when you get everybody who's at the point of care and impacting patients to care about what they do. And part of caring about what you do is recognizing when things could be better.

Ross Baker just did another review of those ten years of patient safety work. And all of the efforts that have been done to try to change the system, to try to put better automatic things in place like checklists and taking more human activity out of the system, making things more mechanical, or electronic, or computer-based order entry, that kind of thing—the numbers haven't really dramatically changed. So I think once we get over the disappointment of all these things we've been trying to do to make things better, it isn't that they haven't made them better, it's that some of the stuff that happens in healthcare are just not—you can't remove it completely. If you're going to continue to have human beings in the system providing care and making decisions and judgments, then we're going to get it wrong sometimes.

Patient Involvement

Pam:
What we hope, and what we're doing a lot in Ontario is trying to involve patients more in their care. The patient wants to live. The pa-

tient wants to get better. And so who better to oversee what we're trying to do, and catch us if we make a mistake? They should know their drugs. They should know what leg's being operated on. They should know what treatment they're supposed to have. So the more we involve them, I think that might be some of the ways to help make this even better.

Most organizations have people in what's called "patient relations" now. We have two people plus myself. And that's the kind of work that we do, is to try and work with families and staff to really try to get those issues resolved. In the moment if they're small issues—that's the best way—and obviously as well if it's a big issue that happens that we have to disclose and where there could be further action taken in terms of litigation or something like that.

Litigation

Pam:
Litigation, while feared by many in the healthcare system, is not as prevalent as it is in the American system because we have universal healthcare. Often what people are suing for in other jurisdictions is to cover the cost of the care that's required now that something's gone wrong. So if they need ongoing homecare, or they need devices or something like that, that doesn't happen in Ontario because we have those things covered. So there's not a reason to sue.

People in my experience sue because we didn't do disclosure and sometimes apology very well. We didn't tell them what they wanted to know and we didn't give them the facts that they needed to know. They do sue sometimes because somebody has died as a result of an error, and that person is the breadwinner of the family. They need to recover some funds to provide ongoing sustenance for a family. And of all the cases that go forward, very, very few ever get to a trial setting.

We have a very strong settlement focus—not just us, but the healthcare community. To say, "If it's true that we did something wrong"—that's my advice when I'm going to my insurance company and my lawyers—I say, "I think we have reason to settle this one, and I think you should settle this one." They don't always listen to me, but most of the time cases get settled.

Insurance

Pam:
There's more fear of litigation than there is actual litigation, and that doesn't help the physician who's sued or the nurse who's involved in a lawsuit. Nurses are covered under the hospital insurance, physicians are privileged, they're not employees, so they're covered under their own organization, CMPA, Canadian Medical Protective Association. All hospitals in Canada are insured. In Ontario, most of the hospitals are insured under a group called the Healthcare Insurance Reciprocal of Canada, which is a big co-pay insurance company.

Blame Culture Doesn't Help

Pam:
So this notion that punishment and blame fixes things, or makes things better or improves quality has been shown over and over again in the research not to be true. It's exactly the opposite. Reactive responses to incidents by blaming and punishing are not the way to go. Proactive education works, and what we call "accountability mechanisms." So yes, you're still accountable, and if you made the error, or something that you did was as a result of education that you lack, we need to fix that for you. We need to improve that. Punishing you is not going to make a difference. Punishing you is not going to fix the system that led you to be able to give that wrong medication. Getting rid of one person is not going to fix the problem that exists.

We're not on opposite sides here. We're all on the same side, we all want the right things, we all want quality care for everyone in the province. And the resources are limited, and events are going to happen. And if we all work together we can hopefully minimize those, and make the best use of the resources that we have.