# ‘Disciplinary’ Case Study from Health Care

**Jack Davis**

**Chairman, CEO.Mobile Inc.**

**(former President & CEO, Calgary Health Region)**

# Preamble

## (former) Calgary Health Region (2004)

- **geographic area**
  - **39,260 sq km**
- **14 communities**
  - **12 acute care sites**
  - **40 care centres**
  - **7,836 beds/spaces**
- **healthcare providers**
  - **24,000 employees**
  - **2,150 doctors**
  - **3,917 volunteers**

# Outline

- **Part 1**
  - **Events of 2004**
- **Part 2**
  - **What did I do?**
  - **What was the outcome?**
  - **What effect did it have on the organization?**
- **Summary**

# Part 1: Events of 2004

- **Unexpected deaths of two ICU patients**
  - **undergoing continuous renal replacement therapy**
  - **potassium chloride (KCl) used instead of intended sodium chloride (NaCl)**
- **We could have had 34 deaths!**


ENTERTAINMENT

**JOLIE'S BAD VIBES**

How Angelina faces evil in new film

**Page D1**

Tvtimes


SPORTS

**FLAMES COLLECTOR POSTER INSIDE** Page E7

**Calgary stings Blue Jackets at 'Dome**

**Page E1**

CALGARY HERALD

SINCE 1883

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# Two patients dead in tragic error at Foothills hospital

**PROWSE** — Kathleen (
thleen (Kay) Betty Miller Pro
stice Hubert Prowse, passed
04, after a brief illness. Kath
20 in Moose Jaw, Saskatche
anadian. She spent her early year
aduating as a Registered Nurse fr
Vancouver, B.C. she moved to
re that she met the love of he
om she was married for forty

A death announcement for Kathleen Prowse ran in the Herald on March 9.

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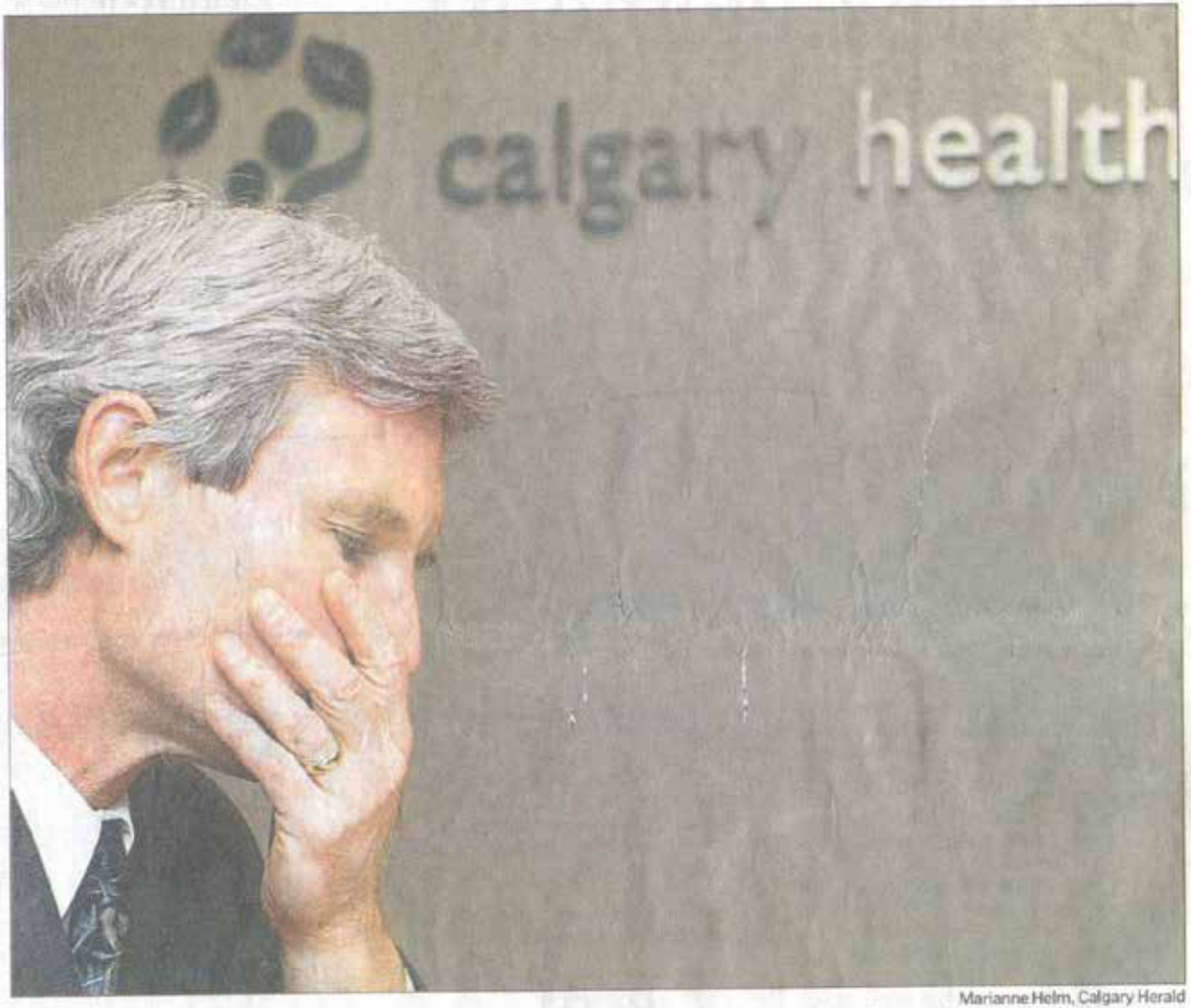


