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Brigham and Women's airing medical mistakes

Hospital reports errors to staff in drive for improvement

By Liz Kowalczyk | Globe Staff
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Brigham and Women's Hospital publishes "Safety Matters" online and will begin distributing copies in staff lounges.

The patient, dying of metastatic cancer, had arrived at the hospital several weeks earlier in agony. But doctors at Brigham and Women's Hospital fashioned a medication regimen that at last eased her suffering, and on the day she was transferred to a rehabilitation hospital, they recalled seeing her smile.

Hours later, the patient was back in the Brigham emergency department, and once again in excruciating pain. Delays in transferring her, a language barrier, and a communications breakdown between doctors meant she did not get her medications on time.

Hospitals typically keep missteps like this quiet. But the Brigham openly recounted this mistake, and the improvements it led to, in a monthly online newsletter for its 16,000 employees. Brigham leaders started the publication to encourage staff to talk openly about their mistakes and propose solutions, and help make sure errors are not repeated.

While many hospitals post information on their websites about patient infections and falls, they rarely provide details of medical errors or candidly discuss with their entire staff how medical mistakes harmed patients. Executives fear the public will find out, sparking lawsuits and scaring off patients.

This reluctance, patient safety advocates warn, may be hampering the push to reduce medical errors because there is not wide discussion of how mistakes happen and can be prevented.

"Open-faced transparency is really valuable to staff at an institution because it causes them to know themselves better," said Paul O'Neill, a member of the Lucian Leape Institute at the National Patient Safety Foundation, a nonprofit research organization based in Boston. But few, if any, other hospitals are doing anything like what the Brigham does, he said: "Unfortunately, I would say it's highly unusual."

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The Brigham doesn't make the newsletters readily available to the public — but it doesn't hide them either; it gave the Globe all issues. The Brigham began publishing "Safety Matters" online in January 2011 on its employee intranet and will start distributing paper copies in staff lounges, conference rooms, and other gathering spots later this spring — a move that some hospital administrators initially opposed because they worried about scaring patients.

Most issues tell a story of medical care gone awry through interviews with caregivers and often with patients, and describe the hospital's response, such as adopting a better transfer process following the case of the cancer patient. Patients are not named, to protect their privacy. Caregivers also are anonymous because hospital leaders do not want to discourage them from reporting problems.

“Other institutions are putting data out there but we are pushing the envelope with our story-telling,” said Dr. Allen Kachalia, associate chief quality officer. “Many patients have just been surprised that we’ve been asking them their side of the story.”

Linda Kenney, who was the subject of a medical error at the Brigham in the late 1990s and is a board member of the National Patient Safety Foundation, said the most common complaint she hears from caregivers when speaking at hospitals is that when they report an error, they never hear back about fixes. “I like the idea the Brigham is encouraging people to speak up,” she said.

Safety Matters

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Retained Foreign Objects: Counting on Safety

The clinicians involved in this case assisted in developing the content for this issue of *Safety Matters*.

Imagine leaving the hospital after surgery and enduring a slow recovery, only to find out that the surgical team has left an item, such as a surgical sponge, inside you.

Retained foreign objects left in surgical patients are the most frequently reported sentinel event, according to The Joint Commission. Public health agencies estimate that between 1,500 and 1,900 patients each year experience retained foreign objects. At BWH, multiple precautionary measures have been put in place to prevent items like surgical sponges and instruments from being left in patients; however, there have been rare events when our efforts have not been successful.

In this issue of Safety Matters, we review two unusual cases of retained foreign objects, and what we are doing to prevent these events from happening. Our patients are counting on us to ensure their safety before, during and after all surgical procedures.

Background

BWH has several systems that are designed to prevent retained foreign objects in patients. Surgical count is a systematic method to account for all surgical sponges, sharps and other instruments used during procedures. In addition, BWH uses surgical sponges that are radiopaque (visible on x-ray) in the event that a surgical sponge is inadvertently left inside the surgi- a bar code reader. Bar code reading is an important double check to ensure the accuracy of the surgical team’s manual sponge count.

