Being accountable for medical errors: Observations on Hong Kong vs Australia

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Background

- Educated and worked in Australia for >20 years
- Chief Medical Officer at Barwon Health
  - One of the largest tertiary health services in Victoria
  - 21 sites, >6,500 staff (~900 medical practitioners)
  - Portfolio responsibility:
    - Professional Governance
    - Clinical Governance
    - Research Governance
    - Health Innovation and Projects
    - Academic link to Deakin University School of Medicine
- Returned to HK 7 months ago and joined the Hospital Authority

Demographics

	Australia	Hong Kong	NSW
Population	25m	7.5m	8m
Land Mass (km^2)	7.7m	1.1k	800k
Population Density (people/km^2)	3.1	6,300	9.7Popl
Life expectancy	82.5 (80.4/84.6)	84.2 (82.2/87.6)	83.1 (81.1/85.2)

Health expenditure

2016/2017	Australia	HK	NSW
Health expenditure	$976b HKD ($181b AUD)	$157b HKD	$296b HKD ($54.8b AUD)
% of GDP	10.28%	6.2%	
Expenditure per capita	>$39,960 HKD (>$7,400 AUD)	$21,433 HKD	>$35,100 HKD (>$6,500 AUD)
Real growth in spending	3.1-4.7% (past 5 years)	5.8% (average from 1989/90)	
Bloomberg Health Care Efficiency ranking 2018*	**8**	**1**	

Quality and Safety

- Quality in Australian Health Care Study (1995)
  - Landmark study
  - 16.6% of hospital admissions in Australia associated with adverse event
  - 51% of events considered highly preventable
- Subsequent studies suggest ~10% of admissions associated with adverse event

- Similar time to other landmark publications by IOM:
  - *To Err Is Human: Building a Safer Health System* (1999)
  - *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001)

Sentinel Events Program

- Similar Sentinel Event Categories (up till December 2018)
  - 8 National, + 1 Others (Victoria)
- In 2018,
  - NSW: ~480 cases
  - Queensland: ~500 cases
  - Victoria: 2015-2016 47
    2016-2017 72
    2017-2018 122 (Category 9 Other Catastrophic: 98/122 **~80%**)

"Our sense is that we are still significantly under-reporting in Victoria"

Prof Euan Wallace, CEO Safer Care Victoria, 2018

Observations in the first 6 months

- Hong Kong Sentinel Events numbers per year…
- How about ‘clinical incident’ numbers?

- When things go wrong, the media focuses on:
  - Which department
  - Is this human error
  - Who is the doctor/nurse/allied health professional
  - Has the staff been suspended from clinical duties
  - What is the punishment for the staff member

- What culture does this encourage?

- Do RCA reports or management inadvertently support this culture?

Letters

For a better Hong Kong hospital system, change the culture of blame when things go wrong

- Research shows that finger-pointing promotes a tendency to conceal mistakes and spread gossip, and creates a reluctance to take up responsibility
- Mature societies value accountability, but on the understanding that human error is inevitable

Letters
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Clinical incidents

- **Who** is accountable/responsible when things go wrong?
- 'Medical Errors' vs 'Clinical Incidents'
- Person vs System

  "Increasingly, teams deliver care. But patients and doctors alike still think of accountability in individual terms, and the law often measures it that way."

  Bell SK, Delbanco T, Anderson-Shaw L, McDonald TB, Gallagher TH. (2011)

- Culture: Blame vs No-Blame vs Just

What Safety & Quality Leaders say

*"NHS staff are not to blame – in the **vast majority of cases it is the systems, procedures, conditions, environment and constraints they face that lead to patient safety problems**."*

Don Berwick, *"A promise to learn – a commitment to act: Improving the Safety of Patients in England"*, 2013

*'…**to blame failures in care on doctors and nurses** trying to do their best **is to miss the point** that bad mistakes can be made by good people. What is **often overlooked is proper study of the environment and systems in which mistakes happen** and to understand what went wrong and encouragement to spread any lessons learned. Accountability to future patients as well as to the person sitting in front of you.'*

Jeremy Hunt, Secretary of State for Health and Social Care, *Global Patient Safety Summit 2016*

However

The need for **"*Balancing "No Blame" with Accountability in Patient Safety*"**

Robert M. Wachter, M.D., and Peter J. Pronovost, M.D., Ph.D. *N Engl J Med*. 2009

