Facing Up To Errors: How Do Systems Respond?

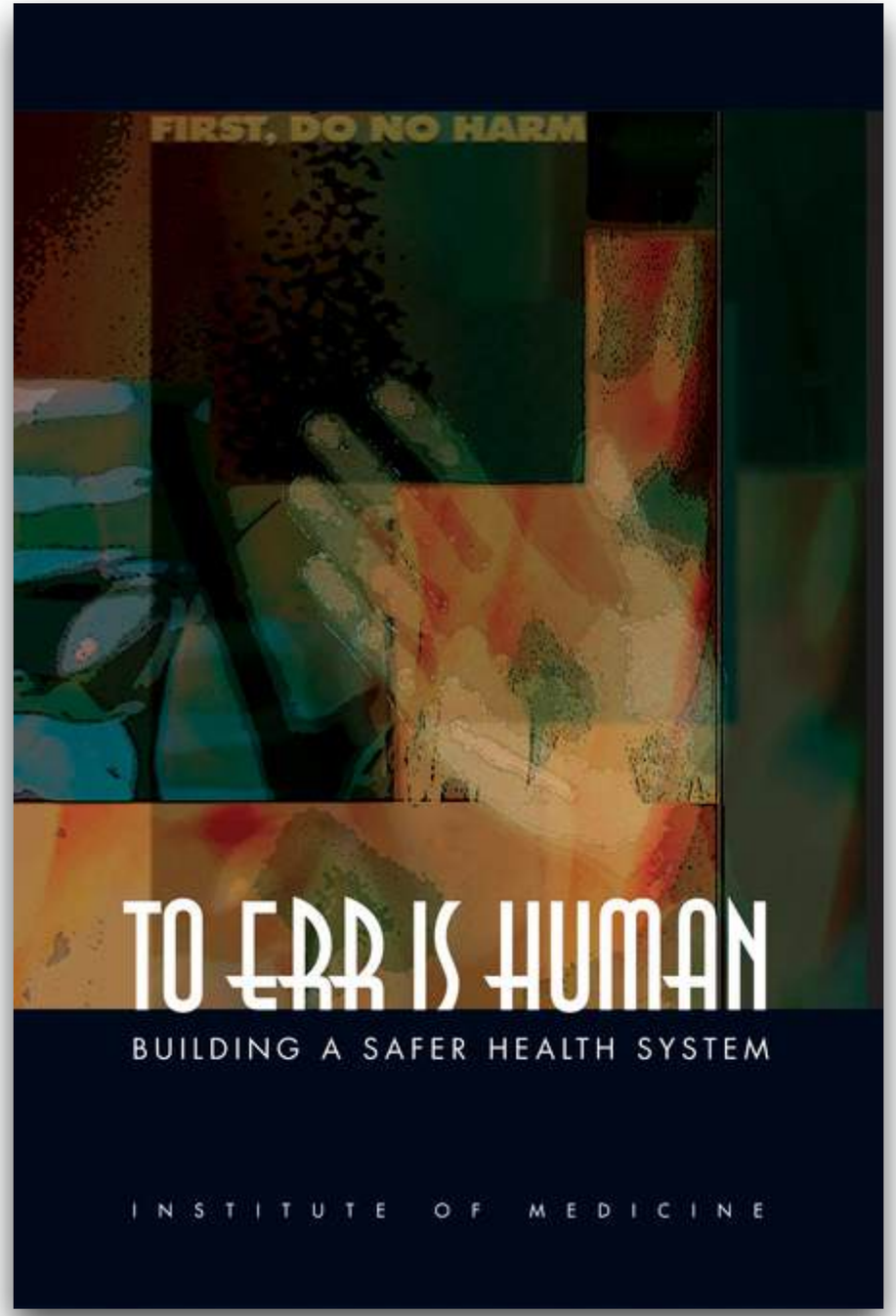
Cardiology 2025: 28th Annual Update on Pediatric and Congenital Cardiovascular Disease

February 20th, 2025

Alan Friedman, MD
Chief Medical Officer, Yale New Haven Hospital
Professor of Pediatrics (Cardiology), Yale University

