

CRE-PS Seminar Mortality Review,
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The Investigation of Hospital Mortality: Pigeon-holing complexity?



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Investigating hospital mortality



- Mortality and Morbidity Review (M&Ms)
- Root cause analysis
- Performance management
- Professional Board Hearing
- Coronial Inquest
- Mortality Review



Increasing
'distance
from the
incident'



Limited
communication
across these
processes

Root Cause Analysis:

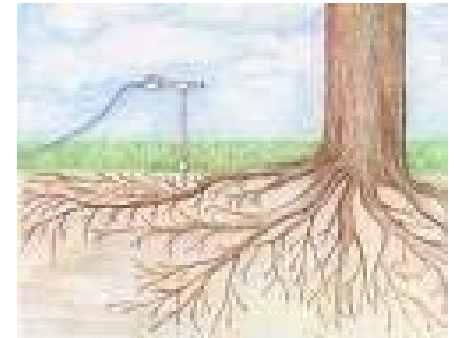


- is interdisciplinary, involving frontline clinicians and experts
- can involve those who are most familiar with the situation
- ‘digs deeper’ by asking ‘why, why, why’ at each cause-effect juncture
- analyses causal chains to identify changes that need to be made to systems
- is impartial (avoids blame)

Wald, H., & Shojania, K.G. (2001). Root Cause Analysis. In K.G. Shojania, B.W. Duncan, K.M. McDonald, R.W. Wachter, & A.J. Markowitz (Eds.), *Making Health Care Safer: A Critical Analysis of Patient Safety Practices (Evidence Report/Technology Assessment: Number 43)* (pp. 51-56). Rockville, MD.: Agency for Healthcare Research and Quality.

A new way of (re)viewing death: the patient/family perspective

- ‘The 100 Patient Stories Project’
- patients/families know the patient journey, its complexity and (frequent and near) incidents
- their ‘trajectory experience’ gives them a different perspective on how (serious) incidents occur
- potential to inform investigation (MR, RCA, ...) to enhance system learning.



An in-hospital death: (From a family's perspective)

- A patient with multiple myeloma (diagnosed 2006)
- Hip replacement (uneventful)
 - Clexane post-op
- Revlamid recommenced weeks post-op
 - patient fatigued
 - develops blood-stained nasal discharge; wife questions continuation of Clexane
 - Haematologist away – platelet count arranged (in home) - very low platelets
- Admitted to hospital (for blood products and assessment)
 - patient develops shortness of breath, extreme pain, confused
 - wife very concerned throughout day about laboured breathing/hot and cold/pain unusual and excessive (despite low platelets) & tried to escalate this knowledge to nursing and medical staff
 - wife's concerns dismissed: 'breathing due to back pain'; reassured & encouraged to go home overnight
 - care stays focused on blood products, replacing tissue cannula (3hrs later) & pain medication



Cont'd ...



- patient condition deteriorates overnight
 - wife called back in to settle patient; “he was struggling to breathe”, puffy and red
 - a decision to admit to ICU is made
 - admission delayed - ICU team attending to another patient & confusion over bed availability
 - (limited information/explanation about condition/deterioration/plan to wife
 - wife told there was fluid causing breathing problems
 - then ICU Reg asks the wife whether she understands the meaning of intubation; she says ‘yes’ without understanding the full meaning of the question; she was asked to leave and wait for husbands (imminent) arrival in ICU
- patient admitted to ICU – 3 hours later
 - pt intubated, central line inserted, sedated (no explanation about progress, implications or condition to wife)
 - medical friend relays information to wife waiting outside ICU about patient’s condition: ‘they are working on him’, ‘ICU is dangerous even for people with a normal immune system’



Cont'd ...



- wife allowed into ICU
 - wife expects to be being informed of treatment plan
 - a staff member asks when the family is ready to switch off life support
- patient arrests
 - wife told to leave; waits in corridor; staff rushing around, yelling for adrenalin
 - wife asks staff member rushing by if patient is OK; told 'no, he is not back [resus'd?]', then told 'he is back'
- ICU doctor meets family
 - acknowledges what happened was a drug error: a Vasopressin overdose
 - conveys husband has sepsis
 - is working on a treatment plan (first time condition identified).
- patient dies when life support withdrawn before remaining family can attend

Current response to investigate such an in-hospital death

- Organisational Review
 - RCA – to investigate a drug error?
 - M&M – who reviews the death - ICU?
- State Review
 - Mortality Review Classification: 2? 4? 5?
- (Organisational response to the family
 - Open Disclosure – of ‘a drug error’)





But ...

- What will a RCA tell us?
- What does the categorisation (2, 4, 5) tell us?
- What happens to the complexity of the incident?
- Will the RCA and Mortality Review take into account:
 - the treating specialist being on leave?
 - the family's attempts to tell staff that the patient's breathing was irregular (and that staff chose not to consider that information)
 - missed sepsis?
 - poor communication?

The wife's response to the incident report

- *“you’ve got a greater problem than a drug error ... you’ve got a massive, big communication problem here”.*

Investigation 'logic'

- People closest to the incident: patient (family?)
- People most affected: patient, family



People least likely to be informed about or involved in investigation processes: patient, family

Understanding the complexity of what goes wrong

- *“[RCA] allows them to improve and allows them to put in place new policies. ... I think unless they understand and see it [how the death came about] as a whole ... unless you put it all together and see overall what’s happening in the care of one patient, you don’t see that there’s so many problems.” (wife of patient)*
- *“When they rang me and said “we’ve got a problem”, I couldn’t let them just address this tiny thing that they saw as “we’ve got a problem” because that’s not what the problem was. The problem was huge.”*

Some theses



- Incidents are often complex, particularly when there is sudden deterioration and death
- This complexity is often erased from incident investigations & reports due to clinicians:
 - knowing only aspects of what happened and of what went wrong,
 - investigations being time-constrained,
 - improvement recommendations needing to be actionable and politically acceptable
- Patients and family members often have knowledge of what happened because ‘they were there’
- Patients and family members do not have a route via which to engage with and gain input into hospital investigation processes
- A gap develops between investigation processes that narrow ‘what went wrong’ down to a single incident and ‘root causes’, and patients’ (family members’) sensibilities towards the complexity and multi-faceted nature of what went wrong.



Recommendations



- Investigation findings should articulate and be aggregated with other mortality review processes at local, state and national levels to provide a complete picture
- RCA and other investigations should incorporate families' knowledge and questions arising out of Open Disclosure
- System learnings and improvement should be based on a professional analysis of incident complexity, not just the 'reported incident'