Marianne Helm, Calgary Herald

Dr. Richard Musto, executive medical director with the Calgary Health Region, speaks Thursday on a fatal drug mix-up.

# Victim matriarch of prominent legal family

■ Dialysis drug mix-up traced to pharmacy

■ Quick-thinking doctor prevented further fatalities

GWENDOLYN RICHARDS

MARIO TONEGUZZI
CALGARY HERALD

Two critically ill patients died recently at the Foothills Medical Centre after they were given an incorrect solution during dialysis treatment.

And Calgary Health Region officials are crediting an "astute" physician for immediately identifying the mistake, reacting quickly and preventing the possibility of many more deaths.

One of the patients has been identified as Kathleen Prowse, who came from a prominent Calgary legal family. She was married to Hubert Prowse, a former Court of Queen's Bench judge in Calgary.

The family did not want to talk Thursday.

Prowse and a middle-aged man, who died in late February, were given a potassium chloride solution instead of sodium chloride while in intensive care.

The error took place while

chloride rather than sodium

lawyer who practised in Leth-

and Judge Sharron Prowse-O'Ferrall still live in Calgary.

ALSO SEE
■ Liberals call for inquiry A4
■ Don Braid A5
■ Mistakes take toll A5
■ Tom Olsen A6

# Initial reaction: Shame & Blame

## Dialysis drug mix-up demands fatality probe

DON BRAID

OPINION

There's never a "right" victim in a tragedy like the CHR's lethal double blunder, but the wrong one has got to be Kathleen Prowse, widow of the late Judge Hubert Prowse.

Kathleen Prowse, 83, was the second person who died at Foothills intensive care units after being given the wrong drug.

She is the one who could have been saved, if only the CHR had realized the first person was killed by an improperly mixed medication.

This Prowse family is well known in judicial offices around town, including that of Judge Manfred Delong, who delivered last year's fatality inquiry report that blistered the health region in the death of Vince Motta.

Three years earlier, Judge Brian Stevenson, the head of DeLong's provincial court, presided over the fatality inquiry in the case of 10-year-old Maren Burkhart.

Kathleen Prowse's daughter, Sharron Prowse O'Ferrall, is a family and youth court judge in Calgary. Another daughter, Maureen Prowse, is a doctor in Rancho Mirage, Calif.

Hubert Prowse was a Court of Queen's Bench justice. Delong and Stevenson are in provincial court. But Calgary's court community is a small world with deep bonds and tight loyalties.

When a fatality inquiry into these latest deaths is inevitably held, the biggest challenge will be finding a local judge who didn't know the Prowse family.

By all accounts, Kathleen Prowse was a warm, energetic

Calgary's medical and legal systems. And she died because of one of the most dreadful medical mistakes ever revealed in Alberta, or all of Canada.

A fluid was improperly mixed in the pharmacy. Two types, one lethal to these patients, one beneficial, were stored in nearly identical containers very close to each other.

That's a practice that shouldn't be tolerated in the chemical section of a hardware store, let alone a hospital pharmacy.

It took a sharp doctor to suspect what was wrong when Kathleen Prowse died.

She had too much potassium in her blood, and the physician ordered a check of the medication.

Several days before, the same batch of medication had killed a middle-aged man. No checks were done, because his

Vince Motta

Maren Burkhart

condition could have produced a high [illegible] level.

[illegible] Johnston, the CHR's chief medical officer, almost cried when he said how sorry everyone is at the CHR.