Examples used: Hand hygiene compliance rates

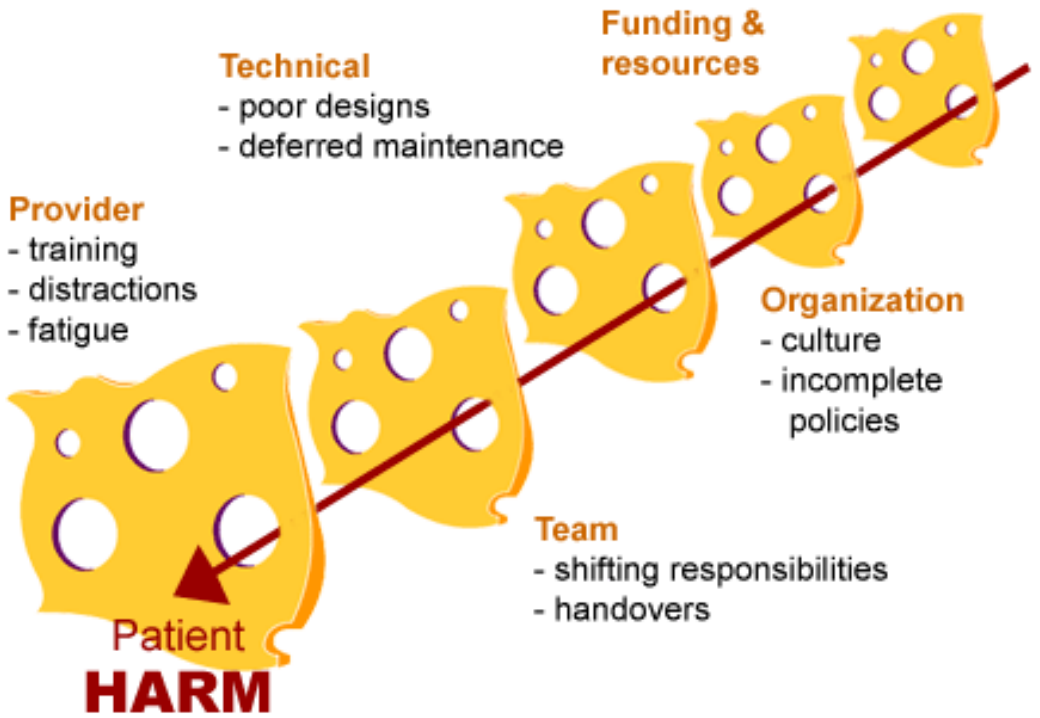
Marking Surgical Sites

Performing Team Time Out

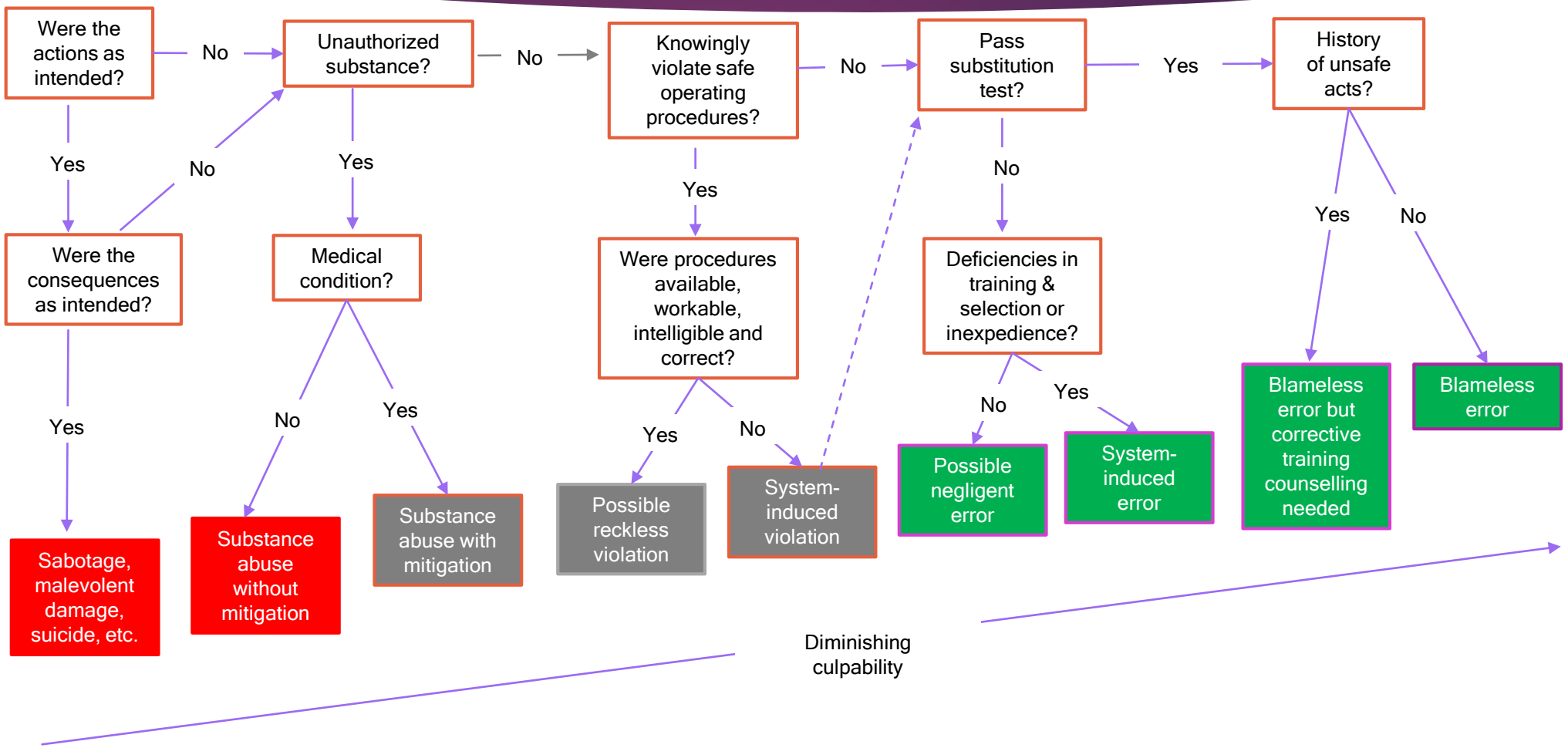
"…once a reasonable safety rule is implemented and vetted (since some rules create unanticipated consequences or work-arounds and need to be reworked after initial implementation), failure to adhere leaves the world of "no blame" and enters the domain of accountability."

But what sort of incidents are we talking about??

- James Reason's Swiss Cheese Model



Culpability Decision Tree and Substitution Test by Dr. James Reason and Neil Johnston



1. Choose the column that best describes the caregiver's action. Read down the column for recommended responses.

The caregiver's thinking was impaired by illegal or legal substances, cognitive impairment, or severe psychosocial stressors	The caregiver wanted to cause harm.	The caregiver knowingly violated a rule and/or made a dangerous or unsafe choice. The decision appears to have been made with little or no concern about risk.	The caregiver made a potentially unsafe choice. Faulty or self-serving decision-making may be evident.	The caregiver makes or participates in an error while working appropriately and in the patients' best interests
IMPAIRED JUDGMENT	**MALICIOUS ACTION**	**RECKLESS ACTION**	**RISKY ACTION**	**UNINTENTIONAL ERROR**
• Discipline is warranted if illegal substances were used. • The caregiver's performance should be evaluated to determine whether a temporary work suspension would be helpful. • Help should be actively offered to the caregiver.	