No Conflicts

1999



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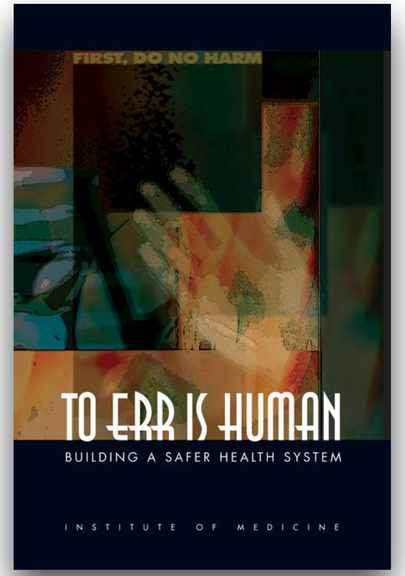
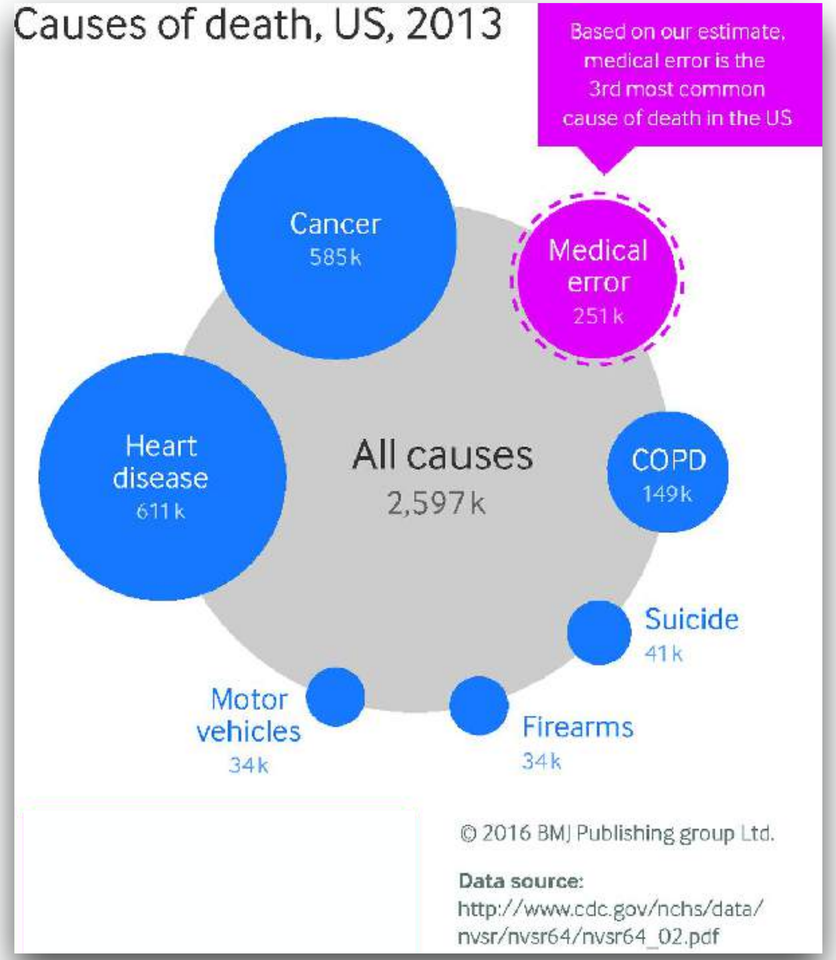
Medical error—the third leading cause of death in the US

Medical error is not included on death certificates or in rankings of cause of death. **Martin Makary** and **Michael Daniel** assess its contribution to mortality and call for better reporting

Martin A Makary *professor*, Michael Daniel *research fellow*

Department of Surgery, Johns Hopkins University School of Medicine, Baltimore, MD 21287, USA





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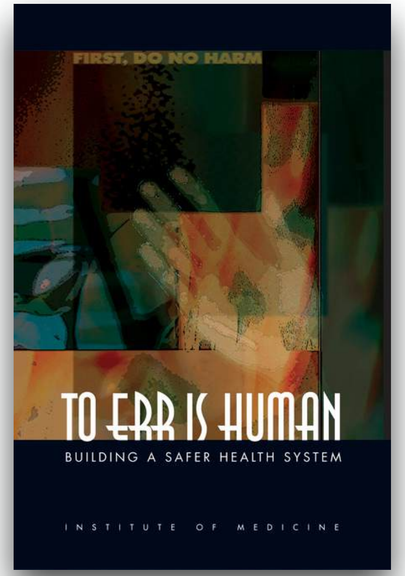
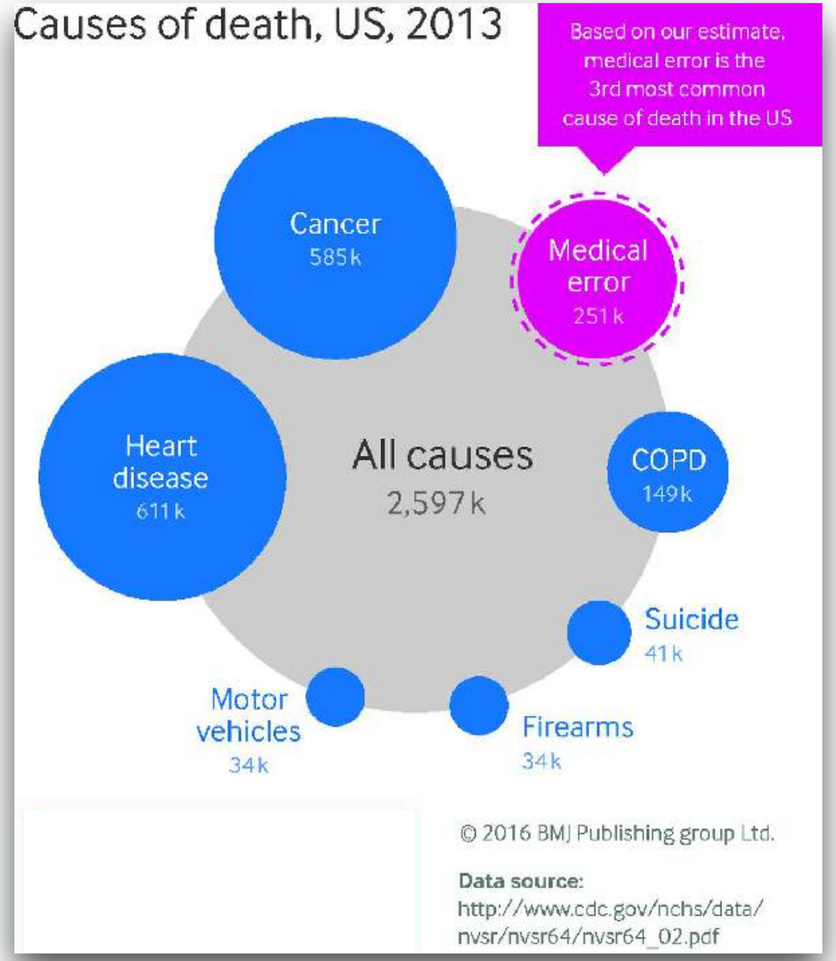


The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Safety of Inpatient Health Care