His pain was utterly genuine, but it can't begin to compare to the grief of families who lost their loved ones to incompetence.

A public fatality inquiry isn't mandatory in this case, but it's hard to see how the province could fail to call one.

The Burkhart case led to an inquiry after the girl died of septic shock resulting from complications of appendicitis.

Her family had taken her away from emergency rooms because of lineups, accusing the system of overcrowding and slow care.

Vince Motta, 23, died Jan. 2, 2001, of an asthma attack after twice leaving crowded Calgary emergency rooms before being seen.

Delong's subsequent report gave the CHR the worst scolding in its history, but not because of medical care.

The judge was furious because he thought the CHR had obstructed his inquiry by stalling and failing to produce documents.

Despite the CHR's constant public relations assurances, he said, emergency care was getting worse instead of better.

Now the CHR says that in revealing the two deaths by medication, it's being open and transparent.

It's a heck of a way to start.

A fatality inquiry into this disaster — the CHR's third major probe in six years — won't be asking if the system killed people, only how.

[illegible]@[illegible].com

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EXCLUSIVE

Pharmacy staff to answer for deaths

■ Health region boss Jack Davis vows those responsible will be held accountable

DON BRAID
CALGARY HERALD

Calgarians can have "complete confidence" they'll get excellent treatment from staff in local hospitals, Calgary Health Region boss Jack Davis says.

At the same time, Davis pledged that those responsible will be held accountable for pharmacy errors that cost the lives of two dialysis patients at the Foothills hospital.

"I am an absolute believer in a very high level of accountability for people in health care," said Davis, the health region's chief executive officer.

"So the short answer is, 'Yes, there will be accountability.' " Davis said Saturday in an exclusive Herald interview.

"But it's also very important to strike the right balance between individual actions and system design and performance.

"Our whole objective is to improve the system, and improve the confidence of the people working in it.

"Yet individual accountability is crucial, and all our healthcare providers would say that, too."

Davis pleaded for the public to understand that the deaths, although "tragic," are isolated

ALSO SEE

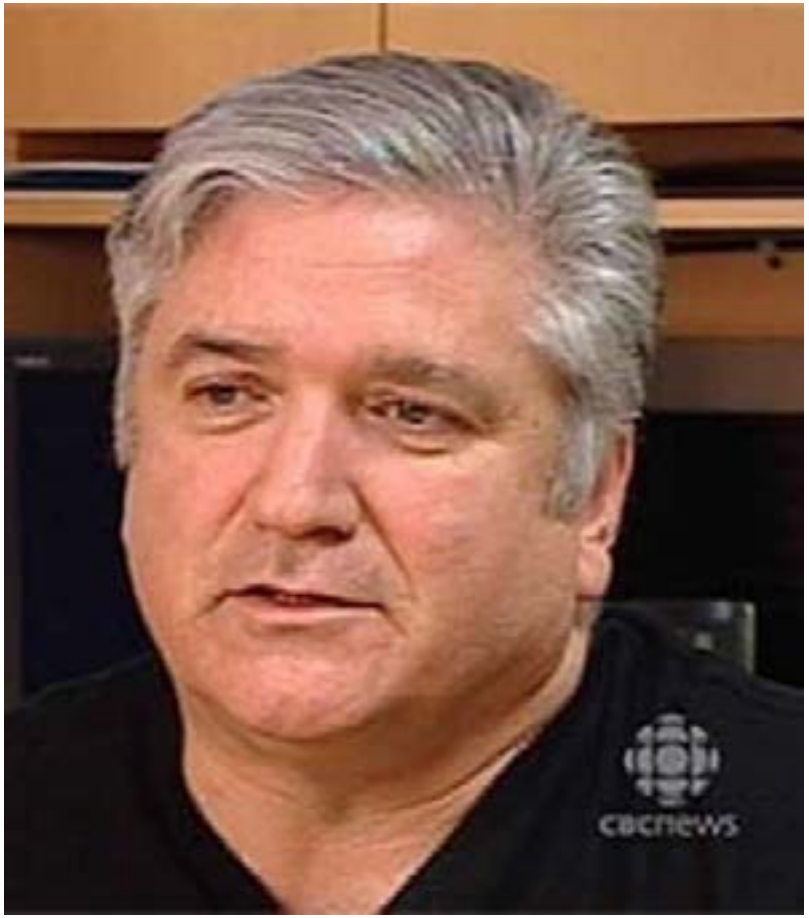
■ Expert urges pharmacy overhaul A3

■ Health region officials respond to 2000 error A3

# Pharmacy staff to answer for deaths

**Health region boss Jack Davis vows those responsible will be held accountable.**

# Part 2: What did I do?



# Facing up to double jeopardy

JOHN GRADON

OPINION

He, she or they is or are out there, somewhere in Calgary or its immediate environs, today suffering agonies and despair, the depth of which the rest of us can only guess.