• Discipline and/or legal proceedings are warranted. • The caregiver's duties should be suspended immediately.	• Discipline may be warranted. • The caregiver is accountable and needs re-training. • The caregiver should participate in teaching others the lessons learned.	• The caregiver is accountable and should receive coaching. • The caregiver should participate in teaching others the lessons learned.	• The caregiver is not accountable. • The caregiver should participate in investigating why the error occurred and teach others about the results of the investigation.

2. If three other caregivers with similar skills and knowledge would do the same in similar circumstances:

The system supports reckless action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.	The system supports risky action and requires fixing. The caregiver is probably less accountable for the action, and system leaders share in the accountability.	The system supports error and requires fixing. The system's leaders are accountable and should apply error-proofing improvements.

3. If the caregiver has a history of repeatedly making mistakes , the caregiver may be in the wrong position. Evaluation is warranted, and coaching, transfer or termination should be considered. The corrective actions above should be modified accordingly.

UK's "Sign up to Safety" Campaign

A trip down memory lane

In the US/UK/AUS/NZ…

- Pre 1990s
  - 'Medical errors' were often met with blame and shame for the responsible 'clinician'
- 1990s-2000s
  - Patient safety movement focusing on systems-based approach
- 2010+
  - Balancing a "no blame" culture with personal accountability

- Where are we (HK) now?