David W. Bates, M.D., David M. Levine, M.D., M.P.H., Hojjat Salmasian, M.D., Ph.D., M.P.H., Ania Syrowatka, Ph.D., David M. Shahian, M.D., Stuart Lipsitz, Sc.D., Jonathan P. Zebrowski, M.D., M.H.Q.S., Laura C. Myers, M.D., M.P.H., Merranda S. Logan, M.D., M.P.H., Christopher G. Roy, M.D., M.P.H., Christine Iannaccone, M.P.H., Michelle L. Frits, B.A., Lynn A. Volk, M.H.S., Sevan Dulgarian, B.S., B.A., Mary G. Amato, Pharm.D., M.P.H., Heba H. Edrees, Pharm.D., Luke Sato, M.D., Patricia Folcarelli, Ph.D., R.N., Jonathan S. Einbinder, M.D., M.P.H., Mark E. Reynolds, B.A., and Elizabeth Mort, M.D., M.P.H.



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2020

"All the News That's Fit to Print"

The New York Times

Late Edition

VOL. CLXIX ... No. 58,560 — NEW YORK, SATURDAY, FEBRUARY 1, 2020 — $3.00

SENATE REPUBLICANS BLOCK WITNESSES, 51 TO 49, CLEARING A PATH FOR THE PRESIDENT'S ACQUITTAL

Ukraine Push Began in May, Bolton Writes

By MAGGIE HABERMAN and MICHAEL S. SCHMIDT

Senator Lisa Murkowski, top, Republican of Alaska, said calling witnesses would only extend a partisan impeachment. Senator Lamar Alexander, above, Republican of Tennessee, also voted no.

Only 2 Side With Democrats — Vote on Trump Is Wednesday

By MICHAEL D. SHEAR and NICHOLAS FANDOS

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A Party Now Less Likely To Tell Trump 'Enough'

TRUMP ON TRIAL

CARL HULSE

Continued on Page A18

Overloaded Pharmacists Warn They're Making Fatal Mistakes

By ELLEN GABLER

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Declaring Health Emergency, U.S. Restricts Travel From China

By MICHAEL CORKERY and ANNIE KARNI

An air traveler getting her temperature checked in Tokyo. Three U.S. airlines are suspending service to China for several months.

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Texas Finds a Vaping Loophole

6 More Nations on Travel Ban

A Charisma Test for Buttigieg

'Won't Fix the Horrors'

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Which Seats Bend?

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Independent Optimism

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Hollywood's Sequel to #MeToo

Big Game Gets More Colorful

19 People Who Walked Away

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A Can't-Miss Star Who Didn't

Icy Embrace of Margaret Court

EDITORIAL, OP-ED A16-17

Roger Cohen

Yale Medicine

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For Alyssa Watrous, the medication mix-up meant a pounding headache, nausea and dizziness. In September, Ms. Watrous, a 17-year-old from Connecticut, was about to take another asthma pill when she realized CVS had mistakenly given her blood pressure medication intended for someone else.

Edward Walker, 38, landed in an emergency room, his eyes swollen and burning after he put drops in them for five days in November 2018 to treat a mild irritation. A Walgreens in Illinois had accidentally supplied him with ear drops — not eye drops.

For Mary Scheuerman, 85, the error was discovered only when she was dying in a Florida hospital in December 2018. A Publix pharmacy had dispensed a powerful chemotherapy drug instead of the antidepressant her doctor had prescribed. She died about two weeks later.

The people least surprised by such mistakes are pharmacists working in some of the nation's biggest retail chains.

In letters to state regulatory boards and in interviews with The New York Times, many pharmacists at companies like CVS, Rite Aid and Walgreens described understaffed and chaotic workplaces where they said it had become difficult to perform their jobs safely, putting the public at risk of medication errors.

They struggle to fill prescriptions, give flu shots, tend the drive-through, answer phones, work the register, counsel patients and call doctors and insurance companies, they said — all the while racing to meet corporate performance metrics

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The New York Times

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This Is Us

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400,000 Hospitalized patients/yr
suffer preventable harm

200,000 patient deaths/yr
from preventable errors

Patients & Families

Today

Doctors, Nurses
and staff

Adverse events cost
Healthcare system
$20 billion/year

Hospital Acquired
Infections cost
Healthcare system
$35-$45 billion/year

4,000 preventable
Significant Surgical
Events Every year

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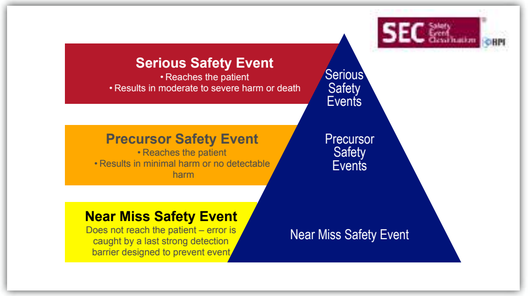

