TRANSCRIPTION

cpsi Canadian Patient Safety Institute
iscp Institut canadien pour la sécurité des patients
Steve Long
Pharmacist

Steve Long: [0:00:09] My name's Steve Long. We're going to take me back to 2004, when I was the director of pharmacy at the Calgary Health Region and responsible for all pharmacy services for the hospitals within the city of Calgary.

Deborah Prowse
Patients for Patient Safety Canada

Deborah Prowse: [0:00:23] I'm Deborah Prowse. And in 2004, I was a family member for my mother that was in hospital. We're here together because the partnership between patients and providers should extend throughout their care to when adverse events occur so that we can go from harm to healing. My mom died as a result of a series of adverse events that led up to the ultimate event that took her life.

[0:01:00] She'd had two medical stays in hospital and both occasions, there were things that didn't go well. On the last occasion, she needed to be put on to dialysis assistance. She received dialysate that was accidentally made of potassium chloride instead of sodium chloride. And this led to her passing.

Steve Long: [0:01:30] The incident with Deb's mother occurred on a Friday afternoon. It was the same as any other Friday, only the pharmacist that was working in the critical care unit came downstairs and said, “You know, we've had a mix up with the dialysate solution. They've taken it to the blood gas lab and they've determined that there's potassium chloride in it. There shouldn't be potassium in it.” We went back to our manufacturing records, check the lot number on the bottle and discovered that, yes, the lot number that was associated with the preparation of that batch of dialysate was, in fact, prepared with potassium chloride. Stated that to the physicians in ICU.

[0:02:23] Later that evening, I got a second call from the physician. The call was from the physician that was working in the ICU. And he essentially stated, “You've killed my patient. What are you going to do about it? How are you going to ensure it never happens again?”

[0:02:42] I had been the director of pharmacy in Calgary for almost 20 years at that point. Never had I dealt directly with an error or an incident of this magnitude. We had recently opened Central Pharmacy. We had designed it. We were aware of the quality and safety

movement and how we could change process to reduce the risk of error. And yet, here in this new facility that was designed to make patients safe, we had done the ultimate damage. We had killed two patients, Deb's mother, and as we found, another patient by looking back.

Deborah Prowse: [0:03:21] Patients and family members have to trust that their care is going to be of high quality and safe. And when things go wrong, historically, there hasn't always been transparency and openness about admitting that. And that is an affront to a trusting relationship. So it's very important that when things go wrong, that there is disclosure of what happened. And three parts of disclosure is the acknowledgment that something happened, the apology, and then the action to ensure that it doesn't happen again. Patients, I think, for the most part, believe health care providers come to work with good intentions and the desire to do well and to care for patients. Sometimes that doesn't go well. I think the greatest fear is that it will be covered up if something goes wrong.

Steve Long: [0:04:33] The region, as Deb has said, decided that we would disclose to the families the cause of death and disclose to the public that the error had occurred. We ended up, as a result of that, on the front page of the newspapers in Calgary for 21 days, three weeks. And it was only ended as the three outside experts were called in to do a full review of the case, much like as a plane crash or a train derailment inquiry. It was gone there.

[0:05:09] What's the first thing that’s shown on the national news is the vial of sodium chloride with its blue cap and the vial of potassium chloride with its purple label and the clipping in the paper. “Don't those dummies know? Blue is good and purple is bad, and they shouldn't mix the two up.” The bottles were almost identical, and the compounding facility that we were working in, the labeling on the box was very nondescript.

[0:05:34] Essentially, we were just trying to cope with all the things that were going on in that immediate period, trying to understand ourselves what happened, trying to keep the operation going, because we still had 2,500 patients in hospital beds that required our due care and attention and expertise to prepare the products that they needed to make them well again. And yet, we're doing it in this environment of distrust, where everything that we prepared, everything that we produced, was questioned, was challenged, whereas before, none of that had gone on.

[00:06:13] So fear, disappointment, humiliation, failure. All of those thoughts were running through my mind as we were going through that immediate period. There was an assistant, three technicians that were involved in the preparation of the product. We believed we had a number of double checks in the system that would prevent errors from occurring and products from getting far. I did a review of the procedures that day and wrote a report, submitted that to my boss. Then my boss came in and sat down with the staff and all that were involved and walked through the process, wrote the report, submitted it. That wasn't accepted.

[0:06:56] The quality and safety people then were invited to the department to do a review of the process and take that forward. That wasn't good enough. An external agency then was called upon to do a review. And so through this whole period, initially the staff stayed at work because it was recognized that the error was a substitution error, something that actually occurs fairly frequently, however, doesn't result in the catastrophic events that occurred in this instance. But as time went on, and as we got further into the review and the pressure mounted in the public sphere, the decisions were made that the staff would be sent home without pay. And so we isolated them totally from the organization and left them out there hanging, wondering whether or not they would continue to be employed or be let go.

Deborah Prowse: [0:07:52] Adverse events affect both patients and providers in very significant ways. I think it's important to have policies and programs or processes that offer support to family members to ensure that they're getting grief support and that the same is offered to providers to ensure that both of us are on a path to healing.

Steve Long: [0:08:19] So one of the things that challenged me to move beyond the air was the fact that we were never given the opportunity just to say the simple thing, that we were sorry, that it wasn't our intent to harm.

Deborah Prowse: [0:08:33] And it was about two years later when I had become involved in the Patient Family Safety Council for the Calgary Health Region. And Steve was involved in a quality council. And a person that we knew that sat on both councils actually made the overture to bring us together. And we had that meeting. And it was from the very moment that we were both in the same room that it felt complete. It felt like the circle had now come around and that we were able to sit and talk about what happened and talk about the impact it had on both of us and what we had gone through that was so similar.

[0:09:25] And following that, they went on to develop four safety policies: disclosure after harm, reporting, informing the public, and the just and trusting culture. That marked a huge change of patient safety in the province of Alberta. And because of the national highlight that these events got, it also started to change the conversation nationally about disclosure.

Steve Long: [0:09:54] After the error and after credibility was lost. I mean, the one piece that I never had closure on was, we never had a chance to say we were sorry. You know, we had caused this great harm. And we know we've done it and we didn't feel very good about it. As we've said earlier, you know, we don't show up at work every day to do harm. We show up to hopefully help people and improve things.

[0:10:28] If you haven't had a medication error or haven't caused harm, it's not because you're an exceptional provider; it's you've been lucky. Secondly, I guess one of my biggest regrets is that I don't know that I checked in enough on my staff to see how they were doing to ensure they got the support that they needed. And then the third thing I would

say is make sure you take care of yourself. Take clues from family, from coworkers, from others, and seek help. I waited far too long before I sought professional help.

Deborah Prowse: [0:11:00] I think Mom would be very pleased that she didn't die in vain, that there has been significant impact as a result of her death. And I think one of the things that has kept me going in the last ten years is the number of providers that have come up after a presentation and said, “You've impacted me. I'm going to do something different as a result of hearing your story.”

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