The after-the-fact remorse and sense of guilt, whether those suffering the emotions are singular or plural, must be simply overwhelming.

And so, simply because we are fellow human beings, there is sympathy for those involved in two unfortunate, unnecessary deaths at Foothills Medical Centre in addition to that for the bereaved families.

After all, no one, except maybe professionals in other far darker areas of life, sets out to work in the morning to deliberately cause death.

Nevertheless ....

The lab technician or technicians involved in the fatal errors that led to 83-year-old Kathleen Prowse and, as the Herald learned Sunday, 53-year-old Bart Wassing of Strathmore, being given a deadly fluid containing potassium chloride instead of sodium chloride must — and, according to Calgary Health Region chief Jack Davis, will — be held accountable.

The degree of that accountability is clear.

A head or heads have to roll. It's simply a matter of justice, of public safety and public confidence.

In an interview with Herald columnist colleague Don Braid during the paper's coverage of the awful affair that is a tragedy for all concerned, the University of Calgary's Dr. Norm Schachar, a surgeon and leading authority on patient safety, makes some fascinating points on that issue.

He asks: "What are we going to do? Hang a pharmacist?

"Somebody else would take over and the bottles would still be the same and eventually it would happen again.

"If the focus is on finding someone to blame, someone to hang, the systems won't be fixed."

Ah, there's the rub.

SEE GRADON, PAGE B4

**A head or heads have to roll. It's simply a matter of justice, of public safety and public confidence.**

# What I started to do

- Considered disciplining in accordance with expectations
  - To calm the noise in media
- Listened to advice
  - Legal
  - Insurance
  - Medical professionals
  - Safety experts

# A fork in the road

- **The press was calling for ‘blood’**
- **My rethinking**
  - **‘You can’t run your life by catering to the media.’**
- **My experts were saying**
  - **“This has happened before; there are methodologies to sort this out. Let’s get going!”**
- **My thought**
  - **They had science and insight behind what they were saying – not making it up.**

# A cold weekend day in the spring

- A walk in the snow led to a decision
  - "Somebody else could be making the same error elsewhere…."
- What should we do?
  - What would make the system better?
  - What would save lives?
  - What would alleviate pain & suffering?
- When you line it up that way
  - There are no other options!

# What we'd done well by that time

- **Full disclosure with family**
  - **explained all the facts**
  - **rare at that time**
- **Shared problem with other HC systems**
  - **to avoid other deaths**
  - **also rare at that time**
- **Went public: held news conference**
  - **were open, honest & transparent**

# What I did

- **Dealt with Pharmacy Technicians**
  - **off with pay during the 3 investigations**
  - **given counselling**
  - **not disciplined or blamed**

# Part 2: What was the outcome?

# Allocation of resources

- **An individual at the Executive Level**
  - **with appropriate authority**
  - **responsible & accountable**
- **$ 5M CAD of $5B CAD budget**
  - **HAVE to budget for safety!**
  - **Relatively modest investments**
  - **Most good things relatively inexpensive**

# Some of ‘WHAT’ we did

- Board Committee for Safety
- Safety Department, with a VP & $
- Code of Conduct
- 4 related policies
  - Disclosure
  - Reporting
  - Informing
  - Just & Trusting Culture
- Safety briefings before meetings
- Reporting software
- Patient Family Advisory Council
  - Active member of Region’s Safety Committee

# Our culture was the problem


- **Hierarchical**
- **Individual responsibility**
- **No sense of system**
- **Organised for failure**
- **Shame & blame**

# System needed to change

- **If a system is inappropriately punitive**
  - **Takes energy to suppress negative feelings**
  - **Contributes to low morale & low energy**
  - **If your energy is low, you can’t care**
- **Needed: appropriately non-punitive system**
  - **Just and trusting culture**
  - **More energy: Cross-over conversations**
  - **Focused on family centred care**
- **The whole system will improve!**

# Part 2: Effect on organization?

# Blinding light of the obvious

**We have the teams and the expertise to solve these problems!**

# From need to effect!

- **Aim was to change the culture**
  - **Amended the Code of Conduct**
  - **Instituted Just & Trusting Culture Policy**
  - **Changed how we approached accountability**
- **People were**
  - **happier & more engaged**
  - **ready to improve the safety of the system**