Classifying Safety Events

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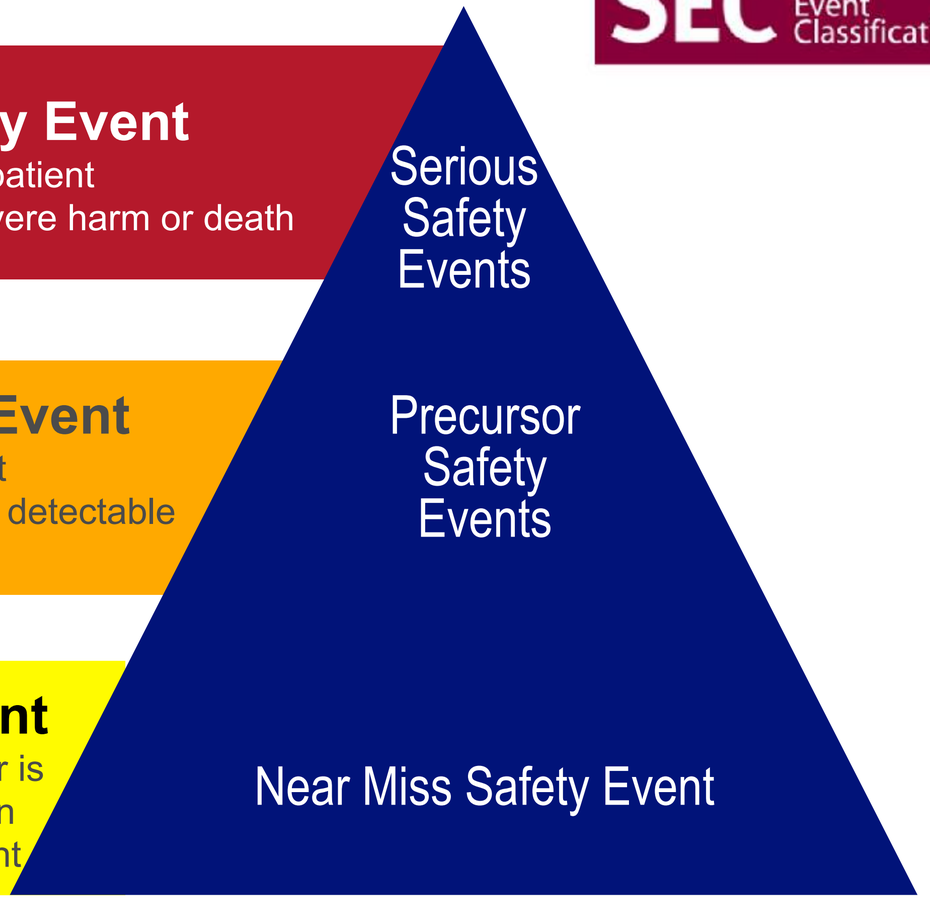
SEC Safety Event Classification®

HPI

Serious Safety Event
- Reaches the patient
- Results in moderate to severe harm or death

Precursor Safety Event
- Reaches the patient
- Results in minimal harm or no detectable harm

Near Miss Safety Event
Does not reach the patient – error is caught by a last strong detection barrier designed to prevent event



How Do Systems Learn of Errors?

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Safety Culture

Safety Culture

- Commitment to Report any and all safety concerns
- Supporting psychological safety for all those who report

- Identifying the contributing factors and events
- Developing multifaceted prevention protocols
- Implementing these strategies
- Transparency with what is learned

High Reliability Organizations (HRO)

- Sensitivity to operations: how does the current state affect safety
- Preoccupation with failure: being alert to small signs of potential problems
- Reluctance to simplify: Avoid simplistic interpretations
- Resilience: Being able to recover from failures
- Deference to expertise: making decisions based on the knowledge of the most qualified

HRO & Safety in Clinical Medicine

- Culture that supports reporting - Praise the reporters
- Reviewing and acting on reports
- Share what is learned across the organization - all sites
- Be transparent with the data
- Flatten the “Power Gradient”

everyone speaks on behalf of safety

How Do People In Safe Systems Respond?

Disclosure

... a humanistic risk management policy that includes early injury review, steadfast maintenance of the relationship between the hospital and the patient, proactive full disclosure to patients who have been injured because of accidents or medical negligence, and fair compensation for injuries.

Disclosure Program

- A communication with patients and families that is based on transparency, integrity, compassion and accountability
- Shift from a culture of “Delay, Deny and Defend” to “Real-time Communication and Collaboration”
- A sincere apology
- An explicit statement that an adverse outcome or an error occurred
  - What the error was
  - Why the error occurred
  - How recurrences will be prevented

The Disclosure Goals

Apology

Commitment

Patient & Family

What Does The Patient Understand?

Convey What We Know

Support The Patient, Family & Team Emotionally

Speak To The Plan

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What Patients Want To Hear

An Expression of Compassion:

“I am so sorry that this has happened”

An Expression of Responsibility only when we know there has been an error:

“I gave you the wrong dose of medicine”

A Commitment between patient, doctor and hospital:

“We will review what happened and meet with you to let you know what we find.”

What Patients Should NOT Hear

PERSONAL HEALTH

The Right Way to Say 'I'm Sorry'

Paul Rogers

By Jane E. Brody

- Failure to take responsibility
- Minimizing the error
- Normalizing the error
- Blaming others

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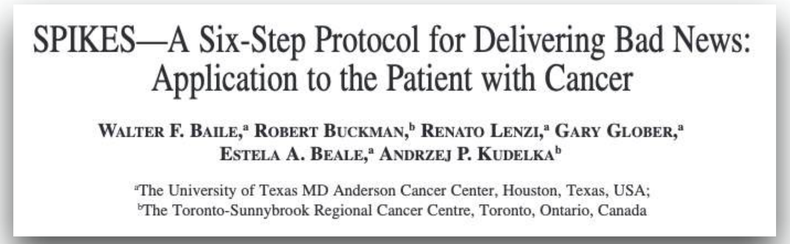
SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer

WALTER F. BAILE,[a] ROBERT BUCKMAN,[b] RENATO LENZI,[a] GARY GLOBER,[a]
ESTELA A. BEALE,[a] ANDRZEJ P. KUDELKA[b]

[a]The University of Texas MD Anderson Cancer Center, Houston, Texas, USA;
[b]The Toronto-Sunnybrook Regional Cancer Centre, Toronto, Ontario, Canada



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S: Set Up	Prepare yourself & the team; know the facts; sit down, connect
P: Perceptions	Assess the patient's and family's current understanding
I: Invitation	Obtain the patient's and family's invitation, permission to meet
K: Knowledge	Give knowledge, state the facts, what happened, how
E: Empathy	Address emotions with empathy, apologize, accountability
S: Strategy	Strategy to take action to prevent future occurrences

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Does It Work?