How useful are RCAs?

In 2005, the WHO defined the characteristics of a successful reporting system

Non-punitive	Reporters are free from fear of retaliation against themselves or punishment of others as a result of reporting.
Confidential	The identities of the patient, reporter, and institution are never revealed.
Independent	The reporting system is independent of any authority with power to punish the reporter or the organisation.
Expert analysis	Reports are evaluated by experts who understand the clinical circumstances and are trained to recognise underlying systems causes.
Timely	Reports are analysed promptly and recommendations are rapidly disseminated to those who need to know, especially when serious hazards are identified.
Systems-oriented	Recommendations focus on changes in systems, processes, or products, rather than being targeted at individual performance.
Responsive	The agency that receives reports is capable of disseminating recommendations. Participating organisations commit to implementing recommendations whenever possible.

RCA recommendations

Are root cause analyses recommendations effective and sustainable? An observational study

Hibbert et al., *International Journal for Quality in Health Care*, 2018

- 227 RCAs
- 1137 recommendations
- 8% 'strong', 44% 'medium', 48% 'weak' (US DVA strength criteria)
- Conclusions:
  - Need more human factors expertise and independence in investigations
  - More extensive application of existing tools to prioritize recommendations
  - Need to understand underlying system factors better
  - Thematic analysis when appropriate

Words of caution

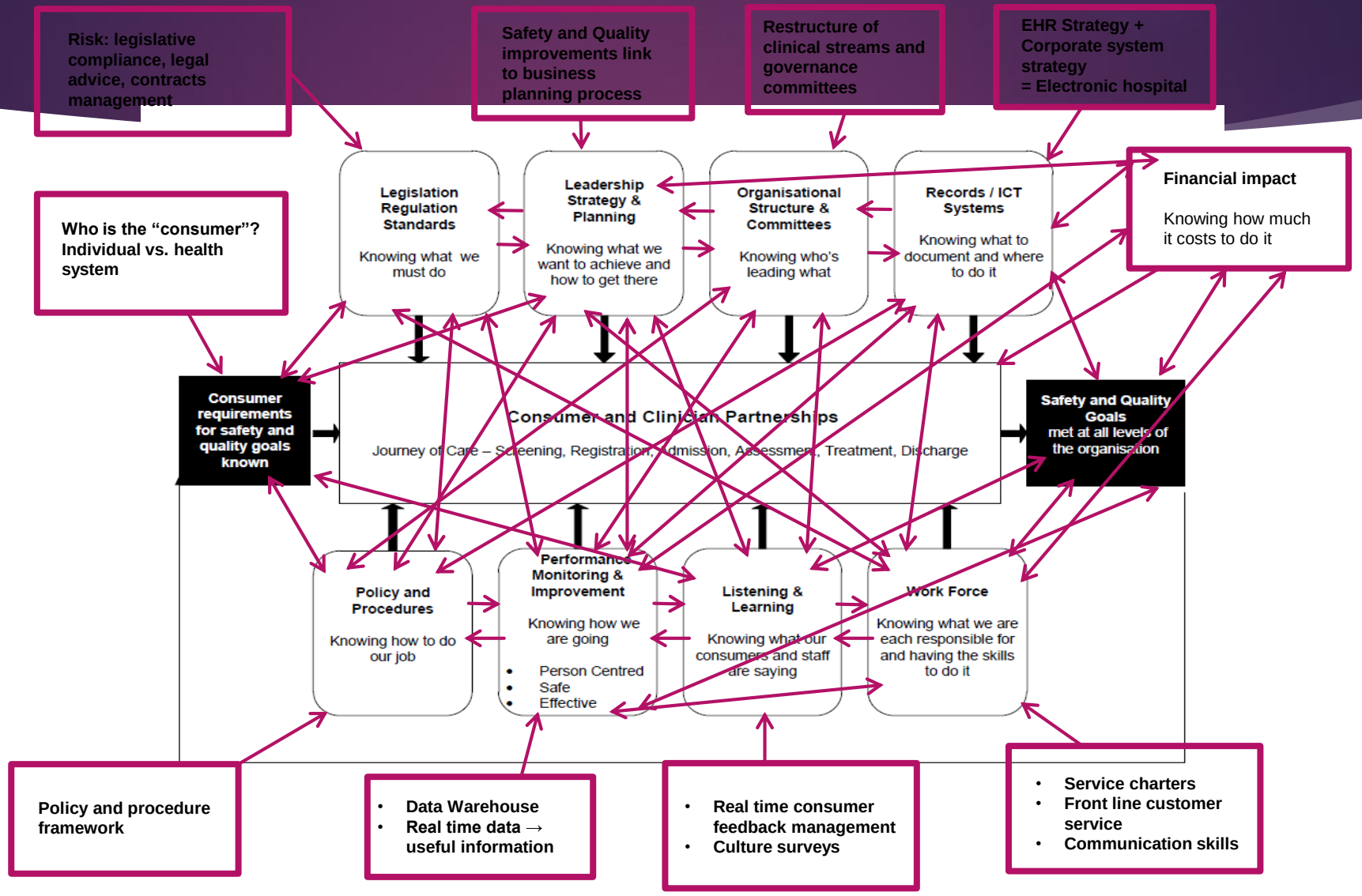
- **"The problem with root cause analysis"**

