



Just culture of safety: Why protecting quality improvement reviews is important for everyone

An article for physicians by physicians
Originally published June 2010

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ABSTRACT

A just culture of patient safety promises better quality and safer care. This article explores protected quality improvement reviews and discusses the benefits of learning from adverse events to limit the likelihood of their reoccurrence.

A 16-year-old male was diagnosed with leukemia. During the last cycle of chemotherapy, his oncologist was running behind and asked a junior resident to administer three chemotherapeutic agents to the patient. The pharmacy sent all three drugs in the same medication pouch. The resident had little orientation to the oncology service and attempted to seek clarity from the supervising oncologist without success. All three drugs, already in preloaded syringes, were administered intrathecally. However, one of the drugs, vincristine, should have been given intravenously. The health care providers involved promptly met with the parents and provided them an initial understanding of the clinical condition of their son, an initial understanding of the facts as to what had happened, and emotional support.

Despite all rescue efforts, the young patient died three days later. The coroner (medical examiner) was immediately notified.

HOW WOULD YOUR LEADERS RESPOND?

Could a similar medication adverse event occur in your hospital? What would be the response of your leaders?

The case describes a real occurrence in Canada. The following, however, is a fictional description of how this serious adverse event could be handled in a just culture of safety. The approach reflects what many patient safety experts and the CMPA see as a fair and effective way to improve the quality of patient care and prevent other similar occurrences.

WHY SHOULD QUALITY IMPROVEMENT REVIEWS BE PROTECTED?

What's in it for health care providers?

- Confidentiality, which encourages meaningful participation with full discussions
- Enthusiasm and empowerment to flag weak spots in the system of care
- Ability to concentrate on improving future care
- Lauded for bringing possible failures forward
- Reduced risk of misapplication of information

What's in it for hospitals and institutions?

- Helps establish cooperative rather than adversarial relationships
- Permits hypothesizing, speculation and opinions on system issues
- Allows learning of what is happening in the organization
- Allows monitoring and improving of quality and safety

What's in it for patients and the public?

- Learn the facts
- Learn what's been changed to improve the system of care
- Better decision making and improved care for everyone

CMPA members are encouraged to contact the CMPA about specific medico-legal concerns at 1 800 267-6522.

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LEARNING FROM ADVERSE EVENTS

The leaders of the hospital did not rush to prejudge and blame the providers for what had happened. Rather, they tried to understand the circumstances and context for the actions and decision-making during the event. A preliminary collection of facts showed there was no deliberate violation of policy or deliberate misconduct. The lack of knowledge or skills on the part of the resident in this case was considered largely a shortcoming of the deficiencies in the orientation to the oncology service. The hospital determined the system of care needed improvement.

The hospital reassured the distraught parents that a quality improvement (QI) review would be held and what they could expect to learn from it.

The QI review was conducted under the auspices of a properly constituted quality improvement program and committee. (Quality improvement committees, depending on the province/territory, may have different titles, for example: Quality of Care, Critical Incident Review, Risk Management committees.) To gain a broader perspective, the hospital reviewed a number of medication policies and practices.

THE QUALITY IMPROVEMENT REVIEW

To be meaningful, quality improvement reviews should include candid and detailed assessments by the providers involved. In addition to reviewing known facts, it is often helpful to consider what could have happened or what the participants wished had happened. Discussions may include

hypothesizing and speculating about weaknesses in system processes. This can be a useful way to identify possible reasons for the clinical outcomes and to develop strategies to try to prevent reoccurrences.

Knowing that the focus was learning and their remarks would not be used against them in other forums, several physicians, nurses and pharmacists, including those involved in the event itself, took part. The group avoided finger pointing and blaming. With facilitation and using a recognized approach for identifying system issues leading to adverse events, the providers speculated and hypothesized on what could have been done differently in the system in this case and in the future. The committee came to an understanding of the facts about what happened and identified several contributing system failures:

- inadequate team communication
- little orientation and supervision of new staff
- confusing packaging and labelling of medications and syringes
- no double checks for certain medications and routes by separate providers
- less-than-ideal physical areas for preparing and administering high-risk medications
- inadequate monitoring
- lack of a policy for administering medications

The hospital made a number of changes. The orientation for all new medical, nursing and support staff was improved. The hospital also improved the procedure for delivering medications to the ward. It developed, tested and implemented policies for handling

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high-alert medications. Syringes containing vincristine are now flagged with a warning against intrathecal use. Many other medication safety practices were introduced including better labelling, segregation of certain sound-alike and look-alike drugs, read backs and clearer writing of drug orders. A similar tragedy has not occurred since, and serious medication adverse events have decreased overall.

The hospital leaders and the providers involved (with the consent of the parents) met and gave the parents a factual understanding of what had occurred and an apology. They discussed the steps that were being taken to improve the medication practices at the hospital.

The traditional response to adverse events has focused on identifying and blaming those providers last in contact with the patient, resulting in calls for higher vigilance, better training, and sometimes professional sanctions or firings. Unfortunately this approach still persists in Canada. The hospital in our example might have taken the traditional approach of blaming and similar adverse events would almost certainly have continued to occur there.

DEFINING A JUST CULTURE OF SAFETY

In a just culture of safety, the leaders and all staff are committed to providing the safest possible care to patients. There is a shared commitment to learn from adverse events and close calls, and to make improvements. The interests of both patients and providers are protected.

QI REVIEWS LEAD TO IMPROVED PATIENT SAFETY

Adverse events occur despite the dedication, training and professionalism of health care providers. An important part of a just culture of patient safety is learning from adverse events and close calls. Systems theory in patient safety emphasizes that focusing on the system rather than on the individual will prevent far more adverse events. Patient safety experts consider a quality improvement review of the system of care by a properly constituted quality improvement committee one of the more effective approaches to improving patient safety in a hospital or health care institution.

Within the system, providers are still responsible for the quality of their work. It is a matter of finding the right balance between improving health care and helping all providers prevent similar events in the future, while fairly addressing any issues of individual provider performance and accountability. If serious concerns regarding a health care provider's performance or conduct are discovered in the course of a quality improvement review, these issues should be appropriately reviewed in a separate and independent accountability process.

For more information, see the CMPA booklet, *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions*, available online at www.cmpa-acpm.ca (search for: learning) or in print by calling the Association at 1 800 267-6522.

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THE BENEFITS OF CONTRIBUTING TO SYSTEM REVIEW BY A QUALITY IMPROVEMENT COMMITTEE

The CMPA encourages its members to take part in legally-structured quality improvement programs. The quality improvement review process, which focuses on system improvement, should be separate from any review of individual professional accountability.

Legislation in each Canadian province or territory protects quality improvement information, deliberations, records and documents from being disclosed in legal proceedings. This legislation reflects the public policy objective of encouraging health care providers to participate in quality improvement. For quality improvement programs to succeed, participants must feel assured that reporting adverse events and further analysis of such events will not be used against them by the hospital/institution or others in legal, regulatory or other

proceedings. Without these assurances, providers will be reticent or unwilling to participate. The potential benefits for system improvement will be lost.

The QI review may confirm the clinical outcome resulted from the patient's underlying medical condition or the risks inherent in an investigation or treatment. Conversely, the review may identify system vulnerabilities or failures.

A patient should be informed of new facts identified in the QI analysis of the event and of conclusions about any system failures. Speculations are not provided and blaming is avoided. An apology may be warranted. Understandably, patients often want to learn of any steps that have been implemented to prevent similar harm to others. It is appropriate to share information about actual system improvements made by the hospital. Where allowed by law, the CMPA believes the system recommendations of QI committees should also be shared.

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