Does It Work?

Practice & Coaching Perspective

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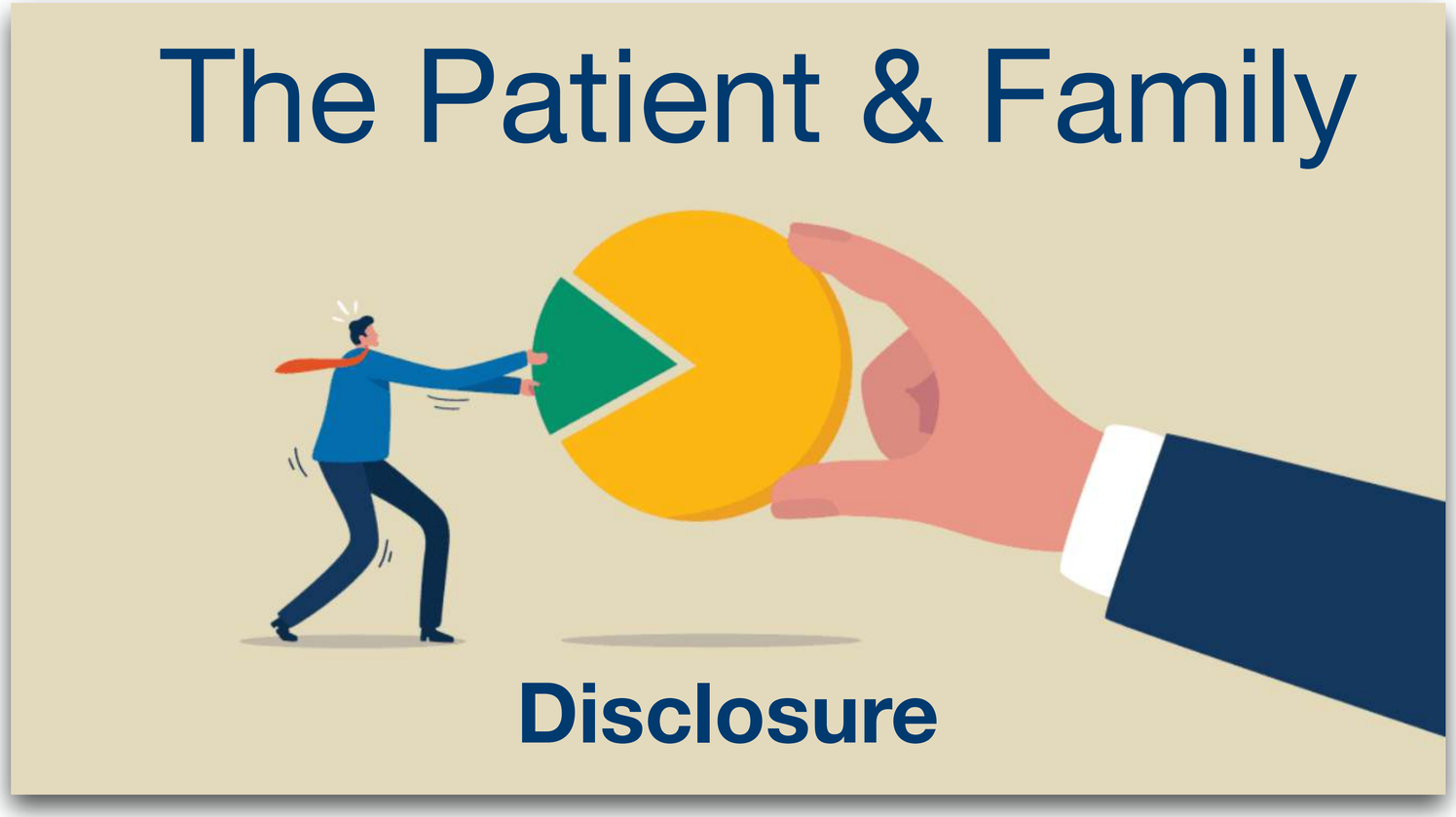
Does It Work?



The Right To Know

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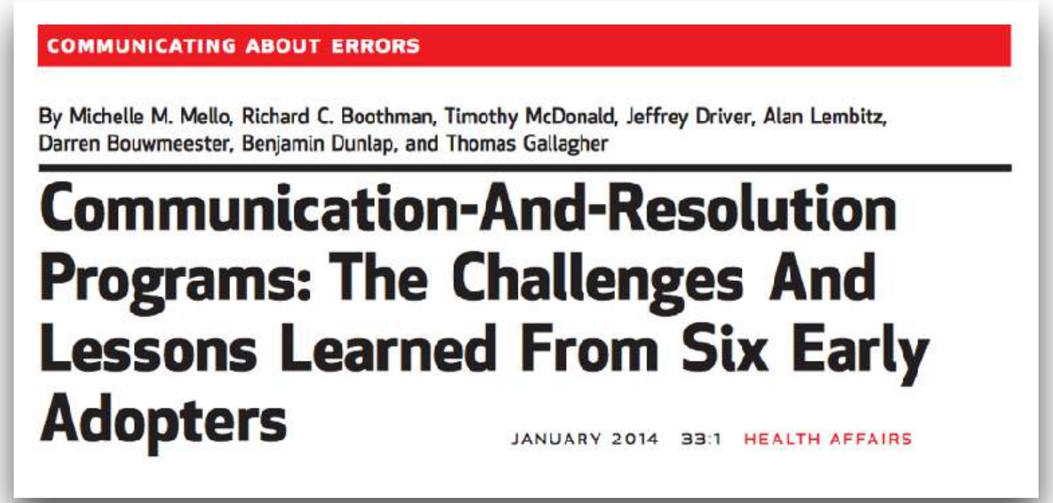
Culture & Risk