# Deb Prouse & Steve Long

# Gave people confidence

- If something goes wrong
  - It's usually NOT about the individual being incompetent and / or needing punishment
  - Generally it's a failure in the system that needs to be addressed

# Just & Trusting Culture Policy

| Policy | |
|---|---|
| Subject/Title<br>**Just and Trusting Culture** | Reference Number:<br>**1628** |
| | Effective Date:<br>**2006/10/18** |
| Approving Authority:<br>**Executive Management** | Date Revised: |
| Classification:<br>**Patient Safety Management** | Last Review: |
| | Next Review:<br>**2008/10/18** |

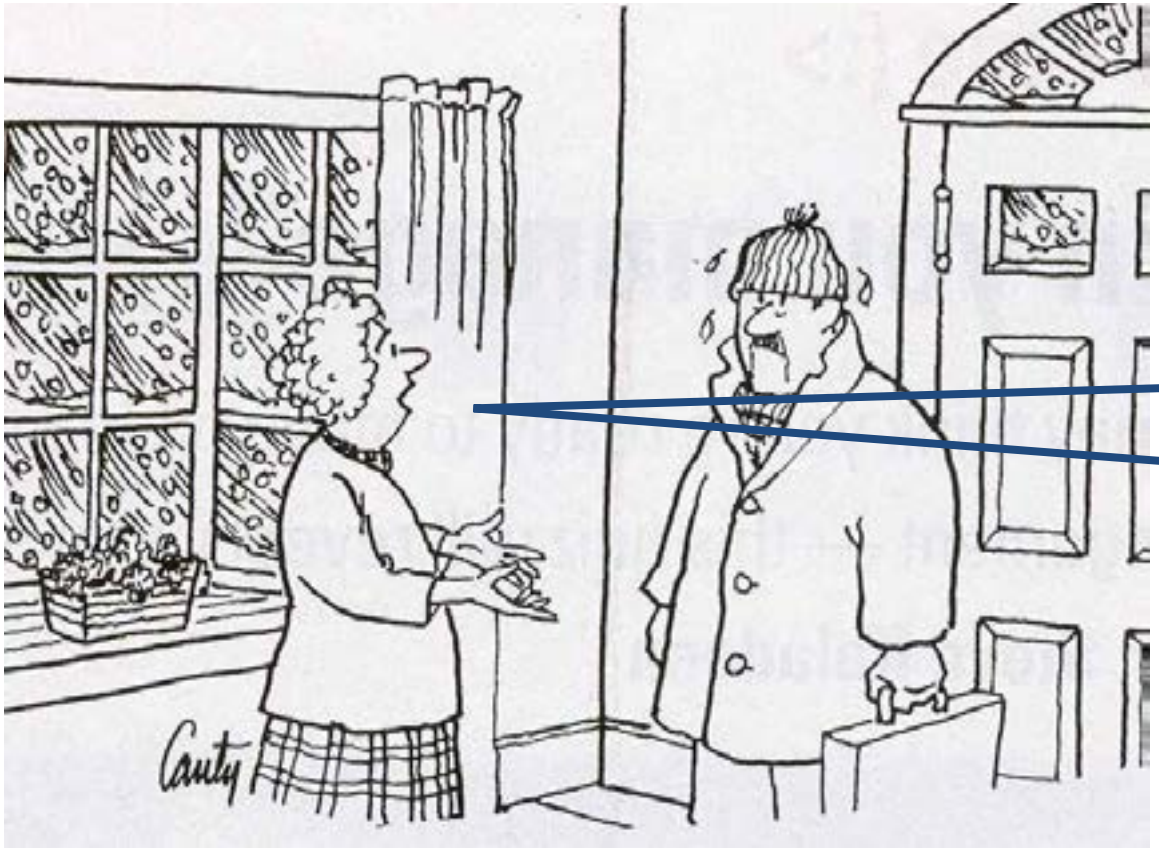
- **ERRORS – when there has been failure in the provision of care to a patient and the health-care provider did not deviate from established policies, procedures, standards or guidelines, then the health-care provider will not be disciplined by the Region.**

# Summary (1)

- **The mission of healthcare**
  - **Saving lives**
  - **Avoiding unnecessary pain & suffering**
  - **Improving the quality of life**
- **Take everything back to these points**
  - **These are the reasons we work in healthcare**
- **Doing the right thing is easier than you think!**

# Summary (2)

## Leadership - a critical success factor




**“The hospital sent non-essential personnel home? But you’re the CEO.”**

# Acknowledgements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  - **Ward Flemons MD FRCPC**
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  - **Carmella Steinke RRT MPA**