BWH has experienced episodes in which items used during procedures that are not radiopaque have been accidentally retained, as well as guidewires and tiny fragments of instruments broken during surgery

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Still, while openness about medical errors benefits patients who are harmed, by making it easier to provide them support and compensation, it is unclear whether transparency has lessened errors at the Brigham or nationally.

O’Neill, a former US treasury secretary, has urged President Obama to require Veterans Affairs hospitals to post online daily all infections, falls, and medication errors, and when caregivers are injured, during the previous 24 hours — a step he believes the Brigham and other hospitals should take, too. “If it’s in real time, it causes people inside to pay the highest level of attention to what is going on,” he said.

Dr. Joshua Kosowsky, vice chairman for clinical affairs in the Brigham emergency department, said the Safety Matters newsletter grabs staff attention in a way other approaches to transparency do not. One issue featured a woman who waited in the emergency room for several hours with abdominal pain, and then left for another hospital, where she got an appendectomy.

“For a lot of staff throughout the hospital, a number is just a statistic,” he said. But discussing “a pretty dramatic experience” has helped change the culture in the emergency department, where “it has long been considered okay for patients to wait.”

The emergency department now gets most patients to a bed within 20 minutes and calls in extra doctors and nurses if patients are waiting too long, he said.

In another issue, employees who write the newsletter interviewed the wife of a patient who had muscle and kidney damage when a doctor overrode computer warnings about dangerous medication interactions. “It pretty much devastated my entire family,” the wife said in the newsletter. The hospital now requires the pharmacist and doctor to discuss side effects before prescribing these particular drugs.

The idea for Safety Matters came from Dr. Elizabeth Nabel, Brigham chief executive, and several other hospital leaders. She has said that one of her goals is to create a more open culture around medical errors, in which staff can report them and seek help without shame.

Last October, she led by example when she described to a hushed auditorium of doctors and nurses an error she made years ago at the University of Michigan.

She was repairing a patient’s aortic valve and punctured the left ventricle of the heart with a wire, causing significant bleeding and requiring the patient to undergo surgery, she told the audience.

“I felt very insecure and my confidence was shaken,” she said, noting that she was the only woman in the cardiac catheterization lab. “I can assure you there were a lot of men who didn’t want me to be there. This would only give fuel to their fire.”

Nabel could talk only to her husband about the case. “Think about how much easier it would have been if I could have talked to my colleagues rather than living in fear I would get stabbed in the back because I made this mistake,” she said. She said she disclosed the error to her patient, who eventually recovered.

Kachalia said caregivers involved in the errors are allowed to review the newsletter before it is published. Only one has objected to having a case included, and the hospital agreed.

Janet Barnes, executive director of compliance, said she initially was hesitant about the project, in part because she worried it would give lawyers ammunition for lawsuits. Staff in her office review the language in each issue to make sure it is factual and does not editorialize; for example; calling an event “horrible” or “terrible.”

“There’s definitely a balance,” she said. “We want people to know we are working to improve. But you want them to come here and feel safe and not come in the door and worry.”

Dr. Kathy Selvaggi, director of the Intensive Palliative Care Unit, was the doctor of the cancer patient whose transfer to Spaulding Rehabilitation Hospital went awry.

“When she had to come back, my heart sank,” Selvaggi said in an interview, describing her pain as “unbelievable.”

“We felt we let our patient down.”

Selvaggi said doctors and nurses from the Brigham and Spaulding immediately met to analyze what went wrong and devise improvements.

One problem was that the patient’s transfer was delayed. A translator needed to provide the patient discharge instructions was late, so the patient did not arrive at Spaulding until 5 p.m.

By that time, key Brigham doctors had left work and could not be reached by the Spaulding caregivers, who were confused by the Brigham’s medication instructions. When they finally figured out the correct drugs, they realized the doses were so high they were outside Spaulding’s policy. So the patient was sent back.

The Brigham made several changes, described in last April’s newsletter. They included not sending patients with complex pain regimens to Spaulding after 4 p.m., and requiring doctors, not just nurses, to speak by phone to review instructions in complicated cases.

Erin McDonough, the Brigham’s senior vice president of communication and public affairs, said stories like this one have more impact than statistics. “That was really our goal,” said McDonough, who helped develop Safety Matters, “to make it memorable so that it would stick.”

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