Disclosure Programs

- Communication & Resolution Programs (CRPs)
- Funded by AHRQ grant in 2010
- By early 2014, 6 programs published their early results:
  - Substantial reduction in liability costs
  - improved patient safety



COMMUNICATING ABOUT ERRORS

By Michelle M. Mello, Richard C. Boothman, Timothy McDonald, Jeffrey Driver, Alan Lembitz, Darren Bouwmeester, Benjamin Dunlap, and Thomas Gallagher

Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters

JANUARY 2014 33:1 HEALTH AFFAIRS

Implementing communication and resolution programs: Lessons learned from the first 200 hospitals

Journal of Patient Safety and Risk Management
2018, Vol. 23(2) 73–78

DOI: 10.1177/2516043518763451
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Timothy B McDonald[1,2], Melinda Van Niel[3], Heather Gocke[4], Deanna Tarnow[5], Martin Hatlie[1] and Thomas H Gallagher[6,7]

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Integrity & Accountability

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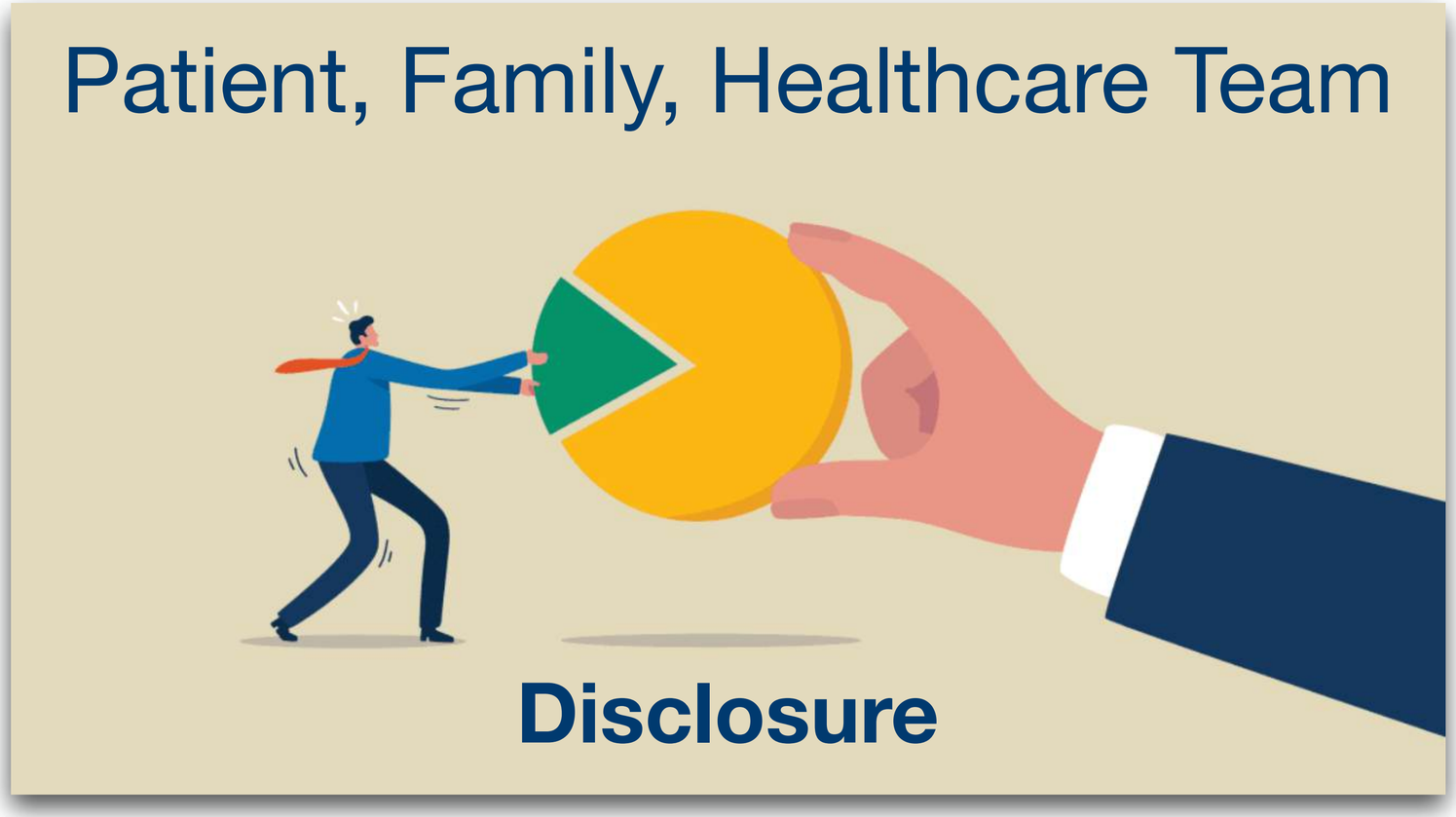