  Peerally MF, Carr S, Waring J, et al. *BMJ Qual Saf* 2017

- The unhealthy quest for 'the' root cause *(it's seldom a single root cause!!)*
- Questionable quality of RCA investigations
- Political hijack
- Poorly designed or implemented risk controls
- Poorly functioning feedback loops
- Disaggregated analysis focused on single organizations and incidents
- Confusion about 'blame'
- Problem of many hands *(involvement of external organisations)*

- ***Hang on – if you can't drive for sh*ts, then you are still going to crash in a Rolls Royce….***

Clinical Governance Framework @ BH



Never Events Program @ Barwon Health

Category	Ref	Never Event List
Surgical	S1	Procedure involving the wrong procedure, patient or body part resulting in death or major permanent loss of function
	S2	Retained instruments or other material requiring re-operation or further surgical procedure
	S3	Intraoperative or immediately postoperative/post procedure death in Anaesthesia [4]
Products or Devices	P1	Intravascular gas embolism resulting in death or major permanent loss of neurological function
	P2	Death or major permanent loss of function associated with the use of contaminated drugs, biologics or devices
	P3	Death or major permanent loss of function associated with an electric shock in the course of a person care process in a health care setting
General Care	G1	Haemolytic blood transfusion reaction resulting from ABO incompatibility
	G2	Medication error leading to the death or major permanent loss of function of person reasonably believed to be due to incorrect administration of drugs
	G3	Death or major permanent loss of function due to misplaced naso / oro-gastric tubes not detected prior to use
	G4	Hospital acquired central line bacteraemia
	G5	Death or major permanent loss of function harm associated with failure to respond immediately to MET Criteria
	G6	Inappropriate resuscitation of person with known treatment limitations
	G7	Death or major permanent loss of function associated misidentification of a person
	G8	Death or major permanent loss of function associated with a preventable fall while being cared for in a health care setting
	G9	Any stage 3, stage 4 pressure injury acquired after admission/presentation to a health care facility
	G10	Death or major permanent loss of function resulting from the irretrievable loss of an irreplaceable biological specimen
	G11	Death or major permanent loss of function resulting from failure to follow up / communicate test results or perform a procedure in a timely manner
	G 12	Suicide of a person or within 24 hours of discharge from a health care setting
Maternity	M1	Maternal / Neonate death or major permanent loss of function associated with labour or delivery
Consumer Protection	CP1	Discharge, release or abduction of a person of any age, who is unable to make decisions, to anyone other than an authorized person
	CP2	Death or major permanent loss of function associated with a burn incurred from any source in the course of a person's care or treatment in a health care setting
	CP3	Death or major permanent loss of function associated with elopement (disappearance) of a person from a health acre facility
	CP4	Death or major permanent loss of function of a person associated with the use of restraint, bedrails or bed poles while being cared for in a health care setting
Imaging	I1	Death or major permanent loss of function of a person associated with introduction of a metallic object into the MRI area
Criminal	C1	Any instance of care ordered by or provided by someone impersonating a doctor, nurse, pharmacist, or other registered health care provider
	C2	Sexual abuse of a person receiving care by a staff member within or on the grounds of a health care facility
	C3	Physical assault of a person receiving care by a staff member within or on the grounds of a health care facility

- Let’s start a conversation…