Healing & Recovery

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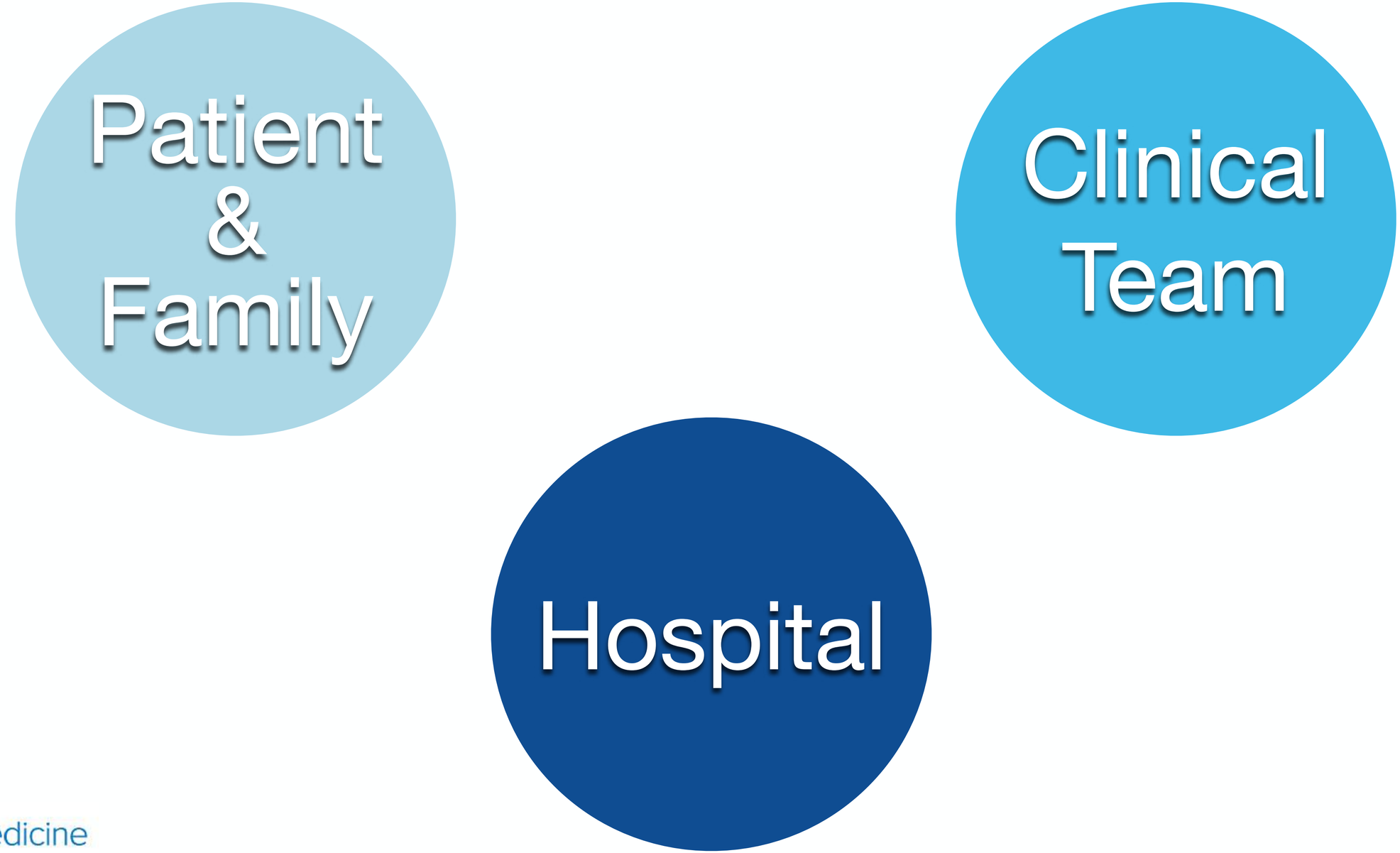
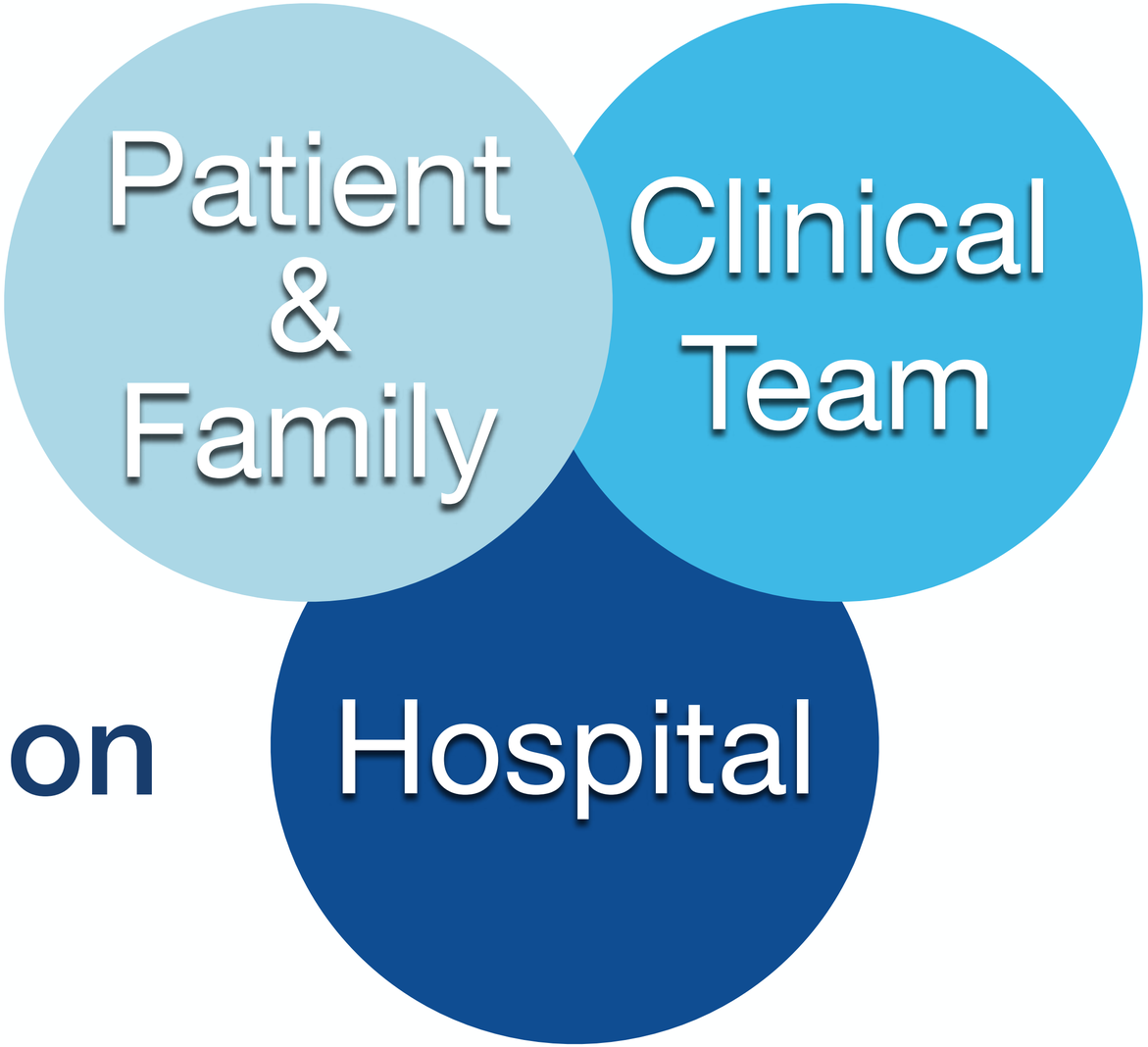

Patient
&
Family
Clinical
Team
Hospital

Improved Safety

Recovery

Healing



Compassion

Integrity

Accountability

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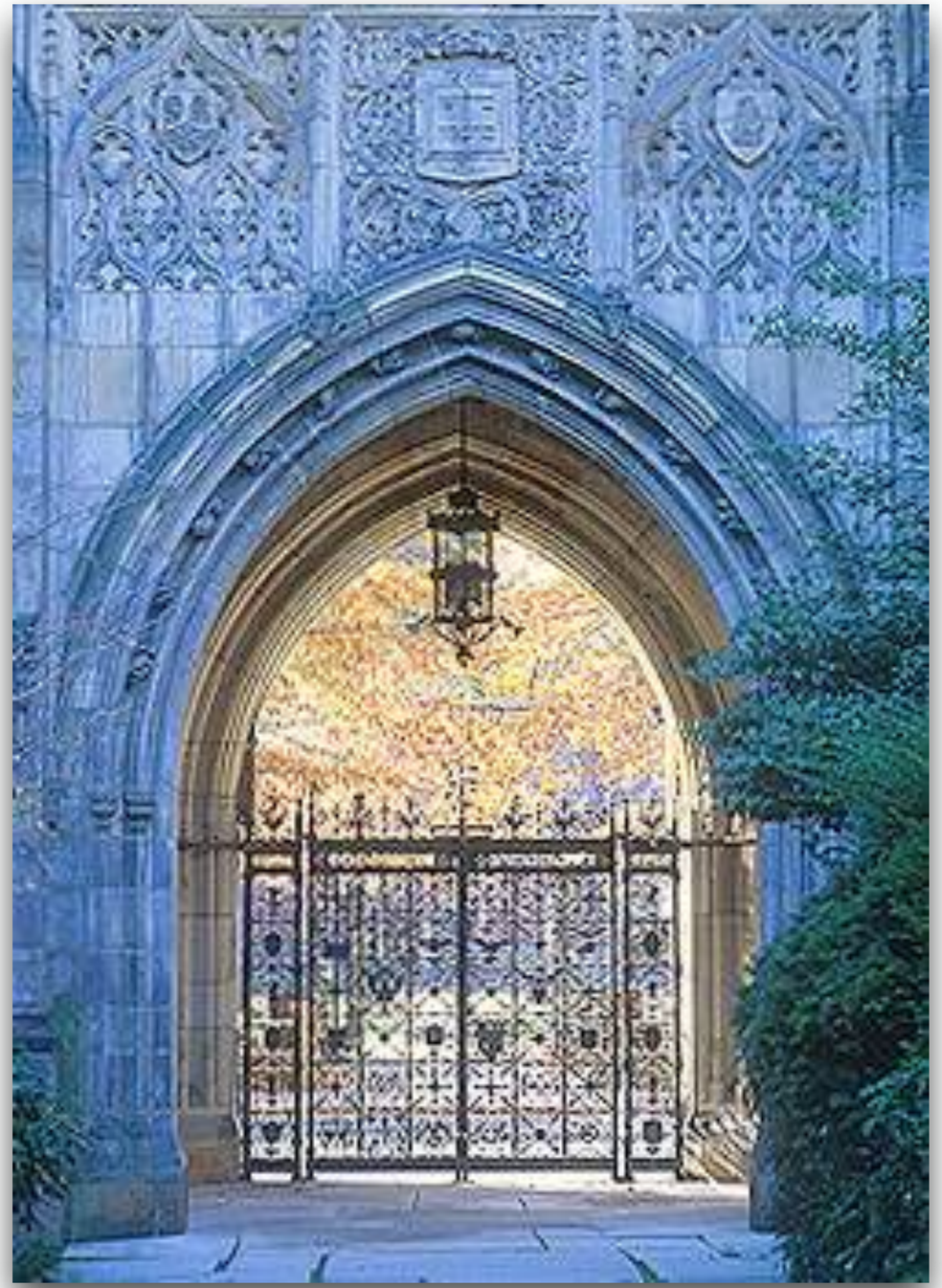
Thank You



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System Responses to Errors

Objectives for today:

- The problem: size, frequency and scope
- How we recognize the problem
- Our response to problems
  - As an institution
  - As clinicians
- Why we do this